External Evaluation Committee Visit to the University of Nicosia Medical School and Clinical Teaching Partners

4 and 5 October 2021

Summary of Activities

The External Evaluation Committee (EEC) carried out a limited evaluation of the 6-year MD programme in the University of Nicosia Medical School in September 2020. Due to the international travel restrictions imposed during the Covid 19 pandemic, a visit to the School was not possible. Instead, the EEC held interviews with senior management, teachers, students, and other stakeholders over 21, 28 and 29 September 2020 using video conferencing. The EEC submitted a report based on the interviews, with the intention of updating the findings, strengths, recommendations, and compliance judgements once a visit became feasible.

Over the 4 and 5 October 2021, the EEC visited the University of Nicosia, the Medical School, Limassol and Paphos General Hospitals and the University of Nicosia Medical Centre and focused on observing the estate, educational facilities, teaching resources and methods of teaching and learning in both the academic and clinical settings.

The External Evaluation Committee (EEC) saw excellent estate and facilities in the University, the Medical School and the UNIC Medical Centre. The Anatomy and Histology Laboratories, Clinical Skills Centre and small rooms for Communication Skills were all very well-equipped, pleasant rooms. [Standards 6.1 and 6.2]
We are grateful for the EEC's positive feedback on our physical facilities, which they deemed to be excellent. We are confident that our state-of-the-art teaching/learning spaces are able to accommodate the range of modern teaching and learning methodologies and support delivery of high-quality medical education.

We noted that ultrasound is being increasingly used in the contexts of anatomy and skills, and of course in clinical practice. [Standard 6.2]
Indeed, we have recently started to incorporate ultrasound in the MD programme curriculum, in a vertically-integrated course, with the ultimate aim being to embed ultrasound in all years of the programme. This initiative will allow students to not only become competent in this important clinical skill but also gain a better understanding of taught subjects (e.g. anatomy, physiology) through ultrasound methodology. The aim is to produce graduates with the needed knowledge and confidence in ultrasonography.

The facilities in the hospitals appeared less suitable, especially for clinical teaching; the side wards and consulting rooms we saw were too small to accommodate the patient, doctor and standard 2 students, making it more difficult to engage in student-focused teaching while prioritising patient- focused care. [Standards 6.1 and 6.2]

The clinical training of students of the University of Nicosia Medical School is delivered across the entire spectrum of healthcare providers in Cyprus. In addition to the hospitals belonging to the Limassol-Paphos Directorate of the State Health Services Organisation/SHSO (Limassol General Hospital, Paphos

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General Hospital and Troodos Hospitals) and the SHSO's Nicosia-based hospitals (Nicosia General Hospital, Makarios Hospital and Athalassa Mental Health Hospital), students receive training in more than ten private hospitals. These include the largest private hospitals in Cyprus, featuring state-of-the-art facilities that contribute to a very positive learning experience for the students, as indicated in their feedback. The majority of these facilities operate under the umbrella of the Cyprus General Healthcare System, as is the case with a range of primary care facilities, private clinics, specialist units and rehabilitation centres that are used for clinical training and complete the options for the education of our students.

We acknowledge that some of the facilities in Limassol and Paphos General Hospitals that the EEC had observed during their on-site visit were less spacious. Planning for clinical training delivery also considers the physical facilities and the number of students is tailored based on capacity of clinical areas. Moreover, we engage with our students in clinical training and take into account their feedback about facilities as evidenced by the School's initiative to design and finance upgrades to the library at Limassol General Hospital and to designate and fully equip a clinical skills room at the same hospital.

SHSO is a new organization, having recently received all public healthcare facilities from the Ministry of Health. The SHSO has a strategic plan to upgrade existing facilities and also construct new wings at the existing General Hospitals. Already, a new wing has been refurbished in one of our collaborating Hospitals, the Troodos Hospital, and refurbishment and expansion is planned for Limassol General Hospital. We have an excellent relationship with the SHSO, have collaborated very successfully not only in undergraduate medical education but also in the delivery of a postgraduate training programme in Limassol with excellent results, and work very closely with the organization so that the needs for clinical training are taken into consideration at the planning stage. For example, work has commenced towards construction of a clinical skills lab in Paphos General Hospital to facilitate student training and self-directed learning.

We would like to emphasize that the majority of clinical teaching areas are spacious. We continue to ensure that clinical facilities are conducive to the delivery of high-quality medical education and that any issues raised are appropriately addressed.

