

**A GUIDE FOR ACCREDITATION REVIEWS AIMED AT
QUALITY ASSURANCE IN SOUTH AFRICAN
UNDERGRADUATE MEDICAL EDUCATION AND
TRAINING**

by

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DECLARATION

I hereby declare that the work submitted here is the result of my own independent investigation. Where help was sought, it is acknowledged. I further declare that this work is submitted at this university for the first time, and that it has not been submitted at any other institution for the purposes of obtaining a degree.

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ABBREVIATIONS AND ACRONYMS USED

AMC	Australian Medical Council
BNQP	Baldrige National Quality Program (USA)
CACMS	Committee on Accreditation of Canadian Medical Schools
CHE	Council on Higher Education (RSA)
CHEA	Center for Higher Education Accreditation (USA)
COHSASA	Council for Health Service Accreditation of South Africa
DEI	Danish Evaluation Institute
EMC	Education and Registration Management Committee (of the MDPB)
EQA	External quality assurance
EU	European Union
GMC	General Medical Council (United Kingdom)
HEQC	Higher Education Quality Council (UK)
HEQC	Higher Education Quality Committee (RSA)
HPCSA	Health Professions Council of South Africa
IIME	Institute for International Medical Education.(USA)
JAMA	Journal of the American Medical Association
JUAA	Japanese University Accreditation Association
LCME	Liaison Committee on Medical Education (USA)
M.D.	Doctor of Medicine (USA)
MDPB	Medical and Dental Professions Board (RSA)
ME	Medical education
NAAC	National Assessment and Accreditation Council (India)
NHS	National Health System (UK)
NQF	National Qualifications Framework (RSA)
PRHO	Pre-registration House Officer (UK)
QA	Quality assurance
QABME	Quality assurance in basic medical education (UK)
RSA	Republic of South Africa
SA	South Africa
SAQA	South African Qualifications Authority
UET	Sub-committee for Undergraduate Education and Training (sub-

	committee of the MDPB)
UK	United Kingdom
USA	United States of America
WFME	World Federation for Medical Education
WHA	World Health Assembly
WHO	World Health Organisation

SUMMARY

Key words:

Quality assurance; medical education; accreditation; standards; rubrics and rating scales; qualitative research; interviews; participant observation; guide for accreditation reviews; planning undergraduate medical education.

Quality assurance is not something new to higher education, but recent years have seen an increase in the interest in the quality of education, mainly due to demands for accountability. This study was conducted to investigate the phenomenon of quality assurance in higher education with special reference to accreditation as quality assurance measure in undergraduate medical education, and to develop a guide for accreditation reviews.

Quality assurance as it manifests in a number of higher education systems in different countries was studied. It was found that social and economic demands, an increase in and a changed student population have contributed to a renewed emphasis on quality, that is, effectiveness and efficiency, in higher education. Medical education could not escape the demands for quality assurance. Recent publications on medical education stress the necessity for change and innovation in medical education, and a concomitant need for measures to ensure that the education and training students receive are of a high standard.

In many higher education systems accreditation is used as a quality assurance mechanism. Accreditation is defined as a process of external quality review used to scrutinise institutions and their programmes to ensure quality in the offerings and to encourage quality improvement. The process of accreditation usually entails a self-assessment by the institution (internal evaluation), followed by an external review conducted by a panel of peers with a view to verifying the findings of the internal assessment. Accreditation usually also has a dual goal, namely to ensure quality and to promote quality.

In South Africa the Health Professions Council through the Sub-committee for Undergraduate Education and Training (UET) of the Medical and Dental Professions Board is the professional body responsible for quality assurance in medical education

and this is brought into effect through a process of accreditation of medical education programmes. The first accreditation reviews took place in 2001, and by the end of 2004 all medical faculties/schools had been subjected to at least one accreditation review visit. The process was based on sound studies and apparently served its purpose well. As different panels comprise different members, however, there is no comparability in the accreditation reviews. Each member, it is perceived, approaches the process from his/her own frame of reference, as no fixed set of standards exists to ground the evaluations. Although panel members are experienced and experts in their disciplines, they are not necessarily experts in the field of modern medical education, and may hold disparate views on what quality in education entails. Therefore, specific standards in terms of which a quality appraisal can be done are required in an accreditation process. Involvement of the researcher in the accreditation process of the UET led to the research problem being identified, namely a lack of a review guide that might be used in the appraisal of medical education programmes and the institutions that offer them. In this study it was assumed that a guide for accreditation reviews, containing standards with rubrics and criteria to use as a measurement tool, would serve well to render the accreditation process more objective and structured, thereby contributing to ensuring quality in medical education in South Africa. Such a guide, it was presumed, would also be useful in the planning processes of medical schools/faculties, especially with a view to quality improvement as well as in the internal self-evaluation, and would contribute to better preparation for the external accreditation review.

As background to the study an extensive literature review was conducted to investigate the phenomenon of quality assurance. Quality assurance in higher education *per se* and in medical education specifically was studied; accreditation as quality assurance mechanism and the role standards have to play in quality assurance mechanisms were attended to, and tools used in quality assurance processes were put to scrutiny. The standards that apply in various quality assurance systems in higher and medical education received special attention during this phase of the study, as these were used as point of departure when the draft guide for accreditation reviews was compiled. The accreditation process of the MDPB of the HPCSA, as implemented by the UET was studied in detail to gain a complete picture of the process as it manifests in South Africa.

A qualitative research design was employed and a phenomenological descriptive and

exploratory approach was followed. The methods employed for data collection included participant observation, individual interviews and a focus group interview, while a literature study provided the required grounding and background.

As the researcher has been involved in the quality assurance process since its inception, participant observation and emanating field notes played an important part in the study. This was amplified with information collected from literature. A draft guide for accreditation reviews in undergraduate medical education in South Africa was compiled based on the information collected. In this guide it is proposed that medical schools/faculties in South Africa should compile a portfolio to serve as evidence of the quality of their teaching and training. The portfolio, it is recommended, should be a (mainly) computer-based document with links to appropriate sites, and should comprise two parts: (i) an overview of and background information on the school/faculty, and (ii) an indication of the extent to which the school/faculty satisfies the standards in the *Standards for accreditation* part of the guide, supplemented by a list of materials (links) to substantiate the response. The proposed use of the guide by medical schools/faculties and the accreditation review panels is described, and the remainder of the document consists of a set of standards for undergraduate medical education with rubrics and rating scales for use by the medical school/faculty and the accreditation panel.

The rubrics are set out in three levels, namely a minimum level, higher level and highest level, requiring the evaluator to indicate for each standard the level at which the school/faculty is in compliance with the standard. It is recommended that each school/faculty in the self-evaluation rates itself in terms of the rubrics. This rating together with the completed portfolio and evidence cited is then submitted to the accreditation review panel, and each panel member rates the school/faculty/ programme individually. The individual ratings and that of the institution are used to structure the subsequent on-site visit. During the visit the panel then verifies the self-evaluation response, and brings out a joint rating of compliance with the standards, together with a report containing recommendations and comments.

The draft *Guide for accreditation reviews* was used as research instrument in the empirical study. Individual interviews were conducted with six deans/heads of medical

schools or their representatives and four former members of accreditation review panels to gauge their views and opinions on the draft guide and to gain their perspectives of the phenomenon under study. Following the individual interviews a focus group interview was conducted with seven members of the UET to collect their opinions and perspectives. The interviews were conducted in a positive spirit and the interviewees were enthusiastic about the possibility of using the proposed guide for accreditation reviews.

The data collected during the interviews were analysed in terms of a data analysis spiral for use in qualitative studies. The data provided the researcher with a clear view of the respondents' perspective of the phenomenon and their opinions on the draft guide. Based on the findings, the draft guide was adapted to incorporate recommendations made by the respondents. The findings were compared to the findings of the literature review in a literature control.

In the final analysis it was found that the participants regarded the current accreditation process as unstructured and rather subjective, and supported the idea of the use of the proposed guide for accreditation reviews, as well as for planning and quality enhancement purposes in medical schools/faculties. The assumption thus could be accepted on the basis of the opinions of the participants in the study, namely that a guide for accreditation reviews would address the research problem, that is, a lack of a tool or mechanism to use in accreditation review evaluations. The use of this guide, it was found, has the potential to render accreditation reviews more structured and more objective, as panel members would no longer conduct evaluations based on their individual frames of reference or background, but on a common set of standards and criteria as set out in the rubrics. This will bring comparability to the accreditation process. The guide will also satisfy the second goal of accreditation, namely improvement of quality, as schools/faculties will be encouraged to strive for higher levels in the evaluations.

It is hoped that this proposed *Guide for accreditation reviews* will receive attention from medical educators, planners and the accreditation body, that the information and perspectives on quality assurance and accreditation presented in the study will contribute to a better understanding of the phenomenon of quality assurance in

education, and that the information and newly constructed knowledge in the study will be applied to the benefit of quality assurance in medical education in South Africa.

As final outcome of the study a *Guide for accreditation reviews* is presented, with the recommendation that it be brought to the attention of the accreditation body for South African undergraduate medical education and training, with a view to implementation as part of the accreditation process. It is also recommended that it be considered for use as planning guideline for medical education programmes, as it has the potential to enhance innovation and improvement in medical education and to be used as benchmarking instrument.

OPSOMMING

Sleutelwoorde:

Gehalteversekering; mediese onderwys; akkreditasie; standaarde; metingsgidse en beoordelingskale; kwalitatiewe navorsing; onderhoude; deelnemerobservasie; gids vir akkreditasie-evaluerings; beplanning van voorgraadse mediese onderwys.

Gehalteversekering is geensins iets nuuts in hoër onderwys nie, maar oor die afgelope aantal jare was daar 'n toename in belangstelling in die gehalte van onderwys, hoofsaaklik as gevolg van eise om rekenpligtigheid. Hierdie studie is uitgevoer om die fenomeen van gehalteversekering in hoër onderwys te ondersoek, met spesifieke klem op akkreditasie as gehalteversekeringsmeganisme in mediese onderwys, en om 'n riglyn vir akkreditasie-evaluasies daar te stel.

Gehalteversekering soos wat dit in verskillende hoëronderwysstelsels in verskeie lande manifesteer, is bestudeer. Dit is gevind dat sosiale en ekonomiese eise, 'n toename in en 'n veranderde studentepopulasie bydra tot hernude klem op gehalte, dit wil sê, effektiwiteit en doeltreffendheid, in hoër onderwys. Mediese onderwys kon nie aan die eise om gehalteversekering ontkom nie. Onlangse publikasies oor mediese onderwys beklemtoon die noodsaaklikheid van verandering en innovering in mediese onderwys, met die meegaande noodsaak van maatreëls om te verseker dat studente onderwys en opleiding van hoë standaard ontvang.

In baie hoëronderwysstelsels word akkreditasie as gehalteversekeringsmeganisme gebruik. Akkreditasie word gedefinieer as 'n proses van eksterne gehalteversekering wat ten doel het om instellings en die programme wat hulle aanbied te ondersoek om die gehalte van die aanbiedings te verseker en uit te bou. Die akkreditasieproses behels gewoonlik 'n selfevaluering deur die instelling (interne evaluering), gevolg deur 'n eksterne evaluering uitgevoer deur 'n paneel eweknieë met die oog op die verifiëring van die bevindinge van die interne evaluering. Akkreditasie het gewoonlik ook 'n tweeledige doel, naamlik gehalteversekering en –bevordering.

In Suid-Afrika is die Gesondheidsberoeperaad van Suid-Afrika deur die Subkomitee vir Voorgraadse Onderwys en Opleiding (UET) van die Mediese en Tandheelkundige Beroepsraad die professionele liggaam verantwoordelik vir gehalteversekering in

mediese onderwys, en wel deur 'n proses van akkreditasie. Die eerste akkreditasie-evaluerings het in 2001 plaasgevind, en teen die einde van 2004 het al die mediese skole/fakulteite ten minste een akkreditasiebesoek ontvang. Die proses is gegrond op deeglike studies en beantwoord oënskynlik aan sy doel. Aangesien ander lede egter telkens in die paneel dien, is vergelykbaarheid van die evaluering nie moontlik nie. Die persepsie bestaan dat elke paneellid die proses volgens sy/haar eie verwysingsraamwerk benader, aangesien daar geen bepaalde standaard gestel is aan die hand waarvan die evaluering uitgevoer kan word nie. Alhoewel die paneellede ervare is en deskundiges is in hul dissiplines, is hulle nie noodwendig deskundiges op die terrein van moderne mediese onderwys nie, en mag hulle uiteenlopende sienings huldig oor wat gehalte-onderwys behels. Spesifieke standaard word dus benodig vir gehalteversekerings-evaluering.

Betrokkenheid van die navorser in die akkreditasieproses het daartoe gelei dat die navorsingsprobleem geïdentifiseer is, naamlik die gebrek aan 'n gids of riglyn wat aangewend kan word in die evaluering van voorgraadse geneeskundeprogramme en die instellings wat dit aanbied. Die aanname is gestel dat 'n gids vir akkreditasie-evaluering wat standaard en metingsgidse (*rubrics*) met kriteria behels, en wat aangewend kan word as metingsinstrument, daartoe sal lei dat die akkreditasieproses meer objektief en gestruktureerd sal wees, en dus sal bydra tot gehalteversekering in mediese onderrig in Suid-Afrika. Daar is van die veronderstelling uitgegaan dat sodanige gids ook nuttig sal wees in die beplanningsprosesse van mediese skole/fakulteite, veral met die oog op die uitbouing van gehalte in onderwys en die interne selfevaluerings, en dat dit ook sal bydra tot beter voorbereiding vir eksterne gehaltebeoordeling.

Om as agtergrond vir die studie te dien, is die fenomeen van gehalteversekering in 'n uitgebreide literatuurstudie ondersoek. Gehalteversekering in hoër onderwys in die algemeen en in mediese onderwys in die besonder, is bestudeer; akkreditasie as gehalteversekeringsmeganisme en die rol van standaard in gehalteversekeringsmeganismes het aandag verkry, en instrumente wat in gehalteversekeringsprosesse gebruik word, is onder die loep geneem. Die standaard wat in verskeie hoër- en geneeskunde-onderwyssisteme gebruik word, het besondere aandag geniet, aangesien dit gebruik is as vertrekpunt toe die konsepgids vir akkreditasie-evaluering opgestel is.

Die akkreditasieproses van die Mediese en Tandheelkundige Beroepsraad van die Gesondheidsberoeperaad van Suid-Afrika, soos uitgevoer deur die Subkomitee vir Voorgraadse Onderwys en Opleiding (UET) is in besonderhede bestudeer om 'n geheelbeeld te kry van hoe die akkreditasieproses in Suid-Afrika manifesteer.

'n Kwalitatiewe navorsingsontwerp is gebruik en 'n fenomenologiese beskrywende en eksplorerende benadering is gevolg. Die metodes wat aangewend is vir data-insameling was deelnemerobservasie, individuele onderhoude en 'n fokusgroeponderhoud, terwyl die literatuurstudie die nodige begroning en agtergrond verskaf het.

Aangesien die navorser van die begin af betrokke was by die akkreditasieproses, het deelnemerobservasie en voortspruitende veldnotas 'n belangrike rol gespeel in die studie. Dit is aangevul deur inligting verkry uit die literatuur. 'n Konsep-gids vir akkreditasie-evaluering in voorgraadse mediese onderwys in Suid-Afrika is saamgestel, gebaseer op die inligting wat versamel is. In die gids word voorgestel dat mediese fakulteite/skole in Suid-Afrika 'n portefeulje saamstel wat kan dien as bewys van die gehalte van onderrig en opleiding. Dit word aanbeveel dat die portefeulje 'n (hoofsaaklik) rekenaargebaseerde dokument moet wees met verwysings (koppelings) na toepaslike webtuistes. Die portefeulje sal uit twee dele bestaan: (i) 'n oorsig en agtergrondinligting oor die skool/fakulteit, en (ii) 'n indikasie van die mate waartoe die skool/fakulteit voldoen aan die standaard gestel in die *Standards for accreditation* (Standaard vir akkreditasie), aangevul deur 'n lys van (verwysings na) materiaal om die response te bevestig. Die beoogde gebruik van die gids deur mediese fakulteite/skole en akkreditasiepanele word beskryf, en die res van die dokument bestaan uit die stel standaard vir akkreditasie-evaluering met metingsgidse en beoordelingskale vir gebruik deur skole/fakulteite en akkreditasiepanele.

Die metingsgidse val in drie vlakke uiteen, naamlik 'n minimum vlak, hoër vlak en hoogste vlak, en dit word van die evalueerder verwag om vir elke standaard die vlak aan te dui waarop die standaard bereik is. Elke skool/fakulteit moet sigself aan die hand van die skale beoordeel tydens die selfevaluering. Hierdie beoordeling, tesame met die portefeulje en bewysstukke (soos na verwys in die portefeulje) word dan aan die akkreditasiepaneel voorgehou, en elke lid van die paneel evalueer dan die skool/fakulteit/program individueel. Die beplanning van die akkreditasiebesoek word

dan rondom die individuele beoordelings en dié van die skool/fakulteit gestruktureer. Gedurende die besoek verifieer die paneel die selfevalueringsresponse, evalueer die mate waartoe daar aan die standaard voldoen is gesamentlik, en stel 'n verslag saam met aanbevelings en opmerkings.

Die konsep– *Guide for accreditation reviews* (Gids vir akkreditasie-evaluerings) is as navorsingsinstrument gebruik in die empiriese studie. Individuele onderhoude is gevoer met ses dekane/hoofde van mediese skole/fakulteite of hul verteenwoordigers, en vier voormalige lede van akkreditasiepanele om hul opinies en idees oor die konsepgids te toets en hul perspektiewe oor die fenomeen wat die onderwerp van die studie was, te bepaal. Na die individuele onderhoude is 'n fokusgroeponderhoud met sewe lede van die Subkomitee vir Voorgraadse Onderwys en Opleiding (UET) gevoer om hul opinies en perspektiewe te verneem. Die onderhoude is in 'n positiewe gees gevoer en die repondente was entoesiasties oor die moontlike gebruik van die voorgestelde gids vir akkreditasie-evaluerings.

Die data wat met die onderhoude ingesamel is, is ontleed aan die hand van 'n data-analisespiraal vir kwalitatiewe studies. Die data het die navorser 'n duidelike beeld gegee van die respondente se siening van die fenomeen en hul opinies oor die voorgestelde gids. Die bevindinge is tydens 'n literatuurkontrole vergelyk met uitsprake in die literatuur oor die tersaaklike aangeleentheid en die konsepgids is aangespas om aanbevelings wat deur die deelnemers gemaak is, te inkorporeer.

Dit is bevind dat die respondente die huidige akkreditasieproses as ongestruktureerd en redelik subjektief ervaar, en dat hulle die idee van die gebruik van die voorgestelde portefeulje en gids vir akkreditasie-evaluasies, beplanning en gehalteverbetering ondersteun. Die aanname kon dus op grond van die menings van die respondente aanvaar word, naamlik dat 'n gids vir akkreditasie-evaluasies die navorsingsprobleem, dit is, die gebrek aan 'n instrument vir die gebruik in akkreditasie-evaluasies, sou aanspreek. Dit is bevind dat die gebruik van die gids die potensiaal het om akkreditasie-evaluasies meer gestruktureerd en objektief te maak, aangesien paneellede nie meer in die evaluerings net op eie ervaring en verwysingsraamwerke aangewese sou wees nie, maar dat hul besluite op die stel standaard en meegaande metingsgidse (*rubrics*) en kriteria gegrond sou wees. Dit sal vergelykbaarheid binne die akkreditasieproses

moontlik maak. Die voorgestelde gids sal ook die tweede doel van akkreditasie help bereik, naamlik die verbetering van gehalte, aangesien skole/fakulteite aangemoedig sal voel om na hoër evalueringvlakke te strewe.

Daar word gehoop dat die voorgestelde *Guide for accreditation reviews* die aandag van mediese onderriggewers, beplanners en die akkreditasieliggaam sal geniet; dat die inligting en perspektiewe oor gehalteversekering en akkreditasie wat in hierdie verslag aangebied word, sal bydra tot beter begrip van die fenomeen van gehalteversekering in onderwys, en dat die inligting en nuut gekonstrueerde kennis wat uit die studie voortspruit, tot die voordeel van gehalteversekering in mediese onderwys in Suid-Afrika aangewend sal word.

As finale uitkoms van die studie word 'n gids vir akkreditasie-evaluering (*Guide for accreditation reviews*) voorgestel, tesame met die aanbeveling dat dit onder die aandag van die akkreditasieliggaam vir voorgraadse mediese onderwys gebring word met die oog daarop om dit te implementeer as deel van die akkreditasieproses. Dit word ook aanbeveel dat die gebruik daarvan as beplanningsriglyn vir mediese onderwysprogramme oorweeg word, aangesien dit die potensiaal het om innovering in mediese onderwys te bevorder en om as ykingsmeganisme (*benchmarking instrument*) aangewend te word.

CHAPTER 1

ORIENTATION TO THE STUDY

1.1 INTRODUCTION

*Quality ... you know what it is, yet you don't know what it is. But that's self-contradictory. But some things **are** better than others, that is, they have more quality. But when you try to say what the quality is, apart from the things that have it, it all goes **poof!** There's nothing to talk about. But if you can't say what Quality is, how do you know what it is, or how do you know that it even exists? If no one knows what it is, then for all practical purposes it doesn't exist at all. But for all practical purposes it really **does** exist. What else are grades based on? Why else would people pay fortunes for some things and throw others in the trash pile? Obviously some things are better than others ... but what's the "betterness"? ... So round and round you go, spinning mental wheels and nowhere finding anyplace to get traction. What the hell is Quality? What **is** it? (Pirsig 1999:184).*

When Pirsig published this "most widely read philosophy work, ever" (*The London Telegraph* in Pirsig 1999:xi) in 1974, the *New York Times* described it as "... profoundly important ... Full of insights into our most perplexing contemporary dilemmas" (Pirsig 1999: Back cover). Today, thirty years later, we can still ask: What is quality? Defining quality has remained a 'contemporary dilemma', as is the determination of the quality of any process or product.

Through this study it is by no means attempted to succeed even in a small way to do what caused the philosophic Pirsig so much "spinning mental wheels", namely to find a way in which to define quality, or find a way in which it can be determined without doubt. What the researcher does hope, however, to have succeeded in, is to have made a small contribution to the maintenance (no, not of motorcycles!) of standards in contemporary medical education and training in South Africa, and thereby to contribute to medical care. Medical education is at the heart of society's mental and physical well-being, because "in no other way does education more closely touch the individual than in the quality of medical education" (Pritchett 1910:xv). Flexner (1910:26) in his report, first published in 1910, wrote about the medical practitioner: "Upon him society relies to

ascertain, and through measures essentially educational, to enforce the conditions that prevent disease and make positively for physical and moral well-being. It goes without saying that this type of doctor is first of all an educated man.”

This now brings us to what lies at the bottom of this study: If it is so difficult to define quality, how can one assure that the education of our medical practitioners is up to standard, of good quality? To find an answer to this question, one has to move from the philosophical to the practical: By determining educational standards for the training of medical students, and providing those who have to decide whether the education students in South African medical schools receive, is quality education, with tools to employ in their deliberations on the quality and the standards of medical education.

1.2 BACKGROUND

The improved health of all peoples is the main goal of medical education (WFME 2003:3), and quality assurance in medical education is intended to ensure that future physicians attain adequate standards of education and professional training (Boelen, Bandaranayake, Bouhuijs, Page & Rothman 1992:5). Accreditation as a means of quality assurance is widely used in medical education systems, as in other higher education systems (*cf.* AMC 1998; Bezuidenhout 2002; HPCSA 1999a; LCME 1995). In the United States of America (USA) accreditation as a means of quality assurance is more than a 100 years old, emerging from concerns to protect public health and safety and to serve the public interest (Eaton 2002:1). In 1910 Henry S. Pritchett in the introduction to Abraham Flexner’s seminal work, *Medicine and society in America* (Pritchett 1910:viii) wrote “... the requirements of medical education have enormously increased. ... The education of the medical practitioner under these changed conditions makes entirely different demands in respect of both preliminary and professional training.” These sentiments are as applicable today as they have been almost a century ago. To ensure that the medical practitioners who are allowed into the profession are of a high standard, medical schools must provide their students with education and training of a high standard - “... in no other way does education more closely touch the individual than in the quality of medical training which the institutions of the country provide” (Pritchett 1910:xv). Society today still depends on medical schools to provide quality education and training.

Quality in medical education, however, is a complex issue - the philosophical mindset underpinning the culture prevailing in a society or at an institution offering medical education partly determines the mechanisms that are acceptable for quality assurance and improvement. Impacting factors in this regard are the value attached to the pursuit of excellence, the considerations of cost, humanitarian values, and other cultural norms, attitudes of staff towards change, and a willingness to change (Suwanwela 1995:S37). In medical education quality assurance goes hand in hand with the concepts of self-regulation and collegial control of academic quality. According to Dill (1999:318) an obvious necessary condition of all models of quality assurance in a profession is that “the members of a guild share a common body of knowledge and a set of strong tacit norms which influence professional behavior”; thus the assumption that standards can be defined and internally ‘controlled’ when professional norms are strong and a shared academic ethic exists (Bezuidenhout 2002:14).

For participants in education, quality has always been important, although frequently taken for granted; three major factors, however, have made education systems more aware of efficiency and effectiveness over the past decade or so, namely socio-economic changes, technological advances, and globalisation (Bazargan 1999:61). Traditionally the goals of the university were seen as the “methodological discovery and teaching of truths about serious and important things” (Shills, quoted by Bazargan 1999:61). Higher education institutions, and medical schools in particular, today have to be more responsive to the current and future requirements of society, or, as Boelen *et al.* (1992:2) stated way back in 1992: the university’s ultimate goal is to prepare people to function properly in society. In discussions of quality assurance found in literature, three points are emphasised, namely that quality assurance is the responsibility of the academic staff and administrators of an institution; the maintenance and enhancement of quality are brought about by means of, in the first place, self-evaluation (internal procedures for discovering and correcting weaknesses), and second, by a system of external verification of the self-evaluation processes, usually as part of an accreditation process (*cf.* Fourie, Strydom & Stetar 1999).

To ensure society of the quality of education, that is, to ensure that future physicians

attain adequate standards of education and professional training (*cf.* Boelen *et al.* 1992:2), academic institutions need to have robust mechanisms for self-evaluation and external quality control, which will facilitate public confidence in the academic standards of an institution. As higher education markets become more sophisticated, a need has arisen for information that will make it possible for degree outcomes to be compared and differentiated (Jackson & Lund 2000:5). This information usually is provided in the form of standards. The purpose of standards is to make explicit those attributes that are indicative of quality (Bezuidenhout 2002:50). Adelman's definition of standards (1983:40) has been found the most suitable for the purposes of this study, namely

Standards are a form of expectations that refer to performance. We use measures to determine whether expectations are being met, and we set benchmarks along those measures to indicate the level of performance that we expect on the measure. If we use the term standards correctly, then, the language of standards is the language of performance, of outcomes.

1.3 QUALITY ASSURANCE

Quality, it is asserted, is the most important and treasured aspect of all higher education institutions, and is based on an institution's capacity to fulfil its mission, aims and objectives and deliver quality programmes of study (Jonathan 2000:46). Quality assurance in higher education has a bearing on the policies, systems and processes directed at ensuring the quality of the education provision in an institution (HEQC 1996:14); thus quality in higher education institutions usually means fitness for purpose.

1.3.1 Accreditation

Literature on quality assurance in education has shown the importance of **accreditation** as a quality assurance mechanism and the role **standards** play in the accreditation process (*cf.* Bezuidenhout 2002; Harvey & Mason 1995; Strydom & Lategan 1996). Another concept in the quality discourse that should be taken note of is the concept of **benchmarks** or benchmarking (*cf.* CHEMS 1998).

Accreditation is a process of external quality review used *inter alia* in higher education to scrutinise institutions and programmes to ensure quality and to encourage quality improvement, and also to bring about comparability and mutual recognition of education

and training standards (*cf.* Bezuidenhout 2002). According to van Vught (1994:42) accreditation may be “the most fully developed institutionalization of the idea of accountability in higher education”. Three main types of accreditation are described in literature, namely institutional accreditation, focused accreditation and specialised accreditation (Bezuidenhout 2002:35; Eaton 2002; Fourie *et al.* 1999; Harvey & Mason 1995). The accreditation of medical education will obviously fall into the last mentioned category, which has a bearing on specialised, demarcated professional fields. The focus in this type of accreditation is on specific programmes, and specific standards will be observed, standards which relate to a large part to performance considered desirable or essential by the accrediting body, and good practice in the programme (educational standards) to ensure that students will achieve the set standards. The ultimate test of specialised accreditation is whether graduates of the programme are acceptable as members of the profession, credentialling bodies, employers and the public (Bezuidenhout 2002:36). Specialised accreditation is a means to verify the quality of academic programmes and the institutions that offer them to external stakeholders, and most often involves a formal review entailing a self-study, evaluations by peers and a report to the accrediting body which will certify programme quality and award or withhold accreditation (Lubinescu, Ratcliff & Gaffney 2001:8).

1.3.2 Standards

The World Federation for Medical Education (WFME) Task Force on defining international standards in basic medical education maintains that in an accreditation process the criteria, standards and procedures for the specific process should be clearly defined. National educational standards should serve as guidelines for medical schools to maintain reasonable standards and to improve the standard of their education and training, as assessment based on generally accepted standards will serve as an important incentive for improvement and for enhancing the quality of medical education and training. Standards can be used by institutions as basis for self-evaluation and quality improvement, and they are an indispensable tool when external assessment and the accreditation of medical schools are carried out (WFME Task Force 2000).

Harvey and Mason (1995:25) assert that **standards** is a word often used in higher education, but seldom defined. Three areas to which standards relate, however, can be identified, namely academic standards, standards of competence and service standards

(Harvey & Mason 1995:25; Strydom & Lategan 1996:40). According to these authors academic standards measure the ability to meet specified levels of academic attainment, i.e. the ability of students to fulfil the requirements of a programme of study, through whatever mode of assessment is required. This usually requires demonstration of knowledge and understanding. Standards of competence measure specific levels of ability on a range of competencies. These may include general, transferable skills required by employers, skills required for induction into a profession, and academic (higher level) abilities, skills and aptitudes. In the context of professional education, standards of competence refer to the ability of the practitioner to apply specific skills and abilities according to occupational or professional criteria (Harvey & Mason 1995:26). Service standards are measures devised to assess identified elements of the service or facilities provided. Such standards may include maximum class size, frequency of personal tutorials, availability of information on complaint procedures, and library services (Strydom & Lategan 1996: 40). Standards for accreditation of an education and training programme involve all three these areas (*cf.* Bezuidenhout 2002).

1.3.3 Educational outcome measures or scoring/rating guides (criteria)

The use of educational outcome measures, or scoring/rating guides (criteria) as a tool in making accreditation decisions is not a widely used concept in quality assurance in medical education. However, in literature on standards for accreditation, use is made of various concepts, describing what is to be demonstrated in order to be able to give proof of having achieved a specific standard. In the World Federation for Medical Education project on global standards for quality improvement (WFME 2003) each standard is followed by *annotations*, to clarify, amplify or exemplify expressions in the standards, and an *Outline for data collection* (WFME 2003:20-27) provides a guide for review which gives an indication of what the expectations are with each standard; however, no rating scale or scoring guide is provided. In the *Competency standards project* of the Council for Higher Education Accreditation (CHEA 2000) the standards are accompanied by scoring guides and rating scales, providing elaborations of the standards, including some of the specific kinds of evidence that might be required for proof of the level of achievement of the standards. Holistic scoring rubrics are also provided for the major dimensions of performance addressed by the standards. In 1997 the Accreditation Council for Graduate Medical Education (USA) endorsed the use of educational outcome measures as a tool in making accreditation decisions about their residency

programmes (*cf.* Leach 2001). In the *Guidelines for the assessment and accreditation of medical schools* of the Australian Medical Council (AMC), educational guidelines, described as “essential requirements for successful basic medical education” are provided for use in accreditation processes (AMC 1998:23). The AMC also provides explanatory *notes* for each of the standards it expects medical schools to achieve in order for their programmes to be accredited. These notes contain commentaries on best practice in each area addressed.

The COHSASA process (Council for Health Service Accreditation of South Africa) is a process where clearly spelt out standards and criteria are used to assess the quality of services in hospitals (*cf.* COHSASA *s.a.*). The *Standard Assessment Manual* that is used by this Council for accreditation purposes, contains a section on service elements and one on generic elements. Each generic element is divided into standards which are defined as “pre-determined expectations set by a competent authority that describes the acceptable level of performance of an organisation or individual in relation to structures in place, conduct of a process, or measurable outcome achieved” (COHSASA *s.a.*:2). The standards are broad, descriptive statements which are further defined in the form of criteria which can be measured. A criterion is defined as a “... descriptive statement which is measurable and which reflects the intent of a standard in terms of performance, behaviour, circumstances, or clinical status” (COHSASA *s.a.*:2). A number of criteria have been developed for each standard in the manual. A rating scale is also provided for evaluation in terms of the criteria (COHSASA *s.a.*:3).

The above-mentioned elucidations boil down to describing tools that might also be applied to identify facets of what is expected of a medical faculty/school/programme to be able to achieve a standard and to assist assessors in making the most objective judgement possible when assessing whether standards have been achieved. **Rubrics** can be defined as a printed set of scoring or rating guidelines or criteria for the evaluation of work (a performance or a product) and for giving feedback, and they are used in education to answer the following questions: By what criteria will the work be judged? What is the difference between good work and weaker work? How can assessors make sure that their judgements are valid and reliable? How can performers and judges focus their preparation on excellence? (Rubrics.com 2002:1).

The term **benchmark** was originally used in surveying to denote a mark on a survey peg or stone that was used as permanent reference point against which the levels of various topographic features could be measured; since it has acquired a more general meaning as a reference point against which something can be measured (Jackson & Lund 2000:4). There are many definitions of benchmarking, but in essence it boils down to a process that involves “analysing performance, practices and processes within and between organizations and industries, to obtain information for self-improvement” (Alstete 1995:20). In higher (including medical) education benchmarking “provides a vehicle for sharing practice within functional communities, identifying smarter ways of doing things and new solutions to common problems, and identifying ways of reducing costs while optimizing the quality of service offered to students and other clients” (Jackson & Lund 2000:5). Higher education institutions, as other institutions and industries, need reference points for good practice and for ways of improving their functioning; therefore benchmarking is as essential in universities as in other spheres (McKinnon, Walker & Davis 2000:2).

1.3.4 The role of these concepts in accreditation

Why are these concepts so important and what role can they play in the quality assurance process for medical education and training in South Africa, that is, the accreditation process of the Health Professions Council of South Africa (HPCSA)?

The process of accreditation is designed to determine and certify the achievement and the maintenance of minimum standards of education (LCME 1995:5). In South Africa, it is the responsibility of the HPCSA, the statutory body for the medical profession and medical education, to attest to the quality of programmes for medical education and training offered by universities*. To this end, an accreditation system for undergraduate medical and dental education programmes in South Africa was instituted by the HPCSA in 1999 after a thorough and scientific investigation into accreditation as a means of

*The Higher Education Quality Committee (HEQC) is the South African Council on Higher Education's quality assurance body, and medical education programmes are subjected to audits by this body too. For the purposes of this study that ramification of quality assurance in South Africa will not be discussed; suffice to say that the HPCSA and the HEQC are in the process of negotiating a memorandum of understanding.

quality assurance in education and training (HPCSA 1999a; Labuschagné 1995), and the first site visits by an assessment panel were carried out in 2001. By the end of 2004 all eight medical schools had received an accreditation visit (in some cases two visits) from a visiting panel of the HPCSA.

In order for their graduates to be allowed to register as practitioners, the undergraduate education programmes of all medical faculties/schools in South Africa must be accredited by the HPCSA. The process of accreditation of the HPCSA has been designed to “provide assurance to the state and the public at large of the continued satisfactory standard of graduates from medical and dental schools” (HPCSA 1999a:1) within the scope of responsibility of the Medical and Dental Professions Board (MDPB) of the HPCSA. The structure bearing responsibility for accreditation and that is accountable to the Board, is the Medical and Dental Education Committee *via* its Subcommittee for Undergraduate Education and Training (UET). The accreditation process comprises an institutional self-evaluation and compilation of a self-evaluation report, and an external peer assessment. The external peer assessment (review) is undertaken by a visiting panel of experts appointed by the UET (HPCSA 1999a:2-3).

The review process, that is, the external peer review designed for the accreditation system, has been structured to render a team assessment of an institution's performance with regard to the medical education programme. The task of the visiting panel or assessment team is “to determine whether generally accepted standards are maintained and conditions met in any or all discipline(s)/department(s) of a faculty/school of medicine or dentistry in terms of the conditions and criteria for undergraduate and post-graduate medical and dental education and training laid down by the Board” (HPCSA 1999a:3). In the *Guidelines for the visiting panel* (MDPB 2003:1) for the accreditation process of the HPCSA, it is stated that the tasks of the visiting panel are to:

- analyse the School's self-assessment report prior to the visit;
- gather evidence during the site visit;
- write a quality assessment report; and
- recommend accreditation/re-accreditation/provisional accreditation/no accreditation.

Although the working procedures for the visiting panel are spelt out in the document

mentioned above, a concrete foundation for team discussions is not given; standards for assessment were only developed in 2002 (Bezuidenhout 2002) (and have not been formally accepted and implemented as yet); except for the guidelines for the education and training of doctors (HPCSA 1999), no criteria, benchmarks or guidelines (for example rubrics), or commentary on best practice is provided for judging the extent to which standards are being achieved, and no measurement tool or mechanism is available for use by the members of the panel. In general, the panel has to reach consensus based on what may well be subjective opinions and judgements, each individual member of the panel using his/her own frame of reference as premise for the assessment. Such a process of team judgement, as used in the accreditation process for medical education and training in South Africa, might be perceived as undocumented and occasionally idiosyncratic (*cf.* CHEA 2000:5). The duties of the members of the visiting panel are to provide the institution with a perspective on the quality of its education and training, and in the process they implicitly compare what they see and find with what they have seen and found in other (often their home) institutions.

Accreditation visits are relatively non-directive with respect to how a given panel conducts its work. The guidelines of the HPCSA and the Medical and Dental Professions Board (HPCSA 1999; HPCSA 1999a) serve as a rough guide, with members breaking up into smaller groups, or acting individually in an attempt to cover the areas (usually by means of interviews, document review and observation) on which the panel has to report. Members of the visiting panels of the HPCSA do not receive training in the process of assessing the quality of the performance of a school or faculty. This is in contrast with, for example, the Baldrige review process (BNQP 2002:i) where the team members are not only thoroughly trained, but they also use detailed review guides based on clearly established protocols to take them through the review process (also *cf.* Ewell 1998:11).

For the site visits of the HPCSA accreditation review process, the panel members, called a panel of independent experts, for each visit are selected and appointed by the UET on behalf of the Medical and Dental Professions Board, based on their knowledge and experience in their discipline and the field of medical education, and in the case of the educationalist member, his/her role and experience in medical education and training. A team comprises five to seven members, approved by the Board, and representation on

the team must provide for a balance between basic and clinical disciplines, and also between teaching and research (HPCSA 1999a:6). An educationalist is included in the panel for each visit. This member of the panel need not be medically trained, and usually is the person responsible for or with a special interest in educational development in his/her own institution. In one cycle, a person may be member of the panel for more than one visit; some others may be appointed only once. Some members therefore, have more experience, whilst in every panel there are members who form part of the panel for the first time (Nel 2003: Personal communication). The chair of the panel must be a member of the UET, and the secretary of the said Board acts as secretary for the panel (HPCSA 1999a).

Members of a visiting panel usually are faculty members (or former faculty members) of one of the eight medical faculties/schools in South Africa. Through this it is ensured that they are well informed of the expectations of higher education authorities and the HPCSA with regard to medical education and training in South Africa; however, the eight faculties/schools do have different underlying philosophies and various educational approaches, strategies and methodologies are employed, as faculties/schools have a relative degree of academic freedom with regard to the way in which they structure their curricula and the strategies and methodologies they choose to use. Panel members therefore may be better informed of educational strategies and methods used in their own institutions, and may perhaps even regard those as better than or superior to the approaches, strategies and methods used in other institutions (Nel 2003: Personal communication).

The external review of a faculty/school visited for accreditation purposes is carried out on the basis of a document of the HPCSA (1999), *Education and training of doctors in South Africa: Undergraduate medical education and training*. The self-evaluation report, a response to the questionnaire (UET Task group 2000) that faculties/schools have to complete prior to the visit, is scrutinised, using the guidelines in the mentioned document as criteria for judgements on the quality of the performance of the school, and the same applies during the on-site visit when the self-evaluation report is verified (HPCSA 1999a). In a previous study (Bezuidenhout 2002) standards were designed for the accreditation of medical education in South Africa. These have been recommended for use by a UET task group in August 2003 (UET 2003), but have not been implemented

yet. In this set of standards no benchmarks or criteria for performance are provided; equally no rubrics, scoring guide or performance indicators are provided with the self-assessment questionnaire to guide the visiting panel in its decision-making process.

Both institutions and external critics of the process of accreditation rightfully often raise questions about the actual basis used in making peer-based judgements about the performance of an institution under review. Such critics allege that the issues raised often may be idiosyncratic and would be different if the composition of the visiting panel was altered. Similarly, members of visiting panels often note that there are few mechanisms available to arrive at a collective assessment of institutional strengths and weaknesses (CHEA 2000:21).

The well-known Baldrige National Quality Programme used by thousands of USA organisations to stay abreast of ever-increasing competition and to improve performance makes use of criteria for performance excellence to provide a framework for assessing performance (BNQP 2001:i). The Baldrige Criteria are used by institutions for self-evaluation purposes and by an external panel of experts who score the self-assessment according to Baldrige scores (BNQP 2001; BNQP 2002).

Most accreditation systems steer away from quantitative measures in their procedures (*cf.* Bezuidenhout 2002; also see Chapter 2). An example of this is the accreditation system of the Liaison Committee on Medical Education (LCME) of the Association of American Medical Colleges. In its accreditation document it is stated that the standards put forward are stated in a fashion which is not "susceptible to quantification or precise definition, because the nature of the evaluation is qualitative in character" (LCME 1995:6); however, following each standard is a lengthy discussion which explains clearly what is to be considered best practice, and what medical schools have to do to be accredited (rubrics). The conditions for the achievement of each standard therefore are explained clearly, which, presumably, renders the task of the panel members to reach consensus easier and makes the assessment more objective.

In the guidelines for the accreditation procedures for Australian and New Zealand medical schools, the Australian Medical Council (AMC) sets forth the educational principles that are to guide the assessment process, namely the general goals of

medical education, specific objectives for medical education and standards for basic medical education (AMC 2002). Each standard is followed by a so-called *note*, which explains what is expected of a medical school to be regarded as achieving the particular standard.

Measurement of competencies, or in the case of educational programmes, of the achievement of standards, is a science still in its infancy (Leach 2001:396). The Center for Higher Education Accreditation (CHEA) in the USA, however, in their *Competency standards project* provides a scoring guide for each standard set, as well as a scoring rubric for each of the major dimensions of performance addressed by the standards (CHEA 2000). The scoring guide is used as basis for the review by providing a concrete foundation for the review panel's team discussions, and a clear means to communicate the panel's judgement to the institution. The scoring guide comprises sets of individual rating scales for each individual standard. Each set of rating scales is accompanied by a further elaboration of the associated standard, and the scoring guide also contains three holistic scoring rubrics, to be used by the panel members to summarise the performance of the institution as a whole on the attributes (CHEA 2000:19).

Against this background it is postulated that a set of rubrics or scoring/rating guides may be of value in an accreditation process to anchor deliberations; however, there should be sufficient flexibility to allow for team members to reach authentic judgements, based on their professional and disciplinary knowledge and experience. As has been stated earlier, members of peer review panels give their perspectives on the quality of the education and training taking place in the institution they visit, and implicitly compare this with the education and training taking place in other (often their home) institutions. Jackson (2000:31) thus describes the visiting panel as "a type of benchmarking agent", and the site visit as "an unstructured, unsystematic and largely implicit type of benchmarking process". The idea that academics might use benchmarking to understand, regulate and improve their practice, might seem new, but, according to Jackson (2000:29) established academic processes such as external examining, accreditation of programmes by professional bodies and programme reviews undertaken by higher education institutions embody notions of benchmarking. However, comparative judgements within such processes are made more on the basis of experience and impressions than on systematic and explicit information that would

render comparisons more trustworthy and objective.

Benchmarking can be regarded as the formal and structured observation and exchange of ideas between organisations, a valuable tool for institutions to improve and adapt their services to meet and exceed the demands of stakeholders (Meade 1998:1). Using benchmarking principles to inform standards for accreditation, and designing rubrics with different levels for the purpose of assessing whether and to what degree a specific standard has been achieved, are approaches used increasingly in higher education as part of quality assurance in education and training (*cf.* BNQP 2002; CHEA 2000; Jackson & Lund 2000; Meade 1998; Wiener & Cohen 1997).

1.4 RESEARCH QUESTIONS AND STATEMENT OF THE PROBLEM

Since 2001 medical schools in South Africa have been subjected to external quality reviews with a view to the accreditation of their medical education programmes with the HPCSA. The review visits are preceded by an internal self-evaluation. The accreditation process has been founded on sound research and is carried out in accordance with what is done in many other systems all over the world (*cf.* Bezuidenhout 2002; HPCSA 1999a; Labuschagné 1995).

Members of the visiting teams that conduct the external reviews are appointed by the Undergraduate Education and Training Sub-Committee (UET) of the Medical and Dental Professions Board, and do not receive training in quality evaluation processes. These members all are experts in their disciplines, and they make independent judgements based on their own unique experiences and frame of reference, after which consensus has to be reached in order to arrive at a panel decision. As a different panel is composed for each medical programme to be assessed, however, the questions may be asked: How can objectivity and comparability be assured in accreditation review visits when the panels visiting the different medical faculties/schools for each visit comprise another group of individuals as members? What is the actual basis the members use for making decisions about institutions' performance? What mechanisms are available to help them arrive at a collective assessment of institutional strengths and weaknesses? How can it be assured that institutions strive for 'best practice'? How can the extent to which they (faculties/schools) achieve this striving be determined, and comparability and

equality of standards in medical education be promoted?

These questions led the researcher to identify the problem that was addressed in this study, namely the lack of a review guide that might be used as a tool or mechanism for the assessment of medical education and training in the accreditation system for medical education programmes in South Africa. The lack of such a guide, it was perceived, might result in different accreditation review panels arriving at subjective conclusions that may be idiosyncratic and based on the individual experiences and even peculiar characteristics of the individual members of the panel. The problem was broken up into different components, namely, first, a need exists for a mechanism or specific tools that might be used as an assessment guide by the members of a review panel to generate a consistent set of judgements and ensure that they arrive at an objective and soundly based decision when they determine the extent to which an institution has achieved particular standards, or when they make a collective decision regarding the strengths and weaknesses of a programme; and second, a need exists for an ongoing and systematic process to introduce best practice in institutions, to promote comparability and equality of standards, and to promote development and improvement in programmes.

1.5 GOAL, AIM AND OBJECTIVES

There is some confusion about the use of the terms goal, aim and objectives in studies (*cf.* Fouché 2002:107), therefore it is necessary to explain what is meant when these terms are used in this study. The goal here implies the broader, abstract conception of the end or ambition towards which the effort with or aim of the study was directed - Fouché (2002:108) calls this the “dream”; the aim refers to the more concrete, measurable “means” to realise this ambition or end. The primary objectives of the study describe the different phases of exploration and description and what each yielded, while the process objectives refer to the process that was employed to achieve the primary objectives by means of which the aim was achieved. Having achieved the aim, it is hoped that the goal will be realised (*cf.* Fouché 2002:108).

The overall **goal** of this study was to make a contribution to the quality of medical education and training in South Africa. Quality assurance in medical education and

training in South Africa is brought about by means of an accreditation process, in which self-assessment and peer reviews play a major role. In both these processes clearly defined standards are pivotal (Bezuidenhout 2002:46; also *cf.* CHEA 2000; Jones & Radcliff 1999; LCME 1995; WFME 2000), and this study, in the first place, attended to ways in which standards for accreditation can be put to use to ensure well-informed assessments of quality, and in the second instance, attention was paid to tools or mechanisms (a guide containing standards) that may be applied to strengthen team decision-making and peer judgements of quality, that is, a guide for assessment in the quality assurance processes. To be really effective and make impact, quality assurance processes must start within an institution itself; therefore a secondary goal of the study is to contribute to each medical faculty's/school's quality assurance process.

The study was **aimed** at developing, and testing the concept of, a guide for use in the accreditation process of the HPCSA (for accreditation reviews), that might also be used for self-evaluation and improvement purposes, which, it is presumed, will contribute to ensuring quality in undergraduate medical education. Such a guide, it was assumed, would give more structure to the peer review (external quality assurance) and self-assessment (internal quality assurance), which are the main components of the accreditation process. It is assumed that it will strengthen expert or review panels' decision-making and deliberations; that it will render peer judgements more objective, reliable and valid, and that it will also promote the objective of bringing about comparability in the assessment process, and equality of standards in medical education in South African medical schools, as it will enable review panels to generate consistent judgements in terms of specified standards, which ought to be a particular priority in an assessment process aimed at ensuring quality and promoting development across the board of South African undergraduate medical education and training programmes. In the internal quality assurance processes of medical schools this guide presumably will facilitate preparations for the external review, and serve as a sound point of departure for planning and developmental actions to improve quality.

To enable the researcher to achieve this aim, the following primary objectives were set for the study:

1. To gain an overall picture of quality assurance in higher education, with special reference to medical education, and the role of accreditation in quality assurance

- processes.
2. To gain knowledge of the role and use of standards in quality assurance processes, and to determine how achievement of standards is measured/judged by accreditation review panels.
 3. To compile a draft guide for use in accreditation reviews.
 4. To test the concept, refine the draft guide, and determine its potential value in the accreditation system for undergraduate medical education in South Africa.
 5. To propose a guide for accreditation review panels to be used to determine the extent to which an undergraduate medical education programme, subjected to accreditation, is succeeding in achieving standards for accreditation, and to be used in planning for quality improvement.

The objectives of this study can be classified as exploratory (to gain insight into the situation/phenomenon) and descriptive (to form a picture of specific details and focusing on the 'how' and 'why' questions), and the study has elements of both basic and applied research - the advancement of knowledge and the solution of problems - as it is concerned with extending the knowledge base of the field of health professions education, and the result will have a practical application in that the study has been planned to induce change in a specific situation (*cf.* Fouché 2002:108; McMillan & Schumacher 2001:18-19).

The process objectives of the study, and how they were pursued to achieve the aim, can be summarised as follows:

1. To study quality assurance processes and systems in education, with special reference to medical education, as well as quality assurance in other spheres of education and service provision, in order to gain a better background of the field of quality assurance and processes/systems employed by institutions to ensure the maintenance and improvement of standards. To this end, literature was studied, and the researcher continued her role as observing participant, making field notes during meetings and as member of accreditation panels (as has been the case since 2001 - see Chapter 5 (5.4), ***Elucidation***).
2. To study the role standards play in accreditation processes, as well as the measures, tools and/or guidelines that are used with these standards to ensure valid

and reliable judgements of peer review or audit panels. The focus here was on assessment rubrics, criteria, indicators, and other measures used in accreditation and other quality assurance systems. Again a study of available literature and participant observation were the means by which information was gathered.

3. To draft a guide for use by review panels in the accreditation of undergraduate medical education in South Africa. On the basis of the findings of the literature review, as well as on information gained as member of visiting panels since 2001 (contained in field notes, memoranda), internal reports of visiting panels, and discussions and meetings with panel members and members of the UET Sub-committee of the HPCSA, a guide for accreditation reviews was drafted. This was done by adapting the standards developed in a previous study (Bezuidenhout 2002) and composing rubrics for each standard to determine the extent to which a specific standard has been achieved. This draft guide contained standards proposed for accreditation reviews and a design for an evaluation procedure and measuring process, including rubrics (with criteria/indicators) for assessment and examples of best practice pertaining to each standard, as well as a rating scale (See Appendix 1.1 – Draft guide for accreditation reviews).
4. To test the concept and refine (with regard to content and purpose) the draft guide for accreditation reviews of undergraduate medical education in South Africa. This constituted the empirical study and was done by means of information gathered through a series of semi-structured individual interviews with a sample of two of the three populations that will be served, namely professionals who have previously served on accreditation panels, and deans/heads of medical faculties/schools in South Africa. The draft guide also was submitted to a sample of the third group of role players in accreditation of medical education in South Africa, namely members of the Undergraduate Education and Training Sub-committee of the HPCSA (the accrediting body) to determine whether such an instrument (the guide) would be a useful tool in the accreditation review process, and whether it could contribute to the maintenance and enhancement of quality in medical education. Data were gathered by means of a focus group interview.
5. To conduct a literature control to ensure that the 'new knowledge' contained in the guide can be related meaningfully to existing frameworks or models and to determine whether the interpretation of the data is in context with existing knowledge in the field. This was done as part of the data analysis procedure, and

the findings indicated that the 'new knowledge' could be underscored by literature.

6. To adapt the draft accreditation review guide in accordance with the results of the analysis of the data collected by means of the semi-structured interviews and the focus group interview, and to make recommendations regarding its usefulness and value, if the results indicated that the assumption could be accepted and that the guide would be useful. The main finding was that the participants did support the idea of the guide, and the assumption was proved correct. The recommendations they had made were incorporated into the draft guide to constitute a final product – a guide for accreditation reviews in South African undergraduate medical education.

The aim of the study was achieved, namely, as final outcome of the study, a guide suitable for use in accreditation reviews conducted in South African medical faculties/schools to evaluate and improve the quality of undergraduate medical education and training was designed (see Chapter 7). Also, and perhaps equally important, it is hoped that this guide will be used by each medical faculty/school offering a programme for undergraduate medical education and training to promote development and planning with a view to the enhancement of the quality of education and training of the programme – which is the goal of the study.

The outcome of the study, that is, the guide for accreditation reviews, will be submitted to the UET Sub-committee of the Medical and Dental Professions Board of the HPCSA with the recommendation that it be used in accreditation reviews, and also that it be made available to medical faculties/schools for use in internal self-evaluation processes in preparation for accreditation visits, and for development and improvement (see Chapter 8 [8.4.1] for recommendations).

For a diagrammatic depiction of the course of the study, see Appendix 1.2.

1.6 RESEARCH DESIGN, METHODS AND PROCEDURES

A brief description of the research approach, design and methods used for the study is given here to inform the reader about the points of departure used in the study, and the ways in which the study was approached and conducted; more detailed discussions are given in Chapter 5.

1.6.1 Research approach and design

This was a qualitative study. A phenomenological explorative and descriptive design was employed. According to the phenomenological approach a problem must be investigated within the context in which it exists, as human behaviour cannot be divorced from its context - the phenomenologist endeavours to understand a phenomenon from the perspective of those involved (Huysamen 1993:172). Leedy (1997:161) defines phenomenology as “a research method that attempts to understand participants’ perspectives and views of social realities.” According to phenomenological theories, subjective experiences are meaningful and provide reliable data for understanding reality (Verma & Beard 1981:187). In phenomenological studies the researcher often has personal experience with the phenomenon and aims to heighten his or her own awareness of the experience, while at the same time examining the experience through the eyes of other participants (Leedy 1997:161). In this research the phenomenological preparation (initial literature review [to provide a philosophical point of departure or paradigm - *cf.* Fouché & Delpont 2002:267-8], and the researcher’s own experiences as member of different review panels - participant observation [*cf.* Strydom 2002a:278-290]) formed the basis and served as preparation for the empirical investigation. The phenomenology thus served the purpose of generating descriptions and propositions for rubrics and criteria that may be of scientific importance in applying accreditation standards.

The theory or concept that was generated during the phenomenological preparation was further developed and verified through systematic data collection and analysis of data pertaining to the phenomenon (Fouché 2002:273). The perceptions of members of the medical education fraternity with regard to these descriptions and propositions (another dimension of the phenomenon) were explored in the empirical study. The researcher thus did not begin with a theory, rather with an area of study, and what was relevant to the problem statement was allowed to gradually emerge. The guide that constitutes the final product of the study can be described as a theoretical model (*cf.* Fouché 2002:274).

As the findings of a phenomenological study need to be related to an existing body of theory and research, a literature ‘control’ was done after the data had been collected (*cf.* Fouché & Delpont 2002:268). This was done during the interpretation phase, in order to relate the results and findings to existing theoretical frameworks or models, and to

determine whether these were supported or falsified by the new interpretation (*cf.* Mouton 2001:109).

A research design is the plan or blueprint for how the research will be conducted (Mouton 2001:55). A qualitative, descriptive and exploratory design was used since the purpose of the study was to explore and describe the phenomenon (quality assurance) with specific reference to measures used to ensure quality in education. The phenomenological approach is one of the approaches indicated for qualitative research (Burns & Grove 1997:67), and is important in participant observation, as the researcher strives to gain in-depth insight into the manifestations of reality (Fouché 2002:280). Qualitative research is a way of gaining insight through discovering meaning by understanding the whole or *gestalt*. By understanding the whole, we are able to explore the depth, richness and complexity of the phenomenon under study. It is mainly concerned with meaning - how people make sense of experiences and structures of their world (Burns & Grove 1997:67; Shank 2002:5).

Descriptive designs are used to provide a picture of situations as they naturally happen, and this is an essential phase in the development of knowledge (Wolcott 2001:111). In this study this was achieved through the systematic collection and description of information about the phenomenon of study.

The purpose of qualitative research is not to establish objective facts, but to explore how participants understand and make sense of a phenomenon (Peck & Secker 1999: 556). The qualitative researcher believes that the world cannot be pinned down to objective meanings, but that all variables must be taken into account in research, including the past experience of the researcher (Chappel s.a.:1). The exploratory design was aimed at exploring the dimensions of the phenomenon, the way in which it manifests, and other factors with which it is related; it leads to insight and understanding. The phenomenon was explored in the literature study and through participant observation, and the new knowledge that emanated, was verified by means of individual interviews and a focus group discussion, exploring the experiences of and the perceptions the study population had of the phenomenon (*cf.* Fouché 2002:273). In this study the researcher was allowed to be “scientific and creative at the same time” (*cf.* Babbie 2001:284). Finally, the findings were related to existing models and used to test the assumption that the

designed outcome would solve the research problem.

1.6.2 Methods and procedures

Phenomenology is both an approach and a strategy (Harris 2002:67-68). In this study the phenomenological preparation involved a literature review and personal experience, while a series of interviews and a focus group discussion were used to verify the initial outcome (that is, the guide that was developed) and to determine its usefulness and value (testing the assumption). This took the phenomenology one step further by collecting the ideas and opinions of the participants on the phenomenon. The development of new knowledge (contained in the draft guide, but also in the idea of structuring accreditation reviews) reflects elements of a grounded theory, as it is a theoretical base or interventive model that emerged from the information collected through observation and interpretation of the phenomenon (*cf.* Brink 2003:121; Fouché 2002:97). The final product was brought about by describing and giving new meaning to the findings of the literature study and personal experience and observations, and by exploring the perceptions of the study population with regard to the newly developed knowledge (empirical study).

1.6.2.1 Literature review

The focus of the literature review was on accreditation as a means of quality assurance in (medical) education and other spheres, with special emphasis on measurement tools and assessment guides used to assess the attainment of standards. Internal and external quality review, audits and peer reviews, standards for accreditation, assessment rubrics, criteria and indicators, and the role they play in quality assurance came under scrutiny. The accreditation system of the Health Professions Council of South Africa was studied to scientifically determine the place and value a review guide might have in the process. The researcher's personal experience in and observation of the accreditation process of the HPCSA (as member of review panels), discussions with experts involved in the accreditation process, and minutes of meetings and a workshop, as well as other documentation of the UET and accreditation teams were taken into consideration in structuring knowledge about the phenomenon. Based on the findings of the literature review and own experience, prior knowledge and observations, a draft guide for the assessment of quality with a view to accreditation and the promotion of quality was developed. During the interpretation phase the literature was reviewed

again, relating the findings to existing knowledge in the field.

1.6.2.2 Data collection

In the empirical study data were captured by means of personal interviews and a focus group discussion (explorative design). Semi-structured one-on-one interviews are generally used to gain a picture of a participant's beliefs or perceptions of a particular topic (Greeff 2002:302). In the first phase of this data collection process semi-structured personal interviews with individuals were used to learn the opinions and views of the participants on the usefulness or value and content of the draft review guide, and to gain a perspective of their opinions and views of the phenomenon.

The outcome of the first phase of the data collection (the individual interviews), that is, the draft guide for accreditation reviews, subsequently was submitted to members of the UET Sub-committee of the HPCSA with the request that it be studied to determine whether the members of the sub-committee, who are instrumental participants in the accreditation process, considered it a useful tool to be used in the accreditation process, and whether they themselves (as heads of schools/deans, members of visiting accreditation panels, and decision-makers regarding accreditation) would use the guide to improve the process of quality assurance through accreditation. They were also requested to comment on the content. A focus group interview was used as data collection method for this phase of the research process.

The focus group interview also served the purpose of triangulation (*cf.* de Vos 2002:341).

1.6.2.3 Participants in the study

According to Leedy (1997:162) phenomenological studies can be conducted with a single participant (or even as an examination of the researcher's own experience), but phenomenologists usually involve five to ten people in their studies. In this study twelve participants were requested to participate in the semi-structured individual interviews, but only ten eventually participated, and seven members of the UET participated in the focus group interview. For the semi-structured and the focus group interviews the participants were selected by means of purposive and stratified sampling from experts in medical education involved in the accreditation process of the Health Professions

Council of South Africa in some or other way. Expert rather than informal or general opinion is often sought in the development of educational policy, as decisions of this nature require critical thinking and reasoning (Clayton 1997:373). Furthermore, when the goal of a study is to solve a problem of a particular group, it is reasonable to believe that the group would be more likely to accept the findings if members of the group have participated in the research (Moore 1987:16). The purposive sampling method was used to ensure that the sample covered the full range of possible characteristics (Katzenellenbogen, Joubert & Karim 1999:179); in this case the range of knowledge and insights on accreditation as quality assurance method in South African medical education, and experiences in or with the process.

The inclusion criteria for participation in the one-on-one semi-structured interviews were that the participants all had to be experienced in medical education and had some experience with the South African accreditation process. Based on this, deans/heads of the medical faculties/schools (or in some cases their representatives) were requested to participate, as all eight schools had gone through at least one visit of an accreditation review team by the time. The second group of interviewees consisted of four medical and/or medical education experts whose names appeared on the list of experts used for the panel reviews. Logistic consideration of time and funding, and potential participants' availability and willingness to participate played a role in their selection (*cf.* Katzenellenbogen *et al.* 1999:179).

Members of the Undergraduate Education and Training Sub-committee of the HPCSA were involved in the focus group interview. Once again the purposive sampling method was used, as the members of this sub-committee are representative of the broad spectrum of the three population groups to be served, and furthermore they are the decision-makers and most informed group of representatives, who have been appointed or selected to their position in the said sub-committee on the basis of their experience with, knowledge of and insight into medical education and the accreditation process, which is the major topic of the study (*cf.* Greeff 2002:310; Huysamen 1994:44). At the time of the focus group interview the sub-committee had nine members, all of which were invited to participate. On the day of the focus group interview, which was scheduled to coincide with a sub-committee meeting, seven members attended the meeting and participated in the focus group discussion.

1.6.2.4 *Data analysis*

Qualitative data analysis techniques were used to generate meaning from the data in order to refine the draft guide (*cf.* Creswell 1998). Data analysis in qualitative studies is said to be a “dynamic, intuitive and creative process of inductive reasoning, thinking and theorizing” (Basit 2003:143). According to the data analysis spiral described by Creswell (1998:142-165) data were collected and organised, and large units broken up into smaller parts, making use of coding (management of the data); this was followed by perusal of the data to get an overall ‘sense’ of the data, and preliminary interpretations (describing) were written down. Next, the data were categorised into themes (classification), and interpreted (assigned meaning). The last step entailed integrating and summarising the data (*also cf.* Leedy & Ormrod 2001:161).

The aim of the analysis was to look for trends and patterns in the responses. The interpretation of the data involved an exploration of lived experiences (with the phenomenon) with the goal of creating meaning and achieving a sense of understanding. Hermeneutic phenomenology came into play here. As interpretation is seen as critical to the process of understanding, the interpretive process sought to bring understanding, to find intended or expressed meanings (*cf.* Laverly 2003:3). The aim of the analysis was to find trends and patterns in the responses, and the basis was the transcribed interviews, tapes, notes and memory (*cf.* Greeff 2002:318).

1.6.2.5 *Pilot study*

The items in the draft guide for accreditation reviews were subjected to a pilot study using the interview schedule (containing a number of specific questions and additional probes) to ensure that the items and questions (in the draft guide and interview/focus group schedules) were precise, clear and unambiguous, and in the case of the interview and focus group items, free of bias (*cf.* Leedy 1997:199). The pilot study provided the researcher an opportunity to practise her interview skills and made her aware of the fact that during the interviews it might happen that she would need to amend probes to glean the required information. The formulation of some of the items in the interview schedules was amended slightly after the pilot interviews, and the pilot study also enabled the researcher to determine the amount of time that would be required for the interviews and the focus group discussion.

1.6.2.6 *Trustworthiness, validity and reliability*

The value of any research endeavour needs to be assessed. Qualitative research, differing from quantitative research in nature and purpose, requires a unique set of assessment criteria. Lincoln and Guba (1985:300) identified four aspects of trustworthiness that are relevant in qualitative studies, namely credibility, transferability, dependability and confirmability (also *cf.* de Vos 2002:351-2). This model for the assessment of the trustworthiness of qualitative data has been used successfully by educators for many years (Krefting 1991:215). The model, and how it was applied in this study, will be described more fully in the chapter on methodology, Chapter 5 (see 5.4).

There is no general consensus in literature about how the traditional topics of validity and reliability should be addressed in qualitative research (Leedy 1997:168; Shank 2002:91-94). Validity, in essence, is about the notion of truth - is what the researcher says has been observed, in fact really what has happened? In other words, is the observational record true? (Shank 2002:92). What is most important here is that the researcher must be honest about his/her position in the research. The researcher must be open about possible biases and predilections, or perspectives that might influence the process of the research (Shank 2002:93). In this study, everything possible was done to be transparent, and to relate findings free of bias. According to Leedy (1997:168) interpretative validity comes into play in qualitative research, that is, the usefulness of the report; the contextual completeness in the description, including the perceptions of and meanings giving by the individuals to the phenomenon; and the researcher's awareness of his/her own influence on the findings - which Shank also points out. The researcher's reporting style also has a notable effect on the credibility of the study, therefore every effort was made to ensure that the reconstruction of the participants' perceptions is reported in a way that renders it authentic (*cf.* Leedy 1997:168).

Reliability is about accuracy. During the interviews participants were asked for clarification and follow-up information when the meaning of what was being said, was not clear (*cf.* Shank 2002:92). Multiple reviews of the interview notes and tapes furthermore ensured accuracy, and an assistant was used to check the transcribed notes (against the tapes) for accuracy.

1.7 SCOPE OF THE STUDY

The study was conducted within the study field of Health Professions Education, and in particular, undergraduate medical education. This field of study is related to higher education and therefore perspectives and information were gained from that field of study too. Cognisance was taken of the demands and requirements made on medical education and quality assurance in higher and medical education from the side of the profession, the regulatory authority of health professions, and higher education quality assurance authorities in South Africa. Quality assurance in medical education and other fields world-wide, with special reference to recent developments and innovations, were considered. The populations involved were the three groups concerned most closely with the accreditation of undergraduate medical education in South Africa, namely the Undergraduate Education and Training Sub-committee of the Medical and Dental Professions Board of the HPCSA, members of accreditation review panels, and the deans/heads of medical faculties/schools as representatives of institutions offering programmes that have to be accredited by the HPCSA.

The final outcome of the study has been tailored specifically for use by medical faculties/schools in South Africa and the accrediting body of South African medical education, as the standards and criteria have been designed to suit South African circumstances. However, a recent study (Nel & Bezuidenhout 2003) has indicated that there are so many similarities between the South African quality assurance process and a process that has been developed for international application, that the possibility of using the envisaged guide over a wider front is not excluded.

1.8 IMPLEMENTATION OF FINDINGS

The guide for accreditation reviews that constitutes the final outcome of the study will be submitted to the UET Sub-committee of the Medical and Dental Professions Board of the HPCSA for possible use in its accreditation process. It is also hoped that it will be used by the medical faculties/schools in South Africa in their quality assurance processes to evaluate their medical education programmes, and to facilitate the maintenance and enhancement of the standards in education and training.

In a study such as this where an intervention measure is designed, the ideal would have been to conduct a pilot implementation or field test (*cf.* De Vos 2002:394-418) as part of the empirical study; however, due to cost and time restraints, this was not possible, as a cycle of accreditation reviews takes up to five years to be completed. It will be recommended, however, to the UET that the guide, should it be acceptable for use, be implemented for one cycle of accreditation reviews as a pilot study. This could then constitute another study to test the review guide, and to update and modify it (if required), based on real-world implementation and conducted without the restraints of time and cost, which form part of an academic study such as the current.

1.9 ETHICAL ASPECTS

Consent has been obtained from the UET Sub-committee of the Medical and Dental Professions Board to use information gained during the researcher's participation in the accreditation process, such as official and working documents, minutes of meetings and reports, and field notes of discussions on accreditation for the purposes of the study (minutes of UET meeting September 2003 – UET 2003). All information obtained, from the interviewees and otherwise, was dealt with confidentially, and no names (of persons or institutions) are referred to in the findings.

The protocol for the study was approved by the Ethics Committee of the Faculty of Health Sciences, University of the Free State (ETOVS number 24/04).

1.10 ARRANGEMENT OF THE REPORT

In **Chapter one**, *Orientation to the study*, an introduction and a background to the study have been given, and the problem that was addressed, has been elucidated. The goal, aim and objectives of the study are stated. The methods of investigation are briefly explained, and some of the matters that came under scrutiny in the study are explained in context.

Chapter two, *Quality assurance in higher, including medical, education*, pays attention to quality assurance processes reported on in literature, with special reference to medical education and training. Various quality assurance processes, the standards

used in these processes, and the purposes they are used for are discussed. Accreditation as quality assurance process comes under scrutiny, with special reference to the dual goal this process usually has. A section in this chapter is devoted to a discussion of quality assurance in medical education in a number of medical education systems in other countries.

Chapter three, *Tools to guide evaluations in quality assurance processes*, takes a look at different guidelines, measurement tools and other instruments and/or tools used in quality assurance and/or assessment processes. Standards, rubrics, benchmarking, scores and rating, and the overall judgement and review report are some of the topics discussed.

In **Chapter four**, *Accreditation of undergraduate medical education in South Africa*, the process by means of which undergraduate medical education and training programmes in South Africa are accredited by the professional body, is discussed.

Chapter five, *Research approach and methodology*, provides a description and discussion of the approach, methods and techniques applied in the study. The individual and focus group interviews for which the draft guide served as point of departure are discussed in detail, as well as the data analysis method, trustworthiness, validity and reliability, and ethical considerations.

The data analysis, interpretation and findings of the study are discussed in **Chapter six**, *Data analysis, interpretation and discussion*. Responses are related in interviewees' own words, and meaning is made of the data.

In **Chapter seven**, *Final outcome of the study: A guide for accreditation reviews*, the result of the study, namely a guide for accreditation reviews and self-evaluations of undergraduate medical education programmes with a view to quality assurance and promotion in South African medical education, is presented. This chapter contains a separate list of sources consulted, as the sources consulted in the development of the guide have not all been used as references in the main body of the study.

Chapter eight, *Recapitulation, recommendations and conclusion*, is devoted to a

discussion of the study, including limitations experienced and the perceived value of the study. Recommendations are made with regard to the possibilities for using the guide, and possibilities for further research on the topic are pointed out.

1.11 CONCLUSION

Quality and quality assurance have become key words in discussions on higher (including medical) education for some time; actually, in medical education it has been a concern from the early 1900s, when Abraham Flexner, an educationist, was commissioned by the Carnegie Foundation to investigate and report on the facilities, resources and methods of instruction of USA medical schools (Pritchett 1910:viii). Medical education is the foundation of sound health care, therefore the quality of the education and training of medical practitioners must always be above suspicion. Flexner's 1910 report was regarded as a starting point for a national effort "to strengthen the medical profession and rightly to relate medical education to the general system of education" (Pritchett 1910:xvi). Medical education today worldwide forms part of educational systems; therefore, naturally, educational standards should be adhered to in a striving for quality, or excellence, in the education and training of medical practitioners.

In South Africa the national quality assurance system for higher education, the HEQC's audit system, is getting into place, but professional bodies also have instituted their own quality assurance processes to ensure the quality of their professionals. Self-studies by higher education institutions and programmes, accreditation reviews and audits are the order of the day, not only in South Africa, but globally.

