

Medical Education in Georgia: Quality Assurance, Main Trends and Challenges



Thematic Analysis

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The Following thematic analysis discusses the problematics of Higher Medical Education in Georgia and is intended for Higher Educational Institutions, Higher Education Quality Assurance Agencies, Clinics and Hospitals, as well as the leading actors involved in Healthcare sector and other stakeholders on local and international levels. The findings and recommendations given in Thematic Analysis is addressed to the National Center for Educational Quality Enhancement, The HEIs that carry out the Medical Doctor programmes and the Ministry of Education and Science. The working group thinks that the discussion and implementation of the results given in the report will be an important basis to initiate dialogue between the stakeholders and trigger effective activities for the sake of sustainable development of medical education in Georgia.

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Table of Contents

Acknowledgements	4
Glossary.....	5
Introduction.....	6
Research purpose and objectives.....	12
Methodology	13
Review of quantitative indicators	19
Memoranda analysis.....	26
Expert report content analysis	27
WFME 1. Mission and outcomes	27
WFME 2. Educational programme.....	28
WFME 3. Assessment of students.....	34
WFME 4. Students.....	36
WFME 5. Academic staff.....	39
WFME 6. Educational resources	41
WFME 7. Programme evaluation.....	46
WFME 8. Governance and administration.....	49
WFME 9. Continuous renewal	51
Focus group sessions with involved parties and stakeholders	53
Discussion.....	58
Recommendations.....	63
Annex	65

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Glossary

Standard – Set of minimal requirements for the HEIs/educational programmes, that should be fulfilled in order for them to be granted Authorization/Accreditation.

Component – Constitutive part of the Standard

HEI/Institution – Teaching or Teaching/Research Institution that carries out Higher Educational Programmes, with the main goal of conducting higher educational and scientific research activities

Criterion – Requirements set by the components of the standards.

Recommendation - Proposal(s) in external QA report, which should be considered by the institution to comply with requirements of the standards, in order for the HEI/programme to comply with the standard requirements and which affects the standard evaluation

Suggestion - Non-binding suggestions for programme development that does not affect the Standard evaluation

Best Practice - Practices, which prove to be exceptionally effective and which may become a benchmark or a model for other higher educations

Narrative – Part of the discussion given under standard components in the external QA report about HEI/Programme

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WFME – World Federation of Medical Education

Expert – Professional in particular sphere, that evaluates the educational programme. Expert could be a representative of Academia, employer and/or Student. Also a representative of relevant regulatory body and/or Professional Association.

Stakeholder – The people involved in the quality assurance process of Higher Education, e.g. Student, Graduate, Clinic Representative, Academic Staff etc.

Sector Benchmarks – The collection of requirements for the educational programme(s) in specific field that involves the requirements concerning both the programme content as well as the resources needed for carrying it out.

PBL – Problem Based Learning

OSCE – Objective Structured Clinical Examination

Affiliation – Written agreement between the HEI and a person holding academic position, by which the person is affiliated to only a single HEI

Academic Staff – Professor Associated Professor, Assistant Professor, Assistant.

Invited Staff – A person not holding an academic position, who is employed in HEI with temporary contract, teaching particular educational components and paid according to the amount of hours worked.

Introduction

Medical education in Georgia has a more than 100 year-old history. The very first Faculty of Medicine in Georgia was the Faculty of Natural Sciences, Medicine and Mathematics at Tbilisi State University, which was established in 1918. In 1930, the Faculty of Medicine of Tbilisi State University became an independent higher education institution called Tbilisi Medical Institute (today, its name is Tbilisi State Medical University). The latter was the country's only higher medical education institution until the early 1990s.

With the collapse of the Soviet Union, new faculties of medicine appeared in the country. Some of them were established on the basis of already existing state universities, while most of them emerged with a growing number of private universities, numbering around 200 in 2005¹, whereas back in 1991, the country had only 19 higher education institutions². In the period from the 1990s to 2005, medical education in Georgia was, virtually, cut off from any external systemic control. The World Directory of Medical Schools refers to 11 medical schools from Georgia, that no longer in operate³. Nevertheless, just by taking a look at the list⁴ of institutions and considering their names, it is possible to conclude that medical programs were implemented by many more educational institutions. Education Management Information System (EMIS) does not have accurate information on the issue.

In 2004, at the initial stage of education reform, in the Law on Higher Education, medical education programs were referred to as regulated, which meant that there had to be “special accreditation requirements” for such programs⁵. However, until 2011, the country had no effective external mechanism to regulate the quality of basic medical education, other than general provisions of the Law on Higher Education. The initial stage of the reform is associated with a significant drop in the number of higher education institutions in the country. As to medical education programs, as mentioned above, the exact number of medical education programs in 1992-2005 could not be identified, although the 2006 report by the National Center for Educational Accreditation already notes that medical education programs were implemented by 21 higher education institutions.⁶

In 2011, by order of the Director of NCEQE, the first sector benchmark for medicine was approved, which set the basic requirements to be met by medical education programs. In 2018, the Sectoral Council for Medicine developed a new sector benchmark for medicine, which is far more extensive and content-rich than the 2011 version. The 2018 sector benchmark is largely based on the Basic Medical Education (BME)

¹ National Center for Educational Accreditation, For Quality Higher Education, annual report, 2006

<https://eqe.ge/res/angarishi2006.pdf>

² Smolentseva, A. (2012). *Access to higher Education in the Post-Soviet States: Between Soviet Legacy and global Challenges*. Retrieved from https://www.salzburgglobal.org/fileadmin/user_upload/Documents/2010-2019/2012/495/Session_Document_AccesstoHigherEducation_495.pdf

³ World Directory of Medical Schools, 2021, retrieved from url: <https://search.wdoms.org/> 03/04/2021

⁴ Ministry of Education, Book of institutional registry, Data about licence holders, Higher Educational Institutions. https://mes.gov.ge/upload/multi/geo/1224578444_umaglesebis%20sia.pdf.

⁵ Law on Higher Education, 2004, Article 2(z³), original version.

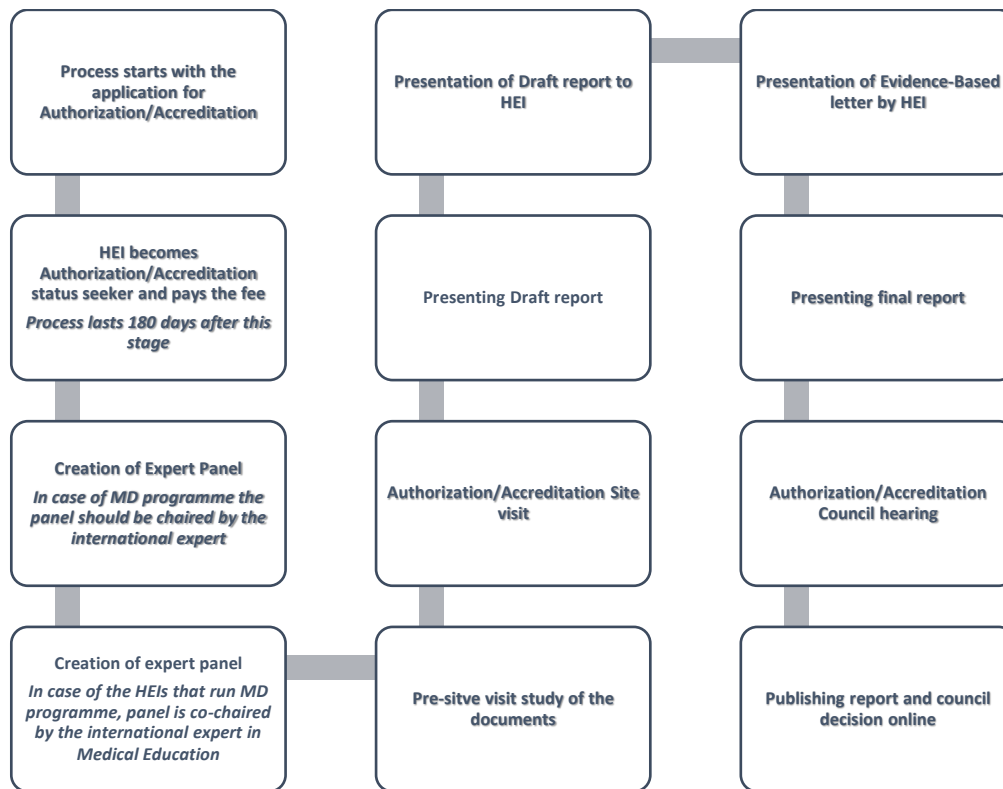
⁶ National Center for Educational Accreditation, For Quality Higher Education, annual report, 2006

<https://eqe.ge/res/angarishi2006.pdf>

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Standards updated by WFME in 2015⁷. As of March 2018, an amendment was made to the HE Program Accreditation Charter, according to which the involvement of an international expert, in capacity of the Chairperson of the Expert Panel, in the process of assessing medical education programs has become mandatory. A pinnacle of the progress made with regard to external quality assurance of medical education was the recognition of NCEQE by WFME in October 2018. Since 2019, the hearings of the Accreditation Council, where decisions are made about one-cycle medical doctor programs, have also been attended by invited members of the Council for Medicine, that participate in discussions of the issue and decision-making. In late 2020, WFME updated its BME Standards once again, and, currently, the Sectoral Council for Medicine is working to bring the sector benchmark in line with them.

Infobox 1- HEI Authorization and Programme Accreditation procedures



At present, both the process of authorization of HEIs implementing medical education programs and the accreditation process of higher medical education programs are carried out involving international experts, and relevant reports are publicly available in Georgian and English. However, today, as never before, Georgian medical education is carefully monitored by international partners. One of the most notable examples is an article published in the Times Higher Education in 2019. The author of the article, Michèle Wera – a WFME and ENQA advisor and reviewer, points to the need for better monitoring of the

⁷ Medicine, HE sector benchmark:

<https://www.eqe.ge/res/docs/20190507151947დარგობრივიმასსიათებელი.pdf>

Georgian medical education industry⁸. The main issue highlighted in the article was the growing trend of medical schools and international students in that field in Georgia. The pathos of the article unambiguously emphasized the extent of NCEQE's attention and work needed to maintain a high standard of quality in medical education. Another article published in the *Tbilinomics* in 2019 and authored by Eric Livny, Vakhtang Surguladze and Revaz Surguladze, highlights the economic benefit derived by medical schools, and, in general, by the country through the involvement of international students. However, there are critical remarks concerning the student admission preconditions as well as the country's clinical potential, which, virtually, mirrors the pathos of the article by Michèle Wera⁹. In addition to the published articles, international experts directly involved in the authorization/accreditation processes have also had remarks concerning the sustainable mechanisms for medical education quality assurance. It is noteworthy that those international experts are, as a rule, quite familiar with the context of Georgian medical education and their analysis is based on real experience.

In addition to the above, NCEQE has received a number of complaints from international students in recent years, mainly related to student recruitment issues, in particular, to the role of the agencies involved in the international student recruitment process, which do not usually participate in the medical schools evaluation process as stakeholders.

According to the data provided by the Education Management Information System (2021)¹⁰, there are 22 HEIs in Georgia that implement 32 one-cycle medical education programs. The number of active students in those programs is 18695. 10 of those programs are taught in Georgian, 21 – in English and 1 – in Russian. More than half of the students in medical doctor educational programs are international students and their number makes up 11889. The number of local students is 6806 respectively.

It is also important to note that local students outnumber international ones only in 6 out of the 22 medical schools. Despite such data, it is noteworthy that the increase in the number of international students is a fairly new phenomenon, as that significant increase in the figures has been observed in the last 5 years. The total number of local graduates (3461) has exceeded the number of international graduates (1878) in the last 5 years. However, given the steady growth trend in the number of the latter, it is likely that the number of international graduates will exceed the number of local ones in a few years. This information is detailed in Figure. N1.

⁸ Michele Wera, *Georgia's medical education industry needs careful monitoring*, Times Higher Education, 2019. Retrieved from link: <https://www.timeshighereducation.com/opinion/georgias-medical-education-industry-needs-careful-monitoring> 05/04/2021.

⁹ Eric Livny, Rezo Surguladze, Vato Surguladze, *Georgia's Medical Education: a Party Soon Coming to an End*, *Tbilinomics*, January 2019, Retrieved from link: <https://tbilinomics.com/index.php/en/education-en/617-georgia-s-medical-education-a-party-soon-coming-to-an-end>

¹⁰ Information provided by the Education Management Information System, June 2021

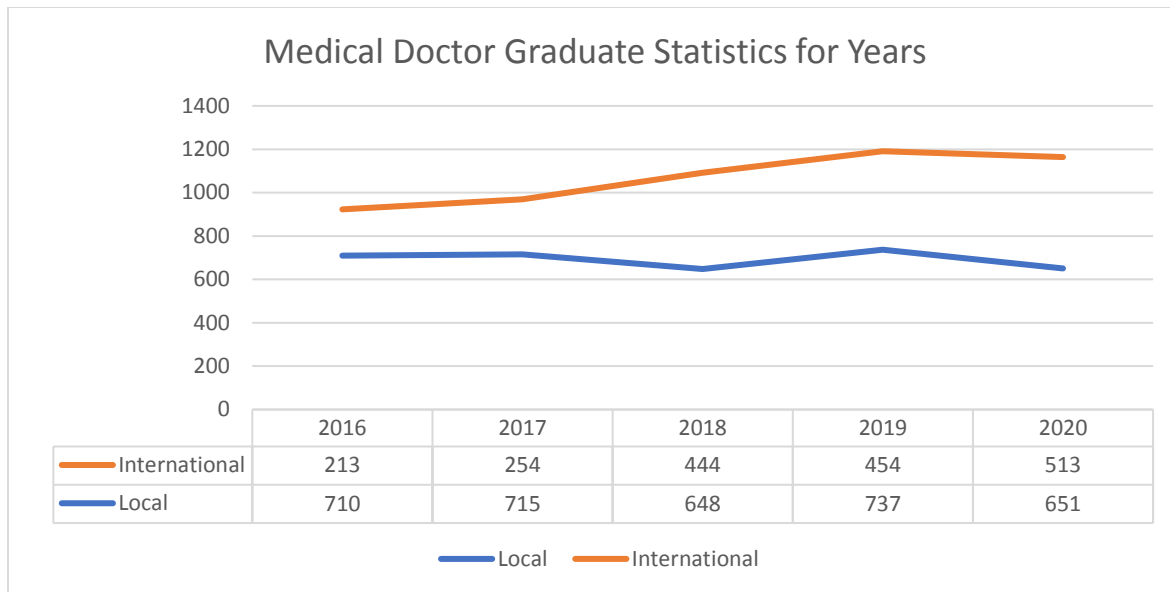


Figure. N1¹¹

The more the number of medical education programs and their students is increasing, the more attention is paid to the effectiveness of basic medical education received in Georgia. A mandatory requirement within the higher education program accreditation process is to provide the educational program graduate employment rate as a percentage. An accreditation self-evaluation report is to indicate the number of graduates employed both in the field and in general. Nevertheless, the information provided is less verifiable. One of the mechanisms concerning the effectiveness of medical education that can be verified by a third party is the results of the post-diploma qualification examination. According to the results of the 2020 spring session of the post-diploma qualification examination held by the State Regulation Agency for Medical and Pharmaceutical Activities, 49% of the applicants successfully passed the examination, whereas considering individual medical schools, only the success rate of graduates of 2 institutions exceeded 50%. At the faculty level, the lowest rate was a positive result achieved by only 25% of the students taking the examination. It should also be noted that in the framework of the research, the WG contacted the Medical Activity Regulation Agencies of India, Nigeria and Sri Lanka and requested information about the results of applicants that had received medical education in Georgia, but none of the regulators has provided such information and therefore the data cannot be reflected in the analysis.

¹¹ Information provided by the Education Management Information System, June 2021

*Infobox N1: Higher Educational Programme Accreditation Standards***1. Educational programme objectives, learning outcomes and their compliance with the programme**

- 1.1. Programme Objectives
- 1.2. Programme Learning Outcomes

2. Teaching methodology and organization, adequate evaluation of Programme mastering

- 2.1. Programme Admission Preconditions
- 2.2. Educational Programme Structure and Content
- 2.3. Course
- 2.4. The Development of practical, scientific/research/creative/performance and transferable skills
- 2.5. Teaching/Learning Methods
- 2.6. Student Evaluation

3. Student achievements and individual work with them

- 3.1. Student Support Services
- 3.2. Master's and Doctoral Student supervision

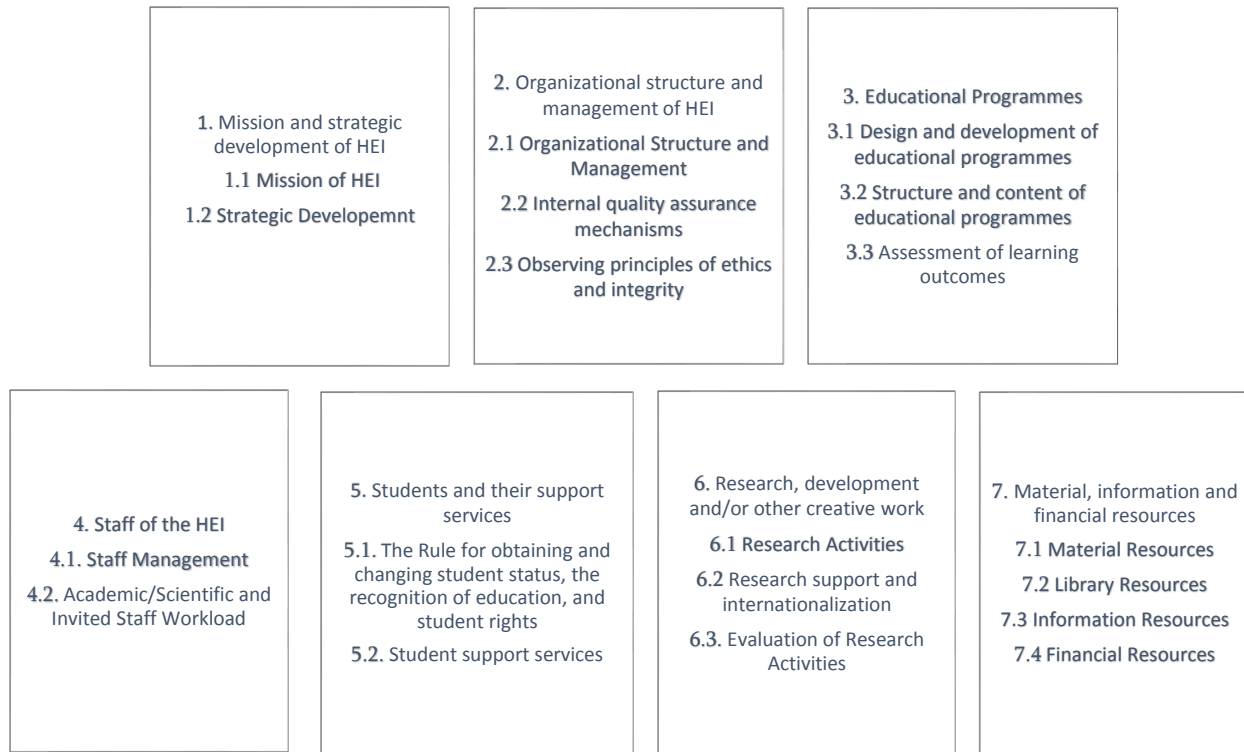
4. Providing teaching resources

- 4.1. Human Resources
- 4.2. Professional development of academic, scientific and invited staff
- 4.3. Material Resources
- 4.4. Programme/faculty/school budget and programme financial sustainability

5. Teaching Quality Enhancement Opportunities

- 5.1. Internal Quality
- 5.2. External Quality
- 5.3. Programme monitoring and periodic review

Infobox N2: HEI Authorization Standards



Research purpose and objectives

Given the above information, the purpose of this thematic analysis is to present the main trends in external quality assurance of medical education and outline the ways of their improvement. The objective of the research is to identify the strengths of and areas for improvement in external quality assurance of medical education (including clinical practice) based on the assessments carried out in the period following the recognition of NCEQE by WFME and the entry into force of the new sector benchmark, as well as to develop recommendations, considering both the standpoint of stakeholders and the analysis performed, in order to further develop the standards and evaluation procedures. It should be noted that this is the first time that research of this type has been conducted in Georgia in the context of medical education. Thus, the research questions proposed are the following:

- What are the general trends in medical education in Georgia as informed by the outcomes of the external QA reports? (RQ1)
- What are the strengths/best practices and areas of development in relation to quality of medical education in Georgia? (RQ2)
- What could be the improvements made in QA standards and/or procedures for better assurance and enhancement of quality of medical education? (RQ3)

It is worth noting that such a research within the context of medical education has been undertaken first time in Georgia.

