General Authority for Health Services
For the Emirate of Abu Dhabi

CRITERIA FOR ACCREDITATION OF TEACHING HOSPITALS

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1-BACKGROUND

Teaching hospitals are essential "classrooms" for physicians, nurses, and other health professionals and providers. Teaching hospitals are providers of primary care and routine patient services, as well as centers for experimental, innovative and technically sophisticated services. Many of the advances started in the research laboratories of medical schools are incorporated into patient care through clinical research programs at teaching hospitals. A **teaching hospital** is a **hospital** which provides medical training to **medical students** and **residents**.

Teaching hospitals have made a tremendous impact in the healthcare community. They have been instrumental in many of the advancements of research and medicine and continue to advance. Hospitals seeking to be designated as a Teaching Hospital must meet certain criteria; criteria that assures that students preparing to be physicians will have adequate preparation in the clinical years of the MBBS program , in the Internship program, and postgraduate training.

The typical features of a teaching hospital include: a high number of beds and a high number of admissions, large number of employees, located in urban areas, and whose missions include service, education and research. Because of these three mandates, teaching hospitals on average have higher costs than other (community level or non-teaching) hospitals.

In considering any hospital (private or public) as a training site, the major areas for assessment are: (1) the administration (2) the facility, (3) the patients in that facility, and (4) the mentors available to guide the education of the trainees. Each of these will be examined in turn.

In general, teaching hospitals are responsible for more complex cases, provide specialized care, and use leading-edge technology. They combine provision of tertiary service with roles in clinical education (for many health professions, across both undergraduate and postgraduate levels) and applied research.

2- REFLECTION ON TEACHING HOSPITALS IN THE WORLD AND THE REGION

In the USA the distinction between university hospitals and teaching hospitals does not clearly exist. Universities own their own hospitals which are usually teaching hospitals. Most also have major affiliations with other hospitals which equally perform the academic role. What delineates a teaching hospital is the academic, training and research role they play, and not only their ownership.

In France Universities with medical schools are mostly public and so are their university hospitals. Centre Hospitallier Universitaire CHU, is a clear university hospital model. It is usually the most important medical center in the region. It has one or more government hospitals with a total of 1000 or more beds.

In Lebanon, Traditionally teaching hospitals were linked to medical schools and university setup. AUB, and St. Joseph Universities were the first two universities with medical schools. They both had affiliated hospitals which assumed a role beyond the traditional role of caring for patients, which is undertaken , by regular hospitals.

- They trained medical manpower
- They initiated the transfer of technology and advances in medical care
- They participated in research
- They provided medical leadership for Lebanon and the region.
- They advised the government agencies and MOH.

Hospitals in Lebanon developed and started to train medical students from Lebanon and abroad. Currently there are 35 hospitals that are classified as A5* which are considered as teaching hospitals.

In Egypt University hospitals are clearly identified. As in France, they are part of the university system, which is public. Moreover postgraduate medical degrees are given according to the university system. In a university-teaching hospital, residents and fellows under the supervision of faculty staff provide patient care.

3- ADVANTAGES AND DISADVANTAGES OF TEACHING HOSPITALS

One advantage is that physicians tend to be the most up to date with research literature and the latest developments. University-teaching hospitals also tend to utilize the latest research protocols. If alternative treatment is required, they are more likely to be connected to the most appropriate network. Patients have the advantage of having faculty physicians and residents in training and a variety of specialists available 24 hours a day. There is increased recognition because of their participation with medical schools. Teaching schools as well as public schools may receive funding from local government and federal funds. The patients, the residents and the faculty will usually have the latest equipment, medical education, and information.

Teaching hospitals are more constrained by higher costs than non teaching hospitals. These higher costs arise from numerous factors, including more clinically complex patients, a disproportionate share of poor patients, more specialized services, urban location, and the training of new physicians.

Additional costs can be direct or indirect. At least 10% extra cost is incurred from direct cost and 15% from indirect cost. In the U.S.A it is estimated that teaching programs add 14% to the running cost of the hospitals. This is the reason why teaching hospitals in the States are compensated via additional payments mechanisms.

Direct costs:

- Cost of interns, residents/fellows and their overheads
- Cost research staff and infrastructure
- Cost of services, programs, medical equipment and non-financially viable units, needed for teaching programs.
- Cost of educational resources and personnel.
- In general, higher staffing ratios > 3.5 staff per bed incurring >10% additional costs

Indirect costs:

- Over prescribing of services, supplies, tests
- Over-use of expensive resources, for example, endoscopy etc
- Tendency to take on difficult medical cases which skews the patient mix into more expensive cases, resulting in:
- Some patients may avoid admission to avoid being treated by teaching staff
- Some elective cases may avoid services because of extended waiting time.

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This document outlines the general criteria for the establishment of a Teaching Hospital and the procedure for a hospital, be it public or private, in applying for assignation as a Teaching Hospital in the Emirate of Abu Dhabi.

Recognition as a Teaching Hospital allows the hospital to enter into agreement with Colleges and Universities to collaborate in the clinical preparation of future physicians. There are both general criteria and specific criteria. These criteria are drawn from the Postgraduate medical standards set by the World Federation on Medical Education (Appendix 1), from the WHO accreditation principles for hospitals, from ACGME , and others.

4- GENERAL CRITERIA

The general criteria that applies to teaching hospitals are the following :

- A hospital that attains and maintains the highest quality of clinical practice and that has a culture of "lifelong" learning and the application of evidence based medicine.

- A hospital that delivers the highest quality undergraduate and postgraduate teaching, and that values and supports research excellence.

- A Teaching Hospital must have at least four (4) qualified departments, two (2) of which must be in the 'traditional' specialties of medicine, OBS/GYN, pediatrics, surgery, family medicine or psychiatry and have clinical resources sufficient to ensure breadth and quality of ambulatory and bedside teaching of its medical students and interns.

- Teaching hospitals should also ensure that physician trainees are exposed to an environment that fosters and supports quality assurance and clinical practice improvement. These concepts are seen as being integral to modern physician practice with lifelong learning and Continuous Professional Development.

- A Teaching Hospital will normally have adequate facilities and staff to have clinical students (years 3-5), interns, and residents from one or more institutions. This will encourage and facilitate student-to-student mentorship and collegial learning. The number of students will depend on the number of beds, the occupancy, the variety of patient maladies and the number of approved Clinical Faculty members.

- A Teaching Hospital should be appropriately organized for the conduct of medical education, including a scholarly environment. It must demonstrate a commitment to excellence in both medical education and patient care. It must have an organizational structure that supports medical education and patient care and adequate resources. An ethical, professional and educational environment in which curricular requirements, scholarly activity and general competencies can be met, must be demonstrated.

- A Teaching Hospital must demonstrate regular assessment of the quality of the clinical program, the performance of Clinical Faculty, and the use of outcome assessment results for program improvement.

- A hospital applying to be a Teaching Hospital must prove the necessary educational, financial and human resources to support a Teaching Hospital designation.

It must ensure that the training environment is sufficiently broad to encompass all elements of graduate medical education and, where appropriate, undergraduate medical education as

well. Toward this end, the training environment should be carefully evaluated, and enhanced where necessary. Medical professionalism, scientific literacy , evidence based and a commitment to life long learning are the foundation of medical education.

5- SPECIFIC CRITERIA

5.1 Administration:

5.1.1 There must be a Director/Coordinator of internship/ Physician Training (DPT) who would be assisted by necessary staff. He /she should have the authority and responsibility for the oversight and administration of the hospital teaching program that works in collaboration with GAHS and with the designated College or University officer in charge of clinical education. The director or coordinator must have adequate qualifications and responsibility for monitoring and advising on all aspects of the teaching program at the hospital.

5.1.2 The administration must have written policies and procedures in place for clinical education students and interns to guide their role, responsibility and authority when in the Teaching Hospital. This should include, but is not limited to, the following: duty hours that support the physical and emotional well-being of the students, promote an educational environment and facilitate patient care; discipline regulations and grievance processes.

5.1.3 There are mechanisms in place to facilitate "practice-based learning" with support from the senior leadership (administrative and medical) of this type of learning within the facility, as trainees add a "cost" to the system.

5.1.4 An environment which supports the establishment of "clinical teaching units"(. e.g., a unit led by a consultant and including post-graduate trainees (residents), interns, medical students and other clinical personnel who are integrated into a team to provide patient care

5.1.5 A department is considered academic if it is headed by a Consultant appointee based full-time at the hospital, and The department is staffed by two or more senior academic appointees .

5.1.6 The administration must have in place a quality improvement process to assess the hospitals performance improvement program. In addition to plans to apply for international accreditation.

5.1.7 There will be a range of other policies dealing with other health and safety issues including needle stick injuries; and infection control.

5.1.8 The administration must have in place a Continuing Professional Program that is accessible to the Clinical Faculty, clinical students and interns.

5.1.9 The hospital must demonstrate access to appropriate and confidential counseling, and medical and psychological support services for clinical students and interns.