Standards usually are used in these systems as basis for the quality evaluation processes, but it is seldom found that criteria are stated in terms of which the evaluations can be done. In South Africa the Health Professions Council is responsible for quality assurance in medical education programmes, and this is done through a process of accreditation. Two of the goals of this accreditation process are: (i) To provide criteria and guidelines and set minimum requirements for curricula and programmes, and (ii) To promote comparability and equality of standards in medical and dental faculties/ schools in South Africa (HPCSA 1999a:3). Thus it is clear that criteria and guidelines (are supposed to) play an important role in accreditation, and to be able to compare something, there need to be criteria on which to base the comparison – how

else would one be able to say whether things are similar or dissimilar, or whether one thing is 'better' than another?

The accreditation process entails a self-study by the medical faculties/schools followed by a review visit to verify the self-evaluation report. It is clear that accreditation and standards go hand in hand, but what is not clear is the way in which these standards are 'measured' in accreditation processes, as criteria for determining the extent to which a standard has been achieved, are seldom defined in accreditation processes.

Having been involved in the development of the HPCSA's accreditation system since 1995, and in the process itself since 2001, the researcher realised that the accreditation process inherently is an evaluation and a benchmarking process, based on the judgement of the experts called upon to do the evaluation – be it the person(s) responsible for the self-evaluation or those doing the external review. But on what common base is this evaluation done? Objectivity cannot be guaranteed if different people with different frames of reference judge a process or outcome without an anchoring set of standards containing criteria to guide evaluative deliberations and decision-making. From the literature consulted it has become clear that a programme or institution is accredited if it achieves certain standards which relate to a large part to performance considered desirable or essential by the accrediting body, and good practice in the programme (educational standards) (see 1.3.1). In a previous study (Bezuidenhout 2002) the researcher developed a set of standards for the accreditation of undergraduate medical education in South Africa, but those still have not been implemented in the accreditation process, and even if they had been, that would not have answered the questions addressed in this study. These questions are about objectivity, the measurability (with a view to comparability of the process) of standards, finding a way in which to structure the process of evaluating a programme in terms of specified standards, creating a point of departure for improvement, and putting this together in an instrument that can be used for self-evaluation and peer accreditation reviews, that can serve as a basis for the faculty's/school's own assessment and the panel's collective assessment, and that might also be useful for giving feedback and in planning for improvement.

The researcher's experience in the accreditation process proved valuable in the search

for answers, but she had to go back to uncover the phenomenon of quality assurance in all its ramifications, in particular the accreditation process and related issues and factors. To do this, information and data were collected by means of literature and document studies, observation and interviewing, and through a process of inductive (qualitative) data analysis the researcher perceived to have arrived at an answer to the questions, and, it is hoped, at a product that will make a contribution to quality assurance as it manifests in accreditation in South African undergraduate medical education.

As it was assumed that a guide for accreditation reviews might contribute to solving the research problem, the study was **aimed** at developing and evaluating a guide for use in the accreditation process of the HPCSA (for accreditation reviews), that might also be used for self-evaluation and improvement purposes. A guide was developed based on the findings of a literature review, participant observation and field notes. In the empirical investigation participants' views and opinions were collected on the phenomenon of study, namely quality assurance, and more specifically, accreditation in undergraduate medical education, and on the draft guide as tool or mechanism to use in accreditation reviews. The findings of the empirical study indicated that the assumption was correct, and that the guide that had been developed presumably would give more structure to the peer review (external quality assurance) and self-assessment (internal quality assurance), which are the main components of the accreditation process. It is hoped that it will strengthen expert or review panels' decision-making and deliberations; that it will render peer judgements more objective, reliable and valid, and that it will also promote the objective of bringing about comparability and equality of standards in medical education in South African medical schools, as it will enable review panels to generate consistent judgements in terms of specified standards, which ought to be a particular priority in an assessment process aimed at ensuring quality and promoting development across the board of South African undergraduate medical education and training programmes. In the internal quality assurance processes of medical faculties/schools this guide, it is presumed, will facilitate preparations for the external review, and serve as a sound point of departure for planning and developmental actions to improve quality.

CHAPTER 2

QUALITY ASSURANCE IN HIGHER, INCLUDING MEDICAL, EDUCATION

A physician well versed in the principles of the science of medicine, but unskilful in his art through want of practice loses his wit at the bedside of his patient, just as a coward is at his wit's end to determine what to do when for the first time he finds himself in the ranks of a contending army. On the other hand, a physician experienced in his art but deficient in ... knowledge ... is condemned by all good men as a quack, and deserves capital punishment at the hands of the king. Both these classes of physicians are not to be trusted, because they are inexpert and half educated. Such men are incapable of discharging the duties of their vocation, just as a one-winged bird is incapable of taking flight in the air.

Sushruta Samhita – 300-400 B.C. (Suwanwela 1995:S32).

2.1 INTRODUCTION

Throughout the ages medical practitioners have occupied a special and revered position in society; the competence and capability that place a medical practitioner in this position should be above question. Society relies on medical practitioners to ensure the conditions that prevent disease and promote physical and mental well-being. To satisfy these expectations, doctors must be well-trained and educated, which places a special and heavy responsibility on the shoulders of medical education institutions and the systems responsible for the quality of medical education.

Higher education (including medical education) has changed markedly in many countries over the past 15 years (and even more so in South Africa over the past 10 years). Widening access, increased demand, new technologies, borderless education, demands for accountability, reduced government funding and new forms of governance all played a major role in recent changes (Harvey & Newton 2004:149). Socio-economic changes, technological changes and the move to globalisation made higher education institutions more aware of efficiency and effectiveness (Bazargan 1999:61). In the light of these changes, the control and maintenance of academic quality have become a major factor

in higher education and engender a steady flow of conferences, projects, books, articles and policies and programmes for quality assurance.

Why this preoccupation with quality at this time? The financial situation that prevails in most countries, together with the escalating cost of higher education compels university administrators, government departments, and other funders to ensure that sound management of human and other resources is implemented. As higher education is becoming more expensive and more and more individuals are seeking higher education, funders are seeking assurance that scarce resources are maximally utilised. The result is that educational institutions are required to justify their claim on increasingly scarce resources. This 'wave of economically driven scrutiny' has resulted in calls for greater accountability and for systematic assessment of the quality of teachers and teaching, higher education institutions and their programmes, and the improvement of higher education in general (Olmesdahl 1999:419).

Although the changes in higher education led to a renewed interest in the maintenance of quality, the assessment and control of the quality of higher education have always been an important focus of attention of higher education institutions – albeit that the words and procedures used, differed from what is used nowadays (van Vught 1994:38).

Van Vught (1994:38-39) summarises the history of quality assurance in higher education since medieval times, and distinguishes two extreme models of quality assessment, stating that they point to two crucial dimensions of quality assurance. One is the French practice of vesting quality control in an external authority, and the other is the typical English model of a "self-governing community of fellows" (van Vught 1994:38).

The French model represents the archetype of what today can be regarded as quality assurance in terms of accountability. In the early 13th century the University of Paris fought a dramatic struggle for autonomy. The chancellor of Notre Dame, acting as delegate of the bishop of Paris, represented the episcopal outlook that universities should be seen as 'ecclesiastical colonies' that should stand under episcopal authority. The chancellor of the cathedral of Notre Dame was an external official set above the master's guild, and as such claimed the right to grant or withhold the teaching license, and to decide about the content of studies. Thus the power to decide what should be

studied and who could teach was in the hands of an external authority. The masters fought this authority and in 1231, after a long and bitter conflict, Pope Gregory IX made an end to the dominance of the chancellor over the master's guild (van Vught 1994:38-39).

The English model of self-governance originated in the aspirations of the masters at the medieval universities of Oxford and Cambridge who strived for complete independence from external jurisdiction. All English higher education institutions founded before 1500 (with the exception of King's Hall, Cambridge) were sovereign, self-governing communities of fellows, with the right of electing the warden, master, president and provost. The 'committee' (the collective body of all members of the board) had the right to remove unsuitable masters and to co-opt new members; thus, it was up to the community of fellows to judge the quality of their colleagues (van Vught 1994:39). This may be the predecessor of what nowadays is called quality assurance by means of peer review.

In the quality assurance movements of the current day, it seems inevitable that both the French model of external assessment and the English of review by peers will have to come into play. A quality evaluation system that relies solely on collegial peer review without taking into consideration the needs of society and accountability to those who are responsible for their funding runs the danger of denial of the legitimacy of the institutions' existence; a quality assurance system that is limited to accountability to external authorities runs the risk of the institutions not being taken seriously by professional experts, as the knowledge, skills and attitudes that comprise a discipline may become distorted, misused or suppressed, as teachers in a discipline are accountable to their colleagues for the integrity of the discipline to be upheld (Frazer 1991:17; van Vught 1994:39).

As the education and training of medical practitioners did not historically take place at universities, quality assurance in medical education also cannot be traced back to medieval times. For many centuries medical training was part of an apprenticeship system, and the quality of the training depended on the capacity and conscientiousness of the master (Flexner 1910:3). Today quality assurance is as important in medical education as in higher education generally, if not more so, but it is also even more

difficult to define the concept. Medicine has a particularly difficult educational responsibility – on the one hand scientific research is considered the most important, whilst others regard practice and practical experience as prime aspects when it comes to assuring quality; some would only be interested in the final product of the educational process, whilst the importance of the educational processes themselves are becoming more and more important as a measure of quality in medical education (Labuschagné 1995:24). Today medical education has to produce graduates “who know the tried and true on the one hand, and on the other, who have been ingrained with standards of excellence against which to test innovations” (Butterfield 1972:x).

2.2 AN OVERVIEW OF QUALITY ASSURANCE IN HIGHER EDUCATION

2.2.1 The notion of quality assurance

Quality has become ‘big business’ in higher education (Scott 1994:51); the reasons for the prominence are obvious. The transition from élite to mass higher education means that quality can no longer be taken for granted. In the past university education was seen as synonymous with high academic standards; universities were assumed to be highly selective, enrolling only the cream of the crop, so to speak. Staff too was assumed to be true scholars involved in high level research; their social and intellectual prestige and standing went unchallenged. The traditional concept of quality is associated with the notion of distinctiveness; it is not something judged against a set of criteria, it is exclusive, apodictic (Trow 1999:14). Today entry is no longer highly selective, many higher education teachers are not active scholars or scientists, and core disciplines are “more likely to be defined in terms of vocational relevance than academic integrity or affinity, the traditional arts and sciences have lost ground to the applied sciences, social and technical” (Scott 1994:51). Thus, it is hardly surprising that questions are raised about the ‘quality’ of higher education - quality can no longer be assumed to be inherent to higher education.

What then is quality? Ashcroft (2003:8-11) describes quality as

- measurement of volume,
- means to ensure minimum standards,
- a means of ranking excellence, and
- a means of improvement.

In his seminal work Pirsig (1999:206) states "... there is such a thing as Quality, but as soon as you try to define it, something goes haywire". Later on he says: "Quality exists, whether it's defined or not" (Pirsig 1999:216). Answers to the question of how to define it, range from Pirsig's initial resignation that when one tries to define it, "it all goes *poof!*" (Pirsig 1999:184), to more definitive answers such as given by Harvey and Green (1993:11-27), who define quality as *exceptional*, as *perfection or consistency*, as *fitness for purpose*, as *value for money*, and as *transformation* (also see Ashcroft 2003:12).

In order to gain a better understanding of the standards and rubrics that will constitute the final outcome of this study (Chapter 7), a brief description of these notions of quality and quality assurance is given. Quality as excellence, as described by Harvey and Green (1993:12), represents two notions, namely excellence in relation to standards and excellence as 'zero defects'. In relation to standards quality may be seen in terms of high standards; an elitist view where quality is only possibly attainable in limited circumstances. This quality is about excelling in input and output – an institution which admits only the best students, and provides them with the best resources, by nature will excel, implying that quality output is a function of quality input.

Another notion of quality as exceptional is more diluted (Harvey & Green 1993:12-13). Here quality refers to having passed a quality check. Instead of being almost unattainable, the quality checks are based on attainable criteria designed to reject 'defective' outputs. Quality thus refers to having fulfilled minimum standards. Quality is the result of scientific quality control, it is conformance to standards. This notion closely resembles what is endeavoured in this study – the standards approach to quality implies that quality is improved if standards are raised – the higher the level of the standard that is met, the higher the quality. In higher education this approach to quality assurance, namely the maintenance and improvement of standards, is prevailing (*cf.* Harvey & Green 1993:13). However, serious concerns about this notion are raised by Harvey and Green (1993:15). Standards in higher education are not easily measurable and quantifiable, therefore it would be more acceptable to move away from 'quality control' of the end process, to continuous quality assurance, ensuring consistency in the process of higher education - as indeed is what is endeavoured with this study.

The notion of quality as excellence from the viewpoint of zero defects refers to excellence in terms of “conformance to specification” (which is predefined and measurable) (Harvey & Green 1993:15). Excellence now becomes perfection, getting it right first time – is this attainable in higher education? Higher education is not about delivering specifications in a near perfect way, it is about developing the student, which involves constant engagement with ‘specifications’, a process of reworking and reconceptualising (Harvey & Green 1993:16).

Quality as fitness for purpose in higher education in essence refers to an institution doing what it purports to do – mission orientation and consumer orientation (Westerheijden, Brennan & Maassen 1994:16). The role of quality assurance is to determine whether the institution is achieving the purposes it set for itself in its mission statement. According to Harvey and Green (1993:19) quality assurance is about ensuring that there are mechanisms, procedures and processes in place to ensure that the desired quality, however defined and measured, is delivered. Jonathan (2000:46) states that although the definition of quality remains elusive, the generally accepted usage in higher education is that of ‘fitness for purpose’, which sees quality in terms of fulfilling customer requirements, expectations, needs and desires. In higher education this is based on an institution’s ability to fulfil its mission, aims and objectives, and deliver a quality programme of study, that is, a programme which will ensure that students achieve specific standards and fulfil the changing needs of society (fitness for purpose) (Kistan 1999:125).

The Higher Education Quality Council of the United Kingdom explains quality assurance as a term which encompasses the policies, systems and processes directed at ensuring the maintenance and enhancement of the quality of education provision in an institution (HEQC 1996:14) – which infers fitness for purpose.

Quality as value for money refers to accountability; institutions are expected to be accountable to their funders and the users of their services (Harvey & Green 1993:22). The transformation view of quality is rooted in the notion of qualitative change – education is an ongoing process of transformation of the participant, be it student or researcher (Harvey & Green 1993:24).

In South Africa the Higher Education Quality Committee (HEQC) Founding Document (Marock 2000:14) states that the HEQC's framework for quality assurance is based on quality as

- fitness for purpose in the context of mission differentiation of institutions within a national framework;
- value for money, judged not only in terms of labour market responsiveness or cost recovery, but also in relation to the full range of higher education purposes set out in the White Paper on Education of 1997;
- transformation in the sense of developing the personal capabilities of individual learners, as well as advancing the agenda for social change.

In his discussion of forms of quality review in European higher education, van Vught (1999:39) defines quality assessment as “a systematic examination to determine whether educational activities comply with planned arrangements and whether the ‘product’ (i.e. the educational process) is implemented effectively and is suitable to achieve objectives”. Trow (1999:29) adds another dimension to quality in higher education by stating that one surely does not only want to judge an institution's capacity to conduct research or teaching, but also its ability to govern itself, to define its own character and mission, and to act effectively in fulfilling that mission. In taking a broader look at academic quality - that is what quality assurance in higher education institutions is about, academic quality – a key question, in the current day and age especially, is: What is the capacity of the institution to respond to change: changes in the body of knowledge, in the student population, in the demands of different constituencies and society, in funding by governments, in demands of higher education and professional authorities and in teaching and learning philosophies and practices in general? The ways in which an institution responds to change point to the quality of the institution's activities – institutions must be able to respond **appropriately** to changes in their intellectual, demographic, political and financial environments (Trow 1999:29).

Even though it is clear that quality has always been important in higher (including medical) education, there is a clear difference between what has been called traditional quality control and the new approaches to quality evaluation, or quality assurance, as described above. Of particular importance is that the external interest in the quality of higher education has increased in importance to a large extent. This is due to several

factors, as described in the introduction (2.1).

To conclude, it thus may be said that quality assurance is, by definition, centred around quality. Kohler (2003:315) maintains that whatever is understood by quality, assuring quality means, by definition, that there is a notion of the existence of and the quest for quality, a willingness to provide quality, a concept of quality, maintenance, enhancement of and monitoring quality. Thus quality assurance is a matter of awareness and commitment, that is, a quality culture, and of techniques, that is, processes, procedures and tools.

In order to put the rationale for and intended use of the standards and rubrics that will constitute the final outcome of this study in context, a brief overview of external quality assurance as it manifests in various countries in the world is given.

2.2.2 External quality assurance (EQA): Rationale, purpose and objectives

The changing landscape of the higher education sector is a global phenomenon. The expansion of higher education from élite to mass, new trends in teaching and learning, and changes in the demands and needs of society are challenging higher education for accountability (Kistan 1999:125). Monitoring the quality of academic programmes through external quality assessment has become the norm the world over. A brief overview of the rationales for EQA is indicated as a backdrop for the discussion of accreditation as external quality assurance method.

External quality assessment is aimed at providing the desired assurances and information to stakeholders to meet accountability requirements, but it should also demonstrate that the existence of an external quality assurance process has changed the institutional perspective on quality and has encouraged institutions to refine their own quality assurance measures (Bégin-Heick 1999:5). The rationale for external quality assurance can be summed up in the call of the European Union (EU) Ministers of Education for more visibility, transparency and comparability of quality in higher education (DEI 2003:5;8). Member states of the EU in 1998 were encouraged to establish external quality assurance (EQA) systems aimed at:

- Safeguarding the quality of higher education within the economic, social and cultural contexts of their countries, while taking into account the European dimension and the rapidly changing world;
- encouraging and helping higher education institutions to use appropriate measures, particularly quality assurance, as a means of improving the quality of teaching and learning, and also training in research;
- stimulating a mutual exchange of information on quality and quality assurance at EU and global levels, and to encourage co-operation among higher education institutions (DEI 2003:12).

A survey conducted by the Danish Evaluation Institute (DEI 2003:9;12) on 34 quality assurance agencies in 23 European countries showed that the three main purposes of the agencies were quality improvement and quality assurance in a traditional sense; disseminating knowledge and information, and accreditation.

In Quebec, Canada, the government in 1993 created a commission for the evaluation of higher education to measure programmes' efficiency in reaching objectives and standards predetermined by the Ministry (L'Ecuyer 1998:16). According to L'Ecuyer (1998:16) this is not a unique situation, as higher education programmes are governed at least partially by objectives and standards set outside the institutions by governments, professional boards, international agencies, etc.

In Sweden the aim of EQA was described as "to establish an instrument for the promotion of continual improvement in the operations in Swedish higher education institutions" (Wahlén 2004:140). Harvey and Newton (2004:151) assert that there is a lack of clarity regarding the purpose of EQA because the rationale is rarely openly admitted; the rhetoric and documentary preambles often refer to quality evaluation as a process of improvement, yet all the emphases, according to these authors, are on accountability, compliance, and in some cases, control of the sector. The National Assessment and Accreditation Council (NAAC) in India consciously adopted improvement as its main objective; accountability concerns were addressed unobtrusively as an incidental outcome: it was felt that there were adequate checks and balances built in the higher education model of the country to ensure the accountability of institutions (Stella 2004:118). External quality assurance in the Netherlands is carried

out by an independent accreditation organisation which accredits all degree courses in higher education on the basis of them meeting certain basic quality standards (Dittrich 2003:20). In order to qualify for accreditation a degree course must be granted a 'satisfactory' assessment in six areas: aims and objectives, nature and contents of the programme and examinations, quality and quantity of staff, facilities and provisions, the achieved results, and internal quality assurance processes.

A study conducted on 38 European countries in 1997 revealed the following as the most important reasons for introducing external quality evaluations (Billing 2004:115):

- Assisting higher education institutions to make improvements;
- accountability to stakeholders;
- changes in law (for example, increased autonomy of universities);
- informing potential students and employers about standards;
- assisting government in making funding decisions.

In summarising the results of this survey, Billing (2004:115) found the purposes of EQA to be "variants of a mix of the same functions" which boil down to:

- improvement of quality;
- publicly available information on quality and standards;
- accreditation (i.e. legitimisation of certification of students);
- public accountability (for standards achieved and use of money);
- contributing to the higher education sector planning process.

In the United States of America (USA) accreditation has become widely accepted as the primary vehicle for assuring the quality of higher education. According to Jones (2002:1) the original audience for accreditation was the academy itself – it did not come into being in response to concerns about quality expressed by external audiences. Therefore, accreditation as quality assurance mechanism served the purpose of identifying/certifying institutions as being legitimate institutions of higher education, qualifying them and their degrees and credits to be accepted as "full-fledged members of a kind of club" (Jones 2002:1), easing the processes through which institutions made decisions about accepting one another's products. By establishing standards for accreditation, institutions were provided with meaningful targets to strive for, which constituted a stimulus for improvement.

In South Africa the Higher Education Act (1997) gives the responsibility of the promotion of quality assurance to the Higher Education Quality Committee (HEQC), comprising the accreditation of higher education programmes and the audit of quality assurance mechanisms of all higher education institutions (CHE 2003:2). The quality promotion role of the HEQC is interpreted as to “promote quality among constituent providers in higher education in order to facilitate the development of quality awareness and quality responsiveness in public and private provision” (CHE 2003:2). The general objectives of the HEQC programme accreditation are (HEQC 2003:s.p.):

- To identify and grant recognition status to programmes that can satisfy the HEQC’s minimum standards for provision, or demonstrate their potential to do so in a stipulated period of time.
- To protect students from poor quality programmes through accreditation and re-accreditation arrangements that build on reports from self-evaluation and external evaluation activities, including HEQC audits, and other relevant sources of information.
- To encourage and support providers to institutionalise a culture of self-managed evaluation that builds on and surpasses minimum standards.
- To utilise all available quality assurance capacity and experience in a co-operative approach to accreditation.
- To cultivate a culture of innovation and continuous improvement in higher education. This implies the implementation of innovative measures by institutions to move beyond the minimum requirements set by the HEQC.

According to Harvey and Newton (2004:151-153) the rationale for external quality assurance (EQA) processes is rarely openly admitted. They identify the main purposes of EQA as:

- Accountability (because of the cost of massification, to account for and prioritise public expenditure, assurance to students of the quality of the ‘service’ they get, and the generation of public information about the quality of institutions and programmes);

- control (of unrestrained growth, to ensure the status and legitimacy of higher education, especially in view of internationalisation and globalisation, and comparability of standards);
- compliance (governmental pressure for higher education to be more responsive to value-for-money concerns, to be more relevant to social and economic needs, to engage in widening access, to ensure comparability of provision and procedures, and compliance in the production of information, for example statistical data, prospectuses, course documents);
- improvement (to encourage institutions to reflect on their practices; the assessment of value added is at the core of improvement-oriented EQA processes).

The above examples have been taken from literature on EQA in an effort to determine the rationale for external quality assurance. From the quoted and other sources (Billing 2004; Faber & Huisman 2003; Glidden 1998; Haakstad 2001; Lemaitre 2004; Randall 2002; Szanto 2004) it is clear that the rationale for EQA is to provide an independent assertion of standards, which is then accepted elsewhere. The movement is still developing and changing; reasons for the growth in interest in EQA, as expressed by the authors mentioned above can be summarised as the increase of the number of students in higher education, the increase in funding by governments, who therefore require more evidence of accountability, the increase in the cost of higher education for students themselves, and the increasing internationalisation of higher education with a concomitant need for comparability.

2.2.3 Types of external quality assurance

Having briefly outlined why and with what purposes EQA systems have come into being all over the world, the question of how EQA manifests must be answered. Harvey and Newton (2004) discuss the preponderant approaches to external quality assurance, and assert that, broadly speaking, external quality assurance can be categorized into four types of activity: accreditation, audit, assessment and external examination (Harvey & Newton 2004:150). They define these types of EQA as follows: accreditation refers to a process resulting in a decision that warrants an institution or programme; audit explores internal quality assurance processes; assessment passes a judgement (often with a grading), usually about the quality of a teaching or research subject area; and external

examination checks standards (be they academic, competence, service or organizational) (Harvey & Newton 2004:150).

Billing (2004:113-137) explores international comparisons of EQA frameworks in higher education. The comparisons he draws, show that a 'general model' of external quality assurance does not universally apply, but that most of its elements do apply in most countries (Billing 2004:113). An overview of literature showed that a number of countries make use of quality audits, such as Sweden (Wahlén 2004:139-147); in the United Kingdom external quality assurance processes include departmental subject reviews, institutional audit, benchmarking, programme specification and performance indicators (Ashcroft 2003:15-16; Gosling & D'Andrea 2001:7-17); in South Africa the Higher Education Quality Committee (HEQC) has responsibility to accredit programmes of higher education, audit the quality assurance mechanisms of higher education institutions and promote quality in higher education (HEQC 2003:1). Medical education programmes in South Africa also are accredited by the professional body, the Health Professions Council of South Africa (HPCSA), and the accreditation process for undergraduate medical education is carried out by the Sub-committee for Undergraduate Education and Training of the Medical and Dental Professions Board of the HPCSA (*cf.* HPCSA 1999a).

Accreditation is the major EQA process in India (Prasad & Stella 2005:3; Stella 2004:115-127); Poland emphasises accreditation, but through voluntary agencies (Billing 2004:118); in Chile a compulsory licensing process and a voluntary programme and institutional accreditation process are used for EQA (Lemaitre 2004:89-99). In the United States of America (USA) accreditation carried out by private non-profit organisations designed specifically for this purpose, thus a non-governmental enterprise, is the national procedure for quality control (Eaton 2002:1; Glidden 1998:1-4). In the Netherlands and Flanders an independent organisation accredits all degree courses in higher education to determine whether they meet certain basic quality standards (Dittrich 2003:20; Faber & Huisman 2003: 236); in Hungary higher education institutions and degree programmes are accredited through a process called 'programme accreditation performed within the framework of institutional accreditation' (Szanto 2004:59). In Austria the *Fachhochschule* Council is responsible for external quality assurance through a process of accreditation – initial accreditation is compulsory to get approval for

a programme to be instituted, followed by evaluation of programmes and institutions for re-accreditation (Sohm 2004:32).

A survey conducted by the Danish Evaluation Institute (DEI 2003:19) showed that accreditation is widely used in European higher education systems as a quality assurance method; it was found to be especially common in the countries of the European Union, where it has been the traditional way to ensure quality, and countries such as Germany, Norway and the Netherlands have, since the survey, decided to use it as main type of quality assurance of higher education.

These are examples of EQA procedures taken from literature. As this study is about standards for accreditation, the process of accreditation needs to be elucidated.

2.3 ACCREDITATION AS QUALITY ASSURANCE PROCESS

2.3.1 Defining accreditation

The term 'accreditation' as found in the literature is not always very precise. It refers to a formal authorising power, making official decisions regarding the recognition (or not) of a study programme or an institution, but it also implicitly refers to the quality of the programme or institution. According to Haakstad (2001:77), no matter what the purpose of the accreditation process, use is always made of a type of benchmarking process, and must always refer to standards, whether these are stated explicitly or not. In their seminal work on accreditation, Young, Chambers, Kells and Associates (1983:21) describe the basic features of accreditation, as its finds expression in the USA model, as:

- A voluntary process, arranged and co-ordinated by the universities;
- based on the philosophy of self-regulation;
- primarily focused on the assessment of the quality of education and training, with a view to protect the consumers against exploitation, and
- based on evaluation (especially self-evaluation).

Accreditation can be defined as a process that examines an educational programme or institution in order to determine that it

- has appropriate purposes;

- has the organisation and resources to accomplish its purposes;
- can demonstrate that it is accomplishing its purposes; and
- gives reason to believe that it will continue to accomplish its purposes

(Cassie, Armbruster, Bowmer & Leach 1999:493; Frazer 1991:5).

Generally, an institution will qualify for accreditation if it maintains certain established qualification and educational standards, as determined through initial and periodic evaluations (RGN 1988:3). The purpose of accreditation thus is to set standards, to do evaluations and to assess whether acceptable levels of quality have been achieved in education and training. It must however be understood that that which is described here as "quality" is an elusive concept and that accreditation, even in the widest sense, cannot provide a guarantee in terms of the expectations entertained regarding such education and training (RGN 1988:3). The following definitions of accreditation, taken from a report of the Human Sciences Research Council (RGN 1988:3-5), must be read and interpreted with this as frame of reference:

Young et al. (1983): Accreditation is a process by which an institution of post-secondary education evaluates its educational activities, in whole or in part, and seeks an independent judgement to confirm that it substantially achieves its objectives, and is generally equal in quality to comparable institutions or specialized units.

Hawes et al. (1982): (Accreditation is) approval of a professional program of studies, or of the study programs of an entire educational institution, by a recognized accrediting body.

Rowntree (1981): (Accreditation is the) recognition and approval of ACADEMIC STANDARDS of an educational institution by some external, impartial body of high public esteem.

More recently accreditation has been defined as "a procedure of quality assessment aiming at formal approval of a study programme (programme accreditation) or an institution (institutional accreditation) by a non-governmental body of experts and, possibly and preferably, by stakeholders" (Kohler 2003:315).

In fulfilling its role, accreditation focuses on two concerns: (i) **educational quality**, as defined and interpreted within the institution's or programme's statement of scope and purpose (mission) as compared with similar institutions and programmes; and (ii) **institutional integrity**, that is, the institution or programme is what it says it is and does what it says it does (Young *et al.* 1983:25). Thus educational quality and integrity are evaluated and promoted by looking at conditions believed to be necessary and desirable to produce educational quality (input, resources and process), and evidence that educational quality is indeed achieved (outcomes) (Bezuidenhout 2002:36).

2.3.2 The accreditation process

Accreditation as a quality assurance process has been designed primarily to encourage and assist an institution to evaluate itself and/or its programmes objectively, and then for the accrediting body to validate what the institution has said about itself/its programme(s). The accreditation process therefore usually comprises two processes: an institutional self-study which is a comprehensive, internal effort to assess the effectiveness of the institution or programme in the light of its own stated objectives, and a peer evaluation, which is an external assessment, and entails judgement by peers from outside the institution (Young *et al.* 1983:25).

Self-analysis (self-study) as first step in the accreditation process is generally conducted as the cornerstone of the external peer review. It is widely accepted because of its cost-effectiveness and its high degree of ownership and acceptance by the academic community itself; especially when the quality assurance process has to result in improvement, self-evaluation by the academics themselves is a crucial step in the whole process (van Damme 2000:11). Institutional self-study can be described as a process by means of which the institution deliberately collects information about itself and its programme(s), that is, conducts an assessment of its activities and structures in the light of stated goals and objectives to determine strengths and weaknesses, determines what actions need to be taken to put into effect those decisions that will enhance the activities, builds out its strengths and implement corrective measures with regard to weaknesses (Bezuidenhout 2002:37). Most quality assurance bodies prescribe guidelines or a framework of questions for self-evaluations, but they differ as to whether they expect the self-evaluations to be self-critical and analytical, or to merely provide information (Billing 2004:121). To summarise then it can be said that the aim of self-evaluation is to show in

a transparent, well-founded and reliable way how the aims, requirements and expectations as defined in the areas to be evaluated, are met.

The internal self-evaluation is usually followed by an external peer review as next step in the accreditation process. The accrediting body appoints a panel of experts that studies the self-evaluation report of the institution to be accredited, conducts an on-site visit, and on the basis of its findings, validates the self-evaluation report. The findings of this accreditation review panel (panel of experts) are then submitted to the institution for verification, adapted if so required, and finally submitted to the accrediting body that makes a decision regarding the accreditation of the institution/programme (Bezuidenhout 2002:42-43; DEI 2003:23; Hamilton & Vandewerdt 1990:542).

Van Vught (1994:44) summarises the steps in the accreditation process, generally speaking, as follows:

- The accrediting body sets standards and indicates the procedures to make accreditation decisions.
- The institution or programme describes, analyses and assesses itself in a self-evaluating process.
- An evaluation team of peers visits the institution or programme and examines it in the light of the documents that have resulted from the self-evaluation process and of what it finds in the institution to determine how it measures up in terms of the standards set by the accrediting body. The team reports both to the institution and the accrediting body.
- The institution or programme responds to the report of the evaluation team.
- The accrediting body decides whether to grant, deny or reaffirm accreditation in the light of the self-evaluation, the report of the visiting evaluation team and the response of the programme or institution.

The aim of external evaluation is to evaluate, on the basis of the internal self-evaluation, whether the aims, requirements and expectations as defined for the areas to be evaluated, have been fulfilled convincingly and transparently (Sohm 2004:34). Quality assurance by means of accreditation thus has both an external and an internal component. In order to enter a phase where it is possible to maintain and improve quality, and also to be held accountable for it, it is necessary for the external process to

be based on the internal.

2.3.3 The dual goal of accreditation

Quality assurance has always been part of higher education. Since about 1980, however, 'new' approaches to quality assurance emerged as a result of the expansion of higher education and other factors as described earlier. A common characteristic of the 'new' quality assessment procedures is that they shifted focus from the previous exclusive aim of control towards attention paid to quality improvement - albeit control or accountability remained a prominent feature - and more emphasis on processes (Fourie 1999:xiv; Westerheijden *et al.* 1994:19).

Vroeijenstijn (1994:96) asserts that external quality assurance in the first place aims at quality improvement; other aims are subordinated to the main purpose. The Japanese University Accreditation Association (JUAA 1996:7) aptly summarises the dual goal of accreditation as providing guidelines (by means of standards for accreditation) for universities to maintain and improve reasonable standards. Quality assurance entails the attempt to strive for the best, to improve, and to ensure the desired goal is reached – therefore one aspect of quality is the will to improve, the other is to measure the degree to which this has been attained (Suwanwela 1995:S37). The World Federation for Medical Education (WFME 2000:665;668-669) states that standards for quality assurance should not aim at uniformity, but function as a lever for change and reform, and provide guidance for achieving it; standards should not only set minimum requirements, but also encourage development beyond the levels specified and be applied as a model for each institution's own programme development. This was also the aim with the standards developed in the study on standards for the accreditation of undergraduate medical education in South Africa (Bezuidenhout 2002:151-166) in which the standards were set at two levels: one for minimum standards of achievement and the other for improvement of quality.

In the current study the dual aim is strived for too: standards are set, and each standard is provided with a rubric to determine the level of achievement; thus recognition is given to the dynamic and evolving nature of quality assurance – it is recommended that as institutions reach the higher levels of compliance with the standards, the accreditation body should adapt the rubrics to include more examples of best practice, thus always

ensuring that institutions will not be satisfied with having achieved minimal standards, but will strive to be exemplars of best practice and beyond, setting new standards to be achieved (see Chapter 7 - *A guide for accreditation reviews*).

2.4 QUALITY ASSURANCE IN MEDICAL EDUCATION

2.4.1 Towards the assessment of quality in medical education

In 1990 Boelen (1990:131) asked: “How far has medical education been reshaped to meet society’s new realities and expectations?” At the time, more than 40 years have passed since the establishment of the World Health Organisation (WHO), of which 20 years of active work have gone into the educational development of health professionals. During the 1970s the WHO initiated a global network of teacher training centres, which contributed to legitimising the concern with the improvement of medical education and resulted in medical education being increasingly recognised as a field of knowledge in its own right (Boelen 1990:131). During 1984 the World Federation for Medical Education (WFME) instituted an international programme for the reorientation of medical education. The cornerstones of this collaborative programme were the Edinburgh Declaration of 1988, followed by the World Summit recommendations on medical education (1994) which were reflected in the World Health Assembly (WHA) Resolution 48.8 of 1995 (WFME Executive Council 1998:549).

The 48th World Health Assembly, in its Resolution 48.8 of 1995 *inter alia* encouraged all countries to undertake activities to reform medical education with a view to increasing relevance, quality, cost-effectiveness and equity in health care; to this end the special contribution of medical schools in attaining health for all needed to be reviewed (WHO 1996:7). Based on the WHA resolution 48.8 the WHO proposed a global strategy to guide and support the design and implementation of appropriate approaches and methodologies for reorienting medical education (and medical practice) to serve the goal of health for all. The strategy for reform in medical education comprised two components: the fulfilment of medical schools’ social mission, and quality in medical education (WHO 1996:13). With regard to quality in medical education it is stated, *inter alia*, that: “Quality in medical education will be promoted, based on principles of relevance to health needs of individuals and communities, adequacy for optimal practice patterns and efficiency of the learning processes. In training programmes, emphasis

should be put on health care management, quality assurance and health economics. ... Tools and procedures for measuring quality in medical education will be designed and validated through field testing for use in internal evaluation, external evaluation or accreditation of medical schools” (WHO 1996:13).

The process of quality assurance in medical education “is intended to ensure that future physicians attain adequate standards of education and professional standards” (Boelen *et al.* 1992:1); and “Quality in medical education results from a co-ordinated effort to ensure relevance and efficiency in the education of future doctors and to ensure these doctors’ optimal fit in society. Implicit in the notion of quality is a special consideration for social accountability” (Boelen 1995:S21). These definitions imply responsibility and accountability of medical education and training institutions for their product. In 1994 the WHO and the Educational Commission for Foreign Medical Graduates co-sponsored a consultation entitled *Toward a global consensus on quality medical education: Serving the needs of populations and individuals*. This consultation was directed towards attaining a global consensus on the definition and elements of quality in medical education and the most appropriate ways in which to evaluate quality. The individuals that participated explored what should be expected of medical schools to achieve the broad goal of meeting the health needs of populations and individuals, while contributing to the generation of new biomedical knowledge and the transmission of that knowledge to future generations of physicians (Wilson & Boelen 1995:Sv). What came under scrutiny here were the evaluation of the educational process in medical schools and its responsiveness to societal needs. It is thus clear that quality in medical education usually has two premises: one is that the educational **processes** are evaluated for effectiveness and efficiency, and second, relevancy and social responsiveness play a major role in defining quality.

2.4.2 Quality assurance systems for medical education

Medical education is described by Boelen (1995:S23) as “the science and art of preparing physicians to function properly in society”. To achieve this in medical education, indicators regarding the design and development of the curriculum and the educational process, as well as regarding the availability and use of resources are required. Furthermore it is necessary to assess institutions’ social accountability to determine the quality of their programmes (Boelen 1995:S27; Boelen 2001:6).

The assessment of quality in medical education varies from system to system, depending on the level under consideration, whether it is national or institutional, or whether it is related to a programme of study, or discipline-based, whether it is related to the objectives of the programme, or the final outcome, whether the quality assurance process is instigated by the higher education authorities, independent accreditation bodies, governments, or professional boards, etc. Also, many people have an interest in the quality of medical education; students have the right to good education and training, and the public has the right to well-educated and well-trained doctors. Therefore, although quality assurance is primarily the responsibility of the academic staff providing the education and training, the requirements of all stakeholders must be taken into account: the profession, the academic world, the students, government, higher education, and the public at large (Vroeijenstijn 1995:S61).

To serve as backdrop for the development of a guide for accreditation reviews of undergraduate medical education in South Africa, it was necessary to investigate the quality assurance processes in other medical education systems. Medical education systems that have well developed quality assurance procedures often discussed in literature are those of the USA, Australia and the United Kingdom.

2.4.2.1 United States of America

A study of quality assurance systems for medical education and training in a number of countries revealed that the United States of America (USA) perhaps has the most extensive and a very well-developed accreditation system (and perhaps the most complicated and confusing!), which differs from what is found, for example, in the United Kingdom, where quality audits and external examinations are the order of the day (*cf.* GMC 1997), or South Africa, where accreditation is the responsibility of the professional council (*cf.* HPCSA 1999).

The accreditation of medical education and training in the USA falls under the auspices of the Liaison Committee on Medical Education (LCME). The LCME defines accreditation as “a process of quality assurance in postsecondary education that determines whether an institution or program meets established standards for function, structure, and performance. The accreditation process also fosters institutional and

program improvement” (LCME 2004b:1). Accreditation is said to be important in that it enables institutions to have a public record of their learning that will be widely accepted by employers, professional associations, and other colleges and universities (LCME 2002:1). It is a voluntary, peer-review process, designed to attest to the educational quality of new and established educational programmes leading to the M.D. (Doctor of Medicine) degree offered by universities or medical schools in the United States. The LCME jointly accredits M.D. granting programmes in Canada in co-operation with the Committee on Accreditation of Canadian Medical Schools (CACMS). The LCME maintains that by judging the compliance of medical education programmes with nationally accepted standards of educational quality, the LCME and CACMS serve the interests of the general public and of the students enrolled in the programmes (LCME 2004: 1-2). To achieve and maintain accreditation, medical education programmes must meet the standards provided in the *LCME Accreditation Standards* documents (LCME 2003; 2004:1-8; 2004a:1-19).

Accreditation by the LCME confers eligibility for participation in federal student loan programmes. Most state boards of licensure require that United States (US) medical schools be accredited by the LCME as a condition for licensure of their graduates; graduates of LCME-accredited schools are eligible for residency programmes accredited by the Accreditation Council for Graduate Medical Education (ACGME) (LCME 2004b:1). The LCME is recognised as a reliable accreditation authority for this purpose by the Congress in various health-related laws, and by the state, provincial (Canada) and territorial medical licensing boards (LCME 2004b:1).

The LCME comprises 17 members who are medical educators and administrators, practising physicians, public members and medical students. The Association of American Medical Colleges (AAMC) and the Council on Medical Education of the American Medical Association each appoints six professional members and one student member, the LCME itself appoints two public members, and a member is appointed to represent the CACMS (Committee on Accreditation of Canadian Medical Schools) (LCME 2004b:2). The visiting team members are appointed by the LCME secretariat and are selected from a pool of around 200 medical practitioners and basic science and clinical educators, educational researchers and administrators (LCME 2004c:2).

These *ad hoc* teams of evaluators conduct on-site surveys. During the on-site visit the team verifies and updates information compiled in the school's medical education database, clarifies issues that are unclear, views the environment and facilities for learning, and meets with administrators, faculty members and students. Students make an important contribution in that they are expected to organise their own self-study of the educational programme, courses and curriculum, student support services, and the learning environment, and they are expected to be represented on the various committees conducting the institutional self-study; groups of students meet with the visiting team (LCME 2004c:2).

The LCME in 1995 laid down standards (which are updated annually) with a focus on output evaluation. According to these standards it is expected of medical schools to document their educational outcomes in terms of their institutional mission and goals (LCME 1995:20). The process of accreditation entails an institutional self-assessment, preparation of a data base, cataloguing the programme, and the site visit. Generally, the process is repeated with seven- to eight-year intervals, and requires of educational programmes to provide assurances that their graduates exhibit general professional competencies that are appropriate for entry to the next stage of their training, and that serve as foundation for life-long learning and proficient medical care (LCME 2004:2). The questionnaires medical schools have to complete for the self-assessment and in preparation of the data base collect data on the revenues and expenditures of schools, on financial assistance, grants, loans, and educational indebtedness for medical students, as well as on operational characteristics of the educational programme leading to the M.D. degree, including details of the curriculum, the demographics and academic antecedents of students admitted to the programme, and resources (faculty members, residents, educational sites, libraries, etc.) involved with the medical education programme. Collective data are summarised in an annual report, which is submitted for accreditation purposes, and is published in the *Journal of the American Medical Association (JAMA)* as part of its medical education data base.

To be accredited, programmes must meet the national standards set forth in the LCME's accreditation document, entitled *Functions and structure of a medical school: Standards for the accreditation of medical education programs leading to the M.D. degree* (LCME 2003). The standards are stated in a fashion that is "not susceptible to quantification or

precise definition, because the nature of the evaluation is qualitative in character and can be accomplished only by the exercise of professional judgment of qualified persons” (LCME 1995:6). In the preface to its standards document the LCME states that while it recognises the existence and appropriateness of diverse institutional missions and educational objectives, it subscribes to the proposition that local circumstances do not justify accreditation of a substandard programme (LCME 2004:2). The importance of the accreditation process for medical schools becomes clear when one reads the introduction to the LCME’s set of standards, namely, “An essential goal of each program of medical education leading to the M.D. degree must be the meeting of standards for accreditation by the LCME” (LCME 2004:2).

Three types of accreditation are granted: (i) Initial, provisional accreditation is granted to new programmes. Surveys (including site visits) are conducted annually, and full accreditation may be given in the year the first cohort graduates. To be considered for initial provisional accreditation a school must submit documentation showing that its proposed programme can be expected to meet the standards for accreditation when the stated number of first-year students will be admitted (LCME 2004b:2). (ii) Full accreditation is granted for a period of 7-8 years. Towards the end of a term and prior to the on-site evaluation, fully accredited programmes compile the medical education database and conduct an institutional self-study in preparation for the site visit to consider renewal. (iii) Accreditation on probation is the term used when it is found that a school does not comply substantially with the LCME’s published standards. Programmes on probation have a maximum of 24 months to achieve compliance with all accreditation standards. Site visits are conducted annually during the probation period to monitor progress addressing the accreditation deficiencies; probation ends when the school is found to be in full compliance with the standards, or may be withdrawn if it fails compliance after the stated period (LCME 2004b:2-3).

2.4.2.2 Australia

The Australian Medical Council (AMC), which was established in 1985, is responsible for the accreditation of medical schools and courses in Australia and New Zealand. The first constitutional function of the AMC was “the accreditation of medical schools and courses leading to basic medical qualifications” (Hamilton & Vandewerdt 1990:541), and to do this the Council established a Medical School Accreditation Committee (AMC

2002:3). A working party was also established to develop the standards for accreditation (AMC 2002:6). In the AMC's definitive document, *Assessment and accreditation of medical schools* (2002), the background and aims of medical school accreditation, the educational standards for medical schools and the procedures for the assessment of medical schools are set out. These standards were based on the Australian Doherty Report on medical education, the UK General Medical Council Guidelines, the standards of the USA LCME, and the World Federation for Medical Education (WFME) international standards for basic medical education (AMC 2002:9-10); in turn, these standards played an important role in the development of standards for the accreditation of undergraduate medical education in South Africa (Bezuidenhout 2002) and the rubrics for accreditation standards which were designed in the current study.

In a submission the AMC states that its accreditation process is benchmarked against international standards and best practice, and that it continually renews the process through ongoing engagement with stakeholders (AMC 2002a:1). In this submission it is further stated that while the accreditation of medical schools is a nationally centralised process, the AMC values diversity and innovation, encouraging medical schools to develop programmes that meet student and community needs within a framework of social responsibility and academic excellence. The AMC views collaboration among medical schools as a positive response to limited resources and allows specialisation within schools to build on unique strengths. It is the AMC's view that all medical schools should achieve equal quality standards, given their role in the provision of doctors for the Australian community (AMC 2002a:1).

The purpose of accreditation of medical schools by the AMC is to enable the AMC to assure the medical registration boards that a medical school's educational programme satisfies agreed national guidelines for basic medical education, and it also accredits New Zealand medical schools for the purposes of registration of their graduates in Australia. The overriding requirement of AMC accreditation is that medical schools produce medical practitioners who are safe and competent to practise as interns under supervision and who have an adequate basis to undertake further vocational training (AMC 2004:1).

The AMC Medical School Accreditation Committee

- develops standards, policy and procedures relating to the accreditation of medical schools and medical courses;
- oversees the Council's programme of accreditation of medical schools and medical courses;
- seeks to encourage improvement in undergraduate medical education in Australia and New Zealand that responds to the evolving health needs and practices, and educational and scientific developments (AMC 2002:52-53).

The accreditation process of the AMC's accreditation committee entails a self-study process based on the standards, and requires of a school due for accreditation to complete a questionnaire inquiring about the overall objectives and priorities of the curriculum; course content; educational methods; assessment techniques; course outcome evaluation; electives; school and course management and governance; staffing, including staff development and review; resources, including lecturing venues, laboratories, hospitals and libraries, community centres and private practices; the school's relations with other stakeholders; student selection, support and remedial programmes, as well as planning for future development, and problem areas identified by the school (AMC 2002:55).

The completed questionnaire and documentation developed by the school are submitted to the committee approximately six months before the on-site visit is to take place; these are then studied and discussed by the assessment team. An assessment team is set up for each accreditation visit, and the team comprises members from a range of medical schools, members from medical science and clinical disciplines, hospital and community-based teachers, and experienced academic managers (AMC 2002a:1). During the site visit the team inspects the physical resources, and consult with, *inter alia*, members of the medical school, the curriculum committee, recent graduates and students, as well as with senior officers of the university, and representatives of the state department of health (AMC 2002:58). At the end of the visit the team presents its preliminary findings to the school, and after response of the school a final, detailed report is drafted. The school may appeal against any adverse recommendations. The report is scrutinised by the Accreditation Committee and submitted to the AMC for a final decision regarding accreditation or not (AMC 2002a:2; AMC 2004:2).

The process and premises of the AMC's accreditation system show many similarities with the system in use in South Africa; which is to be expected, as this system was studied when the accreditation system was developed for the HPCSA (*cf.* Bezuidenhout 2000; Labuschagné 1995).

2.4.2.3 *United Kingdom*

In the United Kingdom (UK) the Education Committee of the General Medical Council (GMC) was charged by statute with the responsibility of promoting high standards of medical education and co-ordinating all stages of medical education in the country (GMC 1993:4). This responsibility entailed that the Education Committee had to ensure that every newly appointed house officer was capable of fulfilling the requirements of the post. House officers (pre-registration year students) engage in clinical practice, albeit under supervision, and the Education Committee must satisfy the Privy Council (the advisory body to the British sovereign) that the requirements for undergraduate medical education as set out in *Tomorrow's Doctor* (GMC 1993, updated 2003) are fulfilled by students that qualify (GMC 1993:6).

The Education Committee's recommendations regarding the requirements for undergraduate medical education as set out in *Tomorrow's doctor* (GMC 1993:7-22) addressed the following aspects of undergraduate medical education:

- A revised curriculum framework
- The core curriculum
- Special study modules
- Learning systems
- Regulation of the undergraduate course
- Goals and objectives of undergraduate medical education
- Curriculum themes
- Assessment
- Pre-medical education
- Intercalated and other degrees
- European Community legislation
- Implementation of recommendations and the role of the GMC.

In summarising the recommendations set out in *Tomorrow's Doctors* the Education Committee stated that through these recommendations it sought to address the widely perceived deficiencies in medical education of the day (GMC 1993:21). The Committee stated unequivocally that there should be change if the ambitions of the Council and of the schools themselves were to be realised. Amongst the barriers to the change that was needed, it mentioned the "quasi-autonomy of individual departments and the continuation of the pre-clinical/clinical divide" which they regarded as inhibiting the development of an integrated faculty-based curriculum (GMC 1993:21).

From 1982 the Committee met its duties by inspection of qualifying examinations, informal visits to medical schools (the last round taking place in the period 1998-2001), and written monitoring (Harte 2002:1). From 1993 this was done in terms of *Tomorrow's Doctors* (GMC 1993). With regard to the process of quality assurance, the Committee, through powers granted by the Medical Act of 1983, was entitled to obtain such information from institutions as it required about courses of study and examinations, to inspect qualifying examinations and to visit medical schools to assess "the sufficiency of the instruction given" (GMC 1993:11). In 2002 the Committee set up a working group to consider whether to develop a continuous and integrated quality assurance system or to continue to rely on the "discrete activities" mentioned above. The working group produced a number of proposals which were approved by the Committee and can be summarised as follows:

A quality assurance system should be put in place that would assure that the curricular outcomes (attitudes, behaviour, knowledge and skills) described in *Tomorrow's Doctors* are achieved. The philosophy underpinning the proposed system was that the system should be efficient, valid, reliable, convenient, fair, focused and professional. Regular visits to universities would be coupled with annual requests for documentary information based on *Tomorrow's Doctors* (GMC 1993) and *The new doctor* (GMC 1997). The visits would be carried out by a small group of trained visitors, looking at particular areas with a focus on issues identified in the annual returns (Harte 2002:2).

In 2003 a new edition of *Tomorrow's Doctors* replaced the former recommendations, and explained that the 1993 edition of the document had signalled a significant change in the guidance of the GMC. The emphasis had moved from gaining knowledge to a learning

process that included the ability to evaluate data as well as to develop skills to interact with patients and colleagues. The medical schools welcomed the guidance and introduced new, ground-breaking curricula. The GMC carried out a series of informal visits to medical schools to monitor their progress in putting into practice the guidance, to identify areas of concern and to highlight and share good practice (GMC 2003:2).

In July 2004 the GMC published a guidance document for quality assurance in basic medical education (QABME) (GMC 2004). In this document it is reiterated that the GMC has the statutory responsibility to set standards for basic medical education (undergraduate education and general clinical training - the pre-registration house officer [PRHO] year) and to ensure that these standards are met. The Education Committee of the GMC has the power to visit universities to make sure that the undergraduate education is appropriate and to inspect examinations to make sure that the standards expected at qualifying examinations are maintained and improved (GMC 2004:1).

The standards set in *Tomorrow's Doctors* (GMC 1993; 2003) form the requirements for undergraduate medical education. These standards identify the outcomes in terms of knowledge, skills attitudes and behaviour required by medical graduates, and place the principles of professional behaviour at the heart of this stage of training (GMC 2004:2).

In a guidance document (GMC 2004:2) the aims of the quality assurance process for basic medical education (QABME) are described, namely:

- to make sure that the outcomes of *Tomorrow's Doctors* are met;
- to identify examples of innovation and good practice;
- to identify, discuss and resolve issues of concern;
- to identify changes that need to be made and a timetable for their introduction;
- and
- to promote equality and diversity in medical education.

The objectives of the QABME process are to

- monitor changes to curricula, assessments and staffing through information received annually from each school;
- make sure that medical schools inform the GMC Education Committee about any new courses they are developing and that they seek formal approval for these;

- allow issues of common concern in undergraduate medical education to be identified, discussed and resolved, thereby contributing to the on-going review of *Tomorrow's Doctors*;
- identify examples of good practice for widening participation in medical education;
- provide evidence that will allow the Education Committee to make a recommendation to the Privy Council about whether a university or institution should be added to or removed from Section 4 of the Medical Act 1983 that allows them to award a primary UK medical qualification (GMC 2004:2).

This quality assurance process comprises four parts:

1. Every year each medical school has to provide a return to the GMC describing any significant changes from their last return.
2. Regularly (at least twice in every ten years) the GMC's Education Committee will visit every school.
3. Special arrangements will come into play if a school proposes major changes to its curriculum.
4. The arrangements for monitoring the progress of new medical schools are similar to those for established schools (GMC 2004:2-3).

To achieve the aims and objectives of the QABME process the GMC needs to know about any major developments in undergraduate medical education. To that end medical schools are required annually to:

- Provide information about how their curricula and assessments meet the requirements of *Tomorrow's Doctors*;
- identify any significant changes to their curricula, assessments or staffing levels;
- highlight issues of concern, corrective actions taken and proposed solutions;
- identify examples of innovation and good practice;
- respond to issues of current interest and debate in medical education including the promotion of equality and valuing diversity (GMC 2004:3).

In a draft document brought out in August 2004 the GMC's Education Committee issued a set of draft *Principles of good medical education and training* for consultation (GMC 2004a). Thirty-nine principles (which might be equivalated to standards) are given under the headings of:

Selection	Resources
Curricula	Adding value
Assessment	Quality assurance
Fitness to practice	Reflecting contemporary society
Teaching, training and support	

(GMC 2004a:1-7).

The principles (standards) described in this draft document of the GMC are generic and broad, and can be made applicable to all stages of medical education and all specialties; in addition to these the quality assurance of individual programmes will continue to employ the specific standards as set out in *Tomorrow's Doctors* and *The new doctor* (for the PRHO year) (GMC 2004a:1). Included in this document one also finds the *Values of Health Care Professionals*, comprising six statements with descriptions of how each should be carried out (criteria) to ensure that all health care professionals can be held personally accountable for their actions and explain and justify their decisions (GMC 2004a:A1-A2).

This new QABME process in the UK was piloted in 2003/4; in 2004 the piloting was to be evaluated, and an external working group also was commissioned to evaluate the QABME programme (GMC 2004:3). The outcomes of these processes are not available yet. For 2004/5 a quality assurance review was planned for four medical schools. The process for the regular visits is to last for about 12 months and comprises three stages, namely

- Stage 1 – Collecting information (June to December)
 - Stage 2 – Confirming information (January to July)
 - Stage 3 – Integrating information and making judgements (June to September)
- (GMC 2004:3).

The QABME process is summarised in Table 2.1.

Table 2.1: Summary of the QABME process

Stage 1: Seeking information (Sept.–Dec.)	Stage 2: Confirming information (Jan.–July)	Stage 3: Integrating information and making judgements (June–Aug.)
<p>The purposes of this stage are to:</p> <ol style="list-style-type: none"> 1. Seek information so that visiting teams can understand the school's curriculum and assessments. 2. Identify areas where the school's plans may not meet the standards set out in <i>Tomorrow's Doctors</i>. 3. Identify areas where there is doubt about the school's ability to deliver and sustain its planned curriculum and assessments with the available resources. 4. Identify innovations and potential good practice to be expected. 	<p>The purposes of this stage are to:</p> <ol style="list-style-type: none"> 1. Determine whether the curriculum and assessments meet the standards in <i>Tomorrow's Doctors</i>. 2. Observe parts of the student learning process (including assessments) to confirm whether they are appropriate for meeting the standards in <i>Tomorrow's Doctors</i>. 3. Observe innovations and areas of good practice. 4. Seek the views of students, teachers and the school's NHS partners about the curriculum and assessments. 	<p>The purpose of this stage is to draw together information from stages 1 and 2 and to:</p> <ol style="list-style-type: none"> 1. Determine whether the curriculum and assessments on paper meet the standards set out in <i>Tomorrow's Doctors</i>. 2. Decide whether the curriculum and assessments are appropriate for meeting the said standards. 3. Decide whether the curriculum can be delivered and sustained with the available resources according to the standards in subsequent years. 4. Agree on examples of good practice and innovations that may be shared.
<p>The evidence for this stage consists of:</p> <ol style="list-style-type: none"> 1. Reports from the school, structured according to the headings of <i>Tomorrow's Doctors</i>, together with supporting documents including internal and external quality assurance reports, e.g. QAA institutional audit reports (template). 2. External examiners' reports for the previous year and information about any action taken to address issues these highlighted. 	<p>The evidence for this stage consists of:</p> <ol style="list-style-type: none"> 1. Discussions with members of the school's staff. 2. The views of students, teachers and employers about the curriculum and assessments. 3. Observation by visitors of the curriculum and assessments. 	<p>The evidence for this stage consists of:</p> <ol style="list-style-type: none"> 1. Information provided in stage 1. 2. Reports from stage 2.

Stage 1: Seeking information (Sept.–Dec.)	Stage 2: Confirming information (Jan.–July)	Stage 3: Integrating information and making judgements (June–Aug.)
<p>The process for this stage involves analysis by the visiting team of the reports and documentation submitted by the school. The visiting team identifies a programme of issues it wishes to pursue with the school and reports these to the Education Committee (the action plan).</p>	<p>The process used to achieve these outcomes involves a series of short visits to the medical school (typically one day) by a number of visitors (2 or 3). Visits focus on areas identified in stage 1 and reports are structured according to relevant headings in <i>Tomorrow's Doctors</i>. The Education Committee notes reports, unless specific advice and guidance are required.</p>	<p>The visiting team produces a report addressing all the areas identified in stage 1. The report is structured according to the headings in <i>Tomorrow's Doctors</i>. The draft report is produced following a synoptic whole team visit to the school to discuss outstanding issues. The draft report is sent to the school for a check for factual accuracy and then finalised. The team's report is considered for approval by the Education Committee.</p>
<p>The outcome of this stage is identification of areas to be pursued in stage 2. This is the action plan and includes:</p> <ol style="list-style-type: none"> 1. Issues to be clarified, understood and resolved. 2. Feedback from students and NHS partners about the curriculum and assessments. 3. Parts of the process to be observed. 	<p>Outcomes for this stage include:</p> <ol style="list-style-type: none"> 1. A decision whether the curriculum and assessments on paper meet the standards in <i>Tomorrow's Doctors</i>. 2. Information about whether the curriculum and assessments are delivered in line with the standards. 3. Information about innovative developments and good practice. 4. The views of students, teachers and the school's NHS partners about the curriculum and assessments. 	<p>The outcome for this stage is a judgement by the visiting team about the school's progress, including areas of good practice and innovation. It also highlights any outstanding issues that need to be followed up:</p> <ol style="list-style-type: none"> 1. A further visit to the school to check progress or observe an innovative element of the course. 2. Further information to be included in the school's response for next cycle's template.
<p>At the end of stage 1 there will be:</p> <ol style="list-style-type: none"> 1. The evidence base submitted by the school. 2. The action plan setting out the areas to be pursued in stage 2. 	<p>At the end of stage 2 there will be a set of reports of focused visits to the school.</p>	<p>At the end of stage 3 an annual report is issued with the visiting team's judgements of the areas identified in stage 1, explored in stage 2, and any areas that need to be followed up. The evidence base provided by the school, its students and NHS partners is published with the team's report.</p>

Source: GMC 2004b:5.

In this guidance document it is asserted that the process will allow visiting teams to collect information, explore issues, and observe parts of the teaching and learning process in a systematic and explicit way. The teams are to be provided with practical guidance to help them collect, confirm and evaluate information so that the process can be based on the requirements set out in *Tomorrow's Doctors*, and managed consistently across all schools. The visiting team will complete all three stages of the process and produce a report that will be submitted to the Education Committee. The final report will be compiled according to the headings of *Tomorrow's Doctors* and will include a statement about the efficiency of the standards at the school visited. An evidence base for the report, based upon the school's response to the template (request for information), will be agreed and published with the final report. The report will be sent to the Privy Council together with the Education Committee's recommendation about the awarding status of the institution concerned (GMC 2004: 4). The importance of the standards set out in *Tomorrow's Doctors* (GMC 2003) is clear; the report has to be structured according to the headings in *Tomorrow's Doctors*, and the final outcome of the assessments depends on the extent to which the requirements in the said document have been satisfied. No rating scale, performance indicators or criteria, however, are provided to serve as basis for the judgement of the visiting teams; it is merely stated that "visitors should remember that their principal role is judgemental" (GMC 2004b:2).

The responsibilities of the visiting team and observers are spelt out in the guidance document for QABME visitors and observers (GMC 2004b:1-4). Visiting teams are reminded to take care to exercise objectivity and fairness in their interactions, to concentrate on major issues, to be aware of current issues in basic medical education, and to be supportive of change and innovation (GMC 2004b:2-3).

This new QABME process of the GMC (piloted in 2003/4) makes provision for systems that allow the GMC to continually improve the process, and communication with the medical schools is regarded as of utmost importance to ensure the success of the endeavour (GMC 2004:4-5).

The GMC does not make use of an accreditation system, but in the light of the outcome of the visits and inspections, the GMC recommends to the Privy Council the recognition, continued recognition or withdrawal of recognition of the primary medical qualification

(PMQ) of a medical school.

This quality assurance system seems to be well structured, and the duration (12 months) holds the promise of ensuring continuing attention to quality assurance in institutions.

2.4.2.4 Final remarks

The three quality assurance systems described above were studied as examples of what is found in developed countries, and it must be made clear that the intention is not to create the impression that all quality assurance systems for medical education were studied in equal detail, nor that these were the only systems studied – an extensive study was made of quality assurance in higher education in general, and the standards used in various systems were scrutinised. These systems described here, however, seemed to be of the best developed and well-known, and the standards set forth in the documents quoted here were used in the literature control to determine whether the essential elements of medical education were covered in the standards and rubrics developed in the draft guide for accreditation reviews for South African medical schools. Other quality assurance systems and standards that were attended to, but which will not be discussed here, are the WFME (2003) *Basic medical education: Global standards for quality improvement*; the Dutch *Training of Doctors: Blueprint* (Metz, Stoelinga, Pels Rijcken-Van Erp Taalman Kip & Van den Brand-Valkenburg 1994; Metz, Verbeek-Weel & Huisjes 2001); the standards for accreditation of medical education in the Gulf Cooperative Council Countries (Hamdy 2003); and the aims and objectives of medical education in Ireland (Medical Council, Ireland 1997).

2.4.3 Discussion

Over the past decades efforts have been made worldwide to improve and ensure the quality of medical education. Different approaches are used in different medical education systems in the quest for relevant, effective and efficient medical education and training, including evaluations, assessments, audits and accreditation. As medical education forms part of the higher education systems of countries, institutions for medical education and training are also subjected to the quality assurance processes of

the higher education systems.

Although different approaches are followed in the various quality assurance systems studied, they all have certain elements in common. The main aim of the quality assurance systems, naturally, is to guarantee quality in the educational processes. For this purpose, standards to attain and maintain are usually set, or the objectives of the educational processes are spelt out. In the systems studied, these standards and/or objectives address given sets of competences and skills to be mastered, and values and knowledge to be acquired, but they also have a bearing on the educational processes and environment in which the education and training take place. Another commonality is the aim of improvement in the quality of the education and training offered. In the quality assurance processes, too, similarities are found: An institutional self-evaluation process to determine the extent to which the set standards and/or objectives are attained and maintained usually forms the basis of quality assurance processes, and this is then followed up by an audit or external evaluation to verify the findings of the self-evaluation. The audit or external evaluation is carried out by a panel of experts, comprising peers from other academic institutions, education specialists and administrators, and in most cases the teams or panels are appointed on an *ad hoc* basis. These teams or panels study the institution's self-evaluation report, conduct an on-site visit and then bring out a report on its findings.

In quality assurance systems studied additional to those discussed in 2.4.2 only a few examples could be found of a guide or measurement tool that might assist educational institutions and evaluation panels in their evaluation or audit processes, and these are not in the field of medical education. Although these systems have not been developed for medical education and the criteria and rubrics contained in them could not be used for present day quality evaluations, as most are not based on innovative educational practices, studying them sparked the idea of designing a guide to be used for the evaluation of quality in medical education. The sources referred to here include the Baldrige National Quality Programme (BNQP 2002), the CHEA (2000) *Competency standards project*, the *Subject review handbook* of the Quality Assurance Agency for Higher Education (QAA 1997) in the UK, the Higher Education Funding Council for England's *Assessors' Handbook* (HEFCE 1996), and the COHSASA (*s.a.*) *Standard assessment manual for hospitals*. These sources are mostly fairly outdated (except for

the Baldrige programme which is updated annually and the COHSASA process), and as they were not designed for medical education, they merely served as an idea generator in the current study.

Thus, albeit that standards and objectives for education and training in undergraduate medical education programmes are spelt out for evaluation purposes in the systems studied, there is no indication of the way in which the extent to which a standard or objective has been achieved might be 'measured', nor are indications given of what a medical education institution might need to do to improve the quality of its education and training in terms of the set standards, that is, no rubrics are provided for the evaluation of the quality of the education and training process. In the final analysis the peer judgement of experts may be sufficient to decide on the quality of an institution's programmes, but the lack of a measurement instrument and rubrics for the peer evaluations may very well result in different evaluation panels or teams arriving at inconsistent conclusions that may be idiosyncratic and based on individual experiences, as each member of the team may approach the task from a different frame of reference, as may be the case with each new team or panel that is composed. There thus can be no comparability among the judgements of the different teams or panels. Nowhere in the documentation indications could be found of a sound basis for deciding on the degree of compliance with the set standards or to what extent the programme or institution has achieved set objectives, or of grounds for the recommendations that might emanate from a quality assurance visit. In some of the systems two levels of achievement, a basic level, which must be achieved, and a quality improvement level are found (Hamdy 2003; LCME 2004; WFME 2003), whilst the Australian Medical Council (AMC 2002a) provides commentary on best practice in each area covered in the standards. It is thus clear that there is no standardisation with regard to the evaluation process and how compliance with the standards is judged, neither is there a clear indication of what an institution is supposed to do to provide proof of the level of compliance with a standard. This also implies that there is no indication of what an institution needs to do to improve its performance with regard to specific standards.

2.5 SUMMARY AND CONCLUSION

Quality assurance and accountability measures have formed part of higher education institutions in some way or other for centuries, but developments and changes on the higher education scene worldwide have given a new dimension to the pursuit for quality in education and training. Social and economic demands, technological developments, an increase in and a changed higher education population contributed to a renewed emphasis on efficiency and effectiveness in higher education enterprises (described in 2.1).

As has been described in 2.3.1 quality assurance in medical education too has received increasing attention over the past decades. Several recent publications describe the necessity for change and innovations in the structure and process of medical education, and the concomitant need for quality assurance measures to be taken to ensure that medical education achieve its main goal, namely the improved health of all people (AMC 2003; Bazargan 1999; Boelen *et al.* 1992; GMC 2003; Hamdy 2003; HPCSA 1999; IIME [Institute for International Medical Education] 2001; LCME 2003; Medical Council, Ireland 1997; Metz *et al.* 2001; WFME 2003).

The present day growth in the concern about the quality of work in higher education can be ascribed to the fundamental changes in the system of higher education as it is moving towards the provision of broader access in all countries. The growth of mass higher education and its increasingly visible differences from the traditional 'elite' forms of higher education raise questions about the adequacy of traditional forms of quality control (Trow 1999:9). According to the WFME (2003:6) only a minority of the 1 600 medical schools worldwide are subject to external evaluation and quality control procedures – which the WFME regards as a serious cause for concern.

Quality is a difficult concept. When considering the quality of education one must consider the requirements set by different stakeholders such as students, the medical profession, higher education, patients, and government. But when it comes to judging the quality of education, it is clear that it is a complicated task. There are many variables and a diversity of factors that impact on the quality of education in different ways; furthermore, the quality of education can only be judged within a specific context (Hamdy 2003:2). Differences in teaching tradition, culture, socio-economic conditions, the health

and disease spectrum, the student population, and different forms of health care delivery systems all have to be taken into account when one wants to evaluate the quality of medical education.

In the quality assurance systems studied, the notion reigns that quality is improved when there is a striving to achieve set standards – the higher the level of the standard, the higher the quality. The approach to quality assurance in higher education thus deals with maintaining and improving standards, but as standards in education are not easily measurable and quantifiable the question remains: How can improvement be ensured if it is difficult to measure the degree of compliance with standards? The answer to this question may be found in this study, namely to provide a continuum of levels across a number of identified standards, describing what should be demonstrated to provide proof of compliance with each standard in the concomitant rubrics. Through such a quality assurance process a move away from quality control of the end product to continuous quality assurance in the process may be brought about, with the emphasis on consistency and improvement.

In the process described in the final outcome of this study (see Chapter 7), the emphasis in quality assurance is on innovation and diversity, and albeit the guide that is recommended is aimed at standardising the quality assurance process and bringing about more comparability in the external accreditation review processes in South African medical education, it by no means endeavours to cast all undergraduate medical education programmes in the same mould. Through this guide medical schools/faculties will be encouraged to ensure that the programmes they offer meet student and community needs, and satisfy the expectations of higher education and the profession within the framework of social relevance and academic excellence, ensuring that South African medical education stays on a par with the best in the world.

CHAPTER 3

TOOLS TO GUIDE EVALUATIONS IN QUALITY ASSURANCE PROCESSES

Simply wandering into tomorrow without knowing the prevailing forces and trends, in an active attempt at creating the reality we want, is to miss the opportunity of creating a better life. Educational evaluation and research, planning and management are the functions that help higher education systems to reach the intended reality.

(Bazargan 1999:66)

3.1 INTRODUCTION

Quality assurance in the educational enterprise is about 'determining the reality' (quality) which is intended to be accomplished. This is done by measuring what is accomplished, and comparing the intention and the accomplishment (performance). Planning and management are the other two crucial factors – quality assurance is not merely about determining the current state of affairs, but also about planning and management to ensure the maintenance and improvement of the quality (*cf.* Bazargan 1999).

Accreditation is a quality assurance procedure that is used in many countries in the world to bring about comparability and mutual recognition of education and training standards, and to bring the determination of norms and standards in education to a level that protects the consumer of the education and training with regard to these norms and standards (Bezuidenhout 2002:2). It thus should be both an evaluative and formative process. In the accreditation of undergraduate medical education in South Africa the process is said to have been designed to "determine and certify the achievement and maintenance of minimum standards of education and training" (HPCSA 1999a:3). In the statement of the objectives of accreditation it is stated *inter alia* that criteria and guidelines are to be developed for the evaluation of the educational effectiveness of faculties of medicine in order to ensure appropriate standards, that accreditation is aimed at improving the quality of education and training programmes, and that the accreditation process would promote comparability and equality of standards in medical

faculties (HPCSA 1999a:3). In the discussion of the rationale, purpose and objectives of external quality assurance systems in other countries (see 2.2.2) the concepts of comparability, improvement of quality, measuring programme efficiency, and accountability also came into play. The questions that must be asked then are: How are these objectives realised? Which tools are used to determine whether the set standards have been achieved? How do we measure efficiency? What is the basis for comparing programmes? In short, how do we evaluate to help us reach the 'intended reality'?

As has been discussed in Chapter 2, quality assurance processes generally entail the collection of information on an institution, usually as part of a self-evaluation process. The information is made available to an external, *ad hoc* team or panel for verification, and this team or panel usually also collects more information during an on-site visit to the institution to be evaluated. On the basis of the standards set by the evaluating body, the information collected is used to pass a judgement on the quality of the education and training programme (in the case of programme accreditation), and a report is brought out on the findings. The mechanisms used (accreditation, audit, etc.) and steps in the process are all usually very well described, **but** for one action, which might be the most crucial in the process, namely the judgement of the quality by the external team. Most of the grievances received about external evaluations relate to the inter-team variance and subjectivity in peer assessments (Stella 2004:117). If one of the purposes of quality assurance is to determine the level of compliance with standards, how is that level determined? Or, if comparability is aimed at, how can programmes be compared if the same measurements are not necessarily used to evaluate them? Or how will a faculty/school of medicine be able to improve compliance with the standards if it is not made aware of what the higher level purports to be?