Methodology

Given the research purpose and objectives, the members of the WG divided the research into stages and identified all the necessary sources of information that needed to be found and used while working on the thematic analysis. At the meetings of the WG, the data processing and analysis methodology to be used at each stage was agreed on and the activities to be performed were distributed. In addition to meetings held on a regular basis, the WG periodically reviewed the progress made by individual members of the group, provided suggestion, ensured consistent use of the research mechanism and maintaining construct validity.

The research covers both quantitative and qualitative parts and is based on a mixed methodology, which is most clearly visible in the final part, namely, in preparation for focus groups and further analysis. The preparation for the focus group and drawing up an interview plan were based on comparing the information obtained in the pre-research quantitative and qualitative parts, as well as on identifying additional research issues. The information obtained at the different stages of the research and from a variety of sources is eventually reconciled once again in the context of a final discussion, and relevant recommendations are provided. A complete methodological picture is given in Figure. N2.

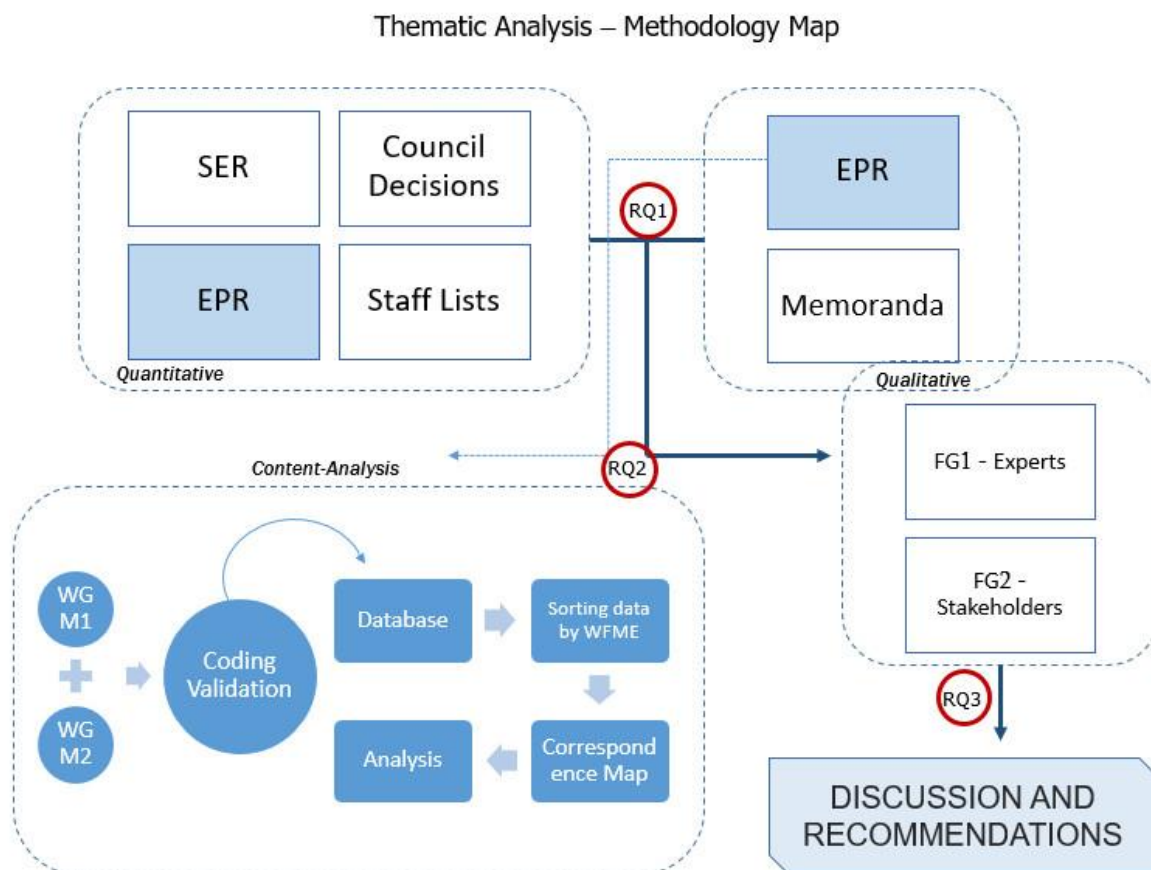


Figure. N2

In response to the 1st research question (RQ1) (see research purpose and objective above) the working group used quantitative review as well as content analysis and data gathered from memoranda. To address the 2nd research question (RQ2) the working group relied on content analysis of expert reports and the data gathered through focus groups, agenda and content of which envisaged all the preceding steps. As for the 3rd research question (RQ3), taking into account the viewpoints voiced during the focus groups and issues and findings addressed in the discussion part of the report, the working group finally elaborated on recommendations for the stakeholders. Rationale and content of each stage of the research, including the way data sources were selected, is discussed below in more detail.

Quantitative review – at the first stage of the thematic analysis, the data to be collected in the quantitative review part were identified, based on higher education program self-evaluations and supporting documents (memoranda, contracts, staff lists), decisions of the Appeals and Accreditation Councils, and expert reports. While identifying the reports to be examined in the framework of the analysis, the WG was guided by the fact that institutions were supposed to adhere to the WFME Standards both in the accreditation and authorization context as early as the beginning of 2019, as it was in that period that an obligation of bringing one-cycle medical education programs in line with the 2018 sector benchmark for medicine arose. The latter, in turn, is based on the WFME BME Standards 2015. As a result, the quantitative review of the research involves 12 one-cycle education program self-evaluation reports and an expert report. It was those 12 programs that were evaluated in 2019-2020, plus the authorization of 2 institutions that implement one-cycle programs as well. However, a more detailed explanation concerning the authorization context will be made in the part covering the content analysis of the reports.

This time, the quantitative review includes the following data (where necessary, the content categories were coded as numerical data): program status, language of implementation, quantitative staff-related indicators (academic, scientific, invited, foreign, administrative staff, invited and academic staff ratio, outflow and scientific indicators, interprogram staff overlapping rates), student and graduate rates in the last academic year (advertised and filled quota, local and international students willing to be enrolled, students with an active status, results of employment, of the certification examination and the examination to move on to the next level), quantitative indicators of accreditation reports (evaluations given in the standard components, the number of recommendations given against the components, suggestion and identified best practices, the amount of the analytical part), status of Council decisions and the number of memoranda/contracts concluded with training/practical training facilities. Based on the above data, the quantitative review covers simple frequencies, ratios, total and percentage distributions, the main descriptive trends of programs available to us.

Compliance map and content analysis - To move on to the qualitative part of the research, based on theoretical data and content compliance, the WG developed an intersectional map between the local accreditation and authorization standards, on the one hand, and the WFME BME Standards 2015, on the other hand. Given that the WFME Standards were the key guiding framework for the report content analysis, the WG coherently linked their components to the Georgian standard components (where necessary, linkages with 2 or more components were highlighted), and in the case where the WFME component could not be unambiguously linked to any of the accreditation components, the link with the authorization components was highlighted. This was the primary task so that the WG could move on to coding the text of the reports, and therefore, the numbers of the WFME components were chosen as the codes. However, on starting the coding and after a closer look at the texts (including the fact that the experts may, while judging, have referred to several standards at the same time and/or not exactly the

component under which the narrative in question is given), the WG further refined the compliance map and therefore, the picture obtained after the coding is somewhat different from the initial compliance. The final picture shows deeper linkages between the local and the WFME Standards. The final output of the coding process was used as a structural framework for content analysis. A relatively concise version of that output, summarized not by components but by standards, is given in Table N1.

	W1	W2	W3	W4	W5	W6	W7	W8	W9
N1	38	36	9	6	13	14	24	8	9
N2	7	181	56	49	26	84	24	11	28
N3	0	10	2	48	1	12	2	1	2
N4	0	18	2	11	96	74	10	58	4
N5	2	14	4	4	1	9	81	14	25

Table N1 – Standard Compliance Map based on identified inter-connections among components during the content-analysis (W = WFME; N = NCEQE Accreditation; color saturation is in line with number of connections)

The coding process involves those parts of the narrative under the components that included analytical findings, followed by suggestion, recommendations and best practices with regard to relevant WFME components. The WG decided that the most optimal approach was to assign a maximum of two WFME component codes to an excerpt of the report that were most relevant to the issue, where it was difficult to establish one specific link between the two systems of standards. One member of the group was responsible for coding the report, which was additionally checked by one more supervisor assigned to that particular report. The latter checked both – the assigned codes and the rest of the report text, hence, s/he, on the one hand, additionally coded, where necessary, the findings that had been looked over, and on the other hand, checked the logical compliance of the already assigned codes. Following such dual supervision, in case of differences of opinion, a specific problematic issue was discussed with the rest of the group. The data obtained using the three-level coding system needed to be systemized and therefore a database was created, which registered the program number, text type (narrative, suggestion, recommendation, best practice), accreditation component (from which the researcher took a specific excerpt), one or two relevant WFME component codes (with which the researcher matched the excerpt taken at the previous stage) and the excerpt itself from the text of the report. It was through the identification of such matchings that it became possible to filter qualitative data based on 9 WFME Standards and each of their components. In total, 791 individual text excerpts (341 double and 450 single links) and 1132 component links were identified (only a few of which were suspended at the research stage due to a coding error).

Using the database, while working on the content analysis, the researcher had the opportunity to retrieve the frequency data concerning compliance of the local standard with this or that WFME component, identify the main topics in the narrative, suggestion and recommendations, whether the text mentioned and reviewed the sector benchmark for medicine in relevant components, how deeply the the WFME components were covered, including the sub-criteria (basic and quality standards). If there was no clear matching between the components, which was also logical due to the specifics of accreditation, the researcher, considering the original compliance map, took a decision to search for the relevant issue in the text of the authorization report (the decisions are referred to in the chapter on content analysis, in relevant components). Therefore, authorization reports were considered an additional, supporting source

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to obtain the information needed for the research, given that in the last 2 years, only 2 such documents have been available to the WG.

Memoranda analysis – at the next stage of the research, in order to better cover and study the clinical training part, the WG working on the thematic analysis focused on the contracts and memoranda concluded with practical training facilities, i.e., with clinics and hospitals. Given that the total number of documents is 288 and due to time constraints the group could not cover the material in full, 5 memoranda were randomly selected for each program and a total of 60 contracts were reviewed by verifying the information provided in them on issues such as internship objectives, duration, clinical disciplines, number of students, spaces and staff provided by clinics, contract term, etc.

Focus groups – as a result of the quantitative and memoranda review and the report content analysis, a great deal of information was identified based on the reconciliation of which, using a kind of triangulation approach, issues to be verified and studied additionally were identified, which could be discussed and double-checked in a focus group format. In this case, focus groups had tasks related to completion, revision, explanation and recommendation. Two focus groups were set up, for which a group-tailored interview guide was selected. However, in order to illustrate standpoints and views concerning the issues more clearly, common broad questions were asked in both groups. Following telephone contact with the experts, focus group meetings were held remotely, online. One group was composed of 7 accreditation experts (expert in the field, employer and student experts) that participated in the evaluation of the above programs, and the other group of 6 members was composed of other stakeholders, including representatives of the Accreditation Council, Administrative Management and Quality Departments of institutions. The WG produced a focus group transcript. Results of the focus group meetings were used both in the critical analysis and the development of final recommendations. For a focus group guide, see Annex N1.

Research ethics – HEIs and related programs, staff identities and the names of practical training facilities are encrypted throughout the research. At the beginning of the focus group session, the participants were informed about the objectives of the research and the format in which the focus group session would be held. The moderators informed them that the recording of the meeting would be kept for the next few weeks to prepare and further analyze the transcript, and that it would be accessible only to the authors of the research, who would delete the recording at the end of the research. In addition, the participants were informed that their identities, as well as the identities of third parties (individuals and legal persons) mentioned by them in the course of the focus group session would remain confidential and would not be mentioned directly in the published part of the analysis. In the end, the group members were informed about the format details and the expected duration of the focus group session. As promised, the analysis maintains confidentiality of the parties, and the recording was deleted as soon as the work on the research was finalized.

Research limitations and future opportunities - as to research limitations, while interpreting the results obtained during the thematic analysis, it should be considered that the group focused on the data generated over the last two years, covering about one third of medical programs and authorizations of only 2 institutions. Therefore, a complete generalization of certain findings in respect of Georgian medical education would not be appropriate. For example, in the results review part, the reader will see that issues related to academic freedom are hardly covered in the findings. However, once again, given the number of authorization processes over the last two years, we have no reason to conclude that it is a system-level

problem. Moreover, as mentioned in the introductory part, the WFME Standards were updated in 2020, and a revision of the national sector benchmark is also planned. Therefore, when planning future research, the above framework documents and the educational programs and institutions adapted to them will have to be taken into account.

The biggest problem for the WG was the restrictions related to the spread of Coronavirus and the difficult situation in the country, which significantly hindered the work process. For example, the issue of holding a focus group session should also be viewed in the same context, considering the fact that state-of-the-art technology, on the one hand, simplifies the gathering of participants, but due to teleworking and periodic technical delays, reduces the uniformity of the discussion space and the moderator's control.

Due to limited time and human resources, the research covered about one fifth of the memoranda of cooperation concluded with practical training facilities, although the picture is fairly homogenous given the random selection. In the future, it is possible to conduct an in-depth thematic analysis of the clinical training component of medical education across Georgia, which is feasible in cooperation with governmental institutions or bodies (the Ministry of Education and Science, the Ministry of Health and Social Affairs, relevant LEPLs), on the one hand, and with the nongovernmental sector (educational institutions, clinics, hospitals), on the other hand. In addition, in terms of future research, it is also possible to study the effectiveness of Georgian medical education from the perspective of postgraduate education and employment, in respect of both local and international students.

WFME Standards for Basic Medical Education 2015

1. Mission and Outcomes

- 1.1. MISSION
- 1.2. INSTITUTIONAL AUTONOMY AND ACADEMIC FREEDOM
- 1.3. EDUCATIONAL OUTCOMES
- 1.4. PARTICIPATION IN FORMULATION OF MISSION AND OUTCOMES

2. Educational Programme

- 2.1. FRAMEWORK OF THE PROGRAMME
- 2.2. SCIENTIFIC METHOD
- 2.3. BASIC BIOMEDICAL SCIENCES
- 2.4. BEHAVIOURAL AND SOCIAL SCIENCES, MEDICAL ETHICS AND JURISPRUDENCE
- 2.5. CLINICAL SCIENCES AND SKILLS
- 2.6. PROGRAMME STRUCTURE, COMPOSITION AND DURATION
- 2.7. PROGRAMME MANAGEMENT
- 2.8. LINKAGE WITH MEDICAL PRACTICE AND THE HEALTH SECTOR

3. Assessment of Students

- 3.1. ASSESSMENT METHODS
- 3.2. RELATION BETWEEN ASSESSMENT AND LEARNING

4. Students

- 4.1. ADMISSION POLICY AND SELECTION
- 4.2. STUDENT INTAKE
- 4.3. STUDENT COUNSELLING AND SUPPORT
- 4.4. STUDENT REPRESENTATION

5. Academic Staff/Faculty

- 5.1. RECRUITMENT AND SELECTION POLICY
- 5.2. STAFF ACTIVITY AND STAFF DEVELOPMENT

6. Educational Resources

- 6.1. PHYSICAL FACILITIES
- 6.2. CLINICAL TRAINING RESOURCES
- 6.3. INFORMATION TECHNOLOGY
- 6.4. MEDICAL RESEARCH AND SCHOLARSHIP
- 6.5. EDUCATIONAL EXPERTISE
- 6.6. EDUCATIONAL EXCHANGES

7. Programme Evaluation

- 7.1. MECHANISMS FOR PROGRAMME MONITORING AND EVALUATION
- 7.2. TEACHER AND STUDENT FEEDBACK
- 7.3. PERFORMANCE OF STUDENTS AND GRADUATES
- 7.4. INVOLVEMENT OF STAKEHOLDERS

8. Governance and Administration

- 8.1. GOVERNANCE
- 8.2. ACADEMIC LEADERSHIP
- 8.3. EDUCATIONAL BUDGET AND RESOURCE ALLOCATION
- 8.4. ADMINISTRATION AND MANAGEMENT
- 8.5. INTERACTION WITH HEALTH SECTOR

9. Continuous Renewal

Review of quantitative indicators

The thematic analysis WG has identified 12 higher education programs that underwent the accreditation process in 2019-2020 by being in compliance with the updated sector benchmark for medicine. Prior to content analysis, the group considered it important to find available sources of information concerning those programs (self-evaluation reports, expert reports, Council decisions, staff lists, memoranda) and to provide a small analytical review of relevant quantitative indicators in view of the entire accreditation cycle.