5.1.10 Significant activity in clinical and basic research on the basis of grants and published papers, should be undertaken.

5.1.11 Fulfill the criteria for licensing section and passed the inspection by GAHS.

5.2 **Clinical Faculty:** a broadly experienced and diverse Clinical Faculty who can serve as role models, are well trained and are enthusiastic about teaching:

5.2.1 There must be at least 3 physicians with appropriate credentials for a department to be designated as an approved department for clinical education.

5.2.2 A hospital must indicate the numbers of practicing physicians, by specialty, who are qualified to be considered clinical teachers. Hospitals making an application should have the physician credentials reviewed by the GAHS. Criteria to be used to judge a physician should be based on the following: Ability to teach, including having participated in a teaching program to understand new methodologies for practice-based education, feedback and evaluation, or commit themselves to participate in a teaching methodology program before becoming a Clinical Teacher.

5.2.3 An ongoing level of research/scholarly activity and Lifelong learning through CME/CPD programs.

5.2.4 Minimum five (5) years clinical experience that evidences effective patient care.

5.2.5 Faculty should have received training to be teachers, with experience in medical teaching., in addition to experience in principles of effective education including feedback and evaluation.

5.2.6 Mentors should be given the time and space in which to facilitate education.

5.3 **Physical facilities:** a hospital that serves as a site for clinical students or interns must have appropriate support space, instructional facilities and information resources. The hospital must provide documentation on the following:

5.3.1 Adequate areas for individual student study based on numbers of clinical students and interns.
5.3.2 Integrated clinical teaching units to provide integrated patient care.
5.3.3 Adequate teaching space (classrooms) for the anticipated numbers of clinical students and interns.
5.3.4 Adequate lecture, large group discussion and conference facilities for clinical students, interns and Clinical Faculty.
5.3.5 Adequate and appropriate space within each department for small group meetings.
5.3.6 A well maintained medical library of sufficient size and breadth and with sufficient information resources to support the education program and other missions, including access to leading biomedical, clinical and other relevant periodicals, either physical or electronic The library should include a library with current books and journals, facilities for use of the computer/Internet and an adequate supply of AV teaching aids/materials.
5.3.7 Evidence of on-line references and access to other library systems.
5.3.8 Sufficient numbers of computers that allow access to the Internet.
5.3.9 Appropriate education software and self-instructional materials.
5.3.10 Appropriate training equipment for the educational objectives of the medical education program to be met.
5.3.11 Sufficient communication resources and IT support for the education program and other missions
5.3.12 Adequate numbers of on-call rooms for clinical students and interns.
5.3.13 Adequate numbers of observation/examination rooms for clinical students and interns.
5.3.14 Lockers or other secure space for clinical students and interns to store personal belongings.
5.3.15 Patient support services, such as intravenous services, phlebotomy services and laboratory services appropriate to and consistent with educational objectives and patient care.
5.3.16 Appropriate laboratory, pathology and radiology services (including CT scanning and Nuclear Medicine) to support timely and quality patient care including effective laboratory, pathology and radiological information systems.
5.3.17 A medical record system that documents the course of each patient's illness and care that is available at all times and adequately supports quality patient care, quality assurance activities and adequate resources for scholarly activity.
5.3.18 Pagers and uniforms for the clinical students and interns.
5.3.19 Available food service for clinical students and interns.

5.4 **Patient data**: An analysis and summary of patient data that demonstrates that clinical students and interns will get appropriate exposure and experience to patients.

5.4.1 The hospital must demonstrate an adequate number, and types of, patients in terms of acuity, age, gender, and nationality for the hospital as a whole and for each department.

5.4.2 The hospital must provide data on admissions, both elective and emergency.

5.4.3 The hospital must provide data on the average number of admissions to each department on a daily basis.

5.4.4 The hospital must provide the numbers of beds in the hospital and in each department. This must be accompanied by patient occupancy.

5.4.5 The hospital must provide data on the average number of outpatient and emergency visits for the previous six (6) months.

5.4.6 The hospital must provide data on the average number of surgical cases, both major and minor, for the previous six (6) months, by type of surgery.

5.4.7 The hospital must provide data on the average number of laboratory and radiology requests for the previous six (6) months.

5.4.8 Each trainee (e.g., at an internship level) should be responsible for 8 – 10 patients.

5.4.9 Data on the average number of admissions to each department on a daily basis and the average number of outpatient visits and emergency visits.

5.4.10 Patients (who are paying for care) need to agree to be subjects for case discussion and clinical education involving trainees.

5.5 **Teaching /Learning methods /Exposure :** The facility is willing and capable of handling the internship curriculum including:

5.5.1 Problem based /practice oriented with focused on hands-on training.

5.5.2 Balanced combination of theory and practice with appropriate apportionment of time.

5.5.3 Adequate ability to build attitudinal skills and nurturing and supportive supervision.

5.5.4 Hospitals are required to ensure all basic physician trainees complete a comprehensive Advanced Life Support (ALS) training course of a minimum three hours duration (as part of a continuous block) by the end of their first term as a basic trainee, if they have not undertaken an ALS course within the past 12 months. Hospitals should be providing support for their basic trainees undertaking such a course.

5.5.5 Physician Trainees should be adequately supervised out of hours and a formal clinical handover following night duty should occur to provide education and support as well as ensure continuity of patient care**.**

5.5.6 ***Teaching/learning methods and processes.*** Besides lectures, emphasis should be laid on small group discussion, observation, medical rounds and participatory observation, on–the-job practical training and focus on active learning, close to reality using simulation, and role-plays.

5.5.7 An Intensive Care Unit where basic physician trainees shall have a role in the longitudinal care of their patients who are admitted to the unit.

5.5.8 An Emergency Department with a director holding a substantial (at least half-time) appointment. Basic physician trainees shall have a role in the initial management of patients admitted under their care through the department.

5.5.9 Exposure to patient management in ambulatory settings. Ambulatory care is any contact with a consultant physician which occurs while the patient is not an in-patient of a hospital. Ambulatory care would include contact with patients at the following locations: physician's office, clinics or community centers, patient's home or nursing home or hostel. Basic trainees should attend at least one ambulatory clinic for one session a week.

5.5.10 In order for trainees to prepare for future independent practice they must have the opportunity to participate actively in the provision of health care; that is, they must have hands-on experience in a system of delegated and graded responsibility, while under supervision. By doing, as well as observing, trainees learn how to question, examine, diagnose, manage, and treat patients, and adopt the necessary attitudes towards patients and their relatives, colleagues and other members of the health care team.

5.6. **Monitoring and Assessment.** A basic requirement was that a plan for monitoring and assessment should be in place *with an emphasis on improving quality.*

5.6.1 Assessment was needed for both students and teachers including, internal and external assessment. Continuous assessment of skills and performance were considered necessary and to be given higher weightage rather than terminal assessment.

5.6.2 Teaching methods should be learner-centered, self-directed, balanced between theory and practical, and mentoring should be available. Monitoring and assessment should be periodic; teaching processes should be assessed; results should be used to improve teaching.

5.6.3 Monitoring of students and faculty should be periodic and focus on knowledge/skills/attitudes of students with periodic assessment of the programme.

5.6.4 Faculty performance should be assessed by the administration, peers, self and students.

5.6.5 Results/Outcomes of monitoring must be used to improve training. The environment should be conducive for the acceptance of results of monitoring/feedback in a constructive manner

Only when the above conditions can be met, should a training site be designated as a "teaching hospital". A hospital upon approval of GAHS will be designated a Teaching Hospital and departments meeting the criteria within a hospital will be approved as clinical rotation departments.

6- PROCESS OF ACCREDITATION

6.1. Process of Accreditation

GAHS will maintain a system for the determination, awarding and maintenance of accreditation of teaching hospitals that ensures the integrity of the processes.

6.2. Responsibilities for accreditation

GAHS is responsible for setting the criteria for determining accreditation status, and for the decision to grant or deny accreditation status on the basis of the information in a survey report and the site visit

The criteria the accreditation body lays down should ensure:

- Transparency of criteria (for organisations being accredited, for surveyors and for the public);
- Consideration for the customers of the service and their safety;
- Decisions based on the achievement of the standards;
- Consideration of how accreditation status will facilitate further quality improvement;
- Consistency between accreditation decisions;
- A non-adversarial process for appeals.

6.3. Basis for accreditation awards

Hospitals will receive designation of teaching hospital, based on the organization's capacity for good clinical care, as demonstrated by compliance with accreditation standards, in addition to overall performance.

6.4. Application of the prospective hospital

A hospital applying to be a Teaching Hospital must submit an application that includes the following :

a. **Hospital Self Assessment** Submission of the completed forms, along with the signature of the director, constitutes the request of the sponsoring institution for institutional review and accreditation. (Appendix 2)

b. **A Hospital Information Form (HIF**), which is completed by the Hospital Director in preparation for a site-visit. The HIF should contain information regarding the Hospital at the time of the site-visit. The Hospital Director is responsible tfor completing the HIF accurately. The information in the HIF, along with all attachments and other documents, requested by GAHS, is considered in the review of an application for a teaching hospital. Submission of the completed forms, along with the signature of the Director of hospital, constitutes the request of the sponsoring institution for Hospital review and accreditation. (Appendix 3)

c. The completed application is to be submitted to GAHS CME/CPD section.