A number of quality assurance systems mentioned in Chapter 2, namely those described in the Baldrige National Quality Programme (BNQP 2002), the CHEA (2000) *Competency standards project* (USA), the *Subject review handbook* of the Quality Assurance Agency for Higher Education (QAA 1997) in the UK, the Higher Education Funding Council for England's *Assessors' Handbook* (HEFCE 1996), and the COHSASA (s.a.) *Standard assessment manual for hospitals* contain measurement tools to guide the judgement of external (and internal for that matter) reviews. These systems, however, were not designed for medical education, thus the standards, rubrics and criteria used

cannot be used for medical education; furthermore quality assurance is a process that is context bound (Jones & Ratcliff 1999:21), and especially when it comes to designing tools for evaluation of quality it should be done within a specified context.

The quality assurance process for undergraduate medical education in South Africa is a fairly new process (in operation since 2001), and although the process has been designed on the basis of sound research (Bezuidenhout 2002:4; cf. Labuschagné 1995), standards for accreditation were not initially developed, and although guidelines were provided, no measurement or assessment tools were available for the assessments, and no indications were given as to the way in which the different accreditation review panels should go about determining the level of compliance with standards in each medical school or faculty visited. As different panels visit different schools/faculties, the probability exists that the evaluations may be based on different premises, and after one round of accreditation visits has now been completed, it has become clear that different panels approached the process from different premises (based on the frames of reference of the individual members of the panels?), and that the outcomes of the evaluations did not lend themselves to comparability (cf. Bezuidenhout 2001-2004). It is thus clear that standards are required to be used in the process, as well as a tool to guide the accreditation review process and to be used as basis and point of reference for a judgement of compliance with the standards. The tool that is used in accreditation processes for quality assurance, however, must also be conducive as a lever for change and improvement, that is, it must lend itself for use in the planning processes of programmes. Kohler (2003:322) states that the tools for quality assurance are important, but that their application takes place too late if they are only used for evaluation – taking into consideration the total process from conceptualising to implementing to finally monitoring an education programme. Thus quality assurance devices should be installed parallel to the entire process of study programme development, and should cover every aspect of the development of the programme. For that reason the *Guide for accreditation reviews* (see Chapter 7) developed here, is intended for use in planning processes too.

To ground the design of such a guide, a literature review was conducted, and the tools and guides used in other systems were investigated.

3.2 MEASUREMENT TOOLS FOR EVALUATIONS/ASSESSMENTS*

In discussions on quality assurance it is often not clear exactly what is meant by certain concepts. For the purposes of this study, accreditation is viewed as a quality assurance *mechanism*, whilst standards, rubrics and criteria, and scoring guides are considered *tools* used in measuring or judging quality.

3.2.1 Standards for quality review

In a study conducted in 2002 (Bezuidenhout) standards for the accreditation of undergraduate medical education and training in South Africa were developed. The set of standards that emanated from that study addresses nine areas, which concur with the areas identified for specific attention in the accreditation process, and which also are the main areas dealt with in the self-evaluation questionnaire that medical faculties/schools in South Africa have to complete prior to an accreditation review visit.

These areas are:

- Aim, purpose and outcomes of the programme
- The programme: Curriculum design, content and organisation
- Student and staff resources
- Teaching, training, learning and assessment
- Student progression and achievement
- Student support, development and guidance
- Staff development and training
- Learning and physical resources
- Governance and organisation
- Quality assurance and enhancement

(Bezuidenhout 2002:76-93).

* Assessment = The collection and interpretation of data and the identification of problems.

* Evaluation = The process of determining the extent to which goals and objectives have been achieved. Actual performance or quality is compared with standards in order to provide a feedback mechanism which will facilitate continuing improvement. For purposes of accreditation an assessment of the performance of an institution based on accreditation standards without or before rendering an accreditation decision.
(COHSASA s.a.)

Thus: assessment is but one step in the accreditation process – evaluation is the complete process up to giving feedback.

The standards that were developed (Bezuidenhout 2002) indicate two levels of achievement: The first is that of minimum standards to be achieved in order to be accredited, that is, standards that are to be regarded as absolute standards. The second level indicates attributes in medical education programmes that are regarded as highly desirable, aimed at promoting improvement (Bezuidenhout 2002:75). This set of absolute standards and standards for improvement is currently under consideration for implementation by the Undergraduate Education and Training Committee of the HPCSA. For the purposes of this study, the standards were adapted slightly and used in the proposed *Guide for accreditation reviews* (see Chapter 7). The main changes were that the levels of absolute standards and standards for improvement were replaced with three levels, namely minimum, higher and highest level, and the standards were supplemented with criteria.

What then are standards and how or why are they used for quality assurance? Adelman (1983:40) defined standards as “a form of expectations that refer to performance”. According to Cohen (2000:600) standards are the “principles governing construction, implementation and evaluation” of an educational programme, and should be built on “a set of assumptions that all those concerned can share”. Standards for accreditation should be “guidelines for universities to maintain and improve reasonable standards” (JUAA 1996a:7). COHSASA (s.a.:s.p.) defines standards as “The desired and achievable level of performance corresponding with a criterion or criteria against which actual performance is measured. For purposes of accreditation, a predetermined expectation set by a competent authority that describes the acceptable level of performance of an organisation or individual in relation to structures in place, conduct of a process, or measurable outcome achieved.”

It is crucial that standards for accreditation be defined clearly, because if the standards and objectives (or rubrics) used are defined in a vague way, evaluators may tend to make their own interpretation and assess according to their own standards, which can be unfair and even damaging to the institution under evaluation (L'Ecuyer 1998:16). In contrast to this view, Randall (2002:196) expresses the opinion that standards should be stated at a fairly high level of generality – if they are defined in too much detail they may become prescriptive rather than enabling, and they should also allow for innovation and diversity of approach and development. In the development of the standards used in the

current study, the approach followed tended more to the latter view.

The importance of standards in quality assurance processes is stressed over and over again in literature. A definitional debate has arisen in understanding the nature of quality in comparison to the notion of standards. Quality, it is claimed, refers to the “totality of features and characteristics of a product that bear on its ability to satisfy stated or implied needs” (Castle & Kelly 2004:52). This implies a dependence on satisfying, rather than aiming for excellence. Standards for accreditation in medical education are used to determine whether expectations are met, **and** to encourage improvement (Adelman 1983:40; Bezuidenhout 2002:52; Hamilton & Vandewerdt 1990:541). Castle and Kelly (2004:52-53) maintain that concerns about standards, rather than quality, have led to institutions using and relying on external accreditation, where the standards are set by the accrediting body; the most common form of external accreditation being that given by professional bodies, since completion of a recognised (accredited) educational programme provides students with professional registration.

The Quality Assurance Agency for Higher Education in the United Kingdom defines academic standards as a way of describing the level of achievement a student has to reach to gain an academic award (for example, a degree). The Agency defines clear and explicit standards for public information and as nationally agreed reference points, and it is expected of institutional review teams in their judgements to express “‘confidence’ (or otherwise) in the academic standards set and achieved” (QAA 2004:1; 5).

Standards are used by the World Federation for Medical Education (WFME) in a recently conducted project to promote change and innovation in medical education. This project on *International standards in medical education* has three main intentions:

- to stimulate medical schools to formulate their own plans for change and improvement in accordance with international recommendations;
- to establish a system of national and/or international evaluation and accreditation of medical schools to ensure minimum standards for medical education programmes;
- to safeguard practice in medicine and medical manpower utilisation, and its increasing internationalisation, by well-defined international standards for medical

education (WFME 2003:5).

The WFME describes standards as a matter of specific conduct and intentional planning – not an either/or matter. Standards must be clearly defined, relevant, meaningful, appropriate, measurable, achievable, and accepted by the users. They must have implications for practice, recognise diversity and foster development (WFME 2003:7).

As an example of a standard for undergraduate medical education, standard 1.1 of the WFME's *Global standards for quality improvement* (WFME 2003:9) is quoted:

*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 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 WFME holds the view that evaluation based on generally accepted standards is an important incentive for improvement and for raising the quality of medical education, especially when reorientation and reform are pursued, but also to promote continuous development (WFME 2003:7) – which is also an objective of the *Guide for accreditation reviews* that emanated from the current research (Chapter 7 of this report). The WFME standards are divided into two categories, namely basic standards (expressed by **must**) and standards for quality improvement (expressed by **should**) (WFME 2003:8). The same approach is followed by the LCME (2004a), the Royal College of Physicians and Surgeons in Canada (RCPSC 2002), the Gulf Cooperative Council (GCC) Colleges of Medicine (Hamdy 2003:6), and also in the standards developed for accreditation in South African medical education (Bezuidenhout 2002:73). Other quality assurance systems only set minimum standards, for example, the South African Higher Education Quality Committee (HEQC 2003:3) and the Institute for International Medical Education (USA) (IIME 2001). Standards may refer to minimum levels of quality (threshold standards), or to excellence – Vidovich (1999:9) maintains that developing countries tend to adopt a minimum standards approach in quality assurance, whilst the industrialised countries tend to aim for the highest possible performance. With regard to

the level of standards applied in quality assurance systems, it might suffice to say that different systems have their own special characteristics suited to their particular circumstances.

Other medical education systems that use standards in their accreditation processes are the Liaison Committee on Medical Education (USA and Canada), the Australian Medical Council, and the Gulf Cooperative Council Countries (*cf.* Chapter 2). In the UK a set of principles and recommendations is set out in *Tomorrow's Doctors* (GMC 2003) to guide medical education and these “make clear to the public the standards of practice and care they should expect” (GMC 2003:2). From another document, explaining the quality assurance of basic medical education (QABME) process, it is clear that what is called guidelines and recommendations in *Tomorrow's Doctors*, are actually regarded as standards, as it is stated that “*Tomorrow's Doctors* sets out the standards for undergraduate medical education by identifying the outcomes, in terms of knowledge, skills, attitudes and behaviour required by medical graduates” (GMC 2004:1). In the Netherlands a set of objectives for undergraduate medical education is used as basis for the external programme reviews. These objectives are contained in a document developed by a National Coordination Committee, as commissioned by the Disciplinary Board of Medical Sciences of the Association of Universities in the Netherlands (Metz, Verbeek-Weel & Huisjes 2001:7). The objectives are similar to standards in that they “concern common educational requirements which all medical schools can guarantee” (Metz *et al.* 2001:17).

Standards or objectives designed for the accreditation of medical education play a crucial role in quality assurance processes. Based on a detailed description of the features of standards for quality assurance (Bezuidenhout 2002:52-55), it can be said that standards first of all must be indications of whether expectations are met, and they should encourage improvement. The accreditation process is both evaluative and formative (Boelen *et al.* 1992:7), and therefore the standards must make provision for evaluation and development. Furthermore, standards are related to specific, identified areas, such as inputs (intentions, facilities, resources – including students and staff), processes (teaching, learning, learning facilitation, assessment of learning, student and staff support and development), and outcomes (what students know - knowledge, can do – skills, and feel – attitudes and behaviour). The Task group of the Undergraduate

Education and Training Sub-committee (JET) of the Medical and Dental Professions Board in South Africa in a working document (Bezuidenhout 2000:1) recommended that the areas for special attention in the accreditation process should be: *curriculum design, content and organisation; student selection and admission; teaching and training, learning and assessment; student progression and achievement; student support and guidance; staff development and training; learning resources; physical and human resources; and quality assurance and enhancement measures*. These then are also the main areas used for the standards and rubrics designed in this current study.

Another important feature of standards is that they should leave room for variations among institutions with regard to differences, for example, in educational approach, culture, regional and institutional needs and priorities, socio-economic differences and potential, the health and disease spectrum and different forms of health care delivery (Bezuidenhout 2002:54). With regard to comparison and ranking of institutions, Bezuidenhout (2002:54) maintains that it is not advisable to use standards for those purposes; rather they should be used for comparisons *over time*, and not to rank institutions. However, standards can play an important part in comparisons, but then to bring comparability to the judging process that is part of quality assurance, to ensure that different accreditation review teams use the same yardsticks in the form of standards in making their judgements of different institutions, as is intended with the standards in the guide developed in this study.

The final feature of standards discussed in Bezuidenhout (2002:55) has to do with the qualitative nature of standards. As the evaluation of institutions' education and training is more qualitative than quantitative - albeit that quantitative data also have a role to play in some accreditation systems - the expert judgement of the evaluators is becoming increasingly important. For that reason, particularly, it is so important to qualify standards by means of explicit rubrics to be used in the evaluations, thereby guiding the evaluators, decreasing subjectivity in evaluations, and giving institutions an indication of why they are judged the way they are on a specific standard. In the current study, however, it became clear that in order to achieve the dual goal of quality assurance, that is, quality assessment and improvement, it is necessary to set standards that are supplemented with criteria or performance indicators indicating and describing different levels of achievement. These performance indicators or criteria, or the standards

themselves, should also give an indication of the way in which an institution can provide evidence or proof of the extent to which the standard has been achieved.

3.2.2 Rubrics

If standards are “a form of expectations that refer to performance” (Adelman 1983:40), the obvious next step in a quality assurance process will be to define the expectations. This is usually done by stating criteria – a criterion being a dimension of the performance that will be assessed or evaluated (Tierney & Simon 2004:2). When a number of criteria are used together in assessment, presenting a continuum of performance levels, it is referred to as a rubric (Marielle & Forgette-Giroux 2001:1). Rubrics are useful in assessment, because they contain qualitative descriptions of performance criteria which work well, especially in formative evaluations, that is, evaluation with a view to determining the level of performance and to promote development (Tierney & Simon 2004:1).

Scoring instruments, rubrics or guides usually are not used in the evaluation of educational programmes, rather the expert judgements of peers is regarded as sufficient for reaching a decision on the quality of educational programmes (Bezuidenhout 2002:55). An example of this viewpoint is found in the Liaison Committee on Medical Education’s statement that its standards “are sometimes stated in a fashion that is not susceptible to quantification or to precise definition because the nature of evaluation is qualitative in character and can be accomplished only by the exercise of professional judgement by qualified persons” (LCME 1995:6); however, ‘professional’ and ‘qualified’ are not defined – are they professional medical practitioners, medical specialists, or educators? How, or in what, are they ‘qualified? And how will their professional status and qualifications ensure that they apply the same or similar yardsticks when they assess the medical education programmes of different institutions? Even if evaluators do have the same professional status and qualifications, how can it be assured that the same measurements will be used when different evaluators judge the programmes of different institutions?

An accrediting body that does recommend the use of a scoring guide and rubrics in its assessments is the Council on Higher Education Accreditation (CHEA) in the USA that requested the National Centre for Higher Education Management Systems (NCHEMS)

to design and pilot a distinctive approach to accreditation with a view to minimise the institutional burden brought along with accreditation reviews and to promote greater consistency and rigour in making judgements about institutional performance (CHEA 2000:5). CHEA's rationale for an innovative approach to accreditation review is said to be that the process of team judgement used in most accreditation visits has been perceived as "essentially undocumented and occasionally idiosyncratic" (CHEA 2000:5). An approach to accreditation review that would emphasise the development of specific tools to enable review teams to generate a consistent set of judgements was regarded a better option, and a set of standards was developed, augmented by criteria, a scoring guide and rubrics (*cf.* CHEA 2000). The document that emanated from that project initiated the idea of an accreditation review guide and served as an important incentive for the current study.

As rubrics are not generally used for evaluations of educational programmes, the descriptions of rubric design found in literature mostly have a bearing on rubrics for the assessment of student learning. However, based on these descriptions it is possible to design rubrics for other evaluation purposes. But first one needs to define rubrics to ensure that they will fulfil the purpose for which they are designed.

Rubrics are defined as a set of scoring guidelines (criteria) for evaluating work (performance or a product) and for giving feedback (Rubrics.com 2001:1). Moskal and Leydens (2000:1) define scoring rubrics as "descriptive scoring schemes that are developed by teachers or other evaluators to guide the analysis of the products and/or processes of students' efforts"; however, these authors qualify the definition by stating that the ideas they present for the development of rubrics are applicable for anyone using scoring rubrics for evaluation.

A rubric can lead to a common and uniform interpretation of performance, as it presents a continuum of performance levels, defined in terms of selected criteria, geared towards full attainment or development of the targeted activity. Rubrics provide qualitative information regarding observed performance in relation to desired performance, and if applied at regular intervals, a rubric can track progress towards higher levels of performance (*cf.* Simon & Forgette-Giroux 2001:1).

An important objective of rubrics is that they clarify expectations and demand of the person/institution to be evaluated to take responsibility for achieving set standards (satisfying expectations) (*cf.* Liu 1995:49). An attribute of rubrics designed for the assessment of student learning that can also be made applicable to rubrics for improving standards in education and training, is that the institutions being evaluated can become involved in designing the rubrics, thereby setting priorities for themselves.

Rubrics answer the following questions:

- By what criteria will the work be judged?
 - What is the difference between good work and weaker work?
 - How can it be ensured that judgements (or ratings/scores) are valid and reliable?
 - How can both performers and judges focus their preparation on excellence?
- (Rubrics.com 2001:1).

These questions are similar to the questions asked in this study. The reasons given for using rubrics in the assessment of student learning can also be applied to the evaluation of other forms of performance, like the performance of an educational institution in respect of a specific programme. These reasons (as adapted for accreditation purposes) are:

Rubrics

- focus preparation – intentionally
- guide feedback – descriptively
- characterise desired results – objectively
- operationalise performance standards – purposefully
- develop self-assessment competence – constantly
- involve those to be assessed – thoughtfully

(adapted from Rubrics.com 2001:1).

Bresciani (2002:14) defines a rubric as “a set of criteria and a scoring scale that are used to assess and evaluate students’ work. Often rubrics identify levels or ranks with criteria indicated for each level”. Rubrics, however, are also sometimes applied to evaluate programme effectiveness, and Bresciani (2002:14) describes the process of designing a rubric for the evaluation of an undergraduate education programme at the North Carolina State University.

This rubric was used to evaluate the meaningfulness of undergraduate programmes, and covered the categories of objectives, outcomes, applications of assessment methods and tools, applications of research facts and evidence, to make decisions for continuous improvement, process plans and control. Table 3.1 illustrates how one category, objectives, is assessed using the said rubric.

Table 3.1 Rubric for undergraduate programme review

<i>Category</i>	<i>Exemplary 4</i>	<i>Accomplished 3</i>	<i>Developing 2</i>	<i>Beginning 1</i>	<i>Score</i>
Objectives	Objectives are clearly all broad, general statements of (1) what the program wants students to be able to do and know, or (2) what the program will do to ensure what students will be able to do and to know	Well-defined, broad, general statements of (1) what the program wants students to be able to do and to know, or (2) what the program will do to ensure what the students will be able to do and to know.	Fairly well-defined statements of (1) what the program wants students to be able to do and to know, or (2) what the program will do to ensure what students will be able to do and to know.	Not well-defined.	

Adapted from: Bresciani 2002:15; Bresciani & Allen 2002:1-4

In these rubrics the standard is stated in the first column, followed by the highest level, and then the other levels are given in descending order in the next three columns.

In the rubrics developed in the current study (see Chapter 7) it was decided to present the standard first, not as part of the table containing the rubric, but preceding it, followed by an explanation, and, in some cases, providing examples of what should be presented as evidence of compliance with the standard. The three levels of attainment then are given in three columns, in ascending order from the minimum to the highest level. This format was decided on in order to make it clear that the standard was the most important feature of the collection of performance activities set out on the page. They are intended to be used in planning processes, to indicate to institutions (programme planners) which aspects of medical education should be attended to when planning and developing a programme, or when a programme is reviewed, and in the final instance, what will come under scrutiny when the programme is evaluated with a view to accreditation. The

explanation provided above the rubric is intended to elucidate and supplement the statement of the standard. The criteria in the rubric are detail to be used during the planning stage, for self-evaluation, and finally to serve as premise and guide for the evaluation in the accreditation review process, and as points of reference in the report.

Standard 1.1 as developed for the guide designed in the current project is given here (Table 3.2) to show the format of the standards and rubrics used in the guide for accreditation reviews.

Table 3.2 Standard for undergraduate medical education in South Africa with elucidation and rubrics

1.1 The medical school has a clearly defined vision, mission, goal and objectives, stating its aim and purpose, and the overall outcomes of the undergraduate medical education and training programme it offers. (*Standard*)

The medical school must provide a copy of the written vision, mission, goal and objectives of the school. The essence of the standard lies in the extent to which the mission, goal, and objectives of the school are stated explicitly, and are made known to all relevant parties. (<i>Explanation</i>)		
At a minimum, it requires a written statement of the mission, goal and objectives of the school, and these are made known to all relevant parties, i.e. parents, students and prospective students, staff, the parent institution and the professional bodies involved. (<i>Rubric: Minimum level</i>)	At a higher score level, the objectives are translated into expected outcomes of the medical education programme the school offers, explicitly stating final outcomes in terms of knowledge, skills and attitudes/ behaviour patterns. Expected outcomes are directly linked to and underscore the mission, goal and objectives of the school and the institution. (<i>Rubric: Higher level</i>)	To meet the highest score level, the school has a mission and vision statement, describing the goal, objectives and educational outcomes of the medical education programme it offers. These statements must be clear and published, be supported by proof of attainment, and must reflect a striving to satisfy the general expectations of the professional body, and the South African health care and education systems. The statements will also indicate a certain uniqueness. (<i>Rubric: Highest level</i>)

Taken from *A guide for accreditation reviews*, Chapter 7.

Another set of rubrics that was taken cognisance of to gain a clear picture of the development of standards, is that of the Kansas Department of Education (KSDE, USA) and the Kansas Staff Development Council, developed to support their efforts to improve and identify model professional development practices (KSDE 2002:1-7). The format used in this staff development rubric is that of five columns with the standard stated in the first, followed by criteria describing four levels of achievement (called levels 1-4 with level I the minimum level) in ascending order. These rubrics provided excellent ideas as

to how the different levels of a rubric may be composed (for the purposes of the current study).

With regard to the nature of rubrics, Simon and Forgette-Giroux (2001: 2) assert that rubrics are essentially qualitative and descriptive in nature and rely on criterion-referenced perspectives. The criteria in the rubrics they designed for scoring post-secondary academic skills are presented in table format and form a horizontal continuum indicating increasing levels of performance. Bresciani (2002:15) labelled her performance levels (also called anchors) in descending order, *exemplary*, *accomplished*, *developing*, and *beginning* (see Table 3.1), whilst Simon and Forgette-Giroux (2001: 2) use *good*, *very good*, *excellent* and *exceptional* (ascending order). More or less the same format was used for the rubrics designed in this study for the accreditation review guidelines, but with only three levels, simply labelled *minimum level*, *higher level* and *highest level*, and no score, but only an indication of the level attained (see Chapter 7). CHEA (2000:60) uses six levels of performance, labelling them level 0 to level 5.

In designing rubrics care must be taken to base the rubrics on descriptive scales and support the evaluation of the extent to which the criteria in the rubrics have been met. Levels may be assigned to do this, or numerical weights may be assigned to the levels. Using only numerical weights, without description of the levels, however, does not provide an indication to the evaluator/institution of how to improve performance (Moskal 2000:2). In the design of the rubrics for the guide for accreditation reviews in the current study no numerical weights have been assigned to the different levels, because the accreditation review is a relatively new process in South Africa, and it was reasoned that numerical scoring might cause anxiety amongst medical schools that it would lead to ranking – which is not in line with the goal of the accreditation of undergraduate medical education programmes in South Africa (HPCSA 1999a:2). The levels are intended to be motivational (*cf.* Moskal 2000:2), aimed at encouraging schools to strive for improvement once they have assured themselves and the accrediting body that they are in compliance with the minimum level of the standards, and providing criteria which give an indication of how to improve.

Two types of rubrics are distinguished in literature, namely analytical and holistic rubrics (Moskal 2000:5). An analytical rubric, much like a checklist, allows for separate

evaluation of each of the criteria – each criterion is scored on a different descriptive scale. However, when it is not possible to separate an evaluation into independent aspects, and there is an overlap between the criteria set for a standard, a holistic rubric is preferable. Holistic rubrics support broader judgements concerning compliance with a standard. In a holistic rubric the criteria are in combination on a single descriptive scale (*cf.* Moskal 2000:5; 2003:4), or in the case of the rubrics designed for the current study, a specific level – this then was the approach used for the guide developed for accreditation reviews in South African medical education (Chapter 7).

The design of the rubrics that emanated from the study in hand took into consideration the steps explained by Moskal (2000:6-8), and incorporated elements from similar processes in sectors outside medical education, for example, the *Competency Standards Project* (CHEA 2000:19), the Baldrige Awards (BNQP 2002), and the COHSASA (*s.a.*) accreditation process. The first step in developing the rubrics was to decide on the number of levels to be set forth for achievement. For the purposes of the guide three levels were decided on. Each rubric is hierarchical and is constructed around multiple attributes in combination (serving as criteria). Level one represents the threshold or minimum level, which indicates the degree of compliance with the stated standard that would be expected from all medical programmes in South Africa. The criteria in this level of the rubric indicate attributes of the standard that medical schools should pay attention to, and the school must be able to provide proof of attending to the specific aspects mentioned. This type of performance would suggest basic compliance with the set standard. At the higher level it is expected of schools to be able to demonstrate that the aspects addressed in the criteria are incorporated in the undergraduate medical education programme and the criteria are descriptive of the proof/evidence of compliance with the standard that the school may submit. The highest level clearly identifies qualities that need to be displayed to demonstrate excellence; these can be described as examples of what is regarded as ‘best practice’ or excellence in undergraduate medical education programmes in most systems in the world – all aspects/criteria should not necessarily be applicable to all programmes, depending on each programme’s unique characteristics. Using these rubrics, the accreditation review panel should score the programme on each standard individually as basis for structuring an initial panel discussion of the institution’s submission, and eventually, after the site visit, for reaching a consensus decision on the faculty/school’s compliance with the

standards.

The elements used as criteria in the rubrics can be traced back to field notes made during the accreditation visits in the first round of accreditation review in South Africa, the reports that emanated from these visits, and discussions among accreditation review panel members about what could be expected of medical schools in South Africa. These elements were then replenished with examples of what is expected of undergraduate medical and higher education systems in other parts of the world (AMC 2002; Bezuidenhout 2001-2004; Bezuidenhout 2002; Boelen *et al.* 1992; GMC 2003; Hamdy 2003; HEQC 2003; HPCSA 1999; IIME 2001; LCME 2004 & 2004a; LCME 1995; Medical Council, Ireland 1997; Metz *et al.* 2001; WFME 2003).

3.2.4 Numerical scores, ratings and grading

In a paper exploring international comparisons of external quality assurance in higher education, Billing (2004:122) maintains that in 24 countries that were surveyed by Frazer in 1997, it was found that only in two countries numerical grades were given, namely in England and Scotland, although some others were found to use grades based on textual descriptions. In his survey Billing (2004:121) found that differences in reporting related to the summative or formative purposes of the evaluation - where the former predominated, reports contained explicit statements such as pass/fail, or quantified grading.

An evaluation system that makes use of scoring is the Baldrige Awards system (BNQP 2002:55). In this evaluation system the criteria and scoring guidelines make up a two-part diagnostic or assessment system. The criteria are a set of 19 performance-oriented requirements, and the scoring guidelines spell out the assessment dimensions, namely *approach*, *deployment* and *results*, as well as the key factors in each dimension (BNQP 2002:7). This set of performance-oriented requirements is the equivalent of a rubric. In this 'rubric' scoring ranges in the form of percentages are used, for example, the lowest level is assigned 0% (indicating no, poor, or anecdotal compliance), followed by levels indicated by 10% intervals, that is, 10%-20%, 30%-40%, and so forth. In assigning a score to an item in the Baldrige evaluation process, institutions have to decide on a scoring range (e.g. 50%-60%) which best fits the specific rubric. This does not require total agreement with all the items in the rubric; assigning an actual score within the

range requires evaluating whether the item response is closer to the statements in the next higher or lower scoring range – thus the ranges between 20%-30%, for example, not being included (BNQP 2002:55).

Table 3.3 is an excerpt from the Baldrige scoring guidelines; only the two minimum levels and the highest are quoted. The criteria items are provided in a separate section of the Baldrige document, with point values assigned to each category, sub-divided into points for each item in the category, adding up to 1 000 points (BNQP 2002:11).

Table 3.3 Excerpt from Baldrige scoring guidelines in the *Results* dimension

SCORE	
0%	There are no results or poor results in the areas reported.
10% to 20%	<ul style="list-style-type: none"> • There are some improvements and/or early, good performance levels in a few areas. • Results are not reported for many to most areas of importance to your key organizational requirements.
90% to 100%	<ul style="list-style-type: none"> • Current performance is excellent in most areas of importance to your key organizational requirements. • Excellent improvement trends and/or sustained excellent performance levels are reported in most areas. • Evidence of education sector and benchmark leadership is demonstrated in many areas. • Organizational performance results fully address key student/stakeholder, market, process, and action plan requirements.

Source: BNQP 2002:56

The Baldrige system is a very complicated system designed for evaluation with a view to assisting institutions in assessing their performance, and also to compete for the prestigious Baldrige Awards.

A review of quality assurance procedures for higher education in Europe by the Danish Evaluation Institute (DEI 2003:36) shows that in the Netherlands a *Framework for assessment* is used according to which the results of assessments are rated on a scale of *poor, insufficient, moderate* or *good*. In a former quality assurance system used in England and Northern Ireland (QAA 1997:2) for subject reviews, a graded profile was used to show the extent to which the student learning experience and student achievement demonstrated that the aims and objectives set by the provider were being met (QAA 1997:50). The creation of the graded profile was achieved by applying a

grade to each aspect of provision, using four numerical grades on the scale 1, 2, 3, 4 in ascending order of merit. For each of the four scale points a clear description was provided (HEFCE 1996:48; QAA 1997:51).

In the *Competency standards project* of the Council for Higher Education Accreditation (CHEA 2000) an assessment scoring guide is used by the assessment team. This guide is said to “serve as a centrepiece for the review by providing a concrete foundation for the team discussion” and “a clear means to communicate the team’s judgement to the institution” (CHEA 2000:19). The scoring guide comprises sets of individual rating scales for each individual standard, and within each standard three different scales attempt to capture distinct aspects of institutional performance related to the standard, namely design, implementation and effectiveness. In addition to the detailed rating scales associated with each individual standard, the scoring guide also contains three holistic scoring rubrics, used by team members to summarise the performance of the institution as a whole on the three broad attributes (quantitative measures thus are used in this accreditation system). The scale used is a 5-point Likert-type scale, and the evaluator may also indicate *Unable to judge* (CHEA 2000:39).

The Liaison Committee on Medical Education (LCME 2001) does not make use of ranking. It evaluates medical education programmes according to standards for organisation, function and performance, but does not attempt to stratify institutions according to their characteristics; the reason being that medical schools differ greatly. While the quality of education is partly determined by the organisation of programmes and the adequacy of resources, it also depends on the dedication of staff to teaching and to creating an environment conducive to learning. These and other efforts, according to the LCME (2001:2) may be obscured by efforts to rank schools by such variables as their size and the reputation of staff, level of research funding, or clinical facilities.

The use of a rating scale involves the acts of scoring, interpreting and judging; scoring occurs when the evaluator identifies within the scale and for each criterion the numerical description that most closely matches the observed performance or demonstrated competency (Simon & Forgette-Giroux 2001:2). For the purposes of the study in hand it was decided that it would suffice to use only interpretation and judging – interpretation

being the decision about the column in the rubric which best describes the performance of the institution (in the medical education programme) on the specific standard, and judging being a comparison of the performance level with the standard concerned (using the rubric as an indicator).

Haakstad (2001:80) unequivocally states that accreditation is a 'yes/no' affair; "therefore what it shouldn't do, is to try to assign marks or ranking orders to institutions or programmes. Accreditation concerns itself with minimum (if still high) standards and similar other forms of product control; it passes no value judgement beyond the 'yes' or 'no', with an added explanation of shortcomings in the case of a 'no' verdict". Although the view of not assigning marks or ranking orders to evaluations applied in the current study too, the researcher did not agree with Haakstad's view regarding not passing a value judgement – rating a programme/ faculty/school in terms of the three levels, it was argued, would encourage and support endeavours to improve (see Chapter 7).

3.2.4 Benchmarking

Accreditation always makes use of a benchmarking method and must always refer to standards, whether these are explicitly defined or not (Haakstad 2001:77). Jackson (2000:31) maintains that a visiting accreditation review panel may be regarded as a type of benchmarking agent, with the members comparing what they see with what they have seen in other institutions, and the site visit thus can be called an "unstructured, unsystematic and largely implicit benchmarking process".

In institutions of higher education there has always been a desire to learn from each other and to share aspects of good practice. This manifests in professional associations, both academic and non-academic, meeting at conferences and congresses to share common interests; visits by delegations from one institution to examine practice in another, professional bodies working collaboratively with institutions in supporting academic provision and mediating standards, and in accreditation systems, where academic staff from one institution participates as assessors of other institutions or programmes (*cf.* Schofield 1998:4).

There are many definitions of benchmarking. Robert Camp, who pioneered benchmarking at Xerox, coupled the process of 'finding and implementing best practice'

with the reason for doing so, namely; 'to improve work processes' (Jackson & Lund 2000:5). In higher education benchmarking provides a means for sharing practice, identifying smarter ways of doing things, and finding solutions to common problems. Weeks (2000:60) calls it a process-driven tool for quality improvement, a natural process for higher education to keep improving and learning from those who are doing fascinating things and performing at extra-ordinary high levels of excellence. At a workshop on benchmarking conducted by the Queensland University of Technology in 1995 the following definition was developed: "Benchmarking is a systematic approach for sharing information between two or more organizations in order to improve the quality and performance of a selected process" (Weeks 2000:61). However, the literature clearly shows that it is not just a matter of transplanting what works in one institution to another – it is a matter of evaluating the appropriateness of best practices found at other institutions for one's own institution (Weeks 2000:66).

According to Jackson (2000:31) about 65 professional and statutory bodies were identified in the United Kingdom by the Higher Education Quality Committee that were directly involved in programme accreditation, which enables them to exert varying degrees of influence of the standards set for programmes with regard to curriculum content, methods of teaching and learning, the assessment of student learning, and resources to support learning, including staffing. The accreditation processes described by Jackson agree with what in this study is proposed for South African undergraduate medical education, namely a scrutiny of relevant institutional documentation in terms of the standards set by the professional body to establish compliance with the standards. Jackson (2000:31) asserts that the professional bodies also create the conditions for benchmarking through the provision of guidance or codes of good practice against which institutions can compare and align their own practice.

In the course of accreditation reviews benchmarking may play a role when the examples of 'best practice' found in medical schools/faculties serve as

- a reference point against which similar 'things' can be evaluated;
- a criterion against which something can be measured; and
- a mark of distinction, that is, the best example of its kind (product, service, process, performance)

(Jackson 2002:140).

The Danish Evaluation Institute (DEI 2003:20) maintains that benchmarking may be regarded as a method or element of evaluation. In the study they conducted on quality procedures in European higher education, benchmarking is defined as a method whereby a comparison of results between subjects, programmes, institutions or themes leads to an exchange of experiences of best practice. Benchmarking is a process; it is continuous, and a method of institutional learning; it can be a tool for stimulating change, and can help institutions grow, develop and mature (Weeks 2000:66).

The definition of Alstete (1995:20) describes best what is meant with benchmarking in the current study, namely “analysing performance, practices, and processes within and between organizations (read *medical schools/faculties*) to obtain information for self-improvement”. It is hoped that the process of using information collected during accreditation reviews will enable ‘benchmarks’ to be created which can be used to promote change in directions that will most likely lead to improvement. This is in fact what has already been happening, as many of the examples of good or excellent practices that have been found during the first round of accreditation reviews of medical schools in South Africa have been compared with what is regarded as best practice in other systems, and taken up in the rubrics developed for use with the set standards for judgements during self-studies and accreditation reviews (see Chapter 7). The ‘best practice’ element common to most definitions of benchmarking implies that, whereas accreditation procedures are typically based on minimum standards or threshold criteria, benchmarking is typically based on excellence criteria (DEI 2003:21). In the study in hand it will be recommended that benchmarking procedures be used in the striving for improvement and that examples of ‘best practice’ identified during the accreditation process, be used to set new standards to be achieved, and to supplement the highest level of performance set out in the guide for accreditation reviews (*cf.* 8.4.1).

3.2.5 The overall summative judgement and review report

The final tool to be discussed has more to do with the improvement of quality than with the assessment process itself, though it is directly based on the assessment. The final judgement of an accreditation review panel on the quality of an educational institution is usually reported in some way or other; the report is submitted for purposes of accreditation, accountability and in some cases it is used for the grading of institutions.

This report may be regarded as a quality improvement tool, because it usually, besides the judgement of the accreditation panel, contains recommendations for improvement and other comments, identifying strengths ('best practices') and weaknesses, recommending the institution/programme, and/or urging it to pay attention to specific aspects of the programme involved. Most sources on accreditation and quality assurance in general do not devote much space to the report that usually concludes an external quality assurance process, and the information found was scanty, but sufficed to get an idea of what the report usually entails.

The Danish Evaluation Institute (DEI) in its study of quality assurance procedures in European higher education institutions found that reports are compiled and published in almost all cases of evaluation, but are sometimes omitted in cases of accreditation (DEI 2003:9). According to the DEI study the reports typically contain conclusions and recommendations, and very often they also contain analyses, while empirical documentation is included only in one-third of all cases. It was also found to be common practice to consult the institutions involved before the reports were published. In three-quarters of the cases the evaluated institutions are responsible for follow-up of the recommendations, while the quality assurance body and government are responsible in a little less than half of the cases. Follow-up takes place in all the cases in some way or other.

Billing (2004:121) in a study exploring international comparisons of external quality assurance found that the differences in reporting among external quality assurance bodies relate to the summative or formative purposes of the evaluation. Where the former predominates, reports contain explicit statements of outcomes, for example, pass/fail or a quantified grade, and are written for external audiences. When the emphasis is formative, the audience tends to be academic, and the reports emphasise recommendations. In cases where there is considerable institutional autonomy (as in the UK) the report tends to be compensated by a summative approach to quality assessment, emphasising accountability. Where there is strong state regulation, like in continental Europe, there is no need for further control through the quality assurance body and a more formative approach is common, emphasising improvement. Numerical grades are only given in England and Scotland, although in some other countries QA agencies give grades in the form of 'textual descriptions' (Billing 2004:122). In five

countries a direct funding link was found.

In the UK a published report sets out the audit team's judgement, with recommendations for consideration by the institution categorised in order of priority: 'essential', 'advisable' or 'desirable'. The main report is preceded by a stand-alone summary for a general audience (QAA 2004:5).

The reporting strategy of the National Assessment and Accreditation Council (NAAC) in India is to give an overall institutional grade supplemented by a detailed assessment report, which is made public (Stella 2004:119). The issue of public disclosure as opposed to confidentiality of assessment reports is a contentious issue in many countries and there are valid arguments in favour of either strategy. The NAAC consciously opted for a published report, and Stella (2004:119) reports that more and more stakeholders have started using assessment reports to inform their decision-making.

The survey report of the LCME (Liaison Committee on Medical Education, USA) comprises a compilation of the written findings from each member of the accreditation team (LCME 2002a:2). The report describes the education programme and accounts for the school's compliance with each of the standards for accreditation as contained in the document *Functions and structure of a medical school* (LCME 1995).

The Australian Medical Council (AMC 2004:2) requires of an accreditation team to draft a report which is circulated to the school concerned within five weeks of the conclusion of an accreditation visit, and the school is invited to comment on the draft. The team then considers the school's comments and prepares a final report for the Medical School Accreditation Committee that develops draft recommendations on the school's accreditation. These are sent to the school for comment. The report, recommendations and any comments by the school are then submitted to the AMC and the Medical Council of New Zealand for their decisions on accreditation.

In the *Competency standards project* of the Council for Higher Education Accreditation (CHEA 2000:18) the review process was designed to render the team's assessment of the institution more consistent and systematic than what typically occurs in the course of

an accreditation visit. Before the site visit, each review team member visits the institution's web-based portfolio and reviews additional materials. Each member then scores the institution independently and generates additional commentary. These responses are aggregated and circulated and discussed within the team – a process which proves to be particularly beneficial to arriving at a consistent judgement and in preparing for the actual visit. On completion of the visit, each member re-scores the institution and adds comments if and where deemed necessary. Using the results of the re-scoring process, a report for the institution is prepared, containing an overall assessment of performance as the basis of the recommended accreditation decision, a summary of observed strengths and weaknesses, an identification of the areas for potential action and development, and shared, detailed results of the team scoring process.

In the South African process for the accreditation of medical education programmes, an official report is prepared by the panel on conclusion of the accreditation review visit. Members of the team are provided the opportunity to consider the report and to have the option of a minority opinion to be noted in the case of major disagreement. The report is then submitted to the dean of the faculty/school concerned for comments on matters of fact and to the chairperson of the panel for final modification if so required. The report should be a detailed document, containing the findings, comments and recommendations of the visiting panel, the Sub-committee for Undergraduate Education and Training (UET) and the Medical and Dental Professions Board (MDPB). Areas requiring attention and areas of special note should also be mentioned. The report is submitted to the UET before it is referred to the MDPB for a final decision regarding accreditation. Once the MDPB has reached a final decision concerning accreditation of the programme, the vice-chancellor of the university concerned and the dean of the faculty concerned each receives a copy of the final report and the resolution of the MDPB (HPCSA 1999a:10).

The final report of an accreditation review panel or team does not actually count amongst the tools used for quality reviews, but it does play an important part in the development for improvement function of accreditation. This report usually contains recommendations for improvement and comments on the strengths and weaknesses that might have been found. These are important with a view to improvement, but also

have a motivational role to play in that institutions/programmes usually are commended for good practices, and especially in countries where these reports are published such comments may be beneficial for the good standing of the school.

For the purposes of the current study the reports of accreditation panels brought out between 2001 and 2004 have been used to identify practices, procedures and outcomes that have been taken up, *inter alia*, in the rubrics designed for the guide for accreditation reviews.

3.3 CONCLUSION

The questions asked in the introduction of this chapter, namely how efficiency can be measured, and what tools are available to those involved in quality assurance activities to determine whether standards have been achieved, presumably can be answered now.

Based on the discussion above, it may be concluded that accreditation essentially is a process with a dual goal, namely assessment and improvement. In a process of accreditation, standards should be used to accredit and re-accredit education and training programmes, and these self-same standards ought to be employed as guidelines for universities to maintain and improve quality. In the pursuit of quality in education and training, institutional self-evaluation and accreditation are without doubt two of the most important factors promoting academic standards. Thus there are two issues at stake here: one, standards must be defined to be used as a measure in accreditation procedures, and two, accreditation, that is, an assessment process with the assurance of quality and the enhancement of quality as its major goals, will promote the maintenance and improvement of standards. Therefore, from which-ever angle standards are viewed, it is of utmost importance that standards should be used as the premise of quality assurance processes, to anchor measurements of compliance with expectations regarding quality.

The World Federation for Medical Education (WFME) on defining global standards for basic medical education maintains that in an accreditation process the criteria, standards and procedures for the specific process should be defined clearly (WFME Task Force

2000:666). Having defined such standards for the accreditation of undergraduate medical education in South Africa (Bezuidenhout 2002), the next step obviously is to describe a way in which these standards should be used in quality assurance processes (the procedures) and defining the criteria to be used to determine the extent of compliance with the set standards.

Having studied literature on higher education quality assurance processes, it became obvious that most aspects of the process are usually described clearly in the different systems, except for the way in which the final conclusion about the quality of a programme (or institution) should be reached. In general, the opinion reigns that the judgement of a panel of peers/experts suffices. However, it became clear from the study and from previous participation in accreditation reviews that members of panels may have different perspectives on what constitutes quality in medical education and training, especially in the light of recent innovations and current trends in medical education. Therefore a guide, containing the set standards of the accreditation body and rubrics with criteria and levels to help the panel members reach consensus about the final decision and recommendation regarding accreditation may be a useful tool to render the final outcome of the assessment more valid and reliable, and to ensure standardisation of the review process.

In line with what normally holds for assessments, rubrics comprising criteria by which a standard may be measured and describing different levels of achievement were considered as a viable option in the search for tools to guide the accreditation assessment and to use in the 'measurement' of quality. These standards, levels and criteria, together with the final report, also have the potential to play an important part in planning for improvement and in encouraging and motivating institutions to strive for higher quality levels, as specific actions and outcomes are described in the rubrics.

The HPCSA (1999a:1) states that the general goal of accreditation is "to exercise control over the quality of education and training, ..., to assure maintenance of academic standards and to bring about comparability of standards". One of the objectives set for this study was to study the role and use of standards in quality assurance processes, to identify standards employed in accreditation processes in South Africa and globally, and to determine how achievement of standards is measured/judged by accreditation review

panels (*cf.* 1.5). The aim of this study is to develop and evaluate a guide for use in the accreditation review process that can also be used for self-evaluation and improvement purposes. After having studied the literature mentioned in this chapter, it was decided that the guide that needs to be designed to achieve the aim should consist of standards with elucidations and rubrics indicating three levels of achievement, and criteria explaining the actions or outcomes required to reach a specific level, thus the proposed guide can be said to be a tool developed for quality assurance and improvement activities.

CHAPTER 4

ACCREDITATION OF UNDERGRADUATE MEDICAL EDUCATION IN SOUTH AFRICA

Medical education in South Africa is on the threshold of extensive and drastic changes. Certain paradigm shifts have already taken place with regard to the training of doctors, and these changes will undoubtedly have an influence on the values, norms and standards which prevail in medical education and practice. New values, norms and standards which are emerging in our new dispensation need not necessarily replace old ones, but cannot be negated either. What is needed thus is a shift in emphasis to more contemporary needs and demands, while at the same time maintaining the norms, values and standards which have been the cornerstone of accountable medical practice for centuries. To be able to do this, each and every medical practitioner and instructor must of necessity become part of the process of change and must keep pace with innovations, while using the existing knowledge and experience to ensure the maintenance of certain values, norms and standards which are inherent in medical education and training. (Nel 1995:i).

4.1 INTRODUCTION

Quality assurance in medical education and training is a complex issue – the philosophical mindset underpinning the culture prevailing in an institution partly determines the mechanisms that are acceptable for quality assurance and enhancement. Impacting factors in this regard are the value attached to the pursuit of excellence; the consideration of cost; humanitarian values and other norms; attitudes of staff towards change, and a willingness to change (Suwanwela 1995:S37). In medical education quality assurance goes hand in hand with the concept of self-regulation or collegial control of academic quality. According to Dill (1999:318) a condition for quality assurance in a profession is strong professional norms and a shared academic ethic – as is the case with medical education.

In the discussions of quality assurance found in literature three key points are emphasised, namely that quality assurance is the responsibility of the academic staff and administrators of an institution, the maintenance and improvement of that quality largely rest on internal procedures for discovering and correcting weaknesses (self-evaluation), and, finally, that the efforts of institutions (and/or their programmes) to ensure quality are strengthened by a system of external verification of the self-evaluation processes (audit or accreditation) (*cf.* Fourie *et al.* 1999).

The fundamental questions quality assurance asks everybody in medical education to make part of their daily life are: What am I trying to do or achieve? Why am I doing it in this way? What is the context in which I am doing it? How do I know that it is effective and that I am doing a good job? Is this the best possible way of doing it? How can I improve my work? (Singh 2000:5; Verkleij 2000:85).

Accreditation is the procedure used in many countries in the world to bring about comparability and mutual recognition of education and training standards, and to ensure that the standards are at a level that will protect the consumer of the education and training, and it is also the process used in South African medical education for quality assurance purposes. The accreditation process of the Health Professions Council of South Africa (HPCSA) forms the common formal basis for the recognition of medical education and training and certifies the achievement and maintenance of standards in medical education. Through this process the professional body (HPCSA) attests to the educational quality of the medical schools and their graduates (Nel & Bezuidenhout 2003:2).

4.2 BACKGROUND

During the past decade health professions education, including medical education, has undergone extensive and profound changes – all over the world, and also in South Africa. In the wake of these changes it became increasingly essential to ensure the maintenance and promotion of high standards in the education and training of health professionals. In South Africa the Health Professions Council of South Africa (previously the South African Medical and Dental Council) fulfils the watch dog role in this regard, and before 2001 it carried out its responsibilities by prescribing a minimum syllabus,

which had to be revised regularly, an academic programme, a system of external examination, and the inspection of medical faculties/schools (Nel 1995:11). However, the inspectors complained that they received no clear guidelines for their inspection assignment, and Nel (1995:11) maintains that the system of inspection was conducted mainly on the basis of experience and tradition – without any scientific grounding. In 1995 Nel, at that time member of the Undergraduate Education and Training Subcommittee (UET) of the Medical and Dental Professions Board (MDPB) of the HPCSA, was assigned the task of compiling guidelines for the evaluation of medical schools and medical education and training (Nel 1995a). This document was aimed at providing medical schools with guidelines according to which the training and evaluation of students in medicine could be inspected, and was the forerunner of the accreditation system that was instituted later. The inspection process, it was recommended in the document, should include the collection of general information and statistical data on medical schools, inspection of the programme, curriculum and courses of the school, inspection of the training process, inspection of the student evaluation process, and the compilation of a report (Nel 1995a:1). The information and data required included information on the courses, student intake numbers, pass/failure rates, information on staff (number, status, positions, etc.) and information on facilities. Information on the faculty's/school's selection procedures, academic climate, status of departments, and scientific standing of lecturers was also to be provided.

Departments were inspected individually, and matters that came under scrutiny included the subject matter covered, duration of the courses offered by the specific department, integration with other courses, number of years per course, whether the department offered training in pre-clinical or clinical training or both; the study year in which the courses were offered, and admission and pass regulations (Nel 1995a:2). Aspects of course evaluation that received attention included how relevant, topical and up to date the course content was, whether content was offered in an integrated way and whether students were exposed to other departments. The education and training process in the departments, learning content, student learning, instructional media and technology and student involvement in management and educational processes were attended to. Student evaluation (currently called assessment of student learning) received ample attention during the inspections. In the report it was expected of the inspectors to comment on the general information and statistical data, on the programmes, curricula

and courses, the training process and the student evaluation processes (Nel 1995a:3-6).

These guidelines carried clear signs of moving into the direction of accreditation of medical schools' programmes, and in the same year, when Nel became chair of the UET, he was commissioned to steer an investigation regarding the possibility of instituting an accreditation process for medical education in South Africa, and to have a document compiled in that regard. After a sound investigation of accreditation procedures used in other countries, a report on *Accreditation in higher education with special reference to medical education* (Labuschagné* 1995) was submitted to the UET for consideration and to serve as background for further planning in this regard. A period of research and planning then started in order to put a plan for an accreditation process for medical education in South Africa on the table.

The first step in this process was to provide guidelines for medical schools/faculties regarding the education and training of undergraduate medical students, and in 1997 Nel and Bezuidenhout compiled a document for the Medical and Dental Professions Board containing guidelines for the education and training of doctors in South Africa. These guidelines provided a profile of the medical practitioner in South Africa, stating that the undergraduate medical education and training of students entailed a period of learning (knowledge), training (skills) and moulding (attitudes and behaviour). On completion of their education and training it would be expected of a graduating student to have been developed into a basic medical practitioner, capable of practising the profession of medicine, broadly speaking. Over the centuries it was expected of doctors to be capable of the following, and it still applied, namely

- to ease pain and discomfort,
- to prevent, diagnose and treat illness and injury, and
- to promote health and provide assistance in rehabilitation

(Nel & Bezuidenhout 1997:3).

In order for students to fit into the profile of the doctor that needs to be trained, attention should be given to

* M.J. Labuschagné is the same person as M.J. Bezuidenhout, researcher in this study

- Attitudes, skills and knowledge
- Prevention, treatment and rehabilitation
- Management, education and research

(Nel & Bezuidenhout 1997:3).

The document goes on to describe the core attributes and qualities a student that has completed the undergraduate medical curriculum successfully should have, it describes the aims, goals and objectives of undergraduate medical education and training, and finally it provides a set of recommendations based on the mission of undergraduate medical education and training which entails that the education and training should enable the graduates to render medical and health care services over a broad front in South Africa, and to specialise in any of the medical disciplines. Within the context of this mission, the following premises held:

- *Undergraduate medical education must make provision for and be sensitive to the academic demands as well as the unique needs of the South African society.*
- *Training institutions are responsible to ensure that the future doctor develops a healthy outlook on life, and that the required ethical principles are installed in students.*

(Nel & Bezuidenhout 1997:7).

Bezuidenhout used this document as premise and after an in-depth survey of literature on medical education and training in South Africa and other countries, other documentation on medical education and training, and discussions with medical educators and members of the Undergraduate Education and Training Sub-committee (UET) compiled a document for the Medical and Dental Professions Board (MDPB) of the HPCSA, entitled *Education and Training of Doctors in South Africa: Undergraduate Medical Education and Training - Guidelines by the Medical and Dental Professions Board* (HPCSA 1999). This document was accepted as the official guidelines by the MDPB in March 1999. The content of this document will be discussed in 4.4.1.

In the same year (1997) a task team was appointed by the UET to design and develop a system of accreditation for undergraduate medical (and dental) programmes offered in South Africa. The team, comprising Profs. C.J.C. Nel, M. Adhikari and C.J. Mieny, co-opted the researcher in this study, who had conducted the initial study on accreditation

(cf. Labuschagné 1995), and after several meetings and discussions, as well as further research by Bezuidenhout, a draft document, entitled *Accreditation of South African medical and dental faculties for education and training* was submitted to a meeting of the UET in 1999. The document was accepted as official accreditation guideline (HPCSA 1999a).

The task group after this was requested by the UET to develop and make recommendations regarding the implementation of the system of accreditation of undergraduate medical education and training in South Africa. Nel and Bezuidenhout (the current researcher) were given the task of compiling documentation in this regard, and at a meeting of members of the task group, namely Prof. C.J.C. Nel – chair, Bezuidenhout (the researcher), Prof. C.J. Mieny, Dr G. Pickworth, Prof. W.D. Snyman, and Prof. D.F. Wittenberg, held in February 2000, the documentation was discussed and a number of recommendations were made by the task group for submission to the UET and MDPB (MDPB 2000:1-3). With regard to a policy for accreditation of undergraduate medical and dental education the following was recommended, and eventually accepted by the UET and the MDPB:

Accreditation policy

By means of the process of accreditation, which comprises an institutional self-evaluation process and an external assessment, the Medical and Dental Professions Board will determine and certify the achievement and maintenance of minimum standards of education and training in all medical and dental schools in South Africa. It is the primary responsibility of this accreditation body to attest to the quality of the programmes of the Board, thereby serving the public at large and the students in the programmes (MDPB 2000:1).

With regard to procedures for the implementation of an accreditation process, it was agreed that a system of self-evaluation by medical and dental faculties/schools was essential to the process of accreditation. The self-evaluation would be done by means of a questionnaire to be completed by the Dean of the Faculty of Medicine/Dentistry to be evaluated, together with heads of departments, programme leaders and chairpersons of modules. This questionnaire should be completed within a period of three months and returned to the Board (MDPB 2000:2).

It was recommended that the accreditation review panels should comprise experts appointed by the Sub-committee for Undergraduate Education and Training (UET). For each accreditation visit a new panel would be appointed. Before every visit, the panel would review the self-evaluation report (completed questionnaire) and communicate with each other prior to the physical inspection to

- a. determine whether additional information should be obtained from the institution;
- b. prepare for the actual physical inspection (MDPB 2000:2).

The panel of experts, it was decided, would visit the relevant university and the training facilities linked to the institution over a period of three days during the academic year, and outside of examination times. On completion of the on-site visit, the panel would compile a report to be submitted to the UET. The report would be submitted to the institution concerned for comments, before it would be finalised and submitted to the UET and MDPB for a decision regarding accreditation.

It was further decided that a questionnaire had to be compiled, the format of which should be in line with that of the South African Qualifications Authority (SAQA) questionnaire, in view of the fact that institutions would have to complete a similar questionnaire for SAQA for audit purposes. The deans of faculties/schools of Medicine/Health Sciences/Dentistry would be requested to submit supportive information and/or documentation with the self-evaluation report (response to the questionnaire).

This information should include:

- a. a copy of the institution's vision;
 - b. a copy of its mission statement;
 - c. goals and objectives;
 - d. summary of the curricula of the various subjects relating to education and training in medicine/dentistry;
 - e. institutional information;
 - f. information on physical facilities;
 - g. strengths, weaknesses, problems
- (MDPB 2000:3).

With regard to the composition of the panel of experts (visiting team), it was recommended and decided that the panel of experts for undergraduate medical

education and training should consist of seven members, namely

- a. chairman – member of the Sub-committee for Undergraduate Education and Training
- b. a representative of the group of physicians
- c. a representative of the surgical group
- d. a representative of the diagnostic group
- e. a representative of the basic sciences group
- f. an educationist
- g. a secretary

(MDPB 2000:3).

At this meeting of the task group it was resolved that a self-evaluation questionnaire and guidelines for the panel of experts should be compiled, as well as a draft for the letter to inform the Dean of the Faculty to be inspected of the accreditation visit and the concomitant preparations, and a draft planning document for the actual inspection. The researcher in the current study was assigned the task of compiling the self-evaluation questionnaire and the guidelines for the panel of experts (MDPB 2001:2-3).

The documents mentioned were drafted and accepted as official accreditation documentation by the UET.

In May 2002 the Education and Registration Management Committee (EMC) passed a set of regulations relating to the accreditation of South African Faculties or Schools of Medicine and Dentistry (EMC 2002), which in essence contained the information discussed above and below.

4.3 ACCREDITATION OF UNDERGRADUATE MEDICAL EDUCATION PROGRAMMES IN SOUTH AFRICA

In order to gain a general overview of the process of accreditation as implemented in South African undergraduate medical education, it was necessary to collect information from various documents, as no single document describing the process in full could be found.

4.3.1 Definitions

The HPCSA uses the following definitions of accreditation for the purposes of its document on accreditation: *Accreditation is the approval of a professional program of studies, or of the study programs of an entire educational institution, by a recognized accrediting body* (as taken from Hawes *et al.* 1982), and *Accreditation is the recognition and approval of ACADEMIC STANDARDS of an educational institution by some external, impartial body of high public esteem* (quoted from Rowntree 1981) (HPCSA 1999a:2). The Education and Registration Management Committee (EMC) in a later document defines accreditation in the South African medical education context as “the process which shall be conducted by an external and impartial body of high esteem to grant recognition and approval to the academic and training standards, and the professional programme of studies of an educational institution or training facility” (EMC 2002:1).

At a workshop held in July 2003 to discuss matters pertaining to accreditation (JET 2003) and from discussions during on-site visits, it became clear that one aspect of the definition was not clear to all concerned, namely that it was the education and training **programme** that was to be accredited and not the faculty or school offering the programme. The matter was cleared up during the said workshop, but in everyday discussions of accreditation, the general usage still is to refer to the ‘school’ or ‘faculty’ being accredited.

The *accreditation body* in the South African system is the “board as defined, acting *via* its subcommittee for undergraduate education and training”; the *board*, being “the Medical and Dental Professions Board established in terms of Government Notice No. R.75 of 16 January 1998” (EMC 2002:1-2). The *visiting panel* is defined as “a group of persons appointed by the board to evaluate a faculty or school of medicine or dentistry and to report to the accreditation body on its findings and recommendations” (EMC 2002:2). Here again it must be noted that it is stated that the ‘faculty or school’ is evaluated, yet it is the programme that is accredited (see EMC 2002:1) – for that reason the document that emanated from the current study states clearly that albeit that reference is sometimes made to the faculty/school, it is done because the faculty/school in the final instance is responsible for the programme offered, but it is the programme that will be accredited. Another interesting choice of words in this definition is the

(emphasised) use of *persons* – in other documentation on accreditation the panel is usually explicitly described as a panel of *experts* (cf. Chapter 2).

4.3.2 Rationale

The rationale for the institution of an accreditation system for medical education in South Africa is explained as follows in the document on accreditation (HPCSA 1999a:1); exactly the same wording has been taken up in the Preamble to the regulations brought out later by the Education and Registration Management Committee (EMC 2002:2):

In order to provide assurance to the state and the public at large of the continued satisfactory standard of graduates from medical and dental schools, recurrent assessment and accreditation are required. A national evaluation and accreditation process will establish a common, formal basis for the recognition of medical and dental education and training and will determine and certify the achievement and the maintenance of minimum standards of education and training. By means of such a process, the Professional Board will attest to the educational quality of accredited faculties and will ensure that those faculties produce medical and dental graduates who are competent to practise under supervision and who have an adequate basis to undertake vocational training.

What immediately strikes one as a missing element in this rationale is that only one of the two goals of accreditation is being addressed, namely the maintenance of minimum standards, while no reference is made to the second and equally important goal, namely the enhancement of standards or improvement of quality.

4.3.6 The goal and objectives of accreditation

In the introduction to the document of the HPCSA on accreditation it is stated that “[t]he general goal of accreditation is to exercise control over the quality of education and training, especially with a view to protecting the user of education against exploitation, to assure maintenance of academic standards and to bring about comparability of standards” (HPCSA 1999a:1; EMC 2002:2). In the self-same document (HPCSA 1999a:3), however, it is stated later that “[t]he general goal of accreditation is to exercise control over the quality of education and training and to serve as proof of the standard of performance of individuals who graduate from an accredited institution for higher education”. In the introduction to the self-evaluation questionnaire the goals of

accreditation are described as “to exercise control over the quality of education and training and to certify the quality and standard of education and training offered by such an accredited institution for higher education” (UET 2003a:1). Under the heading of goals of accreditation it is further stated in this latter document (UET 2003a:1) that

By means of accreditation it will thus be certified that accredited Faculties/Schools –

- *have appropriate goals and objectives;*
- *have the resources required to achieve those goals and objectives;*
- *can demonstrate that they are achieving the goals and objectives; and*
- *give reason to believe that they will continue to achieve those goals and objectives.*

From these goals it is clear that the process of quality assurance in the accreditation process revolves around appropriate goals and objectives – which is in line with the perspective that reigns in education worldwide that the goals and objectives (and outcomes), and resources to support those, establish the criteria in terms of which quality should be measured. Goals, objectives and outcomes have to do with ‘fitness for purpose’ and accountability – an institution has to explain what it is doing, and to ensure quality, it is challenged to show how well it is doing that what it says it is doing (*cf.* Strydom & van der Westhuizen 2001:3-4).

With regard to the objectives of accreditation, documents of both the Education and Registration Management Committee (EMC 2002:4) and the Medical and Dental Professions Board (HPCSA 1999a:3) state that for the purpose of accreditation of medical and dental faculties or schools in South Africa the following objectives apply:

- To develop criteria and guidelines for the evaluation of the educational effectiveness of faculties or schools of medicine and dentistry with a view to ensuring appropriate standards in the education and training of students.
- To improve the quality of education and training programmes in such faculties or schools.
- To guarantee the quality of education and training to all users, concerned bodies and individuals in that accreditation is linked to standards.
- To provide criteria and guidelines and set minimum requirements for curricula and programmes.

- To promote comparability and equality of standards in faculties or schools of medicine and dentistry in South Africa.

From the documentation cited here, it seems that a common set of definitions has not yet been decided on, and whilst the definitions boil down to the same meaning, it might be appropriate for the accrediting body to adopt an official set of definitions for use in its documentation.

4.3.7 The implementation of accreditation in medical/dental faculties/schools

In the documentation on accreditation (EMC 2002:4-8; HPCSA 1999a:3-5) it is stated that the process of accreditation has been designed to determine and certify the achievement and the maintenance of minimum education and training standards in medical and dental faculties/schools within the scope of responsibility of the MDPB. The structure bearing responsibility for the accreditation process and which is held accountable for its decisions by the Board (MDPB), is the Education and Registration Management Committee (EMC), *via* its Sub-committee for Undergraduate Education and Training (UET). In this part of the documentation it is stated that the accreditation visits to the faculties/schools will be undertaken by a panel of *experts*, appointed by the Sub-committee, and the visits will take place under guidance of the said sub-committee (EMC 2002:4; HPCSA 1999a:3).

The MDPB is the body responsible for the process and for creating structures for the planning, design, implementation and execution of the accreditation process. The Board will also bear the costs of accreditation (EMC 2002:4). Albeit the Board takes responsibility for the process, it functions *via* the UET, which, as 'accrediting body' bears the implementation responsibility (EMC 2002:5).

According to the EMC (2002:5) the primary responsibility of the UET is "to attest to the quality of accredited faculties/schools"; while the earlier statement in this regard reads "... to attest to the quality of accredited faculties/programmes" (HPCSA 1999a:4). To be able to do so, the UET has to bear the responsibility for the following:

- Preparing and maintaining an accreditation format.
- Setting and constantly reviewing the minimum standards for undergraduate medical education and training.

- Determining and continuously reviewing the criteria for accreditation at the undergraduate level, with reference to aspects such as:
 - a minimum undergraduate curriculum for medical education and training;
 - the educational and training process employed;
 - the educational methods and techniques used;
 - the criteria with which the end product of the education and training has to comply;
 - the methods by which the end product of the education and training will be evaluated.
- Compiling a list of experts who are acknowledged and accepted as capable to undertake the evaluation of faculties/schools of medicine and their programmes, for accreditation purposes.
- Appointing teams of experts from the list to undertake the full-scale evaluation of the faculties/schools. Such an evaluation includes a site-visit.
- Receiving and reviewing the evaluation reports from the appointed team of experts, and taking such steps as may be required following an evaluation. These steps may include:
 - obtaining additional information required to gain a full picture;
 - obtaining and considering the comments from faculties/schools;
 - ironing out any differences of opinion which may exist between the evaluation report and comments the faculty/school or an individual department may have;
 - preparing and submitting recommendations to the EMC and the MDPB regarding the accreditation status of the faculty/school concerned.
- Receiving requests from faculties/schools and taking whatever steps may be necessary to support the accreditation system. Such requests may relate to any aspect of the education and training programmes of faculties/schools which may affect their present or future accreditation status, or which may have resulted from any resolutions of the MDPB, or the UET, which have a bearing on accreditation.

(EMC 2002:4-6; HPCSA 1999a:4-5).

The main functions of the accreditation body, that is, the UET, regarding the accreditation of medical education programmes are to

- a. lay down minimum standards for undergraduate medical education and training at South African medical schools/faculties;
- b. establish co-operation and the required communication channels between the UET, the EMC, the MDPB and the universities, with their faculties/schools of health sciences/medicine;
- c. formulate the goals and objectives of accreditation with regard to faculties/schools in general, and for the various disciplines in particular;
- d. support the faculties/schools in their preparation for accreditation;
- e. establish visiting panels for the accreditation evaluations of schools/ faculties, or individual disciplines;
- f. design and compile guidelines and criteria in terms of which the accreditation process will take place;
- g. take responsibility in terms of organisational matters and logistical arrangements to prepare for the visits, the site visit, and for dealing with the outcome of the visit;
- h. monitor accredited programmes to ensure the maintenance of standards and to arrange for the renewal of accreditation;
- i. accept and acknowledge the outcomes of the visiting panels' findings, to deal with these in collaboration and in consultation with the university concerned and the MDPB;
- j. maintain regular contact with the faculties/schools to determine whether they are able to uphold their conditions of accreditation;
- k. provide reasonable and appropriate information on accredited programmes, faculties/schools to the EMC and the MDPB, educational and state authorities, and other education and training institutions which may have an interest therein;
- l. prepare and disseminate documentation and publications, provide counselling and arrange meetings in connection with the accreditation process and the maintenance and/or improvement of academic teaching and training standards;
- m. promote the self-regulation of faculties/schools and/or individual departments by promoting internal self-evaluation and the maintenance of quality in education and training

(EMC 2002:7-8; HPCSA 1999a:5).

4.3.8 The visiting panel

In the documents on accreditation (EMC 2002: 8-10; HPCSA 1999a: 6-7) it is stated that the evaluation or assessment of medical faculties/schools, that is, the external quality assurance process, is carried out by a panel of independent experts (HPCSA 1999a:6), while the EMC (2002:8) calls the panel a panel of independent persons. The panel is called a visiting panel, and the members for each panel are selected and appointed by the UET, on behalf of the MDPB, from the list of possible candidates referred to earlier. The chairperson of the visiting panel must be a member of the UET.

The task of the visiting panel is to determine whether generally accepted standards are maintained and conditions met in any or all of the disciplines or departments of a faculty/school of medicine in terms of the conditions and criteria for undergraduate medical education and training laid down by the MDPB (EMC 2002:8; HPCSA 1999a:6).

Representation on the panel must provide for a balance of experience between basic and clinical disciplines and also between teaching and research. A list of possible candidates was compiled by the UET after all medical faculties/schools had been invited to submit the names of eligible candidates for the panels. The list has to be updated regularly (this has been done in 2004), and nominees must be recognised experts in their fields, while their educational knowledge and experience are also taken into consideration. The list is to include representatives from all the universities; professionals in the private and the public sector, hospitals or management positions may also be included. It is of utmost importance that for each panel to be appointed the members should represent a balanced distribution (EMC 2002:9).

The EMC (2002:9) emphasises that it is crucial for the success of the accreditation process that a faculty/school due for an accreditation visit should have confidence in the panel that is to evaluate it.

The number of members of a panel depends on the distribution of responsibilities, and every effort must be made to cover the whole spectrum of disciplines, including education. In selecting a panel for an accreditation visit, the following criteria are applied:

- a. The chairperson must be a member of the UET. He or she need not be a

subject specialist, but experience in management, quality assurance and educational matters serves as a recommendation.

- b. Three to four of the members must be actively involved in medical education.
- c. One member must be an education expert, currently involved in medical education and training.
- d. The secretary is appointed by the Board (MDPB).
- e. The chairperson must have a wide perspective of the field of medical education and training, and of current trends in the field.
- f. In selecting the members, both the basic sciences and clinical disciplines must be covered.
- g. It is crucial that the members of panels should have insight in and topical knowledge and experience of the health structures of South Africa, the higher education system, university and faculty/school structures and their development over recent years, as well as recent developments and innovations in medical education in general.

(EMC 2002:10; HPCSA 1999a:7).

4.3.6 The process

The process of accreditation is described as to be carried out as follows:

- a. The process of accreditation entails a self-assessment carried out by the faculty/school to be visited, the preparation of a data-base reflecting the education and training programmes offered by the faculty/school. This is followed by an on-site visit by a visiting panel of experts in medical education. The process is to be carried out with five-year intervals, but from time to time limited accreditation surveys may be conducted.
- b. The accreditation body is to develop standard procedures for the evaluation of faculties/schools of medicine, both for the self-evaluation and the external evaluation. Even though the primary task of the EMC and the panel is to evaluate the faculty/school concerned and its programmes, consultation will be required with the academic staff and administration to encourage re-examination of content, instructional approaches, methods, strategies and techniques, curriculum development, student welfare, and student and staff development. The visiting panel may also address perceived deficiencies with regard to resources, facilities and staff, and methods to overcome problems.

- c. Internal quality assurance or institutional self-evaluation as the basis of the accreditation process is indispensable in a quality assurance process and is of major importance in any discipline's preparation for accreditation. Internal quality assurance must be geared at the way in which the activities of a department or discipline or programme are organised and carried out, the optimal utilisation of resources, and the achievement of identified goals. The internal self-evaluation report is the primary source of information for the visiting panel. This report must be compiled according to the specific guidelines provided by the accrediting body. It is important to note that the self-evaluation process is essential and the report resulting from the self-evaluation forms the basis of the accreditation evaluation and site visit to be conducted.

(EMC 2002:10-11; HPCSA 1999a:8)

The HPCSA (1999a:8) also points out the difference between accreditation and certification or registration. Accreditation refers to the setting of standards for the curriculum and education programme. The programme (its content and the way in which it is presented) is evaluated; in other words, accreditation investigates the **education and training process**, that is, aspects of and experiences offered in the programme offered by the faculty/school, and those related elements that impact on the education and training. Certification or registration refers to the knowledge and skills of individuals who wish to practise medicine, namely the final outcome of the education process in the sense of an individual who has passed through the process.

4.3.7 Procedures for the external evaluation

In the regulations for accreditation issued by the EMC (2002:11-14) the procedures to be followed for the external assessment of schools/faculties are described as follows:

- a. The visit by the visiting panel must take place according to standard procedures. Before and/or during such a visit the accreditation body must be supplied by the faculty/school concerned with the following documentation and information:
 - An institutional self-evaluation report (based on a questionnaire compiled by the UET).
 - Detailed information regarding the curriculum/programme.
 - The most recent prospectus or similar information.
 - The most recent annual reports on academic work.