Staff 4 out of the 12 programs have undergone primary accreditation, and what is interesting is that in case of the other 8, there are programs that are available in both languages, Georgian and English, though the 4 programs presented for new accreditation are in English. None of the new programs has scientific staff, and the number of academic staff for each program is 33 on average. The distribution of affiliated staff in those programs averages 20 (though this figure is increased due to one HEI data, where all 39 academic employees are affiliated). In case of the new programs, 60% of a total of 133 academic employees are affiliated. The number of invited staff in those programs averages 47, and is 1.4 times higher than the number of academic staff. The ratios between academic and invited staff are 1:1 as well as 1:2. Although the programs are in English, foreign staff involved in the study process can be found only in 2 of the new programs, and their number can be counted on the fingers of one hand. The most noticeable difference in case of institutions is related to the number of their administrative employees, which varies from 7 up to 104. In view of the fact that the programs are new, staff outflow rates are not given in this case. The total number of staff in the programs ranges between 71 and 91. In terms of scientific indicators, the local indicators for two programs are slightly higher than the foreign ones, while the international indicators in case of two programs are significantly higher than the Georgian ones. What is specific to the latter is that they have invited foreign specialists on the staff, and the number of administrative staff is 5 times less compared to the previous two institutions. In total, we have an average of 178 scientific indicators for 4 programs (67 – Georgian, 110 – international).

Out of the 8 programs that were already implemented in the accredited mode, only one has 3 scientific employees, and the number of academic staff for each program averages 43. The distribution of affiliated staff in respect of those programs averages 35. The affiliation rate for that part of programs is higher and exceeds 80% (in total, 344 academic employees). The number of invited staff averages 85 for 8 programs and is 2 times higher than the the number of academic staff (the ratios vary between 1.8 and 4.2). Half of the programs, mainly English-language ones, have several foreign specialists. When it comes to the number of administrative staff, the picture is quite diverse as well – from 10 up to 106. For all 8 programs the number of staff averages 129. The indicator varies from program to program and ranges between 80 and 170.

The perception of the significance of the outflow rate and the scheme of calculation vary from institution to institution, and it is difficult to discuss them in detail, which may be partly due to the lack of appropriate instruction from NCEQE in the context of completing a self-evaluation report template. If we take a look only at the 4 programs, where the reports show exactly how many academic and invited employees have been hired or left in recent years, we will see extremely high figures. In particular, in respect of a total of 160 academic employees we should consider 136 employees that have been added and 69 employees that have left in recent years, whereas in respect of a total of 285 invited employees (for 4 programs), we

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should consider 259 employees that have been added and 49 employees that have left in recent years, - all this, in general, calls into question the sustainability of the programs and the quality of their implementation, the achievement of learning outcomes, etc.

As to the scientific achievements of the staff implementing programs (in total, 8) presented for re-accreditation, there are no national or international scientific indicators available in respect of the Georgian and English-language programs of one of the institutions. If we take the other 6 programs as an example, there are 2503 scientific indicators (1235 – Georgian, 1268 – international) in total. In that regard, in case of most programs, the national indicators are higher than the foreign ones, and the implementation of the two programs, where the international scientific indicator is significantly higher than the national one, involves slightly more foreign specialists and both programs stand out due to their minimum number of administrative employees. This is exactly what is found in case of the new programs.

For 12 programs there are 1208 employees in total, out of whom 614 persons are unique, and if we add to them persons that are indicated repeatedly only in respect of the (bilingual) programs of the same HEI, the number will amount to 740 persons, i.e., in one case, 51% of the staff works for only one specific program, and if we make an exception (1 HEI – 2 programs not considered as repeated), this figure will be higher and will make up 61%. Even so, it turns out that at least 40% of the total staff is involved in the implementation of two or more programs; and if we take into account that a) the lists include non-sectoral staff as well and that b) in addition to the 12 covered programs, there are 12 more other one-cycle medical programs implemented in the country, we can assume based on rough calculations that half of Georgia's total academic staff in medicine is involved in the implementation of at least two programs.

251 employees can be found repeatedly 594 times in total, i.e., each of them covers 2.4 programs on average, and if we deduct some staff (126 persons) in view of the above exception (1 HEI – 2 programs), it can be concluded that 125 employees can be found repeatedly 469 times in total, and they follow 3.8 programs on average in various institutions. To be more specific, 191 employees out of the 251 that are found repeatedly, are involved in 2 programs, 34 employees are involved in 3 programs, 19 are involved in 4 programs, and 7 are involved in 5 programs.

Students This section covers the 8 educational programs presented for re-accreditation, as the quota of students, their employment rate and the rate of passing certification examinations are not available in respect of the new programs. 3 of those programs are implemented in Georgian, and the rest – in English. As to the Georgian programs, the number of foreigners willing to be enrolled in the last year is indicated only in case of one of them (all 14 applicants have been enrolled). As to the 5 programs implemented in English, no admission in three of them has been announced at the national level in the last year, and only international students have been enrolled exclusively. In general, observing the data shows that in some years, some of the programs announce admission only for Georgians, whereas in the following years only international students are admitted. In case of 3 institutions, vacancies have been announced for both categories in the last year, and one of them enrolled twice as many students by adding international students. The information provided by the HEIs concerning the announced vacancies is less clear and transparent. No uniform approach can be seen – whether the quota covers either national or international students, or both. For example, in one case, the institution indicates that the number of vacancies is 0, no Georgian students were enrolled, but at the same time, we see that hundreds of international students were enrolled. In another case, the given figure includes the number of both Georgian and international students. Such a picture can be seen in case of 3 programs (admission at the national level – 0). One of

the private universities has not announced any admission in the last year, but in the preceding academic years – 2017-2018, over 900 international students were enrolled in the program at a time.

HEIs have announced admission to fill a total of 261 vacancies (varies from institution to institution between 15 and 120) in the last year. However, as mentioned above, it is not clear what exactly is covered. Out of the 6 programs that announced admission for foreigners, only two are an exception, as the number of vacancies in fact filled by foreigners was less than the number of foreigners willing to be enrolled. This means that in respect of the majority of programs in question, the institution virtually uses no filtration mechanism and admits all persons willing to be enrolled. As to the 5 programs in respect of which admission has also been announced at the national level in the last year, the total number of persons willing to be enrolled is 5 times higher than the number of vacancies, but the number of applicants that listed the institutions as their first priority almost matches the number of announced vacancies. Real competition can be seen only in respect of one program, where the number of persons willing to be enrolled exceeds the number of vacancies, whereas in other cases the number of priority applicants is even less than the number of vacancies. It should be noted that the number of international and local students enrolled in those programs in the last year is almost equal. If we disregard the exception mentioned at the end of the previous paragraph, enrollment of foreigners in the programs where the vacancies were announced exclusively for foreigners, is approximately 1.5 times higher than the number of international students enrolled in the programs, where both categories were admitted. In total, the number of international students enrolled in the last year is on average 3 times higher than the number of enrolled local students. We should keep in mind that the data refer only to the period of filing an application and preparing for accreditation, and this report does not cover information as to the extent of increase or drop in program enrollments after accreditation, or the situation in that regard in the preceding years.

Out of 8 educational programs implemented by 6 institutions (2 institutions implement medical doctor programs in both languages), each has 363 students on average, with a total of 2905 active students, and at this stage, only 3 programs have graduates. This is due to the fact that most of the programs that underwent primary accreditation were accredited for a period of 5 years, whereas a period of 6 years is, as a rule, applicable to medical doctor programs with 360 ECTS credits. One out of the three programs is taught in Georgian and the other two – in English. The graduate employment rate is 76% on average, and the rate of employment by occupation is 70% (we have no information on whether moving on to residency/postgraduate training level is also meant in this case), the rate of moving on to the next level to continue studies is 71%, and the number of persons having taken the certification examination is 75% and the number of those who passed it is 70% on average. The rates of employment by occupation and of passing the certification examination are higher in case of English-taught programs. However, the data should not be generalized on the basis of a review of only 2 to 3 programs taken as an example, especially when the number of graduates is very low at this stage.

In case of all 8 programs, the number of active students is on average 3 times higher than the total number of staff implementing the programs. Compared to the number of their academic staff, the number of active students is on average 9.4 times higher. Considering the total number of staff, there are only two programs, where the number of employees exceeds the number of students. There are cases, where the number of active students is 4 or 6 times higher than the total number of staff, and 16 or 23 times higher than the number of academic staff, which is particularly noticeable in English-taught programs.

Evaluations of the standard evaluations indicated along the 12 educational programs show that 6 out of the 16 components of the accreditation standards are on average evaluated as “fully” compliant, and the other 10 as “substantially” compliant. Standard-wise, the first and third standards are on average evaluated as “fully” compliant, and the rest as “substantially” compliant.

If we take a look at the distribution frequency of the types of evaluation (see Fig. N3) by components, we will see that in case of accreditation standards 1.1, 1.2, 2.4, 3.1, 4.2, 4.3, 4.4 and 5.2 there is mostly “full” compliance. “Full” compliance component-wise is especially noticeable in case of components 2.1, 2.2, 2.5, 4.1 and 5.3, whereas “partial” compliance is evident with regard to standards 1.2, 2.3, 2.5, 4.1, 5.1 and 5.2. The cases of “non-compliance” are quite few in the second and fourth standards.

As to the final evaluation of the standard (see Fig. N4), in the 1st, 3rd and 5th standards we mostly see “full” compliance, while in the 2nd and 4th standards we see “substantial” compliance. With regard to the 3rd standard no “partial” compliance or incompliance can be found and “partial” compliance can be seen in the 2nd and 4th standards, but just once. “Substantial” compliance is quite frequent in case of the 5th standard, and, cumulatively, the lowest evaluations are overall present in the 2nd standard.

Frequency of used Assessment Types by Accreditation Standard Components

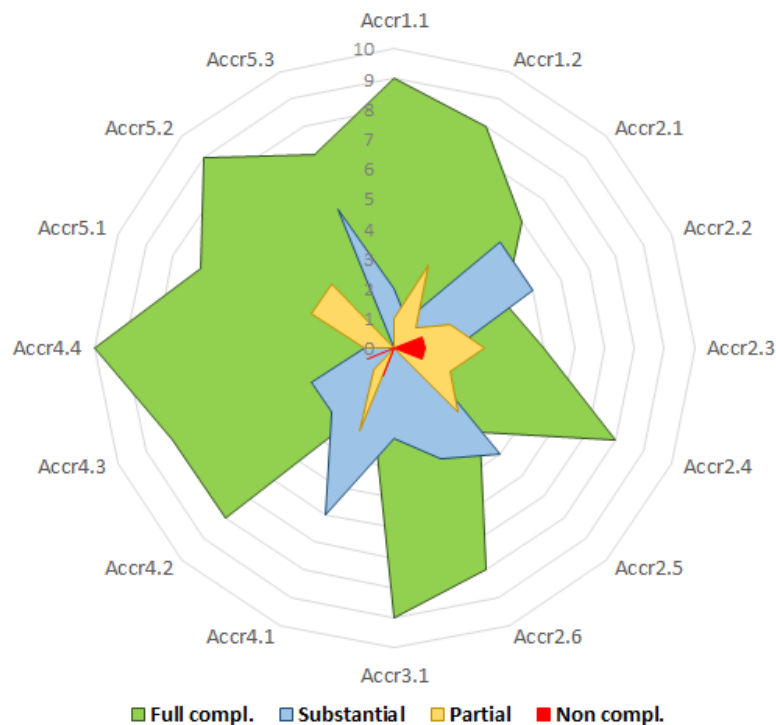


Fig. N3 – Frequency of the compliance assessment levels applied for accreditation standard components (for the description of each component check info-box in the introduction)

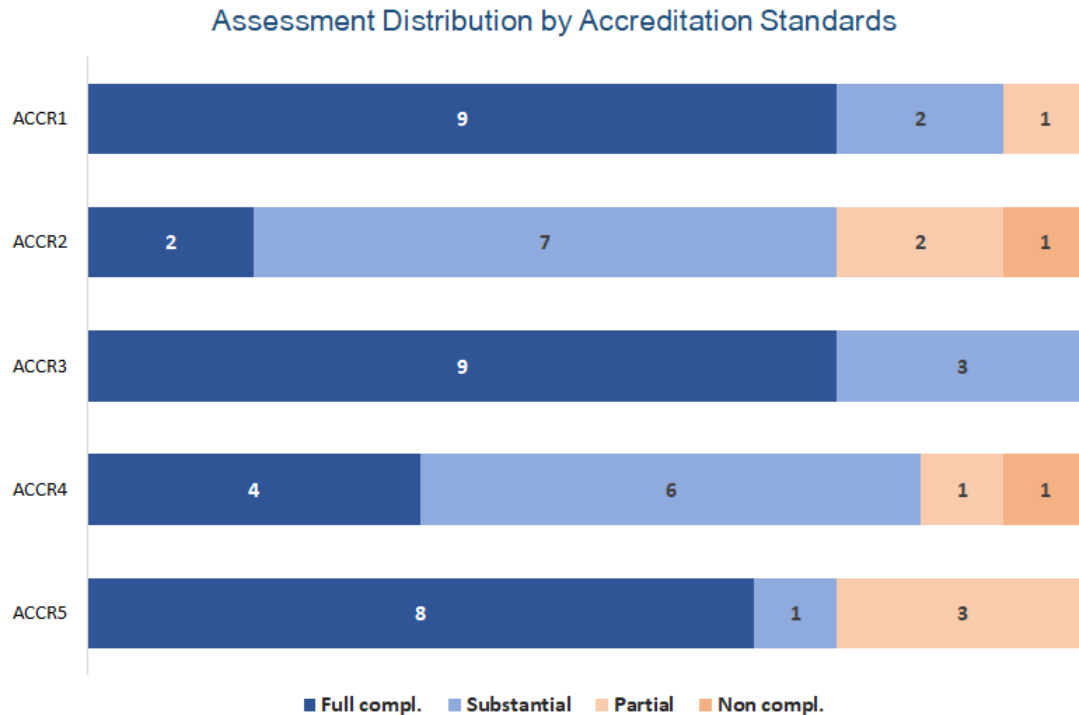


Fig. N4 – Frequency of the compliance assessment levels applied for accreditation standards (for the description of each standard check info-box in the introduction)

In most standard components, on average, only one or two recommendations are given. Most frequently, the experts give recommendations in standards 2.3 (in total, 21) and 4.1 (in total, 20). Next, based on frequency, follow standards 2.2 (in total, 15) and 4.2 (in total, 14). The fewest recommendations are given in components 2.1 (in total, 4) and 4.4 (in total, 3). As to suggestion, the experts mostly give their suggestion in the 3rd (14) and 1st (in total, 22) standards. Next, based on frequency, follow components 2.3 and 4.1. The least amount of suggestion is given in standards 4.2 and 5.3. Best practices can be identified in components 1.1, 2.4 and 3.1, though not frequently. Otherwise, their number in the standards is almost zero. For the purpose of a more simplified illustration of recommendations, suggestion and best practices summarized on the basis of the standards for the 12 educational programs, you can see Fig. N5. The picture additionally shows that in the first standard, in components 2.1, 2.4 and 2.6 of the second standard, in the third standard and in component 4.4 of the fourth standard, there is more suggestion than recommendations. The difference is particularly noticeable with regard to the 3rd standard. In components 2.3 and 4.1, the amount of suggestion as well as the number of recommendations is high. In 5.1, they are actually given in equal amounts. If we compare the peak points of the recommendation line on Fig. N5 with Fig. N3, we will see that in standards 2.2, 2.3, 2.5 and 4.1 the spectrum of evaluation varies, i.e. there are “substantial” and “partial” compliances and the number of recommendations given is higher than the amount of suggestion. However, interestingly enough, the same trend does not apply to components 4.2, 4.3, 5.2 and 5.3, where the number of recommendations also exceeds the amount of suggestion, but the experts mostly evaluate the components as “fully” compliant.

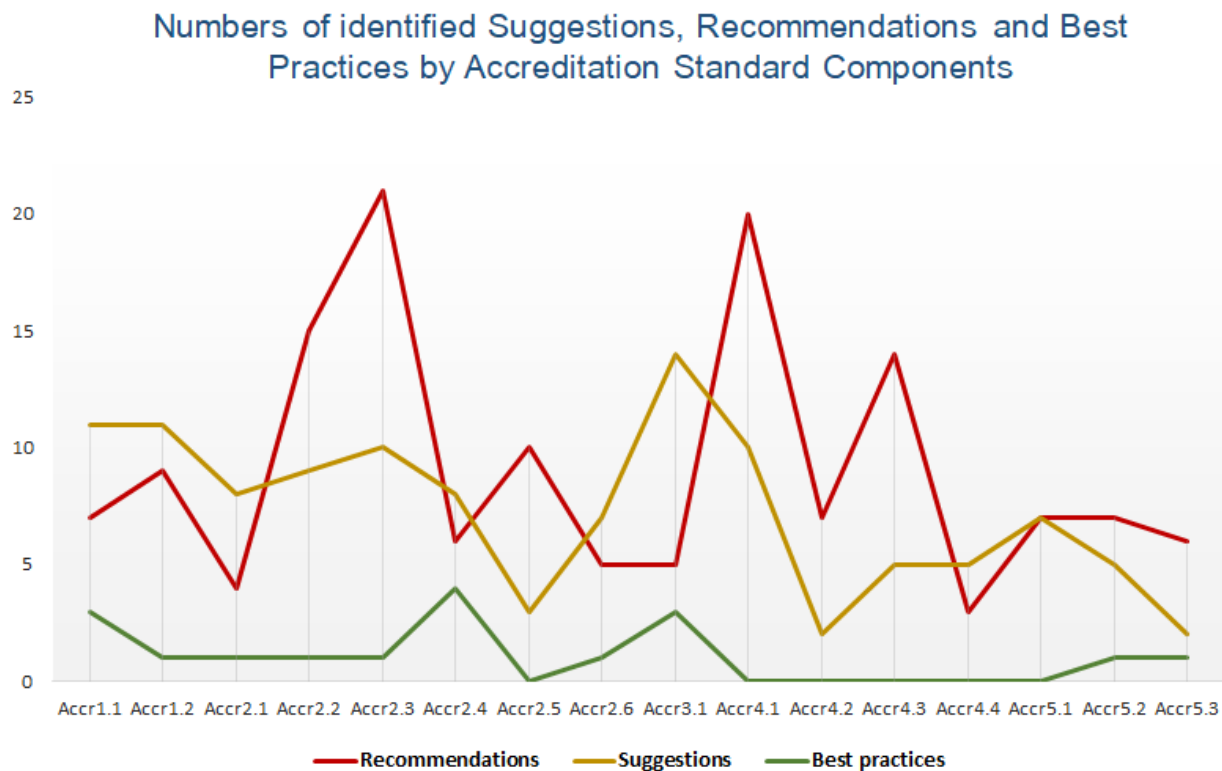


Fig. N5 – Number of issued suggestions, recommendations and best practices distributed across accreditation standard components (for the description of each component check info-box in the introduction)

In order to identify the amount of the narrative part of expert analysis in the reports, the number of lines in the text was used, considering the fact that the documents come in various formats, and some of them are a scanned version. Hence, the most voluminous analysis can be found in components 1.2 (43 lines on average), 2.2 (54 lines on average) and 4.1 (53 lines on average), the smallest parts of the analysis can be found in standards 4.4 (18 lines on average) and 5.2 (16 lines on average). A simple correlative analysis shows that the volume of component analysis is in a positive and strong correlation with the number of criteria in the accreditation standard components¹² and the correlation between the volume and the number of recommendations provided is also fairly strong and positive. It would not be unexpected to find a similar correlation between the number of criteria and the number of recommendations provided, but in this case the correlation did not turn out to be of relevance in statistical terms¹³. No link can be found between the amount of suggestion and the number of recommendations provided. Comparison between the number of component criteria and the volume of the analysis part of the report in the context of the standard can be seen on Fig. N6, which shows that in the reports, the volume of analysis concerning the 3rd, 4th and 5th components is almost in a 1:1 ratio with the number of relevant criteria.