6.5. The Site-visit

Assuming the application is complete, a Visiting Team of 3 persons will be assigned to visit the hospital, and make a recommendation to GAHS for a Teaching Hospital designation.
The site-visitor is responsible for verifying and clarifying the information which has been provided in the documents submitted for accreditation review. The site-visitor for a Hospital, interviews the Hospital Director, Medical Director, as well as administrators, faculty, and interns/residents, in order to prepare a report on the various aspects of the teaching program. The site-visitor does not make recommendations regarding the hospital, does not consult with the Hospital under review, and does not participate in the accreditation decision by the Review Committee formed by the CME/CPD section.

6.6. The Review Process

a. A review committee will evaluate the documents submitted by the hospital and the site visit report.

b. During the Review Committee meeting, the Committee shall evaluate each Hospital based on the applicable requirements effective at the time of the site-visit. The Review Committee shall base its action on the following information:

1. The history of the hospital;
2. The most recent HIF submitted by the Hospital Director;
3. The most recent site-visitor's report;
4. Correspondence pertinent to the review;
5. Additional or revised information that may be submitted by the Hospital Director .

During the Hospital review, the Review Committee shall take formal action on each Hospital or sponsoring institution under consideration. The final action represents a peer judgment by the Committee as a whole.

6.7. The Accreditation Cycle

a. The Hospital review cycle is calculated from the date of the meeting at which the final accreditation action was taken to the time of the next site-visit.

b. Typically, the maximum length of the cycle that may be awarded by the Review Committee is **two years**.

c. When a new Hospital is accredited, the effective date of accreditation shall be stipulated.

d. The accreditation status of a Hospital or sponsoring institution changes only by action of the Review Committee. A Hospital or sponsoring institution remains accredited until action is taken to withdraw accreditation by a Review Committee.

e. If major changes occur between site-visits, a Hospital or institutional review cycle may be shortened, and the Hospital Director shall be notified.

f. Initially designated Teaching Hospitals and approved departments will undergo review every six (6) months.

6.7. Notification of Review Committee Actions

a. GAHS will make sure that the Letter of Notification for each hospital is prepared consistent with the Review Committee action.

b. The Hospital Letter of Notification shall state the action taken by the Review Committee, the current accreditation status, the length of the accredited program, the number of medical students, residents/Interns approved for the Hospital as applicable, and the approximate date for the next site-visit.

c. GAHS public web site is updated with all accreditation actions by the Review Committee approximately two weeks after the Review Committee meeting. A list of approved Teaching Hospitals and their approved departments will be published and distributed by GAHS.

6.8. Accreditation Actions

The following accreditation actions may be taken by a Review Committee in the accreditation of a teaching hospital :

- Withheld Accreditation
- Initial Accreditation
- Continued Accreditation
- Probationary Accreditation
- Withdrawal of Accreditation

Accreditation withheld, probationary accreditation, and withdrawal of accreditation, as well as a reduction in resident/interns complement by the Review Committee, are adverse actions and subject to an appeals process.

6.8.1. Withheld Accreditation

Accreditation shall be withheld when a Review Committee determines that the application for a designation as a teaching hospital does not demonstrate substantial compliance with the requirements.

If a Hospital re-applies for accreditation within two years of its accreditation being withheld, the accreditation history of the last accreditation action of that Hospital shall be included as part of the file.

6.8.2. Initial Accreditation

Accreditation is conferred initially when a Review Committee determines that a proposal for a teaching Hospital substantially complies with the requirements.

a. A Hospital or sponsoring institution should be reviewed within six months of the initial action. If a Hospital has *not* demonstrated substantial compliance on the next review, the Review Committee may propose withdrawal or extend accreditation *with warning* for one year. At the end of this additional one year, the Hospital must demonstrate substantial compliance with the requirements, or the accreditation of the Hospital shall be withdrawn.

b. Initial accreditation may be granted to a new Hospital or a previously accredited Hospital, which has had its accreditation withheld or withdrawn and has subsequently applied for re-accreditation.

6.8.3. Continued Accreditation

Accreditation is continued when a Review Committee determines that a Hospital has demonstrated substantial compliance with the requirements. Typically, the maximum length of the cycle awarded by the Review Committee is two years.

A Review Committee may grant continued accreditation in three circumstances:

a. Hospitals holding initial accreditation that have demonstrated substantial compliance with the requirements;

b. Hospitals holding continued accreditation that have demonstrated substantial compliance with the requirements; or

c. Hospitals holding probationary accreditation that have demonstrated, following a site-visit and review, substantial compliance with the requirements.

6.8.4. Probationary Accreditation

Probationary accreditation is conferred when the Review Committee determines that a Hospital, following a site-visit and review, has failed to demonstrate substantial compliance with the requirements.

Following the next site-visit and review, if the Hospital does not demonstrate substantial compliance with the requirements, or if new areas of noncompliance are identified, an additional one year of probationary accreditation may be granted. At the end of this additional

one-year period, the Hospital or sponsoring institution must demonstrate substantial compliance with the requirements, or the accreditation of the Hospital will be withdrawn. Alternatively, a Hospital or sponsoring institution documenting substantial compliance with the requirements will be restored to continued accreditation status.

6.8.5. Withdrawal

a. A Review Committee may withdraw accreditation of a Hospital under probationary accreditation when a Review Committee determines, following a site-visit and review, that a Hospital has failed to demonstrate substantial compliance with the requirements.

b. Following the final accreditation action for withdrawal of accreditation, the Hospital shall be allowed to complete the current academic year

c. When the Review Committee confirms withdrawal of accreditation and the Hospital has been notified of the effective date of withdrawal of accreditation, no new interns /residents may be appointed to the Hospital.

d. If the Hospital reapplies for accreditation within two years after accreditation has previously been withdrawn, the accreditation history of the last accreditation action of that Hospital shall be included as part of the file.

Appendix 1 : World Federation of Medical Education Postgraduate Standards

PREMISES FOR POSTGRADUATE STANDARDS

The WFME Working Party applied the principles which were developed regarding basic medical education to postgraduate medical education. Attention was focused on the general application of guidelines in quality development of medical education.

Standards must be clearly defined, and be meaningful, appropriate, relevant, measurable, achievable and accepted by the users. They must have implications for practice, recognize diversity and foster adequate development.

USE OF STANDARDS

WFME holds that the set of international standards presented can be used globally as a tool for quality assurance and development of postgraduate medical education in the following ways:

• **Self-evaluation of Programmes**
The primary intention of WFME in introducing an instrument for quality improvement is to provide a new framework against which authorities, organizations and institutions with responsibility for postgraduate medical education can measure themselves in voluntary self-evaluation and self-improvement processes. The guidelines can thus be considered a Self-study Manual.

• **Peer Review**
The process described can be further enhanced by inclusion of evaluation and counseling from external peer review committees.

• **Combination of Self-evaluation and External Peer Review.**
WFME considers such a combination to be the most valuable method.

• **Recognition and Accreditation**
Depending on local needs and traditions, the guidelines can also be used by national or regional agencies dealing with recognition and accreditation of postgraduate medical education.

DEFINITIONS

Postgraduate Medical Education may be defined as the phase in which doctors train under supervision towards independent practice after completion of their basic medical qualification. It comprises pre-registration training, vocational/professional training, specialist and sub-specialist training and other formalized training programmes. Upon completion of a formal postgraduate training programme a degree, diploma or certificate is usually granted. Although Postgraduate Medical Education is a time limited phase of medical education it cannot be clearly separated from Continuing Medical Education (CME) or Continuing Professional Development (CPD). These are carried out during the entire professional life after graduation from the medical school and are characterized by self-directed learning and rarely involve supervised training for extended periods of time.

WFME recommends the following set of global standards in postgraduate medical education structured according to **9 areas** and **38 sub-areas**.

AREAS defined as broad components in the structure, process and outcome of postgraduate medical education and training cover:

1. Mission and Outcomes
2. Training Process
3. Assessment of Trainees
4. Trainees
5. Staffing
6. Training Settings and Educational Resources
7. Evaluation of Training Process
8. Governance and Administration
9. Continuous Renewal

SUB-AREAS are defined as specific aspects of an area, corresponding to performance indicators.
STANDARDS are specified for each sub-area using two levels of attainment:
• **Basic standard**. This means that the standard must be met and fulfillment demonstrated during evaluation of the training programme.
*Basic standards are expressed by a "**must**".*
• **Standard for quality development.** This means that the standard is in accordance with international consensus about best practice for postgraduate
medical education. Fulfillment of - or initiatives to fulfill - some or all of such standards should be documented. Fulfillment of these standards will
vary with the stage and development of the training programme, its resources, the educational policy and other local conditions influencing relevance and priorities. Even the most advanced programmes might not comply with all standards.