- Information on or reports and development plans for teaching, learning and research activities.
 - A selection of lecture notes, study guides, text books used.
 - Examples of curricula and the mission, goals and objectives of the various departments/units/disciplines.
 - Examples of policies, procedures and planning documents.
- b. During the site visit matters such as educational strategies, methods and techniques, curriculum development, evaluation/assessment procedures, staffing, student and staff welfare, support and development, resources, and other matters will come under scrutiny. These should be discussed with the management, lecturing staff and administration to enable the accreditation body to assess compliance with guidelines, standards and criteria for accreditation.
- c. With a view to the site visit to a faculty/school the following actions will be undertaken:
- A data gathering process by means of a questionnaire. This questionnaire must enquire into matters such as stated outcomes, objectives and priorities of the curriculum; course content; patterns of staffing; resources, including laboratories, hospitals and libraries; educational methods, techniques and strategies; student learning assessment/evaluation; selection and promotion procedures (of staff and students); management; options within programmes; responsibilities of hospitals, community centres, individual practitioners; opportunities for electives; academic support and development of lecturers and students; and remedial programmes. The questionnaire will also seek plans for future development and endeavour to identify problem areas which staff or students would wish to discuss. Specific topics may be raised for discussion with the panel.
 - A visiting panel must be appointed.
 - The documentation prepared for the accreditation process will be submitted well in advance of the site visit to allow the visiting panel sufficient time to review the documentation and to make a detailed study thereof in order for the time of the actual visit to be used optimally.
 - The timing of the visit must be arranged in consultation with the dean of the faculty/school concerned, and the dates must be confirmed well in advance with all concerned. The visit must take place during an academic term.
 - During the visit the members of the visiting panel will consult with the heads of

departments or disciplines, teaching and teaching hospital staff, curriculum committee, interest groups or committees in medical education and research, representative staff members, recent graduates and student representatives. The visiting panel will also consult with senior administrative and academic staff of the university and representatives of the provincial department of health. Furthermore the panel will inspect resources, including research and teaching laboratories, libraries, community clinics, general practice settings and hospitals. Additional information may be requested and should the need arise, additional time may be arranged to complete the visit.

- Prior to the final consultation with the dean and others concerned, the visiting panel will agree on the main points and conclusions of the report. Strengths and weaknesses should be identified where applicable, as well as problem areas requiring attention, and specific actions which are to be encouraged. These conclusions will then be presented verbally to the dean and senior officials in the faculty/school and of the university. The discussion should focus on corrections of errors of fact, and should specifically address recommendations and actions which are required in response. No formal recommendation concerning accreditation will be made at this stage as such a decision is a resolution of the board (MDPB) itself in consultation with and on recommendation of the visiting panel.
- An official report is then to be prepared by the panel and its secretary. Members of the team are given the opportunity to ratify the report and to have a minority opinion to be noted in the case of major disagreements. The report is then submitted to the chair of the UET, and to the UET at its next meeting, where the chairperson of the visiting panel will present the report. The report has to be a detailed document, containing the findings, comments and recommendations of the visiting panel, the UET, the EMC and the MDPB. Areas requiring attention and areas worth recommending should be noted.
- The UET makes the report available to the dean of the faculty/school concerned with the request that factual inaccuracies, if any, be pointed out. These, if any, are brought to the attention of the members of the panel within a fortnight, and are corrected (should there be a need). If the dean/faculty/school wishes to do so, a response may be submitted which will be included as an appendix to the report.

- The report and the comments of the faculty/school are subsequently submitted to the UET for a final recommendation to the EMC, and then to the MDPB for a final decision. The Board makes the final decision regarding accreditation on the basis of the report and informs the dean of the faculty/school concerned and other concerned bodies accordingly.
- The report or parts thereof may be made public if the Board wishes to do so.

4.3.8 Options for accreditation decisions

Accreditation of a programme is granted for a period of five years. Three months prior to a follow-up visit, a written report, comprising responses to the accreditation body's questionnaire needs to be submitted, and where-ever possible, evidence that the faculty/school has maintained its standard of education and training, as well as of resources (EMC 2002:15).

Accreditation is granted subject to conditions. This implies that accreditation for any period up to five years will be conditional, depending upon the faculty/school successfully addressing certain issues of concern within the period as specified by the accreditation body. The right is reserved to revisit the relevant institution which will be said to hold accreditation subject to specified conditions. Such an institution should submit a written report in the fifth year following the accreditation visit (EMC 2002:15; HPCSA 1999a:11).

Accreditation may also be granted for a shorter period of time. If a significant deficiency is noted, accreditation may be awarded for a period of less than five years. Such accreditation may then only be extended to a full five-year accreditation after a revisit by an expert panel (EMC 2002:15; HPCSA 1999a:11).

The report referred to above must contain information concerning major curriculum changes, for example, in instructional methods, methods of student learning assessment, as well as any statistical information the accrediting body may require. Even if there have been no major changes in a programme/faculty/school, re-accreditation will only be granted after five years following a further full visit (EMC 2002:15).

In the case of major changes to a medical programme (for example, in the duration or format of the programme, a significant change in the objectives/outcomes or philosophy, emphasis or institutional setting of the programme), the UET must be informed of such changes. Depending on the nature of the changes, they may be approved within a current period of accreditation, conditional accreditation may be granted pending a site visit, or accreditation of the changes may be refused (EMC 2002:16; HPCSA 1999a:11).

When the accreditation body makes a decision regarding accreditation of the undergraduate medical education programme of a faculty/school, various options are available. Provision is made for the following adverse actions:

- a. Denial of provisional or full accreditation.
- b. Probation, which will be imposed for a specified period of time during which the MDPB will expect of the faculty/school concerned to rectify deficiencies which have been identified.
- c. Withdrawal of accreditation.

Explicit procedures for the hearing of appeals against an adverse action still need to be formulated, and will be set out in the accreditation guidelines of the UET (EMC 2002:16).

The documents summarised in 4.3 (EMC 2002; HPCSA 1999a) give a clear overview of what the HPCSA expected to achieve by means of the accreditation process, how they envisaged the process to be conducted, and what is expected of the medical faculties/schools in South Africa in this regard. Having done an extensive study of accreditation as quality assurance process in other higher and medical education systems (AMC 2002; Bazargan 1999; Boelen *et al.* 1992; Cassie *et al.* 1999; DEI [Danish Evaluation Institute] 2003; Dittrich 2003; Frazer 1991; GMC 2003; Hamdy 2003; IIME 2001; Labuschagné 1995; LCME 2003; Metz, *et al.* 1994; Metz, *et al.* 2001; Prasad & Stella 2004; Suwanwela 1995; WFME 2000; Young *et al.* 1983, and others), and taken under scrutiny these documents of the accrediting body in South Africa, it has become clear that the process is on a par with what is done in most other medical education systems where quality assurance processes are conducted – actually, as this is one of the latest quality assurance systems developed, seemingly the best has been taken from existing systems, and incorporated into this system, which renders it a particularly

detailed and effective system. However, there still are some aspects in the process that need to be addressed more explicitly (for example the structure of the self-evaluation and the external evaluation, the setting of standards, and guidelines for the second goal of quality assurance, namely quality improvement), and it also may be stated that these documents need to be reviewed in order to eliminate ambiguities (for example, panel of persons/panel of experts; accreditation of the programme/institution) and to define certain concepts. A question that came to mind too, was: How well have these documents of the professional/accreditation body been brought to the attention of all concerned? Is the researcher's perception wrong (after having visited all the medical schools in South Africa) that some heads of schools, programme directors, academic staff teaching and training in undergraduate programmes, and previous expert panel members are not fully aware of the content (or even existence!) of these documents? In the recommendations emanating from this study this aspect will be addressed (see 8.4.1).

4.4 OFFICIAL ACCREDITATION DOCUMENTATION

Following the compilation of the documents discussed in 4.3, the UET assigned members of the Sub-committee to compile other documentation for use in the accreditation process. The researcher in this study has been instrumental in drafting most of these documents, as has been the case with the HPCSA's documents discussed (HPCSA 1999; 1999a; MDPB 2003; UET 2003a), some of which have been adapted over the past five years as more experience was gained.

4.4.1 Education and training of doctors in South Africa

In the document, *Education and training of doctors in South Africa: Undergraduate medical education and training – Guidelines by the Medical and Dental Professions Board* (HPCSA 1999) it is stated that the UET of the MDPB has been commissioned to formulate objectives for undergraduate medical education as an increasingly strong need exists among all involved in such education for a description of what is to be expected of a doctor at the end of undergraduate medical training. To this end the UET declares that the "unique function of faculties for health sciences/medical schools is to select and educate competent, skilled and caring medical practitioners, capable of meeting the individual's as well as society's expectations of health care and to promote

the health of all people” (HPCSA 1999:1). It is further stated that medical schools should strive to educate and train doctors who are capable of adaptation to change, whose minds can encompass new ideas and developments, and whose attitude to learning is such that it will inspire the continuation of their educational process throughout their professional life. It must be ensured that the essential elements of medical education and training remain embedded in curricula and that a newly qualified doctor is sufficiently prepared for the responsibilities which he/she will encounter (HPCSA 1999:1).

In order to be able to achieve this outcome, the HPCSA requires of medical education to be adapted to the needs of society, and in line with the principles embodied in the Edinburgh Declaration of 1988 and the Cape Town Declaration of 1995, it is reiterated that medical education should be responsive to community needs and at the same time meet global standards (HPCSA 1999:1). Within the framework of expectations of the doctors of the future, various aspects of the profile of the doctor need to be developed during medical education in South Africa, including

- certain attitudes, specific knowledge, skills and professional behaviour;
- the ability to exercise prevention, promotion, treatment and rehabilitation;
- leadership, management, educational and research skills

(HPCSA 1999:2).

Quoting the United Kingdom General Medical Council's *Tomorrow's Doctors*, the Edinburgh World Summit on Medical Education (1993), the Yaounde Declaration (1994), and the Cape Town Declaration (1995) the Council set out expectations of changes to be made in medical education to be able to stay in line with world-wide trends in and recommendations for undergraduate medical education (HPCSA 1999:2-4). The main points covered in these recommendations are:

- There should be a decrease in the number of facts to be digested by students, and a firm understanding of the scientific method should be promoted.
- Problem-based learning should be introduced with an emphasis on real clinical situations to make education more practical, relevant and stimulating. Early clinical contact should become the norm.
- Integrated learning must be encouraged – both horizontal and vertical integration, and integration of basic and clinical training.
- Skills development should be improved. It should start early, using skills

laboratories, simulated patients, models and ultimately patients.

- Attributes that should be enhanced in students include ethical behaviour, appreciation of the importance of team work, responsiveness to community needs, management and leadership skills, self-directed learning and an understanding that medical education is a lifelong process.

In a discussion of the profile of the doctor, it is stated that undergraduate medical education embraces a period of learning (knowledge), training (skills) and moulding (attitudes and behaviour). On the successful completion of the undergraduate curriculum, the student should have developed into a basic doctor, fit to practise the profession over the broad spectrum of medicine or to undergo specialist education and training (HPCSA 1999:4). The core characteristics and qualities of the basic doctor are outlined, the general goals of medical education and training are stated, and the knowledge, skills and attitudinal objectives that should be pursued in undergraduate medical education in South Africa are listed (HPCSA 1999:6-8). This is followed by a number of recommendations relating to the curriculum/learning contents; teaching and learning; clinical training; attitudes and behaviour; general skills; the assessment of student learning; the evaluation of the curriculum/programme; ethical values and norms; management and leadership; and a number of general recommendations (HPCSA 1999:8-13).

In the final paragraph of this document it is stated that these guidelines and recommendations should be phased in in medical faculties/schools within a period of three years (HPCSA 1999:13). This document serves as the basis for accreditation decisions and it is expected of accreditation panels to use it as point of reference during their evaluations of programmes. However, during the accreditation visits over the past four years, as well as during visits to faculties/schools of medicine it seemed (to the researcher) as if many individuals involved in medical education and training have never before set eyes on this document, and still do not ground their curriculum development actions, and/or their education and training on the recommendations set out here.

4.4.2 Questionnaire for self-assessment

The document designed to serve as questionnaire for the faculties/schools (UET Task group 2000), and on the basis of which the self-evaluation report has to be drafted, was

drafted with a view to collecting information from the institution before the on-site visit takes place, and to provide the visiting panel with sufficient background on the institution and its programme. The document first gives the goal of accreditation, and it is stated that it has to be completed by the dean of the faculty concerned in collaboration with heads of department/chairs of phases/ blocks/programmes. The document is divided into twelve sections, namely

1. Aim, purpose and outcomes of the programme
2. Student and staff resources
3. Information on the programme
4. Curriculum design, content and organisation
5. Teaching, learning and assessment
6. Student progression and achievement
7. Student development, support and guidance
8. Resources
9. Management, governance, supervisory structures
10. Staff development
11. Quality assurance and enhancement
12. General clinical training.

Some of the items require statistical data to be provided, whilst others have to be responded to in a qualitative way, describing and evaluating aspects of the curriculum, resources, teaching and training, students and staff, and quality assurance measures. The responses to the questionnaire, that is, the self-evaluation reports, for the first round of accreditation evaluations were rather lengthy documents, ranging between 60 and 90 typed pages. Usually the self-evaluation reports were well-compiled documents, providing the required information, and giving the visiting panel a good overview of the education and training in the programme concerned, staffing, student matters, management, facilities and resources.

At a workshop held in 2003 it was decided to review the self-evaluation questionnaire (UET 2003b:4-5). It was resolved that the items requiring quantitative and qualitative data should form separate sections of the questionnaire, that consideration should be given to the possibility of capturing the quantitative data administratively and that institutions should be requested to update these annually; and that a task team should

be appointed to reconsider the content of the self-evaluation questionnaire and redesign a comprehensive accreditation document. The current researcher was appointed convener of the task team and with the assistance of the other members, the questionnaire was adapted; the adapted questionnaire however, has not yet been put into use by the end of 2004. The main changes involved a separation of quantitative and qualitative information, and an alignment of items with applicable items in the questionnaire of the World Federation for Medical Education's *Global standards for quality improvement* (WFME 2003).

At the same time a standards document, based on the outcome of a master's study to develop standards for the accreditation of undergraduate medical education and training in South Africa (Bezuidenhout 2002) was developed by the convener and submitted to the UET for consideration as instrument to be used for accreditation evaluations. At the July 2003 workshop of the UET it was decided that the standards should be considered for use, and that the researcher (M.J. Bezuidenhout) should align these with the WFME global standards for quality assurance (WFME 2003). This document, which is aimed at being used together with the self-evaluation questionnaire, was compiled and now has been submitted to deans/heads of schools with a view to gain their opinion on its usefulness in the accreditation process. A decision in this regard will presumably be taken by the UET in 2005.

4.4.3 Guidelines for the panel of experts

In April 2001 Bezuidenhout compiled a document for the UET setting out guidelines for the panel of experts that has to evaluate medical education programmes. This document was used until 2003, when it was slightly adapted and accepted by the MDPB as official guidelines for the panels of experts (MDPB 2003).

The document starts off by giving the goal of accreditation (MDPB 2003:1):

The accreditation of a Faculty/School of Medicine has as its purpose the certification that the Faculty/School

- a. has appropriate aims and purposes (stated outcomes);*
- b. has the resources needed to accomplish its aim and purposes (to achieve the stated outcomes);*
- c. can demonstrate that it is achieving the stated outcomes;*

d. gives reason to believe that it will continue to achieve those outcomes.

The main tasks of the visiting panel are described as to:

- analyse the self-assessment report prior to the site visit;
 - gather evidence during the site visit;
 - write a quality assessment report;
 - recommend accreditation/re-accreditation/provisional accreditation/no accreditation.
- (MDPB 2003:1).

The guidelines state that the members of the visiting panel have to analyse the self-assessment report of the faculty/school prior to the site visit to determine whether the aims, purposes and the stated outcomes are clear and satisfy the requirements of the MDPB. Based on the information contained in the report, the visiting panel identifies strengths and weaknesses, as well as problem areas requiring attention and specific activities to be encouraged. A list of aspects that need to be attended to specifically is then provided (MDPB 2003:1-2). The consultations that have to take place during the site visit, the observations that need to be done and the inspection of resources and facilities are described, as well as the materials that need to be scrutinised (MDPB 2003:2).

With regard to the working method of a panel it is stated that each visiting panel may choose its own working method, but a general procedure is recommended and explained in the document. The first step in this procedure involves a discussion between the chair of the visiting panel and the dean of the faculty/school to be visited to discuss arrangements, a programme, matters that will receive special attention, and the manner in which the self-evaluation report is to be compiled (MDPB 2003:2-3).

On receipt of the self-evaluation report, the members of the panel are to study it and then have a discussion to define areas where more information is required, issues of special concern, to formulate questions to be answered during the visit, and to decide on a division of tasks. They also discuss the programme and identify persons they would wish to interview during the visit (MDPB 2003:1).

On arriving at the site of the visit, the members meet with the dean, top structure of the

university (if so wished), and others concerned. The visiting panel gives a brief explanation of its working method and a final programme for the visit is decided on in consultation with those concerned.

During the visit consultations are held, including discussions with students. Instructional sessions are attended and facilities visited. The panel as group and individual members conduct interviews, attend meetings and instructional sessions, and visit facilities, for example, lecturing and group-work venues, hospitals, laboratories, libraries, information technology centres, community health centres where training takes place, and so forth. They also scrutinise instructional materials, examination materials (papers, answer scripts, and memoranda); minutes of meetings, reports and planning documents, curricula, timetables and any other materials they may deem necessary. They also meet with a representative of the provincial health department.

On the last day of the visit the panel has a final discussion with the dean and other representatives of the faculty, including students. At this stage the panel may give an indication of the findings, but it is made clear that the final decision concerning accreditation will rest with the MDPB (MDPB 2003:2-4).

The panel then compiles a report, giving an overview of its findings, as well as specific findings. The dean of the faculty/school concerned is provided with a copy of the report and is given the opportunity to correct factual mistakes, and to comment on the report. The report, with the corrections/comments of the dean, is submitted to the Chair of the UET, who submits it to the members of the UET at a meeting of the sub-committee for a final recommendation regarding accreditation. The report with the recommendation is then submitted to the MDPB for a final decision.

When the MDPB has reached a final decision on accreditation, the report as well as the resolutions of the Board is submitted to the rector/principal of the university concerned and the dean of the faculty/school (MDPB 2003:2-4).

The document also gives lists of documentation to be provided by the institution – some before the visit, others to be available for inspection during the visit. This documentation includes course or programme-related items, general/institutional information, samples

of student-related work, management information, documentation on student support, staffing and staff development, and information on resources (MDPB 2003:4-6). An example of a schedule for an assessment visit is provided, and information on how the accreditation report is to be compiled (MDPB 2003:8-9).

This is a clear and useful document, describing the expectations of the MDPB with regard to the activities of the visiting panel. The guidelines are provided to each member of a panel before a visit, and in general these guidelines can be said to be followed (according to the experience of the researcher). When compared to documentation of other accreditation systems, nothing is found to be amiss, apart from the standards and indicators to determine the level or extent to which a programme satisfies the set standards.

4.4.4 Recommended structure of accreditation report

Another document that warrants mentioning is the document containing guidelines for the way in which the accreditation report, issued by the review panel, should be drafted (MDPB 2003a). According to these guidelines, a brief summary of the education and training programme of the faculty/school that has been evaluated must be compiled, and information on the committees, groups and individuals interviewed must be provided in the report. The programme for the site visit should also be attached, and comments should be included on the comprehensiveness and the quality of the self-evaluation report of the institution (MDPB 2003a:2).

According to these guidelines (MDPB 2003a:3) the remainder of the accreditation report should consist of specific comments on and evaluations of the management and organisational structures of the faculty/school and the student selection and admission procedures. In terms of the Board's requirements (as set out in *The education and training of doctors in South Africa* – HPCSA 1999) the curriculum followed must be commented on/evaluated critically with emphasis on the aim and stated outcomes of the programme, curriculum design, development and organisation, and curriculum content (MDPB 2003a:3-4). Various aspects of teaching and learning, general clinical training, assessment of student learning, student progression and achievement, student support and guidance, staff development and training, learning resources, human resources, research and other publication outputs, and quality assurance and enhancement

measures are to be evaluated critically and commented on (MDPB 2003a:4-9). Finally, the accreditation panel is required to make some general and specific recommendations, to make a recommendations regarding accreditation or not, state the number of students approved for admission per year, and state the period of accreditation (MDPB 2003a:9).

This document is used for every accreditation visit, and the chair, in consultation with the panel members, usually divides the different aspects which should be reported on among the panel members to be covered in detail, while every member of course may make an input to every aspect he/she feels the need to address. This is a very useful document as it ensures that all aspects of the programme and impacting factors will be covered. It also can play an important role in motivating institutions to change and improve their quality of education, as specific comments are required on the innovative nature of the curriculum and the quality assurance measures that are applied in a faculty/school – eliciting negative comments will naturally motivate the institution to endeavour to improve. Panels usually will also point out commendable features in the programme, and will not only concentrate on negative aspects or matters where improvement is required.

4.5 DISCUSSION

As has been described earlier (1.3.4) for each accreditation visit a new panel is called together, albeit some members have been part of the panels more than once. The researcher, who participated as the educationist in six of the first round visits to medical schools, one visit to a dental school, one second round visit to a medical school, and co-ordinated the preparations for the visit to her home institution in 2002, soon realised that different panel members had different perspectives on certain aspects of education and training, and as the situation changed from faculty/school to faculty/school, her own perspectives and views on certain aspects seemed to change too. For example, during the first three visits, the panel did not give the medical faculty/school concerned any indication of whether its programme would be accredited, or of what the general view of the panel on the findings at the faculty/school was; later on, however, it became common practice for chairs of visiting panels to give feedback to the faculty/school on the last day of the visit, including a statement on what the panel's recommendation with regard to accreditation would be.

In the same way, and even more profoundly, different members of the panels who were responsible for reporting on certain aspects of the education programme, held completely different views of what was regarded 'good' practices, or practices that needed attention. An example is that whilst in one medical school the panel congratulated the emphasis on continuous and formative assessment, and the fact that students who attained 60% or more in formative assessments need not take the end of the year final examination, whilst another panel remarked on the same aspect of assessment (at another institution) that it might lead to students not being compelled to integrate the knowledge gained during the course of the year, or to digest the knowledge attained within context, as they are not examined on the whole body of knowledge in one assessment, which might lead to fragmented learning. (Due to the confidentiality of the accreditation reports, no references are given for these examples, and no detailed examples will be quoted.) Also, in one instance, students working on their own a great deal was reported as a commendable feature, whilst another panel member found the same aspect of the instruction at another school as negative, stating that it led to students feeling at a loss about what they need to know. At one medical school the fact that the panel did not receive previous inspection reports to look at, turned into a major issue, whilst in other faculties/schools no mention even was made of previous inspection reports. These might seem rather trivial matters, and when one reads all the reports it does not seem as if there are major causes for concern regarding the different views panels/panel members might have of education and training; however, in the discussions going on during the visits, it became clear that all the members did not regard the same things as important or good practices, and as there is no tool the chair can use to determine the validity of criticisms or favourable comments, it usually rests with the chair to make a final decision on whether some opinions will be included in the report or not.

It is important to note that the accreditation process is a quality assurance mechanism to determine and improve the quality of the education and training process, that is, of all the activities, resources and facilities that impact on the education and training of students (*cf.* last paragraph of 4.3.6). The quality of the final outcome of the process, that is, the graduate student, is but one indicator of quality. Therefore, accreditation as quality assurance process should not be confused with the determination of the quality

of the end product, namely the graduate student. The results of the assessment of students and the final examinations students have to take before they are allowed to register as medical practitioners are only two of the indicators in the totality of the quality assurance process, thus care must be taken not to equalize accreditation and its results with the quality of the students delivered by a medical education programme, albeit the expectation is there that a faculty/school found to have a programme of high quality will also deliver high quality students.

The way these visits were structured and conducted was described in 4.4.3. In the course of the visits, extensive note-taking took place, as a report has to be compiled eventually, with a member of the team commenting on the areas he/she assessed. As educationalist on the team, the researcher attended to all aspects except the disciplinary content of the programmes and some aspects of clinical training. Members of the team discussed various aspects of the programme under review, and the education, training and management in the school on the basis of these notes, and then drafted the accreditation report, with each member contributing his/her findings with regard to the educational standards maintained. These notes, notes taken during discussions and the informal meetings of the team, and the reports themselves were valuable sources of information when data for the draft guide compiled for this current study were collected, and provided 'benchmarks' for the researcher in designing the rubrics for the standards.

4.6 CONCLUSION

Since 1995 there have been various actions to establish a sound quality assurance process for undergraduate medical education in South Africa, which has always been regarded as a country with medical schools which students are well received all over the world. It became imperative, however, to ensure that medical education stays on a par with what has been happening in medical education worldwide, and a system for quality assurance in the educational processes became a necessity, especially in the wake of the many changes in the country's health and education systems, and the demands and requirements these brought with them, and also in response to the changes and trends in medical education in the global context.

Investigations conducted on the quality assurance systems of other higher and medical

education systems, and many discussions and consultations with experts and others concerned, resulted in a system being developed to suit the unique circumstances of medical education in South Africa. A decade after the first document on accreditation for South African medical faculties/schools had been drafted, the HPCSA now has a firmly established system of accreditation which plays an indispensable role in ensuring “control over the quality of education and training, especially with a view to protecting the user of education against exploitation, to assure the maintenance of academic standards and to bring about comparability of standards” (EMC 2002:2). The structures and procedures of the system are all set out clearly in various documents, and the visiting panels, it is maintained, are functioning well.

Having studied the system and other similar systems, the conclusion may be drawn that there still is something amiss, namely a generally accepted set of standards for undergraduate medical education, which is needed for schools'/faculties' planning processes, self-evaluations, and for quality improvement, and which may be used to ensure the continuous improvement of medical education in South Africa. Such a set of standards, with indicators or rubrics to depict different levels of achievement, can be used by the accrediting body as guideline and/or measuring tool in determining the level of quality achievement of an institution with regard to its programme that is to be accredited. The use of a standardised guide for accreditation will ensure a structured accreditation process, will serve as motivation for quality enhancement, and will bring about comparability in the accreditation of different medical faculties'/schools' programmes.

Another aspect that seems worth mentioning with regard to the accreditation documentation currently in use is the discrepancies and ambiguities that have been identified in different documents. Although this might not have a serious impact on the meaning of the information, it will be suggested that the current documentation be reviewed and that a single document, containing the background to the accreditation process, regulations related to the process, guidelines for the faculties/schools and the accreditation panel, definitions and explanations of terminology, and other relevant information be compiled.

CHAPTER 5

RESEARCH APPROACH AND METHODOLOGY

Research – old French *recerché* – meaning to search again

5.1 INTRODUCTION

Laymen tend to associate the concepts of research and science with medicine and natural sciences and breakthroughs made in those fields. Others tend to confuse research with statistical analyses, and regard the methods of the natural sciences as the only way in which new knowledge may be obtained (*cf.* Huysamen 1994:1). The word research is also used in the vernacular to describe almost any kind of collecting information on something, or 'looking things up', or reading extensively on a specific topic. This however, is not scientific research; research as defined by the scientist refers to "exploration, discovery and careful study of unexplained phenomena" (Brink 2003:2). Huysamen (1994:1) defines research as "the scientific method ... used to expand knowledge in one's field of study", and Leedy (1997:3) defines research as the "systematic process of collecting and analyzing information (data) in order to increase our understanding of the phenomenon with which we are concerned or interested".

The phenomenon under study here is quality assurance in education, and, more specifically, how it manifests in undergraduate medical education and training in South Africa. In trying to gain an understanding of this phenomenon and its manifestation in medical education, several questions arose regarding the accreditation review process, that is, the process by means of which it is established whether an undergraduate medical education programme in South Africa satisfies the 'quality requirements' of the quality assurance body, that is, the professional board of the Health Professions Council of South Africa (HPCSA). The questions which arose and led to this study, are: How can objectivity and comparability be assured in accreditation review visits when the panels visiting the different medical faculties/schools for each visit comprise another group of individuals as members? What is the actual premise the members use for making peer-based decisions about institutions' performance? What mechanisms are available to help them (the members of the panel) arrive at a collective assessment of institutional strengths and weaknesses? How can it be assured that institutions strive for

'best practice'? How can the extent to which institutions (medical schools/faculties) achieve this striving be determined, and comparability and equality of standards in medical education be promoted?

These questions pointed at a specific deficiency in the accreditation process, and deliberations on the questions and discussions with Professor C.J.C. (Kerneels) Nel, a former Chairperson of the Undergraduate Education and Training Sub-Committee (UET) of the Medical and Dental Professions Board (the body responsible for accreditation of undergraduate medical education and training) (Nel 2003), a problem statement for the study was formulated, namely that there was a lack of a review guide that might be used as a tool or mechanism for the assessment of medical education and training in the said accreditation system. The lack of such a guide, it was perceived, might result in different accreditation review panels arriving at subjective conclusions, as discussed in Chapter 1 (1.4). If the members of a specific panel, and the different panels visiting different schools for accreditation review, do not have a common point of departure in their deliberations and for their judgements and decision-making, there is no way to ensure objectivity in the assessment and comparability among the standards of education maintained in different schools. Albeit all members are experts in their specific disciplines and are qualified to assess the disciplinary content of a specific part of a programme, their approaches to education and training may differ, and their views on medical education and training, especially in a period of change (such as medical and higher education in general in South Africa is currently experiencing) may differ vastly, leading to findings that may be idiosyncratic and based on the individual experiences and even peculiar characteristics of the individual members of the panel or the group (panel). This problem statement was broken up into different components, namely, first, a need exists for a mechanism or specific tools that might be used as an assessment guide by the members of a review panel to generate a consistent set of judgements and ensure that they arrive at an objective and soundly based decision when they determine the extent to which a medical education programme succeeds in achieving set standards, or when they make a collective decision regarding the strengths and weaknesses of a programme. Second, a need exists for an ongoing and systematic process to introduce best practice in institutions, to promote comparability and equality of standards, and to promote development and improvement in programmes. It was assumed that a guide for the accreditation process, and quality assurance in undergraduate medical education in general, might solve this problem.

In this chapter the research process by means of which the defined problem was addressed, will be described. But before commencing with that, some theoretical aspects of research approach, design and methodology need to be discussed to put this study in context with regard to its theoretical and methodological orientation.

5.2 RESEARCH APPROACH

Research studies can be categorised into two broad categories: qualitative and quantitative studies. The quantitative approach is also known as the traditional, experimental or positivistic approach, while qualitative research, which deals with the complex nature of phenomena, is also referred to as the interpretative, inductive, constructivist, or post-positivist approach (Leedy & Ormrod 2001:101).

5.2.1 Quantitative and qualitative approaches

Based on Leedy's (1997:3) definition of research, we can assume that research starts with collecting information, and we usually collect information by asking questions. By asking different kinds of questions, we will obtain different types of information. If we want to know how often, or how many people behave in a certain way, we shall get answers that are measurable; however, these measurements may not answer the question 'Why?'. In research these different types of questions are answered through different approaches: the quantitative approach and the qualitative approach (*cf.* Leedy 1997:104). Fouché and Delport (2002:79) call these approaches the qualitative and quantitative paradigms, while Chappel (*s.a.*:1) simply calls it a type of research.

The quantitative approach to research is the earlier form; it originated in the natural sciences and was concerned with investigating things that could be observed and measured in some way. These observations and measurements can be made objectively and repeated by other researchers (Hancock 1998:1). Qualitative research, on the other hand, is defined as research that involves interpreting non-numerical data (Chappel *s.a.* 1). Researchers working in the social sciences who were interested in studying human behaviour and the social world inhabited by human beings, later found it difficult to explain human behaviour simply in measurable terms. This was the beginning of qualitative studies – research which attempts to increase our understanding of why things are the way they are, and why people act the way they do (Hancock 1998:1). Shank (2002:5) defines qualitative research, in its most basic terms, as “a form of systematic empirical enquiry into meaning”. It thus is concerned with developing explanations of social phenomena. Creswell (1998:15) defines qualitative research as:

... an inquiry process of understanding based on distinct methodological traditions of inquiry that explore a social or human problem. The researcher builds a complex, holistic picture, analyses words, reports detailed views of informants, and conducts the study in a natural setting.

A qualitative approach was decided on for this study, as that would provide an opportunity to explore a problem which can be classified as a social problem, in the natural setting, and to collect and report the informed opinions and views of the research participants. Such an approach would allow the researcher to explore, describe, interpret and explain the phenomenon under study, and to build a theory. To explain the way in which (and reasons why) a qualitative approach was employed in this study, the summary of differences between quantitative and qualitative studies provided by Leedy and Ormrod (2001:102) (Table 5.1) is used.

Table 5.1 Distinguishing characteristics of qualitative and quantitative approaches

QUESTION	QUANTITATIVE APPROACHES	QUALITATIVE APPROACHES
What is the purpose of the research?	<ul style="list-style-type: none"> • To explain and predict • To confirm and validate • To test theory 	<ul style="list-style-type: none"> • To describe and explain • To explore and interpret • To build theory
What is the nature of the research process?	<ul style="list-style-type: none"> • Focused • Known variables • Established guidelines • Static design • Context-free • Detached view 	<ul style="list-style-type: none"> • Holistic • Unknown variables • Flexible guidelines • Emergent design • Context-bound • Personal view
What are the methods of data collection?	<ul style="list-style-type: none"> • Representative, large sample • Standardised instruments 	<ul style="list-style-type: none"> • Informative, small sample • Observations, interviews
What is the form of reasoning used in the analysis?	<ul style="list-style-type: none"> • Deductive analysis 	<ul style="list-style-type: none"> • Inductive analysis
How are the findings communicated?	<ul style="list-style-type: none"> • Numbers • Statistics, aggregated data • Formal voice, scientific style 	<ul style="list-style-type: none"> • Words • Narratives, individual quotes • Personal voice, literary style

Source: Leedy and Ormrod (2001:102)

The characteristics mentioned here under qualitative research describe the way this study was approached. Details will be discussed later in the chapter (5.3).

5.2.2 Historical and theoretical context

The history of mankind is replete with instances of attempts to understand the world (Lincoln & Guba 1985:14) and to find/expand knowledge. Lincoln and Guba (1985:18) describe three paradigm eras: the earliest period, namely the pre-positivist, is described as both the “longest and least interesting from a modern perspective”. It ranged over a period of two millennia, from the time of Aristotle (384-322 B.C.) to that of David Hume (1711-1776). It might be expected that ‘science’ would have made enormous strides over such a long period, but it did not, mainly because Aristotle and other pre-positivists took the stance of passive observer, and argued that what was, occurred naturally – attempts by humans to learn about nature were interventionist and unnatural, and so distorted what was learned (Lincoln & Guba 1985:18). The entire gamut of understanding of this era centred on Aristotle’s two principles known as the Law of Contradiction (nothing can be both true and false at the same time), and the Law of the Excluded Middle (every proposition must be either false or true). This was the time when scientists were passive.

At the end of the nineteenth century the ‘scientific’ paradigm emerged as the ideal for inquiry into education. In his seminal work on educational psychology Edward Lee Thorndike (1903) expressed the aspiration to apply the methods of ‘exact science’ to educational problems, using accurate quantitative methods (Harris 2002:51). Thereafter the scientific paradigm and its centrepiece, the experiment, held the dominant place as methodology in educational research until the 1970s. Standards for research in education demanded that educational research be framed in experimental designs in which observable variables were measured with instruments that conformed to complex technical standards of validity and reliability (Harris 2002:51).

The development of qualitative methods in social sciences and educational research should be regarded in the context of the two major philosophical traditions or paradigms that influenced the quest for knowledge, namely the scientific or positivist approach, and the humanistic or post-positivist approach (Harris 2002:50). The positivistic approach is also referred to as objectivist or quantitative, and the humanistic approach is also called subjectivist, interpretive, hermeneutic or qualitative (Fouché & Delport 2002:79; Harris 2002:50; Leedy & Ormrod 2001:101; Lincoln & Guba 1985:18-33).

Dilthey, an influential German philosopher, at the turn of the nineteenth century formulated the well-known distinction between the two research paradigms, namely *Erklaren* and *Verstehen*. *Erklaren*, modelled on the natural sciences, uses experimental procedures and emphasises empirical and quantifiable observations, which lend themselves to analyses by means of mathematical tools with a view to explaining, predicting, establishing causal relationships, and generalising. *Verstehen*, on the other hand, uses humanistic and interpretative approaches, emphasising qualitative data and aimed at interpreting and understanding phenomena in their natural context (Harris 2002:50).

This interpretive approach, which stems from the post-positivistic or anti-positivistic paradigm, aims at understanding social life and the meaning people attach to everyday life occurrences (Fouché & Delpont 2002:79). In the 1970s educational researchers began to react against the predominance of quantitative methods in educational research, and stressed the importance of using alternative methods to gain a better understanding of the complex problems of education (Harris 2002:53). Medical education researchers typically have their roots in the fields of social science and education; therefore themes of research in medical education tend to follow trends in social science and educational research in general. Increasing acceptance of the use of qualitative methods in educational research generally has been paralleled by increasing use of qualitative methods in medical education research (*cf.* Harris 2002).

5.2.3 Qualitative designs in social science and educational research

A research design is the plan or blueprint of how a study will be conducted (Mouton 2001:55). The terminology used by different authors sometimes is confusing; thus some of what is described here as designs (Hancock 1998:4; Leedy & Ormrod 2001:149), are called approaches by other authors (Brink 2003:59; Huysamen 1994:165-168); others classify these as strategies (*cf.* Fouché 2002:272-276); Harris (2002:59) calls them methods, and Creswell (1998:64-65) refers to these as traditions or types of qualitative research. For the purposes of this study they will be called types of qualitative research design.

Five major types of qualitative research design are described in literature, namely

biography, phenomenology, ethnography, grounded theory and case study (*cf.* Creswell 1998; Fouché 2002; Hancock 1998; Harris 2002; Huysamen 1994; Leedy & Ormrod 2001). A biography is a broad genre of biographical writings, a study exploring the life of an individual, and his/her experiences as told to the researcher or found in documents and archival material (Creswell 1998:65; Fouché 2002:272-3). Ethnography, meaning a “portrait of a people” has a background in anthropology (Hancock 1998:4). Creswell (1998:246) defines ethnography as the study of an intact cultural or social group (or an individual or individuals in that group) based primarily on observations and a prolonged period of time spent by the researcher in the field. Case study research is used to describe an entity that forms a single unit such as a person, an organisation or an institution (Hancock 1998:6); it can be regarded as an exploration or in-depth analysis of a system bounded by time or place, or a single or multiple case, over a period of time (Creswell 1998:61; Fouché 2002:18).

The qualitative design that was used in this study is phenomenology. Phenomenology literally means the study of phenomena. Phenomena may be events, situations, experiences or concepts (Hancock 1998:4). Phenomenology aims to understand and interpret the meaning that subjects give to their experience of the phenomenon (Fouché 2002:273). Phenomenological research begins with acknowledging that there is a gap in understanding the phenomenon and that clarification and illumination will be of benefit. Phenomenological research raises awareness and increases insight (Hancock 1998:4). According to the phenomenological approach a problem must be investigated within the context in which it exists, as human behaviour cannot be divorced from its context - the phenomenologist endeavours to understand the problem from the perspective of those involved (Huysamen 1993:172). Leedy (1997:161) defines phenomenology as “a research method that attempts to understand participants’ perspectives and views of social realities”. According to phenomenological theories subjective experiences are meaningful and provide reliable data for understanding reality (Verma & Beard 1981:187). In phenomenological studies the researcher often has personal experience with the phenomenon and aims to heighten his or her awareness of the experience, while at the same time examining the experience through the eyes of the participants (Leedy 1997:161), as was the case in this study.

The hermeneutic (interpretative) phenomenology needs to be elucidated here, as it

influenced this study to a certain extent in the ontological, epistemological and methodological realms. The interpretive framework of inquiry supports the ontological perspective of the belief in the existence of not just one reality, but multiple realities that are constructed and can be altered by the knower (Laverly 2003:4). Reality is not something 'out there', but something local and specifically constructed; it is not more or less true, it is simply more or less informed (*cf.* the standards and rubrics as initially constructed in this study based on the knowledge of the phenomenon - accreditation as quality assurance process). Epistemologically the interpretive framework recognises a relationship between the knower and the known – the researcher as the knower is central in hermeneutic phenomenological studies (Laverly 2003:4). The investigator and the investigated (that which is being studied) are linked in the creation of the findings, with the investigator as active participant. Methodologically the interpretivist perspective evolves in a process of interpretation and interaction between the investigator and the research participants. The primary aim is understanding and the reconstruction of experience and knowledge.

Although the grounded theory design was not used, elements of it came into play in this study. In a grounded theory study the researcher generates an abstract analytical schema of a phenomenon, a theory that explains an action, interaction or process (Creswell 1998:241). This involves a process of deriving theories through inductive analysis of empirical data collected through observation, interviewing and document analysis (Harris 2002:59). New theory begins its conception as the researcher recognises new ideas and themes emerging from events, literature, document analysis or what people have said, and memos form in the researcher's consciousness. Hypotheses about the relationships between various ideas are tested and constructs formed, leading to new concepts and understandings – thus the theory is 'grounded' in the data (Hancock 1998:6). In this study the participant observation and relevant documentary analysis made important contributions in the development ('grounding') of the idea ('theory') of a guide for accreditation reviews (*cf.* Hancock 1998: 6) – grounded theory allows a researcher to be "scientific and creative at the same time" (Fouché 2002:274).

In this study it was assumed that an accreditation guide may contribute to solving the research problem. A draft accreditation review guide (standards with rubrics) was compiled, 'grounded' in the data collected from literature, document review and the active participation of the researcher in the accreditation process; this draft guide was

then used as basis for collecting data during the individual interviews. The findings were incorporated in the draft, and the standards and rubrics adapted, and finally the outcome was verified or 'tested' (triangulation) by means of a focus group interview. The data collected were once again analysed, the findings were incorporated in the product; and a literature 'control' was done. The result that emerged formed the final outcome of the study – a guide to be used in accreditation assessment and decisions (see Chapter 7). The data collected during the interviews indicated that the assumption was correct, namely that a guide for accreditation could be used meaningfully in quality assurance in undergraduate medical education.

Another research design that was considered when the study was planned, is that of intervention research – “an exciting new view of applied research in social work, which should be useful to many other human professions” (De Vos 2002:394). Intervention research was initially used for the development of technology in human service professional fields; design and development research (certain aspects of which may be made applicable in this study) is regarded as one of three kinds of intervention research, namely intervention knowledge development – research to extend knowledge of human behaviour, to relate such knowledge to human service intervention, and studies by which the findings from intervention knowledge development may be linked to and utilised in practical application – referred to as intervention knowledge utilisation. Their commonality lies in their belonging to the genre of applied research (a category within which this study falls to a certain extent), and they have a specific intervention mission (De Vos 2002:395). If the standards and rubrics designed in this study are regarded as being a tool to utilise as an intervention to render the accreditation process more effective, this study may fall within the cadre of intervention research, as it has been one of those “studies that attempt to understand problem phenomena, undertaken with the objective of developing interventions” (De Vos 2002:396). This study went through the same phases as the design and development (D&D) model of intervention research, namely

1. Problem analysis and project planning
2. Information gathering and synthesis
3. Design
4. Early development and pilot testing
5. Evaluation and advanced development
6. Dissemination.

In the recommendations section (8.4.1) the implementation of the result of the study in the 'real world' (the accreditation system of the Health Professions Council of South Africa) is discussed as a possible continuation of this study (but does not form part of it) – which will then put the study within the field of intervention research.

It is clear that there is “a wide variety of threads interwoven under the rubric ‘qualitative methods’. A common paradigmatic theme includes the epistemological and ontological view of knowledge as a human construction. Another common theme is reliance on collection, analysis and interpretation of qualitative data, such as observations ... reported in field notes, interviews recorded in transcripts, and document analysis” (Harris 2002:45) - a concept that was applied in this study too.

In qualitative research many different terms are used to define research that does not fit fully within an established qualitative approach or design as described above, also called ‘mixed mode’ (Caelli, Ray & Mill 2003:3). These authors summarise the different efforts to clarify generic qualitative designs: Thorne, Joachim, Paterson and Canam (2002:8) refer to ‘generic’ qualitative research; Sandelowski (2000:335) calls it ‘basic or fundamental qualitative description’; Merriam (1998:11) refers to this genre of research as ‘basic’ or ‘generic qualitative research’, whereas Brink and Wood (Caelli *et al.* 2003:3) refer to all descriptive research as ‘exploratory research’. Qualitative research as applied in this study may perhaps be best described in the words of Merriam (1998:11) who states that generic qualitative studies “simply seek to discover and understand a phenomenon, a process or the perspectives and [world]views of the people involved”.

5.3 RESEARCH DESIGN, METHODOLOGY AND PROCEDURES

This study has been classified as qualitative research, and a phenomenological design was used (see 1.6.1). It furthermore can be classified as exploratory (to gain insight in the phenomenon – the ‘how’ questions), and descriptive (to form a picture of specific details of the phenomenon – the ‘why’ questions). The phenomenon studied is quality assurance in terms of the accreditation of undergraduate medical education in South Africa, and aspects of grounded theory came into play when the draft guide for accreditation reviews was compiled to be verified by the participants to determine whether the assumption that it would be useful in quality assurance was acceptable (*cf.* Fouché 2002:274). A further classification of the study is that it is simultaneously basic

research and applied research, as the purpose is both the advancement of knowledge (creating new knowledge) and finding a solution to a problem (the result has practical applications) (see 1.5).

These aspects of the study need to be put into the context in which they manifested.

5.3.1 A qualitative research design

Qualitative research is concerned with developing explanations and interpreting phenomena (Hancock 1998:2). In the study of accreditation as a means of quality assurance in undergraduate medical education in South Africa, the objectives were to explain human behaviour in the accreditation (the phenomenon) review process, to understand the participants' perspectives and views of the effectiveness and efficiency of the deliberations and decision-making with regard to the standard of the educational programmes they review, and to devise a tool or mechanism to address perceived deficiencies or problems in the accreditation process.

This study, as a qualitative research study, deals with the experiences, opinions and feelings of people – the individuals from whom the data have been collected – and studies the phenomenon as it naturally occurred - no manipulation of the situation has occurred (as is the case with experimental studies) (*cf.* Hancock 1998:2; Leedy 1997:105).

Data in qualitative studies are used to develop concepts and theories, that is, an inductive approach is used and theory is built, not tested (Leedy 1997:106; Leedy & Ormrod 2001:102). New theory began its conception with the recognition of new ideas and as themes emerged from what people involved in the accreditation process had said and from what had been observed (*cf.* Hancock 1998:6). Notes on the experiences gained and discussions during accreditation review visits, meetings of the team members, and a workshop (UET 2003b) and memory notes (*cf.* Hancock 1998:6) formed part of the grounding of the study.

The procedural principles of qualitative research in higher education as described by Crowson (1987:10-11), and which were valid in this study, are as follows:

- The central research objective is to understand rather than to explain or predict;
- true understanding, according to the qualitative approach in higher education will be achieved if the researcher is the prime instrument for data collection;

- the research process is conducted with an emphasis on analytical induction, rather than on hypothesis testing; and
- the search for understanding is heavily value laden.

In this study

- the researcher strived to gain an understanding of the views people have of what standards need to be achieved to what extent in a medical education programme for it to be accredited (the quality assurance process), and to put these down in writing to serve as a guide for use by future accreditation review teams;
- the researcher achieved true understanding by being the prime instrument for data collection – in the literature and document review, participant observation, the individual interviews and the focus group interview;
- analytical induction was applied, although a single hypothesis/assumption was tested too;
- the search for understanding was value laden – the researcher strived to identify what was “good and desirable” (Strydom 2002:63) in an accreditation (quality assurance) process, and this manifested in taking cognisance of the values of the participants as detected from the field notes, documents, and in the interviews.

Qualitative researchers seek a better understanding of complex phenomena (situations); their work is exploratory in nature and they use their observations to build theory – they make specific observations and then draw inferences and develop generalisations (Leedy & Ormrod 2001:102-103).

Qualitative research has a number of characteristic features (Hancock 1998:2), which manifested in this study in the following ways:

- Qualitative research is concerned with the opinions, experiences and feelings of individuals producing subjective data – the opinions, experiences and feelings of people involved in the phenomenon as they came to the fore during the observation periods, and of participants, as they emerged during individual interviews and the focus group interview.
- Qualitative research describes phenomena as they occur naturally – the situation under study (quality assurance process) was not manipulated in any way.
- Understanding of the situation is gained through a holistic perspective – no variables were identified.

- Data are used to develop concepts and theories to promote understanding – new theory/knowledge was developed through an inductive approach.
- Qualitative data are collected through direct encounters, one to one or group interviews, or by observation – individual interviews and a focus group interview were conducted, and information was obtained through observation as the researcher was a participant in several accreditation review processes.
- Qualitative sampling techniques are concerned with seeking information from specific groups - use was made of purposive sampling to select participants, as expertise and experience were required in the information sought.
- Criteria to assess reliability and validity in qualitative studies differ from those used in quantitative studies – validity is described in terms of truth and the contextual completeness of the report; reliability is about the accuracy in understanding, interpreting and conveying the meaning of what has been said by participants. Trustworthiness was the key criterion in assessing the value of the research process (see 5.4).

Babbie and Mouton (2001:309) mention two more characteristics of qualitative research, namely

- An emphasis on the actor's perspective ('insider' or 'emic' view) (*cf.* Shank 2002:58). In this study the researcher, as well as the participants, is directly involved in the phenomenon, that is, they are all 'insiders'.
- The primary aim is in-depth or 'thick' descriptions and understanding of actions and events – much detail is provided on participants' views and opinions, and they are described in detail (*cf.* Shank 2002:74-75).

Having now given a broad overview of the way in which the qualitative approach and design were applied in this study, details on the process need to be provided.

5.3.2 Research process

Qualitative research processes are described as holistic and "emergent" (Leedy 1997:106); the design, data collection instruments and interpretations develop and may change during the process. Researchers enter the setting with open minds, prepared for the complexity of the situation and interact with the participants (Leedy & Ormrod 2001:102). The researcher entered the field of quality assurance in undergraduate medical and dental education as the educationalist member on review panels that visited

medical schools in South Africa with a view to accrediting their undergraduate programmes. In the capacity as team member observation took place in the form of listening and interacting with other members on the issue of quality assurance, and field notes were taken (*cf.* Strydom 2002:285).

Phenomenologists, in contrast to positivists, believe that the researcher cannot be detached from his/her own presuppositions and should not pretend otherwise (Groenewald 2004:3); therefore the researcher's own views and perspectives (as contained in the notes and 'jottings' taken during the reviews – participant observation [*cf.* Wolcott 2001:121]) formed the basis on which the draft guide for accreditation reviews was designed.

Having compiled a draft guide, the perspectives, opinions and ideas, and information on the experiences of the research participants were collected to enhance and verify the draft guide, that is, to determine whether it would serve the purpose the researcher had in view for it. This was done through interviewing. Data storage and analysis are the next steps in the research procedure: The interviews were audio-taped with the permission of the participants and each cassette was labelled with the name of the participant and the date. The audiotapes were transcribed as soon as possible after each interview and the raw data were stored in folders in a Word programme, named according to the names of the participants, with separate files for the transcription of the interview and relevant notes and memory notes. A Word programme was used as the researcher did not have access to (or the expertise to use) a text base managing computer programme (*cf.* Creswell 1998:135).

The analysis of data started early in the process, and continued while the interviewing was still going. The data analysis was mainly modelled on the data analysis spiral proposed by Creswell (1998:142-146). In main, data analysis entailed data reduction, presentation and interpretation. Every effort was made to adhere to the 'critical ingredients' of qualitative data analysis, as set forth by Greeff (2002:318): "Analysis must be systematic, sequential, verifiable and continuous; it requires time, is jeopardised by delay, it seeks to enlighten, should entertain alternative explanations, is improved by feedback, and is a process of comparison."

Qualitative studies tend to use an inductive form of analysis whereby the observations of particular cases may be generalised to a class of cases (Leedy 1997:107); inductive

indicates the process of moving from the specific to the general (Shank 2002:130). Inductive reasoning emphasises explanation and interpretation; theory emerges from careful consideration of the data. According to Shank (2002:130) inductive reasoning is about reasoning to a probable conclusion. The study, however, moved into a more deductive or confirmative mode by verifying the findings of the different steps in the process in subsequent steps, and finally by means of a literature control (*cf.* Leedy 1997:108).

The final step in the process is the report by means of which the findings will be communicated. According to Leedy (1997:108) and Wolcott (2001:20-21) qualitative researchers construct interpretative narratives from the data and employ a more literary style than do quantitative researchers. Description provides the firm foundation upon which qualitative inquiry rests (Wolcott 2001:31); the researcher describes all the nuances of the phenomenon and provides a total, multi-faceted picture of the perceptions of the participants, the so-called *thick description* (Leedy & Ormrod 2001:164; Shank 2002:74-75; Wolcott 2001:36).

Delpont and Fouché (2002:356-357) state that the qualitative research report has distinctive qualities that should be observed when reading it: The qualitative report is

- less structured – it does not conform to the traditional (quantitative) structure of introduction, methods, results and discussion;
- often longer and more descriptive – qualitative researchers use more literary writing styles, which increases length;
- more flexible in design – the design evolves throughout the research process, and in the report the methodologies are explained in more detail;
- uses a narrative writing style; and
- uses ample quotations from the data.

5.3.2.1 *Data collection*

In research the data dictate the methodology (Leedy 1997:104). What then are data? The term data is plural (singular: datum) and derives from the Latin verb *dare*, meaning “to give”. Data, therefore, are those facts that any particular situation *gives* to an observer (Leedy 1997:99). The word *fact* also comes from the Latin – *facere* which means “to make”; thus data are what the situation “makes” or manifests to the observer. Data, therefore, are manifestations of the truth – not truth itself (Leedy 1997:99).

Leedy (1997:103) likens data to ore. Data contain desirable aspects of the truth, but to extract meaning from the facts, one has to employ what is broadly termed *methodology*. For that reason the data that will be required for the solution of a problem will determine the methodology, that is, the data collection methods. Qualitative data are collected through direct encounters with individuals – one-on-one interviews or group interviews, or by observation (Hancock 1998:2).

5.3.2.2 *Literature study*

The literature review is not usually discussed as part of the data collection methods for a study. In this study the literature review has been reported on in Chapters 2, 3 and 4; however, as perspectives gained from literature formed the basis of the draft guide for accreditation reviews, that is, the instrument used in the interviews to collect data, the methodology applied needs to be described here too.

Literature reviews play an important part in qualitative studies; the nature of the literature review, however, is not such a clear-cut matter. There are two schools of thought in this regard: the one holds that the qualitative researcher should set aside all preconceptions and let the “data speak for themselves” (Shank 2002:124). From this perspective the researcher should only read enough to make sure that work already done is not replicated; then once the study is well under way, or even at the end of the data collection, the researcher returns to the literature to review it, based on what has been found in the field study. This is to ensure that the researcher has as fresh a perspective as possible when collecting the data (Shank 2002:124).

The other school of thought stresses the importance of reviewing and understanding the literature on the topic prior to data collection to do a better job of setting up the research – this is done to indicate why and how understanding of the topic is incomplete; however, the understanding that one does have, needs to be documented (Shank 2002:124).

This study emanated from and builds on a previous study (Bezuidenhout 2002) in which standards for the accreditation of undergraduate medical education in South Africa were identified. According to Fouché and Delport (2002:266) the literature review usually builds the framework for a study; in the current study the framework was built on literature reviewed in the previous study and the findings of the previous study,

replenished by more recent work.

In the current study the literature review was done midway through the data collection process, that is, after five of the participant observations (accreditation review visits), but before the last three, and before the individual interviews and focus group interview were conducted. The literature review was thus used as a 'control' for the data collected during the first five participant observation periods, and findings from literature were included with the findings from the participant observations in the draft guide used to establish the interview participants' opinions and views on the phenomenon.

The literature review, however, was also used as a data control after the data had been collected and to relate the findings to the existing body of knowledge (*cf.* Fouché & Delport 2002:268).

An interpretative review was done of literature pertaining to quality assurance in higher education worldwide, with special attention to medical education. An interpretative review of literature is a summary and synthesis of relevant literature pertaining to the research problem (McMillan & Schumacher 2001:108). The discussion of the literature as provided in the earlier chapters provides a framework for the study and puts the research within the context of related studies (*cf.* Fouché & Delport 2002:266). It furthermore provided the rationale for the study.

5.3.2.3 Participant observation

Participant observation is a research procedure that is typical of the qualitative paradigm (Strydom 2002:278). Participant observation is characterised by the researcher becoming part of the situation under study (Leedy 1997:159). In order to understand people's behaviour in a situation (phenomenon) a method or strategy must be used that gives access to the meanings that guide that behaviour (Fox 1998:4). Observation, therefore, is more than just recording data from the environment – when we observe, we are active, not passive collectors like a tape recorder or video machine. Our brains are engaged in the process, organising data so that we can make sense of them; thus, perception is part of all observation (Fox 1998:2).

In this study the researcher has been involved in the accreditation process for four years as a member of review teams. This afforded the opportunity to gain first-hand

knowledge of other team members' perspectives and opinions, the argumentative processes of team members as individuals and also of different teams, and of the way in which accreditation decisions were made. Field notes, memos on specific issues (especially in cases where it was problematic for team members to reach consensus), the researcher's notes on aspects of the programmes under review, and accreditation review reports served as valuable sources of information when the draft guide for accreditation reviews was compiled (*cf.* Hancock 1998:13).

The development of a comprehensive and holistic view of a particular phenomenon (group) can take time – anything from a few months to years (Strydom 2002:279). From 2001 through 2004 the researcher participated in seven accreditation review visits and kept careful notes of her own assessment of aspects of the programmes reviewed, as well as of other members' views on the standards of the education and training at the various medical schools. The field notes taken during the accreditation review visits were not the only source of observation information the researcher used; documents and post-hoc reflections (*cf.* Fox 1998:13) formed part of the record of these reviews. The documents used were in the form of relevant materials submitted by the medical schools as part of their self-evaluation submissions and materials collected during the accreditation review visits, as well as the accreditation reports. The 'post-hoc reflections' (Fox 1998:13) in this study were notes the researcher made while reflecting on the visits after the time, often while scanning the notes as part of the preparation for the next visit. These documents and notes were used as a type of benchmarking tool by the researcher for each subsequent visit, as no other means of comparing and determining the relative quality of aspects of the education and training were available.

According to Fox (1998:4) the value of participant observation is perhaps most obvious in relation to the development of theory – the researcher used the information gained during the accreditation review visits as a major source in developing the draft guide for accreditation reviews. Shank (2002:23) calls the observer who is involved in grounded theory research the "categorizer" – an observer who creates sorting categories and assigns observations to them as a basic and on-going part of the observation process; when we categorise, we organise, thus the process of observing became an active and evolving process of understanding.

Understanding and interpretation of participant observation data will depend on research commitment (Fox 1998:14). A very important aspect of observation is the role of the informants. Fox (1998:14) lists a number of characteristics these informants should have, one of which had a bearing on this study, namely, the informants had specialist knowledge. Information gained from a single key informant, in this study, could not be given absolute privilege – instead, the information collected from one person or accreditation team had to be ‘tested’ against others, as well as against the researcher’s own observations (*cf.* Fox 1998:15).

Good relationships and trust enhance the quality of the data collected during observation periods (Strydom 2002:284). This was easy to do, as the members of the accreditation teams were aware of the fact that the researcher was engaged in a study aimed at developing and improving the accreditation process, and realised the benefits the study would hold for the accreditation process and medical education in South Africa. It is important, however, to point out that the researcher was not included in the accreditation review teams with the aim to do research, but because she was an educationalist with knowledge of the accreditation process, and therefore was included in the different teams to make a contribution to the teams’ assignments – Shank (2002:27) calls this observer the ‘complete participant’, where the researcher is simply a member of the group under study. The researcher, furthermore, did not go into the field with a schedule or predetermined set of research questions to be answered; no question was ever asked with the primary aim of collecting data for the research, neither was any situation ever manipulated or created for the purposes of the research – the activities, discussions, notes and reports that informed this study, were part of the natural process of accreditation, sorted and utilised only afterwards for the purposes of the study. The researcher thus was part of the situation, but at the same time nothing was changed in the situation to benefit the research (*cf.* Strydom 2002:279).

5.3.2.4 Semi-structured, individual interviews

a. Rationale and process

Interviewing, designed to elicit others’ perspectives, is an important data gathering technique, involving verbal communication between the researcher and the subject (participant) (Mathers, Fox & Hunn 1998:1), and has been described as the “favorite

methodological tool of the qualitative researcher” (Denzin & Lincoln 1994:353). According to Shank (2002:42) interviewing is an act of conversing, and all acts of conversing involve the transfer of information; however, interviewing differs from normal conversation in that in normal conversation there is a pattern of reciprocation, which results in a symmetry in the disclosure. In the interview the disclosure is asymmetric – one party seeks information and the other provides the information.

The quality of the interview depends mainly on the skills of the interviewer; therefore if a trained interviewer is not used and the researcher chooses to do the interviewing herself, training is essential (Greeff 2002:292; Mathers *et al.* 1998:5). For the purposes of this study the researcher did self-training, using a video-recording on communication skills (Mosby s.a.), and studied literature on interviewing (Greeff 2002:293-296; Mathers *et al.* 1998:5-13; Shank 2002:45-47).

Semi-structured interviews were used, as the researcher wanted to gain information on the participants’ perceptions on a complex phenomenon and a process (*cf.* Greeff 2002:302).

Possible participants were contacted about two months before the time planned for the interviews to take place. The researcher wrote formal letters, explaining the purpose of the study and explaining the purpose and nature of the interview, and asking whether they would agree to participate (see Appendix 5.1). They were informed of the approximate time the interview would take, and asked, should they agree to participate, whether they would have objections to the interview being audio-taped. In the case of the deans/heads of medical faculties/schools, or their representatives, they were requested to indicate who normally acted on their behalf, should they not be available or willing to participate, so that the researcher could contact that person. In the case of previous members of review teams the researcher selected four members who could be interviewed during the same period as some of the heads of schools with a view to cutting on travelling expenses. Conducting the interviews took the researcher to Cape Town, Umtata, Johannesburg, Pretoria and Durban, which involved high travelling and accommodation costs; therefore she tried to conduct as many of the interviews as possible during one visit to a centre (*cf.* Katzenellenbogen *et al.* 1999:179; Strydom and Delport 2002:334; also see *b. Sampling* underneath with regard to cost and time).

Once the prospective interviewees had agreed to participate, the researcher corresponded with their secretaries by electronic mail to set up the appointments. After that a formal letter of thanks was mailed to each, confirming their participation, the date, time and place of the interview, and informing them that they would receive the draft accreditation review guide and the topics they would be asked to discuss during the interview approximately three weeks before the date of the interview. These were sent by courier for personal delivery to ensure that the participants receive them well before the interview was to take place.

The interview schedule that was used (see 5.3.2.4.c) allowed the participants to express themselves freely, but the questions were focused to ensure that the interviewee gave the information required for the purpose of the study (*cf.* Greeff 2002:303). The draft review guide together with an explanation of the aspects addressed in the interview schedule was submitted to the participants three weeks before the interview was to take place to provide them the opportunity to consider the aspects that would be addressed in context and to get acquainted with the draft review guide. However, during the interview the participants were allowed to address any aspect of the review guide and the accreditation review process *per se*, should they feel a need to do so. This will be discussed in the section on the interpretation of the data.

The interview schedule was not exactly the same for the two groups of participants. The same kind of information, however, was collected. The order in which the topics were addressed also was not the same for all the interviews, but was determined by the general course the interview took (*cf.* Huysamen 1993:149; Shank 2002:45-46), and the participants were allowed freedom to answer whatever question they preferred first (*cf.* Greeff 2002:302). Descriptive as well as structural questions were used, and the crucial aspects of qualitative interviewing as described in literature, were observed (*cf.* Shank 2002:43-44). These included, *inter alia*:

- The interviews sought for key, meaningful themes regarding the phenomenon.
- The themes were explored in ordinary, qualitative language.
- The interviewer 'walked a tightrope' between a tight structure and totally non-directive questions.
- Ambiguities and contradictions were noted, not brushed aside.
- New insights were welcomed as part of the process.

The responses of the participants were captured on audio-tape, with the permission of

the participants, and the researcher also took field notes during the interviews (*cf.* Leedy 1997:201; Mathers *et al.* 1998:12).

The interviews were planned carefully, using the checklist designed by Gall *et al.*, as recommended by Leedy (1997:199), to ensure that they meet the demands of professional planning and conduct. The most important recommendations in the checklist adhered to, were:

- Assuring the participants of confidentiality
- Explaining the potential benefits of confidentiality
- Talking less than the participant
- Specifying the frame of reference of the questions posed
- Using simple probes
- Using simple probes when information on a response was required
- Avoiding contradicting or appearing to be cross-examining the participant.

Informed consent was assumed with the participants' agreeing to participate (*cf.* Groenewald 2004:3).

The interviews took place at the institutions of the interviewees, in the offices of the interviewees or another venue they themselves arranged, at a time arranged beforehand, and were conducted between 28 October and 18 November 2004. The interviews lasted one hour (the time set aside for the appointment); one participant had more time available and that interview lasted about one hour 20 minutes, as the participant needed some more time to cover aspects of the draft guide s/he wanted to discuss. The duration of the other interviews was sufficient to cover all aspects the researcher and the interviewees wanted to address; apart from the one exception, the time set aside for the interviews proved to have been exactly the amount of time needed. The spirit in which the interviews were conducted was friendly and collegial, and when the participants were thanked for their participation, they indicated that they felt they also had benefited by the exercise and expressed their appreciation for having had the opportunity to make a contribution to the study.

b. Sampling

According to Groenewald (2004:3) in phenomenological studies, the phenomenon dictates the method, including the type of participants. In phenomenological studies the participants are usually chosen purposefully, because the researchers depend almost

exclusively on interviews. This is done to increase the utility of information obtained from small samples - participants are selected on the grounds of being knowledgeable and informative about the topic that is studied (Babbie 1989:165-166). In purposeful (purposive) sampling the formulation of criteria for the selection of the sample is of cardinal importance (Strydom & Delpont 2002:334).

The criteria for the selection of the participants in the one-on-one semi-structured interviews therefore were that all had to be experienced in medical education, and had to have been involved in the accreditation process of undergraduate medical education in some way or other. The two groups that were included were deans/heads of medical faculties/schools (or their representatives), as all eight the medical schools/faculties already had received at least one visit from an accreditation review panel, and the second group comprised medical and/or medical education experts who were on the list of experts used for panel reviews of medical schools and had been a member of a review team at least once. The names of persons who satisfied the criteria (heads of medical schools and members of previous review panels) were obtained from the secretary of the Undergraduate Education and Training Sub-Committee of the Medical and Dental Professions Board. All heads of medical schools (some held the position of dean of the medical faculty), or their representatives, were selected (criterion sampling – *cf.* Creswell 1998:119), and members of previous accreditation review teams were selected on the basis of availability, cost involved in travelling to their basis for the interview (convenience purposeful sampling – *cf.* Creswell 1998:119), and their not having been members of the same review team (stratified purposeful sampling – *cf.* Creswell 1998:119).

The sample size with regard to the deans of faculties/heads of schools was determined by the number of medical schools in South Africa, that is, eight, as it was regarded important to include all schools in this way to ensure an unbiased finding. With regard to the members of previous review teams, the sample size was determined by the logistical issues of time and funding (*cf.* Katzenellenbogen *et al.* 1999:179), as well as the availability and willingness of potential participants. According to Strydom and Delpont (2002:334) sampling in qualitative research is relatively limited, the size is not determined statistically; it should involve low costs and not be time-consuming. For this study eight heads of medical schools/deans of medical faculties (or their representatives) and four members of review panels were selected. This was slightly more than the

recommended maximum, as Fouché (2002:273) recommends that no more than 10 people should be interviewed, and Leedy (1997:162) recommends no more than 5 to 10 participants for qualitative studies. Other potential ways of defining the sample size would have been to continue in the field until sufficient information has been collected and no or very little new information was being collected from successive interviews, that is, when saturation is reached (*cf.* Katzenellenbogen *et al.* 1999:180). In the end, the number of interviews was brought down to ten. This was due to the fact that two of the interviews did not realise, as the two potential participants cancelled the appointments shortly before the interviews were due. Despite efforts of the researcher to set up other appointments with the two people involved or their representatives, it could not be arranged, because no suitable alternative dates could be found. It was the end of the academic year and the participants and possible representatives were very busy, and the researcher herself could not travel to the participants' institutions again, as both institutions are far removed from her home town, and she had travelled there once to interview the other participants in the study. Efforts to set up a telephone interview or to get written responses from the representatives from the two medical schools involved were fruitless. They made it clear, however, that it was not because of lack of interest or negativity, but only a matter of them not having time to participate. As it was also clear by the time that saturation has been reached and that the interviews in general rendered similar responses, it was decided that six interviews with heads of schools/deans of faculties or their representatives would suffice for the purposes of the study, especially as other faculty members of the schools involved had participated in the study in other categories.

c. Interview schedule or guide

The interview schedules were compiled to gain insight into the participants' experiences, feelings, beliefs and convictions about the phenomenon, "to unfold meaning of people's experiences" (*cf.* Groenewald 2004:4), to test the assumption that a guide for accreditation reviews would be useful in the process, and to provide them an opportunity to make recommendations about how to improve the draft review guide on the basis of their experiences and views of the phenomenon.

Semi-structured interviews involve a series of open-ended questions based on the topic areas the researcher wants to cover (Mathers *et al.* 1998:2), and aspects of these topics (probes) regarding the theme under study, and which the researcher will touch upon during the interview, if the participant does not broach these him/herself (Huysamen

1993:149; Leedy 1997:199). An interview guide (called a schedule by some authors, e.g. Greeff 2002:302) with open-ended questions does not pre-determine the answers and allows room for the participants to respond in their own terms (Greeff 2002:293). The open-ended questions in the schedule defined the topic, but provided opportunities for both the researcher (interviewer) and the participant to discuss some topics in more detail, or broach new topics. When the participants had difficulty in answering a question, or provided only a brief response, the interviewer used cues or prompts to encourage the interviewee to consider the question further, or to elaborate on the original response (*cf.* Huysamen 1994:145; Mathers *et al.* 1998:2).

The interview guides/schedules for the individual interviews comprised the following:

Interview schedule and probes: Deans/Heads of Medical Faculties/ Schools/their representatives

1. What do you think of the suitability or not of this accreditation review guide for use in medical schools for quality assurance and improvement purposes?
2. What kind of contribution, if any, might this accreditation review guide make to the quality assurance and improvement process in your School?

(Will it facilitate a school's internal quality assurance and improvement processes? Will it facilitate the preparation for accreditation reviews? Will it facilitate planning for improvement?)
3. What is your opinion of the use of such a guide in the accreditation process of the HPCSA?

(Probes: Will it promote consistency in the evaluations? Promote comparability and equality of standards? Render a more structured report?)
4. Strengths and/or weaknesses in the draft accreditation review guide? Anything important left out (gaps) and/or unnecessary items? Any recommendations with regard to the content of the guide?

Interview schedule and probes: Former members of accreditation panels

1. Describe the role and value (if any) you think such an accreditation review guide/this accreditation review guide may have in the evaluation processes of accreditation review panels.

2. Do you think the use of this guide might promote objectivity in the evaluation of medical schools with a view to accreditation? Please elaborate.
3. Will such a/this review guide help the panel to arrive at a collective assessment decision (to reach consensus)? Why (not)? If yes, how, and why is this important?
4. This guide has been drafted for use by medical schools in their preparations for accreditation visits and for use by panel members during the process to render accreditation reviews less cumbersome and more structured. Please comment on this aim and whether you think it may be achieved.
5. What do you think are the strengths and/or weaknesses in the guide? Anything important left out (gaps) and/or unnecessary items? Any recommendations with regard to the content of the guide?

The items in the schedules served their purpose fully. The participants answered some of the questions even before they were put; actually, the interviews turned into lively discussions, and the researcher did not really have to put many questions – the responses mostly flowed naturally from the discussion, but in the end all the points put down in the interview schedules and probes were addressed fully and expanded on. The last item in the interview questionnaire, namely how the guide could be improved, rendered sound advice. The fact that few recommendations were made requiring profound changes to the content of the draft guide probably may be ascribed to the fact that the participants had nothing similar with which to compare the guide and the items contained in it.

5.3.2.5 *Focus group interview*

a. Rationale and process

The outcome of the observation and individual interview phases of the research, that is the adapted draft accreditation interview guide, was verified or 'tested' (triangulation) by means of the focus group interview. In using the focus group interview as part of the instrument development aspect of the study, the researcher wanted to investigate perceptions in the defined area of interest, and to gain insight into the meaning and interpretation of the results of the preceding steps of the study (*cf.* Greeff 2002:306; 309).

