



## **1. Adoption of a system of easily readable and comparable degrees**

The medical degree is already easily readable and comparable within the EU through the Medical Education Directive EC 93/16. This can further be improved through implementation of the Diploma supplement.

## **2. Adoption of a system essentially based on two main cycles, undergraduate and graduate.**

We are concerned about negative consequences in implementing a two-cycle structure in medical education. Current efforts to update the medical curriculum recognise that the early integration of basic and clinical science is essential to produce better doctors. This provides a meaningful context in which to integrate current research with basic care. It is also supported by adult learning theory, which acknowledges the difference between having factual knowledge and being able to apply it to a real-life situation. The implementation of a two-cycle structure must not be allowed to cement the traditional division between the basic sciences and clinical sciences, as described in the Flexner Report of 19104.

In those countries with a two-cycle structure for medicine, students should be required to have a Bachelor of Medicine or bachelor degree with academic equivalence to enter the Master of Medicine, to ensure the quality of those who graduate as physicians.

Without a European consensus on implementing the two-cycle structure in medicine, two degree systems will result, seriously hampering easy readability and mobility.

Some medical curricula teach subjects over several years. The implementation of the two cycle structure in such curricula will lead to an artificial separation of these subjects, limiting mobility. This must be avoided by introducing guidelines for bachelor and master content. One model for this is described in the idea of a European *Core Curriculum* in medical education, as mentioned by the British General Medical Council in 1993 and defined by AMEE Education Guide no 55.



At the same time, we recognise the value of having a unified degree structure for higher education in Europe. For medical education, we recognize potential improvements in flexibility and mobility, and more opportunities to choose a master degree.

### **3. Establishment of a system of credits, such as the ECTS system.**

Establishment of ECTS can easily be done in most European countries, and has already been implemented at several European medical schools. We require that a European grading system must be researched and evidence-based to determine the most appropriate manner in which to assess medical students. A correct and consistent implementation of ECTS and the grading system is of great importance for mobility and quality of assessment throughout Europe.

### **4. Promotion of mobility.**

Mobility is desirable on all levels of medical studies, from individual courses or clinical clerkships, as in today's Erasmus program, to entire degrees. The recognition of common guidelines for the content in the degrees would increase mobility. The Lisbon Convention<sup>6</sup> has established a means to get degrees and courses recognized, and this is an important step to increase mobility.

### **5. Promotion of European co-operation in quality assurance.**

We urge the ministers to agree on a system for quality assurance in Europe. The task of creating this system should be given to independent experts. For medical education this could, for example, be AMEE. Student involvement in this process is absolutely necessary. Quality Assurance can be achieved through the establishment of common guidelines for the content of the degrees and an adoption of, for instance, the WFME Global Standards for Quality Improvement<sup>7</sup>. A common European system for accreditation of medical schools would establish and maintain high educational quality and provide a means for comparison between different medical schools. We welcome harmonization, but preserving the diversity of the individual medical schools in Europe is of utmost importance.



## **6. Promotion of the necessary European dimensions in higher education.**

We recognise that the cultural diversity of Europe is currently reflected in the way medicine is taught in different countries. We hope that the future European medical education is based on a holistic view of the complex world we are living in and reflects the fast changing environment and growing knowledge base of tomorrow's physicians. More focus on language learning would enhance communication in the profession and improve mobility.

## **7. Integrate life long learning into the overall strategy.**

The healthcare environment is rapidly changing making continuous professional development essential after graduation. The role of medical schools in preparing their graduates for this process cannot be stressed enough. We see the utilization of modern teaching methods and self-directed learning as setting the foundation for life long learning.

## **8. Higher education institutions and students.**

The recognition of students as *competent, active and constructive partners* is a step forward in increasing the quality of medical education. We welcome this invitation of the ministers for more active student participation which we hope will be welcomed and implemented *at all levels*. We feel strongly about our education and that of the generations to come. We are the key to shaping tomorrow's education. We will, after all, be tomorrow's teachers.

## **9. Promoting the attractiveness of the European Higher Education Area.**

Through establishing a common European system for quality assurance and safe-guarding, easily readable and comparable degrees, Europe will be more attractive for both European and non-European students.



## **10. Establish a European research area.**

In our knowledge-based society, research is one of the pillars of the modern university. We see the potential benefits of the establishment of a European research area and appreciate its importance in academia.

In conclusion, we strongly welcome most points of the Bologna process, which encourages flexibility, mobility and quality assurance. We are concerned about the negative implications of the two-cycle structure on medical education. However, not implementing the two-cycle structure should not be an excuse not to implement the rest of the Bologna process. We emphasise the importance of common European guidelines for the content of medical degrees. The integration of the basic sciences and clinical worlds from day one is paramount to our success as future physicians.

We look forward to active participation in Europe's drive towards the highest quality medical education possible.