*Standards for quality development are expressed by a "**should**".*

ANNOTATIONS are used to clarify, amplify or exemplify expressions in the standards.

1-CPD refers to the continuing development of the multi-faceted competencies inherent in medical practice and drawn from various domains of knowledge and skills (e.g. medical, managerial, social, personal) needed for high-quality professional performance. Although often used to designate the period commencing after completion of postgraduate training, it is evident that CPD is a much more far-reaching activity. The shaping, re-shaping and development of a professional - responding to changing societal and individual needs within the context of the evolution of medical science and health care delivery – is a life-long continuing process, starting when the student is admitted to medical school and on-going as long as the doctor is engaged in professional activities.

2 WFME is aware of the complex interactions and links between the various areas and sub-areas.

1. MISSION AND OUTCOMES

1.1 STATEMENTS OF MISSION AND OUTCOMES

Basic standard:

The competent authorities **must** define, in consultation with the professional organisations, the mission and outcome objectives for the various types of postgraduate medical training and make them known.

The statements of mission and outcomes **must** describe the practice-based training process resulting in a medical doctor competent to undertake comprehensive up-to-date medical practice in the defined field of medicine in a professional manner, unsupervised and independently or within a team, in keeping with the needs of the health care system.

Quality development:

The mission and outcome objectives **should** encourage appropriate innovation in the training process and allow for development of broader competencies than minimally required, and constantly strive to improve patient care that is appropriate, effective and compassionate in dealing with health problems and promotion of health. The training **should** encourage doctors to become scholars within their chosen field of medicine and **should** prepare them for lifelong, self-directed learning and readiness for continuing medical education and professional development.

Annotations:

• *Statements of mission and outcomes* would include general and specific issues relevant to national and regional policy.

• *Competent authorities* would include local and national bodies involved in regulation of postgraduate medical training, and could be a national governmental agency, a national board, a university, a competent professional organisation or a combination of these.

• *Types of postgraduate medical training* would include pre-registration training, systematic vocational training, specialist training and other formalized training for expertise in specified areas of medicine.

• *Scholar* refers to deeper and/or broader engagement in the development of the discipline, including responsibility for education, development, research, management, etc.

• *Chosen field of medicine* would include recognized specialties,
including general practice, sub-specialties and expert functions.

1.2 PARTICIPATION IN THE FORMULATION OF MISSION AND OUTCOMES

Basic standard:

The statement of mission and outcomes of postgraduate training **must** be defined by its principal stakeholders.

Quality development:

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

Annotations:

• *Principal stakeholders* would include trainees, programme directors, scientific societies, hospital administrators, governmental authorities and professional associations or organisations.
• *A wider range of stakeholders* would include representation of supervisors, trainers, teachers, other health professionals, patients, the community, organisations and health care authorities.

1.3 PROFESSIONALISM AND AUTONOMY

Basic standard:

The training process **must**, be based on approved basic medical education, and further strengthen the professionalism of the doctor.

Quality development:

The training **should** foster professional autonomy to enable the doctor to act in the best interests of the patient and the public.

Annotation:

• *Professionalism* describes the knowledge, skills, attitudes and behaviours expected by patients and society from individuals during the practice of their profession and includes concepts such as skills of lifelong learning and maintenance of competence, information literacy, ethical behaviour, integrity, honesty, altruism, service to others, adherence to professional codes, justice and respect for others.

1.4 TRAINING OUTCOMES

Basic standard:

The relevant competent authorities **must,** in consultation with the professional organisations, define the competencies, which must be achieved by trainees as a result of the training programmes.

Quality development:

Both broad and specific competencies to be acquired by trainees **should** be specified and linked with the competencies acquired as a result of basic medical education. Measures of competencies achieved by trainees **should** be used as feedback for programme development.

Annotation:

• *Competencies* can be defined in broad professional terms or as specific knowledge, skills, attitudes and behaviours. Competencies relevant for postgraduate training (see references 9-12) would, at a level dependant on the chosen field in medicine, include the following areas:
• Patient care that is appropriate, effective and compassionate for dealing with health problems and health promotion
• Medical knowledge in the basic biomedical, clinical, behavioural and clinical sciences, medical ethics and medical jurisprudence and application of such knowledge in patient care
• Interpersonal and communication skills that ensure effective
information exchange with individual patients and their families and teamwork with other health professionals, the scientific community and the public
• Appraisal and utilization of new scientific knowledge to continuously update and improve clinical practice
• Function as supervisor, trainer and teacher in relation to colleagues, medical students and other health professionals
• Capability to be a scholar contributing to development and research in the chosen field of medicine
• Professionalism
• Interest and ability to act as an advocate for the patient
• Knowledge of public health and health policy issues and awareness and responsiveness to the larger context of the health care system, including e.g. the organisation of health care, partnership with health care providers and
managers, practice of cost-effective health care, health economics,
and resource allocations
• Ability to understand health care, and identify and carry out system-based improvement of care.

2. TRAINING PROCESS

2.1 LEARNING APPROACHES

Basic standard:
Postgraduate medical training **must** follow a systematic training programme, which describes generic and discipline-specific components of training. The
training **must** be practice-based involving the personal participation of the trainee in the services and responsibilities of patient care activities in the training institutions. The training programme **must** encompass integrated practical and theoretical instruction.

Quality development:
Postgraduate medical training **should** interface with basic medical education and continuing medical education/ professional development. The training
should be directed and the trainee guided through supervision and regular appraisal and feedback. The training process **should** ensure an increasing degree of independent responsibility as skills, knowledge and experience grow. Every trainee **should** have access to educational counseling.

Annotations:

• *The training process* would, when appropriate, proceed via a common trunk from general to more specialized content.
• *Educational counseling* would include access to designated tutors or mentors.

2.2 SCIENTIFIC METHODS

Basic standard:

The trainee **must** achieve knowledge of the scientific basis and methods of the chosen field of medicine, and through exposure to a broad range of relevant clinical/practical experience in different settings in the chosen field of medicine become familiar with evidence-based medicine and critical clinical decision- making.

Quality development:

In the training process the trainee **should** have formal teaching about critical appraisal of literature, scientific data and evidence-based medicine, and be exposed to research.

Annotation:

• Training in scientific basis and methods may include the use of elective research projects to be conducted by trainees (cf. 6.5).

2.3 TRAINING CONTENT

Basic standard:

The training process **must** include the practical clinical work and relevant theory of the basic biomedical, clinical, behavioural and social sciences; clinical decision-making; communication skills, medical ethics, public health policy, medical jurisprudence and managerial disciplines required to demonstrate professional practice in the chosen field of medicine.

Quality development:

The training process **should** ensure development of knowledge, skills, attitudes and personal attributes in the roles as medical expert, health advocate, communicator, collaborator and team-worker, scholar, administrator and manager.

Annotations:
• *The basic biomedical sciences* would, depending on local needs, interests and traditions, typically include anatomy, biochemistry, physiology, biophysics, molecular biology, cell biology, genetics, microbiology, immunology, pharmacology, pathology, etc.
• *Clinical sciences* would include the chosen clinical or laboratory
disciplines and in addition other relevant clinical/laboratory disciplines.
• *Behavioural and social sciences* would, depending on local needs, interests and traditions, typically include medical psychology, medical sociology, biostatistics, epidemiology, hygiene and public health and community medicine, etc.
• *The behavioural and social sciences and medical ethics* should provide the knowledge, concepts, methods, skills and attitudes necessary for understanding socio-economic, demographic and cultural determinants of causes, distribution and consequences of health problems.

2.4 TRAINING STRUCTURE, COMPOSITION AND DURATION

Basic standard:

The overall composition, structure and duration of training and professional development **must** be described with clear definition of goals and expected
task-based outcomes and explanation of their relationship to basic medical education and health care delivery. Components which are compulsory and
optional **must** be clearly stated.

Quality development:

Integration of practice and theory **should** be ensured in the training process.

Annotations:
• *Structure of training* refers to the overall sequence of attachment to the training settings and responsibility of the doctor and not the details of the training experiences.
• *Integration of practice and theory* would include didactic learning sessions and supervised patient care experiences.

2.5 THE RELATIONSHIP BETWEEN TRAINING AND SERVICE

Basic standard:
The apprenticeship nature of professional development **must** be described and respected and the integration between training and service (on-the-job training) **must** be assured.

Quality development:
The capacity of the health care system **should** be effectively utilized for service based training purposes. The training provided **should** be complementary and not subordinated to service demands.

Annotations:

• *Integration between training and service* implies on one hand delivery of proper health care service by the trainees and on the other hand that learning opportunities are embedded in service functions.
• *Effective utilization* refers to optimizing the use of different clinical settings, patients and clinical problems for training purposes, and at the same time respecting service functions.