A focus group is said to have enormous evaluative potential, especially in gauging the

effectiveness of training materials and programmes, and when judgements about the quality of a product needs to be backed up with qualitative information (Erkut & Fields 1987:74). The focus group is said to have been designed to elicit individuals' perspectives on specific issues in a social context where they can consider their own views in the context of others' views (Harris 2002:63). Focus group interviews constitute a means for better understanding of how people feel or think about an issue, product or service (Greeff 2002:305) - in the case of this study, the accreditation review guide - and they provide a way of generating candid, evaluative feedback with concrete recommendations for improvement (Erkut & Fields 1987:75). The aim of the focus group interview was to establish the participants' opinion on the usefulness of such an accreditation review guide, to collect their perspectives on the content of the guide, and in general to serve as triangulation with regard to the data collected earlier by means of observation and individual interviews. The comparative advantage of a focus group as data collection technique lies in the opportunity it provides to observe interaction on a topic (Babbie & Mouton 2001:292).

The participants in a focus group are to be selected on the basis of having certain characteristics in common that relate to the topic of the discussion (*cf.* Erkut & Fields 1987:74); in this study it was achieved by them all being members of the UET, the committee which bears responsibility for conducting the accreditation process. If, according to Moore (1987:16) the goal of a study is to solve a problem of a particular group, it is reasonable to assume that the group will be more likely to accept the findings if they have participated in the research process. The group is 'focused' in that the interview involves a collective activity, where members are encouraged to share their perceptions, points of view, wishes and concerns, without the pressure to vote or reach consensus (*cf.* Greeff 2002:306).

The researcher was the facilitator in the focus group discussion (assisted by the chair of the UET), and a number of carefully selected questions were used to elicit responses (*cf.* Greeff 2002:314) (see 5.3.2.5.c).

The participants were requested to participate six weeks before the time by means of a formal letter (Appendix 5.2). The date proposed was to coincide with a UET Committee meeting, as this was the only way to get the group together without extra cost for the researcher and time from their side. The nine members (six standing and three co-

opted) of the UET were informed by means of a formal letter (which was mailed) of the purpose of the study and of the focus group interview, and requested to participate in the interview. All the members of the UET were provided with a copy of the review guide and of the topics that would be addressed during the interview (interview schedule or agenda) in order to provide them with an opportunity to read the review guide and consider the issues that would be addressed in relation to the review guide. Their permission was gained to use a tape recorder during the interview, and their agreement to participate was regarded as informed consent.

The focus group interview took place at the Conference Centre at the Johannesburg Airport on 2 March 2005. Seven members (four standing and three co-opted) attended the meeting which preceded the focus group interview, and they all confirmed their willingness to participate in the focus group discussion, which had been entered by the chair of the UET as an agenda point. The researcher acted as facilitator (also known as moderator – Greeff 2002:313), but was supported in the task by the chair of the Committee, who summarised the discussions on the items in the interview schedule whenever the participants seemed to have concluded discussion of a certain aspect. The researcher operated the tape recorder and made field notes. Of extreme importance in this focus group discussion was the ability of the researcher to communicate clearly on the topic, as she was adequately knowledgeable about the topic (*cf.* Greeff 2002:314).

The focus group interview turned into a (not very structured) lively discussion of the draft guide for accreditation reviews. Before the participants embarked on a discussion of the items in the interview schedule, the chair of the UET elucidated the differences between the current accreditation process and the one proposed in the guide, as he saw it, to make sure from the researcher and the members that all got the meaning of the proposed guide right. As the participants had had time to study the draft guide and the interview schedule, the focus group discussion was a meaningful discussion of the content and purpose of the guide. The participants all agreed that they supported the proposed guide in principle and responded in the affirmative to the questions the researcher put in her interview schedule. The focus group interview lasted two hours, with participants asking explanations and elucidations from the researcher, and generally discussing the guide and the ways it could be put to use in the accreditation process of the MDPB in detail. A spirit of support and expectations of what could be achieved with the guide was evident. The exercise turned out extremely satisfactory for

the researcher – not only because the idea of the draft guide in general met with approval, but also because it became clear that a real need had been addressed.

b. Sampling

The members of a focus group should have something in common which is important to the topic of investigation, for example members of the same profession, or they may work in the same team (Hancock 1998:11); members of the UET (none of whom had been involved in the individual interviews) were invited to participate in the focus group interview. Homogeneity is important in focus group interviews (Greeff 2002:311), as it is likely to increase candour in the responses (Erkut & Fields 1987:74), hence the decision to use the members of the committee, who all have the same interest in the quality of undergraduate medical education in South Africa, and share the responsibility for a successful accreditation process.

The only inclusion criterion that was applied, was that the participants in the focus group had to be (or have been) a member of the UET Committee in the period 2001 –2004; the exclusion criterion being that members who had participated as heads of their schools or as review panel members in the individual interviews would not be considered for the focus group; therefore the researcher on purpose did not include any UET members in the individual interviews. As communication among the participants should be encouraged in a focus group interview, the group should be large enough to ensure different points of view to come to the fore, but it must also be small enough to give every participant a chance to talk freely and to exchange comments with all the others (Erkut & Fields 1987:74); therefore the number of members of the UET was suitable and all were invited to participate. Hancock (1998:11) and Greeff (2002:311) state the number of participants usually involved in focus groups as between six to ten - a balance must be struck between having enough people to generate a discussion, but not so many that some may feel crowded out. Seven members eventually participated: one dean of a faculty of health sciences, two deans of dental schools, two heads of academic departments at medical schools, one head of a dental school and one private medical practitioner. It needs to be explained here that since medical and dental schools in South Africa apply the same accreditation process, the participants in the study who serve as representatives on the UET have the same interest in and knowledge of the process.

c. Interview schedule (guide)

With regard to the items for the schedule for the focus group interview the researcher paid attention to the principles for focus group questions as set forth by Greeff (2002:314-315). These are, *inter alia*:

- Questions must be asked in a conversational manner.
- The questions must be clear, that is direct, forthright, comfortable and simple.
- Feedback on the items was gained beforehand from a pilot study and colleagues of the researcher who are knowledgeable on focus group interviewing.
- The terminology used in the questions was the same the researcher would use when talking about the matters generally.

The following items were used for the focus group interview schedule:

1. Is there a place for an accreditation review guide like this in quality assurance and improvement activities in medical education in South Africa? Please discuss the role such a guide may play in the accreditation processes of the HPCSA, and whether it will be of value (for example, Will the use of this guide facilitate the evaluation processes of accreditation visiting panels, in that it will promote consistency in the evaluations of different panels, comparability and equality of standards? Will the use of the guide in the accreditation process contribute to the identification of best practices and benchmarking in medical education?)
2. Please discuss the suitability of this guide for use by medical schools in their quality assurance and improvement processes, and also in preparing for accreditation visits. (Will the use of this guide contribute to the promotion of standards and improvement of medical education in general in South Africa? Ought the use of such a (this) guide be recommended to all medical schools in South Africa? Any other comments/recommendations with regard to the guide and its possible use?)
3. Please discuss the content of the guide. (Possible strengths and weaknesses in the guide? Anything important left out (gaps) and/or unnecessary items? Any comments and/or recommendations with regard to the content and structure of the guide?)

In conducting the focus group interview the questioning route (*cf.* Greeff 2002:315) was followed, that is, a sequence of questions were posed in complete, conversational sentences, but much time was also spent on elucidations and general discussion of the ideas contained in the proposed guide. The schedule given here was used as a basis,

but the researcher formulated the questions to fit in with the general trend of the focus group discussion. The chair of the committee supported the researcher in facilitating the discussion.

As the phenomenologist's aim is to learn how the participants experience the phenomenon, the discussion during the focus group interview was aimed at finding out whether, from the participants' view, the proposed accreditation review guide would have an impact on the phenomenon of quality assurance, and specifically the accreditation process, in undergraduate medical education, as they are the persons with most experience and knowledge of the phenomenon (*cf.* Huysamen 1994:167). The focus group discussion served its purpose well, and valuable perspectives came to the fore.

5.3.3 Pilot study

For purposes of validity and reliability (Huysamen 1994:198) and to refine methodology (Burns & Grove 1997:52), it is virtually mandatory to test out a self-developed measuring instrument in a pilot study (a small-scale study). The items in the draft guide for accreditation reviews were subjected to a pilot study using the interview schedules to ensure that the items and questions (in the draft guide and interview/focus group schedules) were precise, clear and unambiguous, and in the case of the interview and focus group questions, free of bias (*cf.* Leedy 1997:199).

By testing the questions of the interview schedule and the schedule for the focus group, the researcher is in a position to amend the schedules, if required, to ensure optimal responses during the data collection phase, and the pilot study may contribute to enhancing the researcher's communication pattern with a view to the interviews and facilitating the focus group. In qualitative studies the purpose of a pilot is to determine whether the interviews will render relevant data; however, a statistically correct pilot study does not play as important a role in qualitative studies as in quantitative research (Strydom & Delpont 2002:337).

In this study, the head of an academic department in the School of Medicine of the University of the Free State who takes a special interest in medical education and has been chair of the Education Committee of the School for several years, and a higher education specialist who works in a research unit for quality assurance, and is regarded a specialist in data collection tools, were the participants in the pilot study for the individual interviews. As the document (the draft guide for panel reviews) they had to

read in preparation for the pilot interviews was rather lengthy, the same persons were requested to comment on the interview schedule/agenda for the focus group interview, and the researcher conducted a mock focus group interview with one pilot participant.

A few changes were made to the wording of the items in the interview schedules on the basis of recommendations of the participants, but the main value of the pilot study was that it gave the researcher the opportunity to 'trial run' the interviews and to be prepared to answer unexpected questions. The pilot study proved to have been a very valuable exercise. It also gave an indication of the time that would be needed to conduct the individual interviews and to cover the agenda or schedule for the focus group interview, namely one hour.

5.3.4 Data handling and management

With interviews the researcher has a choice whether to take notes or use a tape recorder during the interview (Hancock 1998:14). In this study both methods were used, although the tape recordings played a more important role; the researcher made some notes, she relied more on the tape recordings as the whole interview was captured, not only that which made immediate sense or seemed relevant (*cf.* Hancock 1998:14). The researcher, however, made notes as soon as possible after each interview (called 'memoing' by Groenewald 2004:13), and recorded reflections on the interview – that is, what was seen, heard, experienced; hunches and impressions (*cf.* Groenewald 2004:14).

Data management was crucial in this study, due to the volume of field notes and transcripts generated. A good system was critical to keep track of the data and to permit easy and reliable use of the data (*cf.* Harris 2002:62). Each interview was recorded on a separate cassette, and all notes and recordings were clearly marked and dated, using the name of the interviewee on the label. As soon as possible after each interview the researcher listened to the interview and supplemented the notes made immediately after the interview. Based on Groenewald's (2004:15) method, four types of notes were made:

- Observational notes: Things deemed important enough to be noted – 'What happened notes'
- Theoretical notes – 'attempts to derive meaning' as the researcher thinks and reflects about the interview shortly afterwards

- Methodological notes – ‘reminders, instructions or personal critique to oneself’ on the process of the interview
- Analytical memos – end-of-the-day summary or progress review.

All the notes were filed on the computer (Word programme) in a folder marked clearly with the number and date of the interview, and the specific type of notes in a file named according to the types described above. The transcription of the interview was added to the same folder under ‘Interview Transcription’.

All hard copy notes and the transcriptions that were printed immediately after they had been made, had broad margins, where notes were added every time the researcher read through them, especially references to other files; if possible information categories could be identified, the category would be written down, and reminders or issues that were not clear, were also noted – in fact, these margins were used for anything that the researcher thought might come in helpful later during interpretation, or that the researcher wanted to remember about the interview or the specific part of the interview. At this stage the researcher also referred back to the literature review, data collected during the observation period and previous interviews, as well as previous memos and notes, and made notes to establish links or point out discrepancies, uncertainties, and similarities. Different colour pens were used for working on the hard copies.

The researcher did the initial transcribing herself, as “good quality transcribing is not simply transferring words from the tape to the page” (Hancock 1998:14). Tone and inflection are indicators of feelings and meaning, and the researcher used specific ways in which to put this to paper – a system of upper case lettering, underlining, using bold face, colour highlighting, and notes in brackets was used, which the researcher worked out and noted down, so that she could assign clear and consistent meaning to specific parts of interviews as transcribed (*cf.* Hancock 1998:15). As the researcher also made use of ‘constant comparative analysis’ (Hancock 1998:15) or ‘preliminary analysis’ (de Vos 2002:343), that is, analysing the data on an ongoing basis, this method of making notes during transcribing proved helpful.

A research assistant checked the transcriptions with the tapes to ensure the correctness, and in some cases the transcriptions were sent back to the participants for verifications. Those who did not do this indicated that they trusted the researcher to accurately

transcribe the interviews, as they did not have more time available at that time of the year to spend on the project.

5.3.5 Data analysis and interpretation

Qualitative data analysis tends to be primarily an inductive process of organising data into categories and identifying patterns in the categories, called *content analysis* (cf. Katzenellenbogen *et al.* 1999:180; Mathers *et al.* 1998:17). Qualitative analyses do not follow a linear procedure as statistical analyses do; rather they tend to occur in several cyclic, overlapping phases where the researcher moves back and forth between different levels (Leedy 1997:165). The data analysis of phenomenologists is characterised by being more open, tentative and intuitive (cf. Leedy 1997:162), and in this instance too, there was more focus on ‘meaning units’, that is, small segments of text that are meaningful by themselves are described.

With the data analysis the main aim was to bring order, structure and meaning to the (mass of) collected data. The data analysis spiral of Creswell (1998:143) (see Figure 5.1) was used as premise for the data analysis. The first loop in the spiral represents the data management which has been described in 5.3.4. This was followed by reading the transcripts to make meaning of the whole database – to get a sense of the whole before trying to break it up into parts – and making memos and notes in the margins. This was followed by coding, classifying and categorising, while interpreting and describing. Category formation was important here, and themes or dimensions of information were looked for; the researcher started coding the data, which means that common themes were identified, and grouped into the categories (cf. Creswell 1998:144-145; Katzenellenbogen *et al.* 1997:180). In this loop of the spiral, the researcher started with interpretations in the light of views gained from participant observation and from literature. The interpretation loop involves making sense of the data. To verify and interpret the results the researcher also used triangulation in which

the results of the different data collection methods (participant observation, interviews and focus group interview) were compared to see whether and how they complemented each other (*cf.* Katzenellenbogen *et al.* 1997:180), and the literature control was used to this end too. This was followed by reducing the information to a small, manageable set of themes to be written into the final narrative (*cf.* Creswell 1998:144-145). In the final phase of the spiral the researcher presented the data.

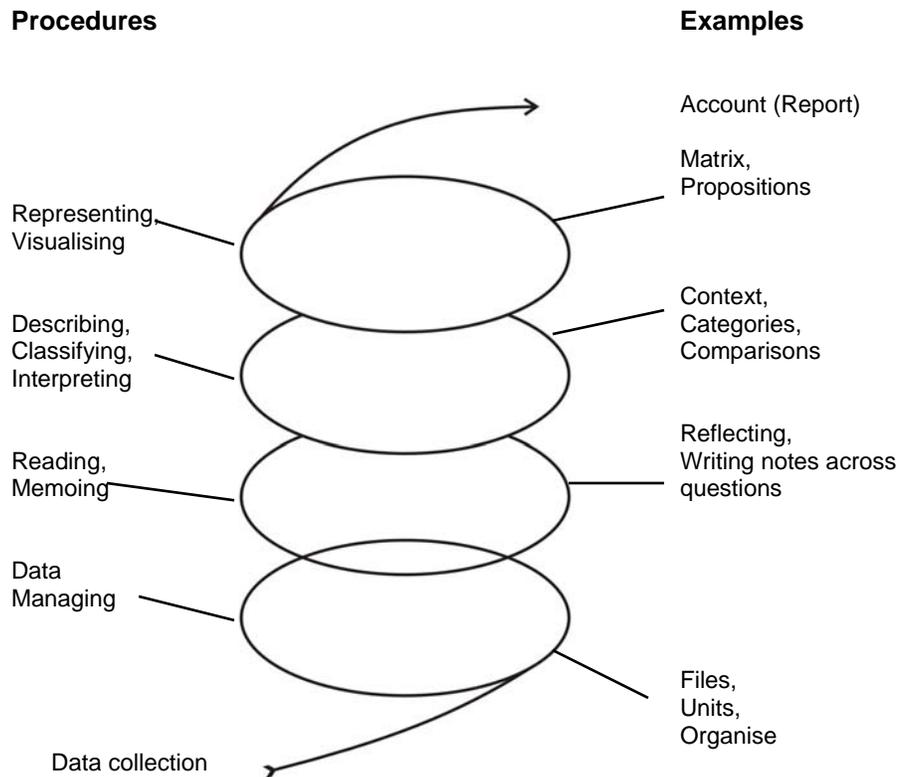


Figure 5.1 The data analysis spiral [*sic*] (Source: Creswell 1998:143)

Ertmer (in Leedy 1997:162) states that phenomenological analysis of transcribed data focuses on 'meaning units' as units of analysis – that is, the smallest segments of text that are meaningful by themselves. Themes and patterns were identified, and are given in categories and sub-categories.

Data analysis in the case of semi-structured interviews usually is qualitative. Typical comments, in the participants' own words, often increase the credibility of research reports. Quantification may be possible by giving an indication of the number of participants who responded negatively/positively to particular items, but although even in

the most unstructured interview themes may be found that are repetitive, researchers are cautioned not to attempt to force data into a statistical format that may damage the credibility of the analysis (Wolmarans & Eksteen 1987:59). This type of quantification was used on small scale in a few instances.

The basis of the analysis was the transcripts, tapes, notes and memory (*cf.* Greeff 2002:318). In the case of the focus group analysis, the group interactions were noted too; therefore, in coding, individuals' responses and the discussions of the group were balanced (*cf.* Greeff 2002:318-9).

5.4 TRUSTWORTHINESS, VALIDITY, RELIABILITY

Although there is not agreement about how to address the traditional issues of validity and reliability in qualitative research (see 1.6.2), there is general consensus that the credibility or worth of qualitative findings must and can be ensured (*cf.* Babbie & Mouton 2001: 274-275; Harris 2002:65; Krefting 1991:214; Leedy 1997:168; Shank 2002: 92-93).

The views of these mentioned authors were all carefully noted and they were kept in mind in this study as criteria or 'canons' "phrased as questions to which all research must respond" (Strydom & Delpont 2002:351). In the final analysis, however, it was decided to put the findings of the research to the test in terms of Lincoln and Guba's (1985: 290-301) model of trustworthiness of qualitative studies.

Lincoln and Guba (1985:290) state that any inquirer must persuade the audience that the findings of a study are worth taking account of – the basic issue is: How trustworthy are the findings? They identified four aspects of trustworthiness that can be employed to increase the rigour of a qualitative study, namely truth value, transferability, consistency and neutrality (Lincoln & Guba 1985:294-301).

The truth value of a study (also called credibility – Strydom & Delpont 2002:351) is found in an accurate description or interpretation of the experience/phenomenon. This was brought about in this study by the prolonged engagement of the researcher with the process, persistent observation (over a period of more than four years), triangulation (using the focus group interview after the findings of the observations and field notes, and the individual interviews had been processed), accuracy of referencing (all notes,

reports and audio tapes are available as records), and member checks with participants (Lincoln & Guba 1985:303-307; also *cf.* Babbie & Mouton 2001:277).

As all observations in qualitative studies are defined by the specific context in which they occur, the qualitative researcher does not claim that knowledge gained from one context will necessarily have relevance for other contexts (Babbie & Mouton 2001:277). Guba and Lincoln (1985:298) state that if there is to be transferability, the burden to prove transferability lies with the one who wishes to make the application elsewhere, not with the original researcher. The responsibility of the original researcher ends in providing sufficient description to make similar judgements possible. The 'thick' descriptions in qualitative studies play (as in the current study) an important role – sufficient detail is reported to allow judgements of transferability to be made by a reader. Furthermore, the purposive sampling maximised the range of specific information that could be obtained from and about the context – which might facilitate transferability in that this increased the amount of descriptive data collected, which in turn, increased the possibility of comparison (*cf.* Lincoln & Guba 1985:298; 316; also *cf.* Babbie & Mouton 2001:27).

The third criterion for trustworthiness considers the consistency or dependability of data – whether the findings would be consistent if the study were replicated. This assumes a single reality, something that is unchanging and can be used as benchmark (Krefting 1991:216) – qualitative research, however, emphasises the uniqueness of the human situation, so that variation in experience is sought, rather than identical replication. In the current study the richness of the information was the important factor – to learn as much as possible; qualitative research looks at the range of experiences rather than the average. Therefore, those who want to conduct policy or design studies within the same parameters as the current study will be able to determine whether the findings described can be generalised to their own settings (*cf.* De Vos 2002:352). This study's generalisability is also enhanced by the multiple data sources – having used three methods of data collection and multiple informants strengthens the study's usefulness for other settings. Lincoln and Guba (1985:317-320) introduced the notion of an inquiry audit. Such an auditor would examine documentation and attest to the dependability of the study. To establish the dependability of the findings, the data, findings, interpretations and recommendations would be examined to ensure that everything is supported by data and is internally coherent – in the current study the researcher checked the responses during the interviews by repeating responses and ensuring that the meaning she assigned to responses was what the participant really meant, listened

to the tapes more than once, checked the transcriptions against the tapes, and used a research assistant to do additional checking.

The appropriate criterion for confirmability is that of neutrality (Krefting 1991:217). Rather than considering the neutrality of the researcher, Lincoln and Guba (1985: 323) place the emphasis on the data - they refer to the confirmability audit trail, which boils down to the researcher leaving a 'trail' that would enable one (an auditor) to determine if the conclusions, interpretations and recommendations can be traced to their sources.

In Table 5.2 the criteria used in the qualitative research process are given, as compared to that of a quantitative process.

Table 5.2 Comparison of criteria by research approach

Criterion	Qualitative approach	Quantitative approach
Truth value	Credibility	Internal validity
Applicability	Transferability	External validity
Consistency	Dependability	Reliability
Neutrality	Confirmability	Objectivity

Source: Krefting 1991:217

Table 5.3 gives a summary of the strategies used to establish trustworthiness. With regard to the first criterion, credibility requires adequate submersion in the research field to enable recurrent patterns to be identified and verified (*cf.* Krefting 1991:217). The researcher spent much time, observing and participating, over a period of more than four years with informed people in the field of quality assurance and accreditation in medical education in South Africa, as described. The next step in data collection was the individual interviews – these lasted between one and one hour 20 minutes each and thus much time was spent on data collection through interviewing too. The focus group interview lasted two hours.

In Table 5.3 the strategies used to establish trustworthiness in the current study are summarised.

Table 5.3 Strategies through which trustworthiness was established

Criteria – qualitative approach	Strategy used in study
Credibility	Prolonged experience in the field Reflexivity (weighing literature and experience; observation; field notes) Triangulation (experience, literature, focus group interview) Member checking Establishing authority of researcher (experienced in field) Structural coherence of the study Referential adequacy and proof
Transferability	Purposive samples Thick description
Dependability	Extensive description of research methods Triangulation Checking data Literature control Checking transcriptions
Confirmability	Triangulation Reflexivity

Adapted from Krefting 1991:217.

It must be noted here that the research situation was dynamic, and the researcher was a participant, not merely an observer. The researcher reflected on her role in the study, and kept notes (field notes) not only of the proceedings, but also of her own role in the study and how this might affect the data gathering and analysis (*cf.* Lincoln & Guba 1985:327).

Triangulation was done by means of data collection methods (participant observation, literature, individual interviews, focus group interview).

Member checking was done by having some participants check the data to ensure that their viewpoints had been accurately translated (others stated that they trusted the researcher to give their views correctly – due to time constraints they did not see their way open to read through the transcripts again). During the interviews (data gathering process) the researcher checked responses to decrease the chances of misinterpretation, and also rephrased, repeated, recapitulated and expanded on questions to enhance credibility (*cf.* Krefting 1991:220).

The authority of the researcher has been established on the basis of her familiarity with the phenomenon and the setting as described further on in this section, her interest in the theoretical knowledge and her ability to conceptualise large amounts of qualitative

data, the ability to look at the subject under investigation from different theoretical perspectives, and her good investigative skills, developed through literature reviews, previous experience with qualitative methods and course work in research methodologies (*cf.* Krefting 1991:220).

The structural coherence of the study is found in the fact that there are no unexplained inconsistencies between the data and their interpretations – every effort is made to explain any apparent contradiction by means of interpretation.

The transferability criterion has been satisfied through the purposive sampling. The thick description of the background and the selection criteria for the participants provide sufficient information about the participants and the context of the study to allow other researchers to assess how transferable the findings are (*cf.* Krefting 1991:220).

To ensure dependability the methods of data gathering, analysis and interpretation are described clearly. Triangulation took place (as described earlier). Checking data involved listening repeatedly to the audio recordings (*cf.* Groenewald 2004:18), going back to transcriptions and checking them against the audiotapes, and use was also made of an assistant to check the transcribed interviews. The code-recode procedure entailed going back to coded data after a few days, recoding the same data, and checking whether the results were the same. The researcher also made notes during and immediately after each interview, noting points for checking and making memory notes. The three promoters in the study checked the research plan and implementation to ensure dependability (*cf.* Krefting 1991:221).

To establish confirmability, use was made of triangulation of multiple methods, data sources and theoretical perspectives (as has been described). Documentation and sources are provided for every claim made and for the interpretation of the findings. Reflexive analysis (reflexivity) is used by the researcher to describe her awareness of her influence on the data.

Elucidation

The role of the researcher came to the fore in most aspects of the study, and needs to be elucidated and put into context here. The process of accreditation as it is used for quality assurance purposes in undergraduate medical education in South Africa is well-

known to the researcher who played an active part in its development and design (Labuschagné 1995; HPCSA 1999a), and has been involved in its implementation as a member of seven accreditation review teams between 2001 and 2004 (Accreditation reports: University of Pretoria 2001; University of the Witwatersrand 2001; University of Stellenbosch 2002; University of Cape Town 2002; University of Transkei 2003; Medical University of SA 2004; University of the Witwatersrand 2004). Having been a member of seven of the accreditation review teams made the researcher one of the most experienced members of the group from which the members of the teams are selected for accreditation visits. Furthermore, the theoretical knowledge the researcher gained on the topic of accreditation due to her involvement in the development of the process since 1995 caused other team members to discuss problems and experiences with her and in the process she learned much about the members' opinions and ideas regarding quality assurance in education *per se* and the accreditation process in medical education in South Africa in particular; she thus came to know much of how people closely involved in the phenomenon under study experienced it.

In 2002 the researcher was the co-ordinator of the preparations for the accreditation visit to the School of Medicine, University of the Free State, and was instrumental in preparing the self-evaluation report and other documentation. Under guidance of the Dean she planned the activities for the period of the visit, and arranged the programme for the visit. These activities brought with them a perspective from the 'other side' of the accreditation process, namely the opinions and experiences of the people who are on the receiving end, so to speak.

In 2002 the researcher completed a master's study dealing with standards for accreditation of medical education (Bezuidenhout 2002), which can be regarded as a forerunner of the current study.

5.5 ETHICS

Ethical considerations do not figure equally important in all research projects (Huysamen 1994:178); however, ethics should be considered in any project. To ensure that no ethical rules were transgressed, the researcher obtained consent from the Undergraduate Education and Training Sub-Committee of the HPCSA for using unpublished material and documents of the Committee; the Committee was duly informed of the researcher's study, and she gained its consent for using information

collected during the accreditation review visits, meetings, workshops and other discussions on the accreditation process. Confidentiality was observed throughout the study, and no names of persons or institutions are mentioned, except where duly referenced and with informed consent. Participants in the interviews and focus group interview were requested in writing to participate, and full details of the study were provided – their agreement to participate was regarded as informed consent.

The researcher endeavoured to honour a professional code of ethics in research (Leedy 1997:116), striving for the following:

- Maintaining scientific objectivity
- Recognising the limitations of her competence
- Recognising every person's right of privacy and dignity in treatment
- Honouring confidentiality
- Presenting the research findings honestly and without distortions
- Not using the prerogative of a researcher to obtain information for other purposes
- Acknowledging all assistance, collaboration and sources.

The study was approved by the Ethics Committee of the Faculty of Health Sciences, University of the Free State (ETOVS number 24/04).

5.6 SUMMARY AND CONCLUSION

To observe and trying to interpret what one observes, is a natural human activity. In scientific studies observation and interpretation are conscious, deliberately conducted acts. This is called research – searching again; scientific research constitutes pursuits of truthful knowledge. Knowledge is never complete, and there are problems everywhere, waiting to be solved. Research thus is important for any profession (*cf.* Huysamen 1994; Leedy 1997).

Educational research in general, and medical education research in particular, are not research disciplines *per se* with their own specialised theories and methodologies; rather they are fields of inquiry of investigators in many different disciplines (Norman 2002:1). In this study qualitative methods were employed, and an overview of quantitative and qualitative methods in general has been given here, and as background the different

traditions in qualitative inquiries have been discussed briefly as they manifested in this study.

This chapter was written to explain, qualify and justify aspects of the study, in particular the methodology. It was deemed necessary to provide an explicit theoretical and historical overview of the research approach, as confusion seems to enter into different descriptions of qualitative studies and their ramifications, and the researcher had to establish a sound framework and background for herself to gain clarity on the procedures she planned to follow. It is expected that a phenomenological researcher will select a topic that is personally meaningful (*cf.* Leedy 1997:161), and the data analysis and interpretation described drew much on the researcher's experiences with accreditation as the phenomenon under investigation, as elucidated in this chapter.

In qualitative research, as in all studies, the research questions are driven by the identified problem. The problem in this study, namely a lack of a tool to use in accreditation reviews, led the researcher to gain a full picture of the phenomenon of quality assurance, including accreditation, and to understand it from the perspectives of the people most directly involved. Using the participant observations and literature as grounding, the researcher was able to devise a research instrument to use in individual interviews to collect opinions and perspectives (data) from informed participants. This instrument, a proposed guide for accreditation reviews, it was assumed, could be used in quality assurance processes to address the research problem as stated in 5.1. After having processed and interpreted the data, a focus group interview was used as triangulation to verify the findings. Finally the researcher returned to the literature to conduct a 'control' on the findings.

The next chapter reports on the data analysis and interpretation.

CHAPTER 6

DATA ANALYSIS, INTERPRETATION AND DISCUSSION

6.1 INTRODUCTION

As has been described in Chapter 5 (5.3.5) the main aim of the data analysis and interpretation is to organise the data into categories and to identify patterns in the categories through an inductive process, that is, reasoning from the particular to the general (*cf.* Mathers *et al.* 1998:17). Data in the empirical part of this study were collected by means of semi-structured interviews and a focus group interview. For the individual interviews two groups of participants were used, namely deans/heads of medical faculties/schools or their representatives, and previous members of accreditation review panels; members of the Sub-committee for Undergraduate Education and Training of Medical and Dental Professions Board participated in the focus group interview.

Deans/heads of faculties/schools or their representatives were requested to discuss the suitability of the proposed guide for self-assessment and accreditation reviews for use in their schools, whether it would make a contribution to the planning and quality assurance processes in their schools, what their opinion was about the use of such a guide in the accreditation process (to test the assumption) and to comment on the content of the guide.

In the case of members of previous accreditation panels - the second group of participants - the participants were asked to comment on the possible role and value of the proposed guide in the accreditation process, whether it might promote objectivity in the assessment of the panel, whether it would support schools in their preparation for accreditation (testing the assumption), and also to comment on the content.

The goal of the focus group interview, which served a triangulation purpose, was to evaluate the final outcome of the study, that is, the members of the focus group were requested to make a statement about whether they (as representatives of the accreditation body) thought there would be a place for such a guide in the accreditation

process, and what value it would hold (if any) (to find out if the assumption was correct). They also had the opportunity to discuss the use of the guide by medical schools/faculties in their quality assurance processes, and in the preparation for accreditation. Finally, the members of the focus group were requested to comment on the content of the guide.

The semi-structured nature of the interviews allowed the participants to elaborate on the topics the researcher raised. The individual interviews were reciprocal, as both the interviewer (researcher) and the participant were engaged in the dialogue. The interview schedules (see 5.3.2.4) were provided to the participants with the draft guide some two weeks before the interviews took place, which resulted in them being prepared to answer the questions even before they were put, and that led to a lively discussion, rather than an 'interview' situation.

The purpose of the interviews was to test the concept of and refine the draft guide for accreditation reviews (see 1.5 – Objectives of the study). The data gathering thus had a dual purpose: apart from its phenomenological nature (to view the phenomenon through the eyes of the participants), it also had an evaluative aim. In the data analysis a phenomenological data analysis procedure was followed (see 5.3.2 and 5.3.5), and the evaluative aim was achieved through determining whether the assumption that the guide could be used in quality assurance in medical education, could be accepted as correct.

An outstanding impression left with the researcher was that the participants were honestly and truly interested in medical education and wanted to make a contribution to maintaining and improving the quality of medical education in South Africa; in the words of one participant: "I think this is an effort that will put our accreditation system amongst the best in the world, and it will take South African medical education to where it belongs – right at the top. Quality in education is so important for medicine, but sometimes people in this country don't seem to realise it" (Individual interviews; see 6.2.2.2).

A second outstanding conclusion from the interviews, which will become clear in the data analysis, was that the participants were overwhelmingly positive towards the idea of the guide, and also found the content an answer to a dire need in determining what is to be regarded quality in medical education: "This is a superb document, especially with regard to education. Education is more important today than ever before in South Africa – our student population has changed so much – and this is an aspirational document to

bring home to staff the importance of good educational methods” (Individual interviews; see 6.2.1.2).

6.2 DATA ANALYSIS AND INTERPRETATION: INDIVIDUAL INTERVIEWS

The data analysis was an inductive process (the inference of a general conclusion from various instances), which was brought about by organising or classifying the data into categories, and identifying patterns in the categories, the so-called content analysis (see 5.3.5). The data analysis spiral that was used as guideline for the analysis is described in Chapter 5 (see 5.3.5 & Figure 5.1). Throughout the process of data analysis a continuous and conscious attempt was made to not allow personal bias, assumptions and presuppositions to contaminate the participants’ meanings and opinions (‘bracketing’ – *cf.* Groenewald 2004:6; Burns & Grové 1997:532), but to get a clear picture of the participants’ views; interpretation, however, was done in the light of the pre-knowledge of the researcher and the views collected from literature (see 5.3.5).

Directly after each interview the researcher made notes (memoing) on how she had experienced the interview, her impressions and feelings, and about ideas that came to her when reflecting on the process (observational notes – *cf.* Groenewald 2004:5). This might be regarded as part of the data interpretation process. As soon as possible after each interview the researcher listened to the interviews and transcribed them verbatim, after which those that had been conducted in Afrikaans were translated into English. Notes were made again – called theoretical notes (*cf.* Groenewald 2004:5) – in which the researcher started to derive meaning from the content of the interviews as she reflected on what was said (interpretation process). The transcripts were read through several times in order to gain a full picture of interviewees’ ideas and opinions – Groenewald (2004:6) calls this developing a holistic sense, the ‘gestalt’. This was followed by coding – using different colour pens and letters of the alphabet, themes and topics were marked in the margins and in the text to highlight them.

According to the next loop of the data analysis spiral (Creswell 1998:143; see Figure 5.1), the data were then classified according to the topics for discussion as indicated by the items in the interview schedule. This required of data to be interpreted, put in context, compared and classified. Categories were then created and the data, classified according to the topics, were categorised. The researcher and an assistant listened to the recordings of the interviews again, checked the transcriptions and translations for correctness, and the coding was repeated too (code-recode procedure described in

5.3.5).

6.2.2 Individual interviews: Deans/heads of medical faculties/schools, or their representatives

With this group of participants six interviews were conducted. In the case of two medical faculties/schools the participants who had initially agreed to the interviews postponed the appointments, and later cancelled them, due to circumstances. The post descriptions of the participants will not be linked to the responses, because that might lead to the participants being identified, as faculties/schools use different post descriptions for the heads/chairs of their undergraduate medical programmes, and by divulging that, the school concerned can be identified, which would imply breach of confidentiality. The positions the participants held at the time of the interview can be classified in the following categories: (i) Deans/heads of medical faculties/schools: dean/acting dean; head of a school; (ii) Representatives: chair of undergraduate programme; programme director; undergraduate portfolio manager.

6.2.1.1 Classifying and categorising

In the coding process, data were classified according to the themes for discussion as identified in the interview schedule, called *a priori* concepts (*cf.* Lacey & Luff 2001:18), namely, for the interviews with deans/heads of medical faculties/schools or their representatives:

- i. Suitability/usefulness of guide for use in medical faculties/schools/ programmes for quality assurance and improvement
- ii. Contribution the guide might make to planning and preparing for accreditation reviews
- iii. Contribution the guide might make to a more structured/standardised accreditation review
- iv. Possible obstacles to using the document (guide)
- v. Comments regarding content of the guide.

For each theme categories were created, and then the data were categorised accordingly, as the analysis proceeded. During the analysis, two topics were added, namely *Overall opinion* and *Recommendations* (only recommendations not dealt with under the other themes came into play here). The comments regarding the content of the standards were evaluated in terms of what was found in literature and other participants' opinions, and in the cases where they were found valid, or where it was

clear that the comment contained a recommendation that would bring about an improvement in the formulation of the standard, the guide was amended to incorporate the recommendation (see 8.1). Other recommendations which could not be addressed in this study are dealt with in the section on recommendations (8.4).

The themes, categories and sub-categories that emerged during the data analysis are summarised in Table 6.1.

Table 6.1 Themes, categories and sub-categories as identified in analysis of data collected by means of interviews with deans/heads of faculties/schools/their representatives

THEMES	CATEGORIES	SUB-CATEGORIES
Suitability/ usefulness for QA and planning in school/ programme	<p>Enthusiastic, very positive</p> <p>Less positive, though not negative</p>	<p>Suitable for self-evaluation All aspects addressed are important for QA and for planning Absolutely essential for planning and QA/improvement Valuable/superb document Will be helpful to ensure quality education Similarity with SAQA documentation – dual goal - for HPCSA & HEQC Equalizer Relevant; complete; applicable Will provide direction for where one wants to go Guideline for things we have to address Shows how we can improve our programme Will help to stay on a par with other schools/institutions world-wide Will make us aware of our strengths and weaknesses – that will give self-confidence/confidence in new programme</p> <p>Aspirational document/ Schools may find it difficult to comply with higher levels of some standards Scope/extensiveness of document; big job to work through it Can we be measured in terms of UK/European yardsticks?</p>
Contribution to planning and preparing for accreditation	<p>Positive remarks</p> <p>Cautions/ concerns</p>	<p>Long overdue document Standardising document for planning for accreditation Excellent for planning for accreditation/schools will be better prepared Provides a goal to pursue Putting in writing things often thought Will make inspections easier on schools Will provide structure for planning and preparation/ A compass Updated portfolio is an excellent idea Provides back-up for efforts to improve Sufficiently generic to be used by all types of programmes Will contribute to planning for improvement Feasible & useful standards – not ideas that cannot be achieved; contextualised for SA Will know which criteria will be used for evaluation/what to prepare for/what evidence to provide Can be used as a lever to bring about change in school Will give self-confidence to know we're on right track</p> <p>Will HPCSA panels use it? Measurability of some standards may prove difficult</p>

THEMES	CATEGORIES	SUB-CATEGORIES
Overall opinion	<p>Positive comments</p> <p>Cautions</p>	<p>I want to start using it in my school immediately</p> <p>The UET should accept it</p> <p>It should become the official accreditation document of the Board</p> <p>It highlights the importance of a division for educational development/ medical education</p> <p>If this system becomes Board requirements, it can be used as a lever to get Province to support medical schools more</p> <p>Long overdue; almost too late</p> <p>Positive development; clearly not designed for punitive purposes</p> <p>Excellent for planning</p> <p>Excellent for standardisation</p> <p>Excellent to point out the importance of educational development in a striving for successful medical education</p> <p>Many strengths in document/Superb document/Admirable piece of work</p> <p>Extensiveness of document may be a problem</p> <p>May ask more of medical schools than they can deliver</p> <p>May be a problem in times of change to nail down things to this extent – sufficient flexibility?</p>
Recommendations	<p>General</p> <p>Specific</p>	<p>Document must become everyday working document for all staff</p> <p>Preparation for this accreditation review should also be sufficient for HEQC audit</p> <p>Portfolio should be implemented immediately</p> <p>Workshops should be presented at all schools to introduce document</p> <p>Run document for a trial cycle – make amendments if necessary, then implement as official</p> <p>Trust that when this study is written up it will receive positive response it deserves</p> <p>MDPB should be careful not to create a pyramid system where one school is at the top; rather a plateau where all must be</p> <p>Some criteria should perhaps be tailored 'downwards'</p> <p>Attach weights to standards</p> <p>Use numeric scales to indicate level of compliance with standards</p> <p>Bring in scales for recommendations of accreditation review panel</p> <p>State maximum of minimum levels allowed; for good schools most rankings will be at higher/highest levels</p>

6.2.1.2 Discussion

The phenomenon that was studied here is quality assurance in undergraduate medical education in South Africa, with specific reference to the accreditation process used to that end; the purpose was classified as being both basic and applied research, that is, creating new knowledge and finding a solution to a problem (*cf.* 5.3). The experiences, opinions and feelings of the participants, expressed during the interviews, gave a clear picture of the phenomenon (*cf.* 5.3.1), and the theory that a guide for accreditation reviews and for the preparation for the reviews would be a useful instrument, was established; the assumption thus could be accepted as valid (*cf.* 5.1).

The data were classified into themes according to the items the participants were requested to address during the interviews. Within the themes a number of broad categories were detected, and these were further refined into sub-categories (see Table 6.1). The overall picture presented by the data was that of a need for more structure, clearer guidelines, standardisation, more objectivity in accreditation evaluation and a mechanism to use as a point of departure in planning for improvement and in preparing for quality assurance activities. These were the elements in the proposed guide for accreditation reviews highlighted by the participants. However, some concerns about the implementation of such a guide were expressed too, as will be discussed.

i. Suitability/usefulness of guide for quality assurance and planning in the faculty/school/programme

There was no doubt in the opinion of any of the participants that the guide would be useful for planning purposes and for enhancing the quality of education in their programmes/schools/faculties (100% positive response). In the participants'* own words:

1. *This is absolutely suitable for self-evaluation, it is long overdue. It can be described as direction-giving, guiding; an excellent document for planning, and a document for standardisation. What came to my mind when I read it was: This is excellent, it will be useful for planning, and it will help with standardisation in undergraduate medical education. It does not create the feeling of being designed for punitive purposes; rather, it gives a feeling of a document for planning for improvement.*
2. *I think this is superb, actually. There is a small echelon of staff that agrees with this, and realises that educational methods must be adapted, but there are hosts of others with whom we work who are not interested, and I am concerned. This is a fine document, so it has to make a very positive contribution; clearly it has to contribute to planning for improvement.*

* The participants have been assigned numbers for use in reporting – these numbers were assigned randomly, but the same number has been used for the same participant throughout the report; thus all responses reported under 1, for example, originated from the same person. This will enable the reader to compare the responses of the participants, but also to compare different responses from the same participant.

3. *All the aspects that quality assurance usually looks at, are covered – it will be useful in planning – it will be a useful reminder to medical schools ... it will give them an indication of what we should be aiming at for as minimal standard, and what to do to achieve higher levels. Actually it is absolutely essential for planning, and it will be a motivation for improvement.*
4. *This is a valuable document. So as to the specific value – it would change the preparation for accreditation from a fishing exercise to something where a person can say we can build up to this point with information. We can see in which respects we are under the norm and where we have gone beyond. If it is a fishing expedition we just try but don't know how to improve. If we are measured in terms of criteria, and perform in a certain number at minimum level, then we know those are the things we need to address. This will be to the advantage of schools, it will support efforts to improve and it will serve as an equaliser.*
5. *It is a good document that will be helpful for schools to ensure quality education. It has a strong similarity with SAQA (South African Qualifications Authority) documentation, thus it will serve a dual goal. I would like to start implementing it now as a planning for quality document. Especially the people on the curriculum development committee will find it most helpful - it gives direction as to where we should go. And in preparing for the accreditation visit – we will be better prepared, so we shall not fall around for evidence once the accreditation panel is here.*
6. *This is unbelievably useful – in my own case: I now know I have to take into account all these aspects of education, they are all important. Previously I had nothing to go on – we just had to decide what we wanted to do and how well; now this will serve as a measurement tool; this is a guideline for what is to be done in good medical education. If we have a guideline as to the things that need to be addressed in education to make it excellent, we know how we can improve. Our staff members are doctors; they don't know what is good in education – now they have guidelines; that will help schools to stay on a par with what is happening in other schools/world-wide. As for the aspects addressed – they are all relevant and applicable – the document is very complete. It will make us aware of our strengths and weaknesses - which will give self-confidence in a new programme.*

Under this topic, two participants indicated that they fully supported the idea of the accreditation review guide, but they had some doubts as to the general acceptability:

2. *I agree with the aspirational aspect of this; but we should be careful not to build*

in failure for a number of schools. We don't have the education units one sees overseas – the system must be realistic for South African circumstances. I'm not concerned that we will not continue to deliver a quality doctor – the South African milieu is such that the clinical experience is superb. But I wonder if we can measure ourselves in terms of these United Kingdom/European yardsticks?

4. *I think the extensiveness of the document may be a problem for some people – working through it will be a big job; but if one can make them understand that a specific committee should just work through it, they can do it. But it will be a big job, and it will have to be budgeted for.*

ii. Contribution to planning and preparing for accreditation

When the participants were asked to discuss their opinions and views of the contribution the proposed guide might make in terms of the planning and preparation schools/faculties have to do for accreditation review visits, once more there was a 100% positive response, that is, all the participants stated that the current situation was not acceptable, and that the implementation of an instrument such as the proposed guide would be to the benefit of all schools/faculties, albeit some participants had minor concerns about its use too. They voiced their opinions as follows:

1. *As for preparation for accreditation – absolutely yes, it is long overdue, but more than that. I like the idea of the portfolio. ... [Expands on the advantages of having a portfolio] The standards have been contextualised for South African medical education, so they are feasible and useful – it wouldn't have been useful to strive for things we can never achieve. It is an excellent standardising mechanism – it will give schools/programmes the opportunity to plan in a standardised way. The guide is sufficiently generic for all schools to use, no matter whether it is a problem-based or system-based or any other type of programme, and clearly planned for improvement. It doesn't contain ideas that cannot be achieved. I am very much in favour of this concept; it is a major contribution to our accreditation system.*
2. *Absolutely – I mean, as I said, this is a superb document. The reality is that education has undergone a major paradigm shift, following Tomorrow's Doctors and Kerneels Nel's reworked Guidelines for Medical Education [This is a reference to the document, Education and training of doctors in South Africa: Undergraduate medical education and training, HPCSA 1999.]. Clearly it has to contribute to planning for improvement. It will promote consistency,*

- comparability. It will be so useful to know which criteria will be used. I'm quite sure schools will use it – it doesn't need to be presented in another form. It's just that one also will have to have the people with skills to get it in place, you know.*
3. *Yes, of course it will be most useful! It will be a compass. Obviously great care has been taken with the description of the different levels – so I think it is now reasonably clear, even if people may disagree on exactly how one might measure. The important thing is, it is clear from the levels there is progression, and there is something to be worked on towards. In the past it was very wishy-washy. Now we will know what to prepare for, and what evidence to provide.*
 4. *There is no question with me as to the usefulness of this in preparing for accreditation. The responsibility for the preparation for accreditation in my faculty rests with the committee; it would be ideal for them to have a list of things that would be attended to, to say that the concept of quality rests in the following – then we could say, we can be measured in terms of these. So as to its specific value, I must say, it would change the accreditation process and the preparation that precedes it from a fishing exercise to something where we can say we prepared up to this point and built up with information, and then we cut. Then we can see in which respects we are under the norm, and where we have gone beyond. We will have a goal to pursue – no more fishing to try to do the right things; we will know these are the things to address.*
 5. *In my school it will definitely make a difference – for the better. It identifies the matters that need to be addressed. It will make the whole inspection much easier on us. We will be better prepared, so that we shall not need to fall around to come up with evidence once the team is here. My staff didn't know beforehand what the team would want to see – we were surprised at some of the things they wanted to see and see proof of. And each member of a team has his own idea about what is acceptable or good.*
 6. *Such a guide, I now realise, is absolutely essential. Previously we had nothing to work on - this will give us some footing. It will also serve as a lever to help me convince staff to make mind changes. In the past we did our best, but never knew whether it was sufficient – now we can measure ourselves, and we have something to back up our efforts to improve. It gives structure to planning and preparation for accreditation – all the important aspects of education that need to be attended to are clearly spelt out and summarised. This is a wonderfully helpful tool for all planners and managers of medical education programmes. It will also be motivational – the guide puts names to the things we tried to achieve,*

but didn't really know how to get people to make the important mind shifts. And it will give self-confidence to know we are on the right track.

Once again, some cautions and reservations were expressed under this theme:

3. *But the obvious question is: Will the panel look at the things covered in the proposed Guide? Also, people from different schools may read some of the items in terms of **their** understanding, and what that would imply with regard to what needs to be brought out as evidence in terms of a particular standard. Maybe it would be beneficial to be more specific about definitions of terms. One must also make sure about the measurability of the standards. I think that is something education has discovered: one has high ideals of evaluating certain things, one agrees it is important, the literature points out its importance, but how do we measure it in practical terms? How will schools measure themselves?*

iii. Contribution to more structured/standardised accreditation reviews

This item in the interview schedule clearly brought out the opinions and view the participants had of the accreditation process as it is currently conducted. Once again there was a 100% positive response that the proposed guide would bring about an improvement, but very important, it became clear that the participants viewed the current process as unstructured, subjective and something to fear rather than a process to bring about improvement. Although the overall view was that the proposed guide would be welcomed and should be used, once again concerns were voiced, too. On whether this proposed guide could contribute to a more structured and standardised accreditation review process, the participants reacted as follows (some of the concerns are dealt with together with the positive responses to put the concerns in context):

1. *As a standardising mechanism this is excellent. I am very much in favour of this concept for the accreditation visits. The only question I have is: On which basis will the panel decide whether a programme is accreditable or not? How many standards must be achieved at what level? But I think this is how it should be: It will help the panel reach consensus, and on the basis of the information studied beforehand and the indication of how the school /programme sees itself, the panel will know what to look for, what to inspect more closely. As for a more structured report, I agree fully. I've seen it myself – there is no comparability; I've seen big variations in terms of the completeness and the quality of reports. This definitely is the way to go – a report based on these standards and levels will be*

much more useful and accurate.

2. *Absolutely – it will definitely promote consistency, comparability and ultimately render a more structured report, more useful for schools too. You see, the panellists are amateurs, and each one deals with the process differently.*
3. *I hope the UET will use this document. As to the aspect of comparability – particularly in this country it is perhaps moot, but at the same time, I realise the HPCSA would like to know there is a certain standard being achieved by all medical schools, but at the same time we have such a variety of medical programmes; granted, they may shake down to the same kind of flavour. At the moment we've so many different ways of trying to achieve the same end – it may be counterproductive to try to shape everything in the same sort of way, because that is defined as 'best practice'. In a time of flux and change it may be a concern to nail down things to such a degree. But perhaps the remark I made about people interpreting things differently will allow for sufficient flexibility. It would be interesting to see how the process develops if one at least starts off from a common jumping-off point – we shall have to see how this will help us to evaluate different programmes in different schools. It is important that schools shouldn't feel they are being compared to other schools – it must be an enabling document. In that, this will be enormously helpful – as it is not always the same panel that visits schools, at least now they will have a common jumping-off point. This must bring about comparability in the accreditation process, but not be used to compare schools.*
4. *A measuring instrument is required. Then we can see in which respects we are under the norm and where we have gone beyond. Secondly, it would be an equaliser: one isn't elevated because you're good, but all will have to be good enough. The purpose of accreditation is not to say we have the best medical school in the country, we must say we have a good school, and we have to satisfy the requirements. Where we do not satisfy the requirements, we have a goal to pursue – if it is a fishing exercise we don't know how to improve. But if we have criteria, and we are measured in terms of those criteria, one will know what to address. And this document addresses all the most important factors in medical education – so the report will tell us where to go. Furthermore, there was no comparability amongst panels' views – this can perhaps be regarded as a standardisation process. Now it is a toothless exercise, because the only thing the panel can do is collect information, but what do you do with it? Now there will be an incentive for the schools to improve.*

5. *The document will definitely ensure more consistency in the accreditation process. There are such big differences in the curricula of schools, that I don't think we should expect wonders to happen in this regard, but still it will be an improvement, as the accreditation team will look at the same things in the different faculties, and will not concentrate on certain aspects in one faculty and on completely different matters in another, depending on who serves in the team. I'm glad you say faculties must be evaluated according to their missions and must retain their uniqueness. That was not the impression we got with previous reports. We got the impression that the team wanted our school to perform according to what happens in their own schools – that was very subjective. For example, a panel member working in a PBL curriculum wants to see things that are found in a PBL curriculum, and if these are not there, he thinks the programme isn't up to standard!*
6. *This document will bring about uniformity in the panels' views and standardisation – at least we shall all know what they are looking for, all will be treated alike. Then it doesn't matter so much that it is different teams that review different faculties, because they will use the same criteria. Currently there is no standard. It will also do away with another problem, namely that of discipline specialists appointed to teams who are not informed of educational principles and have not yet accepted the educational innovations. How can they judge an innovative programme? So this guide will tell them what is acceptable in the field of education. The panel members who are not converted to new educational approaches will have to adhere to the standards set out here, and judge a school's programme accordingly.*

As stated, some concerns were raised, albeit minor concerns, and according to the participants, made without detracting from the merit of the guide; they should only be regarded as cautions.

2. *I agree with the aspirational aspect of the document, but one has to be careful – one should not build in failure on the part of a number of schools. Schools having an education development unit are fortunate, even if it sometimes comprises only one person. We don't have the education units one sees overseas – we need people with skills to get something like this in place. The document has to be realistic for the South African education environment.*
3. *It is important that schools shouldn't feel they are being compared to other*

schools.

4. *I agree wholeheartedly, but one of the things that may be dangerous is the competition factor. We should never in South Africa move to a pyramid system where some or one school is at the top. That would be fully negative. What I would like to see is that we must have a plateau where we all must be. Some may score on individual items where they have certain outliers, that would not be a problem, but the moment schools start saying, I'm better than you are, then we'll have a big problem. I think if the Board uses this proposed system, it must be built into it that the possibility of competition is removed.*

iv. Why the guide might not be used/Obstacles to the guide being used

This item on the interview schedule did not elicit much response. The general feeling the researcher had when the discussion was steered this way, was that there were so many positives, that they would cancel the (possible) negatives. When kindly pressed to think of reasons why schools might not choose to have this document implemented, participants did come up with 'possible' reasons:

1. *Of course, everything will not happen at once - taking into consideration time, money and person-power restraints, it may take time to realise a complete portfolio. Also some standards are valid for university staff, but what about those on joint establishments? Also the faculty/school/university concept – some of these standards have to do with matters that are university policy, or have to do with the relationship with province. Perhaps that type of issues may need to be sorted out.*
2. *It's a question of how realistic some of this is. Here we come to the tension with the state – our lords and masters. The reality is that a medical school has a staff policy at basic sciences level, but it is not its own master in relation to the clinicians. I'm just wondering whether that reality hasn't got somehow to be understood.*
3. *What struck me about some of the items was how people from different schools might read some of the items in terms of their understanding of a particular term, and what that would imply would be examined. One might be more specific about definitions of certain terms and look at the measurability of some standards. How do we measure in practical terms? How do we decide: Is this good, bad or what? Is it there, or is it not? Those are the sort of things that occurred to me. But you've obviously taken a lot of trouble with the description of*

the levels, so there is a definite sense of this is what we're looking for at the basic level, and the extra detail or information on extra quality that may be added is reasonably clear – even if people disagree about exactly how it is to be measured, there is a clear sense of progression.

4. *I think the thing against a measuring instrument is that schools may be fearful to be identified as the worst. But that is why I prefer this system rather than the individual panels' opinions. If some-one in an undergraduate programme says, 'I don't want to have anything to do with this document', it will not be because of lack of manpower, or it is too difficult to understand, or too much detail, it will have to do with the fear that a school may be identified as the worst; therefore, in using this document one must make sure that that possibility doesn't exist. The component of best or worst must never come into play.*
5. *The only problem I can think of is the relationship with the province – aspects of the academic programme depend on that.*
6. *The only possible obstacle I can see is that it will require a mind shift. Because I can see people think everything to do with quality assurance is a difficult task.*

v. Comments on content of guide

Under this theme the comments and remarks were mostly favourable, and some good recommendations were made. All in all the participants thought the guide covered all aspects required for a good measurement of the quality of education in an undergraduate medical school in South Africa. Those recommendations that had to do with the formulation of the standards and rubrics that were regarded as having the possibility to improve the proposed guide were written into the standards. Some comments are quoted to provide an overall feeling of the participants' train of thought on this theme.

1. *The one thing that really hit me when I read this was that I thought: This is what I would really want to see to happen here in this faculty. That is the effect the standards and rubrics had on me. But there are some things I would like to point out, for example, in some standards it may be difficult to differentiate between the higher and the highest level. Then also, how will some of these be proved, for example, the standard on students' attitudes and behaviour (Standard 2.18)? I haven't seen anything in the standards about health systems and health systems/practice management – that is very important and should be added. Then the standards that have to do with aspects that we can't do anything about, for*

example, the role model of staff on the joint establishment – joint establishments cause a lot of complexity. Then, for example, some have a bearing on matters which fall under university policy, such as standard 6.2 (dealing with promotion of staff and how to demand satisfactory performance of staff). Then a final comment – in some faculties the undergraduate programme is housed in a specific school, in others it is a faculty concern – rather use faculty/school or simply programme; not only school, because more than one school may have inputs in the programme.

2. *I mean, as I said, this is a superb document – but you have to be careful. We are fortunate to have an education development unit, which actually comprises one person. I can see the standards are based on what came out of previous reports, and some are based on overseas literature. But you see, the panellists are amateurs – for example, standard 2.1 (reading: The medical education programme satisfies the standards of the NQF level at which the programme is registered), the highest level is a tall order – it is a matter of lack of time and who does it. Also, standards 1.3, highest level (requiring longitudinal studies to provide proof of the subsequent success in professional performance of former graduates of the school) – how attainable is that? To track 200 graduates into the future? What is needed to attain this is a research entity, it needs funding. How does a school assess attitudes? It would be helpful if you could indicate in the document what some of the strategies might be that would answer or prove compliance with some of the standards. All the rest was really just great. But then again, standard 6.1 (reading: Members of the academic staff have the capability and continued commitment to be effective educators and trainers) – you know, here I've written: How? The problem is: teacher training, teacher appraisal, staff development programmes – how can an education unit with one staff member actually undertake this? I understand the aspiration behind this, and I wish we could all go this route, but how? Again we come to the tension with state – our lords and masters. The standards on educational resources (7.1): if you look at the higher and highest levels (dealing with adequate buildings and equipment), we are so badly limited here. The same with a number of other standards – we are all going to attain the minimum, but I am worried about anything higher. You see, areas geographically removed from the main campus, I mean, there we are totally dependent on what provincial administration permits, including remuneration – budget comes down from the university, and staffing at the clinical level is determined by the joint provincial/university relationship. Please note, I think this is a superb document, it's just that circumstances in this country at the present time*

... . And I don't know that we would be pleased as medical schools to just keep attaining the minimum standard.

3. You've obviously taken a lot of trouble with the description of the different levels. So that it is there gives a definite sense of this is what we're looking for at the basic level, but these extra pieces of detail or information on what is being done, adds another level. I think that's reasonably clear, even though people may disagree about exactly how one is going to measure. It is clear that there must be progression, that there's something to work towards. We were not sure of what the panels were looking for; I think the descriptions give an indication that there is progression – that is something that can be perceived, even if one can't put a number to it. The expert observer is the person who unconsciously or subconsciously takes all those parts and says, 'Well this is my global estimation of the particular quality of this thing'. There are occasional areas where there may be overlaps – but then maybe it's about the flavour of what one is drawing out – looking essentially at the same sort of thing but with a different view in mind. For example, take standards 2.12 and 3.7 (dealing with proficiency in basic clinical skills, and clinical and practical skills development from the early years of training) – those are obviously different, but to what degree does one distinguish between clinical skills 'are developed', and 'skills are developed early'? I suspect one can perhaps be an aspect of the other in terms of the hierarchy of levels: Are they developing clinical skills? Yes, they are, but are they developing them right at the end or early so that they can have a chance to consolidate – that might constitute a higher level, rather than a separate standard.
4. As to the standards there are very few comments – the most important thing is how to prove a standard has been achieved, but that lies with the judgement, as you say, what has to be proved with the documentation. Personally I would like to see this system run for one cycle, then one would be able to determine whether there are problems with interpretation. But then again I don't think there would be problems. The second aim would be to see if schools/faculties will be able to lift their levels. I think this has a very good chance to make a difference, a big contribution, to what is happening in our country with regard to the quality of medical education. I think there are many strengths in here. People may ask: Is the philosophy founded? Is the measurement founded? Is it right to say that if you satisfy a few of the minimum level standards, and a number of the higher levels, to then bring forward a judgement to say a programme is actually at a higher level, even if all the elements have not been achieved? But then there is no system that

can satisfy that. And that is why the internal evaluation is so important, followed by the external, to see whether the same judgement will be made.

I really hope that when this study has been written up it will receive the response it deserves.

5. *I do not really have any comments at this point in time. A big problem in medical education is that so few teachers and trainers have educational qualifications. That is something I regard as a big deficiency, and I am glad that is pointed out specifically in the standards. That is the one strong point I am very glad about.*
6. *I think all the important issues are addressed. I feel if we can have these standards to work on, we will be aware of our own strengths and weaknesses. This can also be used to bring around those staff members who till now have not taken to the new curriculum, who always want to go back to old ways. The document ought to be made part of every staff member's everyday work – like a lecturer guide. Each lecturer must use it to set his/her own standards, to know what we are working towards, why we are aiming in that direction. That's one of the big problems with the Board's expectations – the people on the ground are not always aware of these types of documents and what they contain, like for example the Guidelines for undergraduate medical education in South Africa. Some of our staff has never even heard about it. This should be discussed regularly at a workshop in every programme. The standards themselves and the elucidations and explanations you give with the rubrics are fantastic, but you should add a table of contents to make it easier to look up things. This is why I like the way you did it – it explains why things are important, why it should be done. This really is excellent work, and must have been an enormous task. This is in line with how all assessments must be done – one must be able to say why you give a certain grade or mark. It also provides the assessors the opportunity to explain why they have judged the way they did – they need to give reasons for their judgements, and that will be the impetus for improvement. I really think this is long overdue – it should be accepted for use ASAP!*

vii. Recommendations and comments

Some general recommendations and comments were made during the course of the interviews. The highlights of these are:

1. *I like the portfolio idea. That's one of the things Board should consider instituting right away. If these are on computer, for the Board and ourselves, this updated*

portfolio will be a wonderful tool to work on and from. It will provide the opportunity to keep all information on the programme together – it will be good to have the information kept together like this. This is something we should all start using immediately – and it is something that will not sit on a shelf and gather dust – we will use it everyday.

2. *I am quite certain schools will use it – in the format it is. But perhaps some of the criteria need to be tailored ‘downwards’, maybe?!!*
3. *The aspect of comparability – this is moot, particularly in this country, but at the same time one realises that the HPCSA would like to know there is a certain standard being achieved, and that they can say, ‘Yes we’re putting out from whichever medical school graduates who have certain competencies, intellectually and in terms of skills and attitudes’, and I recognise that need, but at the same time we have such a variety of schools and medical education programmes in the country, at the moment we have so many different ways of trying to achieve the same end. It would depend on a particular panel whether they would be flexible to a degree; the different hierarchies probably also will allow for a degree of flexibility. The point that the aim is to compare reviews rather than schools is important – the work of the panels should be compared, not schools. Panels must look at the same things in different schools, and schools must be prepared.*
4. *I agree with your decision not to quantify the scores, but how will the panel decide to grant accreditation for a programme? My first choice for the ranking would be to rank the categories in a rubric, but that would be difficult to manage. My second choice would be to state the number of lowest rankings (minimum level attainments) a school would be allowed. The good school will be the one with most rankings at a higher level, the third level will be the dream, where the excellent school will be. The good school will not necessarily be the one with all rankings at the highest level. The good school is the one – and that is the good school in my plateau vision of good schools – where the consumer, i.e. the patient and the prospective student, will expect that the majority of the standards will be at a higher level, and the number of standards achieved at the highest level is the aim, the dream, and that is our excellent school. So then one can say the plateau for the excellent school is that, and for a good school is that, and one still has an idea of which is best. But if one is not in competition, if it’s a process of benchmarking, you take what you have and make the best of it, so people won’t say we don’t have sufficient staff, etc. So eventually one would say how many of these standards can be reached at the highest levels, and the higher levels will*

indicate growth with regard to quality. Considering repeated visits then, one can start looking at how many minimum levels have changed to higher and higher to highest. The minimum lowest levels a school will be allowed to have will probably also have to be defined.

Also according to the context in which a school operates, it will decide where its strengths lie and decide on a model to follow. Thus if a school decides this is our strengths, they will spend time to build that out, but also to ensure that in other aspects they attain at least a minimum, because all the standards should be achieved at minimum. There are many of the standards that should be regarded in a wider context. The value of this system is not in that we should all be the same, rather that we should all be good, and excellent at that which we choose and proclaim to be our strengths.

5. *This is a good proposal – it will be most helpful for all schools. Also it has a strong similarity with the HEQC (Higher Education Quality Committee) quality assurance documentation which means that once a school has prepared for one external audit, it will be ready for the other too. Also, it will ensure standardisation with regard to panels' views – some panel members are so outdated, to get a good report from them will mean a school has to go back to the old educational approaches that have been proved to be not as effective as the innovative methods and curricula we strive to implement. In my school this document will definitely make a contribution.*
6. *In our school I am sure we have attained most of the standards at the minimum level already, some at higher levels and some even at the highest level. But if we take away our division for educational development, we will not attain so many at the higher and highest level. That is because we want to ensure that our staff is informed about the latest developments in medical education. I think that is the crux of quality in education – people must be informed about innovations, developments and educational principles. I think it should become a requirement for all schools to have a unit for education. Furthermore, if this system is implemented we will have a lever to get province to become more involved – they would also want the schools in their provinces to perform at high levels.*

I was thinking, can't you categorise some of the items and then say if a school has attained x number of standards at the highest level, the school falls into the highest level in that category – that is, differentiate some standards to say a school is, for example, a higher level with regard to resources, but a highest level with regard to student support. That will motivate people and they will concentrate on their

strengths to enhance them further, without neglecting their weak points, because all schools must achieve the minimum level for all standards. And if you know you are at the highest level in at least some category, that will give each school something to use for marketing and it will make them proud. Also, perhaps some categories should carry more weight than others – for example, student learning should be more important than student selection.

In summary it may be said that the interviews were conducted in a spirit of goodwill and the participants were appreciative of and excited about the proposed system. With a single exception, they stated that they had studied the document well; the exception being a participant who read through the document, but said the criteria had not been studied well. All said that they understood the background and rationale, and agreed with the proposed system in principle. Some of the participants were so keen on the proposed guide that they asked permission from the researcher to start using the documentation in draft form in their institutions, because they felt it contained valuable information, set out in clear terms, with the rationales why these aspects were important for good education.

6.2.2 Individual interviews: Members of accreditation review panels

With this group of participants four interviews were conducted, as arranged. One participant is a medical educationist, and the other three are heads of departments in their respective schools/faculties. They were members of accreditation panels between 2001 and 2004; one having served in only one panel, while the others served in two and more panels. For reasons of confidentiality, more details about their positions, involvement in accreditation panels, or their institutions cannot be given, as that may result in them being identified. In these interviews the emphasis was on the possible contribution the proposed guide could make to the accreditation process, rather than on what it would mean to their institutions, as they were interviewed to elicit the meanings of participants in accreditation review panels; however, opinions on how the proposed concept could influence their own institutions also came to the fore during the interviews. The responses contributed to gaining a perspective on how they viewed the phenomenon of quality assurance in medical education.

6.2.2.1 *Classifying and categorising*

The same procedure was followed in the coding process as with the first group of interviews, namely the data were classified according to the themes or topics for discussion as identified in the interview schedule, namely

- i. The role and value of the proposed guide in the evaluation processes of an accreditation review panel
- ii. Contribution the guide might make to promoting objectivity in evaluations and to arriving at a collective panel decision
- iii. Contribution the guide might make to preparation of medical schools for accreditation visits
- iv. Should the UET of the MDPB use this in all accreditation reviews?
- v. Strengths and weaknesses in the document

A sixth category was included, namely

- vi. Comments and recommendations

which could not be classified under one of the other themes.

Recommendations regarding the content of the standards were evaluated and in the cases where they were found valid and in line with what was found in literature, or where the recommendation clearly proved to contain an improvement in the formulation of a specific standard, the guide was amended to incorporate the recommendation. This will be dealt with in a separate part of the report.

The themes, and the categories and sub-categories that emerged during the data analysis are summarised in Table 6.2.

Table 6.2 Themes, categories and sub-categories as identified in analysis of data collected by means of interviews with former members of accreditation review panels

THEMES	CATEGORIES	SUB-CATEGORIES
Role & value of guide in accreditation review process	Positive/ Enthusiastic	<p>Measurement tool to be used</p> <p>Clear expectations</p> <p>No room for window-dressing</p> <p>Clear criteria for evaluations</p> <p>Makes the importance of educational processes in medical education and training clear – too many trainers are not informed about educational processes</p> <p>Clear guidelines for evaluation – panel & school can address same matters</p> <p>Will improve effectiveness and efficiency of panel</p> <p>Level descriptors are explained clearly – less subjectivity in measurement</p> <p>More accurate measurement; more uniformity in review process, more consistency</p> <p>Provides benchmarks for schools/faculties</p> <p>Guide is based on principles, leaves room for individuality of faculty/school to be appreciated</p>
Promoting objectivity in evaluation of medical schools /Will it help panel to arrive at a collective assessment decision?	Definitely/ positive	<p>Some panel members don't know the basics of educational principles – this will make the evaluation more objective, it gives guidelines</p> <p>Panel evaluations differ depending on the chair – this will result in more objectivity, from the chair too</p> <p>In the past – an arbitrary process, influenced by the chair</p> <p>No room for long discussions and beating about the bush – will promote effective and efficient decision-making by panel</p> <p>Panel decisions will be rendered more credible and valuable</p> <p>Guide will counter variety in interpretation of what constitutes good educational principles</p>
Making preparations for accreditation reviews less cumbersome	Useful	<p>Faculty/school can compare its own evaluation with that of panel and identify misconceptions if those are present</p> <p>Will give structure to preparations</p> <p>Schools/faculties will not grapple in the dark and revert to window-dressing – will know what to expect, be prepared</p> <p>Preparing for accreditation review in this way will already result in upgrading of standards – all relevant educational issues will be attended to</p> <p>MDPB must make it an official document, it must be authoritative, else it will not bear results</p> <p>To educate has become a science – this will sensitise lecturing staff to educational principles</p> <p>Guidelines show how educational principles should be interpreted – good for schools</p> <p>Guide will be useful at institutional level as well as at departmental level – apart from preparation for accreditation review it is a useful planning document</p> <p>Good for people to do self-assessment: Where are we? Where do we want to be?</p> <p>Guide is not prescriptive – each institution can interpret guidelines/levels in terms of its own mission.</p> <p>Should be used, but effectiveness and efficiency will depend on resources, and what is practical in a specific faculty</p> <p>Will help medical education to adjust to demands of the future</p>

6.2.2.2 Discussion

i. Role and value of guide in accreditation review process

The participants (n=4) were very positive about the value the proposed guide might have in accreditation reviews, and were all of the opinion that it could play an important role in enhancing the process of accreditation. They all expressed the opinion that the current process left much to be desired in terms of subjectivity and consistency, that individuals 'drove the process according to their own will', and that the assessments were unstructured, leaving the panellists to comment on aspects of the medical education programmes, without stating what the expectations were with regard to these aspects.

Only one category could be identified under this theme, namely that of participants reacting positively and enthusiastically. Extracts from the interviews are quoted to give a flavour of their feelings.

1. *I am very positive about this idea. Based on my experience with the accreditation reviews, I can say it is a very arbitrary process. Every time the process is different, depending on the chair of the panel. This proposed system gives clear guidelines according to which a panel will be able to work effectively and efficiently, addressing the real issues. The value of this will be that it will improve effectiveness and efficiency – the deficiency in the current process is that it depended on who chairs the panel and who are the panel members. What is needed is that the panel should work according to principles and a laid-down process. This is excellent!*
2. *This will definitely contribute for the better – the need for a guideline is big. We need consistency in the process, and we need norms and benchmarks. Here you've identified them. These guidelines are broad, based on principles. You know, when I first read this, I almost phoned you to say: 'Hey, this is what the accreditation panels need', but as medical schools we also need this! I think it is long overdue. You know, the English brought out Tomorrow's Doctors in 1994 already. So where does that leave us – more than ten years behind?! Among panel members there will always be differences of opinion, but until now we had nothing to back us up when we take a stand. With this, we can just say: Is it in the standards?*
3. *With regard to the role it may play – I hope it will! – I think this is excellent. I have always wondered: What are the measures I am supposed to use in an accreditation visit? Now I've seen it clearly for the first time – you captured it very*

well. This will give us the measurement tool we lacked in previous visits, the tool which will enable panel members to reach clear-cut conclusions. Currently the judgement is very 'soft' – we didn't really have a standard in terms of which to measure. If one gives a Faculty a 1 or a 2 on each of the rubrics, it will eventually give an average, which will make comparisons possible. Now one has a given standard which can be measured at three levels. That is of great value. Currently, when a panel member receives the document on which you have to reply, you see a heading, for example, Quality control, and have to make your own inferences about what should be addressed and included, but as panel member, you don't really know what the UET has in mind, or what should be regarded as important – every panel member has to work from his/her own frame of reference, which may be totally different from some-one else's. With this we'll have something to work on – once one has a rubric, you'll know what you see may be worth only a 1 and not a 2 or a 3, for example. One can see what the expectations are, and in the end it will also render a much more worthwhile report. The other advantage is that when the report is issued, and certain aspects did not receive a high rating, the rubric will explain why that is so, because the expectations are set out clearly.