¹² In components 2.6 and 4.2, the number of criteria related to the doctoral level is not considered.

¹³ Correlation: a) the volume of analysis and component criteria - $r_s = 0.79$, $p < .01$; b) the volume of analysis and the number of recommendations - $r_s = 0.62$, $p < .05$ (The result will be similar if we perform the analysis based on the programs rather than the components, - namely, the more voluminous the analysis in the report is, the higher the number of recommendations is, $r_s = 0.74$, $p < .01$).

The analysis concerning the first standard is not sufficiently representative, whereas it is excessive in the analysis concerning the second standard.

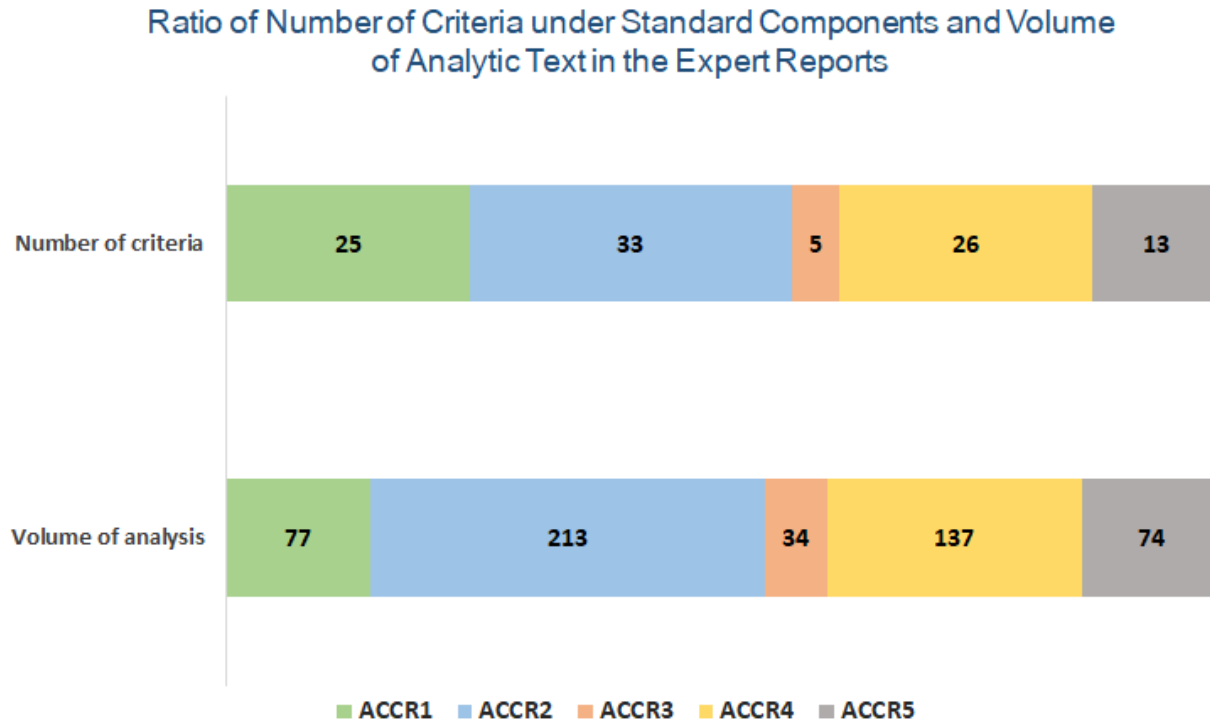


Fig. N6 - The ratio/correspondence between the numbers of criteria under standard components and relevant analytic narrative lines¹ in reports.

There is an average of 12 recommendations for each of the 12 educational programs, but we have a big variation, as there are programs in respect of which there are no recommendations, whereas in respect of one of them there is a total of 34 recommendations. In terms of suggestion, we have a more uniform picture and an average of 10 pieces of suggestion in respect of each program. All in all, most programs had to undergo full accreditation (with or without a report), only one program had to undergo conditional accreditation or accreditation with monitoring, and three programs were denied accreditation (or their accreditation was cancelled). In the latter case, the HEI applied to the Appeals Council concerning all 3 programs. The Appeals Council upheld its initial decision as valid only in one case, and granted conditional accreditation or accreditation with monitoring in the other two cases.

Memoranda analysis

In the framework of the research, the WG examined the 2019-2020 memoranda concluded within accredited one-cycle educational programs in medicine with the clinics in which clinical training is to take place. In view of the fact that the 12 reports examined by the WG referred to 10 HEIs, 5 memoranda were selected for each program, and in the case of 2 institutions, where the two programs of each were covered by reports, 10 memoranda for each were selected respectively. While analyzing the memoranda, the WG was guided by the following questions:

Whether or not the memorandum/contract provides for the following:

- Objectives and outcomes of the practical training and clinical disciplines in which students will undergo practical training;
- Duration of the practical training;
- The number of students the clinic is ready to receive;
- Identification of the clinical staff involved in the practical training;
- Identification of the parts of the clinical space (i.e. auditoriums, practice rooms) that students will use in the course of their practical training;
- The term of the memorandum and conditions for prolongation thereof

Most memoranda do not predetermine the number of students to be admitted to clinical practice, nor do they specify the size of groups for practical training. In some cases, there are paragraphs stipulating that the institution informs the clinic of the number of students in advance. It should be noted that almost all memoranda refer to a portion of the fee that the institution will pay to the clinic for the practical training.

Most memoranda specify the objectives and outcomes of the practical training, which are directly required in component 2.4 of the accreditation standards. However, most memoranda do not provide for specific clinical disciplines in which students will undergo practical training and which virtually is very important while planning the practical training content-wise. Such specification can rarely be found in the memoranda concluded with large, multi-profile clinics. The objectives and outcomes of the practical training are, as a rule, very general and it is difficult to extract any specific type of information. Moreover, almost none of the memoranda specify the duration of the practical training.

Most probably the most problematic part of the memoranda examined is that the vast majority of them do not specify how many clinical staff members will be involved in the practical training of students, i.e. who will supervise the clinical training. Nor do they identify parts of the clinic that will be used for practical training purposes. We see, but general explanations concerning both issues. As to the term of the memoranda, the latter is specified in almost each memorandum and most of them specify the conditions for prolongation as well.

Expert report content analysis

WFME 1. Mission and outcomes

With regard to WFME standard 1 (Mission and Outcomes), the thematic analysis WG has identified 37 texts covering analysis/evaluation/findings in the narrative part of the accreditation reports produced by the experts, plus 7 recommendations, 3 pieces of developmental suggestion and 0 best practices.

As a result of coding, WFME Standard 1.1 is clearly linked to accreditation component 1.1. WFME Standard 1.2 cannot be found in the accreditation standards, but is directly linked to components 2.1 and 2.3 of the 2nd authorization standard. As to WFME 1.3, its link with accreditation component 1.2 is most obvious. Its link to a lesser degree with accreditation components 1.1 and 2.3 is also noticeable. In the case of WFME 1.4, the connection is not so obvious, though it can be found in accreditation components 1.1 and 1.2 to a certain extent.

1.1. Mission

In the narrative part of the reports, the experts have highlighted several important topics. The evaluations mostly refer to the evaluation of the program goals in several different aspects. In particular, the narrative evaluates compliance of the program goals with the mission and strategy of the institution, where no clear problem can be identified, the evaluations are positive, and there are no recommendations. As a rule, the experts report that the program goals are in line with international standards. However, there is no in-depth evaluation at the level of this or that standard. On the other hand, we can find identical developmental suggestion concerning the fact that the program should provide for international standards to a higher degree:

“The goal should make it more clear that the program produces specialists that meet international standards”. (Suggestion, NCEQE – 1.1)

The major issue that can be identified in the narrative related to the program goals is the training of qualified staff that has relevant knowledge, competences and skills. The evaluations in this part are mostly positive. The expert analysis shows that the knowledge and competences provided for in the program goals take into account both local and global requirements. However, there is one critical note in the narrative, where the experts highlight that the knowledge, skills and skills are well-defined in the program goals, but sound unrealistic if we consider the human and material resources of the institution.

1.2. Institutional autonomy and academic freedom

The legislation of Georgia defines the scope of institutional autonomy, but only two authorization reports produced in 2019-2020 were available to us, given the research criteria. However, it should be noted that the WG failed to find any specific text in the authorization reports, where the experts indicated, at least in the narrative, the requirements of the standard in question.

1.3. Learning outcomes

In the narrative part, the experts, on the one hand, evaluate compliance of the learning outcomes of the program with the accreditation standards, and on the other hand, analyze whether the outcomes are in

line with the sector benchmark for medicine. The expert evaluations are mostly positive, and for the purpose of evaluating the programs the following frequently recurrent characteristics are used: specific, achievable, measurable, realistic and transparent, which exactly replicates the text of the standard. Moreover, the trend is mainly positive when when evaluating against the sector benchmark, but in this case, the experts do not go that deep and briefly note that the learning outcomes meet the requirements set in the sector benchmark, e.g.:

“The learning outcomes are based on general and sectoral competences, are in line with the sector benchmark for medicine and are achievable [.....]” (Narrative, NCEQE -1.2)

There are only several recommendations with regard to the learning outcomes of the program, and they are mostly of a technical or general nature as well, e.g.:

„In certain syllabi, the learning outcomes need to be adjusted“. (Recommendation, NCEQE - 2.3)

It should be noted that in the narrative we can find texts that are clearly formulated as a recommendation, referring to the identity of sectoral learning outcomes, but they cannot be found in the recommendations part of the reports:

“The learning outcomes in certain syllabi are completely identical, which requires a revision. A study course should not lead to an identical outcome through a knowledge competence, new knowledge should be built up and deepened.“ (Narrative, NCEQE - 2.3)

The experts positively evaluate staff capabilities and examples of practical involvement (together with other stakeholders) in developing learning outcomes.

1.4. Participation in formulation of mission and outcomes

In their reports, the experts mainly cover the participation of academic staff in formulating the mission and learning outcomes, though they also mention the involvement of students, graduates and employers. In most reports, the evaluations are positive and the experts emphasize broad involvement, while where a problem is identified in that regard and the expert provides a recommendation, it is not specified exactly which party should be involved.

Therefore, in respect of WFME Standard 1, the expert analysis concerning the program goals, mission, outcomes and involvement in their formulation is only of a general nature, and the evaluations are mostly positive in terms of compliance with the standard. The reports do not provide evaluative information about many important issues, such as, for example, postgraduate retraining, continuing education, professional and social values.

WFME 2. Educational programme

In respect of WFME Standard 2, the thematic analysis WG has identified 191 texts covering analysis/evaluation/findings in the narrative part of the expert reports, as well as 29 recommendations, 34 pieces of developmental suggestion and 6 best practices.

As a result of coding, most linkages have been found between WFME Standard 2 and the second accreditation standard. In some cases, a linkage with the 4th and 5th standards was also found.

2.1. Framework of the programme

The basic requirements of WFME standard component 2.1 serve the purpose of defining a curriculum and ensuring that principles of equality are maintained in that process and in relevant teaching and learning methods. The examined reports mostly cover the issues related to curricula and teaching and learning methods. The above standard, as evidenced by the compliance map, is closely linked to accreditation standards 2.3 and 2.5 and to the first standard to a lesser degree.

The narrative part of the reports brings up teaching and learning methods and their compliance with the components of the program as an important topic. Those issues are highlighted in almost every report. In most cases, they are viewed in a positive light. However, some reports provide recommendations in that regard. The recommendations concerning teaching and learning methods can be found with regard to both the pre-clinical and clinical components.

In some cases, we can find narrative parts indicating that the teaching methods need to be brought in line with the content of courses, and that the staff involved in the program needs to be retrained so that their awareness concerning the methods in use is raised

With regard to the curriculum, the reports provide more descriptive rather than evaluative components. The evaluations in the reports are more or less positive and the views are positive. In cases, where there are recommendations, it is mainly the sequence of program components that are highlighted. Moreover, in some cases, the issue of compulsory hours for the components is brought up. All in all, in the parts related to methods and curricula, we can see that the experts are strongly focused on student-centered learning, which is expressed through the following recommendations:

“The competence map (levels one to three) should more clearly demonstrate the progress made by students.” (Recommendation, NCEQE – 2.3)

The evaluations concerning equality issues are not homogenous. In some narrative parts, the evaluations in that regard are positive, but there are cases, where we find suggestion that the study process should be more inclusive and that the question whether in fact the program is delivered to students on equal terms should be more highlighted:

“Irrespective of ethnic diversity of students, we would advise the Faculty of Medicine to evaluate the data on the progress made by students and link them to their ethnicity and gender in order to ascertain if there is any linkage between the achievements and those demographic parameters.” (Suggestion, NCEQE - 1.2)

In relation to this component there are some other critical remarks concerning the integration of a spiral curriculum. We find a number of recommendations on the topic. However, it should be noted that in addition to the recommendations, in some cases, the successful integration of the latter is emphasized, which may mean that in general there are some signs of progress in that regard. Moreover, it should be noted that we also have a best practice case related to this component, which refers to the successful integration of problem-based learning into the program.

In general, in the narrative parts, we also find remarks concerning the teaching and learning methods defined in the sector benchmark for medicine, but in that regard, we usually deal with the descriptive part. Interestingly enough, the sector benchmark for medicine, in fact, formulates and defines the methods for achieving the required competences. In view of that, the fact that the sector benchmark is not mentioned so frequently in the reports, even with regard to those methods, becomes more obvious.

2.2. Scientific method

WFME component 2.2 is largely linked to accreditation component 2.4, which is related to the development of research and transfer skills. In addition, it should be noted from the beginning that this component is strongly linked to WFME Standard 6, which covers the material and technical base required for teaching, learning and research.

In the studied reports, the experts were much more critical of the material and technical base required for research, while within the content of component 2.2., in most cases, the descriptive narrative texts concerning research skills exceed the analytical ones and are viewed in a rather positive light. Most of the reports mainly emphasize the presence of a research method within the curriculum, and the fact that the experts have given no recommendations on issues related to component 2.2 is noteworthy as well. The review of the part of evidence-based medicine is also terse, and is, in fact, reflected only in one report. In the same report we find the most interesting suggestion in terms of its content. However, even that suggestion is, by its nature, strongly linked to the part of the material and technical base. One of the examples is as follows:

“The implementation of a plan related to acquiring research skills is not entirely convincing. In fact, the research infrastructure is not so well-developed, and the active participation of students in major research activities [.....] did not look convincing during laboratory visits and interviews with academic staff”. (Suggestion, NCEQE – 2.2)

One of the reasons why we find positive evaluations of the integration of research skills into the curriculum in almost all reports may be due to the fact that the latter is prescribed by the sector benchmark, and each institution implementing a medical education program has to consider the requirements of the sector benchmark. However, especially in connection with the material and technical base, we find more criticism in that regard, as the experts ask whether in reality it will be possible to acquire those skills.

2.3. Basic biomedical sciences

The integration of biomedical sciences into the curriculum is directly prescribed by the sector benchmark. According to the compliance map, the given issue is most likely to be linked to components 2.2 and 2.3 in relation to the accreditation standards, as they cover program structure and its components. However, the links are not clearly outlined. There is very little mention of biomedical sciences alone in the reports. The issue is mostly raised at the level of descriptive narrative texts and critical remarks are rare. In fact, only one piece of suggestion could be identified, which sounds as follows:

“In order to improve the innovation and quality of the program, as well as to acquire knowledge of innovative therapeutic approaches, e-learning courses on advanced topics in biomedicine may be introduced”. (Suggestion, NCEQE - 2.5)

2.4. Behavioural and social sciences, medical ethics and jurisprudence

The situation is almost identical in the case of component 2.4 of the WFME Standards (which is weakly linked to accreditation standards 2.2 to 2.4). In particular, the integration of behavioural and social sciences in the curriculum is also mandatory based on the sector benchmark. Probably this the the reason why we find only descriptive narrative in that regard in the reports, and as in the case of component 2.3, we find almost no critical remarks of any kind. In fact, the reports imply that the programs meet the requirement, but no details are provided. The rare pieces of suggestion given in that regard usually relate to the structure of the curriculum itself, and one of their examples is as follows:

“The list of courses is comprehensive and covers all relevant courses, including elective courses to study relevant transfer skills, such as communication. Some additional courses in project management, data protection and management, and entrepreneurship may be an asset to this international program”. (Suggestion, NCEQE – 2.3)

Components 2.3 and 2.4 may be summarized together and it may be noted that due to the perfunctory narrative it is difficult to mention anything specific in this part, except that the parts of quality development of those components are not explicitly covered, even though they look at biomedical, behavioural and social science, as well as at medical ethics and jurisprudence issues in the education of doctors more dynamically than we can see in the static descriptions of the reports. Moreover, the sector benchmark is also mentioned to a lesser extent, even though it should actually be a leading document in that respect.

2.5. Clinical sciences and skills

Due to the specifics of the field, topics related to clinical skills are scattered in many different accreditation standards. In addition to 2.4 component, which covers practical skills, we read about clinical sciences and skills in components 2.2 and 2.3 directly linked to the curriculum, in component 1.2 related to learning outcomes, in the fourth standard – in the light of resources, and in the fifth standard as well, which covers quality development mechanisms. According to the compliance map, WFME 2.5 was most clearly linked to accreditation components 2.2 to 2.4 and 4.3, based on the expert reports.

The issue of clinical sciences and skills development is widely covered in the analyzed reports. We find a number of recommendations, as well as suggestion and even best practices in that regard.

An important issue is the transfer of formally given realities into practice, which concerns both the practical application of the rules developed for planning practical training, as well as the actual implementation in practice of the data described in the documents. The issue is continued through those narrative texts from the reports, which are related to institutionalization of clinical practices and separation from simulations.