2.6 MANAGEMENT OF TRAINING

Basic standard:
The responsibility and authority for organizing, coordinating, managing and assessing the individual training setting and the training process **must** be clearly identified.

Quality development:
Coordinated multi-site training within the chosen field of medicine **should** be ensured to gain exposure to different areas and management of the discipline. The authority responsible for the training programme **should** be provided with resources for planning and implementing methods for training, assessment of trainees and innovations of the training programme. There **should** be representation of staff, trainees and other relevant stakeholders in the planning of the training programme.

Annotation:

• *Other relevant stakeholders* would include other participants in the training process, representatives of other health professions and health authorities.

3. ASSESSMENT OF TRAINEES

3.1 ASSESSMENT METHODS

Basic standard:

Postgraduate medical training **must** include a process of assessment, and the competent authorities **must** define and state the methods used for assessment of trainees, including the criteria for passing examinations or other types of assessment. Assessment **must** emphasize formative in-training methods and constructive feedback.

Quality development:

The reliability and validity of assessment methods **should** be documented and evaluated and the use of external examiners **should** be encouraged. A complementary set of assessment methods **should** be applied. The different stages of training **should** be recorded in a training log-book. An appeal mechanism concerning assessment results **should** be established and, when necessary, second opinion, change of trainer/supervisor or supplementary training **should** be arranged.

Annotations:

• The *definition of methods used for assessment* may include consideration
of the balance between formative and summative assessment, the number of examinations and other tests, the balance between different types of examinations, the use of normative criterion - referenced judgments, and the use of portfolio and special types of examinations, e.g. objective structured clinical examinations (OSCE).
• *Evaluation of assessment methods* may include an evaluation of how they promote training and learning.
• *External examiners* or auditors may increasingly represent global perspectives.

3.2 RELATION BETWEEN ASSESSMENT AND TRAINING

Basic standard:

Assessment principles, methods and practices **must** be clearly compatible with training objectives and **must** promote learning. Assessment **must** document adequacy of training.

Quality development:

The assessment methods and practices **should** encourage integrated learning and **should** assess predefined practice requirements as well as knowledge, skills and attitudes. The methods used **should** encourage a constructive interaction between clinical practice and assessment.

3.3 FEEDBACK TO TRAINEES

Basic standard:

Constructive feedback on the performance of the trainee **must** be given on an ongoing basis.

Quality development:

Acceptable standards of performance **should** be explicitly specified and conveyed to both trainees and supervisors.

Annotation:

• *Feedback* would include assessment results and planned dialogues
about clinical performance between trainees and trainers/supervisors with the purpose of ensuring instructions and remedies necessary to enhance competence development.

4. TRAINEES

4.1 ADMISSION POLICY AND SELECTION

Basic standard:

The competent authorities and the medical professional organisations **must** agree upon a policy on the criteria and process for selection of trainees and **must** publish and implement it.

Quality development:

The selection policy **should** define criteria, which considers specific capabilities of potential trainees in order to enhance the result of the training process in the chosen field of medicine. The selection procedure **should** be transparent and admission open to all qualified graduates from basic medical education. The selection procedure **should** include a mechanism for monitoring and appeal.

Annotations:

• The statement on *process of selection of trainees* would include both rationale and methods of selection and may include description of a mechanism for appeal.
• *Monitoring of admission policies* would include improvement of selection criteria, to reflect the capability of trainees to be competent and to cover the variations in required competencies related to diversity of the chosen field of medicine.
• *Criteria for selection* may include consideration of balanced intake according to gender, ethnicity and other social requirements, including the potential need of a special admission policy for underprivileged groups of doctors.

4.2 NUMBER OF TRAINEES

Basic standard:

The number of trainees **must** be proportionate to the clinical/practical training opportunities, supervisory capacity and other resources available in order to ensure training and teaching of adequate quality.

Quality development:

The number of trainees **should** be reviewed through consultation with relevant stakeholders. Recognizing the inherent unpredictability of physician manpower needs in the various fields of medicine, the number of training positions **should** currently be changed with careful attention to existing needs of the community and society and the market forces.

Annotations:

• *Stakeholders* would include those responsible for planning and development of human resources in the local and national health sector.
• Forecasting of the *needs of the community and society* for trained physicians includes estimation of various market and demographic forces as well as the scientific development, migration patterns of physicians, etc.

4.3 SUPPORT AND COUNSELLING OF TRAINEES

Basic standard:

The competent authorities **must,** in collaboration with the profession, ensure that a system for support, counseling and career guidance of trainees is available.

Quality development:

Counseling **should** be provided based on monitoring the progress in training and incidents reported and **should** address social and personal needs of trainees.

Annotation:

• *Social and personal needs* would include professional support, health problems, housing problems and financial matters.

4.4 WORKING CONDITIONS

Basic standard:

Postgraduate training **must** be carried out in appropriately remunerated posts/stipendiary positions in the chosen field of medicine and **must** involve participation in all medical activities - including on-call duties - relevant for the training, thereby devoting professional activities to practical training and theoretical learning throughout standard working time. The service conditions and responsibilities of trainees **must** be defined and made known to all parties.

Quality development:

The service components of trainee positions **should** not be excessive and the structuring of duty hours and on-call schedules **should** consider the needs of the patients, continuity of care and the educational needs of the trainee. Part-time training **should** be allowed under special circumstances, determined by the competent authorities and structured according to an individually tailored programme and the service background. The total duration and quality of part-time training **should** not be less than those of full-time trainees. Interruption of training for reasons such as pregnancy (including maternity/paternity leave), sickness, military service or secondment **should** be replaced by additional training.

Annotations:

• *Contractual service positions* would include internship, residency, registrar, senior registrar, etc.
• *The service components of trainee positions* must be subject to definitions and protections embodied in the contract.

4.5 TRAINEE REPRESENTATION

Basic standard:

There **must** be a policy on trainee representation and appropriate participation in the design and evaluation of the training programme, the working conditions and in other matters relevant to the trainees.

Quality development:

Organisations of trainees **should** be encouraged to be involved in decisions about training processes, conditions and regulations.

Annotation:

• *Trainee representation* would include participation in groups or committees responsible for programme planning at the local or national level.

5. STAFFING

5.1 APPOINTMENT POLICY

Basic standard:
The policy on appointment of trainers, supervisors and teachers **must** specify the expertise required and their responsibilities and duties. The policy **must** specify the duties of the training staff and specifically the balance between educational and service functions and other duties.

Quality development:
All physicians **should** as part of their professional obligations recognize their responsibility to participate in the practice-based postgraduate training of medical doctors. Participation in postgraduate training **should** be rewarded. The staff policy **should** ensure that trainers generally are current in the relevant field to its full extent and sub-specialized trainers only approved for relevant specific periods during the training.

Annotations:
• *Expertise* would include recognition as a specialist in the relevant field of medicine
• *Training staff* would include medical doctors and other health personnel

• *Other duties* would include administrative functions as well as other educational or research responsibilities.

5.2 OBLIGATIONS AND DEVELOPMENT OF TRAINERS

Basic standard:
Instructional activities **must** be included as responsibilities in the work-schedules of trainers and their relationship to work-schedules of trainees **must** be described.

Quality development:
Staff policy **should** include support of trainers including training and further development, if appropriate, and **should** appraise and recognize meritorious
academic activities, including functions as trainers, supervisors and teachers. The ratio between the number of recognized trainers and the number of trainees **should** ensure close personal interaction and monitoring of the trainee.

Annotation:
• *Recognition of meritorious academic activities* would be by rewards, promotion and/or remuneration.

6. TRAINING SETTINGS AND EDUCATIONAL RESOURCES

6.1 CLINICAL SETTINGS AND PATIENTS

Basic standard:
The training locations **must** be selected and recognized by the competent authorities and **must** have sufficient clinical/practical facilities to support the delivery of training. Training locations **must** have a sufficient number of patients and an appropriate case-mix to meet training objectives. The training **must** expose the trainee to a broad range of experience in the chosen field of medicine and, when relevant, include both inpatient and outpatient (ambulatory) care and on-duty activity.

Quality development:
The number of patients and the case-mix **should** allow for clinical experience in all aspects of the chosen specialty, including training in promotion of health and prevention of disease. Training **should** be carried out in academic teaching hospitals and, when appropriate, part of the training **should** take place in other relevant hospitals/institutions and community based settings/facilities. The quality of training settings **should** be regularly monitored.

Annotations:
• *Community-based settings* would include specialist practices, specialty clinics, nursing homes, primary health care stations and other facilities where health care is provided.
• *The quality of training settings* can for example, be evaluated through site visits.

6.2 PHYSICAL FACILITIES AND EQUIPMENT

Basic standard:

The trainee **must** have space and opportunities for practical and theoretical study and have access to adequate professional literature as well as equipment for training of practical techniques.

Quality development:

The physical facilities and equipment for training **should** be evaluated regularly for their appropriateness and quality regarding postgraduate training.

Annotation

• *Physical facilities* of the training location would include for example, lecture halls, tutorial rooms, laboratories, libraries, information technology equipment, and recreational facilities where these are appropriate.