4. *It will definitely be of great value. When I participated in a panel visit, I experienced it as a deficiency that we had no guidelines. We need criteria for evaluating a school or a programme. It was very unstructured.*

ii. Promoting objectivity in evaluation of medical schools / helping panel to arrive at a collective assessment decision

The participants agreed 100% that the proposed guide and system would promote objectivity in the evaluation of medical education programmes. Some expressed themselves strongly about what they perceived as deficiencies in the current system. The following are some of their remarks under this theme:

1. *Depending on who is the chair and who are the panel members, objectivity can be influenced negatively. I don't say it was the case, but the current process creates the opportunity for that to happen. If we have an instrument to use for all visits - and I think the level descriptors are set out very well – each panel member will know exactly what is expected. More uniformity can be brought about, and the panel will be able to make a more accurate and better measurement of the quality of the education in a programme. Some panels find it more difficult to reach consensus than others. If the chair is good, and things are organised well, he/she*

will bring together everything. But sometimes the discussions resulted in a lot of talking about trivial issues, and debates occurred about matters that should have been cleared up before the visit. My response thus is: Strategically the proposed system and guide must and will promote objectivity. This is important to render the decisions of the panels more credible and valuable. If the same basis is used for decisions, there will be more objectivity and credibility.

2. *This will help with objectivity. These guidelines are not restrictive, they leave room for imagination – but they give direction. We need consistency in the accreditation process. Panel members also must be chosen from faculties following innovative curricula, or must be open for innovations – traditional members are subjective in their judgements.*
3. *Definitely yes. What I found very disturbing during the accreditation visits, was the subjectivity of the panel members. The UET went out of its way to give different people the opportunity to serve in the panels, for example, they would use **a basic medical scientist**, and not necessarily **an expert medical scientist, who also is informed about educational principles** to serve in the panels. And then you find what I experienced, that some of the panel members do not know the basics of educational principles, and they would be critical of a programme where things are being done according to medical education principles, and when you try to explain to the panel members, they don't even know , what Miller's pyramid is, or the Neijmegen classification! Then one realises the person isn't up to date as regards education, but they call themselves medical educators; they're not informed of modern educational principles, but they evaluate others' programmes! Absolutely, this guide will promote objectivity, but it goes hand in hand with the expertise of panel members. Members must be educational experts. I ask the question: Why doesn't the UET identify expert medical educators, i.e. experts in education, and use only those people in the panels? But of course my remark is more applicable to the current system – with the proposed system panel members will be brought back to the basics of education through the standards, and even the less informed will be a better panel member than was the case in the current system where non-experts in the field of modern education served on the panels without any guidelines. And please note, I'm a medically qualified basic scientist, who made it my job to become an expert in modern medical education – so there are no excuses for uninformed staff who teaches medicine.*
4. *Yes definitely, the evaluations will be more objective in the proposed system. Every time it is a new panel with another chair that does the evaluations, and these*

are not structured in the same way. That may lead to the evaluations not being comparable. This will definitely be a great help.

iii. Making preparations for accreditation reviews less cumbersome for medical schools

The participants were in agreement that the proposed system would be to the benefit of schools/faculties in preparing for accreditation. They didn't expand much on this theme, as they were supposed to respond from the viewpoint of a member of the panels, but even from that perspective they pointed out the advantages of the proposed system and the guide for the institutions.

- 1. Sometimes an institution only realises something is an issue once the visit has started – then they are not prepared. But if the panel and the school work according to the same model there will not be time wasted and so much beating about the bush. Schools that are open for improvement and innovations, and operate in a transparent manner will welcome this. Those that cling to outdated practices and want to operate according to their old ways may see this as a threat. A strong point in the proposed guide is the emphasis on medical education and the need to inform staff about modern educational practices. It looks into medical education research – that makes it the ideal to have a unit for medical education in every medical school. Education as a field of study is neglected in many medical schools – staff tends to think if they are good doctors they will be good teachers; being a good doctor does not imply that you will be able to make a good doctor of a student. Research has shown this is not necessarily the case, and schools should take cognisance of that. Education has changed and the student body has changed. The proposed guide will play a role in educating teaching staff with regard to educational principles, which are so important, especially with our new student population.*
- 2. The need for the guidelines is real, also for schools to prepare better. I've been head of my department now for some time, and I see people with different expectations – so even in departments there is a need for a guiding document on education. People interpret things differently, take for example, active learning: What I think is active learning may not necessarily be what you think it implies – medical teachers are doctors, not trained educationists, therefore the guidelines*

are essential to show us how to interpret and apply educational principles. From an educational point of view it is very important to know: This is what a medical school should have, this is what should be in place. And because of the variety of interpretations, the guidelines should be a great help. As I said, these standards can be used from departmental level. That makes it an excellent planning document for accreditation, but more important, for planning in the course of our work. It should become part of our everyday teaching practice and planning for teaching and training to consult this guide. Then we can say, 'Okay, let's assess ourselves, and we'll see where we were and where we are now, what progress we've made'; it will help motivate us to improve. It's a good planning document, and as I said, it's not prescriptive. Older schools have a lot of old traditions to get rid of; this will help those people see things differently, help with changing over to innovative education.

3. A big value - if you make this available to a faculty, it can prepare better. For the panel members it will also be of great value. The guide will serve a purpose in informing medical educators about modern medical education. Then we won't have the problem of people clinging to outdated practices used to evaluate other programmes. With regard to the faculties, what I see now is that when the faculty has to complete the current questionnaire, they get a topic like: "Explain how you assess students". Then the person who has to respond writes a story – each one will write his own story, not knowing what is really expected. But once we use this, one will see what the expectations are, and pitch oneself at one of those levels. It will prevent those long stories, which sometimes don't really tell the panellists anything. The participants will come to the point, which will make it easier for the panel to judge the responses. This doesn't leave room for window-dressing.
4. Yes, definitely, the document will help schools in planning, especially new programmes. But the document and system must be accepted by the HPCSA as official, and it needs to be authoritative. That will help all medical schools, because they will know how they will be evaluated. It will also lead to more uniformity amongst medical schools – which is good on the one hand, but on the other hand that might not be so good. One should not cast all schools in the same mould. But the proposed system does leave room for diversity. A good document containing all the relevant information for modern medical education, trends and requirements and underwritten by Council will definitely be very useful for medical teachers.

iv. Should the UET use this guide for accreditation reviews?

In reply to the question whether the participants, as members of previous accreditation review panels thought the UET should use this document and system, the participants once again replied 100% in the positive. The sentiment that was expressed most explicitly, was that of the members of the panel having felt themselves at a loss, because they had found it difficult to assess a programme without criteria, and secondly, although they themselves had been members of such panels, they had a feeling that there was no consistency in the accreditation reviews; the outcome depended on who served in a panel, not on sound criteria for assessment. Participants also expressed the opinion that such a guide would contribute to improvement of the quality of programmes, because it provided a motivation and guidelines for continual enhancement of programmes. Another important opinion, although not all the participants mentioned that, was that such a step would highlight the importance of **education** in medical education.

The participants worded their opinions as follows:

- 1. If the UET starts using this guide as a reference or source, it will be a start. It is important for the UET to give it authority, then schools will start using it in their planning. As for the accreditation process, that will not so much depend on who serves in the panel. The process will be above suspicion – all schools will be dealt with in the same manner, the same points of departure will be valid for all. This system will serve well to manage the whole process, especially the on-site visits; it will limit or eliminate the discrepancies that now sometimes occur with regard to on-site visits and reports. There is no yardstick, thus no comparability – this guide will fill that void. This is important for benchmarking. It **must** be put to use in all medical schools by the UET. To educate has become a science. Worldwide the importance of sound educational principles is recognised, but in South African medical education it does not receive sufficient attention. Bigger education units are required in most schools. Medical education units should have power and be respected as full partner in the medical education enterprise. Then quality education will become a reality. The UET must use this guide to make the importance of medical education clear. To have a successful end-product, one must start with the process and systems.*
- 2. The UET should definitely use this document as guide. It is long overdue. Until now the panel had nothing to go on – we were at a loss for criteria. If the UET accepts this, we can just say: What are the criteria? Proper educational methods*

are so important, and modern educational methods make provision for the needs. They are all in the proposed guide.

3. *Yes definitely, the UET should use this. It gives structure. It will also ask more of an effort of the Committee, because they will have to judge the panel's report in terms of the criteria. Anyway, the UET should come more to the fore. Why doesn't the Committee communicate more with us – tell us what is expected of medical education? But then, do the UET members have sufficient insight in educational matters to see the importance of a document such as this? If they don't have a background and interest in education, they may not realise the importance and value of a document such as this and the proposed system. I really do hope they will prove me wrong and immediately grasp the opportunity you offer them for improving the accreditation system and medical education.*
4. *Yes, I think it is a good document, and it should be used by the UET. Each time a new panel with another chair does the evaluations – without criteria there is no consistency. This will result in more structure, helping the panel to reach conclusions.*

v. Strengths and/or weaknesses in guide

In the first category, namely strengths of the guide, the participants mentioned the clearly explained standards and rubrics - according to them the standards are well-defined and the levels are clear. They were of the opinion that all the important educational principles are spelt out clearly, and that is something that medical schools/faculties need, because doctors who are the trainers in medical schools are not always well-grounded in education; the same can be said of panel members. The idea of an electronic portfolio also met with approval.

Weaknesses or aspects that might be improved, had to do with the extensiveness of the document, that people might find it intimidating to receive such a long document to work through, and they also thought that some standards might be perceived to overlap, although they were cognisant of the fact that that was due to different categories, and that some of the standards could be viewed from different perspectives.

In general the proposed system (the document) was found to leave very little to desire, and the participants were positive that its value was such that with a few changes here and there it could be used for the purposes it had been designed for. Changes to the guide that were recommended by the interviewees and incorporated in the guide are

discussed in Chapter 7.1.

Some remarks on this theme are quoted to illustrate the participants' perspectives:

1. *A definite strength is that the document makes it clear that the role and value of medical **education** should be recognised in the training of doctors. And it explains the educational processes. It is about HOW things should be done, what we should look at to ensure we do the right things, like for example, horizontal and vertical integration – the rubrics clearly spell out what to do to attain it maximally. The standards address issues we know are important, but they are seldom measured because it is so difficult to do that. Now you have given rubrics, and put it all in writing – so there is no reason any longer to avoid it. The rubrics are very clear – I can see the **must have**, **should have**, and the **nice to have**. But the nice to have here equals **excellence**. The minimum is what we all should exceed, except where there are specific circumstances that prevent it; we would all like to be at the higher level, and then we would strive for excellence. Most schools would reach the highest level in some standards, and that must be given recognition; such a school will then be a centre of excellence in that regard. That is why I think this is so good – fields of excellence can be identified. Another strength is that it clearly identifies the need for departments or bureaus for medical education in all medical schools – medical education and training can no longer do without that.*

As for weaknesses – I haven't really identified any; perhaps some of the criteria are a bit lengthy, but then again, the explanations are important. Detail may be unnecessary for the accreditation reviews, but for planning – the more things are spelt out, the easier it will be to convince people that this is the route to go.

2. *A strong point is the number of criteria on assessment. We are generally happy with what we are doing in that regard, but I think assessments can be improved according to modern educational strategies. Assessment drives learning – students learn in the way they will be assessed, that's why the standards on assessment are so important – they underscore that. The other standard that is very important is on inter-professional co-operation – we must find ways to train our health professionals together. It is important in our training to think ahead – what will our doctors need to do in ten years' time? Are we adjusting for the future? Also we have a problem with the school system, so our students need more than some years ago – the right educational methods will put that right – and those are in this document. The whole document is of value – there is no question*

about that. We had nothing to go on to ensure that we uphold high standards. Now we can look at the minimum level, and we can go up from there. The first level is what we can all attain; that is the broad base, it must be there. Then we can go like a pyramid, perhaps fewer at the second level, and fewer will attain the highest level, but the broad base is level one, we must all be there. Each school will have areas of excellence – there we will reach the highest level, and we must receive credit for that.

As for the portfolio – the people can start to get that together now at departmental level, and if we know the UET will use it – which we hope! – we can be ready. I do not think I spotted anything that can be called a deficiency or a weakness.

- 3. I think the work document must be shorter. The document as it is, gives structure, but this extensive one can be used as a reference. People may otherwise be put off by the sheer length of the document, and not be as eager to implement it. The document of the Netherland's Ministry for Education puts the standards in such a cryptic way. Furthermore, I would prefer a 5-point Likert scale for each standard. The panel will then have to give reasons why it differs from the faculty/school in the evaluation of a standard. The panel must make a comment on each standard – why they score as they do. I would also like to see that the panel give each comment they make a value – that is something I miss here. For example, one comment may be rated a 5, meaning it should receive attention ASAP; another may be just a recommendation that would be a nice to have, that would be rated a 1. So if the panel returns for the follow-up visit, those recommendations that were rated 5 that have not received attention would call for urgent attention from the Board. But the 1s and 2s wouldn't be so crucial. But in the final instance, I cannot really find fault with this – I think this is an effort that would put us amongst the best accreditation systems in the world.*
- 4. This is a good document containing all the information a school needs to make its education efforts a success. Ultimately I think one would need a condensed version to work with – once everybody has been informed about the full content. It should also be more attractive and compact – not in A4, but a neatly printed and bound booklet would be ideal. But the work has been done very thoroughly, and should be used as basis. The standards themselves – they are well-defined, and the three levels are a good thing and well chosen. It actually is a good document and you can just proceed, and we must hope the UET will use this – it will be to the benefit of medical education.*

vi. Comments/Recommendations

The recommendations and other general comments the panel made were not really drastic, and most have been addressed already in some way or other under the different themes. Some remarks, however, justify mention:

1. *Excellence in teaching must be rewarded – that is most important; therefore it is so good that it is put in writing and should serve as a standard. These standards might change medical schools' attitudes regarding teaching and educational research. If teaching serves as a standard schools might start considering it more seriously for promotion – the importance of education in medical education must be recognised – this guide will contribute to that. I can tell you, it is not often that a new model put on the table has so much potential value. It will take South African medical education to the forefront and the research that has been done here may play a role in medical education globally – strengthening the image the public and the world will have of our medical education system and processes.*
2. *This is the ideal, but to realise it will depend on many things, like resources, and what is practical. A stumbling block may be the relationship with province. When students go out to work in hospitals the medical school does not really have much influence on the type of role model the students meet. But it is excellent as a planning model – when we know what we should strive for, we might get there, notwithstanding problems; it is better than not having anything to strive for. And the portfolio is a good idea too; that will compel departments to do continuous assessment of what they are doing – if we get it together and keep it updated, there will be progress, because we will see where we were, where we are, and wish to do better.*
3. *I wonder, wouldn't it be possible to condense this document to a working document with only a few words or a sentence for each level, and then use this more elaborate one only as a reference document. The more experienced person will only need a few words to remind him of the standard, and he need not go through the whole document each time. The more inexperienced person can use the complete document. Also, I think this must be made available electronically. But on the whole this is excellent and will lead to big things for medical education in South Africa. It will put our accreditation system amongst the best in the world. Quality in education is so important in medicine, but people don't seem to realise that in our country.*

4. *I actually think this is excellent work – you must just proceed. Ultimately I think one will need a condensed version. This can be the mother document. The work has been done thoroughly, and can serve as a basis for the Board to refine it and present it to medical schools as official document. One can see a lot of very in-depth work has gone into this – congratulations, this will do South African medical education a lot of good.*

The interviewees greatly appreciated, and were excited at the prospect of this guide being implemented in the accreditation review process. It was clear that the panellists interviewed felt that such a structured process would contribute to the effectiveness of the accreditation reviews, and that it would define the task of the panel members, safeguarding them against doubts in executing their assignment. It became clear that panel members had not always been sure exactly what was expected of them, and that they felt that the way in which an accreditation review was approached depended mostly on who chaired a panel – at times leaving panel members confused.

6.2.2.3 Interpretation of the findings

The qualitative methodology that was used in this study was highly appropriate, as the interviews provided the researcher with an excellent opportunity to obtain the views, and gain insight into the perceptions of the participants. Storr (2004:424) describes this style of inquiry as intending to gain an authentic understanding of people's experiences and perceptions, and this is exactly what the researcher succeeded in doing. The overall picture presented by the data portrays the participants' view of the current accreditation system (the phenomenon) as not coming up to their expectations with regard to the aspects addressed in the study, and associated with this is an expressed need for a guide and system as proposed in this study. The analysis of the data facilitated the theory grounded in the data. It has become evident that the proposed guide was seen as a summary of what the participants regarded as important to ensure quality in undergraduate medical education; the proposed standards and the way in which they are complemented with rubrics covering three levels were perceived by the participants as not only useful for accreditation reviews, but for institutional and departmental planning and, very important, as a tool to enhance continuous quality improvement.

As a measure to render the accreditation decision more objective, the guide was also perceived as an answer to the current perceived problem of panel members not using standardised measures in their decisions, but depending exclusively on their own

experience and 'frame of reference'. This finding is underscored by literature (*cf.* BNQP 2001; CHEA 2000; LCME 1995), where clear standards are set forth with explanatory rubrics in systems which are perceived as objective, albeit, in the case of the last-mentioned two systems (LCME and CHEA), the evaluations are of a qualitative nature. This then is the dominant finding after having analysed the data: deans/heads of medical faculties/schools/their representatives, as well as previous members of accreditation review panels clearly have the perspective and are of opinion that the proposed guide for accreditation reviews will facilitate objectivity in accreditation processes, and will set the minds of medical schools/faculties at rest in that the same measures will be used for all schools/faculties.

An important finding is that the participants viewed the proposed guide as a tool to get medical educators aboard who are too set in their ways and are not interested in innovations in medical education. This tendency to resist change and innovation is seen by participants as a factor hampering progress in South African medical education and the set of standards contained in the proposed guide is perceived as a possible remedy for the refusal of teachers of the 'old school' to adapt to changes. If these standards, as content of the proposed guide for accreditation reviews, are accepted by the Medical and Dental Professions Board as official standards for undergraduate medical education, every-one involved in medical education and training will be obliged to accept change and innovation in education, thus ensuring that South African medical education stays on a par with what is happening world-wide. This finding is in line with Trow's (1999:29) view that an institution's response to change is an indicator of quality.

The findings suggest that the time is ripe for medical schools/faculties to start paying more attention to the educational aspects involved in medical education. The medical curriculum consists of the fundamental theory and practice of medicine, that is, basic medical, behavioural and social sciences, general clinical skills, clinical decision-making skills, communication abilities and medical ethics; however, training medical doctors is an educational process, and to ensure quality, the process is equally relevant (*cf.* WFME 2003:5).

An important aspect that must be noted is the opinion that through the proposed evaluation procedure the requirements of higher education might also be satisfied, that is, participants expressed the hope that the portfolio that would emanate from the proposed self-evaluation might also be used for quality assurance by the Higher

Education Quality Committee (HEQC), as the proposed guide addresses the same aspects of education and training that the HEQC addresses in the quality assurance exercises.

Some concerns came to the fore, mostly having a bearing on the problematic nature of relationships between medical schools and other role players. Recommendations concern the extensiveness of the proposed guide, the importance of making it official and authoritative, and presenting it in a user-friendly and attractive format.

The study identified a desire amongst participants in accreditation (those heading the programmes that are subjected to reviews, as well as those participating as reviewers) for a change in the way accreditation reviews are conducted. From the findings it can also be inferred that the proposed guide will have value as a way of informing medical educators of the importance of educational principles and innovations in medical education and training. The findings suggest that the proposed guide will contribute to promoting change and innovation in medical education (as has been advocated since 1984 by the WFME in its programme for the reorientation of medical education, the Edinburgh Declaration [1988], and the World Health Assembly [WHA] Resolution 48.8) (*cf.* WFME 1988 & 1998; WHA 1995). The standards contained in the proposed guide represent an effort to address the changes and innovations expected of undergraduate medical education, and are based on literature in this regard (see Chapter 7: *Guide for accreditation reviews, Sources used*).

6.3 DATA ANALYSIS AND INTERPRETATION: FOCUS GROUP INTERVIEW

The focus group interview, which was aimed at triangulation, was used to gauge the opinions of the members of the Undergraduate Education and Training Sub-committee (UET) of the Medical and Dental Professions Board (MDPB), that is, the body responsible for the accreditation process. The members of the focus group were asked to discuss whether there was a place for a guide as proposed in the accreditation process for undergraduate medical education in South Africa, whether the proposed guide would also be suitable for use by medical schools in preparing for accreditation visits, and in the process, whether it would contribute to the maintenance and improvement of standards in general, and they were also requested to discuss the content of the guide. As this study partly fell into the category of intervention research (*cf.* 5.2.3) and as the goal of the study was to solve a problem of a particular group (*cf.*

1.6.2), it was important to involve the members of the UET, because the possibility of their acceptance of the findings would thus be enhanced. In the final analysis the focus group interview was used to verify or test (triangulation) the findings of the individual interviews (*cf.* 5.2.3).

Seven members (the committee comprises nine members) of the Sub-committee for Undergraduate Education and Training (UET) attended the meeting during which the focus group interview was conducted. The participants were a dean of a faculty of health sciences, two deans of dental schools, one private medical practitioner, two heads of departments in medical schools, and one head of a dental school. (It needs to be explained here that the dental schools in South Africa use the same accreditation process as is used for medical schools, therefore the participants from dental schools could make similar inputs than those from medical schools.)

6.3.1 Classifying and categorising

Much the same procedure was followed in the coding process as with the individual interviews, namely the data were classified according to the themes or topics for discussion as identified in the focus group interview schedule, namely

- i. Whether there is a place for an accreditation review guide like this in quality assurance and improvement activities in medical education in South Africa, and the role and value of such a guide in the accreditation processes of the HPCSA.
- ii. To discuss the suitability of the proposed guide for use by medical schools in their quality assurance and improvement processes, and also in preparing for accreditation visits.
- iii. To discuss the content of the guide - possible strengths and weaknesses, gaps and/or unnecessary items; comments and/or recommendations with regard to the content and structure of the guide.

Although the interview schedule focused on these aspects, the interview was allowed to follow a natural flow of conversation. The themes, categories and sub-categories identified in the data analysis are summarised in Table 6.3.

Table 6.3 Themes, categories and sub-categories as identified in analysis of data collected by means of the focus group interview

THEMES	CATEGORIES	SUB-CATEGORIES
The place, role and value of the proposed system and accreditation review guide in the accreditation process	Positive, supportive Concerns, cautions	A more structured process is proposed Schools/faculties rating themselves – involvement in assessment process Rating based on specific standards Prior identification of discrepancies; will lead to a more focused visit More rigorous process More consistency and comparability in process Ratings to be in terms of faculty/school's own mission Some standards may need to be reviewed What will be the final deciding factor for accreditation?
The suitability of the guide for medical schools/faculties in preparing for accreditation reviews, as well as in planning and quality improvement processes	Positive, supportive Concerns, cautions	Excellent for schools/faculties for planning and quality improvement Useful for self-assessments Will start an effective development process in schools/faculties Will be of assistance in preparing for accreditation Will eliminate the 'fear factor' concerning accreditation reviews Less judgemental Will make faculty/school staff aware of important matters in medical education Will counter current perception that the only measure for quality is the pass rate Will support schools/faculties re quality assurance by Higher Education Quality Committee A big change – UET will need buy-in from deans/heads of schools/programme directors
Content of the proposed guide: Strengths and weaknesses; recommendations; comments	Excellent, good, useful Points to reconsider	Provides key performance areas Qualitative assessment is good Final judgement is left to expertise and experience of evaluators Process measurement Faculty/school to provide evidence to support their claims Scoring system as proposed is good Standards don't leave much room for differentiation – schools/faculties to suggest additional standards in line with their unique features Overlap amongst standards Sometimes difficult to differentiate among three levels

6.3.2 Discussion

The focus group interview served well as a triangulation, as the aspects mentioned by the individual interviewees were touched upon again, and the ideas and perceptions of the focus group interviewees corresponded with what was found in the individual interviews. Much time was spent on discussions of the various points. The members of

the UET Sub-committee regarded the proposal as an important contribution to medical education in South Africa, and that underscores Moore's (1987:16) view that if a study is aimed at solving a problem of a particular group, the group will be more likely to accept the findings if they have been involved in the research. Although some participants voiced a few concerns, they all expressed support of the proposed guide.

i. Place and role of the proposed guide in the accreditation system

In the category of positive and supportive responses, it was felt that such a more structured process, based on a structured document would contribute to more objectivity in the accreditation process, and would in general be an improvement. That would be a major change from the current rather unstructured accreditation reviews. The proposal that schools/faculties must also have an opportunity to rate themselves in terms of the standards was welcomed, as that would give them ownership in the process, and involve them in the decisions regarding accreditation. Rating based on specific standards will render the process more equal and if the panel members can discuss their individual ratings and that of the faculty/school prior to the visit, it will enable them to compare the ratings and identify discrepancies or gaps, which will result in the panel being able to focus the visit much more carefully with a view to finding information to fill the gaps and clear up the discrepancies. In the words of a participant:

This will be an opportunity to find evidence to resolve disagreements. This therefore is a much more rigorous method, specifying the standards that have to be met, and checking that the evidence is available to verify the assessment.

A participant put these sentiments in words as follows:

According to this proposal, schools first have to rate themselves; second, panellists are asked to rate the schools individually before they get together for a consensus rating; third, the whole rating is based on a whole series of individual standards, not a vague, overall impression that we've been forming up until now. Then the purpose of the visit is focused on the evidence of the standards which might not be clear from the documentation/ electronic evidence received, resolving discrepancies between the self-assessment and the panel's findings.

Another participant summarised the opinions of the participants as follows:

We think this is useful; good for consistency and comparability in the accreditation process.

The participants expressed some concerns about the proposed guide too. The first had to do with the possibility of differentiating amongst institutions. Although the intention with the proposed standards is exactly that, to leave room for differentiation amongst institutions, and the point of departure in the proposed guide is that schools/faculties should be evaluated in terms of their missions, one participant felt that this should be made clear. The concern was worded as follows:

Shouldn't faculties be invited to suggest standards that will highlight their uniqueness? The standards don't leave much room for differentiation, and I wondered, if faculties can suggest standards that would be in line with their own mission or goal, with their unique features, and that might also cause them to modify some of the other standards; to give an example, how they view basic sciences, and they may feel that's justified on the basis of their mission; some are going for competent primary care practitioners, so they teach basic sciences that's needed for primary care practitioners; others may put emphasis on research, they may want to train scientists or researchers, and would like their students to have a much stronger foundation in the basic sciences. I think the standards as they are currently phrased, don't leave much space for that. Thus I think that the document that goes out must invite schools/faculties to emphasise their uniqueness.

It was also stated during the interview that some standards may need to be reconsidered, but when asked which standards and what would be recommended, the participants replied that it "would require more thinking to perhaps understand it better".

The participants answered their own question as to what would be the final deciding factor when it comes to a decision about accreditation, by stating that it is clear from the proposed guide that the final decision will rest with the accreditation panel's recommendation – the members' experience and professional judgement will clinch matters. The participants all seemed to be in agreement that this would suffice, as the decision would be based on the self-assessment of the faculty/school, the assessments of individual members, and then finally, a joint decision by the panel members, based on the set standards.

The overriding sentiment thus was that the participants held the view that the proposed guide would play a meaningful role in giving structure to the accreditation process, thereby rendering it more objective and acceptable, and less threatening to schools/faculties.

ii. Suitability of proposed guide for medical schools/faculties in preparation for accreditation and planning

Once again, the responses were very positive. The sentiment was expressed that the proposed guide would be an excellent tool for schools/faculties to use in their planning processes, as well as in preparation for accreditation, as the two aspects go hand in hand, and the first actually only is an underpinning of the second. In the participants' opinion the proposed guide can be put to use for self-assessments and for quality improvement; it might start an effective development process in schools/ faculties. As the idea of quality assurance rests heavily on self-assessment, this is regarded as an important strength of the proposed guide: if accepted and used, it will compel institutions to start evaluating themselves. But apart from that, it will help institutions to prepare better for the external reviews, as they will know what to prepare for, and they will first assess themselves in terms of the standards that will be used in the external assessment. That will eliminate the 'fear factor' concerning accreditation reviews. A participant that felt strongly about this, put it this way:

I think people feared the judgement, they didn't realise we wanted to assist; now the fear factor will be eliminated – they will know what to expect; this is much gentler, less judgemental.

In supporting the proposed guide, the opinion was voiced that it would make staff in schools/faculties aware of important aspects of medical education. As a participant said:

This should be a working document in all schools; it should be used in planning, making the people aware of the importance of these educational principles, of the importance of the things taken up in the standards. Too many educators out there don't know these things – the time is ripe now to educate them, and this is a good way to do so.

Another opinion expressed in the interview was that the guide would counter the perception that the only measure for quality lies in a school's/faculty's pass rate. In accreditation there are numerous process measures, but the general view is that people don't mind what institutions do or how they do it, as long as the students pass. That is a perception that needs to be changed: in the current higher education situation, with demands for equal opportunities and a changed student population, there needs to be a strong focus on the educational processes in institutions – and this proposed guide will facilitate that.

The participants expressed the hope that by using the proposed guide, schools/faculties would satisfy the requirements of the Higher Education Quality Committee (HEQC) too. This would be a bonus – in the participant's own words:

The HEQC said they would not bother if they are satisfied with the internal quality assurance process. My hope with this is that a faculty can go through an assessment along these lines, meet all the requirements, and then it will simply need to hand over to the central university the results and say, 'Here it is guys, we've done it'.

Only one concern was raised on this theme, namely that the proposed system and guide would bring along a big change, and that the UET should make sure that it be accepted. The participant who raised this, summarised the sentiment as follows:

I am hearing that this is a good way to go, also for individual faculties. What we should do, I think, is put this to a workshop, and get through it by the deans and the faculties. This is such a big change, we should get a buy-in.

To summarise, the overall feeling was that the proposed guide would support and facilitate planning in schools/faculties, promote quality assurance, and help schools/faculties in preparing for accreditation reviews.

iii. Content of the proposed guide

The participants expressed the opinion that the standards and the proposed guide *per se* were excellent, good, and useful. This was due to the guide providing the required key performance areas that should be addressed in undergraduate medical education programmes, and the qualitative assessment proposed. Other strengths pointed out are the fact that the judgement will be elucidated by the explanations given in the rubrics, the process measurement that is advocated, and that the final judgement will be left to the experience and expertise of the panel, but based on laid down criteria. Other strengths mentioned are that the faculty/school will have the opportunity to assess itself and then provide evidence to support its claims, and that no numerical scores come into play, but that the measurements will be of a qualitative nature. The latter opinion was put by a participant as follows:

I support the qualitative measure proposed, because I think it would be a very sensitive issue if we start giving points. I think a school would in some of the standards go for the highest levels. But for the remainder would remain at higher or minimum levels. As people get more comfortable with the system, we could move into the direction of points,

but it is a developmental process. We should give schools the opportunity to develop, to move to higher levels, and then our process can develop too, perhaps into the direction of giving numerical scores for some standards. But not to start with; we don't want to make it difficult for schools; we don't know how panels will look at this; people can be very hard in their judgement of others.

Another strength mentioned is that the guide emphasises the importance of educational principles and innovation in education – this guide would 'educate' teachers in this regard.

In the second category, that of concerns or cautions, it was mentioned that the standards as proposed didn't leave much room for differentiation and that schools should have the opportunity to suggest additional standards in line with their unique features. When the researcher explained that the first standard, namely that the faculty/school should state its mission, should guide the panel in its assessment, the panel agreed that that alleviated the concern, but that it should be made clear that the assessments should take place with due consideration of an institution's mission. A paragraph to that effect was added to the guide (see Chapter 7: *A guide for accreditation reviews, Executive summary*). Other concerns mentioned were that some members felt there was an overlap amongst some standards, and that it was in some cases difficult to differentiate amongst the three levels. The researcher explained that what could be regarded as overlaps, was due to some standards being approached from different perspectives in the different categories of standards, and the way in which the three levels (minimum, higher and highest) were constructed was explained too. The explanations seemed to smooth over the concerns, but the participants requested that the explanations be taken up in the guide, which was done (see Chapter 7, *A guide for accreditation reviews*).

A participant expressed the opinion that a quantitative measurement would perhaps have been a more valid assessment, but agreed that the qualitative analysis perhaps is better for the current situation. This participant was supported by all; as one participant put it:

I think your point which I agree with is that our decision should not only be what might be best science or the best method, but what would be politically appropriate. We actually have some new educational systems; we know we have schools which vary in approach, they're not all the same, some have better end results, some have been around longer

and have not changed with times; others may be newer, but have changed with the times. We've got to win acceptance, and that will be influenced by the methods we use, even if it is not simply the best method. We should be careful of sensitivity.

To summarise, it may be stated that the focus group interview suggested support of and enthusiasm for the proposed guide. The concerns and cautions expressed were noted, and taken into consideration in the final drafting of the proposed guide for accreditation reviews. Most encouraging was the way in which the findings of the focus group interview in general supported and underscored the findings of the individual interviews, although some other points for consideration were raised too.

6.4 DISCUSSION OF DATA ANALYSIS AND INTERPRETATION

This part of the study was aimed at determining the ideas and perceptions of the participants regarding the phenomenon of study, namely the accreditation of undergraduate medical education in South Africa, to gauge their views on the proposed guide for accreditation reviews, and to provide them an opportunity to make inputs to the content. The findings of the individual interviews clearly indicated a certain degree of discontent with the current accreditation process, and the participants all supported the idea of the proposed guide, as in their opinion it would rectify the deficiencies which currently hampered the process. During the focus group interview, specific deficiencies were not pointed out as was the case during the individual interviews, but the changes that the proposed guide would bring with it were supported with the same enthusiasm as in the individual interviews, albeit without stating that they regarded the current process as deficient or not effective.

Overall the following came to the fore during the data analysis: With regard to the suitability or role and value of the proposed guide the participants were positive and supportive, and actually very enthusiastic at the prospect of the value this guide might hold for the accreditation process in general, and in medical schools/faculties for planning for improvement and accreditation reviews (this finding underscores Kohler's [2003:322] opinion). This can be ascribed to the proposed guide's potential to give direction to the process, to render the process more structured, and the fact that the prior identification of deficiencies would lead to a more focused process. The set of standards was described as relevant, complete and applicable, a guideline for matters that need to be addressed in medical education. The unanimous feeling was that the

guide would start an effective development process in medical schools/faculties. For purposes of the accreditation review process the proposed guide was seen as having the potential to bring about comparability in the reviews; it contains clear criteria to be used as measurements, and will not leave room for individual panel members' personal perspectives to bias the process. This finding that specific mechanisms, and clearly spelt out policies, procedures and processes are required for quality assurance in education is underscored by literature (*cf.* CHEA 2000; Harvey & Green 1993:19; HEQC 1996:40).

An outstanding finding is that the participants agreed that this proposed system would result in more objectivity in accreditation reviews. This is an important finding as there was a strong feeling amongst the participants in the individual interviews that the current process was not objective. The high premium the participants put on objectivity in accreditation evaluations is in line with what was found in this regard in literature (*cf.* GMC 2004b:1-4; Stella 2004:117).

The idea that the guide should be used by all involved in the education and training of medical students was strongly emphasised – this would eliminate the need to do last minute preparations for accreditation reviews, which sometimes tend to end up in 'window-dressing' – in literature this view is supported by Kohler (2003:322) who makes it clear that quality assurance tools should not only be used for evaluation, but should be used continually from the onset of the programme. According to the participants in this study the proposed guide will assist schools/faculties in preparation, and in the self-evaluation process; the fact that schools/faculties will have the opportunity to evaluate themselves in terms of the same criteria as the panel would use, would render the process more fair, valid and reliable, and provide an opportunity for the institutions to compare their view of the quality of their education with that of the accreditation review panel, thus identifying any misconceptions that might have existed. This finding is supported by what was found in literature regarding the use of rubrics (*cf.* Rubrics.com 2001:1); and also in the Baldrige National Quality Program (2001; 2002), COHSASA (s.a.) process, and the QABME process in the UK (GMC 2004).

The participants also stressed the importance of clear communication between the accrediting body and the institutions offering the medical education programmes – institutions need to be kept informed officially by the accrediting body. This finding is in line with what is said in literature (*cf.* GMC 2004:4-5).

To educate is a science – the importance of sound educational principles in achieving success in medical education and training is emphasised in the proposed guide, and this was appreciated by all participants, who expressed the opinion that too many teaching staff members and even accreditation review panel members are not well informed of educational principles and their impact on medical training, and innovations in education. The proposed guide would contribute to informing medical educators of important developments in education, and support the ability to respond to change. This finding is supported by the literature (*cf.* AMC 2002a:1; GMC 2004b:2-3; Trow 1999:29). Participants also pointed out the importance of divisions or units for medical education within medical faculties/schools and the role they play in the enhancement of quality (see 6.2.1.2: participants 2 and 6; 6.2.2.2: participant 1).

In the final analysis it was found that the proposed guide was generally regarded as a crucial document, 'long overdue', that it should be put to use as soon as possible, and that it would ensure that good educational principles be adhered to in medical education. It would render the accreditation reviews fully credible, removing the possibility of personal biases to enter, and providing schools/faculties the opportunity to participate in a meaningful way. This finding is supported by literature (CHEA 2000:5).

Cautions that were expressed included that the proposed guide might be regarded as too extensive, and it was recommended that a condensed version be prepared for general use and the complete document could be reserved for reference purposes. This will be addressed in the recommendations section of this report (8.4.1). The complexity of lecturing staff appointed on joint establishments and matters that fall under university policy, and how this would affect compliance with some standards were also mentioned as a concern, and in the same vein, the concern about the limitations placed on medical faculties/schools by provincial administration and university budgets. These are issues for which solutions cannot be found within the ambit of this study, but perhaps one participant (individual interviews, participant 6 – see 6.2.1.2), who stated that this proposed system might be used as a lever in negotiations with provincial administrations that would also wish for the medical education institutions in their provinces to be assessed favourably, has a valid point.

Another concern raised (6.2.1.2: participant 2), was that the proposed guide might be too 'aspirational' - failure should not be built in for some faculties/schools, especially those

with no or small medical education units. The recommendations of other participants may prove to hold the solution to this concern – at least two participants (6.2.1.2: participant 6 and 6.2.2.2: participant 1) recommended that all medical faculties/schools should have medical education units, and some other participants implied the same sentiments.

A caution expressed was that faculties/schools should not be compared – it would be dangerous if a competition factor came into play. The proposed guide, however, nowhere leaves room for ranking or comparing institutions. The problematic nature of measuring performance and of the measurability of standards was also mentioned, however, the researcher could point out that the criteria had been designed with that in mind – to provide a tool for measuring compliance with a standard (*cf.* Tierney & Simon 2004:1-2, who explain the use of rubrics and criteria to measure performance).

Concern was expressed that the panel members might not use the criteria in the guide, or might apply them in terms of their own views. It may be pointed out here that that is what is happening currently in accreditation assessments (according to the participants), and that the criteria and rubrics are meant as a step in the direction of eliminating exactly that.

The focus group participants pointed out that the proposed system would mean a big change in the accreditation system and that the Undergraduate Education and Training Sub-committee of the MDPB would need the deans to be in accord with it being implemented. They regarded the first standard about mission and goals as most important – faculties/schools should be evaluated in terms of their own mission and goals. The focus group was of the opinion that once a programme has been approved by Council (the HPCSA), it needs only prove that it is achieving its own mission and goals, and that the educational approaches and methods followed to do so are effective and in line with accepted norms. This would safeguard the uniqueness of programmes. This finding is in line with findings of the literature study, particularly as related in Chapter 2 (2.2.1) in the description of quality as fitness for purpose (also *cf.* GMC 2003; JUAA 1996; Kistan 1999; LCME 1995; Westerheijden *et al.* 1994).

The qualitative approach used in this study served the purpose well. The phenomenological exploratory approach allowed the researcher to test ideas generated

early in the research by means of participant observation and the literature study (the assumption). The methodology of interviews (individual and focus group) was used to obtain the views and perceptions of the participants on the phenomenon of quality assurance by means of accreditation in South African undergraduate medical education. The approach and methods used were found highly appropriate in this study to yield the required and relevant insights. The focus group interview proved pre-eminently useful for triangulation purposes and to help the researcher interpret the phenomenon as seen from the perspective of the participants, that is, the body responsible for the accreditation process. The findings of the study seem to endorse references in literature to the usefulness of criteria (AMC 2002; BNQP 2001; CHEA 2000; COHSASA s.a.) and self-assessment in efforts to improve quality (*cf.* LCME 2004; WFME 2003). Standards for quality assurance have been discussed widely in literature (see 1.3.2 & 3.2.1) and the findings of this study concur with the view expressed generally that clearly defined standards are crucial in constructing, implementing and evaluating an educational programme, and that standards for accreditation also serve as a guideline for institutions to maintain and improve performance (3.2.1). The opinion that most of the grievances regarding external reviews relate to inter-panel variance and subjectivity in peer reviews (Stella 2004:117), that team judgements might be perceived as undocumented and occasionally idiosyncratic (CHEA 2000:5), and that there are few mechanisms available to help panels arrive at collective assessment judgements (CHEA 2000:21) was shared by the participants in this study. The participants also endorsed in their opinions the view of Jackson (2000:29) that the judgements made in external assessments are usually based on experience and impressions, rather than on systematic and explicit information that would render the judgements more trustworthy and objective.

The findings of this study seem to have provided answers and solutions to the research questions posed in 1.4, namely

How can objectivity and comparability be assured in accreditation review visits when the panels visiting the different medical schools for each visit comprise different individuals as members? What is the actual basis the members use for making peer-based decisions about institutional performance? What mechanisms are available to help them arrive at a collective assessment of institutional strengths and weaknesses? How can it be assured that institutions strive for 'best practice'? How can the extent to which they achieve this striving be determined, and comparability and equality of standards in medical education be promoted?

The findings suggest that:

- Objectivity and comparability could be assured through the use of the proposed guide.
- The proposed guide could be used as basis for peer-based decisions about institutional performance.
- The proposed guide could be used as a mechanism to help panel members arrive at a collective assessment of institutional strengths and weaknesses.
- The proposed system and the guide would encourage and support institutions in their striving for best practice.
- The proposed guide would enable institutions and accreditation review panels to determine the extent to which they achieve this striving, and promote comparability and equality of standards in medical education.

The research problem that was addressed in this study was the lack of a review guide that might be used as a tool or mechanism for the assessment of medical education and training in the accreditation system for medical education programmes in South Africa (1.4). It is postulated that a solution was found to the problem investigated in this study: Based on the findings it may be assumed that the proposed system with the guide for accreditation reviews has the potential to satisfy the need for a mechanism or tool to be used as an assessment guide by the members of a review panel to generate a consistent set of judgements and ensure that they arrive at an objective and soundly based decision when they determine the extent to which an institution has achieved particular standards. Second, the need for an ongoing and systematic process to introduce best practice in institutions, to promote comparability and equality of standards, and to promote development and improvement in programmes could equally be addressed by using the proposed guide. Therefore, the assumption that a guide for accreditation reviews may provide a solution to the research problem can be accepted as proved correct.

6.5 RECOMMENDATIONS

The recommendations made by the participants have been dealt with in the discussion of the interviews, but the following recommendations deserve mention.

Regarding the implementation of the proposed guide the following recommendations were made by the majority of the participants:

- The document should become the official accreditation review document of the UET of the MDPB; working according to laid down principles and a more structured process will render accreditation reviews more effective and objective (see 6.2.1.2: all six participants; 6.2.2.2: all four participants; 6.3.2: general consensus in focus group).
- The use of the proposed guide in the planning and internal quality assurance processes of all medical schools/faculties should be recommended (6.2.1.2: all six participants; 6.2.2.2: all four participants; 6.3.2: the focus group participants agreed).
- The document should become a (an official) guideline for planning in undergraduate medical education – the UET should use it to make the importance of education in medical education clear (6.2.1.2: all six participants; 6.2.2.2: participants 1, 2, 4).
- The document should become an everyday working document of all staff in medical education; it will enhance planning for improvement and compel departments to do continuous evaluation of what they are doing (6.2.1.2: all six participants; 6.2.2.2: participant 2, 3, 4; 6.3.2: focus group).
- The UET should ensure that all medical schools/faculties be informed of the document; in general, the Board should devise means to ensure that its official documentation reach all schools/faculties, as well as all staff involved in medical education and training (6.2.1.2: participant 6; 6.2.2.2: participant 3).
- The portfolio should be implemented as soon as possible (6.2.1.2: participant 1, 2; 6.2.2.2: participant 2, 3, 4).
- The proposed system should be run for a trial cycle, amendments can then be made if required, and then it should be implemented as official (6.2.1.2: participant 4).
- The possibility of comparing faculties/schools should be eliminated (6.2.1.2: participants 3; 4; 6.3.2: focus group).
- Excellence in teaching must be rewarded/lack of educational expertise in trainers must be addressed (6.2.1.2: participants 5 & 6; 6.2.2.2: participants 1; 2, 3).

Regarding the content of the guide the following recommendations were made by participants (the number of participants making a specific recommendation is given in brackets; total number of participants in individual interviews = 10):

- A concise version of the guide should be made available (5) (6.2.1.2: participants 4 and 6; 6.2.2.2: participants 1, 3 and 4).
- Weights should be attached to the standards (2) (6.2.1.2 participant 6; 6.2.2.2: participant 3).
- Numerical scales should be used to indicate the level of compliance with the standards (2) (6.2.1.2: participant 6; 6.2.2.2: participant 3).
- Numerical weights should not be used to indicate levels of compliance (2) (6.2.1.2: participant 4; 6.3.2: focus group).
- The maximum number of minimum levels allowed should be stated (2) (6.2.1.2: participants 4, 6).
- The guide should be made available in attractive format, for example, a printed booklet (2) (6.2.2.2: participants 3 and 4).
- The different categories in the guide should carry different weights, for example, the category on student support should carry more weight in an accreditation process than the one on student selection (2) (6.2.1.2: participant 6; 6.2.2.2: participant 3).
- Scales should be devised for the recommendations of the panel too (1) (6.2.2.2: participant 3).
- More examples of the types of proof an institution can provide should be given in the guide; as well as definitions of terms and how to measure compliance with a standard (2) (6.2.1.2: participants 2 and 3).
- Faculties/schools must be provided the opportunity to suggest standards in accordance with their uniqueness (6.3.2: focus group).

6.7 CONCLUSION

The findings of the study succeeded in answering the research questions and it is postulated that the research problem has been solved successfully in that the assumption that a guide for accreditation would provide a solution, was proved to be acceptable. The study identified the need for amendments to the current accreditation system for undergraduate medical education, and the findings as discussed in this chapter suggest that the guide for accreditation reviews that had been devised might succeed in attending to needs with regard to a more structured and objective review, and that it will also support schools/faculties in their planning processes and in preparing for accreditation. The proposed guide, according to participants, also has the potential

to play a vital role in supporting the striving for improvement, in developing an awareness of the importance of educational principles and methods, and in bringing about change and innovation in medical education.

Finally the findings of the study suggest that medical educators are aware of the importance of ensuring quality in medical education, and are ready and willing to embark on a more rigorous but standardised process of quality assurance.

CHAPTER 7

FINAL OUTCOME OF THE STUDY: A GUIDE FOR ACCREDITATION REVIEWS

Now ... traditional informal academic self-regulation – which for centuries was held to be sufficient in guaranteeing quality – has been replaced by explicit quality assurance mechanisms and related reporting and external accountability procedures (van Damme 2000:100).

7.1 INTRODUCTION

In this chapter the final outcome of the study, namely a proposed guide for the accreditation of undergraduate medical education programmes in South Africa, will be given. Before that is done, however, the changes to the draft guide, as recommended by the interview participants, are listed. These recommendations were taken up in the guide as given in 7.2.

- A table of contents should be added (6.2.1.2: participant 6).
- It should be stated explicitly that undergraduate medical education programmes will be assessed for accreditation with due consideration of the mission of the faculty/school concerned. That would ensure that the uniqueness of programmes be acknowledged and that they receive recognition for their own particular strengths and characteristics within the context of their missions. This will prevent efforts to 'cast all programmes in the same mould', without detracting from the efforts to ensure quality education (6.2.1.2: participant 5; 6.3.2: focus group).
- 'Medical school' should be replaced with 'medical faculty/school' or else reference should be made to the medical education 'programme', as some departments that give input to medical education programmes are not part of the medical school in some institutions, and in other institutions no medical school exists, only a faculty of medicine, comprising different departments (6.2.1.2: participant 1; 6.3.2: focus group).
- A note should be added to explain the difference between the three levels (6.3.2: focus group).
- It should be made clear that the use of the guide does not lend itself to quantification – there will not be a counting of levels achieved; the final

judgement will still rest with the expert opinion of the panel, BUT now panel members will have to apply the same measures in their assessments, the same yardsticks will apply (6.2.1.2: participant 3; 6.3.2: focus group).

- Examples should be included of the types of proof that may be provided (6.2.1.2: participant 2). [Student feedback regarding the role models of staff, notes made by consultants during ward rounds, and reports on elective periods in private practices regarding student attitudes and behaviour, etc. have been added.]
- Standards 2.1 and 2.2 should be adapted to include criteria, rubrics and a rating scale for three levels (in the draft guide no criteria and only two levels were provided) (6.2.1.2: participants 1 & 4).
- A standard about training in health systems management and practice management should be included (6.2.1.2: participant 1). [Standard 2.18 has been added.]
- With regard to standard 2.1 (the NQF level descriptors) a higher level should be included. The minimum level would indicate that the programme takes cognisance of the level descriptors, whilst the higher level would indicate that the programme is successful in complying with the standards set in the level descriptors and can provide proof of its achievement in this regard (6.2.1.2: participant 1).
- In standard 3.8 (clinical skills) counselling procedures should be added (6.2.1.2: participant 6).
- Anaesthesiology should be added in standard 3.8 (6.2.1.2: participant 1).
- Some standards should be grouped together to eliminate overlapping (6.2.1.2: participants 1, 4, 5; 6.2.2.2: participants 1 & 3). [This was done in the case of the previous standards 3.7 and 3.8 – the criteria were incorporated to cover one standard, 3.8, and 3.7 was omitted. The same was done in standards 6.4 and 6.5 – some criteria of 6.5 were incorporated into 6.4, and 6.5 was taken out.]

In some instances minor changes have been made with regard to wording or formulation, as recommended by participants. These have not been listed here, but where feasible were incorporated in the guide.

7.2 FINAL OUTCOME OF THE STUDY

A GUIDE FOR ACCREDITATION REVIEWS

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A GUIDE FOR ACCREDITATION REVIEWS

To be used for internal and external quality assurance processes

EXECUTIVE SUMMARY

The primary aim of this guide for quality assurance* is to implement a review methodology that might minimise the institutional burden associated with accreditation processes, provide a tool to be used in quality enhancement exercises, and at the same time promote greater consistency and rigor in judgements about the performance of medical schools/faculties as part of the accreditation process.

The mechanisms used in the guide are:

The portfolio

The first part of the guide describes a portfolio that each medical faculty/school has to prepare, based on the standards for accreditation, to provide proof of the extent of the school's/faculty's compliance with the standards. It is recommended that the portfolio should be a computer-based document, with links to appropriate sites in the presentation.

The portfolio will comprise two parts:

- (i) An overview of and background information on the faculty/school, containing information and material providing a basic orientation to enable an accreditation panel to become familiar with the faculty/school and the education and training it offers.

* It must be noted that quality assurance in education does not intend an evaluation of the outcome or 'product' of the process, but a judgement of the processes and structures in place to ensure successful (efficient and effective) education and training.

- (ii) For each standard cited under ***Standards for the accreditation of undergraduate medical education in South Africa***, the faculty/school will need to indicate the extent to which it is satisfied, and provide a list of material (links) to substantiate the response. These links will be to policies, documents, instructional materials, data-bases, specially compiled responses, etc., but may also be references to materials not available electronically, which will be on exhibit during the site visit. The portfolio only needs to be updated regularly, especially with regard to quantitative data.

The portfolio compiled by the medical faculty/school will be submitted to the review panel well in advance (at least six weeks) of the actual accreditation site visit. The panel will study the portfolio (overview and background information, the completed standards rating guide and materials submitted/cited as evidence) before the visit takes place. The review panel members (individually) then will score the faculty/school on the basis of its (the school's/faculty's) rating and concomitant submission of materials. Individual panel members may rate the faculty/school on all the standards, or only on those in respect of which they feel competent to evaluate the school's/faculty's submission. During the accreditation review panel's meeting prior to the on-site visit, the discussion on how the visit will be conducted will be based on the individual member's findings on the school's/faculty's submission.

It must be noted that the accreditation panel will assess the programme with due consideration of the mission of the faculty/school concerned. That would ensure that the uniqueness of programmes be acknowledged and that they receive recognition for their own particular strengths and characteristics within the context of their missions. This will prevent efforts to 'cast all programmes in the same mould', without detracting from the efforts to ensure quality education.

Standards

This part of the guide contains a set of standards in terms of which the faculty/school has to measure its achievement. The same set of standards will be used by the visiting (review) panel of the HPCSA in verifying the portfolio to determine the extent to which the standards contained here, have been satisfied. Each standard is followed by a brief description of elements to be addressed to demonstrate the school's/faculty's compliance with the specific standard, including examples of the specific kinds of evidence that might be sought in the portfolio and/or during the site visit.

The set of standards is intended to enable the faculty/school to measure, analyse and reflect on its achievement. The standards are evaluative tools that enable both the faculty/school and the accreditation review panel of the HPCSA to determine the extent of achievement.

The guide will give more structure to the self-assessment (internal quality assurance) and the peer review conducted by the accreditation review panel (external quality assurance), which are the main components of the accreditation process. It will strengthen the review panels' decision-making and deliberations; will render peer judgements more objective, reliable and valid, and will bring about comparability in the assessments. It will also promote equality of standards in medical education in South African medical schools, as it will enable review panels to generate consistent judgements in terms of specified standards, which ought to be a particular priority in an assessment process aimed at ensuring quality and promoting development across the board of South African undergraduate medical education and training programmes. In the internal quality assurance processes of medical schools this guide will facilitate preparations for the external review, and serve as a sound point of departure for planning and developmental actions to improve quality.

Rubrics with rating scales

Each standard is provided with a set of rubrics and a rating scale for the faculty/school (for self-evaluation purposes) and an accreditation review panel (external evaluation) to capture the extent to which the standard has been achieved. Using the school's/faculty's portfolio and the specific evidence (materials) cited and/or provided, the accreditation reviewers will rate the faculty/school on each standard individually as a basis for structuring a panel discussion of the school's/faculty's submission. Panel members will be able to indicate the extent to which the faculty/school has succeeded in achieving the standard by making use of the rubric. They will also be allowed to indicate *Unable to judge*, or *Not achieved at all*, and to comment on the achievement of the standard.

With regard to the development of the levels, the first level, generally, will require of a faculty/school to prove that it has taken cognisance of the standard in that there is something in writing on the particular standard and that it is striving to comply with it. To achieve a higher level, there must be evidence of compliance, and at the highest level, a

faculty/school must provide proof of achieving the standard and going beyond – that it may be regarded as a centre of excellence in that particular aspect of education and training.

It must be pointed out here that no quantification of ratings will take place with a view to making a final judgement regarding accreditation of a programme – that will rest with the expertise and experience of the panel, based on the ratings in the standards document. The main aim of the rubrics and level ratings is to enable a faculty/school and the panel to compare their respective assessments, and for the panel to compare the individual assessments of the members. The rubrics serve the purpose of explaining why a faculty/school has been found to have achieved a specific level with regard to a particular standard. Furthermore, the rubrics should serve as guideline in efforts for improvement.

A

THE PORTFOLIO

The purpose of the portfolio is to provide the medical faculty/school under accreditation review an efficient method to communicate evidence of the extent to which it meets standards. The portfolio represents an effort to ground the entire review (or as much as possible of it) on a web-based presentation, structured around the set standards.

The portfolio comprises two parts:

- (i) An overview of and background information on the faculty/school, containing information and material providing a basic orientation to enable the accreditation panel to become familiar with the faculty/school and the education and training it offers in its undergraduate medical programme.
- (ii) For each standard the faculty/school needs to indicate the extent to which it is satisfied, and provide a list of materials (links and/or actual documents to be available for scrutiny during the on-site visit of the panel) to substantiate the response. The links will be to policies, documents, instructional materials, databases, specially compiled responses, etc., but may also be references to materials not available electronically, which will be on exhibit during the visit. The portfolio should be updated regularly, especially with regard to quantitative data.

The portfolio should be presented electronically as far as feasible to decrease the amount of paper usually involved in accreditation review visits (with the concomitant costs), and to facilitate regular updating of information.

With regard to each standard in the set of standards to be addressed the portfolio will contain evidence in the form of a curriculum document describing the undergraduate medical education curriculum, policy certification (where applicable), data demonstrating institutional capacity and performance (for example, information on funding, student pass rates, numbers of staff and students, research output, etc.), evidence of quality assurance activities, and samples of student work, materials students receive, assessments, etc. The intent of these exhibits is to demonstrate the degree of compliance with the specific standard.

Having said this, it is self-evident that the portfolio should be structured around the

standards, that is, evidence included in the portfolio should be developed and presented under each standard. The key to the standards approach to quality assurance is to capture the spirit of each standard, then organise the evidence or proof of the extent to which the standard is achieved around different elements included in the standard.

The set of standards with rubrics in terms of which compliance will be measured, will be made available as a web-based document to enable medical schools/faculties to incorporate it in their ongoing quality assurance processes. It must be made clear here that the intention is not to demand of schools/faculties to compile a portfolio immediately prior to each accreditation review visit; rather, the portfolio should be part of the school's/faculty's planning and quality assurance procedures and should be kept updated as the faculty/school progresses to higher levels of achievement. Prior to the accreditation review visit the review panel then will be given access to the portfolio with the required links to enable the panel members to 'visit' the faculty/school electronically in preparation of the actual on-site visit.

The accreditation review panel members will then rate each faculty/school in terms of the standards, and use the individual results to structure their discussions. During the actual visit to the faculty/school, the panel will verify the school's/faculty's responses (self-evaluation and portfolio). To be able to do this, panel members will scrutinise materials, have discussions with individuals and groups concerned, attend meetings, classes, clinical sessions, etc., and inspect facilities, as they may deem necessary, and again use the set of standards to arrive at a joint conclusion about the degree of compliance with the standards, and other matters which may need attention. The panel will then draw up a draft evaluation report on the school's/faculty's performance, and submit this to the faculty/school for comment. A final report will be compiled once the faculty/school has responded to the draft report, and this will be submitted to the Medical and Dental Professions Board, that will make a decision regarding accreditation of the undergraduate medical education programme the faculty/school offers.

Quality is a dynamic and evolving concept, and as the medical schools/faculties in South Africa reach higher levels of compliance with the set standards, the accreditation body will adapt the standards to incorporate more examples of best practice, thus always ensuring that schools/faculties will not be satisfied to have achieved minimal standards, but will strive to be exemplars of best practice and beyond, setting new standards to be achieved.

B

STANDARDS WITH RUBRICS AND RATING SCALES FOR THE ACCREDITATION OF UNDERGRADUATE MEDICAL EDUCATION IN SOUTH AFRICA

The set of standards* is recommended for use for the purposes of self-evaluation and external reviews in the accreditation process of undergraduate medical education and training in South Africa. Standards are supplemented by rubrics with criteria, describing three levels of attainment:

- Minimum level: It is expected of medical schools/faculties in their undergraduate programmes to meet all standards at least at a minimum level from the outset, and demonstrate their achievement of the criteria during the external review; schools/faculties should demonstrate that they are aware of the higher level criteria, and are striving to satisfy them.
- Higher level: This level includes the attributes of the minimum level. To be evaluated as achieving a higher level, schools/faculties must satisfy these criteria. They should be able to demonstrate that they are complying with most of the attributes of the standard, and that they are aware of the attributes at the highest level of the standard as being important as part of best practice in medical education.
- Highest level: The attributes (criteria) indicated in the rubrics as at the highest level are currently being regarded as best practice in medical education and training, and medical schools/faculties in their undergraduate programmes should strive to attain standards at this level.

It must be noted here that although the undergraduate medical education and training **programmes** of medical schools/faculties are accredited, in the set of standards and the rubrics reference sometimes is made to the **faculty/school** offering the programme,

* These standards have been derived from a set of standards developed in a previous study by the researcher (*cf.* Bezuidenhout 2002), and adapted for use in this study. The standards and concomitant criteria have been augmented, corroborated and verified by means of a literature control, using the literature cited under *Sources consulted*.

because, in the final analysis, it is the faculty/school that is responsible for the programme that has to ensure that the standards are achieved and maintained.

USING THE STANDARDS

This part of the guide contains the set of standards to be used by schools/faculties in their quality assurance activities and planning, and for preparing for an accreditation visit, and it will be used by the visiting panels (accreditation review panels) of the accrediting body. Each standard is followed by a rubric, providing a description of different elements to be addressed (criteria) to demonstrate the school's/faculty's performance with regard to the specific standard, including some of the specific kinds of evidence that might be sought in the portfolio and/or during the site visit of the accreditation review panel.

The standards are categorised into nine areas, and the rubrics are divided into three levels of achievement, namely **MINIMUM LEVEL, HIGHER LEVEL AND HIGHEST LEVEL**. Higher level ratings will always include the attributes provided in the rubrics at lower level(s).

Each standard is provided with a description of the essence or focus of the standard, a rating scale for a reviewer (in the faculty/school, and accreditation review panel) to capture the extent to which the standard is being achieved (indicating a specific level), to indicate if the standard is not achieved at all, and an opportunity for the evaluator to comment on the achievement of the standard. Using the school's/faculty's portfolio (including the standards ratings) and the evidence (materials) cited and/or provided, the accreditation reviewers will rate the faculty/school/programme on each standard on the basis of the attributes (criteria) indicated in the rubrics as indicators of performance at each level. The rating will be done individually by the members of the accreditation review panel to serve as a basis for structuring a panel discussion of the school's/faculty's submission. **Higher level ratings will always include the attributes provided in the rubrics at lower level(s).** Panel members will also be allowed to indicate *Unable to judge*, or *Not achieved at all*, and to comment on the achievement of the standard at a specific level.

STANDARDS, RUBRICS AND RATING SCALES FOR EVALUATIONS WITH A VIEW TO THE ACCREDITATION OF UNDERGRADUATE MEDICAL EDUCATION IN SOUTH AFRICA

1. VISION, MISSION, OBJECTIVES AND OUTCOMES

1.1 The medical faculty/school has a clearly defined vision, mission, goal and objectives, stating its aim and purpose, and the overall outcomes of the undergraduate medical education and training programme it offers.

The medical faculty/school must provide a copy of the written vision, mission, goal and objectives of the faculty/school. The essence of the standard lies in the extent to which the mission, goal, and objectives of the faculty/school are stated explicitly, and are made known to all relevant parties. The mission will provide the context within which the programme will be evaluated.

<p>At a minimum, this standard requires a written statement of the mission, goal and objectives of the faculty/school, and evidence that these are made known to all relevant parties, i.e. parents, students and prospective students, staff, the parent institution and the professional bodies involved.</p>	<p>At a higher score level, the objectives are translated into expected outcomes of the medical education programme the faculty/school offers, explicitly stating final outcomes in terms of knowledge, skills and attitudes/behaviour patterns. Expected outcomes are directly linked to and underscore the mission, goal and objectives of the faculty/school and the institution.</p>	<p>To meet the highest score level, the faculty/school has a mission and vision statement, describing the goal, objectives and educational outcomes of the medical education programme it offers. These statements must be clear and published, be supported by proof of attainment, and must reflect a striving to satisfy the general expectations of the professional body, and the South African health care and education systems. The statements will also indicate a certain uniqueness.</p>
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ATTAINED AT: MINIMUM LEVEL **HIGHER LEVEL** **HIGHEST LEVEL**

Not achieved at all

Unable to judge

COMMENTS:

- 1.2 The medical faculty/school regularly reviews its vision, mission and objectives and the stated outcomes of its programme in consultation with its major stakeholders and the regulatory authority, and with due consideration of demands and trends in health sciences and services, and higher education, in South Africa and elsewhere in the world.

The medical faculty/school must provide a statement on or copy of its policy regarding the review of the vision, mission, objectives and outcomes of its programme. The focus of this standard is on programme review as a continuing process, with input from the major stakeholders and the regulatory authority. Major stakeholders should include the dean, representatives of senior and junior faculty members and students, the community, medical and allied health care practitioners, education and health care authorities, professional organisations, and the professional and/or regulatory authority.

<p>At a minimum, attainment of the standard requires a statement regarding the review of the mission, objectives and outcomes of the medical education programme, describing appropriate professional and academic involvement (from the fields of education, medical sciences, clinical practice, etc.) from individuals attached to the faculty/school and/or university in the review process.</p>	<p>To achieve higher score levels the faculty/school in its programme review process has gone beyond its own personnel to involve appropriate expertise from the profession, allied professions, other academic institutions, relevant employment or professional bodies, and health care sectors. Evidence could include written inputs from stakeholders involved; minutes of discussions involving stakeholders.</p>	<p>At the highest score levels the faculty/school reviews its medical education programme on a regular basis, extensively drawing on inside and outside expertise (national and international), to satisfy changing health care needs in the country and to align its programme with international trends and standards. Evidence will include a review schedule, with proof of external inputs.</p>
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ATTAINED AT: MINIMUM LEVEL **HIGHER LEVEL** **HIGHEST LEVEL**

Not achieved at all

Unable to judge

COMMENTS:

1.3 The medical faculty/school is successful in achieving its goal and the stated outcomes of the programme, as submitted to and approved by the South African Qualifications Authority and the HPCSA for registration of the programme.

<p>The faculty/school must provide proof of achievement of its goal and the stated outcomes in the form of assessment reports and results of final year assessments. This standard focuses on quality assurance measures through which the achievement of the goal and outcomes of the programme can be monitored and judged. Appropriate professional and/or academic expertise is used in the development and review of methods used to determine whether the programme is achieving its goal and whether students are achieving the stated outcomes.</p>		
<p>At a minimum, attainment of this standard requires evidence that subject experts are involved in the assessment of students' achievement of the exit-level outcomes. The standard further requires that the methods used to determine student achievement be valid and reliable and that moderators are involved in preparing for and validating assessments. Evidence will include assessors'/ moderators' reports.</p>	<p>At higher levels proof must be provided of assessment methods being scrutinised and updated regularly through the involvement of persons with expertise and experience in assessment, to ensure valid and reliable assessments of students' performance. Subject and educational experts, both from within and outside the faculty/school are involved in developing assessment methods and tools, in assuring the quality of assessment methods and tools, and in the final assessment of student performance, proving achievement of the goal of the programme.</p>	<p>To attain the highest score levels verification of the school's/faculty's assessment records demonstrate that the attainment of the goal and outcomes is achieved consistently, and longitudinal studies provide proof of the subsequent success in professional performance of former graduates of the faculty/school.</p>

ATTAINED AT: MINIMUM LEVEL HIGHER LEVEL HIGHEST LEVEL

Not achieved at all

Unable to judge

COMMENTS:

1.4 The medical faculty/school is successful in addressing the recommendations set out in the Guidelines for Undergraduate Medical Education and Training (HPCSA 1999: 9-13; 15-16).

<p>The document of the faculty/school containing its mission and goal and the stated outcomes of the programme must bear proof of being based on the guidelines/recommendations of the HPCSA, and must define the competencies of students to be acquired by graduation. These competencies are described under the objectives of medical education and training in the <i>Guidelines by the Medical and Dental Professions Board for the Education and training of doctors in South Africa</i> (HPCSA 1999).</p>		
<p>At a minimum this requires of the school/faculty to demonstrate its striving to satisfy the requirements and expectations with regard to the core characteristics and qualities required of a basic doctor, set out in the <i>Profile of the doctor</i> (HPCSA 1999). Evidence is contained in documentation made available to students and staff containing information on the core characteristics of the basic doctor.</p>	<p>To attain higher score levels, the mission, goal and stated outcomes of the programme are made known to students in student guides, manuals, module guides, etc. and the desired characteristics and qualities students are expected to demonstrate on graduation, are explicitly stated, and inculcated in students throughout the programme. Proof is found in the outcomes of modules stating which competencies, characteristics and qualities need to be demonstrated.</p>	<p>To attain the highest score levels, evidence is provided that the assessment of student performance explicitly includes direct or authentic demonstration of the characteristics, qualities and competencies described under knowledge objectives, skills objectives and attitudinal objectives (HPCSA 1999:6-8) required of students, as well as a demonstration of the unique characteristics expected of the graduates of the programme.</p>

ATTAINED AT: MINIMUM LEVEL HIGHER LEVEL HIGHEST LEVEL

Not achieved at all

Unable to judge

COMMENTS:

2. CURRICULUM DESIGN, CONTENT AND ORGANISATION

2.1 The undergraduate medical education programme of the faculty/school satisfies the standards of the National Qualifications Framework level at which the programme is registered (*cf.* Level descriptors of the NQF).

The essence of this standard lies in the faculty/school providing evidence that the programme satisfies the criteria and parameters for qualifications at level 7 of the NQF, the level at which professional baccalaureate programmes are registered. Programmes registered at level 7 are required to deliver students with the competencies listed.

*** Typically a learning programme leading to the award of a qualification at this level should develop learners who demonstrate:**

Applied competence:

- a. a well-rounded and systematic knowledge base in one or more disciplines/fields and a detailed knowledge of some specialist areas;
- b. a coherent and critical understanding of one or more discipline/field's terms, rules, concepts, principles and theories;
- c. effective selection and application of the essential procedures, operations and techniques of a discipline/field; and understanding of the central methods of enquiry and research in a discipline/field; a knowledge of at least one other discipline/field's mode of enquiry;
- d. an ability to deal with unfamiliar concrete and abstract problems and issues using evidence-based solutions and theory-driven arguments;
- e. well-developed information retrieval skills; critical analysis and synthesis of quantitative and/or qualitative data; presentation skills following prescribed formats, using IT skills appropriately;
- f. an ability to present and communicate information and own ideas and opinions in well-structured arguments, showing an awareness of audience and using academic/professional discourse appropriately.

Autonomy of learning:

- g. a capacity to operate in variable and unfamiliar learning contexts, requiring responsibility and initiative;
- h. a capacity to accurately self-evaluate and identify and address own learning needs;
- i. an ability to interact effectively in a learning group.

* Source: Ministry of Education, RSA 2004. *The Higher Education Qualifications Framework (Draft)*.

At a minimum the level descriptors of NQF level 7 are made known to staff and are incorporated in the curriculum document.	At a higher level, the level descriptors are teased out to indicate in which phase/part of the programme they are specifically attended to, and are taken cognisance of in the development of modules. This is evidenced in the outcomes of modules concerned.	At the highest level attainment of the expectations of the level descriptors are clearly evidenced in assessments of student performance.
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ATTAINED AT: MINIMUM LEVEL **HIGHER LEVEL** **HIGHEST LEVEL**

Not achieved at all

Unable to judge

COMMENTS:

- 2.2 The duration of the undergraduate medical programme is at least five years (of 32 weeks in the first year, 36 weeks in subsequent years), as recommended by the HPCSA. Where the medical curriculum is a post-graduate course, applicable undergraduate studies are given recognition.

The faculty/school must provide a diagram of the structure of the medical education programme, depicting the number of study years, the academic weeks in each year, and the notional hours.		
This standard refers to the duration of an undergraduate medical education course. The requirements of the HPCSA in this regard apply as minimal standard, and deviations from this will be regarded seriously by the review panel, and must be motivated by the medical faculty/school in writing, e.g. in cases of post-graduate admissions to the undergraduate medical education programme and recognition of prior learning, these must be explained in detail if it results in students completing the medical education programme in less than the prescribed number of years. When the duration of the programme is elucidated, the number of credits (derived from notional studying hours) must be given and a description of the division of each academic year must be provided. The notional hours for the programme and the concomitant credits should be on a par with what is reasonably expected of similar programmes in medical schools/faculties in South Africa.		
At a minimum proof is provided that the duration of the academic programme satisfies the requirements of the HPCSA, and the curriculum document clearly explains the division of each academic year in terms of weeks of tuition and assessment times.	At a higher level proof is provided that the academic programme is adhered to, and times spent on direct student-staff contact, electives, self-study, work in the community, private practices, etc. are described.	At the highest level there is evidence that the time spent on the curriculum is sufficient to achieve the outcomes stated in the curriculum document. In cases where the duration of the programme exceeds the minimum duration as prescribed by the HPCSA, proof is provided that this enhances the quality of the programme and/or the unique features of the programme.