“The rules for nominating a clinical mentor, and qualification requirements should be laid down. The practice of pre-clinical simulation is acceptable, but the availability of students in clinical subjects should be ensured in respect of actual clinical cases, and the time allotted for bedside teaching should be fixed”. (Recommendation, NCEQE – 2.3)

Another issue worthy of note which is related to the development of clinical skills is the integration of the Georgian language into the curriculum. The main emphasis made by the experts in the report concerns the fact that the growing number of international students that acquire clinical skills in the Georgian educational and medical area, will, by all means, need to know the Georgian language to interact with real patients. We find this issue both in the narrative part of the components, as well as in the suggestion and recommendations.

“From the very beginning of the program, pay special attention to the development of Georgian language skills in students, to enable them to better communicate with patients, as well as with staff in the clinic”. (Recommendation, NCEQE – 2.3)

Despite many problems, we also find an example of best practice in terms of clinical training:

“The concept of “real patient” which refers to patients on a payment basis, with various, mainly chronic diseases, to improve students’ “skills of communication with patients and examination skills”. (Best practice, NCEQE – 2.4)

Overall, the narrative texts referring to clinical sciences and skills stand out as critical and address a number of problematic issues, the settlement of which must most likely be a top priority for each medical school. The reports cover almost all issues provided for in the WFME 2.5 component criteria. There is little mention of the sector benchmark. However, we still have instances, where the experts discuss how achievable the competences set in the sector benchmark are based on the program curriculum. It should also be noted that in some narrative texts there are cases where clinical training is viewed in a positive light. For example, we find passages where early patient contact is mentioned, but those parts clearly lack details which would support the arguments of the expert panel. Content-wise, the connection of this component with WFME component 6.2 is very important, as it implies the material and technical base for developing clinical skills.

2.6. Programme structure, composition and duration

As a result of coding, WFME component 2.6 is mostly covered in the part of accreditation standards 2.2 and 2.3. Before discussing the component, it should be noted that in the Georgian education area it is the sector benchmark that largely determines the program structure and duration. In view of this aspect, most narrative texts of the reports evaluate the program structure and the incorporation of compulsory and elective/optional components into it more or less positively. The emphasis on the horizontal and vertical integration of the program is mostly positive, and it is noted that the integration has been achieved at least to a certain extent. Even so, we find excerpts that emphasize the lesser degree of awareness of the staff involved in the program concerning integration issues.

“The head of the program understood the integrated nature of the curriculum, its vertical and horizontal distribution in full and in great detail. Many members of the academic staff, despite

their in-depth knowledge of the subject matter, could only explain this integration in general terms and could not understand many other details. This was even more evident in the case of the invited staff". (Narrative text, NCEQE – 1.2)

Overall, the structure-related evaluations are quite positive. As mentioned above, an important factor may be the fact that the structure of programs is usually based on the sector benchmark. Moreover, the integration part, which is also directly required in the sector benchmark, is evaluated highly. However, it should be noted that at this stage the requirements of the sector benchmark do not set the exact levels of integration.

2.7. Programme management

It is difficult to directly link component 2.7 of the WFME Standards to any specific accreditation standard, as it covers involvement of various parties in the development of the program and academic leadership, which is the bottom line of most accreditation standards, and became evident in the process of coding. The reports evaluate the program management line quite positively, often emphasizing the involvement of various stakeholders in self-evaluation groups, which, given the Georgian context, may be partially perceived as similar to a curriculum committee, in view of the fact that a curriculum committee as such, as a group dedicated to program development and curriculum update on a regular basis, is not widespread in the Georgian education reality. In the reports we find evaluations of representation in self-evaluation groups, as well as evaluations of mechanisms for evaluating program development processes. Even so, in certain cases, we also find some problems in that regard. One of the critical cases in that respect refers to a mismatch between the documents and the reality, in relation to which the expert panel has provided the following recommendation:

"Written documents should reflect the reality. A detailed year-round schedule for the program should be in place, including the name(s) of the teacher(s), the size of each group, the time and place where specific training will take place and where all students will be admitted". (Recommendation, NCEQE – 2.2)

We have covered this recommendation in this part due to the fact that the experts put in question some reality provided as a given by the institution and the opportunities of achieving it, which is largely a matter of program management and planning. It should also be noted that in the given context we find cases of best practices as well, for example, the following:

"Involvement of staff and students in contextualizing PBL cases is an effective way to ensure that materials are presented to students in the most relevant way". (Best practice, NCEQE – 1.1)

Overall, we can say that the requirements of the program management component are reflected in the reports, but their evaluation is not homogenous, and covers both critically negative and optimally positive evaluations.

2.8 Linkage with medical practice and the health sector

Links with WFME component 2.8, as a result of coding, as in the case of the previous component, are scattered in a number of standards. In general, most reports emphasize that the program takes into

account the requirements of the labour market, but this part clearly highlights an issue that seems quite problematic in the Georgian medical education area, in particular, it is important to consider the fact that most medical education programs in Georgia are English-taught and are designed for international students. In the reports we also find excerpts stating that the program has taken into account the requirements of the international market, although there are fewer specific details as to how the institution approached the issue. Moreover, one of the expert panels asks the institution the following:

“The suggestion of the site visit team is that the requirements of the Georgian labour market should not be the subject of discussion”. (Narrative text, NCEQE – 1.2)

The fact that market specifics will still be an important issue when planning a program in the future, is certain. However, given the ambiguous content of the reports, it is probably desirable if institutions pay more attention to the issue of labour market relevance within program development and work out diversified approaches. In order to create an overall picture in that regard, it is extremely important to keep a record of and monitor professional development of graduates.

In addition, it should also be noted that most reports indicate rather close links with clinics, both as practice providers and employers, and there is no particular criticism in that regard. Nevertheless, we can view these issues from a completely different angle, if we go beyond the fact that the memoranda are formally in place and consider the above links in terms of verifying resources. This is discussed in more detail in Standard 6.

WFME 3. Assessment of students

With regard to WFME Standard 3 (Assessment of Students), the thematic analysis WG has identified 50 texts covering analysis/evaluation/findings in the narrative part of the accreditation reports produced by the experts, plus 16 recommendations, 8 pieces of developmental suggestion and 0 best practices.

After coding, component 2.6 of the Georgian accreditation standard was considered as most closely linked to WFME Standard 3.1, and components 1.2 and 2.2 were considered as linked, but to a lesser degree. No clear linkage with WFME Standard 3.2 was found, and identified references are scattered in components 2.2, 2.3 and 2.6 of the Georgian accreditation standards.

The national sector benchmark for medicine is not mentioned at any point in the expert reports.

3.1. Assessment methods

In some cases, the experts refer to the issue of overall compliance of the types and methods of student assessment with the accreditation standards and legislation of Georgia, provide the list of methods used, and the breakdown of assessment scores in the syllabi. Information on those topics is general, details concerning study courses and relevant syllabi are less specific. In a couple of cases, reference is made to the documents governing assessment procedures, which are in place in some institutions, with regard to the OSCE format and retakes as well. The role and functional relevance of information technology in the context of student assessment are rarely evaluated. There is no suggestion in that category, but there are several recommendations, in which the experts ask institutions to outline assessment tables in the syllabi,

consider OSCE as part of assessment, and bring the regulation governing retakes in line with the legislation.

The second category, which is relatively large thematically, incorporates the kind of analysis which is related to the target, relevance, reliability and validity of the assessment rules and methods. In some cases, the experts focus on a uniform approach of the assessment systems in study courses, which does not fit the specifics of teaching all subjects. Some good examples are also underlined, where the assessment components were developed target-wise and tailored to the needs of students or the level of curriculum integration. The need to use portfolio to improve mentoring and self-learning was emphasized. Certain key methodological issues, for example, those in relation to the OSCE and MiniCEX formats, were put in question, as the experts note that there are no letters of consent concerning participation in the assessment process as a patient, and the opportunity of using specific formats is not evidenced by the contracts concluded with clinics. In most cases, the experts could not find evidence related to reliability and validity of the methodology used, and as it turned out, only one institution applies the psychometric approach in that regard:

“The overall results regarding consistency, homogeneity and heterogeneity issues have been achieved considering quality assurance. This work requires a lot of time if done manually, therefore [.....] is looking for an opportunity to purchase an application” (Narrative text, NCEQE-2.6)

The recommendations are related to enhancing the diversity of assessment methods, developing patient consent forms when using the OSCE format (for international students as well), retraining relevant examiners, enhancing contextual integration in tests (however, there are no recommendations concerning reliability and validity calculation, as emphasized in the narrative text), and synchronization of methods in the contracts concluded with clinics. The suggestion is mainly related to using portfolio as a self-evaluation mechanism in PBL groups, reviewing the number of OSCE stations and testing hours so that competence assessment is thorough and reliable.

The issues least covered by the experts were related to complaints and involvement of external examiners. Even so, one case has been identified, where the institution did not fulfill the recommendation provided in the course of accreditation preceding the involvement of an external and/or second assessor. There are only a couple of pieces of suggestion and recommendations in that regard:

“The university should take into account the immediate need for providing external supervision to deliver and assess the curriculum” (Narrative text, NCEQE-5.2)

No best practice has been identified for any of the categories.

3.2. Relation between assessment and learning

The experts address to a small degree the issue of student assessment and timely feedback after assessment, as well as the topic of timely reflection of assessment, when the process is carried out manually, without using a computer. A couple of recommendations were provided concerning elimination of gaps in the syllabi.

The analysis reflected in the reports is mainly related to fitting the assessment method to the teaching method, the possibility of identifying the achievement of learning outcomes, and in that regard the importance of portfolio, a self-learning approach, raising the minimum threshold is emphasized, together

with the need for demonstrating the link between the curriculum and assessment system. The suggestion and recommendations mainly create the same picture as in 3.1, though there are some interesting exceptions as well, for example, the following:

“Set and closely monitor the student-teacher ratio for each teaching and learning method”
(Recommendation, NCEQE-2.5)

Some reports are more comprehensive in relation to the standards, some are relatively perfunctory, but overall, the expert reports cover almost all criteria – both basic and related to quality control - of WFME component 3.1. The situation is almost similar in respect of Standard 3.2, although the issue of intermediate and summative assessment is not covered thoroughly. Their content, structure and distribution in relation to academic semester progression is not reviewed.

WFME 4. Students

With regard to WFME Standard 4, the thematic analysis WG has identified 84 texts covering analysis/evaluation/findings in the narrative part of the accreditation reports produced by the experts, plus 15 recommendations, 15 pieces of developmental suggestion and 4 best practices.

After coding, component 2.1 of the Georgian accreditation standards was clearly linked to WFME Standard 4.1. As a result of coding, WFME component 4.2 was mainly matched with accreditation standards 2.1 and 4.1, but the linkage is not sheer, which is not surprising, as content-wise the above component is more related to the authorization standards. WFME components 4.3 and 4.4 are clearly linked to accreditation component 3.1.

There are no texts concerning the sector benchmark.

4.1. Admission policy and selection process

Most reports clearly state that the prerequisites for admission and admission policy are in line with the legislation of the country. However, there are several pieces of suggestion and recommendations indicating that in addition to testing English language proficiency, examinations in other subjects should be set and high selectivity should be achieved when admitting students to the program.

“Consider introduction of clear admission criteria for international students (e.g., IELTS or multiple mini-interview assessments) in order to admit students capable of coping with the first years of study more easily”. (Suggestion, NCEQE – 2.1)

As to the availability and implementation of an appropriate policy for students with special education needs, the reports provide almost no information in that regard except in one case, where the narrative text mentions that actually there is no policy for persons with disabilities, but no recommendation follows.

The expert panels report the following views: clear criteria should be set for student transfers, students moving from other institutions should not be enrolled at least during the first years of the program implementation, and the credits they have already accumulated should be recognized more transparently. As to the WFME quality development standards, the reports examined by us relate, but only to a small degree, to the linkage of the enrollment policy with the program and mission, the direct

periodic review of the enrollment mechanism, whereas the issue of appealing enrollment-related decisions is not mentioned at all.

4.2. Student intake

While assessing the size of student intake in the accreditation reports, the experts focus on the methodology used by the program on the one hand, and on the other hand, considering the current resources, assess the intake of students planned for the future. The small number of staff, as well as their workload at other institutions, is focused on. In most cases, the size of planned intake of students is assessed critically and as unfavourable to the program, for example:

“In case the number of students increases, the number of available lecturers and their workload at other universities will jeopardize the sustainability of the program.” (Narrative text, NCEQE – 4.1)

In some cases, the experts assess the number of students to be taken in considering not only staff in general, but in a more narrow sense, considering clinical teachers as well:

“In the context of the workload of the faculty staff, especially the workload of clinical teachers, together with the need for hiring new staff, admitting a growing number of students poses a significant risk in terms of reducing the quality of education”. (Narrative text, NCEQE – 2.1)

In their recommendations, the experts ask program implementers to strictly set and control student-staff ratios, group sizes, critically review future enrollment calculations considering the number of instructors and labour market requirements.

It should be noted that the authorization reports are also critical in assessing the number of staff in relation to the number of students, and underline the insufficiency of the resource for the implementation of the program.

4.3. Student counselling and support

The basic requirements of WFME Standard component 4.3 relate to student counselling and support, as well as financial or other individual assistance. Almost all components of the above topics are more or less covered in the examined reports.

In the narrative text, the expert panels describe that institutions provide counselling services to students, taking into account factors such as support for academic and research activities, career advancement, continuing studies at the next level. The strategic goal of some universities is to implement and develop a student-centered system offering students a social support policy, which is about awarding grants or scholarships, and promoting their involvement in national or international research and professional projects. The reports also mention several times that students have the opportunity to benefit from an individual and flexible payment schedule, which helps them to continue their study process without obstacles.

There are very few pieces of suggestion and recommendations provided by the experts, but they address important issues, such as access to information (including information on their future career) for international students in the relevant language, student involvement in representative and governing

bodies and facilitating their integration with local students. Some best practices are also identified. For example:

“The university student portal (can be accessed using a mobile phone) gives students access to all information, including schedules, regulatory and learning materials, such as student guides, and connects students with one another and the staff”. (Best practice, NCEQE – 3.1)

In addition, the best practice noted by the experts is the fact that students were supported to participate in national and international conferences. However, this is clearly all about meeting the requirements of the standard, rather than an exceptional case.

The examined reports do not address the issue of maintaining confidentiality related to assistance and counselling, nor do they make it clear whether counselling is provided in connection with academic performance.

4.4. Student representation

The narrative text of the examined reports partially raises the question of whether students have an opportunity to participate in university management. The experts note that students are involved in curriculum development, program self-evaluation, and decision-making bodies. However, it is also noted that the students involved in the processes are selected by the staff themselves.

In one of the reports the experts note that in order to accelerate exchange of information between the faculty and students, two students are selected from each group that instantly inform students of planned activities and changes, and present students’ proposals and remarks to the Administration. Moreover, the position of an assistant to lecturer has been introduced for which advanced year students are selected to assist first-year students.

In addition, only one report mentions that the university Action Plan together with its budget will provide financial support to the student self-governance for the next three years, with growing dynamics. The issue of funding self-governance is mentioned in other cases only as suggestion in respect of increasing funding.

In contrast to the above, there are reports where the experts point out that student self-governance is rather formal by nature, and that no responsibilities and no accountability are documented. In some cases it turns out that there is no student body or union at the institution, which leads to the question of who represents their interests before the Administration.

“Active support in developing a student union is strongly recommended, [...] introduction of student organizations in various directions”. (Recommendation, NCEQE – 3.1.)

In the part of best practice, it is only noted that one of the universities has an expert tutoring and mentoring mechanism for students.

The examined reports do not evidence that the issue of student representation in relation to the school mission and program design is taken into account.

WFME 5. Academic staff

With regard to WFME Standard 5 (Academic Staff), the thematic analysis WG has identified 96 texts covering analysis/evaluation/findings in the narrative part of the accreditation reports produced by the experts, plus 30 recommendations, 12 pieces of developmental suggestion and 1 best practice.

After coding, component 4.1 of the Georgian accreditation standards was linked to WFME Standard 5.1 to a greater degree. As to WFME Standard 5.2, an equal clear linkage with both accreditation component 4.1 and component 4.2 has been established.

The sector benchmark for medicine is mentioned only twice – once in the text of a recommendation, and the second time – in a narrative text, and all this within one report only.

5.1. Recruitment and selection policy

Two key issues were identified when processing textual data for this component. The first relates to the number and qualifications of academic or invited staff responsible for transferring/imparting knowledge and skills to students, namely, whether that number is sufficient considering the current student intake, a particular study and methodical group. It is also discussed whether their workload is realistic given the above factors. In the case of several programs, the experts noted that the staff-student ratio was not adequate, including in the practical skills training groups. They state that in the current context, the institutions' plans to increase the number of students to be admitted in the coming years are unrealistic, as the number of teachers is small on the one hand, and the current staff and, hence, program stability are jeopardized on the other hand, when even in the case of affiliation, lecturers teach within other programs.

“Both the academic and invited staff are teachers of other institutions, thus the study process is carried out depending on their free time, which, in some cases, means 8 hours of lecturing in one day” (Narrative text, NCEQE-4.1)

In the same context, the problematic side of short-term temporary contracts was underlined in case of one program. Positive findings were also noted with regard to several programs, where the experts highlighted the qualifications of the staff and the adequacy of the student-staff ratio. For example, it turned out that one of the institutions used a special formula to set the threshold levels of the number of their staff, but the experts did not underline it as best practice in the relevant section.

The experts give recommendations and suggestion that student-staff ratios should be strictly determined not only for each study course, but also for teaching technique, attention should be paid to the distribution of affiliated, academic and invited staff in respect of this or that study course, and to the involvement of practitioners with proven record into clinical training. They ask institutions to set their staff workload hours, as well as increase the number of staff both under long-term contracts and involved in clinical training, and to plan such aspects considering the number of students to be admitted to the program in the coming years.

The second topic highlighted while analyzing component 5.1 relates to human resources management policy, its compliance with legislative requirements, staff induction practice, including having resumes that are in order. The experts mostly point out that the policy documents of the institutions are in order, comply with the legislation, the induction rules are documented in accordance with the principles of

competition and considering relevant experience, the workload covers time allocated for academic, scientific and counselling activities. However, they also note that the resumes need to be updated, as the information on their affiliation is not evident, and no relevant experience in respect of some courses and clinical mentoring can be seen. There were also cases when the names of some lecturers were written on the syllabi they were not familiar with. A couple of recommendations were devoted to collecting the updated documents, compliance of the staff selection process with the relevant law and sector benchmark, and drawing up a staff workload scheme. In most cases, the suggestion is also related to technical accuracy of the documents.