Everywhere the EEC went, we met friendly, engaged, and enthusiastic teachers who were patient, respectful of and helpful to their students. Unfortunately, we did not have an opportunity to speak to clinical teachers immediately after their teaching session. [Standards 5.2 and 6.2]

We are pleased to hear that the enthusiasm and engagement of our clinical teachers were evident to the EEC. We are particularly grateful that the EEC noted that teachers were helpful to students. We consider student support, both academic and pastoral, to be one of the strengths of the programme, and our staff and faculty work closely with one another and the students to ensure appropriate support is provided.

In regard to opportunities for the EEC to speak with clinical teachers, at the request of the EEC, we arranged for student, but not clinical teachers, meetings. We hope that the online meetings with teachers, including those in the clinical environment, were helpful to support the work of the EEC.

We were pleased to meet thirteen Y4/5 students across the two hospital sites. They appeared very keen on their studies, very grateful for the work done by the University and Hospital in providing their education. They would all recommend the School and their placements, and the only constructive comment we could draw from them was that those students based in Paphos would like to see more patients by themselves. [Standards 2.1, 2.7, 3.1, 3.2, 4.3, 6.2, 7.1, and 7.2]
We are extremely grateful that the EEC noted the satisfaction of our students with the quality of their

education, including their clinical training experience. We would like to clarify that students are provided with many opportunities to clerk and examine patients, perform clinical procedures and take histories. While we acknowledge that students would appreciate more opportunities to see patients by themselves, we would like to clarify that the EEC observed Year 5 students, in the beginning of their clinical training at Paphos General Hospital. Students increasingly take on more responsibility as they progress through the programme, culminating in assistantship-type attachments in Year 6 in Internal Medicine, General Practice and General Surgery. It is also important to note that due to the nature of some specialties, for example paediatrics and obstetrics & gynaecology, the level of responsibility given to students varies. Additionally, there could be some variability as to how students take advantage of opportunities for independent learning. While students are briefed about how to learn in the clinical environment in Year 5, based on the EEC's constructive feedback, we are planning for the delivery of a session to students in pre-clinical years by the Chair of Clinical Education to manage early on expectations and to encourage students to take advantage of all opportunities offered in the clinical environment, at the appropriate level of supervision. At the same time, our ongoing work with providing appropriate training and practical guidance to our clinical teachers will further ensure that clinical teachers place emphasis on independent learning, for example by continuing to encourage students to clerk patients on the wards and present them to their tutors. Our carefully-constructed approach to training of clinical teachers is described in more detail later on.

Students also spoke of a didactic format of peer teaching and some Interprofessional Education, but the latter focused on nurses teaching medical students some skills and procedures in the clinical setting. [Standards 2.1, 7,1, 8.1 and 8.5]

We thank the EEC for their observation about peer teaching, which allows us to provide an update into this important aspect of student-centred learning. Students are very keen and willing to support their peers in their learning, which additionally allows them to develop further, personally and professionally. The delivery of peer teaching so far has been based on student-led initiatives outside of the formal delivery of the curriculum, with support from teachers, for example in validating the teaching content. Following the EEC's on-site visit, we have now introduced a more formal peer teaching strategy, which is in line with the School's aspirations to further enhance student-centred learning. This is a highly structured programme, whereby students will be carefully selected, trained and evaluated on their participation in small-group teaching. In fact, students have already been invited to express their interest to participate as tutors in communication skills teaching and this will expand to other small group teaching sessions, for example Anatomy and clinical skills.

In regard to interprofessional learning (IPL) and interprofessional education, acknowledging the need for a more systematic approach to IPL, we have made significant progress in this area, under the leadership of the appointed IPL Academic Lead. Specifically, we have compiled the IPL Strategic Plan, which was approved by the MD programme committee in April, 2021 and provides opportunities for more systematic embedding of IPL in the MD programme across all years. The Strategic Plan clearly defines our objectives and specific actions and defines the timeframe for completion of each action and responsible person(s). Importantly, measures of achievement are included to allow us to monitor and reflect on our progress over the next three years. To ensure careful planning, implementation and monitoring, and following input from our International Advisory Board, in the current academic year, we are designing and implementing IPL activities in Years 1 and 4, in accordance with the IPL Implementation Plan, approved by the MD programme committee in July, 2021. Such activities include, for example, briefing sessions for students, training delivered to faculty members by the Centre for the Advantage of Interprofessional Education (CAIPE) and joint teaching sessions with students from other disciplines, e.g. Nursing