ATTAINED AT MINIMUM LEVEL **HIGHER LEVEL** **HIGHEST LEVEL**

Not achieved at all

Unable to judge

COMMENTS:

2.3 The curriculum is not overloaded with facts, but a core curriculum has been defined, emphasising the knowledge, skills and attitudes required to become a general practitioner.

<p>The emphasis in this standard is on topics/themes included in the compulsory part of the curriculum. A document containing the core curriculum must be provided, giving evidence that core knowledge is not regarded as inferior or scaled down knowledge, but essential knowledge. The mere retention and recall of factual knowledge should be countered by opportunities to inculcate the principles of scientific method and evidence-based medicine to replenish the core.</p>		
<p>At a minimum this standard requires documentary proof that the knowledge, skills and attitudes described in <i>Education and training of doctors in South Africa (4. Objectives of medical education and training)</i> are covered in the core curriculum. Curriculum documents bear evidence that specialist detail does not cause factual overload of the curriculum. Students have the opportunity to master the scientific method to enable them to find and process knowledge themselves.</p>	<p>At higher levels curriculum documents provide evidence of an understanding of the principles underlying the development of a core curriculum, taking into consideration that because the scope of medical knowledge is growing so fast and many aspects of practice are changing rapidly, the emphasis in basic medical education should be on the principles underlying medical science and on practice, rather than on the acquisition of detailed current knowledge or a comprehensive list of clinical skills. The curriculum ensures the mastering of the principles of the scientific method and evidence-based medicine to replenish the core.</p>	<p>At the highest score level, curriculum documents bear proof of an emphasis on the enhancement of students' analytical and critical thinking skills, demanding of students to develop life-long learning skills, including skills to practise evidence-based medicine, and providing them the opportunity to digest core factual knowledge in context (instead of promoting the regurgitation of facts), and to process knowledge from information.</p>

ATTAINED AT: MINIMUM LEVEL **HIGHER LEVEL** **HIGHEST LEVEL**

Not achieved at all

Unable to judge

COMMENTS:

2.4 The medical faculty/school through its curriculum addresses demands due to changing demographic and cultural contexts and the health needs of society.

<p>This standard concentrates on the extent to which the curriculum addresses health needs and takes cognisance of the demographics and cultural contexts of the country. The faculty/school should examine its offerings in the light of changes in the demographics and cultural background and development of society, and the changes in the health needs of communities.</p>		
<p>At a minimum this requires proof of periodic examination of the content of the programme in the light of current emphases and practices in health services to align the curriculum with the health policy of the country, and to address emerging needs.</p>	<p>To attain higher scores the faculty/school has developed a mechanism to recognise local and national needs, regularly benchmarks its offerings against best practices in this regard elsewhere, where relevant. Proof is provided that heed is taken of the needs of the immediate communities and the country in general. Relevance of the core curriculum is a key criterion and must be proved.</p>	<p>To attain the highest score levels the faculty/school must provide evidence that purposeful efforts are made to stay informed of changing demands and needs, and to address these in the curriculum as well as in research and service projects where students are involved. The extent to which the curriculum addresses local, regional and national health problems is made clear in curriculum documents.</p>

ATTAINED AT: MINIMUM LEVEL HIGHER LEVEL HIGHEST LEVEL

Not achieved at all

Unable to judge

COMMENTS:

- 2.5 The content and sequencing of the curriculum components, the core curriculum and optional/elective elements of the programme are described clearly.

<p>The essence of this standard lies in the extent to which the content of the curriculum components and their sequencing are stated clearly and made accessible. Documentation must be submitted/made accessible in which the core curriculum is explained in terms of the individual topics, intended outcomes, and assessment criteria. The choice of themes of which in-depth studies can be made as optional to the core curriculum is given in detail too. Sequencing of topics is stated clearly.</p>		
<p>At a minimum this requires a written curriculum plan, including content and intended outcomes for each stage of the curriculum - as part of the core curriculum, or as electives. The sequencing of the components is indicated.</p>	<p>At a higher level, content, outcomes and standards for assessment are well-elaborated in terms of attributes, competencies and skills to be attained during each stage of the programme. This is contained in a curriculum document, made available to staff and students, either in writing or electronically.</p>	<p>To meet the highest score level, statements describing the curriculum themes, topics, content and educational outcomes are published and understandable, indicate the core curriculum components clearly, as well as the optional/elective elements. To attract prospective students and inform them of the unique features of the programme, this information is published publicly.</p>

ATTAINED AT: MINIMUM LEVEL **HIGHER LEVEL** **HIGHEST LEVEL**

Not achieved at all

Unable to judge

COMMENTS:

2.6 The sequencing of the curriculum components promotes horizontal and vertical integration of contents, as well as the integration of basic and clinical disciplines.

<p>The essence of this standard is that student learning should occur in a structured and integrated curriculum, where the sequencing ensures that the outcomes with regard to knowledge and understanding, skills and attitudes at each stage of the programme will be achieved at the expected level. The curriculum document submitted must indicate the integration between theory and practice, and knowledge and skills.</p>		
<p>At a minimum the curriculum document bears evidence that the programme is sequenced to allow for an appropriate balance of theoretical, practical and experiential knowledge and skills training. It must be indicated how student learning is enhanced through integration from early in the programme by demonstrating the relationship between theoretical content and subsequent clinical training, and eventual medical practice. The sequencing of modules demonstrates contextualisation of learning content.</p>	<p>At a higher level the curriculum document bears proof that the clear divide between pre-clinical and clinical training has faded or has been eliminated. Vertical integration includes opportunities to revisit and further develop knowledge and skills covered in the earlier phases. Horizontal integration is encouraged through integrated course work and assessments, putting into context knowledge gained in various modules running concurrently, <i>inter alia</i> through the use of case studies and vignettes.</p>	<p>At the highest level the curriculum document indicates that the sequencing of the curriculum has a spiral development, allowing for vertical and horizontal integration, with conjoint clinical and basic science teaching, interdisciplinary seminars and problem-solving opportunities, and early clinical contact. Clinical training naturally builds on earlier theoretical and practical education and training, and includes reinforcement of the knowledge base.</p>

ATTAINED AT: MINIMUM LEVEL **HIGHER LEVEL** **HIGHEST LEVEL**

Not achieved at all

Unable to judge

COMMENTS:

2.7 The curriculum includes elective options/special study modules designed to supplement the required (core) curriculum elements and to provide opportunities for students to pursue individual academic interests.

<p>This standard focuses specifically on the extent to which opportunities are created for students to spend time on elective topics. Elective periods should grant students the opportunity to study certain areas in depth, or to experience the practice of medicine in other environments; however, this time also enables students to fill gaps in their knowledge or experience. Assessment of student learning achieved during elective periods is as rigorous, structured and well-planned as in the other components of the curriculum.</p>		
<p>A policy or document describing the faculty/school's approach to elective studies must be submitted. At a minimum, the school/ faculty must provide a statement regarding the time set aside for elective study. In the students' module guide/manual on the elective period(s) the time to be spent on elective study must be stated explicitly, as well as the outcomes for the learning experience, and information regarding the assessment of student learning during the elective period.</p>	<p>At a higher level, the faculty/school must provide evidence of clear guidelines for students for electives. Proof is provided that the learning taking place during elective periods contributes to the achievement of the outcomes of the curriculum and to the overall learning experience of students in general, that is, their achievements during this period must be taken into consideration in the assessments of their learning.</p>	<p>At the highest level, the faculty/school provides proof of ensuring that the core curriculum is meaningfully supplemented by the elective studies of students: any gaps that might exist in a student's knowledge and/or experience must be addressed in this time, the learning experiences gained are assessed rigorously; independent and self-directed study is enhanced through the concept of electives, as well as a critical approach to medicine which is questioning and self-critical.</p>

ATTAINED AT: MINIMUM LEVEL HIGHER LEVEL HIGHEST LEVEL

Not achieved at all

Unable to judge

COMMENTS:

2.8 The curriculum makes provision for training in and the application of research methods.

<p>The medical faculty/school must educate and train students in the principles of scientific method and evidence-based medicine. During elective periods, and/or in other components of the curriculum, the core curriculum should be replenished by special study modules (SSMs) which allow students to study topics in depth and which provide them with insight into the scientific method and discipline of research. The curriculum document submitted must contain an elucidation of the training students receive in the scientific method and evidence-based medicine.</p>		
<p>At a minimum the faculty/school must provide evidence of how the curriculum makes provision for the formal teaching of research methodology and projects in which students can put this to use to promote critical thinking and analytical skills development.</p>	<p>At a higher level evidence is provided that the curriculum makes provision for opportunities for students to learn bio-statistics and the critical appraisal of research methodology and medical literature. Teaching staff takes responsibility to facilitate the involvement of students in research.</p>	<p>At the highest level there is documented proof of an active research environment in the medical faculty/school which provides undergraduate students opportunities to observe and participate in on-going research programmes, either as mandatory part of their modules, or as elective components. A milieu is created in which curiosity and a spirit of inquiry are encouraged, and lifelong learning skills are enhanced, such as skills required for problem-solving, data analysis, updating knowledge, expanding the boundaries of knowledge, and a desire to find out for oneself.</p>

ATTAINED AT: MINIMUM LEVEL HIGHER LEVEL HIGHEST LEVEL

Not achieved at all

Unable to judge

COMMENTS:

- 2.9 The medical faculty/school has identified and incorporated in the curriculum the contributions of the basic medical sciences to create an understanding of the scientific knowledge, concepts and methods fundamental to acquiring and applying clinical science.

<p>This standard focuses on the identification of the basic medical sciences that contribute to the medical education programme, and the clear description of their contribution at the different stages of the curriculum. The curricular contributions of the various basic medical sciences to developments in the science, practice and delivery of health care must be indicated in the curriculum document submitted.</p>		
<p>At minimum levels, outcomes for basic medical sciences bear proof that students are gaining sufficient knowledge and understanding of basic sciences applicable to the practice of medicine. Basic medical sciences as taught are relevant to clinical application, and in line with what is expected in a core curriculum, emphasising content that ensures understanding of the scientific knowledge, concepts and methods of clinical science. This standard requires of a curriculum to make clear the role of basic medical sciences in the practice of medicine, and not to teach these as separate entities, unrelated to clinical medicine.</p>	<p>At higher score levels it is demonstrated in the curriculum document that basic medical science teaching is relevant to the overall outcomes of the programme, and the relevance is made apparent to students, requiring basic medical science learning programmes designed specifically for medical studies, and illustrating the applicability of principles learned to the understanding of human health and disease. In the more clinically oriented phases of the curriculum the basic sciences are revisited, and clinical cases or problems are used to ensure integration of basic sciences and clinical teaching.</p>	<p>At the highest score levels the curriculum documents demonstrate recognition of the fact that advances in medicine to a great extent depend on an understanding of basic mechanisms. Medically qualified teachers are involved in the teaching of basic medical sciences, and the curriculum offers opportunities for combined teaching sessions built around clinical problems to enforce basic concepts and highlight the relevance of basic sciences to clinical practice.</p>

ATTAINED AT: MINIMUM LEVEL **HIGHER LEVEL** **HIGHEST LEVEL**

Not achieved at all

Unable to judge

COMMENTS:

2.10 The medical faculty/school has identified and incorporated 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.

<p>This standard focuses on the contributions of the behavioural and social sciences, medical ethics and medical jurisprudence to the overall contents of the curriculum. The curriculum document must clearly indicate which of the behavioural and social sciences and disciplines of medical ethics and jurisprudence have been incorporated in the curriculum, at what stage of the curriculum they are presented, and in which way they are intended to foster effective communication, clinical decision-making and ethical practice.</p>		
<p>At a minimum behavioural and social sciences (typically including medical psychology, medical sociology, biostatistics and epidemiology, hygiene, community medicine, etc.) form part of the undergraduate curriculum. The curriculum document demonstrates how and where in the curriculum structure human development and aspects of psychology and sociology relevant to medicine, as well as medical ethics, human values and the legal aspects of medicine are incorporated as part of the core knowledge.</p>	<p>At a higher level the curriculum document provides proof that students are equipped to understand and acknowledge the impact of social, economic, cultural, demographic and behavioural factors on disease, both at individual and community levels, as well as the principles of ethical decision-making, and an awareness that law and ethical codes regulate professional practice.</p>	<p>At the highest level, documentation bears proof that the contributions of the behavioural and social sciences and medical ethics and jurisprudence are incorporated in the curriculum throughout the undergraduate programme, and provide the knowledge, concepts, methods, skills, and attitudes required to understand the role of socio-economic, demographic and cultural determinants in the cause, distribution and consequences of health problems, and an awareness that the prevention and treatment of disease should always encompass consideration of these determinants.</p>

ATTAINED AT: MINIMUM LEVEL HIGHER LEVEL HIGHEST LEVEL

Not achieved at all

Unable to judge

COMMENTS:

2.11 The curriculum is designed to prepare students to have a sound knowledge and understanding of health care, the promotion thereof and the prevention and management of disease.

<p>This standard focuses on the principles of disease prevention, health promotion and the management of disease, including therapeutic care/rehabilitation within the broader theme of population/public/community health. The curriculum document must clearly describe the outcomes in this regard.</p>		
<p>At a minimum the outcomes require of students a sound knowledge and understanding of health care, the promotion thereof and of the prevention and management of disease. For this purpose, knowledge is required of the normal structure, development, organisation and functions of the body, as well as of abnormal structure and function, that is, human diseases and pathological processes, and the body's defence mechanisms.</p>	<p>At a higher level the outcomes require knowledge of the promotion of health and prevention and management of disease and caring of the ill. This includes broad knowledge of genetic and environmental factors which determine disease and responses to illness, at molecular, cellular, organ and whole body level, as well as of the person as a whole and as an individual within the context of the family and the community.</p>	<p>At the highest level evidence is sought that students can demonstrate understanding of medical scientific principles, principles of health promotion and health education, therapeutic care and rehabilitation and population health/public health and community health care. This includes the capability of medical problem-solving and decision-making regarding population health/public health within the local demographic and cultural context.</p>

ATTAINED AT: MINIMUM LEVEL HIGHER LEVEL HIGHEST LEVEL

Not achieved at all

Unable to judge

COMMENTS:

2.12 The curriculum is designed to deliver graduate students who are proficient in basic clinical skills.

<p>In essence this standard refers to students' mastering of clinical skills and abilities, and the clinical training provided by the faculty/school. The curriculum document must clearly describe outcomes, as well as the learning experiences in this regard.</p>		
<p>At a minimum the curriculum outcomes bear evidence that students are trained proficiently in basic clinical skills, i.e. the ability to take an accurate history in a tactful and organised way, perform an accurate physical and mental state examination, interpret and integrate the findings of the history and physical examination, to make an appropriate diagnosis or differential diagnosis, to treat diseases; the ability to formulate a management plan, communicate clearly and considerately with patients and colleagues, and to counsel effectively in order to prevent illness and promote health.</p>	<p>At a higher level the curriculum bears evidence that clinical instruction covers all organ systems; clinical experiences in family medicine, internal medicine, obstetrics and gynaecology, surgery, paediatrics, and psychiatry are included. The outcomes ensure that students gain the ability to recognise serious illness and to perform common emergency and life-saving procedures.</p>	<p>At the highest level clinical instruction includes the important aspects of preventive, acute, chronic, continuing, rehabilitative, palliative and end-of-life care. Clinical experience in primary care is included, and both out-patient and hospital settings are utilised for training. Education and training to promote professional reasoning and problem-solving as part of clinical practice form an integral part of the curriculum from the early stages. Proof of this is provided in the stated outcomes and assessment documents.</p>

ATTAINED AT: MINIMUM LEVEL **HIGHER LEVEL** **HIGHEST LEVEL**

Not achieved at all

Unable to judge

COMMENTS:

- 2.13. The medical education curriculum makes provision for early patient contact, and the different components of skills training and involvement in patient care are structured according to the principles of an integrated curriculum, that is, integration of theory and practice, and basic and clinical sciences.

<p>The essence of this standard lies in the scope the curriculum offers students to acquire skills competencies and provide opportunities to master and practise these skills within the context of an integrated curriculum. Early patient contact must be the norm in all medical schools/faculties, in order to motivate students from the beginning of their medical studies, and to foster attitudes such as a desire to serve humanity and a community orientation, and to enhance communication and human relations skills.</p>		
<p>At a minimum the curriculum provides evidence of opportunities for students to master the skills required within the context of the theoretical teaching. *Generic and clinical skills training is facilitated by introducing students to communities, potential patients and patients during the early study years. The curriculum document spells out the outcomes with regard to the skills to be acquired.</p>	<p>At higher levels curriculum design makes provision for integration of theoretical teaching with generic and clinical skills training and relevant aspects of patient care. Patient contact takes place and practical, generic and clinical skills are practised in real life situations from the early years, concomitant with theoretical instruction to ensure maximum contextualisation. Proof of this is found in curriculum and assessment documents.</p>	<p>At the highest level curriculum documents bear evidence that students are trained in health promotion, disease prevention and patient care from the early years. Students have the opportunity to spend time in direct contact with patients to learn of the complex interplay of causative factors and other pathogenic processes, and of psychological and physical factors in patients. Patient care includes relevant communication, leadership and team work skills, as well as community work experience and team work with other health professions.</p>

*Generic skills refer to skills such as communication (written and oral) skills, time management, skills in using information technology, group work skills, finding, evaluating, analysing and using information, self-assertiveness, decision-making skills, problem-solving skills, etc.

ATTAINED AT: MINIMUM LEVEL HIGHER LEVEL HIGHEST LEVEL

Not achieved at all

Unable to judge

COMMENTS:

2.14 The curriculum is designed to provide a grounding in the body of knowledge represented in the disciplines that support fundamental clinical training, and must ensure that the graduating student is able to utilise diagnostic aids, and is well-informed with regard to advances in therapy and technology.

<p>The focus of this standard is on the effective and efficient application of diagnostic aids. The curriculum outcomes must cover knowledge and skills that support the fundamental clinical subjects, for example in diagnostic imaging and clinical pathology, as well as new technologies and therapy.</p>		
<p>At a minimum this demands of the curriculum to provide opportunities for training in the diagnostic disciplines and to gain knowledge and a clear understanding of the utilisation of special investigations, diagnostic aids, new technologies and therapies. This is explicitly described in the curriculum document.</p>	<p>At higher levels the curriculum document provides proof that the outcomes demand of students to master the knowledge and skills required for informed decision-making regarding the appropriate and cost-effective utilisation of special investigations, diagnostic procedures, relevant therapies and new technologies, as well as referral procedures.</p>	<p>At the highest levels outcomes require of students to demonstrate that they are competent in selecting the most appropriate diagnostic procedures, based on sound clinical decision-making. The outcomes require of students to have the ability to interpret and integrate history and physical examination findings to guide them in the decision-making process regarding diagnostic aids, special investigations, therapeutics and referrals.</p>

ATTAINED AT: MINIMUM LEVEL **HIGHER LEVEL** **HIGHEST LEVEL**

Not achieved at all

Unable to judge

COMMENTS:

2.15 Interdisciplinary co-operation between medicine and the other health care professions, as well as between health care and social welfare professions is encouraged in teaching, training and research to the advantage of the patient in rendering health services.

<p>This standard focuses on preparation for the professional role of the medical practitioner in communities and as member of the health care team. The curriculum must provide opportunities for students to acquire an awareness of their role in the health care and social welfare systems. Instruction in all the phases of the programme must stress the need for students to be concerned with the total health care needs of patients and the effects of social and cultural circumstances on their well-being and health.</p>		
<p>At a minimum, curriculum outcomes clearly demonstrate that students are made aware that their role as doctor will include working with other professionals and community groups in disease prevention and alleviation. From the early stages in the curriculum students are exposed to interdisciplinary co-operation in health care and social welfare.</p>	<p>At a higher level the curriculum document provides proof that students are being prepared for their role in addressing the medical consequences of common societal problems, for example, providing instruction in the diagnosis, prevention, reporting and treatment of violence and abuse, drug reliance and alcohol abuse, child abuse and the abuse of the elderly, etc. Instruction in the prevention, detection and assessment of disease and health related social problems, and related interventions include contributions regarding broad public policy, and cognisance of inputs from other health care and social welfare professions.</p>	<p>At the highest level there is proof that assessment of population health care needs aimed at the provision of services, the identification of special areas of concern, the influence of environmental, and social/cultural factors on health and well-being, and the promotion of health and prevention of illness are addressed in various contexts and at different stages in the curriculum, with inputs from other health care professions, and are not addressed only in a specific module. Outcomes in this regard are assessed. Proof is provided in the form of student portfolios, assignments, interdisciplinary group tasks, etc.</p>

ATTAINED AT: MINIMUM LEVEL HIGHER LEVEL HIGHEST LEVEL

Not achieved at all

Unable to judge

COMMENTS:

2.16 The curriculum ensures that the student has the opportunity to develop the ability to make independent medical decisions with due consideration of ethical aspects.

<p>This standard puts an emphasis on the curriculum design providing opportunities for students to hone their skills in decision-making, while always keeping in mind ethical principles and standards. For decision-making students need to develop the ability to make accurate observations of biomedical (by implication including physiological and pathological) phenomena, and to analyse data critically. In decision-making, students must learn and exhibit adherence to ethical principles in research, patient care, and in relating to patients, their families and colleagues.</p>		
<p>At minimum levels the curriculum document provides proof that students learn the fundamental principles of medicine, and outcomes demand of them to acquire skills of critical decision-making and judgement based on evidence and experience. Students are coached appropriately and effectively to make decisions based on essential knowledge and evidence, and to adhere to scrupulous ethical principles.</p>	<p>At higher levels students are coached in professional reasoning and problem-solving as an integral part of clinical practice, they are guided in making independent medical decisions with due consideration of ethical aspects, and equipped through role-modelling to cultivate ethical awareness. They are provided opportunities to develop the ability to use these principles and skills in decision-making regarding health and disease matters. Evidence is provided in the assessment of clinical practice, portfolios and student reports.</p>	<p>At the highest level students demonstrate the ability of independent decision-making based on sound knowledge and understanding, active student participation and problem-solving, the ability to use their analytical skills and to organise knowledge, and an awareness of medico-legal issues and ethics. Evidence of this is found in reports of their clinical residencies, portfolios, reflective diaries, group work reports. Assessments demand clinical reasoning and decision-making in authentic (real-world) situations.</p>

ATTAINED AT: MINIMUM LEVEL **HIGHER LEVEL** **HIGHEST LEVEL**

Not achieved at all

Unable to judge

COMMENTS:

2.17 The curriculum is designed to deliver a graduate student who has appropriate attitudes and behaviour patterns to ensure quality health care.

<p>This standard focuses on attitudes and behaviour that demonstrate respect for patients and colleagues, a striving for quality care, and an awareness of the need for doctors who recognise the importance of primary care and a community orientation. The curriculum document should contain outcomes in this regard.</p>		
<p>At a minimum the curriculum document provides proof that students are made aware of the importance of unprejudiced and respectful behaviour towards patients and colleagues, the recognition of patients' rights, the moral and ethical responsibilities of doctors, and quality service at all health care levels.</p>	<p>At higher levels lecturers demonstrate that they are excellent role models regarding attitudes and behaviour, and through coaching, guidance and example instil in students the desire to act accordingly, including a commitment with regard to their own physical, mental, psychological and social well-being, as well as that of their peers and the community at large. Recognition of the importance of primary health care and community service is expected. Proof is provided in student evaluations of instruction and lecturers (role modelling and coaching), and outcomes in this regard are assessed during clinical training/residencies/electives.</p>	<p>At the highest level assessment of student performance, including reports on clinical residencies/ electives/community work, provides proof of students' attitudes and behaviour being exemplary of what will be expected of them as professionals, namely a desire to serve humanity in general and their communities in particular, a willingness to render primary care services, a respect for the rights of patients and human rights in general, a recognition of ethical values, a community orientation, and a commitment to their studies which is a precursor to becoming committed doctors.</p>

ATTAINED AT: MINIMUM LEVEL HIGHER LEVEL HIGHEST LEVEL

Not achieved at all

Unable to judge

COMMENTS:

2.18 The curriculum makes provision for instruction in basic management principles as these come into play in self-management, practice management and health systems management.

<p>This standard focuses on the basic principles of management of oneself and one's work, and the basics of the management of health practice and health systems, in hospitals, the community, private practice, the public sector, etc. The curriculum document should contain outcomes in this regard.</p>		
<p>At a minimum the curriculum document provides proof that students are made aware of the important role of management principles in their personal lives and in their future careers as professional health practitioners at all health care levels.</p>	<p>At higher levels the curriculum document provides proof of management principles being included in the outcomes of relevant modules/themes. Teaching and guidance in management principles are attended to explicitly. Outcomes in this regard are assessed.</p>	<p>At the highest level proof is provided that specific modules/instructional periods are devoted to introducing students to management principles. Training in management principles is provided and students are prepared for the management of their future careers, and their role in the management of the health system in which they will practise their profession.</p>

ATTAINED AT: MINIMUM LEVEL HIGHER LEVEL HIGHEST LEVEL

Not achieved at all

Unable to judge

COMMENTS:

2.19 Communication skills are emphasised throughout the curriculum.

<p>In essence this standard requires of the medical faculty/school to have a policy or established mechanism for actively guiding, coaching and/or training students in communication skills. Good communication skills are essential in working with colleagues, patients and their families, in team work and in written work. Communication skills include the ability to be good listeners, and to counsel and give advice and explanations which are comprehensible to patients and their relatives. Competency in using scientific language is included in this standard.</p>		
<p>At a minimum this requires a language and communication policy. Assessment of students' communication skills takes place and opportunities are provided to improve these skills where they are found lacking. The ability to communicate clearly, considerately and sensitively with patients, relatives, doctors, other health professionals and the general public receives attention throughout the duration of the curriculum.</p>	<p>At higher levels the curriculum makes provision for specific instruction in communication skills as they relate to the responsibilities of a doctor, and opportunities are provided for students to become conversant in the language(s) of the majority of the patients they will see. The language policy ensures that all students are proficient in the language of instruction and medical scientific language.</p>	<p>At the highest level it is demonstrated clearly in the curriculum document that much time and effort go into instruction in and the improvement of communication skills, both at the level of communication with patients and relatives (who often may not be proficient in the language used by the students), and colleagues and other health professionals. Assessments prove that students use medical scientific terminology with confidence.</p>

ATTAINED AT: MINIMUM LEVEL HIGHER LEVEL HIGHEST LEVEL

Not achieved at all

Unable to judge

COMMENTS:

3. TEACHING, TRAINING, LEARNING AND ASSESSMENT

3.1 The strategies for teaching, training, learning and assessment articulate clearly with the aims, objectives and stated outcomes of the programme.

This standard requires that the instruction and assessments taking place be based on the philosophy and educational model the faculty/school proclaims to follow. The faculty/school must have an educational policy, elucidating the underlying principles of the curriculum and the educational approaches and strategies, as well as an assessment policy. Copies of the policies must be available.		
At a minimum lecturers and others involved in the teaching and training of students are in agreement with the educational philosophy and are fully informed of the basic principles of the curriculum model, its objectives and the desired outcomes, including the most appropriate strategies and instructional methods to achieve the outcomes.	At higher levels staff members are involved in regular information sharing and development actions to ensure that they are competent in employing the strategies required by the curriculum model, and the committee overseeing the implementation of the curriculum monitors the teaching, training and assessment strategies used to ensure that they are in agreement with the policies.	At the highest levels staff and student feedback is sought regularly regarding instructional and assessment policies and strategies to ensure that the educational process is in line with the educational philosophy and premises of the programme, and that it articulates with the mission and goal of the faculty/school and the stated outcomes of the programme.

ATTAINED AT: MINIMUM LEVEL HIGHER LEVEL HIGHEST LEVEL

Not achieved at all

Unable to judge

COMMENTS:

3.2 The teaching, training, learning and assessment activities are appropriate in terms of the intended learning outcomes, in particular with regard to the development and assessment of knowledge and understanding, key (generic) skills, cognitive skills, and specific practical/clinical skills.

The essence of this standard is that the descriptions of learning opportunities provided to students clearly communicate what will be expected of students to achieve the set outcomes.		
At a minimum this requires all teaching, training, learning and assessments to be based on the outcomes that have to be achieved, covering the areas of knowledge development and understanding, generic, cognitive and practical/clinical skills, and attitudinal /behavioural skills. Proof of this is to be found in the student manuals and assessment documents.	At higher levels learning activities are logically linked to the achievement of the outcomes; the subject material to be covered is identified clearly, as well as the knowledge and skills to be acquired, and the learning methods to be applied to achieve the outcomes. Evidence is provided in learning materials, student and staff manuals and assessment documentation.	At the highest level the descriptions in student and staff manuals and documentation include clearly identified learning outcomes, with descriptions in the form of competency statements, establishing clear relations between the stated outcomes and the competencies, describing the ways in which achievement is assessed, as well as the assessment criteria.

ATTAINED AT: MINIMUM LEVEL HIGHER LEVEL HIGHEST LEVEL

Not achieved at all

Unable to judge

COMMENTS:

3.3 Education is student-centred, curiosity-driven and to a large extent self-directed, geared at self-exploration and critical evaluation of content. The curriculum and instructional methods used ensure that students take responsibility for their learning, and prepare them for lifelong, self-directed learning.

This standard addresses the degree to which the learning opportunities provided to students demand of them to become actively involved in the learning process.		
At a minimum the educational model used is clearly described and ensures that students take responsibility for learning processes and prepares them for self-directed, lifelong learning. The emphasis is not on the mere transmission of facts (lecturer-based teaching), but teaching and learning are student-centred, problem-based/oriented and evidence-based. The major role of the lecturer is that of resource person and facilitator of learning, rather than transmitter of knowledge.	At higher levels the educational model requires of students to adopt a resource-based learning approach, and fosters the development of reflective, analytical and critical thinking, demanding active participation and responsibility for their learning. Evidence is provided in curriculum and assessment documents that it is expected of students to learn to find, collect, evaluate and process information, instead of merely learning already processed factual knowledge.	At the highest levels purely didactic lectures are limited to a minimum, directed self-study or self-directed learning is the norm; active student participation in all instruction and training is evident. Students are motivated to base their learning on 'wanting to know'. There is proof that students accept responsibility for their own learning; the focus is on active study and involvement in the educational process rather than on passive learning.

ATTAINED AT: MINIMUM LEVEL HIGHER LEVEL HIGHEST LEVEL

Not achieved at all

Unable to judge

COMMENTS:

3.4 Teaching and learning systems are grounded in modern educational theory and the ranges of available technological aids are used optimally. Innovative, relevant and situationally applicable teaching and learning strategies are employed.

The essence of this standard is that the faculty/school must ensure that modern educational theory forms the basis of education, training and learning processes and models, and that faculty members are well informed of and apply innovative educational methods and techniques.		
At a minimum this requires of curriculum documents and educational policies to bear evidence that instructional and training methods make provision for interactive presentations, self-activity, group learning opportunities, problem-solving and resource-based learning, supplemented by applicable and relevant use of technological instructional aids.	At higher levels proof is provided that students are encouraged to become reflective learners through the use of innovative educational strategies and methods (e.g. portfolios, journals and reflective diaries); they are trained and motivated to use information technology optimally, and co-operative learning is promoted.	At the highest levels there is clear evidence that the passive, uncritical acquisition of facts is not promoted, but that students are guided to active participation and self-directed learning, using relevant and applicable learning strategies. Assignments bear proof that they are encouraged to be critical in their approach to learning, and to make use of a wide variety of resources and technological aids. Critical thinking and reasoning skills, skills in interpersonal contact, communication, and the use of information technology are promoted.

ATTAINED AT: MINIMUM LEVEL HIGHER LEVEL HIGHEST LEVEL

Not achieved at all

Unable to judge

COMMENTS:

3.5 Teaching, learning and assessment are built on sound educational principles; lecturers are not only masters in their subject, but also have expertise in teaching, training and learning facilitation.

This standard focuses on the importance of educational principles in striving for success and excellence in medical education.		
At a minimum the staff policy expects of faculty members a commitment to development in the field of education. The faculty/school has the services available of faculty members who have a background in education and can take the lead regarding educational principles and premises; cognisance is taken of modern education theory and practice in all aspects of curriculum design and delivery.	At higher levels staff policy makes provision for the educational development of staff, and teaching merit and qualifications are rewarded. Teachers understand the importance of and are informed of the principles of curriculum design, teaching and training, and learning, and are committed to excellence in their role as teacher and facilitator of learning. The importance of medical education as a field of study is recognised, and mechanisms exist for the advancement, co-ordination and evaluation of the necessary educational reforms.	At the highest level a medical education unit exists in the faculty/school, and has mechanisms in place for promoting, co-ordinating and evaluating the educational aspects of policy formulation and decision-making, curriculum design, development and delivery (i.e. the teaching, learning and assessment processes), staff and student development, and educational research.

ATTAINED AT: MINIMUM LEVEL HIGHER LEVEL HIGHEST LEVEL

Not achieved at all

Unable to judge

COMMENTS:

3.6 Early patient contact – from the start of the programme - is the norm to support the integration of theory and practice, and of the basic and clinical sciences, and to motivate students for clinical training.

<p>This standard emphasises the benefit of students being introduced to communities, potential patients and patients during the early stages of the curriculum, as this facilitates enthusiasm and motivation to become a doctor, and fosters attitudes such as a desire to serve humanity and a community orientation. Clear outcomes should be stated for patient contact and community-based educational activities, including service learning projects.</p>		
<p>At a minimum the education and training policy makes provision for students to make contact with patients and/or people in the communities in the early years of the programme. Facilities/ resources are available for students to observe, master and practise generic and clinical skills from the early years of training. The curriculum in the early years includes training in the skills of history taking, basic examination skills, basic clinical procedures (making use of models), computer skills, communication skills, the ability to work in a multi-professional team and referral skills. Clear outcomes are set for all skills training.</p>	<p>At higher levels the curriculum document provides proof that clinical skills are rigorously trained and practised from the early years on in skills units, etc., using models, fellow students, simulated patients, and ultimately patients. Skills are practised concomitant with theoretical instruction to ensure maximum contextualisation and to ensure integration of theory and practice. Students do not merely observe when patient contact takes place, but have the opportunity to actively participate and to practise basic skills in communication and dealing with patients and their families; opportunities to make patient contact are provided in community-oriented education and training and service learning projects.</p>	<p>At the highest level evidence is provided that students are involved from early on in determining community needs, and participation in community health care and education is promoted; they have contact with patients and communities in general and are involved in community projects, which enhance communication and human relations skills. Skilled clinical teachers are involved in skills training and serve as role models. Students in the early years are afforded the opportunity to accompany seniors and consultants on hospital rounds, clinic visits, community visits and in theatre to observe the practising of clinical skills.</p>

ATTAINED AT: MINIMUM LEVEL HIGHER LEVEL HIGHEST LEVEL

Not achieved at all

Unable to judge

COMMENTS:

3.7 Clinical skills, including skills in patient care, are acquired under supervision and assessed thoroughly throughout the curriculum.

The focus of this standard is on rigorous clinical training under supervision and equally rigorous assessment of clinical skills.		
At a minimum the curriculum document makes provision for clinical training experiences in the fields of primary health care, community-based training and clinical care. Clinical training covers all the organ systems and clinical experiences in family medicine, internal medicine, obstetrics and gynaecology, paediatrics, psychiatry, surgery and anaesthesiology. Clear outcomes are set for all clinical training.	At higher levels training initially takes place in skills units/laboratories, and during community visits, and later in out- and in-patient situations, and in emergency rooms, working on real patients. Clinical training includes the important aspects of preventive, acute, chronic, continuing, rehabilitative, therapeutic and palliative care. Proficiency in skills is rigorously assessed in terms of pre-determined assessment criteria. The clinical component of the curriculum (clinical cases) must be passed separately, and not be compensated for by other curriculum components.	At the highest levels educational experiences are available in multi-disciplinary content areas, such as emergency medicine and geriatrics, and in disciplines that support general medical practice such as diagnostic imaging and clinical pathology, counselling and education. Clinical skills include history taking, physical examination, procedures and investigations, emergency procedures and patient care, as well as communication, team work and leadership skills. Clinical training is continuously adapted to changing patterns in health care delivery.

ATTAINED AT: MINIMUM LEVEL HIGHER LEVEL HIGHEST LEVEL

Not achieved at all

Unable to judge

COMMENTS:

3.8 Learning outcomes are stated for all the parts of the programme, and provide direct guidance for assessment. Assessments are consistent with these outcomes. Required outcomes and standards of achievement are communicated widely through the programme materials, policies, publications and other communications.

This standard emphasises that teaching and assessment are directly related and that teaching and learning should be based upon and visibly guided by clearly stated outcomes, the attainment of which is proved during assessment.		
At a minimum this standard requires evidence that clear outcomes have been set for all components of the programme, that the exit level outcomes are made known to students at the outset, and that teaching, learning and assessment are based on these outcomes. The intended outcomes and required standards of achievement of each phase of the programme as well as of each component of the programme are made known to students to ensure proper preparation for assessments. Assessments are based on clear assessment criteria.	At higher levels there is a match between the intended outcomes, teaching and learning methods, and assessments, i.e. assessments of student learning are appropriate, promote learning and measure the attainment of the intended learning outcomes. Assessment methods comprise a variety of approaches, and measure student attainment of knowledge, skills, attitudinal and behavioural outcomes at the appropriate cognitive, skills and affective levels. Clear assessment criteria are available to students and moderators.	At the highest level proof is provided that all assessments are regularly reviewed to ensure that they are consistent with the intended outcomes, in line with the teaching and learning methods used, and promote integration. The exit level outcomes are written in a way that enables students to prepare sufficiently for the final assessments, reflecting the integrated nature of the curriculum. The exit level outcomes are published in all relevant publications to ensure that interested parties (students, prospective students, parents, the public at large, etc.) are informed of the attributes the faculty/school strives to inculcate in its students.

ATTAINED AT: MINIMUM LEVEL **HIGHER LEVEL** **HIGHEST LEVEL**

Not achieved at all

Unable to judge

COMMENTS:

3.9 Assessments of student learning are fair, valid and reliable.

<p>This standard requires of the medical faculty/school to have a rigorous method and appropriate mechanisms of quality assurance with regard to the assessment of student learning.</p>		
<p>At a minimum the standard demands an assessment policy to be in place and evidence is provided that all assessments of student learning are in accordance with the policy. There is proof that assessment procedures are effective in measuring student attainment of the outcomes. A variety of assessment methods are employed to ensure that all outcomes are assessed validly. To ensure reliability, a system exists that maximises the accuracy, credibility and consistency of the assessment results, regardless of who conducts the assessment.</p>	<p>At higher levels the medical faculty/school has a quality assurance process for assessments in place through which to ensure that all assessments, including formative assessments, are valid, fair and reliable, and satisfy standards. Clearly stated guidelines exist for the marking and grading of results, and use is made of moderators in all assessments. Multiple-method assessments are used in the final examinations, and proof of the quality of assessments is available in the form of examiners' and moderators' reports.</p>	<p>At highest levels the faculty/school monitors and regularly updates its assessment approaches and methods to ensure that they are current with changes in the specific fields and/or changes in assessment technology and methods. In each component of the curriculum the standards of achievement are set by experts in the field and education, and the system for the assessment of students' achievement employs a variety of measures to assess knowledge, skills and professional behaviour. The medical faculty/school ensures fairness, validity and reliability in assessments by making use of external moderators and examiners, especially in final assessments.</p>

ATTAINED AT: MINIMUM LEVEL **HIGHER LEVEL** **HIGHEST LEVEL**

Not achieved at all

Unable to judge

COMMENTS:

3.10 Integrated assessments should play a major role, in accordance with integrated instruction and learning; assessment modes should be compatible with the modes of instruction; instructional objectives and learning outcomes are clearly compatible with assessment principles, modes and practices. Every assessment should be a learning opportunity.

<p>The focus of this standard is on decreasing the compartmentalisation effect that assessments in separate components of the curriculum may have, and on using assessment methods that are in line with the instructional methods. The importance of assessment being a learning opportunity is stressed.</p>		
<p>At a minimum the modes of assessment used are defined and described in the assessment policy of the faculty/school, and in line with instructional approaches and methods. Assessments are based on stated outcomes and aimed at promoting learning. By integrating assessments of various curricular elements, integrated learning is encouraged. Final assessments involve theoretical and clinical demonstration of the mastered knowledge and skills, as well as appropriate attitudes and behaviour, accomplished in varied contexts. Regular feedback ensures that each assessment is a learning opportunity.</p>	<p>At higher levels the assessment policy makes provision for formative and summative assessments, comprising a variety of approaches such as written assessments (including short and essay answer items; case studies, etc.), oral assessments, projects, documentation of performance (e.g. portfolios), reflective writings, log books, clinical case examinations and objective standardised clinical examinations (OSCEs), to reflect the various modes of instruction and enable students to demonstrate achievement of outcomes in a valid way. Continuing/formative assessments are emphasised to facilitate the early identification of inadequate progress and other problems, so that remedial/development measures can be taken in time.</p>	<p>At highest level the methods used for assessment promote integration (vertical and horizontal, and between theory and practice), and indicate how the achievement of standards is validated against external criteria/benchmarks. Students are informed of the assessment policy, which describes the balance between formative and summative assessments, the number and nature of assessments, the balance between oral and written and other types of assessments, the nature of clinical testing, etc. The criteria for passing levels are clearly described. Final assessments involve direct or authentic demonstration of the competencies described under knowledge objectives, skills objectives and attitudinal objectives (HPCSA 1999:6-8). Evaluations of assessment modes (quality assurance measures) include an evaluation of how assessment promotes learning.</p>

ATTAINED AT: MINIMUM LEVEL **HIGHER LEVEL** **HIGHEST LEVEL**

Not achieved at all

Unable to judge

COMMENTS:

3.11 The focus in assessment is on problem-solving, contextualising, critical thinking, applications, professional competence and social values rather than an emphasis on the recall of facts (which promotes rote learning).

<p>The focus of this standard is on the attainment of the educational goals of the programme for undergraduate medical education, which include knowledge, skills, and attitudinal and behavioural outcomes, and emphasises the importance of achieving outcomes at higher cognitive levels, higher levels in the domains of generic and clinical skills, and in the affective domain.</p>		
<p>At a minimum level the assessment policy adequately requires of students to demonstrate achievement of outcomes at all levels of the cognitive domain. The need to learn excessive numbers of pure facts is reduced and assessment of problem-solving, clinical reasoning, integration skills, applications and communication skills is emphasised. Clinical skills are assessed rigorously from the onset. Clear outcomes and assessment criteria are set for all levels of the cognitive domain and all areas of assessment.</p>	<p>At higher levels a system is established which ensures assessment of student achievement throughout all components of the curriculum by employing a variety of measures of knowledge, generic and clinical skills, behaviours and attitudes, rather than an emphasis on the uncritical recall of facts. Problem-based assessments, case studies and authentic assessments are used to ensure that students have the ability to apply knowledge and use problem-solving skills. Assessment criteria cover all the levels of the cognitive domain, as well as the affective (behaviour and attitudes) and skills domains.</p>	<p>At the highest levels there is evidence that assessments ensure that students have acquired and can demonstrate the core clinical skills, behaviours and attitudes specified in the curriculum outcomes. Added to the assessment of applied knowledge and skills, assessments measure domains such as the ability to integrate, independent learning, critical thinking, communication with patients and colleagues, working as member of the health team, and problem-solving, as well as desired and appropriate attitudes and behaviours, including professional competence and social values.</p>

ATTAINED AT: MINIMUM LEVEL HIGHER LEVEL HIGHEST LEVEL

Not achieved at all

Unable to judge

COMMENTS:

4. STUDENTS

- 4.1 The medical faculty/school has a recruitment, selection and admission policy document, explicitly stating the selection criteria and admission requirements for the programme.

<p>The essence of this standard requires of medical schools/faculties to have an admission policy document, clearly stating what the recruitment and selection processes entail, recognising that no single method of selection and admission is regarded as the most appropriate, as diverse approaches to medical education are followed by schools/faculties. In the selection criteria cognisance is taken of the unique features and special demands of the specific programme</p>		
<p>At a minimum level, the faculty/school has a policy on selection and admission (including a statement on recruitment) in which the methods and procedures applied are defined clearly, and the body responsible for the selection is stated. A description of the selection process must be available to prospective students.</p>	<p>At higher levels the selection and admission process is reviewed periodically, based on relevant societal, professional and educational data to comply with the educational and societal responsibilities of the faculty/school and the health and educational needs of the community and society. The statement on the selection process must include both a rationale for the methods and a clear description of the methods, including a definition of the criteria for selection. The target population for the recruitment process is described.</p>	<p>At the highest level the recruitment, selection and admission policy describes the relationship between the recruitment and selection criteria, the faculty/school's programme and the desired outcomes of the programme. A description of how the mechanisms used test prospective students' ability, competencies and/or potential to be successful in medical studies must be included in the policy. While the faculty/school strives to select students who possess the cognitive and affective abilities (i.e. intelligence, integrity, personal and emotional characteristics) perceived necessary to be successful in their academic careers and in the medical profession, provision is made for students with potential. The faculty/school ensures quality in the selection and admission procedures through evaluating the outcome of its policy in terms of subsequent student achievement.</p>

ATTAINED AT: MINIMUM LEVEL **HIGHER LEVEL** **HIGHEST LEVEL**

Not achieved at all

Unable to judge

COMMENTS:

4.2 The medical faculty/school has structures in place for student academic support, development, guidance and counselling.

<p>This standard refers to the extent to which the faculty/school provides students with appropriate and effective structures, mechanisms and experiences to develop their abilities as learners, and in particular, how provision is made for students with potential who do not perform as required by the standards of the programme.</p>		
<p>At a minimum level, the faculty/school has a policy on academic support for students. Students have access to learning-to-learn strategies, and opportunities are available for them to master generic life and learning skills required for successful medical education.</p>	<p>At higher score levels, structures exist within the faculty/school to ensure that students receive the support they might need to be successful in their academic careers. The medical faculty/school ensures that arrangements for the development of required generic skills, academic guidance and support, and academic counselling are well matched to the student profile, the curricular structure and the teaching, learning and assessment procedures.</p>	<p>At the highest levels general skills training and support form an integral part of the curriculum, and efficient structures and procedures ensure the integration of academic provision, development and support. Students' progress and achievement are monitored rigorously and causes for drop-out/failure are identified and addressed by means of academic guidance/development/support/ remedial programmes to ensure that each student has a fair opportunity of maximising his/her potential.</p>

ATTAINED AT: MINIMUM LEVEL HIGHER LEVEL HIGHEST LEVEL

Not achieved at all

Unable to judge

COMMENTS:

4.3 The medical faculty/school has support services available necessary for special needs of students, for example with regard to physical and mental health needs, financial needs and social and welfare needs.

<p>The essence of this standard is in the extent to which the faculty/school supports and provides for the student holistically. The faculty/school must have a policy for student support, guidance and counselling.</p>		
<p>At a minimum the medical faculty/school or the institution has counselling, support and guidance structures and/or programmes geared at addressing social and personal needs of students, and needs regarding financial matters, academic support, and career guidance. The faculty/school has a policy in terms of which students, who might be in need of support, guidance and counselling are identified, and/or supported/ referred.</p>	<p>At higher levels the system for personal support and guidance is integrated with academic support and development to ensure a holistic approach to student support. Resources for financial aid are available, well-managed and brought to the attention of students. The faculty/school has an effective system for personal counselling, that includes mechanisms to promote the overall well-being of students and facilitate their adjustment to campus life and the physical and emotional demands of medical faculty/school. Given the relative isolation of students on attachments to rural and remote sites, students are appropriately supported during clinical training away from campus. Confidential counselling by health professionals (including mental health) is available to students.</p>	<p>At highest levels, the medical curriculum specifically addresses issues of self-care, doctor health and the responsibility to identify and assist peers in distress. Medical student associations, mentors, academic and clinical staff encourage peer support as a duty of care. Mechanisms exist to identify students in need of physical, psychological, social, financial and academic support, and students have access to programmes to provide such support. The faculty/school has procedures for dealing with impaired students, including students with a psychiatric condition, or drug and/or alcohol dependence. Students have access to confidential counselling and services from professionals who are not involved in their academic programmes or assessments.</p>

ATTAINED AT: MINIMUM LEVEL HIGHER LEVEL HIGHEST LEVEL

Not achieved at all

Unable to judge

COMMENTS:

- 4.4 The medical faculty/school has a policy dealing with students' general safety and exposure to infectious and environmental hazards, as well as procedures for preventive and therapeutic health services to students.

This standard focuses on the medical faculty/school's responsibility towards students with regard to infectious and environmental hazards or other occupational injuries.		
At a minimum the medical faculty/school has a policy on health and exposure to infectious and environmental hazards, addressing education of students in methods of prevention; the procedures for care and treatment after exposure, including definition of financial responsibility; and the effects of infectious and/or environmental disease/injury or disability on student education activities. The school/faculty strictly adheres to the guidelines regarding required and appropriate immunisation.	At higher levels the faculty/school has strict regulations governing the application of its student health and safety policy (policies). Given the HIV/AIDS problem, accuracy and detail are essential in South Africa. Specific guidelines for support of and follow-ups on students who are injured/infected, exist and are adhered to.	At the highest level, the faculty/school has developed specific policies that articulate the faculty/school's responsibility to protect students from infectious diseases in the course of their training, and policies that address the faculty/school's and the students' responsibility to ensure that patients are not put at risk from infected students. At this level it is essential that medical schools/faculties develop policies and procedures for dealing with students who meet academic requirements for progression in the course (or for graduation), but whose own health or behaviour raises concerns about future fitness to practise medicine with safety or interact with patients.

ATTAINED AT: MINIMUM LEVEL HIGHER LEVEL HIGHEST LEVEL

Not achieved at all

Unable to judge

COMMENTS:

4.5 The medical faculty/school has mechanisms for addressing student grievances.

This standard aims at ensuring that the faculty/school has a clear policy for and follows established procedures to receive and deal with student complaints and grievances.		
At a minimum this demands of a faculty/school to have published statements or policies in this regard, with clear guidance on when and how a student should proceed to file a grievance or lodge a complaint.	At higher levels evidence must be available that shows that the school/faculty follows these procedures, and deals fairly and appropriately with students to resolve grievances.	At the highest levels the faculty/school takes grievances seriously and uses instances of complaints to bring about appropriate changes where and when required. At the highest level, however, there should be evidence of few complaints and grievances in the first place.

ATTAINED AT: MINIMUM LEVEL HIGHER LEVEL HIGHEST LEVEL

Not achieved at all

Unable to judge

COMMENTS:

5. STUDENT PROGRESSION AND ACHIEVEMENT

5.1 The students demonstrate achievement of the stated outcomes and satisfy the set standards for achievement.

This standard requires of the medical faculty/school to have an acceptable and established mechanism for determining student performance. Information in this regard is available to all parties concerned.		
At a minimum there is evidence that student performance in relation to the achievement of stated outcomes is recorded and analysed on an ongoing basis, determining progression rates, completion of programme rates, and time for completion of programme.	At higher levels regular evaluations of the adequacy of the outcomes and standards are undertaken and involve detailed analyses of past student performance. Views concerning student achievement from external examiners' reports, reports of accreditation reviews, students themselves and destination data/employer views are used as data in these analyses. Reasons for non-completion of the programme are identified. Pass, drop-out and failure rates are analysed and the results are used to develop/ devise methods to improve the retention rates, the learning success of students and the standards of achievement.	At the highest levels student performance is analysed in relation to student background, conditions of entry and entrance qualifications. Measures to determine student achievement of outcomes and standards of achievement include information on average study duration, scores, pass, failure and drop-out rates, and student evaluations of the programme. Results of analyses of student progression and achievement are used in planning for curriculum review, student selection and student counselling and support, and the findings regarding student performance; achievements and progression are benchmarked against those of other institutions and professional standards.

ATTAINED AT: MINIMUM LEVEL **HIGHER LEVEL** **HIGHEST LEVEL**

Not achieved at all

Unable to judge

COMMENTS:

6. STAFF

6.1 Members of the academic staff have the capability and continued commitment to be effective educators and trainers.

<p>The essence of this standard is found in the premise that the quality of academic staff is a vital ingredient of medical education.</p>		
<p>At a minimum this standard requires the faculty/school to have a staff policy, which recognises that effective teaching requires knowledge of the discipline and an understanding of education as a field of knowledge. Evidence is given of staff being adequately qualified and willing to participate in professional development activities. If difficulty is encountered in recruiting /appointing competent and committed staff, the faculty/school recognises the problem and takes appropriate steps to resolve it.</p>	<p>At higher levels, there is proof that it is expected of persons appointed to academic positions in the faculty/school to show a commitment to continuing scholarly productivity and development, both in their field of expertise and the field of medical education. Staff members have access to development programmes appropriate to their needs and the requirements of the medical education programme. Staff involved in the development and implementation of the programme or parts thereof has the ability to design learning and assessment activities in a manner which is consistent with sound educational principles. Newly-appointed staff is oriented, and opportunities exist for mentoring. The faculty/school has a policy which addresses a balance between the capacity for teaching, research and service functions, as well as recognition of meritorious academic activities, with appropriate emphasis on research attainment and teaching achievements.</p>	<p>At highest levels, the staff policy addresses teacher training and development as well as teacher appraisal, and the school/faculty demonstrates adherence to the policy. Staff development programmes enable staff to upgrade their skills and to obtain favourable appraisals of their performance, and participation is encouraged by appropriate incentives. The academic staff is an expert professional body consisting of competent, committed individuals who are academically prepared and qualified, and who accept responsibility for maintaining the highest level of professional excellence.</p>

ATTAINED AT: MINIMUM LEVEL HIGHER LEVEL HIGHEST LEVEL

Not achieved at all

Unable to judge

COMMENTS:

6.2 The medical faculty/school has clear policies for the appointment, promotion and dismissal of staff members.

<p>This standard requires of a faculty/school to have a commitment to appoint staff who will render services that are to the benefit of the mission, goal and objectives of the school/faculty, and who can identify with the overall purposes of the medical education programme.</p>		
<p>At minimum level, the faculty/school has a clear policy on recruitment, appointment, dismissal and promotion of staff to ensure that the academic staff is sufficiently trained and qualified to teach and train in the programme. The policy makes provision for the fair treatment of staff, and for opportunities for self-development and promotion, but also demands satisfactory performances of staff. The position and expectations of staff on joint establishments are addressed in the policy.</p>	<p>At higher levels, adherence to the staff policies ensures that staff members are adequately qualified and experienced to be effective and efficient in fulfilling their tasks. The faculty/school has sufficient staff to enable them to participate in developmental activities, achieve their full potential and be good role models. Good relationships with other stakeholders and communication regarding the expectations of staff on joint establishments are a priority to ensure a mutual striving for teaching and training excellence.</p>	<p>At highest levels the medical faculty/school has defined criteria for staff recruitment and selection, permanent appointment and promotion, with due consideration of scientific, managerial and educational merits, relationship to the mission and aim/goal of the institution, involvement in teaching, research and service, rewards for personal and academic development and achievements, and other issues such as race, gender, language, etc., as well as the diversity of the student body. The faculty/school ensures that it has a sufficient number of staff members who have a comprehensive knowledge of and expertise in their major disciplines as well as in one or more subdivisions or specialties, and who are able to teach in an integrated curriculum. Staff members are excellent role models. The medical faculty/school strives to ensure appropriate diversity of population group, language, gender and age in academic staff ranks, without derogating merit as the ultimate criterion in selecting staff.</p>

ATTAINED AT: MINIMUM LEVEL **HIGHER LEVEL** **HIGHEST LEVEL**

Not achieved at all

Unable to judge

COMMENTS:

6.3 Excellence in teaching is recognised and rewarded.

<p>This standard focuses on staff's teaching ability and methods to promote and reward teaching competence. Special efforts should be made to ensure excellent teaching and training in clinical areas. Excellence in teaching is recognised/rewarded.</p>		
<p>At a minimum the staff policy requires of staff members to have the capability and continued commitment to be effective teachers and to develop their teaching and training skills. They are encouraged to attain educational qualifications, attend medical education meetings and conferences, and participate in educational development activities. Qualifications in medical education are recognised for promotion purposes.</p>	<p>At higher levels, the faculty/school has established effectiveness-related standards of performance for all teaching staff (including staff on joint establishments), and regularly evaluates their overall performance. Recognition for staff performance in the field of education is on a par with recognition of performance in other fields, e.g. research performance. Recognition of meritorious academic activities includes teaching rewards, promotion, and remuneration possibilities.</p>	<p>At highest levels, teaching staff is encouraged and supported to gain expertise in curriculum design, pedagogy and assessment methods, as well as curriculum management. Units for medical education exist, and offer professional and educational development opportunities for staff. Teaching and training portfolios are used as tool in promotion decisions, and rewards in the form of study leave, conference participation, merit awards and financial remuneration serve well to promote excellence in teaching.</p>

ATTAINED AT: MINIMUM LEVEL HIGHER LEVEL HIGHEST LEVEL

Not achieved at all

Unable to judge

COMMENTS:

6.4 Academic staff members receive academic support with regard to innovative educational approaches, strategies and instructional methods and techniques. The importance of medical education as a discipline is recognised at all levels in the faculty/school.

<p>This standard emphasises the necessity of supporting academic staff members to acquire the capability and continued commitment to be effective teachers. Staff must be informed of and empowered to utilise and employ innovative educational strategies and techniques.</p>		
<p>At a minimum evidence exists that the faculty/school recognises that effective educational processes are a precondition for quality in medical education and training. This requires of staff knowledge and an understanding of curriculum design and development and instructional and assessment methods. The faculty/school provides evidence of documented participation of academic staff in professional development activities related specifically to teaching, assessment of student learning and programme/curriculum development and evaluation.</p>	<p>At higher levels there is a unit/division for the development of and research into medical education, and the academic development and support of staff, and to promote and facilitate the availability of educational expertise in the school/faculty. Academic staff members are encouraged to acquire formal educational qualifications, and are rewarded accordingly. Attendance of regional, national and international meetings on medical education is encouraged and staff participates actively in national and international medical education activities such as professional educational societies, associations and working groups.</p>	<p>At the highest levels staff training and development programmes form an integral part of the academic activities of the faculty/school. Staff involved in clinical training is under obligation and empowered to fulfil teaching responsibilities in a manner consistent with the faculty/school's stated objectives and the stated outcomes of the programme; to be effective teachers, serve as role models for students, and to provide insight into contemporary methods of clinical training and patient care. Evidence exists that in view of the changing educational environment staff, including those in clinical training areas, is continually updated with regard to innovative educational approaches, strategies, methods and techniques, with special reference to the different skills required for large and small group teaching, tutoring and facilitating learning in clinical and problem-solving situations, and dealing with a diverse student population with differing learning approaches.</p>

ATTAINED AT: MINIMUM LEVEL HIGHER LEVEL HIGHEST LEVEL

Not achieved at all

Unable to judge

COMMENTS:

7. EDUCATIONAL RESOURCES

7.1 The facilities and amenities of the medical faculty/school (including hostels) create an environment that is conducive to teaching, training and learning.

This standard requires of the faculty/school to have established and appropriate facilities and amenities that facilitate learning, and ensure the holistic development of all students.		
At a minimum the faculty/school has, or is assured of the use of sufficient physical facilities for students and staff to ensure that the curriculum is delivered adequately. Physical facilities include appropriate lecture halls, tutorial rooms, laboratories, research facilities, libraries, information technology facilities, study and recreational facilities.	At higher levels the faculty/school has buildings and equipment appropriate to achieve its educational goal. The learning and residential environment is conducive to learning, and is improved by regular updating and extension of facilities to match developments in educational practices, e.g. information and communication technology. The institution ensures a safe environment for residential and commuting students, and the medical faculty/school regularly obtains feedback from students with regard to their accommodation and transport.	At the highest level the medical faculty/school has, or is assured of the use of buildings and equipment that are qualitatively and quantitatively adequate to provide an environment conducive to high productivity of students and staff. At this level, physical facilities include adequate parking, lounge and locker and food service areas. The hostels provide an environment that is conducive to learning, i.e. with adequate equipment and without disturbances. The school/faculty has a clear policy and procedures in connection with students with disabilities, and facilities to accommodate them. The general environment fosters the intellectual spirit of inquiry appropriate to a community of scholars.

ATTAINED AT: MINIMUM LEVEL **HIGHER LEVEL** **HIGHEST LEVEL**

Not achieved at all

Unable to judge

COMMENTS:

7.2 The facilities and amenities in the clinical areas are sufficient, adequate and appropriate for the purposes of the curriculum, and create an environment that is conducive to teaching, training and learning.

<p>The focus of this standard is on the availability, appropriateness, safety and adequacy of facilities available for clinical training. The role and responsibilities of other stakeholders/role players are clearly spelt out, and negotiations ensure effective co-operation.</p>		
<p>At a minimum the students have access to adequate clinical training facilities and experience, including resources for clinical training. This includes hospitals, clinics, primary health care centres, and other community health care settings, as well as skills laboratories. Sufficient models, simulated patients and patients are available for clinical experience. Provision is made for the safe transport of students to clinical areas, and for their safety in the areas. The training students receive in clinical areas is under control of the medical faculty/school, and sufficient and appropriate supervision is ensured.</p>	<p>At higher levels the clinical resources are sufficient to ensure breadth and quality of clinical instruction. This refers to adequate numbers and types of patients (acuity, case mix, age, gender, race and culture, etc.), as well as equipment. Facilities for clinical training include access to hospitals at all levels of care, community health care facilities where students can be trained according to a community-based orientation to care, and private practices. Facilities for overnight accommodation, quiet study, meals, safe parking and recreation are available. Good role modelling on the side of trainers and supervisors is a priority in the choice of facilities.</p>	<p>At the highest level, appropriate instructional facilities include health care settings where the staff participating in student training is of a high standing and has a specific commitment to student training. Clinical resources include adequate facilities where the full spectrum of medical care is provided. Clinical training facilities include areas for individual study, as well as for group sessions and presentations. Sufficient information resources are present or readily available in the vicinity, including library sources and technological information access (computers with access to the network/library/lecturing staff, etc.). Medical equipment and supplies represent the grade and type used for good medical practice. Proper equipment and supplies support the instruction and training in such a manner that clinical and life-long learning skills are developed.</p>

ATTAINED AT: MINIMUM LEVEL **HIGHER LEVEL** **HIGHEST LEVEL**

Not achieved at all

Unable to judge

COMMENTS:

7.3 The medical faculty/school environment is conducive to close interaction between staff members and students, and among staff members.

<p>This standard refers to the importance of the faculty/school's ability to create a milieu where staff, including those from other health care disciplines, and students work together and in close collaboration to promote medical education, the health sciences and health care.</p>		
<p>At a minimum this requires staff offices, lecture halls and tutorial rooms, laboratories and administrative offices to be located in close proximity and within easy reach of students. The school/faculty has ensured the functional integration of staff at remote sites, and regular and close contact is kept with students working at clinical areas removed from the main campus of the faculty/school.</p>	<p>At higher levels evidence obtained through staff and student feedback provides proof that staff and students share a common goal, and work together in teaching, learning, research and health care services in an environment where a positive attitude reigns, existing knowledge is disseminated and new knowledge is generated. Staff members are aware of their importance as role models, and students appreciate and make full use of opportunities to work closely with staff in teaching, research and health care projects.</p>	<p>At highest levels, evidence based on student and staff feedback indicates that the medical faculty/school environment provides for close interaction among staff members. Those skilled in teaching and research in the basic sciences maintain an awareness of the relevance of the disciplines to clinical problems. Such interaction is equally important to clinicians, for new knowledge that can be applied to clinical problems comes from the basic sciences. Staff from basic and clinical sciences work together on, and student input is sought in curriculum design. Inter-disciplinary and inter-professional co-operation is promoted, in teaching, learning, clinical training and health care delivery.</p>

ATTAINED AT: MINIMUM LEVEL HIGHER LEVEL HIGHEST LEVEL

Not achieved at all

Unable to judge

COMMENTS:

7.4 The students and staff have access to a well-equipped information centre/ library and/or multi-media centre, sufficient in size and scope to support the educational programmes of the faculty/school.

<p>This standard focuses on the importance of information resources and instructional media, both for updating knowledge and for fostering a spirit of lifelong learning and intellectual curiosity, and for rendering instruction more effective. The use of information and communication technology forms part of education for evidence-based medicine and in preparing students for lifelong learning and continuing professional development.</p>		
<p>At minimum level, the students and staff have access to well-maintained library and information facilities, sufficient in size, breadth of holdings, and information technology to support the education (teaching and learning) and research of the faculty/school. Professional staff is available for support and provides instruction in effective information resource usage and information retrieval, as well as the use of instructional media.</p>	<p>At higher levels the information and media facilities include access to computer-based reference systems, supportive staff and a reference collection that is adequate to meet the demands of the curriculum and research requirements. Provision is made for needs regarding the use of multi-media in education, and a variety of media is used in instruction and learning. Special efforts are made to address staff and student needs for communication links and information during extended hours and at remote sites.</p>	<p>At the highest level, the information centre/library and other learning resources, such as a multi-media centre, are equipped/suitable to allow students use of new methods of retrieving and managing information, and to support the use of self-instructional materials. Staff is trained in the use of and have access to multiple educational media for instruction. The library/ information centre/media centre provides physical and/or electronic access to information and provides learning opportunities through a variety of media. Leading biomedical, clinical, educational and other relevant periodicals and other information sources are readily available. At remote clinical areas library and/or computer-based literature search facilities are available to staff and students.</p>

ATTAINED AT: MINIMUM LEVEL HIGHER LEVEL HIGHEST LEVEL

Not achieved at all

Unable to judge

COMMENTS:

7.5 The medical faculty/school ensures the use of information and communication technology in the education and training programme, and stays contemporary in the use of technology.

<p>This standard emphasises training in and the use of information technology as an increasingly important part of medical education. Problem-based, resource-based and evidence-based education requires training and adequate, state of the art equipment and facilities.</p>		
<p>At a minimum the faculty/school has a policy for training in and the use of information technology for education. Students and staff receive training in the use of information, instructional and learning technology and media, and facilities are available for the use of technology by staff and students.</p>	<p>At higher levels, the use of computers is integrated in the medical curriculum and access is provided to computers and internal and external networks. Teaching and learning approaches used demand of students and staff to become information technology literate and skilled in the use of instructional and learning technology. Information and communication technology and a variety of media are used effectively and efficiently in teaching and learning and for research, and the systems and the way they are used are regularly evaluated and updated to stay current.</p>	<p>At the highest level, evidence exists that students and staff are able and encouraged to use information and communication technology and a variety of media for teaching and learning, self-study, accessing information, assessment of learning, as well as for patient management and working in the health care system. The use of information technology is recognised for its important role in a student-centred educational approach, as well as in preparing students for evidence-based practice and continuing professional development. To this end the services of experts in information technology and instructional media are indispensable.</p>

ATTAINED AT: MINIMUM LEVEL HIGHER LEVEL HIGHEST LEVEL

Not achieved at all

Unable to judge

COMMENTS:

8. GOVERNANCE AND ORGANISATION

8.1 The governance structures and functions of the medical faculty/school are defined, including the relationship with the university, health and educational authorities and other stakeholders (e.g. NGOs, and other interested parties where the school/faculty may have clinical involvement).

This standard is intended to ensure effective governance structures and healthy relationships with stakeholders and interested parties, and good governance in all areas.		
At a minimum this requires a clearly set out governance structure, and documented descriptions of the faculty/school's relationship with the university, health authorities and other stakeholders. Committee structures and functions are clearly described, and roles and responsibilities are defined.	At higher levels committee structures within the governance structure reflect representation of staff from different ranks, students and other stakeholders in decision-making. Responsibilities and reporting lines of committees are clearly stated. The committee structure of the faculty/school includes a curriculum committee with authority to design, implement and manage the medical education curriculum, including the education and training in clinical areas.	At highest levels academic staff, students and other participants in the education and training processes are represented in the governing bodies of the medical school/faculty. The faculty/school has sufficient autonomy to enable it to direct resources in an appropriate manner to achieve the overall objectives of the faculty/school. The school/faculty has a constructive relationship with the state health department, that has representation in the committee structure. Policies/guidelines exist for the management of relationships with external stakeholders.

ATTAINED AT: MINIMUM LEVEL HIGHER LEVEL HIGHEST LEVEL

Not achieved at all

Unable to judge

COMMENTS:

8.2 The dean/head of the medical faculty/school is qualified by education and experience to provide leadership in medical education, in scholarly activities and research, in care of patients and in the general management of the school/ faculty.

This standard has a bearing on the academic and professional standing of the leadership of the faculty/school. Management roles are clearly defined.		
At a minimum it is expected that the academic head of the medical faculty/school should be medically qualified and have sufficient professional, educational and managerial expertise to ensure effective leadership in all the functions and activities of the faculty/school.	At higher levels the academic leaders in the faculty/school demonstrate leadership in the management of the activities of the school/ faculty, as well as in relationships with the university and other stakeholders. This requires active involvement in the management, education, research and service activities of the school/ faculty, including the relationship with staff and students.	At the highest levels the leadership of the faculty/school demonstrates the ability to achieve the goals and objectives of the faculty/school with the support and co-operation of staff and students, is committed to the mission and goals of the school/ faculty, demonstrates a willingness to co-operate and make contributions, as well as to provide responsible leadership in relationships with other stakeholders, and is recognised locally, nationally and even internationally for contributions to and leadership in medical education. The dean/head of the faculty/school is committed to and intensely involved in the educational, research, service, and management activities of the faculty/school, and takes a personal interest in staff and students. The leadership qualities of the dean/head ensure a closely knit, committed community where a spirit of co-operation and collaboration in the pursuit of scientific knowledge is the main aim.

ATTAINED AT: MINIMUM LEVEL HIGHER LEVEL HIGHEST LEVEL

Not achieved at all

Unable to judge

COMMENTS:

8.3 The academic leaders at all levels of the faculty/school have clearly stated responsibilities, and are evaluated at defined intervals with respect to achievement of the mission and objectives of the faculty/school/programme.

<p>This standard refers to the leadership and managerial roles of the persons responsible for the academic management and leadership in the faculty/school. These roles need to be clearly defined, especially in an integrated programme that spans departmental boundaries. The execution of leadership and management responsibilities should be subjected to quality assurance measures at regular intervals.</p>		
<p>At a minimum the faculty/school has a management and governance policy regulating the appointment/ selection of people in management/ leadership positions and defining the roles and responsibilities attached to these positions. Persons in leadership positions demonstrate a commitment to ensuring successful governance and management in the faculty/school and the educational programmes, and to ensure an environment that motivates staff and students in their educational, research and service enterprises.</p>	<p>At higher levels there is proof that leadership and management responsibilities are carried out according to clear, documented commissions, aimed at achieving the mission, goal and objectives of the school/ faculty, and the programmes offered. These commissions and the way in which they are executed are reviewed regularly, and leadership is subjected to regular appraisal to ensure that it contributes to the smooth running of the faculty/school, the achievement of the mission, goal and objectives of the faculty/school, and the attainment of the outcomes of the educational programmes of the faculty/school. Appraisals of leadership show that a high premium is placed on sound and healthy relations with staff and students.</p>	<p>At highest levels leadership and management appraisals require of leadership to demonstrate excellent leadership qualities, a clear commitment to the school/ faculty and its activities, leadership and participation in faculty/school activities, managerial as well as educational. The leadership of the faculty/school has ready access to the leadership structures of the university that have final responsibility for the faculty/school, and there is a clear understanding of the authority and responsibility for medical faculty/school matters. Leadership demonstrates that it is supportive and has good relations with staff and students, as well as with other stakeholders; that it plays a role in national (and international) medical education activities, and strives to increase the standing of the faculty/school.</p>

ATTAINED AT: MINIMUM LEVEL **HIGHER LEVEL** **HIGHEST LEVEL**

Not achieved at all

Unable to judge

COMMENTS:

8.4 Staff, students and others concerned are involved in planning, decision-making and quality assurance processes and other matters by means of committee structures.

<p>This standard is closely related to previous standards on governance and management structures, and emphasises the requirement of representation, transparency and participative decision-making.</p>		
<p>At a minimum the governance structures of the faculty/school reflect representation from academic staff, managerial staff, support staff, students and other stakeholders. Clear guidelines exist for decision-making and reporting procedures.</p>	<p>At higher levels the faculty/school has a clear policy on representation and decision-making. Decision-making powers, responsibilities, reporting and communication channels of committees, as well as voting rights of members are clearly stipulated, as well as the terms of service in specific structures/committees. The policy includes a statement on transparency and participative decision-making.</p>	<p>At highest levels, staff, students and others concerned are involved in decision-making with regard to academic planning, curriculum design and review, teaching and training, student support, staff development, admissions, promotions, administration and organisation by means of committee structures. There is clear evidence of transparency in decision-making and open communication channels. Students are encouraged to participate in the organisational and decision-making structures of the faculty/school. Organised student representative activities are encouraged and facilitated. External stakeholders are involved where feasible and where their input can make a contribution to the quality of the activities of the faculty/school.</p>

ATTAINED AT: MINIMUM LEVEL HIGHER LEVEL HIGHEST LEVEL

Not achieved at all

Unable to judge

COMMENTS:

8.5 The medical faculty/school has effective administrative management structures in place.

This standard requires the faculty/school to have established appropriate administrative management structures to support the activities of the faculty/school.		
At a minimum the administrative staff of the faculty/school is sufficient in numbers and appropriate to support the core activities of the faculty/school, and to ensure good management of its resources.	At higher levels the administrative structures demonstrate effectiveness and efficiency in carrying out their responsibilities, which include <i>inter alia</i> , management of registration processes (students and programmes), orientation programmes, keeping a suitable system of records, and maintaining programmes for student and staff activities, financial assistance to students, and other financial and organisational matters of the faculty/school.	At highest levels the administrative component has sufficient autonomy to manage administrative processes and direct resources to achieve the overall objectives of the faculty/school. Administrative staff participates in development programmes and is subjected to quality assurance procedures.