5.2. Staff activity and development

This component highlights, on the one hand, both categories described in 5.1, and on the other hand, the evaluation of the work performed by the additional academic and invited staff, their achievements, merits and planning of future developmental activities, the issues of incentivization and funding. In terms of staff qualifications, in the case of several programs, the question of competence was raised. As it turned out, despite the relevant methodology provided for in the document for the transfer of knowledge and practical skills to students, the staff themselves needed, in the first place, proper training in, awareness raising on sectoral integration, and on documenting learning outcomes, and in some cases, the staff themselves were aware of the above.

“Their [the staff’s] responses showed that they did not fully understand how to implement new methods in their activities. They expected to be trained concerning that issue, but it was not clear to them where and how it would be organized” (Narrative text, NCEQE-2.5)

The above issue concerns, inter alia, the OSCE examination methodology and relevant centers. In respect of a number of programs a problem was identified evidencing that the majority of the staff, except for the head, failed to perceive the curriculum in a uniform manner. The experts believe that the ratio of students and lecturers needs to be clearly determined in respect of each method, and that residents should not be involved in clinical training, especially in the light of the fact that both the staff and patients of clinics are far from being fluent in English. It is also emphasized that if the number of students increases, there will not be enough staff, considering the fact that they teach several programs at the same time. In respect of two programs there are recommendations concerning the need for setting ratios, while in respect of other two programs the recommendation concerns upskilling and enhancing the knowledge of pedagogics and methodology.

In respect of the human resources management policy the experts identified some gaps. In particular, despite general compliance with the legislation, staff responsibilities were not clearly documented for two programs; in the case of one program, there are two departments that are responsible for identifying whether the person’s competences correspond to the position held, but in fact the two departments are not in cooperation concerning the issue; in the case of three programs it was identified that the issue of affiliating research papers of the staff with the institution is completely unregulated, and there is a risk that any institution where the person holding an academic position is employed may take credit for those papers; in the case of one program, the experts failed to trace the methodology used to determine the required number of staff. On a relatively positive note, with regard to several programs it was noted that the staff workload scheme was clearly documented, and covered academic and research workload, as well as student counselling and involvement in other activities. The recommendations provided relate to

the use of the FTE approach in calculating workload, the exact size of student intake and work groups. The suggestion provided in that part concerns the issue of updating contracts and resumes, and distribution of responsibilities among the staff more horizontally.

As to staff development activities, in the case of several programs it has been ascertained that the institution assesses staff achievements and qualification needs, and consequently, plans further incentive events or events for support/development purposes. A special institution-based department often serves that purpose. However, in the case of several other programs, such a mechanism is not in place, the staff need to be trained in PBL methodology, the OSCE examiners need more training, some members of the staff need to enhance their proficiency in English, and examples of their involvement in international projects or conferences are missing. In some cases, these gaps were identified with regard to the programs, the development mechanism of which was approved by the same experts at the concept level. Suggestion and recommendations that do not differ much from one another in terms of their formulation refer to training need identification, skill and competence enhancement.

*“[It is necessary] to recruit and retrain OSCE examiners at an early stage of the program to ensure a relevant number of trained examiners that will be available for summative assessments”
(Suggestion, NCEQE-4.2)*

One best practice has also been identified related to a case, where the institution helps its staff or students to be involved in national and international conferences, but it can be said that this is more about meeting the accreditation standard and it is not best practice.

In terms of staff recruitment and management policy, the experts do not address the balance among biomedical, behavioural and social, and clinical sciences. With regard to the same criterion, they do not refer at all to the balance between medical and non-medical academic staff, or in general, between academic and non-academic staff. It is true that the workload schemes are found ambiguous, the responsibilities are found ambiguous or inaccurate, but only the report on two programs refers to full and part time issues. In the case of several programs, the experts positively assess the fact that the workload and incentive scheme covers academic, research and other activities, but they make little attempt to directly assess the balance between those activities/obligations. The experts express no opinion regarding the quality standards, namely, regarding the fact whether economic or other social and cultural factors are considered in the recruitment policy. The issues of staff activity and development are much better covered by the experts.

WFME 6. Educational resources

With regard to WFME Standard 6, the thematic analysis WG has identified 136 texts covering analysis/evaluation/findings in the narrative part of the reports produced by the experts, plus 30 recommendations, 21 pieces of developmental suggestion and 4 best practices.

As a result of coding, the strongest linkage has been found between WFME Standard 6 and the second and fourth accreditation standards. Namely, as a result of coding, WFME Standard components 6.1, 6.2 and 6.3 mainly intersect with accreditation standard component 4.3, WFME 6.4 intersects with accreditation component 2.4, but no strong intersection has been identified with regard to the rest of the 6th standard.

6.1. Physical facilities

This standard is mainly linked to accreditation component 3.4, which generally refers to the material and technical base required for the implementation of the program. However, given the requirements of the field, the WFME Standards detail general physical facilities, resources required for clinical training, as well as information and technological resources.

In terms of physical facilities, it is quite difficult to highlight common trends in the examined reports, as the pictures described vary from report to report. One of them, which can be seen in the case of new educational programs quite actively, is the lack of access to reading. In that regard, the lack of printed versions and limited electronic access have been highlighted. The majority of suggestion and recommendations related to the component requirements refer to the topic.

“Ensure that students have access to relevant learning materials, for example, to books [.....] throughout the program implementation. Expand and maintain online databases [.....] throughout the course”. (Recommendation, NCEQE – 2.3)

It should be noted that in most cases the simulation resources are more or less positively evaluated and their active use in the study process is underlined. However, in exceptional cases, we also find recommendations about an increase in that regard. In the examined reports we can also find remarks concerning other issues related to the material and technical base, especially with regard to clinical and research laboratories. In some cases, it is questionable whether the material and technical base is appropriate for the implementation of the curriculum. In contrast to the many emphases on human resources, analysis concerning a link between the material and technical base and the number of students to be admitted is quite rare, as exemplified in the following part:

“The number of students admitted to the program should not be more than 50 per year, considering the laboratory equipment”. (Narrative text, NCEQE – 2.1)

In addition, it is noteworthy that in terms of material resources, we find an example of best practice concerning the use of corpses in teaching.

Overall, reading and book stock, research and clinical laboratories, as well as the development of facilities that support clinical skills are the three main areas identified in the reports, but it is clear that the issue of link between material resources and planning the number of students should be outlined more clearly.

6.2. Clinical training resources

When discussing the evaluation of the clinical training resources part, it is necessary to take into account the assessments of component 2.5, which are closely linked to the requirements of component 6.2, and therefore a number of issues mentioned above will be repeated in the description of this component as well. The following is an excerpt from one of the reports that may be relevant at the system level:

“The panel believes that the main problem with medical education in Georgia is the lack of contact with real patients, as there are fewer clinical facilities compared to the high number of medical students”.

If we continue the pathos of the excerpt, first of all, it should be noted that currently only two HEIs own university clinics in Georgia, while other HEIs mainly have contracts and memoranda with clinics. The issue is governed by the sector benchmark for medicine, based on which “a university/training and/or affiliated clinic” has to be in place in order to implement a medical education program. All examined reports evidence that there are contracts with clinics, but, as mentioned above, in some cases, it is questionable whether the aspects described in the documents can be put in practice.

One of the key questions highlighted in the reports in terms of clinical skills development is the planning of clinical practice considering relevant resources, which is covered quite well in the following excerpt:

“Review the quality of clinical training and evaluate clinical subjects in terms of the number of students, available teachers and patients, that may be involved in clinical training”. (Recommendation, NCEQE - 4.3)

In general, the issue of relevance of the spaces available for clinical training revolves around the same topic in the reports. It is mainly due to the fact that, as mentioned above, most Georgian medical schools do not have their own university hospital, and in some hospitals there are students from many different institutions doing practical training, which, in the long run, calls into question the quality and effectiveness of practical training:

“Many students from many institutions study at the same facilities and this does not assure the quality of clinical training”. (Narrative text, NCEQE - 4.3)

Moreover, there are remarks concerning trouble-free operation of clinics and their relevance for the clinical training process, which is exemplified in the following excerpt. This challenge becomes even more complicated when linked to the issue of human resources, as evidenced in the following excerpt:

“The inadequate number of large hospitals (currently, two hospitals), where there is no indication as to which subjects are taught in those hospitals. The hospital staff, that are to teach students, are also affiliated with other PhD programs”. (Narrative text, NCEQE - 4.3)

In some cases, the issue of human resources is linked to the plan governing contact with patients, as exemplified in the following excerpt:

“Real contact with patients is not planned, despite the fact that it is mentioned [.....]. Moreover, holding real practical training in a 25-student group with one teacher is not convincing in terms of acquiring practical skills”. (Narrative text, NCEQE – 2.4)

If we summarize the analysis of components 2.5 and 6.2, it becomes clear that one of the major issues that has emerged is the ambiguous and fragile ties between universities and clinics. In most cases, this very issue is covered in the narrative texts of the reports with regard to clinical training. The first requirement of the standard concerning the number of patients that students will deal with in the clinical training process, is, in fact, not covered in the reports. The clinical training supervision part is also covered to a lesser degree, but, as mentioned above, some reports do place such emphases. Eventually, there are no emphases in the reports concerning the development of practical training bases. The reports make it clear that in terms of links with clinics, there are *laissez-faire* approaches in the Georgian education area, evidenced by less control over the number of students admitted at the level of clinics, which poses a real threat to the quality of medical education received.

6.3. Information technology

Most reports highlight the availability of computer facilities at the institutions, as well as free access to the e-libraries and the Internet. In this regard, most evaluations concerning the program providers are quite positive. The access to a number of e-resources, such as Anatomy tv, is also viewed in a positive light. Some reports note that students and staff members have access to research bases. Even so, the nature of most resource evaluations is mainly descriptive.

What is more important is that, in fact, there are no emphases on the development of IT skills in the medical context, which is one of the basic requirements of the WFME Standard and is covered by the sector benchmark for medicine as well. At that, there is little information on the use of information technology in the teaching and learning process.

In some cases, there are remarks concerning the creation of student portfolios, but it should be noted that a number of reports highlight the availability and operation of e-portfolios. This issue is reflected quite well in the following suggestion:

“Consider improving the student journal/PBL notebook so that it can be transformed into an official “portfolio” from the second year of study onwards, in which the student provides evidence of their “recorded practical training” before and after completion of their studies”. (Suggestion, NCEQE - 2.5)

Moreover, in a different context, the experts refer to creating online database portfolios, which is linked to the issue of general access to research bases. As to access to online libraries and books, the issue is mentioned above. Overall, it can be concluded that in terms of information technology the information provided in the reports is scarce. Pedagogical emphases in that regard are particularly few, whereas the aspects of developing IT skills linked directly to medicine are missing.

6.4. Research and education

We have covered the research part several times, namely, it came up while reviewing WFME component 2.2, which refers to the integration of research components into the curriculum. It also came up in component 6.1, where material and technical resources required for research are a major focus. Within the scope of component 6.4 we mainly deal with real research activities within a medical school. It should be noted that the development of research skills is not the primary goal of basic medical education, but we should take into account the fact that both the relevant level descriptor of the NQF and the sector benchmark for medicine refer to research skill development in the case of a medical doctor program.

We should start reviewing this component in connection with component 6.1, where the lack of laboratory resources was strongly emphasized. The latter calls into question the fact that the level of carrying out research activities in medical schools will match the descriptions provided in the documents.

In addition to material resources, the reports clearly note the lack of financial resources as well, and a number of reports provide both suggestion and recommendations to solve the problem. Plus, a few remarks concerning the need for financial development, as well as the need for additional human resources and changes in organizational views in the light of research, in general. Namely, broader links

are needed in that regard with other educational units of the institutions, with clinical practice, and the need for strategic integration of research.

“Due to the relevance of research development in the future plans, it is necessary to clearly draw up research-related strategic and action plans. The main areas for development should be described and agreed on in them. This will help staff and students to publish their research outcomes and make an impact on the field”. (Recommendation, NCEQE - 1.1)

The emphases on students’ involvement in research activities sound to be in contrast with the above. Namely, in some reports we find narrative texts describing that students are actively involved in research and are awarded research grants. However, apart from one exception, there are no specific examples or figures evidencing students’ actual involvement in research. There is only one report noting that students will succeed in acquiring theoretical knowledge in respect of research, but in the same report the opportunities of their involvement in actual scientific and research activities are called into question considering the current resources.

The experts note that it is questionable whether the scientific and research works listed in the documents actually belong to the institution, but then it is clarified that even though the works have been published by the staff involved in the program, in fact, they belong to another institution. The same problem has been identified while analyzing other components.

Overall, on the basis of the reports, we have a picture evidencing that research is not a top priority for most medical schools. In accordance with the requirement of this WFME component, which considers research activities as the basis for curricula, the documents provide a number of statements with regard to research activities, but their feasibility is questionable, thus leaving an impression that the documents incorporate those parts only to formally meet the standard. Moreover, hardly any information is provided about research policy, as required by the WFME Standard. Eventually, it is questionable whether in practice research makes an impact on the learning and teaching process and whether it prepares students for future research activities.

6.5. Educational expertise

Educational expertise is a part least covered in the examined reports. However, in some components there are remarks that are closely linked to the latter content-wise. In general, it is quite difficult to identify such narrative texts that directly match the requirements of this component. In some cases, the experts highlight the top qualifications of the persons involved in the program and emphasize their activities in capacity of medical education experts. On the other hand, some cases refer to training sessions attended by staff members for upskilling purposes. In one case, the opportunity of combining own resources with the resources of another educational institution for development purposes is mentioned. In fact, there is only one case where we find a recommendation concerning educational expertise, which directly complies with the WFME requirements, namely:

“Increasing the number of experts you cooperate with in order to have expertise in medical education methods”. (Recommendation, NCEQE – 2.5)

In cases other than the above case, it is difficult to directly link the remarks to the issue of educational expertise. As mentioned above, in some cases, in standards 5 and 7, we find narrative texts, for example, concerning staff development and external program evaluation, which cover the prospects of program and human resources evaluation. By combining those narrative texts we can conditionally assume that the WFME requirements, such as taking action to improve teaching and assessment methods and the use of expertise to develop the curriculum, are covered, though in a perfunctory manner. However, in view of the above, program evaluations in the light of educational expertise are rather scarce in the expert reports.

6.6. Educational exchanges

The information about educational exchanges, i.e., international cooperation and mutual exchange, is rather scarce in the reports, which is somewhat unusual due to high importance of the issue in the case of present-day educational systems. In some cases, it is underlined that the institution has developed an internationalization strategy and policy, whereas in other cases broad links of the institution with various international universities and networks are discussed. However, there are recommendations directly indicating the need for increasing the number of exchange program at both staff and student levels, as exemplified in the following recommendation:

“Increasing the number of international partnerships to have more student and academic staff exchange program opportunities, as well as a business plan and resources for sustainable internationalization”. (Recommendation, NCEQE – 3.1)

Even though one case refers to high level of program internationalization in terms of academic staff, overall, this part leaves a lot to be desired in terms of both expert evaluations and the importance of the issue in the reports, which is clearly higher compared to the way it is reflected in the present case.

WFME 7. Programme evaluation

With regard to WFME Standard 7, the thematic analysis WG has identified 100 texts covering analysis/evaluation/findings in the narrative part of the accreditation reports produced by the experts, plus 22 recommendations, 17 pieces of developmental suggestion and 2 best practices.

After coding, the strongest linkage has been found between WFME Standard 7.1 and the entire accreditation standard 5 of Georgia, and there is but some linkage with 1.2. There is no strong linkage with WFME Standard 7.2. As to components 7.3 and 7.4, there is some, though not very strong, linkage with accreditation components 1.2 and 5.3 respectively.

The sector benchmark for medicine is not mentioned.

7.1. Mechanisms for programme monitoring and evaluation

With regard to this component, the experts are mostly focused on the effectiveness of the QA mechanism – relevant methodology, practice, procedures, regulations and persons that are considered key actors in those processes. The number of positive findings in the narrative texts of the reports is in that respect twice as many as the number of remarks and identified gaps. The experts note that the Quality Department is actively involved in the program monitoring process, together with academic staff, students, administrative bodies and other stakeholders. The program evaluation process takes place periodically on a permanent basis, during which they rely both on direct surveys, and other sources of

information. After processing the data, recommendations are developed and submitted to relevant parties with a view to improving the program. As the description shows the review is rather perfunctory. The type of data collected is noted only in the case of two programs, and only in respect of one program it is specified that the monitoring cycle is year-long. In general, questionnaire content evaluations, areas for improvement as identified by students, examples or evidence of practical use of the analysis performed by the Quality Department are missing. As to critical findings, in the case of several programs, the experts double-checked the information received from the institution and concluded that though the questionnaire forms and the documents describing the process are in place, a clear picture of a complete monitoring cycle could not be created – the stakeholder involvement in the development process, the frequency of reviewing at the meetings findings obtained as a result of analysis could not be identified, technical gaps were identified in the documents governing quality or the questionnaires were not completed and processed on a regular basis.

“The ongoing quality assurance process for all operational and educational aspects of the program relies on a limited number of persons processing the data manually” (Narrative text, NCEQE-5.3)

The expert analysis concerning evaluations of the achievement of learning outcomes can be considered as a kind of subcategory of the same topic, on the basis of which the curriculum is adjusted in accordance with targets and market requirements. In this regard, evaluations of the institutions are mainly positive, whereas in respect of critical findings there are recommendations, which mostly fall in the first category under a complete quality cycle. There are more recommendations than suggestion provided by the experts, that request institutions that their QA teams actually perform their duties, improve and put to practice the program development processes and mechanisms, namely, the questionnaires should be more detailed, the approach to data collection and processing should be more structured, the frequency of reviewing results obtained as a result of analysis should be specified together with experts in program implementation, and overall, the PDCA cycle should be followed. There are no recommendations and suggestion directly concerning evaluations of the achievement of learning outcomes. One best practice has been identified, where the Quality Department shares information and consults with stakeholders, but it is clearly required by the accreditation standard and cannot be qualified as best practice.

Another important thematic category concerning external program evaluations and considering those evaluations was identified while analyzing the component. The expert reports evidence the variety of external evaluators – NCEQE, private specialists, international universities and quality agencies, or grant awarding organizations. The expert evaluations are mostly positive. There are several pieces of suggestion and recommendations emphasizing the relevance of sharing recommendations received through external evaluation, expanding the range of evaluators and involving healthcare actors and employers in the process.

7.2. Teacher and student feedback

The experts have found that representatives of the institutions receive information from students and staff about the issues that are of relevance to them somewhat regularly. On the one hand, the source of information is surveys, where students evaluate the study courses and teachers/lecturers. One case has is exemplified, where the staff of an English-taught program was replaced due to their linguistic proficiency issues and was moved to a Georgian-taught program, but when verifying the staff lists beyond the content analysis both program lists turned out to be identical. The institutions construct a picture

concerning their staff based on their self-evaluation reports and attending their lectures. There is only one case, where the institution provides relevant feedback to its students after surveys and data processing. One piece of suggestion and one recommendation have been provided. No best practice has been identified and, in general, the component analysis is rather scarce. Even so, in the course of the analysis, the WG partially covered the evaluation of this component in part 7.1.