6.3 CLINICAL TEAMS

Basic standard:

The clinical training **must** include experience in working as a team with colleagues and other health professionals.

Quality development:

The training process **should** allow learning in a multi-disciplinary team resulting in the ability to work effectively with colleagues and other health professions as a member or leader of the health care team and **should** develop competencies in guiding and teaching other health professions.

6.4 INFORMATION TECHNOLOGY

Basic standard:

There **must** be a policy, which addresses the effective use of information and communication technology in the training programme with the aim of ensuring relevant patient management.

Quality development:

Trainers and trainees **should** be competent to use information and communication technology for self-learning and in accessing data information and working in health care systems.

Annotations:

• A policy regarding the use of computers, internal and external networks and other means of *information and communication technology* would include coordination with the library services of the institution.

• The use of *information and communication technology* may be part of education for evidence-based medicine and in preparing the trainees for continuing medical education and professional development.

6.5 RESEARCH

Basic standard:
There **must** be a policy that fosters the integration of practice and research in training settings. Description of the training setting **must** include research facilities and research activities and priorities.

Quality development:
Opportunities for combining clinical training and research **should** be made available. Trainees **should** be encouraged to engage in health quality development and research.

6.6 EDUCATIONAL EXPERTISE

Basic standard:
There **must** be a policy on the use of educational expertise relevant to the planning, implementation and evaluation of training.

Quality development:
Access to educational experts **should** be available and evidence demonstrated of the use of such expertise for staff development and for research in the discipline of postgraduate medical education.

Annotations:
• *Educational expertise* would deal with problems, processes and practice of postgraduate medical training and assessment, and would include medical doctors with experience in medical education, educational psychologists and sociologists, etc. It can be provided by an education unit at the institution or be acquired from another national or international institution.
• *Medical education research* investigates the effectiveness of training and learning methods, and the wider institutional context.

6.7 TRAINING IN OTHER SETTINGS AND ABROAD

Basic standard:
There **must** be a policy on accessibility of individualized training opportunities at other sites within or outside the country fulfilling the requirements for the completion of training and for the transfer of training credits.

Quality development:
Regional and international exchange of academic staff and trainees **should** be facilitated by the provision of appropriate resources. The competent authorities **should** establish relations with corresponding national or international bodies with the purpose of facilitating exchange and mutual recognition of training elements.

Annotation:
• Transfer of *training credits* can be facilitated through active programme coordination between training institutions.

7. EVALUATION OF TRAINING PROCESS
7.1 MECHANISM FOR PROGRAMME EVALUATION

Basic standard:
The relevant authorities and the profession **must** establish a mechanism for evaluation of the training programme that monitors the training process, facilities and progress of the trainee, and ensures that concerns are identified and addressed.

Quality development:
Programme evaluation **should** address the context of the training process, the structure and specific components of the programme and the general outcomes.

Annotations:
• *Mechanisms for programme evaluation* would imply the use of valid and reliable methods and require that basic data about the training programme are available. Involvement of experts in medical education and assessment would further broaden the base of evidence for quality of postgraduate training.
• *Identified concerns* would include problems presented to programme committees, trainers and tutors, etc.
• *The context of the educational process* would include the organisation and resources as well as the learning environment
• *Specific components for programme evaluation* would include training programme description and performance of trainees
• *General outcomes* would be measured e.g. by career choice and performance.

7.2 FEEDBACK FROM TRAINERS AND TRAINEES

Basic standard:
Feedback about programme quality from both trainers and trainees **must** be systematically sought, analyzed and acted upon.

Quality development:
Trainers and trainees **should** be actively involved in planning programme evaluation and in using its results for programme development.

Annotation:
• *Feedback about programme* would include trainee reports about conditions in their courses.

7.3 USING TRAINEE PERFORMANCE

Basic standard:
The performance of trainees **must** be evaluated in relationship to the training programme and the mission of postgraduate medical education.

Quality development:
The performance of trainees **should** be analyzed in relation to background and entrance qualifications, and **should** be used to provide feedback to the committees responsible for selection of trainees and for programme planning and counselling.

Annotation:
• Measures of *trainee performance* would include information about average duration of training, scores, pass and failure rates at examinations, success and dropout rates, as well as time spent by the trainees on areas of special interest.

7.4 AUTHORISATION AND MONITORING OF TRAINING SETTINGS

Basic standard:
All training programmes **must** be authorized by a competent authority based on well-defined criteria and programme evaluation and with the authority
able to grant or, if appropriate, withdraw recognition of training settings or theoretical courses.
Quality development:
The competent authorities **should** establish a system to monitor training settings and other educational facilities via site visits or other relevant means.

Annotation:
• *Criteria* for authorization of training settings would include minimal values for number and mix of patients, equipment, library and IT facilities, training staff and training programme.

7.5 INVOLVEMENT OF STAKEHOLDERS

Basic standard:
The processes and outcome of evaluation **must** involve the managers and administration of training settings, the trainers and trainees and be transparent to all stakeholders.

Quality development:
The processes and outcome of evaluation **should** be credible to the principal stakeholders

Annotations:
• *Stakeholders* would include the medical professional organisations,
other health professions, health authorities and authorities involved in training of doctors and allied health personal, hospital owners and providers of primary care, patients and patient organisations.
• *Principal stakeholders* include trainers, trainees and health authorities.

8. GOVERNANCE AND ADMINISTRATION

8.1 GOVERNANCE

Basic standard:
Training **must** be conducted in accordance with regulations concerning structure, content, process and outcome issued by competent authorities. Completion of training **must** be documented by degrees, diplomas, certificates or other evidence of formal qualifications conferred as the basis for formal recognition as a competent medical doctor in the chosen field of medicine by the designated authorities. The competent authority **must** continually assess training programmes, training institutions and trainers. The competent authority **must** be responsible for setting up a programme for quality training.

Quality development:
Procedures **should** be developed that can verify the documented completion of training for use by both national and international authorities.

Annotation:
• *Recognition as a competent medical doctor* would, depending on the level of training, include doctors with the right to independent practice, specialists, sub-specialists, experts, etc.

8.2 PROFESSIONAL LEADERSHIP

Basic standard:
The responsibilities of the professional leadership for the postgraduate medical training programme **must** be clearly stated.

Quality development:
The professional leadership **should** be evaluated at defined intervals with respect to achievement of the mission and outcomes of postgraduate medical training.

8.3 FUNDING AND RESOURCE ALLOCATION

Basic standard:
There **must** be a clear line of responsibility and authority for budgeting of training resources.

Quality development:
The budget **should** be managed in a way that supports the mission and outcome objectives of the training programmes and of the service.

Annotation:
• *Budgeting of training resources* would depend on the budgetary practice in each institution and country.

8.4 ADMINISTRATION

Basic standard:
The administrative staff of the postgraduate medical training programmes and training institutions **must** be appropriate to support the implementation of the programme and to ensure good management and deployment of its resources.

Quality development:
The management **should** include a programme of quality assurance and the management **should** submit itself to regular review to achieve quality
improvement.

8.5 REQUIREMENTS AND REGULATIONS

Basic standard:
A national body **must** be responsible for defining the number and types of recognized medical specialties and other medical expert functions for which
approved training programmes are developed.

Quality development:
Definition of approved postgraduate medical training programmes **should** be made in collaboration with all relevant stakeholders.

Annotations:
• *A national body* established according to national laws and regulations would act in the interests of society as a whole.
• *Relevant stakeholders* would include national and local health authorities, universities, medical professional organisations, the public, etc.

9. CONTINUOUS RENEWAL

Basic standard:
In realizing the dynamics of postgraduate medical training the relevant authorities **must** initiate procedures for regular review and updating of the structure, function and quality of the training programmes and **must** rectify identified deficiencies.

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

• *Adaptation of the mission and outcome objectives of postgraduate training to the scientific, socio-economic and cultural development of the society.*
• *Modification of the competencies required on completion of postgraduate training in the chosen field of medicine in accordance with the needs of the environment the newly trained doctor will enter.*
• *Adaptation of the learning approaches and training methods to ensure that these are appropriate and relevant.*
• *Adjustment of the structure, content and duration of training programmes in keeping with the developments in the basic biomedical sciences, the clinical sciences, the behavioural and social sciences, and changes in the demographic profile and health/disease pattern of the population, and in socio-economic and cultural conditions.*
• *Development of assessment principles and methods according to changes in training objectives and methods.*

• Adaptation of recruitment policy and methods of selection of trainees to changing expectations and circumstances, human resource needs, changes in basic medical education and the requirements of the training programme.
• Adaptation of recruitment and policy of appointment of trainers, supervisors and teachers according to changing needs in postgraduate training.
• Updating of training settings and other educational resources to changing needs in postgraduate training, i.e. the number of trainees, number and profile of trainers, the training programme and contemporary training principles.
• Refinement of the process of programme monitoring and evaluation.
• Development of the organisational structure and management principles in order to cope with changing circumstances and needs in postgraduate training and, over time, accommodating the interests of the different groups of stakeholders.