ATTAINED AT: MINIMUM LEVEL HIGHER LEVEL HIGHEST LEVEL

Not achieved at all

Unable to judge

COMMENTS:

8.6 The medical faculty/school maintains regular and close interaction with the university, health and health-related sectors of society and government, and allied health professions.

This standard has a bearing on the relationships with other sectors/stakeholders/role players involved in or having an influence on the education and training of students.		
At a minimum this requires proof of constructive interaction with the university, health and health-related sectors in society and of government, allied health professions, as well as professional bodies concerned, supported by formalised collaboration within the organisational structures and guided by sound management principles.	At higher levels, there is proof that in the relationship between the medical faculty/school and its collaborators, the educational programme for the medical students is under the control of the medical school/ faculty, and the arrangements regarding the mission, objectives and stated outcomes of the school/ faculty, as well as the provision of resources, teaching and clinical facilities and staff are made explicit. The relationship between the medical faculty/school, the university, allied health professions, professional bodies, health sectors involved and non-governmental organisations is beneficial to all parties concerned.	At highest levels formalised arrangements protect the relationships and collaboration, and there are effective communication and liaison between the medical faculty/school and the university, health authorities, health care and research institutions, and professional bodies. The health sectors include institutions and regulating bodies concerned with health promotion and disease prevention, e.g. state and non-governmental bodies with environmental, nutritional and social responsibilities. Shared responsibilities are described clearly, especially with regard to training in the clinical areas, service learning, community outreach programmes, staff appointed on joint establishments, and non-academic staff in areas where clinical training takes place. The medical faculty/school ensures development of sound organisational structures and management principles in order to cope with changing circumstances and needs of the medical school/ faculty, government and society, accommodating the interests of different groups of stakeholders.

ATTAINED AT: MINIMUM LEVEL **HIGHER LEVEL** **HIGHEST LEVEL**

Not achieved at all

Unable to judge

COMMENTS:

9. QUALITY ASSURANCE AND ENHANCEMENT

9.1 The medical faculty/school has a quality assurance policy and a programme for quality assurance.

This standard centres on the extent to which the faculty/school is committed to ensure quality in all its endeavours.		
At minimum levels the faculty/school has a policy for quality assurance which extends over the leadership, management, educational, administrative and support structures and activities of the school/faculty, and clearly describes quality assurance measures that are in place. The faculty/school is engaged in a process of quality appraisal and improvement as part of an established quality assurance programme. The undergraduate medical education programme satisfies the quality assurance reviews of the institution, higher education authority and professional board with a view to accreditation of the programme.	At higher levels there is evidence of quality assurance measures and activities in all programmes, and in all the departments, units, etc. of the school/faculty. Quality assurance measures include appraisals of the performance of leadership, governance and administration of the faculty/school, the academic staff and the students. In its process of quality assurance and improvement, the school/faculty strives to satisfy national standards for medical education, and to ensure that the curriculum reflects contemporary trends in medicine and medical education, and remains relevant.	At highest levels the process of renewal and quality improvement is based on prospective studies and analyses, surveys and impact studies, as well as benchmarking against examples of best practice. The faculty/school provides clear evidence that in its striving for excellence it is responsive to changes in the South African and global education and health care contexts, and addresses through the curriculum issues identified as of contemporary importance. The school/faculty strives to satisfy global standards for undergraduate medical education, and to deliver graduates who are sought after in this country and elsewhere.

ATTAINED AT: MINIMUM LEVEL **HIGHER LEVEL** **HIGHEST LEVEL**

Not achieved at all

Unable to judge

COMMENTS:

9.2 The medical faculty/school regularly benchmarks its learning experiences and assessment outcomes against those of other institutions, nationally and internationally, and professional standards.

This standard requires of medical schools/faculties to have a regular process in place to review their curricula and teaching, training and learning activities in the light of evidence of best practice.		
At a minimum the school/faculty has a policy in place for the regular review of the curriculum and the outcomes of the programme. Self-assessments form an integral part of the activities of every instructional unit (department/phase/block/module, etc.) in the school/faculty, to ensure a smooth and well-prepared accreditation review process. Students, staff and others concerned are involved in evaluations of curricula, teaching and training, instructional materials, and assessments.	At higher levels the school/faculty seeks input from professionals outside the faculty/school in the review of the curriculum, teaching and training, and pays attention to the local, national and international contexts of medical education when conducting self-assessment and review processes, to ensure benchmarking over and above the accreditation and audit processes of the educational and professional authorities.	At the highest levels the processes and outcomes of the medical education programme are benchmarked regularly against those of similar and other institutions within the country and outside, over and above the regular audit and accreditation processes. Evidence of best practices will be sought and used in planning and reviewing the curriculum, and instructional approaches and methods.

ATTAINED AT: MINIMUM LEVEL HIGHER LEVEL HIGHEST LEVEL

Not achieved at all

Unable to judge

COMMENTS:

9.3 In the evaluation of programmes and other activities the opinions of staff, students and external opinions (evaluations by experts) are included, and the results of the evaluations are made known.

<p>This standard has a bearing on the quality assurance programme of the faculty/school and the mechanisms used for examining the performance of staff, students, and the programme in general. Quality assurance should form an integral part of the activities of all medical schools/faculties and students, all levels of staff, the educational programme <i>per se</i>, management, facilities, and the educational practices and activities should be subjected to on-going appraisals, aimed at quality assurance and enhancement.</p>		
<p>At a minimum, the faculty/school has a quality assurance policy and programme, and uses an array of methods and ways in which the satisfaction and performance of management, academic staff and students are monitored, e.g. through surveys, interviews and tracking records. Evaluations cover aspects such as leadership/management performance, teaching performance, assessment of student learning, teaching and learning materials, student support, student satisfaction, staff satisfaction, student progress, facilities and logistic arrangements.</p>	<p>At higher levels the faculty/school evaluates its programmes, leadership/management performance, staff performance and student performance regularly, and includes external opinions in the evaluations. The faculty/school ensures that basic data about all aspects of the programmes, and staff and student performance are available through monitoring management activities, the delivery of programmes, staff performance and student progress, and ensures that development actions address identified concerns.</p>	<p>At highest levels the faculty/school has established procedures for reviewing and updating its mission, structures and activities to define and rectify deficiencies and satisfy changing needs. The school/faculty has mechanisms run by a department/unit for medical education to identify strengths and weaknesses, and institute processes to enhance strengths and address the weaknesses. Relevant stakeholders (e.g. professional boards and associations, community and private bodies, government agencies, students) participate in the evaluations, and all have access to the results of programme evaluations and assessments of education and training in the faculty/school.</p>

ATTAINED AT: MINIMUM LEVEL **HIGHER LEVEL** **HIGHEST LEVEL**

Not achieved at all

Unable to judge

COMMENTS:

9.4 Quality assurance by means of self-evaluation is an on-going process in all divisions, departments, units of the faculty/school, as well as by all individuals and groupings, concerning all the activities and processes, and all facilities and resources.

This standard speaks for itself: For every action taken, the question must be asked: 'Is this done well enough? How can it be improved?'		
At a minimum level a quality assurance process in the form of self-evaluations is part of the everyday activities of leadership and management, every programme, department, unit, individual and group, and all the activities in the faculty/school, and forms the basis of planning. Evidence to prove this exists.	At higher levels there is evidence that developmental and/or remedial actions follow on self-studies and external reviews (HPCSA accreditation and HEQC audit reviews) with a view to improving governance and management, education and training, student performance, student satisfaction, staff satisfaction, staff performance, facilities and resources of the medical faculty/school on an on-going basis.	At highest levels, plans for future enhancement of the activities of the faculty/school are devised on the basis of continuous self-evaluations and in response to external quality assurance activities, and made available to those concerned. The faculty/school has a substantial array of examples of the use of self-evaluation information to improve aspects of its programme delivery or other activities, and is able to demonstrate the effectiveness of the improvements.

ATTAINED AT: MINIMUM LEVEL HIGHER LEVEL HIGHEST LEVEL

Not achieved at all

Unable to judge

COMMENTS:

SOURCES CONSULTED*

AMC 1998. *Guidelines for the assessment and accreditation of medical schools*. Canberra: Australian Medical Council.

AMC 2002. *Assessment and accreditation of medical schools: Standards and procedures*. Kingston Act: Australian Medical Council Incorporated.

Baldrige National Quality Programme 2002. *Education criteria for performance excellence*. Gaithersburg: National Institute of Standards and Technology.

Bezuidenhout M.J. 2001-2004. Field notes and reports on accreditation review visits. Unpublished documentation. Bloemfontein, Faculty of Health Sciences, UFS.

Bezuidenhout M.J. 2002. *National standards for the accreditation of undergraduate medical education and training in South Africa*. Magister in Health Professions Education: Dissertation, Faculty of Health Sciences, University of the Free State, Bloemfontein.

Boelen C., Bandaranayake R., Bouhuijs P.A.J., Page G.G. & Rothman A.I. 1992. *Towards the assessment of quality in medical education*. Geneva: WHO.

CHE 2003. *Proposed criteria for the HEQC's first cycle of audits: 2004-2009*. Discussion document. Pretoria: Higher Education Quality Committee.

CHE 2003a. *Improving teaching and learning resource*. Draft for 2003 workshops. Pretoria: Higher Education Quality Committee.

CHEA 2000. *The competency standards project: Another approach to accreditation review*. Washington DC: Council for Higher Education Accreditation.

Commission on Institutions of Higher Education 1992, revised 2001. Standards for accreditation. Burlington: New England Association of Schools & Colleges. <http://www.neasc.org>. Retrieved 10/5/2004.

GMC 1993. *Tomorrow's doctors: Recommendations on undergraduate medical education*. London: General Medical Council.

GMC 2003. *Tomorrow's doctors: Recommendations on undergraduate medical education*. <http://www.gmc-uk.org/med-ed/tomdoc.htm>. Retrieved 15/11/2004.

Hamdy Hossam 2003. Standards for accreditation of undergraduate medical education in Gulf Cooperative Council (GCC) Countries: Implications on quality in medical education. Paper delivered at AMEE Conference, Switzerland. (Received via electronic mail from author, November 2003.)

Health Professions Council of South Africa 1999. *Education and training of doctors in South Africa: Undergraduate medical education and training. - Guidelines by the Medical and Dental Professions Board*. Pretoria: Medical and Dental Professions Board.

IIME 2001 *Global minimum essential requirements in medical education*. White Plains, New York: Institute for International Medical Education.

Liaison Committee on Medical Education (LCME) 2003. *Functions and structures of a medical faculty/school: Standards for accreditation of medical education programs leading to the M.D. degree*. Washington: Association of American Medical Colleges.

LCME 2004. *Annual LCME Medical Schools Questionnaires*. Revised 12 July 2004. Liaison Committee on Medical Education. <http://www.lcme.org/questionnaires.htm>. Retrieved 11/4/2004.

McKinnon K.R., Walker S.H. & Davis D. 2000. *Benchmarking: A manual for Australian Universities*. Canberra: Department of Education, Higher Education Division.

Metz J.C.M., Stroelinga G.B.A., Pels Rijcken-Van Erp Taalman Kip E.H. & van den Brand-Valkenburg B.W.M. *Blueprint 1994: Training of doctors in the Netherlands*. Nijmegen, the Netherlands: University of Nijmegen Publication Office.

Metz J.C.M., Verbeek-Weel A.M.M. & Huisjes H.J. 2001. *Training of doctors in the*

Netherlands: Adjusted objectives of undergraduate medical education in the Netherlands.

<http://www.med.uni-giessen.de/intranet/lehre/blueprint%20netherlands.pdf>

Retrieved 11/04/2004.

Ministry of Education, RSA 2004. *The Higher Education Qualifications Framework (Draft)*. Pretoria: DoE.

The Higher Learning Commission 2003. *The criteria for accreditation and operational indicators*. Chicago: North Central Association of Colleges and Schools.
<http://www.ncahigherlearningcomission.org>. Retrieved 10/5/2004.

UET 2001-2003. Reports on accreditation review visits to medical schools. Unpublished reports of visiting (accreditation review) panels to medical schools. Secretariat, Undergraduate Education and Training Sub-committee of the Medical and Dental Professions Board, HPCSA, Pretoria.

WFME 2003. *Basic medical education: WFME global standards for quality improvement*. Denmark: WFME Office, University of Copenhagen.

* As the information taken from these sources was incorporated in an integrated way in the guide for accreditation reviews, mostly as augmentation or corroboration of the criteria formulated by the researcher, it is not possible to provide an exact reference for each time information from a particular source was used.

M.J. Bezuidenhout
Bloemfontein
June 2005

7.3 CONCLUSION

The proposed guide given in 7.2 constitutes the final outcome of this study. By compiling this guide and putting it through a process of verification and evaluation as described in Chapters 5 and 6, the researcher endeavoured to make a contribution to the enhancement of the quality of undergraduate medical education in South Africa, in that a tool for quality assurance processes was developed. The empirical study showed that the relevant aspects in undergraduate medical education have been covered in the guide, the standards (developed in a previous study by the researcher – Bezuidenhout 2002) have been adapted for use in this study, and assessment criteria in the form of rubrics have been created for each standard. Together with the rating scale this constitutes the assessment tool.

The proposal that faculties/schools should compile their self-assessment portfolios by doing a self-assessment on the basis of the standards and rubrics is aimed at ensuring that the same yardsticks be applied across the board, the document and proposed process will help faculties/schools to prepare for accreditation visits in a structured way, and the guide will serve the very important goal of being a planning and quality assurance document at the same time. Built into such a quality assurance process is the expectation of more objective assessments of programmes with a view to accreditation.

The methodology used and the selection of the participants ensured that all the medical faculties/schools in South Africa were involved in the study. The staff members that participated are all, at high level, closely involved in their respective undergraduate medical education programmes. The participation of the members of the Sub-Committee for Undergraduate Education and Training brought another dimension to the study, as these participants included the decision-makers in the accreditation processes, and chairs of previous accreditation teams.

At the beginning of the study it was assumed that a measurement tool could be applied to address perceived shortcomings in the current accreditation process. The empirical study proved that the assumption could be accepted as true, and the proposed guide, as related in this chapter, was finalised.

CHAPTER 8

RECAPITULATION, RECOMMENDATIONS AND CONCLUSION

... a master's or doctoral student should not merely be performing a degree-acquiring exercise, but indeed attempt to extend the boundaries of his or her field of knowledge (Alberts 2002:xiii).

8.1 INTRODUCTION

In the introduction to this study Pirsig (1999:184) was quoted on quality, asking: "What is quality?" Further on in his work, Pirsig (1999:233) states that the whole purpose of scientific method is to make a valid distinction between the false and the true in nature, to eliminate the subjective, unreal, imaginary elements from one's work so as to obtain an objective, true picture of reality. This study then also was an attempt to gain a picture of reality; to find a way of trying to render quality decisions more objective. In his philosophic meanderings on quality, Pirsig states that one has to suggest instruments that will detect quality, or, if there are no instruments to do so, then the conclusion must be that the whole quality concept is "a large pile of nonsense" (Pirsig 1999:229).

This study has investigated the phenomenon of quality assurance in education and endeavoured to find an instrument to 'measure quality' in medical education and training with the purpose of informing quality decisions regarding the education and training of medical students. In reality quality assurance is not anything new in higher education. In Chapter 2 it has been shown that quality has always been important in education, and in modern times it has become a focal point. The quality of academic activities, which in the past has been regarded as a self-evident aspect of academic work, an integrated element of the professional activities of academics, now has become part of accountability in higher education, giving a new dimension to quality assurance.

In medical education in South Africa, the accreditation system has been instituted as recently as 2001, and accreditation as a quality assurance method no longer is a completely new notion. Involvement in the process has shown that the time was ripe to take a new look at the process, to examine the phenomenon, and to determine whether there is room for improvement in a process that is claiming time and energy from those

concerned with ensuring that doctors of quality are delivered into society with the purpose of improving the health of people.

8.2 RECAPITULATION

The study was conducted to investigate the phenomenon of quality assurance with special reference to accreditation as it relates to undergraduate medical education in South Africa, and to devise means to satisfy a perceived need for a mechanism to render the undergraduate medical education accreditation review process more structured and objective.

As the researcher has been involved in the quality assurance process of the HPCSA for more than ten years (*cf.* Labuschagné 1995; Bezuidenhout 2002), it seemed obvious that a research approach in which the researcher is part of the situation would be the natural way to go. The role of the researcher as participant observer empowered her to elicit meaning from observations and other participants' opinions and views. This involvement in the accreditation process gave rise to certain questions about the accreditation process and the phenomenon of quality assurance in general, which called for answers which could only be found by means of an investigation of the phenomenon. These questions were: How can objectivity and comparability be assured in accreditation review visits when the panels visiting the different medical schools for each visit comprise different individuals as members? What is the actual basis the members use in making peer-based decisions about institutional performance? What mechanisms are available to help them arrive at a collective assessment of institutional strengths and weaknesses? How can it be assured that institutions strive for 'best practice'? How can the extent to which they achieve this striving be determined, and comparability and equality of standards in medical education be promoted? These questions indicated a need for a mechanism or tool to be used in the accreditation system for the assessment of undergraduate medical education and training in South Africa. The problem to be solved in this study thus was the lack of a guide for accreditation reviews (see 1.4 & 5.1).

It was assumed that an accreditation review guide could address the research problem, namely the perceived need for a tool or mechanism to be used in the assessment of medical education and training in the accreditation system for medical education programmes in South Africa.

In the investigation to address the research problem a qualitative approach applied,

namely phenomenology, and the study can also be classified as both basic and applied (see 1.5 and 5.2.3). As the phenomenology is a method that “attempts to understand participants’ perspectives and views”, and the researcher in these studies usually has personal experiences with the phenomenon (Leedy 1997:161), the approach and methods satisfied the needs of the study and the researcher.

Quality assurance is a complex issue, and because an interpretative approach was followed in the study, it was important to review literature on the topic, especially as it manifests in medical education as part of the higher education environment. The literature review (reported on in Chapters 2, 3 and 4) provided a framework for the study; against the backdrop of what quality assurance entails, what is happening in this regard in education systems internationally and locally, what mechanisms and tools are used in the process, and, more specifically, exactly what the accreditation system as quality assurance method in South African medical education entails, the research could be approached with understanding.

The information collected during the periods of participant observation was processed and used, together with information collected from literature, to develop the draft guide for accreditation reviews (see Chapter 5, 5.3.2.2). The data collection by means of participant observation started in 2001 (as part of a previous study – Bezuidenhout 2002) when the researcher first took part in an accreditation review visit. Careful notes were made during the visits – both of own experiences, what was observed as part of the accreditation reviews, and of discussions with other panel members and faculty members of the institutions under review. These notes (field notes) were used together with the information collected during the course of this study, as well as in the literature survey to inform the draft guide that was used as research instrument in the interviews. The standards for undergraduate medical education in South Africa which the researcher had developed in a previous study (Bezuidenhout 2002) served as premise in the design of the draft guide; the three levels with rubrics and criteria were developed on the basis of information contained in reports of previous accreditation reviews, the researcher’s field notes and experience in medical education, as well as the perspectives gained from literature.

Having drafted a guide for accreditation reviews based on participant observation and the literature study, however, did not mean that the research questions were answered empirically. The information collected from the informants during participant

observations and the literature study had to be 'tested' by gaining the views and opinions of more participants (*cf.* Fox 1998:15). The draft guide, therefore, was subjected for scrutiny to the participants in the empirical study, who were all involved in some way or other in the process of accreditation of undergraduate medical education in South Africa, to glean their opinions and views, both regarding the phenomenon of study and the proposed guide as a factor that might influence the process of quality assurance, the phenomenon. At the same time the researcher gained a perspective of the phenomenon as viewed by the participants. In the attempt to answer the research questions the researcher thus conducted an empirical study, using individual interviews and a focus group interview to elicit perspectives on the phenomenon in a structured way, and to test the assumption, namely the idea of the draft guide to solve the research problem. The researcher's experience in education, quality assurance and the accreditation process gave her sufficient experience to listen with insight, contextualise the opinions, and appreciate the subtleties of the participants' shared world, of how they experienced the phenomenon. This provided the opportunity to determine whether the assumption, that is, that an accreditation guide would solve the research problem, was valid or not.

From the data collected during the interviews a clear picture of the participants' views of the phenomenon was gained, and they agreed that the proposed guide would serve the purpose of a guide for accreditation reviews well.

Based on the findings of the interviews the draft guide for accreditation reviews could be adapted and can now be submitted as final outcome of the study. A number of recommendations will be made, emanating from the study (8.4). The assumption that a guide to use in accreditation reviews (and for planning with a view to quality enhancement) might address the research problem was found to be valid and can be accepted on the basis of the responses of the interviewees.

The approach and methods served the purposes of the study well and meaningful results were obtained from data collected by means of a literature survey, participant observation and interviews (individual and a focus group). These were described in detail in Chapters 5 and 6. With regard to the approach followed in this study, it must be stated again that the study did not adhere to one specific qualitative approach; rather it had elements of more than one approach, as has been described in Chapter 5 (5.2.3).

In the analysis of the data collected by means of the interviews there was a focus on 'meaning units' (*cf.* 5.3.5) and themes and categories were grouped together to make meaning of the database. As the views the participants had of the phenomenon would give the researcher their perspective on the proposed guide, the data could be categorised in two main categories, namely (i) positive, supportive and enthusiastic, and (ii) cautious, expressing concern. The responses mainly fell into the first category, that is, the participants were all positive and supportive of the guide, most were enthusiastic, and those responses that were categorised as cautious, or expressing concern, had to do with certain aspects of the composition of the guide, or with external factors that might influence the effective implementation of the guide, and not with the idea of the guide *per se*. The findings indicated that the participants' view of the current accreditation process was that it was mainly unstructured, the assessments were not experienced as altogether objective, and in some cases panel members were perceived as not being specialists in (or even informed about) medical education principles. Therefore the proposed guide was seen as a mechanism that could contribute to a more acceptable accreditation system, and as having the potential to promote quality in general in undergraduate medical education, should it be used as a planning tool. The findings and the recommendations made by the participants have been discussed in Chapter 6 (see 6.4 and 6.5).

Some minor changes to the content of the draft guide were recommended and those were incorporated in the final version of the guide (the outcome of the study) as given in Chapter 7.

8.3 LIMITATIONS IN THE STUDY

There is no single research method that can guarantee that no flaws will occur, and even with the best planning, studies do not always proceed as planned. Even though, or perhaps because, this study involved the utilisation of several research approaches and methods, it still was not without limitations.

With regard to the participant observation it may be regarded as a limitation that the researcher did not participate in the accreditation review visits to two of the South African medical schools; however, this limitation was addressed during the individual interviews, as the researcher then had the opportunity to discuss the draft guide with faculty members from the schools concerned, and would have picked up any matters

that might have been overlooked during the participant observation period.

In the case of the individual interviews, two interviews with the dean/head of a faculty/school or his/her representative did not realise. The limitation was partly overcome by the schools having been represented in the focus group interview, and in the case of one of the schools also in the interviews with former panel members. However, because the interviews were not conducted from the same perspective, it remains a limitation that the views and opinions of the heads of all schools had not been included in the study.

Another limitation was the fact that the focus group interview had not been piloted specifically in a focus group situation, as that would have been too time-consuming and the draft guide was regarded rather lengthy to expect of a number of people to read through it and sit for a pilot focus group interview; rather, the researcher asked the two members of the pilot study for the individual interviews to make recommendations regarding the agenda for the focus group interview, and conducted an individual interview with one participant in the pilot study on the same basis as she would have done with a focus group interview. This was not the ideal situation, but the researcher felt confident that the focus group interview would satisfy the expectations and criteria for such interviews, which in the end proved to have been the case.

The researcher does not claim that the final outcome of the study can be generalised for use in the entire field of quality assurance in medical education, but the guide that has been designed for accreditation reviews does have the potential to be useful over a wider front than in South African medical education institutions. It has been tailor-made for South African undergraduate medical education programmes, but with certain amendments to address the unique features of particular systems, it may be usable in other undergraduate medical education systems and accreditation systems too.

8.4 RECOMMENDATIONS

8.4.1 The proposed guide for accreditation reviews

Based on the findings of the study a number of recommendations regarding the possible use of the proposed guide* are made, aimed at achieving the goal of the study, namely

* Henceforth 'the guide' will be used to refer to the proposed guide for accreditation reviews that is the outcome of this study.

to contribute to quality education and training in undergraduate medical education in South Africa.

8.4.1.1 Accreditation reviews

This study was aimed at finding a solution for a problem that had been identified regarding the accreditation process for South African medical schools (see 1.4). Although standards for quality assurance have been formulated by, for example, the WFME (2003), the findings of this study constitute a tailor-made guide for South African circumstances. The participants in the study, in one way or the other, are involved in the accreditation process, and based on their responses it is proposed that the body responsible for accreditation of undergraduate medical education in South Africa should take note of this study and its outcome. The inference can be made that the general view of the participants, as representatives of the role players in medical education programmes, is that the current accreditation process could be improved, and the proposed guide may be a useful tool or mechanism to that end.

With regard to this recommendation, the researcher is of the opinion that it may be feasible for the accreditation body, should it decide to use this guide, to consider first piloting the guide, or parts thereof, in a number of accreditation reviews, in order to establish how feasible its implementation in South African institutions would be, and to refine and adapt it if and where required (*cf.* CHEA 2000).

8.4.1.2 Planning document

Based on the responses of the interviewees (see 6.5), it is proposed that the guide could be made available to medical schools/faculties in South Africa as a guiding document on quality education and training. Schools/faculties could implement it as planning and quality assurance tool or mechanism in their programmes for undergraduate education and training, as the inference can be made from the findings of the study that the use of the guide might foster a quality culture in institutions. It is postulated that it may provide an effective mechanism to help institutions determine where they are in relation to complying with the set standards, and it gives direction about what to do to improve. The use of the guide has the potential to enhance teaching and learning in undergraduate medical education programmes as a result of the emphasis that is put on good and innovative educational practices.

8.4.1.3 Format of the guide

It is further proposed, based on the views of the participants (see 6.5), that a condensed version of the guide be compiled, containing the standards without the full descriptions contained in the rubrics. This could be made available for general use, but still supplemented by the full guide for reference purposes. Both the condensed version and the supplement could be made available in print form in the form of a booklet. The guide could also be available in electronic format – to ensure broader access and to facilitate the self-evaluation prior to an accreditation review visit (*cf.* AMC 2004; GMC 2003; LCME 2004a).

8.4.1.4 Benchmarking

The researcher further recommends that the quality assurance process as proposed in the guide be used as a benchmarking process, which will foster quality enhancement as an integral part of the quality assurance process. It is suggested that this may be done by disseminating information on good practices collected during accreditation reviews to other institutions to serve as reference points for good practice (*cf.* McKinnon *et al.* 2000:2).

8.4.1.5 Enhancing innovation in medical education

As the guide supports an orientation towards innovative and improved educational strategies (see the data interpretation in 6.4, and recommendations by participants in 6.5), it might be useful in bringing about change in staff members and accreditation review panel members who are not informed of innovations and current developments in education. The profession might benefit from this study if the contents of the guide could be brought to the attention of teaching and training staff during staff orientation and/or staff development courses.

8.4.1.6 Status of the guide

The general feeling amongst participants was that the guide would have to be declared official by the professional body and the accreditation body, and that top-level commitment to the strategies proposed would be required to render the use of the guide successful (see 6.5). To achieve this, medical schools/faculties would need to accept in

principle the implementation of the guide. Once the guide has been refined to a version the accreditation body considers fit for implementation, a national workshop could be organised to introduce it, to compare it with similar documents available (for example, WFME 2003), and to consider possible implementation.

8.4.1.7 Implementation

Should the accreditation body decide to adopt the guide as an accreditation mechanism, it should ensure guidance and support for putting it in practice, and gain commitment from all role players and stakeholders. Medical schools/faculties could be requested to conduct workshops in which the guide may be introduced and the advantages of using it in planning could be pointed out. All participants in medical education thus could be informed and empowered to strive for excellence in their endeavours.

Once the guide has been refined to a mechanism the accreditation body may wish to implement, it might be to the advantage of the professional body regulating medical education to make it available worldwide, as this might prove to be a mechanism or tool other medical education and training institutions may find useful too – which will render South African medical education a leader in quality assurance.

8.4.2 Recommendations for further studies

The field of medical education lies fallow and ample opportunities exist for studies, especially with regard to quality assurance. With regard to further investigations in this field, the following recommendations are made:

- The researcher would recommend that this study be followed up with a pilot implementation study. Although every care has been taken to ensure trustworthiness, validity and reliability, and much effort has gone into the development of the proposed guide, it has not been piloted. Therefore, the logical next step would be to start using it in the accreditation process, and to determine whether any adaptations in formulations are required, whether schools/faculties find it a feasible and useful document, whether the format should be changed, and whether it renders the expected results in a real world situation.
- It was recommended in the focus group interview (see 6.3.2.i) that institutions should be granted the opportunity to add standards to the guide that highlight the

uniqueness of their programmes. Each medical education institution could start a project to identify the unique features of their programmes, convert these to standards and rubrics to render them measurable, and request the accreditation body to add those standards to the accreditation review guide for use in their particular institutions. This would also serve the purpose of ensuring that all institutions are not cast within the same mould, and have the opportunity to maintain their uniqueness.

- Participants recommended the drafting of an abridged version of the guide for general use (see 6.5), but within the ambit of this study it was not possible to respond to the recommendation, due to financial and time constraints. This recommendation, however, suggests the possibility of a further study project, namely to condense the proposed guide to a format that might be used more readily, with the full guide as reference source.
- As quality assurance is a dynamic and evolving process, the researcher recommends that the accreditation body should start a process of continually taking the proposed standards under scrutiny with a view to updating the guide to ensure that the process of on-going improvement does not lose momentum. The impetus behind improvement of quality is the challenge of continually striving to achieve higher standards. It is therefore recommended that such an action research process be started, determining the results of a first round of accreditation reviews carried out in terms of the standards in the proposed guide, followed up by a review of the standards, followed by a next round of accreditation reviews, and so forth. Such a cyclic process will ensure that South African undergraduate medical education stays on a par with other programmes worldwide.
- The researcher further would recommend that the documentation on the accreditation process in South Africa (*cf.* Chapter 4) be reviewed, updated and adapted as required, and that an inclusive document on the rationale, history and background, and the process of quality assurance in medical education in South Africa be compiled. Such a document should contain relevant regulations, guidelines, definitions and explanations of terminology, and be made available to all stakeholders in medical education in South Africa

8.5 VALUE OF THE STUDY

The value of the study lies in it being a thorough investigation into quality assurance in undergraduate medical education, the results of which may serve as a useful reference guide for all concerned with undergraduate medical education, and, more specifically, with quality assurance in medical education. The extensive literature study puts the matter of quality assurance in higher and specifically medical education in perspective and could serve as a point of reference for other studies on the topic.

The part of the study that deals with the current accreditation process of the HPCSA provides a compilation of information on the process as it has evolved, and could serve as a point of departure for future developments.

The guide for accreditation reviews that has been developed has the potential to serve a multiple goal as a quality assurance tool in the formal accreditation process, as well as a mechanism that can be used in the development of programmes for undergraduate medical education, for planning purposes, for internal self-evaluations, for the preparation for accreditation reviews, and in general for informing faculty members of educational principles and trends that have a specific value for medical education and training.

The ultimate value of the study lies in the contribution it can make to quality assurance and enhancement in undergraduate medical education in South Africa. To deliver quality medical practitioners, institutions offering education and training to medical students should be above suspicion with regard to their education and training processes, and it is hoped that the results of this study will contribute to proving institutions' claim that South Africa produces doctors of the highest quality. As such a complete set of standards with rubrics has not yet been developed for purposes of accreditation in medical education elsewhere, this may well put South Africa in the vanguard of development in that respect.

8.6 CONCLUSION

The quality of medical education and training has come under scrutiny as early as 1910 when the well-known Flexner Report saw light (Flexner 1910). Flexner, an educationist, realised that basic educational principles had to form the basis of medical education. Over the past two decades, once again, there has been a proliferation in the interest in

the quality of medical education, which was most probably kicked off with the WFME's establishment in 1984 of an international programme for the reorientation of medical education (see 2.4). The programme was given impetus by the Edinburgh Declaration of 1988, followed by the World Summit recommendations (1994) and the World Health Assembly (WHA) Resolution 48.8 of 1995, in which quality in medical education was mentioned as one of the two main components of the strategy for reform in medical education (see 2.4.1). This resolution stated *inter alia* that tools and procedures should be designed for use in the internal and external evaluation and accreditation of medical education (WHO 1996:13).

In 2003 only a minority of the 1600 medical schools worldwide were subject to external evaluations or accreditation processes (WFME 2003:6). This was a cause for concern, and the WFME published a set of generic standards for quality improvement in basic medical education (WFME 2003), which, first of all, was intended for internal evaluations and quality improvement, although external evaluations and accreditation are integral to the proposals. External quality assurance has become a norm in higher education worldwide to ensure visibility, transparency and comparability of quality in higher education. The importance of external quality assurance to verify the self-evaluations of institutions has been described in Chapter 2 (2.2.2).

In Chapter 2 a number of external quality assurance systems for undergraduate medical education are discussed as found in different countries worldwide. In 2000 the Health Professions Council of South Africa replaced its former system of inspection of departments in medical schools/faculties with an accreditation process as quality assurance system (see Chapter 4). This brought South African medical education in line with the systems such as those found in the USA and Canada, Australia, the United Kingdom and the Netherlands (see Chapter 2).

In the five years since 2001 all the medical schools/faculties in South Africa offering undergraduate medical education have received visits from an accreditation review panel. These panels comprise six to eight members at a time, representing the major medical disciplines and education. For each visit a new panel is selected, albeit some members have served on quite a number of panels. The chair is appointed by the UET and must be a member of the UET.

The documentation that guides these visits and the whole accreditation process have

been discussed in Chapter 4. Suffice to say here that no set standards exist in terms of which the accreditation decisions can be made; the only guideline for use by the panel is a document in which the profile of the doctor is spelt out, the goals and objectives of medical education are explained and a number of recommendations regarding education and training are made (HPCSA 1999). This, together with the changing nature of the review panels caused the researcher (having been a member of seven accreditation review panels between 2001 and 2004) to identify a need to study the accreditation process in depth, and to find answers to some questions regarding the consistency and objectivity of the judgements passed by these panels in the light of the lack of a mechanism or tool to use in their decision-making processes, and in the absence of set standards by which to measure the performance of institutions (see 1.4 and 5.1 for a discussion of the research questions). Another important issue the researcher wanted to address was how to determine whether and how medical education institutions were striving to improve the quality of their offerings.

The answer to these questions, the researcher has found, lies in a guide for accreditation reviews, comprising guidelines in the form of a set of standards and rubrics, which could be used by medical schools/faculties to do their programme planning, to encourage improvement and to prepare adequately for accreditation reviews; should the accreditation review panel then use the same guide and standards to evaluate the quality of the programmes, it is postulated that a more structured and consistent process will result, rendering more objectivity in the panels' decisions, and, most important, a process of continual striving for the improvement of the quality of undergraduate medical education programmes will be established.

The study was an extensive and enriching exercise, and the hope is expressed that the outcome will prove to be useful in and beneficial to quality assurance in medical education in South Africa. It is also hoped that the information on quality assurance collected and the perspectives presented in this thesis will contribute to a better understanding of the field of quality assurance in education, and that these will be taken note of in deliberations on quality assurance and accreditation specifically.

A study of a topic such as quality assurance, which represents an evolving and live phenomenon, cannot claim to be all-inclusive or conclusive, and the researcher in no way will claim that this study was that, but it was a profound exercise, looking at quality assurance from a variety of angles, seeking to exploit existing knowledge, to incorporate

the perspectives of those closely involved with the reality of the phenomenon, and to render a product that represents new perspectives and newly organised insights, that is, to make a novel contribution to the existing body of knowledge on the phenomenon.

in the race for quality, there is no finishing line

(David Kearns)

LIST OF REFERENCES*

*Please note: The sources consulted in the drafting of the *Guide for accreditation reviews* have not been taken up in this list of references, unless directly referred to in the text of the thesis. These sources, however, are listed at the end of Chapter 7.

- Adelman C. 1983. The major seventh: Standards as a leading tone in higher education. In J.R. Warren (Ed.) *Meeting the new demand for standards*. San Francisco: Jossey-Bass.
- Alberts L. 2002. Foreword. In A.S. de Vos (Ed.) *Research at grass roots: For the social sciences and human service professions* (2nd edition). Hatfield, Pretoria: Van Schaik Publishers.
- Alstete W.J. 1995. *Benchmarking in higher education: Adapting best practices to improve quality*. ASHE-ERIC Higher Education Report No 5. Washington, DC: George Washington University.
- AMC (Australian Medical Council Incorporated) 1998. *Guidelines for the assessment and accreditation of Medical Schools*. Kingston: AMC Incorporated.
- AMC (Australian Medical Council Incorporated) 2002. *Assessment and accreditation of medical schools: Standards and procedures*. Kingston Act: Australian Medical Council Incorporated.
- AMC 2002a. Australian Medical Council Submission: Higher Education Review. Submission 43, 24 June 2002. <http://www.amc.org.au/accreditation/MISC/AMC>. Retrieved 23/7/02.
- AMC 2004. *Australian Medical Council: Assessment and accreditation of medical schools*. <http://www.amc.org.au/accredit.asp>. Retrieved 11/4/2004.
- Ashcroft K. 2003. Enterprise activity in UK higher education: Models and approaches to quality. *Higher Education Review* 36 (1):3-23.
- Babbie E.R. 1989. *The practice of social research*. Belmont: Wadsworth.
- Babbie E.R. 2001. *The practice of social research* (9th ed.). Belmont: Wadsworth.
- Babbie E. & Mouton J. 2001. *The practice of social research*. Oxford: Oxford University Press Southern Africa, Cape Town.
- Basit T. 2003. Manual or electronic? The role of coding in qualitative data analysis. *Educational Research* 45 (2):143-154.
- Bazargan A. 1999. Introduction to assessing quality in medical education in Iran: Challenges and perspectives. *Quality in Higher Education* 5(1):61-67.
- Bégin-Heick N. 1999. Guarding the guardians: The meta-evaluation of an external quality assurance process. *QA: International Network for Quality Assurance*

Agencies in Higher Education 18 (July):5-8.

- Bezuidenhout M.J. 2000. Accreditation of undergraduate medical and dental schools (Draft). Unpublished document. Division of Educational Development, Faculty of Health Sciences, UFS, Bloemfontein.
- Bezuidenhout M.J. 2002. *National standards for the accreditation of undergraduate medical education and training in South Africa*. Magister in Health Professions Education: Dissertation, Faculty of Health Sciences, University of the Free State, Bloemfontein.
- Bezuidenhout M.J. 2001-2004. Field notes and reports on accreditation review visits. Unpublished documentation. Bloemfontein, Faculty of Health Sciences, UFS.
- Billing D. 2004. International comparisons and trends in external quality assurance of higher education: Commonality or diversity? *Higher Education* 47:113-137.
- BNQP 2001. *Baldrige National Quality Program*. Gaithersburg: National Institute of Standards and Technology.
- BNQP 2002. *Baldrige National Quality Program: Education criteria for performance excellence*. Gaithersburg: National Institute of Standards and Technology.
- Boelen C. 1990. A call for systematic action for changing medical education: Reaction of working partners. *Medical Teacher* 12(2):131-142.
- Boelen C. 1995. Prospects for change in medical education in the twenty-first century. *Academic Medicine* 70 (7) Supplement: S21-S28.
- Boelen C. 2001. Accreditation and development of medical schools: A global project. *Towards unity for health* 4 (October):6-9.
- Boelen C., Bandaranayake R., Bouhuijs P.A.J., Page G.G. & Rothman A.I. 1992. *Towards the assessment of quality in medical education*. Geneva: WHO.
- Bresciani M.J. 2002. Development of a rubric to evaluate academic programme assessment plans at North Carolina State University. *Assessment Update* 14(6):14-15.
- Bresciani M.J. & Allen J. 2002. Undergraduate academic program review (UAPR) assessment. <http://ncsu.edu/undergrad-affairs/assessment/files/evaluation/uapr-process-evaluation-rubric.htm>. Retrieved 12/7/2004.
- Brink H.I. 2003 (6th impression). *Fundamentals of research methodology for health care professionals*. Lansdowne: Juta & Co.
- Burns N. & Grove S.K. 1997. *The practice of nursing research: Conduct, critique and utilization*. USA: WB Saunders Co.
- Butterfield J. 1972. Foreword. In M.A. Simpson *Medical education: A critical approach*. London: Butterworths.

- Caelli K., Ray L. & Mill J. 2003. 'Clear as mud': Toward greater clarity in generic qualitative research. *International Journal of Qualitative Research* 2(2). <http://www.ualberta.ca/~ijqm/backissues/pdf/caellietal.pdf>. Retrieved 1/06/2004.
- Cassie J.M., Armbruster J.S., Bowmer M.I. & Leach D.C. 1999. Accreditation of postgraduate medical education in the United States and Canada: A comparison of two systems. *Medical Education* 33:493-498.
- Castle R. & Kelly D. 2004. International education: Quality assurance and standards in offshore teaching: Exemplars and problems. *Quality in Higher Education* 10(1):51-57.
- Chappel C. s.a. A look at qualitative research. <http://www.gsu.edu/~mstsw/courses/it>. Retrieved 19/03/2004
- CHE 2003. *Proposed criteria for the HEQC's first cycle of audits: 2004-2009*. Discussion document. Pretoria: Higher Education Quality Committee.
- CHEA 2000. *The competency standards project: Another approach to accreditation review*. CHEA Occasional Paper. Washington, DC: Council for Higher Education Accreditation.
- CHEMS 1998. *Benchmarking in higher education: An international review*. s.l.: Commonwealth Higher Education Management Service.
- Clayton M.J. 1997. Delphi method: Technological forecasting. *Educational Psychology* 17(4):373 – 387.
- Cohen J.J. 2000. Defining international standards in basic medical education: The World Federation of Medical Education has initiated a timely discussion. *Medical Education* 34: 600-601.
- COHSASA s.a. *Standard assessment manual for hospitals*. Pinelands: Council for Health Service Accreditation of Southern Africa Association Incorporated in South Africa.
- Creswell J.W. 1998. *Qualitative inquiry and research design: Choosing among five traditions*. California: Sage Publications.
- Crowson R.L. 1987. Qualitative research methods in higher education. In J.C. Smart (Ed.) *Higher education handbook of theory and research (Vol. II)*. New York: Agathon Press.
- Delpont C.S.L. & Fouché C.B. 2002. The qualitative research report. In A.S. de Vos (Ed.) *Research at grass roots: For the social sciences and human service professions* (2nd ed.). Hatfield, Pretoria: Van Schaik Publishers.
- De Vos A.S. 2002. Intervention research. In A.S. de Vos (Ed.) *Research at grass roots: For the social sciences and human service professions* (2nd ed.). Hatfield,

- Pretoria: Van Schaik Publishers.
- De Vos A.S. (Ed.) 2002. *Research at grassroots: For the social sciences and human service professions* (2nd ed.). Pretoria: Van Schaik Publishers.
- DEI (Danish Evaluation Institute) 2003. *Quality procedures in European higher education: An ENQA survey*. ENQA Occasional Papers 5. Helsinki: European Network for Quality Assurance in Higher Education.
- Denzin N.K. & Lincoln Y.S. (Eds.). 1994. *Handbook of qualitative research*. Thousand Oaks: SAGE.
- Dill D.D. 1999. Through Deming's eyes: A cross national analysis of quality assurance policies in higher education. In *Quality management in higher education institutions*. CHEPS Reader Unit 3. Utrecht: Lemma.
- Dittrich K. 2003. Accreditation in the Netherlands and Flanders. *TUFH Newsletter* 01 (June):20.
- Eaton J.S. 2002. Accreditation. In James J.F. Forrest & Kevin Kinser (Eds.). *Higher Education in the United States*. <http://www.chea.org/About/accreditation.cfm>. Retrieved 24/07/2002.
- EMC 2002. Regulations relating to the accreditation of South African Faculties or Schools of Medicine and Dentistry. Medical and Dental Professions Board: Education and Registration Management Committee. HPCSA, Pretoria. Unpublished.
- Erkut S & Fields J.P. 1987. Focus groups to the rescue. *Training and Development Journal* October:74-76.
- Ewell P.T. 1998. *Examining a brave new world: How accreditation might be different*. Council for Higher Education Accreditation (CHEA). Downloaded 7/23/02. <http://www.chea.org/Events/Usefulness/98May/98-05Ewell.html>.
- Faber M. & Huisman J. 2003. Same voyage, different routes? The course of the Netherlands and Denmark to a 'European model' of quality assurance. *Quality in Higher Education* 9(3): 231-241.
- Flexner A. 1910 (reprinted 1972). *Medical Education in the United States and Canada: A report to the Carnegie Foundation for the advancement of teaching*. New York: Arno Press & The New York Times.
- Fouché C.B. 2002. Problem formulation. In A.S. de Vos *Research at grassroots: For the social sciences and human service professions* (2nd ed.). Pretoria: Van Schaik Publishers.
- Fouché C.B. & Delport C.S.L. 2002. The place of theory and the literature review in the qualitative approach to research. In A.S. de Vos *Research at grassroots: For the*

- social sciences and human service professions* (2nd ed.). Pretoria: Van Schaik Publishers.
- Fourie M. 1999. Preface. In Fourie M., Strydom A.H. & Stetar J. (Eds.). *Reconsidering quality assurance in higher education: Perspectives on programme assessment and accreditation*. Bloemfontein: Unit for Research into Higher Education, University of the Free State.
- Fourie M., Strydom A.H. & Stetar J. (Eds.) 1999. *Reconsidering quality assurance in higher education: Perspectives on programme assessment and accreditation*. Bloemfontein: Unit for Research into Higher Education, UFS.
- Fox N. 1998. *Trent Focus for research and development in primary health care: How to use observations in a research project*. Nottingham: Trent Focus. Retrieved 28/6/2004. <http://www.trentfocus.org.uk>.
- Frazer M. 1991. Quality assurance in higher education. In Alma Craft (Ed.) *Quality assurance in higher education: Proceedings of an International Conference (Hong Kong)*. London: Falmer Press.
- Glidden R. 1998. The contemporary context of accreditation: Challenges in a changing environment. Keynote address: 2nd CHEA "Usefulness" Conference. *CHEA Chronicle*. <http://www.chea.org/Events/Usefulness/98May>. Downloaded 7/23/02.
- GMC 1993. *Tomorrow's doctors: Recommendations on undergraduate medical education*. London: General Medical Council.
- GMC 1997. *The new doctor*. London: General Medical Council.
- GMC 2003. *Tomorrow's Doctors: Recommendations on undergraduate medical education*. <http://www.gmc-uk.org/med-ed/tomdoc.htm>. Retrieved 11/15/2004.
- GMC 2004. *Quality assuring undergraduate medical education – an overview: QABME - Guidance document. October 2004*. <http://www.gmc-uk.org/EDUCAT\General\Guidance>. Retrieved 11/4/2004.
- GMC 2004a. *Principles of good medical education and training: Draft for consultation*. August 2004. <http://www.gmc-uk.org/med-ed/principles-good-med-ed-and-training.pdf>. Retrieved 11/4/2004.
- GMC 2004b. *QABME visitors and observers - Guidance document. June 2004*. http://www.gmc-uk.org/EDUCAT\General\Guidance\UME\FINAL\PDF\G003_AQMBE-Visitors and Observers. Retrieved 11/4/2004.
- Gosling D. & D'Andrea V. 2001. Quality development: A new concept for higher education. *Quality in Higher Education* 7(1):7-17.
- Greeff M. 2002. Information collection: Interviewing. In A.S. de Vos (Ed.) *Research at*

grass roots: For the social sciences and human services professions. Hatfield, Pretoria: van Schaik Publishers.

- Groenewald T. 2004. A phenomenological research design illustrated. *International Journal of Qualitative Methods* 3(1). Article 4. Retrieved 17/5/2004 from http://www.ualberta.ca/~iiqm/backissues/3_1/html/groenewald.html.
- Haakstad J. 2001. Accreditation: The new quality assurance formula? Some reflections as Norway is about to reform its quality assurance system. *Quality in Higher Education* 7(1): 77-82.
- Hamdy H. 2003 Standards for accreditation of undergraduate medical education in Gulf Cooperative Council (GCC) Countries: Implications on quality in medical education. Paper delivered at AMEE Conference, Bern, Switzerland.
- Hamilton J.D. & Vandewerdt J.M. 1990. The accreditation of undergraduate medical education in Australia. *The Medical Journal of Australia* 153 (November): 541-545.
- Hancock B. 1998 (updated 2002). Trent focus for research and development in primary health care: An introduction to qualitative research. Nottingham University, Nottingham. Retrieved 28/6/2004. <http://www.trentfocus.org.uk>.
- Harris E.B. 2002. Qualitative methods. In G.R. Norman, C.P.M. van der Vleuten & D.I. Newble (Eds.). *International handbook of research in medical education*. Dordrecht, The Netherlands: Kluwer Academic Publishers.
- Harte K. 2002. Proposals for new quality assurance of basic medical education: Draft document – Policy Advisor, Education and Development, General Medical Council. E-mail: gabme@gmc-uk.org. Received 28/05/2004.
- Harvey L. & Green D. 1993. Defining quality. *Assessment and Evaluation in Higher Education* 18(1):9-34.
- Harvey L. & Mason S. 1995. *The role of professional bodies in higher education monitoring*. Birmingham: QHE & University of Central England.
- Harvey L. & Newton J. 2004. Transforming quality evaluation. *Quality in Higher Education* 10(2):149-165.
- HEFCE 1996. *Assessors' Handbook: October 1996-September 1998*. Bristol: Higher Education Funding Council for England: Quality Assessment Division.
- HEQC (Higher Education Quality Committee). 2003. *Proposed criteria for the HEQC's programme accreditation cycle: 2004-2009. Discussion document*. Pretoria: CHE.
- HEQC (Higher Education Quality Council) 1996. *Guidelines for quality assurance*. London: HEQC.
- HPCSA 1999. *Education and training of doctors in South Africa: Undergraduate medical education and training – Guidelines by the Medical and Dental Professions Board*.

Pretoria: MDPB, HPCSA.

- HPCSA 1999a. Accreditation of South African medical and dental faculties/schools: Guidelines by the Medical and Dental Professions Board. Pretoria: Health Professions Council of South Africa. Unpublished.
- Huysamen G.K. 1993. *Metodologie vir die sosiale en gedragwetenskappe*. Halfweghuis: International Thomson Publishing (Suider-Afrika).
- Huysamen G.K. 1994. *Methodology for the social and behavioural sciences*. Halfway House, South Africa: International Thomson Publishing.
- IIME 2001 *Global minimum essential requirements in medical education*. White Plains, New York: Institute for International Medical Education.
- Jackson N. 2000. Benchmarking educational processes and outcomes. In N. Jackson & H. Lund (Eds.) *Benchmarking for higher education*. London: SRHE & Open University Press.
- Jackson N. & Lund H. (Eds.) 2000. *Benchmarking for higher education*. London: SRHE & Open University Press.
- Jackson N. & Lund H. 2000. Introduction to benchmarking. In N. Jackson & H. Lund (Eds.) *Benchmarking for higher education*. London: SRHE & Open University Press.
- Jackson N. 2002. Growing knowledge about QAA subject benchmarking. *Quality Assurance in Higher Education* 10(3):139-154.
- Jonathan L.T. 2000. Quality assurance and evaluation in African universities: Developing a sustainable quality culture in a challenging environment. *South African Journal of Higher Education* 14(2):45-49.
- Jones D.P. 2002. *Different perspectives on information about quality: Implications for the role of accreditation*. CHEA Occasional Paper. Washington DC: Council for Higher Education Accreditation.
- Jones E.A. & Ratcliff J.L. 1999. Global perspectives on programme assessment and accreditation. In *Reconsidering quality assurance in higher education: Perspectives on programme assessment and accreditation* by M. Fourie, A.H. Strydom & J. Stetar (Eds). Bloemfontein: Unit for Research into Higher Education.
- JUAA 1996. *Japanese University Accreditation Association*. Tokyo: JUAA (Information brochure).
- JUAA 1996a. *Japanese University Accreditation Association*. Tokyo: JUAA. <http://www.juaa.or.jp/english/main/hyouka.html>. Retrieved 12/3/2004.
- Katzenellenbogen J.M., Joubert G. & Karim S.S.A. (Eds.) 1999. *Epidemiology: A manual for South Africa*. Cape Town: Oxford University Press Southern Africa.

- Kistan C. 1999. Quality assurance in South Africa. *Quality Assurance in Education* 7(3):125-133.
- Kohler J. 2003. Quality assurance, accreditation, and recognition of qualifications as regulatory mechanisms in the European higher education area. *Higher Education in Europe XXVIII* (3):315-330.
- Krefting L. 1991. Rigor in qualitative research: The assessment of trustworthiness. *The American Journal of Occupational Therapy* 45(3):214-222.
- KSDE 2002. Draft Kansas staff development rubric for district/school use: Based on National Staff Development Council (NSDC) standards. Kansas Department of Education. Retrieved 06/02/2003.
http://www.cde.state.co.us/pdssp/downloads/SAC_word_KSDERubric.pdf.
- Labuschagné M.J. 1995. Accreditation in higher education with special reference to medical education. Unpublished report. Pretoria, HPCSA & Bloemfontein: Division of Educational Development.
- Lacey A. & Luff D. 2001. *Qualitative data analysis*. Trent Focus for Research and Development in Primary Health Care. Nottingham: Trent Focus. Retrieved 28/6/2004. <http://www.trentfocus.org.uk>.
- Laverty S.M. 2003. Hermeneutic phenomenology and phenomenology: A comparison of historical and methodological considerations. *International Journal of Qualitative Methods* 2(3). Article 3.
<http://www.ualberta.ca/iqim/backissues/2-3final/html/laverty.html>. Retrieved 26/03/2004.
- LCME (Liaison Committee on Medical Education). 1995. *Functions and structure of a medical school*. Washington DC: Association of American Medical Colleges and the American Medical Association.
- LCME 2001. *Liaison Committee on Medical Education: Frequently asked questions*. <http://www.lcme.org/faqlcme.htm>. Retrieved 8/7/02.
- LCME (Liaison Committee on Medical Education). 2002. *Guidelines for the conduct of accreditation survey visits*. Washington & Chicago: Association of American Medical Colleges & Council of Medical Education, American Medical Association.
- LCME 2002a. *Liaison Committee on Medical education: Accreditation procedures*. <http://www.lcme.org/procedur.htm>. Retrieved 8/7/02.
- LCME (Liaison Committee on Medical Education). 2003. *Functions and structure of a medical school: Standards for accreditation of medical education programs leading to the M.D. degree*. Washington D.C.: Liaison Committee on Medical Education.
- LCME 2004. *LCME Accreditation standards (in narrative format)*. From *Functions and*

structure of a medical school, Part I, updated 18 February 2004. Liaison Committee on Medical Education.

<http://www.lcme.org/functionsnarrative.htm>. Retrieved 28/5/2004

LCME 2004a. *LCME Accreditation standards (in list format, with annotations)*. From *Functions and structure of a medical school, Part 2*, updated 18 February 2004. Liaison Committee on Medical Education.

<http://www.lcme.org/functionslist.htm>. Retrieved 28/5/2004.

LCME 2004b. *Overview: Accreditation and the LCME*. Revised 7 July 2004. Liaison Committee on Medical Education. <http://www.lcme.org/overview.htm>. Retrieved 11/4/2004.

LCME 2004c. *Accreditation procedures*. Revised 21 October 2004. Liaison Committee on Medical Education. <http://www.lcme.org/procedur.htm>. Retrieved 11/4/2004.

Leach D.C. 2001. The ACGME competencies: Substance of form? *Journal of the American College of Surgeons* 192 (3): 396-398.

L'Ecuyer J. 1998. Three years of evaluation in Quebec colleges. *QA: International Network for Quality Assurance Agencies in Higher Education* 15 (January): 16.

Leedy P. 1997. *Practical research: Planning and design* (6th edition). Up Saddle River, New Jersey: Prentice Hall Inc.

Leedy P.D. & Ormrod J.E. 2001. *Practical research: Planning and design* (7th edition). New Jersey: Merrill Prentice Hall.

Lemaitre M.J. 2004. Development of external quality assurance schemes: An answer to the challenges of higher education evolution. *Quality in Higher Education* 10 (2): 89-99.

Lincoln Y. & Guba E.G. 1985. *Naturalistic inquiry*. London: SAGE.

Liu K. 1995. Rubrics revisited. *The Science Teacher* 62(7):49-51.

Lubinescu E.S., Ratcliff J.L. & Gaffney M.A. 2001. Two continuums collide: Accreditation and assessment. In E.S. Lubinescu, J.L. Ratcliff & M.A. Gaffney (Eds.) *How accreditation influences assessment*. San Francisco: Jossey Bass.

Marielle S. & Forgette-Giroux R. 2001. A rubric for scoring post-secondary academic skills. *Practical Assessment, Research & Evaluation* 7(18).

<http://PAREonline.net/getvn.asp?v=9&n=2>. Retrieved September 23 2004.

Marock C. 2000. *Quality assurance in higher education: The role and approach of professional bodies and SETAs to quality assurance*. A report commissioned by the HEQC. Pretoria: Council on Higher Education.

Mathers N., Fox N. & Hunn A. 1998. *Trent Focus for research and development in primary health care: Using interviews in a research project*. Nottingham: Trent

- Focus. Retrieved 28/6/2004. <http://www.trentfocus.org.uk>.
- McKinnon K.R., Walker S.H. & Davis D. 2000. *Benchmarking: A manual for Australian universities*. Canberra: Department of Education, Training and Youth Affairs.
- McMillan J.H. & Schumacher S. 2001. *Research in education: A conceptual introduction*. New York: Longman.
- MDPB (Medical & Dental Professions Board) 2000. Report on a meeting of the Task group on the development and implementation of the system and process of accreditation. Meeting held in the HPCSA Building, Pretoria, on 16 February 2000. (Unpublished).
- MDPB 2003. Accreditation of Schools of Medicine and Dentistry at the undergraduate level: Guidelines for the visiting panel. Pretoria: Medical and Dental Professions Board, HPCSA. (Unpublished).
- MDPB 2003a. Recommended structuring of an accreditation report. Pretoria: Medical and Dental Professions Board, HPCSA. (Unpublished).
- Meade P.H. 1998. *A guide to benchmarking*. Dunedin: University of Otago.
- Medical Council, Ireland 1997. Statement on undergraduate medical education: Aims and objectives of medical education.
<http://www.medicalcouncil.ie/statementugmedic.htm>. Retrieved 8/1/02.
- Merriam S.B. 1998. *Qualitative research and case study applications in education*. San Francisco: Jossey Bass.
- Metz J.C.M., Stoelinga G.B.A., Pels Rijcken-Van Erp Taalman Kip E.H. & Van den Brand-Valkenburg B.W.M. 1994. *Blueprint 1994: Training of Doctors in the Netherlands*. Nijmegen: University of Nijmegen.
- Metz J.C.M., Verbeek-Weel A.M.M. & Huisjes H.J. 2001. *Blueprint 2001: Training of doctors in the Netherlands: Adjusted objectives of undergraduate medical education in the Netherlands*.
<http://www.med.uni.giessen.de/intranet/lehre/blueprint%20netherlands.pdf>. Retrieved 11/04/2004.
- Moore C.M. 1987. *Group techniques for idea building*. Thousand Oaks, California: SAGE.
- Mosby s.a. *Basic principles of communicating effectively in nursing*. Video produced by Samuel Merritt College, Studio Two Productions.
- Moskal B.M. 2000. Scoring rubrics: What, when and how? *Practical Assessment, Research & Evaluation* 7(3):1-9. <http://PAREonline.net/getvn.asp?v=7&n=3>. Retrieved 7 December 2004.
- Moskal B.M. 2003. Recommendations for developing classroom performance

- assessments and scoring rubrics. *Practical Assessment, Research & Evaluation* 8(14):1-9. <http://PAREonline.net/gettvn.asp?v=7&n=3>. Retrieved 07/12/2004.
- Moskal B.M. & Leydens J.A. 2000. Scoring rubric development: Validity and reliability. *Practical Assessment, Research & Evaluation* 7(10). <http://PAREonline.net/gettvn.asp?v=7&n=10>. Retrieved 07/12/2004.
- Mouton J. 2001. *How to succeed in your master's and doctoral studies*. Pretoria: Van Schaik Publishers.
- Nel C.J.C. 1995. Die handhawing van norme, waardes en standaarde in geneeskunde-
onderwys in Suid-Afrika. [The maintenance of norms, values and standards in
medical education in South Africa]. Paper read at a meeting of the Academy for
Arts and Sciences by the Dean, Faculty of Health Sciences, University of the Free
State. (Unpublished).
- Nel C.J.C. 1995a. Guidelines for the evaluation of a medical school and medical
training. Document compiled for the HPCSA (unpublished). Bloemfontein, Faculty
of Medicine, University of the Free State.
- Nel C.J.C. 2003. Dean, Faculty of Health Sciences, University of the Free State &
member of the Undergraduate Education and Training Committee, Medical and
Dental Professions Board, HPCSA. Personal communication, Bloemfontein,
February.
- Nel C.J.C. & Bezuidenhout M.J. 1997. Die opleiding van geneeshere in Suid-Afrika:
Riglyne van die Mediese en Tandheelkundige Professionele Raad [The training of
doctors in South Africa: Guidelines of the Medical and Dental Professions Board].
Unpublished. Division of Educational Development, University of the Free State,
Bloemfontein.
- Nel C.J.C. & Bezuidenhout M.J. 2003. A comparison of accreditation by the Health
Professions Council of South Africa and the WFME pilot study. Paper presented at
the WFME Conference on Global standards in Medical Education, Copenhagen.
- Norman G. 2002. Introduction. In G.R. Norman, C.P.M. van der Vleuten & D.I. Newble
(Eds.) *International handbook of research in medical education*. Dordrecht, The
Netherlands: Kluwer Academic Publishers.
- Olmesdahl P. 1999. Preoccupation with quality. *Teaching in Higher Education*
4(3):419-424.
- Peck E. & Secker J. 1999. Quality criteria for qualitative research: Does context make a
difference? *Qualitative Health Research* 9(4): 552-558.
- Pirsig Robert M. 1999. *Zen and the art of motorcycle maintenance*. London: Vintage
(First published in 1974).

- Prasad V.S. & Stella A. 2005. Accreditation of higher education institutions: Indian experience. Paper presented at a conference of the NAAC, Bangalore.
<http://www.che.ac.za/document/d000091/seminar-9-3-05-Int-trends-qa-prof-prasad.pdf>. Retrieved 5/5/2005.
- Pritchett H.S. 1910. Introduction. In Flexner A. 1910 (reprinted 1972). *Medical Education in the United States and Canada: A report to the Carnegie Foundation for the advancement of teaching*. New York: Arno Press & The New York Times.
- QAA 1997. *Subject review handbook: October 1998-September 2000*. Gloucester: Quality Assurance Agency for Higher Education.
- QAA 2004. Reviewing standards and quality. *The Quality Assurance Agency: An introduction*. <http://www.qaa.ac.uk/aboutus/qaaIntro/intro.asp>. Retrieved 03/12/2004.
- Randall J. 2002. Quality assurance: Meeting the needs of the user. *Higher Education Quarterly* 56(2):188-203.
- RCPSC 2002. General standards applicable to the university and affiliated sites. Ottawa: Royal College of Physicians and Surgeons of Canada, Educational Standards Unit. Updated 2002. Retrieved: 7/23/02.
<http://rcpsc.medical.org/english/residency/accreditation/genstandards-e.html>.
- RGN (Raad vir Geesteswetenskaplike Navorsing) 1988. *Akkreditering in die RSA*. Verslag van die Hoofkomitee van die RGN-onderwysnavorsingsprogram [Accreditation in the RSA. Report of the Human Sciences Research Council Main Committee], No. 12. Pretoria: RGN.
- Rubrics.com 2001. Helping you design assessments: Easy to use software.
http://www.rubrics.com/4DAction/W_ShowmemberArticle/1/1. Retrieved 06/02/03.
- Rubrics.com 2002. *Rubric basics*. Article archive vault.
<http://www.rubrics.com/Online/Standard4600.qif>. Retrieved 11/12/2002.
- Sandelowski M. 2002. Focus on research methods: Combining qualitative and quantitative sampling, data collection and analysis techniques in mixed-method studies. *Research in Nursing and Health* 23:246-255.
- Schofield A. 1998. An introduction to benchmarking in higher education. In Commonwealth Higher Education Management Services Monograph (Ed.) *Benchmarking in Higher Education*. United Kingdom: CHEMS.
- Scott P. 1994. Recent developments in quality assessment in Great Britain. In D.F. Westerheijden, J. Brennan & P. Maassen (Eds.). *Changing contexts of quality assessment*. Utrecht, the Netherlands: LEMMA.
- Shank G.D. 2002. *Qualitative research: A personal skills approach*. Upper Saddle

River, New Jersey: Merrill Prentice Hall.

- Simon M. & Forgette-Giroux R. 2001. A rubric for scoring postsecondary academic skills. *Practical Assessment, Research & Evaluation* 7(18).
<http://PAREonline.net/getvn.asp?v=7&n=18>. Retrieved 23/09/2004.
- Singh P. 2000. Editorial: Quality assurance in higher education in South Africa. *South African Journal of Higher Education* 14(2):5-7.
- Sohm K. 2004. Austria: Accreditation in Austrian Fachhochschule sector. In P. Di Nauta, P. Omar, A. Schade & J.P. Scheele, *Accreditation models in higher education: Experiences and perspectives*. ENQA Workshop Report 5. Helsinki: European Network for Quality Assurance in Higher Education.
- Stella A. 2004. External quality assurance in Indian higher education: Developments of a decade. *Quality in Higher Education* 10 (2):115-127.
- Storr L. 2004. Leading with integrity: A qualitative research study. *Journal of Health Organization and Management* 18 (6):415-434.
- Strydom H. 2002. Ethical aspects of research in the social sciences and human services professions. In A.S. de Vos (Ed.) *Research at grass roots: For the social sciences and human services professions*. Hatfield, Pretoria: van Schaik Publishers.
- Strydom H. 2002a. Information collection: Participant observation. In A.S. de Vos . *Research at grassroots: For the social sciences and human service professions* (2nd ed.). Pretoria: Van Schaik Publishers.
- Strydom H. & Delport C.S.L. 2002. Sampling and pilot study in qualitative research. In A.S. de Vos (Ed.) *Research at grass roots: For the social sciences and human services professions*. Hatfield, Pretoria: Van Schaik Publishers.
- Strydom A.H. & Lategan L.O.K. 1996. *Quality at South African universities: The state of the art*. Bloemfontein: Unit for Research into Higher Education, UFS.
- Strydom A.H. & Van der Westhuizen L.J. 2001. *A guide for institutional quality assurance and management based on self-evaluation in higher education*. Bloemfontein: Unit for Research into Higher Education, UFS.
- Suwanwela C. 1995. A vision of quality in medical education. *Academic Medicine* 70(7) Supplement: S32-S37.
- Szanto T.R. 2004. Programme accreditation in Hungary: Lessons from the past, plans for the future. *Quality in Higher Education* 10 (1):59-64.
- Thorne S., Joachim G., Paterson B. & Canam C. 2002. Influence of the research frame on qualitatively derived health science knowledge. *International Journal of Qualitative Methods* 1(1). <http://www.ualberta.ca/~ijqm/>. Retrieved 25/06/2004.

- Tierney R. & Simon M. 2004. What's still wrong with rubrics? Focusing on the consistency of performance criteria across scale levels. *Practical assessment, Research & Evaluation* 9(2). <http://PAREonline.net/getvn.asp?v=9&n=2>. Retrieved 23/09/2004.
- Trow M. 1999. Academic reviews and the culture of excellence. In CHEPS & QSC *Quality management in higher education institutions*. Reader 3. Utrecht, the Netherlands: LEMMA.
- UET 2003. Minutes of the 14th meeting of the Subcommittee for Undergraduate Education and Training, Medical and Dental Professions Board, HPCSA, Pretoria. 27 August 2003.
- UET 2003a Self-evaluation questionnaire to be completed by Faculties of Health Sciences/Medicine/Dentistry. Medical and Dental Professions Board, HPCSA, Pretoria. (Unpublished).
- UET 2003b. Report on the workshop on matters pertaining to accreditation of the Subcommittee for Undergraduate Education and Training, 29 July. Unpublished. UET, HPCSA, Pretoria.
- UET Task group 2000. South African Medical and Dental Schools/Faculties: Self-assessment with a view to accreditation - Questionnaire (unpublished). Pretoria: HPCSA.
- Van Damme D. 2000. European approaches to quality assurance: Models, characteristics and challenges. *South African Journal of Higher Education* 14(2):10-19.
- Van Vught F.A. 1994. Intrinsic and extrinsic aspects of quality assessment in higher education. In D.F. Westerheijden, J. Brennan & P.A.M. Maassen (Eds.) *Changing contexts of quality assessment*. Utrecht: Lemma.
- Van Vught F.A. 1999. The Humboldtian university under pressure: New forms of quality review in Western European higher education. In *Quality management in higher education institutions*, CHEPS Reader Unit 3. Utrecht: LEMMA.
- Verkleij A.C.L. 2000. Scope and limitations of self-evaluation processes. *South African Journal of Higher Education* 14 (2):85-93.
- Verma G.K. & Beard R.M. 1981. *What is educational research? Perspectives on techniques of research*. Aldershot: Gower.
- Vidovich L. 1999. Quality teaching and learning in Australian universities: Policies and practices. In J. Weir (Ed.) *Towards a quality culture in higher education: Processes, outcomes and challenges*. Bentley: Curtin University of Technology.
- Vroeijenstijn T.I. 1994. Preparing for the second cycle: External quality assessment in

- Dutch universities. In D.F. Westerheijden, J. Brennan & P.A.M. Maassen (Eds.). *Changing contexts of quality assessment*. Utrecht, the Netherlands: LEMMA.
- Vroeijenstijn T.I. 1995. Quality assurance in medical education. *Academic Medicine* 70(7) Supplement: S59-S67.
- Wahlén S. 2004. Does national quality monitoring make a difference? *Quality in Higher Education* 10 (2): 139-147.
- Weeks P. 2000. Benchmarking in higher education: An Australian case study. *Innovations in Education and Training International* 37(1):59-67.
- Westerheijden D.F., Brennan J. & Maassen P.A.M. 1994. Changing contexts of quality assessment. In D.F. Westerheijden, J. Brennan & P.A.M. Maassen (Eds.). *Changing contexts of quality assessment*. Utrecht: Uitgeverij Lemma.
- WFME (World Federation for Medical Education) 1988. The Edinburgh Declaration. *Lancet* 8068:464.
- WFME (World Federation for Medical Education) 2003. *Basic medical education: WFME global standards for quality improvement*. Copenhagen: World Federation for Medical Education Office, University of Copenhagen.
- WFME (World Federation for Medical Education) Executive Council 1998. International standards in medical education: Assessment and accreditation of medical schools' educational programmes – A WFME position paper. *Medical Education* 32:549-558.
- WFME Task Force 2000. WFME Task Force on defining international standards in basic medical education: Report of the working party, Copenhagen, 14-16 October 1999. *Medical Education* 34:665-675.
- WHA (World Health Assembly) 1995. *Reorientation of medical education and medical practice for health for all: WHA Resolution 48.8*. Geneva: WHO.
- WHO 1996. *Doctors for health: A WHO global strategy for changing medical education and medical practice for health for all*. Geneva: World Health Organization.
- Wiener R.B. & Cohen J.H. 1997. *Literacy portfolios: Using assessment to guide instruction*. Upper Saddle River, NJ: Prentice Hall.
- Wilson M.P & Boelen C. 1995. Preface. *Academic Medicine* 70(7) Supplement:Sv.
- Wolcott H.F. 2001. *Writing up qualitative research*. Thousand Oaks: Sage Publications.
- Wolmarans I.S. & Eksteen J.J. 1987. *Behoeftebepaling* [Needs analysis]. Pretoria: Gutenberg.
- Young K.E., Chambers C.M., Kells H.R. & Associates. 1983. *Understanding accreditation*. San Francisco: Jossey Bass.