7.3. Performance of students and graduates

In this part, the experts mainly cover academic progression of students, collection and analysis of required student life cycle data with a view to program monitoring and improving student performance. The evaluations are mainly positive and there are some pieces of suggestion. The experts note that the institution has developed approaches to analyze exam results, employment rate, mobility trends, poor performance of students and other challenges, and to put into operation mechanisms for intervention. However, those mechanisms are not reviewed in detail and no further evaluations are available. The experts suggest the institutions that such evaluations should be adapted to specific needs, for example, while analyzing research and outcomes, they should consider ethnicity, individuals with special educational needs, sex and other cultural or social factors.

“Analyze student dropout rates to identify any trends and issues that may reduce them by way of proper intervention” (Suggestion, NCEQE-2.1)

The experts believe that the data on academic progression/performance should be collected and analyzed on a more regular basis, and that the results should be used for program improvement purposes. Graduates are referred to only in one suggestion and in one analysis and narrative part. No best practice has been identified.

7.4. Involvement of stakeholders

At the end of the 7th standard, the absolute majority of analysis, suggestion and recommendations identified by the WG was about the involvement of various stakeholders in the design, improvement and development of the program. The expert findings are mainly positive or neutral in terms of their formulation, but considering the above, the number of provided pieces of suggestion and recommendations is unusually high. The reports note that working on the program self-evaluation was a participatory process. It involved academic and administrative staff, students and graduates. The views of employers and program advisors were taken into account. Moreover, the monitoring process involves, together with the above parties, partner organizations, and in the case of one program – a joint committee of graduates and employers. Market requirements are taken into account. Even though the list is long, no specific examples of involvement of the above parties in the monitoring process can be identified, relevant mechanisms, responsibilities and other examples of effective implementation of the process are not described. In their suggestion and recommendations, the experts ask the institutions to frame stakeholder involvement in a more systematized manner, cover a wider range, including clinical staff, meetings with students should be held on a more regular basis, attention should be paid to the views of administrative staff, etc.

“The data processing processes should be designed in such a way that all stakeholders have easy access to information, so that, where necessary, they make more data-based decisions” (Recommendation, NCEQE-5.1)

One best practice has been identified, where the experts highly appreciate the fact that graduates stand by and support smooth operation of the medical school.

The evaluations with regard to WFME component 7.1 are mainly provided at the mechanism and concept level in the reports, the effectiveness of their operation in respect of the curriculum and parts of the program, as well as gap elimination is not reviewed. Therefore, the criteria of the quality standard of the component are hardly covered. In component 7.2, both the basic and quality standards are covered partially, as an example of providing feedback to students in response to surveys is cited only in one report. Overall, the use of student and staff feedback for program development purposes is also referred to at the mechanism level, and there are no clear examples or evidence. The analysis in the case of component 7.3 is also rather perfunctory. Data collection and processing are reviewed, but it is not clear to what extent that information is analyzed with regard to the curriculum, learning outcomes and resources. In terms of quality standards, achievements of students and graduates and their academic performance data are not analyzed in respect of qualifications required for admission to the program. It is not clear how such achievement data are provided to the body responsible for student support and how the latter uses them. It should also be noted that in their reports the experts do not refer to the issues of graduate employment and taking qualification examinations. In this regard, component 7.4 is less problematic.

WFME 8. Governance and administration

With regard to WFME Standard 8, the thematic analysis WG has identified 60 texts covering analysis/evaluation/findings in the narrative part of the accreditation reports produced by the experts, plus 24 recommendations, 6 pieces of developmental suggestion and 2 best practices.

After coding, the strongest linkage has been found between WFME Standard 8.3 and component 4.4 of the Georgian accreditation standard, between WFME 8.2 and 4.1, and between WFME 8.5 and accreditation component 4.3. Despite being scattered across multiple components, WFME 8.4 can be linked to accreditation component 5.1 most of all. In this regard, the linkage is the weakest in the case of WFME component 8.1, which is mainly linked to authorization issues.

8.1. Governance

In quantitative terms, there is no considerable accumulation of analysis in this component. Even so, there are several recommendations, where the expert panel asks the Administration to hold more regular meetings with staff, enhance their representation in the management bodies and clearly set forth responsibilities of the other levels of management in their development scheme.

Naturally, the authorization reports cover the issues of institution governance and management, but not directly in relation to the medical field.

8.2. Academic leadership

In the accreditation expert reports there are evaluations concerning distribution of responsibilities in the academic team, where the major part of the narrative text is about the outsized role and exorbitant responsibility of the managers and the dean. There are suggestion and recommendations that refer to moderate distribution of responsibility, for example:

“Distribution of responsibility in the academic team should be focused on. This will raise awareness of the academic staff concerning the study program and lessen the risk of too much dependence on the head of program”. (Suggestion, NCEQE – 1.2)

Even though the qualifications of the heads of programs have high evaluations, the experts are concerned that the rest of staff does not properly perceive the whole curriculum, its integrated nature and relevance. The experts seem to have found it difficult to judge the role and potential of some staff, as there is no systematized information about their employment in other institutions and there are frequent cases, where the resumes are not updated.

8.3. Educational budget and resource allocation

In some reports the experts describe an overall financial position of the institution, the budget, obligations, and action plans of the institution and their impact on the sustainability of the program. In other cases, the expert analysis is based directly on the program context and is more specific. The evaluations are mostly positive. The experts refer to investments made by the institution, namely, in terms of program funding or renewed material resources.

Even so, there are alternative evaluations as well, which are more critical in respect of the funding model, where the program is linked only to the fee payable by students. In this case, the recommendation reads as follows:

“Any budget which relies only or mostly on the fee payable by students, is vulnerable in the process of changes/regress. There should be other sources of funding as well”. (Recommendation, NCEQE - 4.4)

Therefore, the experts ask program providers to have reserves, more transparency and to consider all budgetary costs, including costs for involving students in research.

8.4. Administration and management

As to WFME component 8.4, in the reports, the expert analysis mainly refers to the degree of involvement of the Administration in the program management, financial support and quality control processes. The role of the Administration is mostly viewed in a positive light. Even so, there are remarks in the context of quality control, where the experts find it difficult to assess the effectiveness of the mechanisms in place on the basis of evidence. In this regard, the identified problem concerns the fact that the competence related to the knowledge of quality mechanisms cannot be identified at different managerial levels. One of the recommendations is about considering clinical training in the context of administrative supervision:

“Increase the number of administrative staff, including staff working in a clinical environment”. (Recommendation, NCEQE - 4.1)

In general, the number of recommendations is quite high. In their recommendations, the experts ask program providers to control the number of qualified teachers in relation to the number of students, consider their overall workload, separate or clearly identify tasks of the units responsible for staff development.

8.5. Interaction with health sector

As to WFME component 8.5, in the reports, the expert analysis covers cooperation of the institutions that implement programs with local and international medical institutions, contracts concluded for cooperation, communication with other stakeholders and achieved results.

In some reports, the experts note that contracts are concluded with a sufficient number of clinics, but in other cases, it is obvious that the number is insufficient. Moreover, in a couple of reports, it is evident that contracts concluded with clinics are short-term or they do not specify what is studied by students in the clinic.

There are a total of 3 expert recommendations, which refer to deepening interaction with health sector actors both locally and internationally, and to identifying mechanisms for assessing outcomes achieved by students involved in clinical training.

There are 2 best practices identified by the experts, one of which refers to international cooperation, which provided students with an additional opportunity to pass the Maastricht progress test, and the other best practice is about an achievement of the institution, which made it possible, on the basis of cooperation with the government, to use a teaching model based on corpse dissection.

Consequently, the reports partially cover the basic criteria of WFME Standard 8, but the review is not in-depth. Apparently, the issue that has not been assessed by the experts concerns internal institutional evaluation of effectiveness of the Administration and administration process and its periodic revision.

WFME 9. Continuous renewal

The basic criteria of WFME Standard 9 refer to initiating and introducing procedures for regular review and update of the process, structure, content, outcomes/competences, assessment and learning environment. In addition, they cover rectification of identified gaps and resource allocation for continuous renewal. The examined reports cover more or less all components of the above aspects.

After coding, the strongest linkage has been found between WFME Standard 9 and components 2.3, 5.1 and 5.3 of the Georgian accreditation standards. Some linkage has been found with components 1.2 and 2.2. In total, the number of identified analytical narrative texts is 35, plus, 18 recommendations, 12 pieces of developmental suggestion and 3 best practices.

In the examined reports, the experts note that the institution has mechanisms for continuous monitoring and quality assurance, the institution is proactive in respect of student and academic staff involvement, raises awareness to encourage participation in surveys, shares assessments with lecturers and informs students about changes introduced on the basis of research. In some cases, it is emphasized that students and staff are involved even in the process of introducing changes planned for program improvement. For example, there are changes in credit allocation, or students have been involved in the PBL/CBL case contextualization process, etc.

Some programs definitely deserve to be criticized in this regard. The criticism covers a lot of issues, including the fact that responsibilities of the program committee and self-governance are not documented, the staff workload scheme needs to be revised, the syllabi topics need to be separated, the

amount of credit needs to be regulated, learning outcomes need to be measurable. According to the experts, in some cases, program monitoring and quality control documents are in place, but it is not clear how the mechanism works in reality:

“The university should introduce QA culture in accordance with the internal QA policy, and carrying out actual processes should coherently match description of the systems that ensure program adjustment”. (Recommendation, NCEQE – 5.1)

The sector benchmark is referred to only in one report, where the experts note that a number of changes have been introduced to the program to bring it in line with the sector benchmark (“there are changes in credit allocation, teaching methodology, learning outcomes and assessment”).

A number of recommendations are about rectifying mistakes or inaccuracies identified in other respects – the ones in the course titles, syllabi, learning outcomes, competence map. With regard to more serious issues, the experts opted for moderation and providing developmental suggestion. For example, the suggestion refer to relocation of modules/subjects within the program structure, credit adjustment, need for clearer links between the courses and learning outcomes.

“The number of credit hours should be aligned in the regulatory document and educational program”. (Suggestion, NCEQE – 2.2)

The above pieces of suggestion are formulated in such a way that readers may automatically consider them as recommendations. In addition, in the case of several programs, there is also suggestion concerning the fact that the Program Quality Department should ensure that the program is monitored and improved periodically, which is a rather problematic text, as it evidences that the standard is not met and lowers the quality of the whole report.

The expert panels qualify as best practice the fact that in the case of one program both staff and students were involved in PBL case contextualization. In another case, contact with stakeholders on a regular basis is also considered as best practice, which apparently is just a requirement of the standard.

As to covering the requirements of WFME Standard 9, the reports examined by us partially cover all components. The issues, such as adaptation of school mission statement to the scientific, socio-economic and cultural development of the society, as well as adaptation of academic staff recruitment and development policy according to changing needs are covered to a lesser degree.

Focus group sessions with involved parties and stakeholders

As already mentioned in the methodology part, different focus groups involved, on the one hand, experts assessing one-cycle educational programs, and on the other hand, stakeholders – representatives of the Quality Departments and other administrative units of institutions, and representatives of medical clinics and the Council. The members of the first group will be referred to as “the experts” in this chapter, whereas the members of the second group will be referred to as “the stakeholders”. It should be noted that some members of the first group are, at the same time, representatives of various institutions. Most questions asked within the focus groups were similar, which enabled the research team to identify important regularities and create a holistic picture of specific issues in the interests of the research. However, in the discussion mode, the participants’ conversations were adapted to their roles and viewpoints in a particular focus group, which was understood and taken into account by the moderators both in the process and while analyzing the data.

In general, it should be noted that the members of the focus groups were very active. One could feel that they showed interest in the issues in question while talking about current challenges, as well as ideas related to future prospects. While analyzing the qualitative information obtained from the focus groups, three major issues were identified, which received the most attention from and were discussed at length by both groups.

The status quo of medical education and challenges related to its assessment in Georgia Apart from the difficulties and challenges related to the assessment of one-cycle medical education programs, the stakeholders talked about the overall status quo of medical education in Georgia, and drew parallels with both Eastern Europe and the world. When comparing, talking about future plans, progress and challenges, the starting points were taken exactly in relation to European and Western (USA, Canada, Australia) experience and standards. According to the members of the group, considering the background of the country’s economic development, Georgia has made significant progress in recent years in terms of medical education, and in this regard, has outpaced the medical activity regulatory (health) system itself. Several members of the group noted that Georgia is one of the leaders in providing medical education within the post-Soviet space, and is ahead of some Eastern European countries that are members of the EU.

Despite achievements, the stakeholders admit that the progress is fragmented, the homogeneity in terms of quality is still to be achieved, and therefore, introducing mechanisms for collaboration between medical schools plays a major role. According to the members of the group, discussing QA of medical education will never be sufficient if the system is not perceived in a holistic way and undergraduate education remains disconnected from postgraduate education (residency), - under the regulation of various authorities/ministries:

“Residency is already beyond us, we do not have a bridge between the two levels, [...] we have to look at it from a global perspective – it is not a graduate that is employed, we have to see what s/he manages to do after residency, we have to talk about the employment of persons that graduated 4 to 5 years ago”. (Council – stakeholder)

When talking about challenges, the stakeholders usually note that similar challenges are typical of developed Western countries as well. In this regard, the experts viewed the Western experience in a more positive context and cited examples of best practice in response to dealing with challenges.

Looking ahead, the experts emphasized the need to increase the academic staff and student ratio, reduce student intake and increase the fee. The stakeholders also expressed readiness to set forth the Georgian language competence as a necessary component for international students and introduce it in the very first year of study.

Both parties discussed the roles of the Council and NCEQE, as well as issues related to international experts. The role of NCEQE came up in group discussions a couple of times, as it was said that the representative should lead the evaluation process more actively, and later, either NCEQE or the Council has to clearly voice their opinion if the evaluations in the report are not in line with the standard or the law. Several wishes were expressed in respect of NCEQE, in terms of refining and simplifying the process. Namely, the experts noted that the duration of the visit and the time allocated for reviewing the documents should be increased, and a kind of supporting “check lists” should be developed not to overlook important issues. A rather painful topic for those involved in the research was the issue of invited Council members, and both groups clearly expressed their opinion that the authority/powers of the Sectoral Council should be increased in terms of reviewing medical education programs. All in all, the role of the Sectoral Council was also linked to the experience of experts, their retraining and the need to speak in the same context, using one common language:

“Working with an international expert is about sharing a wealth of experience, but on the other hand, we often have differences, because, for example, an international expert, not European but American, finds Georgia’s health system completely incomprehensible”. (Expert/HEI – the experts)

In this regard, both groups, especially the stakeholders, referred to the idea of active training of foreign experts. One of the participants also emphasized the role of a local expert in terms of sharing with them the country’s context and experience in the process of evaluation and cooperation.

The process of further refinement of the standards and sector benchmarks is acceptable to the representatives of both groups and they realize the necessity of taking into account particular countable data. However, the experts request such an approach more actively and emphasize the relevance of component and criteria measurability.

“You have to prove that any restriction in place is necessary and proportional”. (HEI – stakeholder)

“Unless there is more measurability, in a few years all universities will have the same report”. (Expert/clinic – the experts)

The stakeholders support the so-called golden mean to maintain the business model of medical education and, at the same time, firmly adhere to the minimum requirements of quality standards, that will be laid down involving medical schools. Whereas the stakeholders support defining ratio ranges by discipline in the context of quantitative data, the experts expect more clearly defined criteria and thresholds so that final evaluations are objective. According to them, there are also a number of questions in the standard itself that need to be specified:

“If the staff has been retrained by one institution and they teach in the other institution, will it be the other institution that will take credit for taking care of staff development?; we, experts also do have questions when it comes to things where the institution should be or should not be given credit”. (Expert/HEI – the experts)

On the other hand, when the moderator asked about the relevance of data related to graduates (including the results of their certification examinations) and their inclusion in the reports, the experts did not show willingness and enthusiasm to look deep into the topic, - the relevance of such data was emphasized, but the reserved approach was noticeable, and it was even voiced that one should be cautious in that regard. Nevertheless, the somewhat reserved approach corresponds to the standpoint of the other group concerning graduates, based on which, graduates are not doctors and the issue related to them should be considered in the context of postgraduate education.

Finally, authorization and accreditation of medical schools are viewed as a single process by both groups and they consider it important to combine them in the future, which, according to the participants of the research, is especially relevant in the case of medical education.

Quality of clinical training When the discussion covered the topic of clinics and hospitals more actively, some differences of opinion were expressed among the stakeholders – the issue concerned the fact that the number of hospitals in the country was not sufficient for the current intake of students, nor was the number of patients, given the small number of the population. Focus group participants repeatedly stated that involvement of clinical staff in the study process, kindling their interest in practice-based training and their attraction is a challenge in any developed country. On the other hand, the experts noted that there should be an opportunity to verify whether the student actually undergoes practical training in this or that clinic, where s/he is supposed to acquire skills rather than listen to lectures:

“Students should have a local coordinator in the clinics as well”. (Expert – the experts)

“Students should have an environment enabling them to acquire clinical skills. Nowadays, about 5% have this opportunity.” (Expert/clinic – the experts)

While the experts were discussing how to cover various medical specialties on the basis of student practical training modules, the stakeholders tried to bring the issue of prioritization to the fore. Namely, as they explained, the primary healthcare level needs to be strengthened in that regard, and later, critically relevant and available specialties should be offered to students (considering the criteria, for example, hospitalization and neurosurgery are not considered as a top priority), which is an approach used in many Western countries:

“We should diversify the modules and clinics, and we should know what they need to undergo and where”. (Council - stakeholder)

The stakeholders are careful when it comes to the topic, relevant regulations and restrictions. However, even the idea that foreign citizens should undergo part of practical training in their own countries was flatly rejected by one of the participants. The following opinion was expressed by one of the members. It was somewhat critical in terms of considering the feasibility of practical training as realistic and caused some outrage:

“We, Georgians are used to saying “the more the better”, meaning more income for the country as well; I believe that the student intake needs to be adjusted. If I really have 600 to 700 fourth and fifth-year students, who can I deceive by saying that it is feasible to accommodate them” (HEI – the stakeholders)

However, the group soon agreed that specific minimum standard indicators need to be developed and met. The threat that the number of schools may be reduced was mentioned several times, which, in general, was not viewed as a desirable development by the group, and maintaining quality and objective assessment of student throughput within the system were named an alternative to such a radical approach. There was an attempt to continue the conversation with regard to a merger of some schools and provision of a joint clinical base, however, the discussion did not go into depth and it was clear that the members of the group were taking a somewhat cautious approach to the issue. In turn, the experts confirmed that memoranda concluded with clinics are often ambiguous and unrealistic, and therefore need to be more specified at the criteria level, which will make further verification possible. Opinions about the affiliation of clinics (inter alia, how many HEIs they may cooperate with, how many students they may admit, etc.) were also expressed, and the possibility that NCEQE could grant them “university” status was also touched on. On the other hand, the stakeholders raised the issue of taking into account the reputation of clinics and hospitals.