APPENDIX 2 : A FRAMEWORK FOR HOSPITAL SELF-ASSESSMENT (HAS)

Providers of health care in hospitals should have and be able to demonstrate systems for quality management, which improve services to patients, develop staff skills and maintain a safe environment.

A Policy

There should be a written, approved and disseminated policy on quality management, and documented plans for its implementation and review

	Yes	No
1 **The hospital has a written strategy for quality management**		
1.1 - which integrates patient, clinical and managerial approaches		
1.2 - which has been formally adopted by the hospital Board		
1.3 - which has been agreed by principal purchasers		
1.4 - which is disseminated through the organization		
1.5 - which specifies the nature and purpose of performance		
1.6 - which has been updated within the past two years		

B Organization

Responsibility and mechanisms for quality management should be defined within the organizational structure and in relation to external agencies

	Yes	No
1 **A member of the senior management has defined responsibility and authority for the co-ordination of quality support throughout the Hospital**		
1.1 - who manages all quality/audit support staff		
1.2 - who manages a defined budget for quality support		
2 **Responsibility for quality is defined in management job descriptions**		
3 **There is a defined group which has formal, regular and documented meetings to monitor, support and advise on quality management**		
4 **There is an identified lead clinician to co-ordinate clinical audit within each clinical department**		
5 **There is a recognized mechanism by which national guidelines on best practice are incorporated into each department**		
6 **There is a central record of recent and current quality improvement projects**		
7 **An annual program of quality improvement (including clinical topics) is incorporated into the current business plan**		

8 **There is a current annual report of quality improvement activity and achievement in the previous year**		
8.1 - which is formally received by the Hospital Board		
8.2 - which is available throughout the Hospital		
8.3 - which identifies methods, lessons learned and quantified benefits		

C Methods

There should be evidence that relevant standards are defined, systematically measured, and improved with respect to safety, user satisfaction, staff skills, clinical practice, machine performance and service delivery

1 Health and safety

	Yes	**No**
1 There is a current documented preventive maintenance program		
1.1 - electromechanical patient equipment		
1.2 - calibration of blood pressure measurement		
1.3 - patient hoists		
1.4 - fire extinguishers		
1.5 - lifts		
2 Safety assessments and reports dated within previous two years are available for all sites		
2.1 - radiation protection		
2.2 - environmental health and hygiene (e.g. kitchens)		
2.3 - fire control		
2.4 - infection control		
3 There is documented evidence of appropriate response to these		
4 Records are kept of individual participation in staff training		
4.1 - in manual handling		
4.2 - in fire safety		
4.3 - in departmental procedures e.g. food-handling		
5 There is evidence of action on non-participants		
6 There is an effective mechanism for incident reporting		
6.1 - all departments contribute		
6.2 - collection and analysis are documented		
6.3 - there is evidence of resulting action		
7 There is an effective mechanism for infection control		
7.1 - reports are routinely monitored and documented		
8 There is a hospital-wide antibiotic policy		
8.1 - updated/reviewed within the past two years		
8.2 - adherence is regularly monitored and enforced		

2 User satisfaction

	Yes	No
The rights of patients are freely available in writing		
Satisfaction surveys systematically assess the experience of patients		
Information leaflets about the hospital are available to patients		
Complaints and resulting actions are recorded systematically		

	Yes	NO
3 Staff skills		
induction program for all staff		
- generic		
- departmental		
credentialing		
performance review		
continuing development		
training budget		
4 Clinical practice		
1 General methods recorded in current annual report		
1.1. - adverse event/occurrence screening		
1.2. - routine indicator monitoring		
1.3. - criterion-based topic audit		
1.4. - care/recovery pathways		
2 Documented evidence of each clinical audit project includes		
2.1. - quantified performance before and after the review		
2.2. - definition and origins of standards and criteria used		
2.3. - what conclusions were reported to whom		
2.4. - resulting actions taken		
5 Machine performance		
Lab calibration, Xray, sphygmos,defibrillators		

	Yes	No
6 Service delivery		
General methods adopted include		
- Investors in People		
- ISO 9000 certification		
- Accreditation/organizational audit		
-JACAHO		
D Resources		
There should be identifiable resources available to enable staff to implement the agreed quality management programme		
Time		
1 There is an allocation of time agreed with management and defined in contracts for participation in formal quality improvement activity		
Support staff		
2 Trained clinical audit support staff are available to all clinical staff ***Training***		
3 Records of staff training in quality improvement are maintained		
Data		
4 Aggregated data on diagnosis, interventional procedures and diagnostic tests are complete, accurate, and available for analysis		
Information		
5 Staff have access to information on relevant standards, methods and results of projects completed within the hospital		
6 Current relevant periodicals are available in libraries for staff		
7 Outcomes briefing		
Budget		
8 There is a training budget identified for audit and Quality Improvement		

APPENDIX 3: TEACHING HOSPITAL INFORMATION FORM (HIF)

GENERAL INSTRUCTIONS

This is the form for a HOSPITAL making an **initial application to become designated as a teaching hospital**. All sections of the form applicable to the hospital must be completed in order to be accepted for review. For items that do not apply, indicate NA in the space provided. Where patient numbers are requested, estimate what you expect will occur. If any requested information is not available, an explanation should be given and it should be so indicated in the appropriate place on the form.

Note that the process **takes approximately three months** from the time the application is received until it is evaluated by the CME/CPD section at GAHS . A site visit will be scheduled during that period.

The Hospital Director is personally responsible for the content of the completed forms. The forms will not be considered complete without the appropriate signatures on the basic hospital information form. The recommendation of the Review Committee will be based to a large extent upon the information submitted. By signing, the Hospital Director attests to the accuracy of the information submitted. The PIF must also be signed by the Department Chairman/Chief of Service and the Designated Institutional Official of the sponsoring institution.

For questions regarding the completion of the form (content), contact the CME/CPD section at GAHS.

SPECIFIC INSTRUCTIONS

DO NOT ATTACH ANY INFORMATION THAT IS NOT REQUESTED. DO NOT ATTACH BROCHURES, REPRINTS, OR MANUALS AS SUBSTITUTES FOR INFORMATION REQUESTED IN THE HIF. PLEASE BE CONCISE WHEN RESPONDING TO NARRATIVE QUESTIONS.

Signatures

The Hospital Director is responsible for the composition and accuracy of the information supplied in the HIF. By signing, the Hospital Director attests the accuracy of the information being submitted. If the signature is not present all the documents will be returned. The signature of the designated institutional official is also required.

HOSPITAL INFORMATION FORM (HIF)

When you have the completed forms, number each page sequentially in the upper right hand corner. Start on Part 1, Section 1 of the HIF. Report this pagination in the Table of Contents and submit this cover page with the completed HIF.

TABLE OF CONTENTS

(FOR OFFICE USE ONLY)

GAHS Hospital I.D. #: Hospital Name:

HOSPITAL INFORMATION FORM (HIF) (Part 1)

FOR NEW APPLICATIONS ONLY

SECTION 1. GENERAL HOSPITAL INFORMATION

A. Accreditation Information

Date:
Title of Hospital:
GAHS **Hospital ID#** (for accredited hospitals):

B. Coordinator of Postgraduate Medical Education

Name:		
Title:		
Address:		
Telephone:	FAX:	Email:
Date First Appointed:		
Principal Activity Devoted to Medical Education:		
Primary Specialty Board Certification:		Most Recent Date:
Secondary Specialty Board Certification:		Most Recent Date:
Number of years spent teaching in GME in this specialty:		
Number of hours per week Director Spends in: Clinical Supervision: Administration: Research: Didactic/Teaching:		
Is the coordinator also Department Chair?	( ) YES	( ) NO
If No, Chair Name:		

SECTION 2. PARTICIPATING INSTITUTIONS

SPONSORING INSTITUTION: (The university, hospital, or foundation that has ultimate responsibility for this hospital.)				
Name of Sponsor:				
Address:	Tel			
	Fax			
Type of Institution: (				
Ownership Type:				
Name of Designated Institutional Official:				
Name of Chief Executive Officer:				
Does SPONSOR have an affiliation with a medical school (could be the sponsoring institution)?		( ) YES	( ) NO	
If yes, name the medical school below and have an affiliation agreement that describes the effect of these arrangements on this hospital available.				
Name of Medical School #1				
Name of Medical School #2				
International Accreditation :	JCAHO Approved?	( ) YES	( ) NO	( ) NA
Website E-mail address				

Affiliated hospitals and clinics to the principle institution

Name	Type	Available Rotation

Brief Educational Rationale for the above affiliation

SECTION 3. INTERNS/RESIDENTS/MEDICAL STUDENTS

A. Number of Positions (For the current academic year)

Positions	Total
Number of Requested Positions	
Number of Filled Positions*	

* Not applicable to new application or new hospitals with no interns/residents on duty.