Staff – number and qualifications The participants of both focus groups emphasized the role of state of the art information technology in respect of analyzing staff workload – including the use of regulations to keep track of employee working time and a QMS base, which, according to the participants of the research, should be available to both NCEQE and institutions to enable them to better verify and consider information about employees hired by them. As to the fact that most staff are involved in the implementation of two or more programs at the same time, the stakeholders refer to one simple aspect that due to their degree of specialization some staff members are involved only in courses that last for a few days and therefore their right to being involved in other programs as well should not be restricted. They believe that neither dry numerical data construct a complete picture:

“There is no standard applicable to student and staff ratio. The issue is controversial. For example, we have up to 200 staff members and 100 of them are specialized in narrow fields. It does not allow you to say that the program is really staffed. It is a game of numbers.” (HEI – the stakeholders)

However, some experts focused on more alarming data related to the cases, where the same core part of the academic staff keeps moving from program to program for a short period of time, but after receiving accreditation, they are replaced by other academic or invited staff:

“While authorization and accreditation are under way, all persons that have a PhD are hired in a body, but when the process is over, there is a shake-up” (Expert/clinic – the experts)

“Some observation should take place in capacity of “hidden guest”. Cyclical assessments make no sense when everyone is prepared” (Expert/HEI – the experts)

The issue of not having any actual generational change in some universities was also touched on. Following some differences of opinion concerning the academic degrees of lecturers, the relevance of holding an academic degree for the study process and the need for increased affiliation were emphasized. The issue of linguistic competence was also brought up in respect of staff that is hardly subject to

replacement by way of competitions and whose hours are in fact part of the workload of invited staff. The stakeholders expressed a clear opinion concerning the issue, stating that experienced clinicians that have extensive practical as well as internship-related experience in teaching foreigners cannot be required to pass a language test, and that otherwise, a lot of staff will be lost. As to overall workload, an opinion was voiced that calculating teaching, research and practical training hours in combination and using the FTE methodology would not be appropriate, as in that case, staff would be fully loaded in a given HEI and would not be able to be involved elsewhere. However, one of the participants pointed out that his institution actively applies the above methodology. Another participant shared an idea that observation should take place with regard to yearly rather than weekly workload data.

Discussion

Within the thematic analysis, the WG has examined and processed a great deal of information concerning medical education, including sources available to NCEQE, as well as those requested from relevant authorities. Considering the goals and objectives of the research, the WG's approach, in capacity of actors responsible for external quality assurance, was, on the one hand, metacognitive in order to further deepen the perception and cognition concerning the major framework documents and to build further analysis only on such competence. On the other hand, in order to achieve a high degree of triangulation, the WG relied on different types and various sources of information, mixed methodology for analysis, and by taking into account the needs and interests of all stakeholders, tried to formulate relevant recommendations. Below are the key findings that we think should be given special attention by NCEQE, experts, institutions and other leading actors in the field of health and medical education.

Given that the WFME Standards are a kind of structural framework for our analysis, it would be appropriate to start by discussing the expert reports analyzed in the context of those standards. In respect of the first standard, the main finding is that the goals of the medical school, the issues of autonomy and academic freedom, as well as the content of the program learning outcomes and the involvement of stakeholders in their development are reviewed rather generally in the reports. There are few relevant recommendations and pieces of suggestion. The same trend can be observed in respect of the second standard, and the lack of linkage with the sector benchmark is obvious not only in terms of the whole text of the reports, in general, but in part 1.2 as well, where the standard directly refers to the need for compliance between program learning outcomes and the sector benchmark. The above applies to both learning and teaching methods and components directly linked to the program content. The fact that, in general, the experts do not go deep into content-related issues in connection with the sector benchmark is especially noteworthy. In most cases, they offer us general technical remarks concerning the program structure and a particular syllabus.

In terms of research skills, the linkage of skill development opportunities with the material and technical base and with the issue of compliance between the standards and resources required for basic research became evident. Without the linkage between them it would be difficult to discuss success in terms of acquiring scientific and research skills, as well as evaluation of that success. Another noteworthy fact is that the absolute majority of programs evaluated in 2019-2020 have no scientific staff involved. Therefore, it is clear that the issue of scientific and research skill development should be evaluated comprehensively within the programs. Despite the fact that the medical doctor educational program is not aimed at producing researchers, in accordance with both local and the WFME requirements, it should link individuals to the health sector and prepare them for moving on to the next level of studies. Moreover, in terms of a linkage between research and learning and teaching, the reports evidence that there is a lack of research prospects in the programs, to say nothing of any kind of research policy. In general, it seems that research is not a priority for most institutions.

As to clinical training, as mentioned above, it is closely linked to the availability of a proper material and technical infrastructure. Considering this, first of all, it should be underlined that we are facing a problem related to detalization in the relationship between universities and clinics, as well as a problem of planning

student intake and the number of patients, which was clearly identified in the course of memoranda analysis. Both the experts and other stakeholders realize and emphasize that within the program students need to deal with a diverse range of patients (diversity in the context of medical history), but the formal documents for cooperation with the clinical sector hardly specify the disciplines in respect of which practical training is to take place. Excerpts evidencing supervision of clinical training and particular spaces or material and technical facilities that will be allocated for students can be found neither in the reports, nor in the memoranda. In addition, in some cases, even the issue of compatibility of clinics with the learning and teaching process was emphasized. It should be noted that currently, the sector benchmark does not set any specific requirements for clinics where practical training can take place, and therefore, there are no objective criteria to measure the relevance of such clinics.

Most reports positively evaluate development of students' clinical skills in the part of simulated work environments. Even so, it is important to clearly separate skills to be acquired in simulation centers and clinical environments and ensure proper learning and teaching in the part of practical training as well. At that, it should be noted that though the number of programs designed for international students is on the increase, according to the benchmark, it is not a must for international students to know the Georgian language. Not knowing the language will prevent students in practice from achieving learning outcomes, as it is impossible to communicate with local patients and develop relevant skills. The experts also emphasize the necessity of using portfolios in the course of clinical training to accumulate students' experiences. Sadly enough, the reports do not provide any emphases on IT skill development in medical context, which is required by both a WFME standard and the sector benchmark, and is very important for doctors' effective performance in today's world.

Another noteworthy point is that, in terms of supporting the continuous development process of programs, there are almost no curriculum committees at the institution level in the evaluated medical schools. Consequently, the reports do not provide any systematic analysis of labour market research in connection with the infrastructure required for program implementation and the memoranda concluded with clinics. In their reports, the experts hardly refer to the issue of graduates and the extent or the way of their connection with the health system after completing the program. Based on the 2020 spring session results requested by the WG from the LEPL – Regulation Agency for Medical and Pharmaceutical Activities, 49% of graduates, on average, managed to pass the certification examination. However, in respect of this issue it should be noted that the majority of programs evaluated in 2019-2020 did not have graduates at the time when the self-evaluation reports were submitted, and in this regard, more reliable information can be gathered in the coming years.

In the case of international students, it is clear that, except for some individual cases, practically all persons willing to be admitted are enrolled into the programs. This fact is closely linked to complaints filed to NCEQE by international students in recent years, that refer to the involvement of private agencies in the recruitment process. Another point to be considered in this regard is that in some cases, where the program intends to admit only international students in a given year, the self-evaluation reports do not refer to the quota announced for the program (or if both local and international student intakes are allowed, only the quota announced for local students is reflected), which is another sign that there is a lack of transparency in this regard and the way the mechanisms for student intake planning are examined

is ineffective. All in all, it is safe to say that the issue of international student recruitment remains beyond external QA mechanisms for higher medical education.

According to the experts, the policy for enrolling students directly and through mobility, including the prerequisites, needs to be refined. In some cases, their evaluations are strictly negative, stating that the size of student intake planned by institutions for the coming years does not correspond to their actual capacities, and does not consider their human and material resources. Given the ratios referred to in the self-evaluation reports, this threat becomes even more obvious. On the other hand, the reports evidence that the mechanisms for integrating local students with international students are not effective, and, in general, students are not actively involved in the representation and governance processes of the institution. The experts also note that institutions use feedback received from students (and other stakeholders), which takes place on a regular basis, but there are hardly any examples of activities or changes planned and introduced on the basis of feedback, which leaves their positive evaluations without any basis in respect of the introduction and use of the PDCA cycle by institutions.

Another important point is that the reports provide high evaluations concerning program integration. However, in this regard it should be noted that currently there are no integration-related targets. Such rathets are not covered in the WFME standard either. It is noteworthy that there were remarks in the part of integrated curriculum implementation, especially in terms of staff awareness concerning the issue. This is extremely important in the light of responsibility distribution and maintenance of program sustainability, as the main burden under such circumstances is taken up by heads of program and faculty deans. While analyzing the reports it became clear that in addition to a lack of staff awareness, in some cases, there is a lack of staff involvement in program development, which also increases the powers of heads of program and deans, and puts additional question marks over the actual use of mechanisms for continuous QA of programs.

In respect of learning and teaching methods and assessment it can be said that both of them are evaluated as formally compliant with the standard and legislation, but the experts provide suggestion and recommendations that the methods should be diversified and based on evidence. At that, it became clear that the experts show almost no interest in familiarizing themselves with exam materials within evaluation.

In terms of human resources involved in medical programs the very first point that became evident based on the reports is the lack of clear human resources management policy in most institutions. A logical continuation of the problem is the issue of staff and student ratios and staff workload. In terms of ratios it is clear that institutions should actively compare the numbers of students and human resources and should plan the size of student intake accordingly. Moreover, the experts noted that most staff were hired by several institutions at the same time, which calls into question their actual workload, considering the fact that in practice, some staff involved in programs are also clinicians. This analysis is supported by a trend identified within quantitative evaluation evidencing that 50% of academic and invited staff are involved in implementing two or more programs. This is a clear threat to both program sustainability and professional development of staff. In the course of the research it was identified that in some cases, the staff involved in the program of one institution were retrained by another institution, and the experts failed to understand to what extent they had to take that issue into account with regard to the program

in question. In general, the reports also identified an issue of professional retraining of teachers in respect of present-day learning, teaching and assessment methods. Another point to be noted is that it is quite obvious that the rate of program staff attrition is very high, which makes a negative impact on program sustainability, and what's more, there are no effective control mechanisms. In respect of the issue, in the course of focus group sessions, it was mentioned that NCEQE had developed a QMS system, which should, in theory, register full workload of employees, but practice-wise it is clear that the system lacks complete information and has no effective mechanisms to respond to the information registered in it. Considering the above, it is safe to say that the lack of qualified human resources in medical education programs is obvious, which is viewed by the experts and stakeholders from a different angle. The latter think it is a global problem, stating that due to time and financial factors, it is more and more difficult to kindle clinical staff's interest in academic life worldwide. The experts underline that it is one strong core group of qualified staff that design programs in Georgia, but once the authorization and accreditation procedures are over, they are quickly replaced.

In terms of resources, apart from the above issues concerning clinical and research infrastructure, it should be noted that most reports positively evaluated the fact that the institutions possess resources, such as moulage, mannequins, phantoms, etc. Even so, it should be underlined that currently, the sector benchmark does not predetermine the number of such resources in relation to the number of students. In view of the fact that we have identified multiple emphases placed by the experts in respect of planning student intake on the basis of relevant resources, it will be difficult to construct a satisfactory picture in this regard without predetermined ratios.

The reports cover the issues of the use of educational expertise in program development and program internationalization rather scarcely. In respect of these issues it is important to recall the observations made during focus group sessions concerning the need for enhanced collaboration between universities, which may be one of the favourable factors for institutional development in both ways.

The description of the issues of continuous program evaluation and monitoring in the reports is perfunctory. We find almost no cases, where it could be identified how stakeholder feedback was used for development. Moreover, we find suggestion and recommendations concerning even the extent of stakeholder involvement, which indicates that so far stakeholder involvement in the monitoring and control process has been solely formal. The experts hardly analyze instruments used in evaluation, which is important in terms of evaluation target and its effective use. Even though the analysis is scarce, the experts note that the program evaluation and monitoring processes need to be more structured, cyclical and institutionalized, and that evaluation results should actually be used in program development. This, in fact, means that compliance with the standard is questionable and is in contrast with the picture, where the panels refer to full or substantial compliance in terms of quality. The fact that evaluation and monitoring mechanisms are formal and there is little evidence of their utilization, which is clear in relation to a number of standards, indicates a systemic challenge not only in medical education, but in a broader context, and makes the trend of ritualism in the university QA space and process implementation even more obvious. In addition, it should be noted that the experts assessed the issue of external evaluation quite positively. It mainly covered involvement of a diverse range of neutral external evaluators in program development. In this regard we can say that the experts almost never identify best practices

(despite the fact that such cases do exist considering the examples of narrative texts), and wherever best practices are identified, the majority of cases are not extraordinary and noteworthy, and mostly evidence compliance with the standard.

In view of the data reflected within the content analysis, it should also be noted that the experts in the focus groups referred to the need for clear countable criteria within evaluation to make evaluations more objective. The stakeholders have a relatively more reserved approach to the issue and support setting ratio ranges to maintain flexibility to a certain extent. Even within the content analysis it is clear that being guided only by content standards leads to ambiguity in the reports, as it is impossible to clearly identify the actual resources of medical schools and they cannot be weighed against the current and planned student intake.

The need for further professional retraining and development of experts, especially international experts involved in evaluations, has also been identified, as they have scarce information about the national context and legislation. In the course of the research the need for raising awareness of the invited members of the Accreditation Council with regard to medical education QA standards became clear as well, as according to the findings of the focus group, in some cases, despite the extensive professional experience of Council members, Council members and experts did not speak the same language.

Finally, the research has identified the need for approximating accreditation and authorization mechanisms in such a way that the standards are fully covered, but do not overlap one another. In addition, the research made it clear that there is a problem of continuous medical education at the system level, which is linked to the fact that undergraduate and postgraduate education operate as different systems. The focus groups emphasized the need for combining those systems in the future as a necessary prerequisite for producing highly qualified medical staff.

Recommendations

- For the sake of better monitoring of Learning outcome achievement and evaluate the efficacy of QA service, the NCEQE should plan relevant activities for the experts (Guides, Trainings etc.);
- Main actors of Medical Education field should start discussion about strengthening scientific-research component in Medical Doctor programmes, which we believe is necessary considering the qualification level and the experience needed to continue studies on higher level.
- The exact number of students that are going to have a practice, as well as specific medical sub-fields, practice-supervisors and specific spaces of the clinic that are to be used by the students, should be indicated in the memoranda between the HEIs and the Clinics.
- For the better management of future policy in Medical Education database should be created where the memoranda between the HEIs and the clinics, as well as the quantitative data of their relations will be stored.
- Evaluation mechanism for the clinics should be created, in order to decide whether the clinics are fit for the purpose of teaching/learning procedures. The mechanism should quantitatively evaluate the potential and capacity regarding the number of students to be received. Additionally, it is necessary to define the mean number of patients in the clinic and their ratio to the admitee students.
- Georgian language should be taught at least on B1 level to the International Students, in order for them to better integrate in clinical practices as well as Universitie’s social and academic life.
- In order to assure the continuous cycle of programme development, curriculum committees should be established in each medical school, which will involve different stakeholders (e.g. Gradutes, Healthcare sector representatives).
- Mechanisms for tracking down and styding the employment and professional development rate of graduates should be established. The HEIs should stay in touch with their international graduates and periodically check their career and academic progress, results of the local and international post-diploma qualification exams for the sake of programmes’ further development.
- The NCEQE should be regularly getting information about the success rate in post-diploma qualifications exam from the relevant agency and in case of non-compliance to pre-determined critical threshold, case-based monitoring could be initiated.
- Recruitment process of international students should be maximally transparent in order to defend the rights of the applicants and bring the expectations closer to reality. It is advisable that the potential students have direct contact with the HEI; The recuriters should be present during the NCEQE site-visits.
- Presenting the locally or internationally acknowledged language certificate should be mandatory for the international students in order for them to get admitted to English language programmes;
- HEIs should support the integration of international and local students; This should include the mixed courses and clinical practice;
- Experts should pay more attention to the study of exam materials; They should be compared to the students’ and graduates’ academic achievements.
- Accreditation council should set maximum number of students to be admitted to the Medical doctor programmes and in case the numbers are exceeded monitoring should be initiated in order to assess the Material and Human resources.

LEPL – National Center for Educational Quality Enhancement

- Effective mechanism for tracking down staff's activities should be established. This is important in regards to programme sustainability. Maximum rate for the fluctuations in staff number should be established, exceeding of which should cause monitoring;
- Sector Benchmarks should contain ratios between the students' number and material-technical base needed;
- In order to support the common understandings and consistency of procedures, the NCEQE should offer the local and international experts united and thematically complex training sessions;
- In future perspective systematic linkage of pre-diploma and post-diploma medical education should be discussed on the Education and Healthcare policy level. It is important that post-diploma programmes should also be evaluated against WFME standards.
- Accreditation standards and Medicine Sector benchmarks should better incorporate the topics related to the management of medical schools.

Annex

Focus group plan

- How can an expert evaluate the staff attrition rate against the student intake and program content? How can an expert evaluate program sustainability risks? What additional mechanisms need to be in place?
- In some cases, it is stated that clinics serve students from many universities, and that even the memoranda fail to detail practical training, which raises questions in terms of actual feasibility of adequate clinical training. What can the medical education system do to lessen the risks?
- About one half of employees are involved in two or more programs, and some of them have clinical practice, research/academic/administrative responsibilities at the same time – considering this, according to the findings in the reports, on the one hand, it is necessary to plan the number of students against the number of staff, and, on the other hand, it is necessary to increase and retrain the number of qualified staff in different ways. What can the medical education system [NCEQE, HEIs, clinics, citizens] do to lessen the risks associated with program sustainability and achievement of learning outcomes?
- In some cases, the program directly relies on the fees payable by students. To what extent can such a program be considered as sustainable? What additional mechanisms can be introduced to lessen the risks and to assess the budget?
- In some cases, some WFME standards are covered only in the part of authorization, and not in accreditation (e.g., 1.2 – Autonomy). There is a chance that one evaluation may not cover the federation standards in full and this full coverage may take place within a different process, a few years later (authorization and accreditation). How would you evaluate this? What could be the solution?
- How can an expert evaluate the issues of graduate certification/employment? How usable are these data? What should the system do?
- Should international students be taught the Georgian language on a compulsory basis? How to balance the requirements of the Georgian and foreign labour markets in the program?
- Based on what criteria should an expert evaluate whether the clinic is adapted to the learning outcome? What role can the system play in improving the process?