B. Actively Enrolled Interns/Residents (if applicable)

List all interns/residents actively enrolled in this hospital as of August 31 of current academic year (see Section 3.A). List names alphabetically within Year in Hospital.

Name	Hospital Start Date	Expected Completion Date	Year in Hospital	Years of Prior GME	Year of Med School Graduation

C. Scholarly Activity (if applicable)

Based on Academic Year Ending	June 30, ____.	June 30, ____.	June 30, ____.
Number of Nationally Peer-Reviewed Published Articles Authored or Co-Authored by Interns/Residents in the Past Year.			
Number of Interns/Resident Presentations at Regional or National Meetings in the Past Year.			

HOSPITAL INFORMATION FORM (HIF) (Part 2)

SECTION 4. BACKGROUND INFORMATION

A. Previous Citations or Concerns (if applicable)

List the citations or concerns, if any, from the notification letter that was sent following the last survey and hospital review, and which contained an accreditation status decision; describe the steps that have been taken to correct any area of noncompliance. If you submitted a subsequent progress report to the RC, reiterate your comments for verification by the site visitor. If such correction is documented in the hospital information form you prepare for this review, provide page references.

B. Changes (if applicable)

Briefly describe major changes, other than those included in the response to previous citations and/or concerns (above), that have been implemented since the last survey and review. Include changes in sponsoring organization, participating hospitals, required rotations, resident complement, etc.

SECTION 5. GENERAL HOSPITAL ANNUAL STATISTICS

Provide the statistics requested for all participating Departments in the educational programs of the interns.

Statistics	Institution 1	Institution 2
Number of Beds		
Annual Admissions		
Medicine		
Pediatrics		
Obstetrics		
Gynecology		
Family Practice		
General Surgery		
Average Daily Census		
Total Outpatient Visits (Excluding Emergency Department)		
Emergency Department Visits		

SECTION 6. SPONSORING DEPARTMENTS

A-Departments

List the departments in the hospital requesting accreditation for the internship program. Department that provides Fundamental Clinical Skills (FCS) training, are eligible. The FCS disciplines are: Emergency Medicine, Family Practice, Internal Medicine, Obstetrics-Gynecology, Pediatrics, and General Surgery. In addition to department that provide elective services like radiology etc. Provide the name of the chairman of the department requesting accreditation and all other information requested.

Department Name	Chairperson Name	Number of interns

B. Letters of Commitment from Sponsoring Departments

For each department listed on the previous table , attach a LETTER OF COMMITMENT (Attachment B). This letter is to be addressed to the Internship coordinator or postgraduate coordinator and signed by the chair of the department. Each letter should include the following information:

1. The Department's commitment to the Internship program in terms of the number of interns/residents it agrees to train on the specialty's service.

2. The amount of time an intern or trainee may spend rotating on the specialty's service and the responsibilities the intern will have while rotating on the specialty's service.

3. The faculty who will be responsible for supervising the trainee, and the type of supervision that will be available. The processes that will be used for evaluating the trainee while on the specialty's service and the methods available to residents to evaluate their rotations;

4. The methods used or opportunities available for providing assurance that the rotations of the Transitional Year residents on the specialty's service are carefully monitored so that there is no compromise of educational resources provided to the categorical residents.

SECTION 7. DEPARTMENT CHAIR CREDENTIALS

Provide the following biographical data on EACH OF THE DEPARTMENT CHAIR **:**

Name:		
Position/Title:		
Educational Summary		
Medical School:	(School)	(Year Graduated)
Residency:	(Institution)	(Years)
Subspecialty Training:	(Institution)	(Years)
Advanced Degree:	(Institution)	(Degree/Date)
Certification(s) Summary		
Specialty/Subspecialty:	(Certification)	(Year Certified/Recertified)

Relevant prior experience:

Organizations, societies and honors:

Research or other scholarly activities:

List up to ten relevant publications:

SECTION 8. THE INSTITUTIONAL COORDINATION COMMITTEE (ICC)

A. Membership

List the NAME and TITLE of each member who serves on the Institutional Coordination Committee for the postgraduate training and internship Year. Indicate the SPECIALTY of the member and the DEPARTMENT where the member is WORKING.

1. The "FCS" and all other departments listed in Section 6 by the Hospital Director should have representation on this committee.

2. If members are fulfilling dual responsibilities (i.e., CEO/IM Faculty), list both responsibilities under "Title".

3. Identify the CEO or designee(s) in the Department of Medical Education (if it exist) with an asterisk (*); include the administrative title(s).

4. Identify the peer-selected intern member with a double asterisk (**).

Note: The ICC may be a free-standing committee or may be a subcommittee of the *Graduate Medical Education Committee*.

Name of Member	Title	Specialty	Responsibilities

B. Description

Provide responses to each of the following questions.

1. How many times a year does the ICC meet?

2. How are its members appointed and by whom?

3. Identify lines of reporting for the CEO designee(s).

4. Attach ICC minutes for the 2 most recent academic years as Attachment C**.**

SECTION 9. POSTGRADUATE/INTERNSHIP FACULTY

A. Key Faculty

List the KEY FACULTY (no more than 15) who regularly participate in the education of and supervise the Transitional Year residents. Provide the information requested below for each faculty member. Include the average number of hours per week each devotes to the Transitional Year hospital, and describe the nature of the assigned duties.

Name of Faculty	Specialty	Board Certified (YES/NO)	Average Hours/ Week**	Nature of Duties*

* i.e., Chief, Attending, Consultant, etc.
**When the Transitional Year resident is assigned to the service.

B. Faculty Scholarly Activity

Describe the scholarly activity for the last 3 years for each of the faculties listed above. Please limit to one page per faculty. Scholarly activities include:

1. Publication of research or reviews (e.g., journal articles, books, chapters, abstracts);
2. Formal teaching (e.g., medical school lectures, grand rounds, seminars at professional meetings, curriculum development);
3. Professional advancement (e.g., recent Board certification or recertification, award of advanced degree);
4. Service (e.g., National committees, international committees, professional societies, others).

SECTION 10. INTERNS TRAINING RESPONSIBILITIES AND DUTIES

Provide a response to each of the following. Use additional sheets of paper as necessary and number and letter each page sequentially.

Task	Yes/No	Explanation
Goals and objectives		
Are Available		
Distributed at the beginning of each rotation		
Supervision Provided by		
Residents		
Specialists		
Consultant		
Resident Responsibilities		
Decision making		
Direct patient care		
Record keeping		
Order writing		
Continuing management		
Evaluate and manage emergency patient		
Ambulatory Care Experience Available		
Family medicine		
Internal Medicine		
OBS & GYN		
Pediatrics		
Duty Hours and On-Call Requirements		
ICC monitors duty hours		
Resident stress, fatigue and function are monitored		
Planned Educational Activities		
Maintain resident attendance records		
Encourage Conference attendance		
Support Facilities Available		
Radiology		
Laboratory		
A system available for retrieval of radiology and laboratory results exist.		

Task	Yes/No	Explanation
Support Facilities Available		
Nursing and technician support provided to residents.		
Are residents' responsibilities for starting IVs, drawing blood, performing ECGs,		
Communication systems are available to residents to contact supervising Staff		
Availability of computer-based resources for information retrieval.		
On-site medical library		
The availability of decent on-call sleeping facilities,		
Assessment		
Internship coordinator receives a performance evaluation of each trainee for each rotation.		
Internship coordinator meets with each trainee at least three times each year for evaluation purposes.		
Trainee are required to evaluate the hospital, each rotation, and each faculty member		
Internship coordinator Or the Hospital Director provide a final written evaluation for each trainee who completes the training		

The signatures of the director of the hospital, and the coordinator of postgraduate medical education attest to the completeness and accuracy of the information provided on these forms.
Signature of Hospital Director (and date):
Signature of Chief/Department Chair if different from Hospital Director (and date):

TEACHING HOSPITAL INFORMATION FORM

HOSPITAL INFORMATION FORM (HIF)

Directions

Please use a larger font size for your responses than that used for the questions. The pagination of the form must be maintained in the upper right corner; if necessary, paginate the forms by hand.

Checklist

Use this checklist before submitting the forms to the RRC Office. **First, review the instructions that accompany the form and check to see that they were followed.** The signature of the Hospital Director on the forms indicates his/her approval of the content.

_____ Have the required signatures been provided?

_____ Has the internal consistency of data reported on the block diagrams and in the specialty sections been verified?

_____

_____ Are the letters of agreement/affiliation, the letter of commitment from the sponsor, and all other required documents appended as requested?

_____ Has the final copy been carefully proofread and checked to see that every question has been answered, every chart completed, etc?

_____ Has the Table of Contents been completed?

_____ Has every question been answered or an explanation provided?

_____ Have the following included, if applicable:
Attachment A: Letter of COMMITMENT FROM THE HOSPITAL
Attachment B: Letters of commitment for each department chair;
Attachment C: ICC minutes

Once the form has been completed and assembled correctly, make the appropriate number of copies and review each **copy for completeness and legibility**.