students. In the clinical environment, a wound care session is being planned for Semester 8, to take place at the University of Nicosia Medical Centre, for medical and nursing students. Further implementation will take place in 2022-2023 and 2023-2024, for Years 2 and 5 and Years 3 and 6, respectively, in line with our strategic plan. At the same time, students have opportunities for IPL experiences in Years 5 and 6, including communication skills sessions but also in the clinical environment where they learn about and from other healthcare professionals. For example, students participate in multidisciplinary team meetings in Psychiatry, nurse-led infusion therapy sessions in rheumatology and technician-led sessions in the pulmonary function and electroencephalography units. Furthermore, our students have a unique opportunity to participate in IPL activities through the Medical School's mobile clinic and its multiple health promotion events and health screening primarily in remote communities. Medical students have been accompanied by, in addition to members of our clinical faculty, other healthcare professionals such as physiotherapists, nurses and nursing students. Participation in the mobile clinic combines service to the community with rich learning opportunities about other health professions and alongside other learners and allows participation in a multidisciplinary effort. The mobile clinic is about to resume its activities after a pandemic-related interruption.

Members of the EEC watched several lectures, most of which were of good quality. There was one whose structure and slides were somewhat disorganised. All lectures were of a hybrid nature with some students joining online while others were present in the lecture theatre. The main format was didactic, but several lecturers engaged the students by asking direct questions. The interactivity however focused on a few members of the class. Seldom did we observe the teacher repeating questions and answers to ensure all students could hear them. We did not see the use of buzz groups or team-based learning to engage the quiet or reluctant students – and the closed question and feedback format never broke into a conversation or Socratic questioning to explore students' thinking and understanding. We did not see any opportunities for students to discuss questions amongst themselves before answering, so most of the interaction was lecturer-student-lecturer. [Standards 2.1, 6.3, and 6.5]

In regard to the delivery of lectures, we acknowledge that further work needs to take place to fully meet our aspirations for student-centred learning. We have in fact taken significant strides over the Spring Semester 2021 to train our faculty members (as described below) and pilot further implementation of student-centred teaching methodologies. For example, during the Spring Semester we implemented and piloted the flipped classroom methodology in pre-clinical years in the basic and social sciences. This has enabled us to collect faculty and student feedback, which will further inform our efforts in this area. Additionally, we have enhanced interactivity and peer-peer learning. For example, we have introduced integrated case studies in the pre-clinical years, which allow students to be active participants in the learning process, with their teachers taking on the role of a facilitator. Following the pilot phase of the Spring Semester, a meeting was held between faculty members to discuss their experiences and further implementation in the Fall Semester. We will continue to monitor the extent to which student-centred teaching is delivered and its quality through our quality assurance processes. For example, all Course Leads have provided their teaching plans and how their teaching will be modified to meet the School's student-centred objectives, as part of the planning process for delivery of the Fall Semester. Additionally, we have further updated the peer review and student feedback forms to place more emphasis on capturing activities that further encourage student interaction. In regard to the EEC's finding that teachers did not repeat questions to ensure they were audible for all students, we have placed emphasis on the importance of repeating questions not only for the sake of students attending face-to-face but also for those joining online. Lecturers have been made aware to be more mindful of this and the peer review

evaluation form specifically addresses this point.

We would also like to clarify that the observations of the EEC were based on the delivery of lectures. All courses are complemented with tutorials, which are small-group learning activities and allow students to take on a more active role in their own learning by attempting problems, discussing case studies and solving practice questions. The tutor facilitates, rather than teaches these sessions and students are provided with further opportunities for peer-peer learning.

The EEC observed approximately 10 episodes of clinical teaching in the hospitals. Unfortunately, we were not able to observe Workplace Based Assessment (WPBA). [Standards 2.5, 3.1, 3.2, 6.1, 6.2, 6.5 and 8.5].

It is noted that the EEC did not have the opportunity to observe WPBAs, which are very important assessment and learning activities that take place on a daily basis as key components of clinical training. This was related to the timing of the visit and the fact that the majority of WPBAs take place in the ward environment. We acknowledge that this would be helpful and we hope that the provision of student WPBA portfolios supported the work of the EEC.

Students assured the EEC that clinical teachers observed them practising and giving them constructive feedback. We did not see this interactive type of clinical teaching i.e., engaging the clinician, patient, and student. Instead of 'talk with patients' we observed 'talk about patients'. In the clinical discussions, taking place once the patient left the room, clinical teachers often chose to give information rather than engage students through questions and feedback. In turn, teachers were often questioned in depth by the students, and teachers failed to take the opportunity to turn this around to quiz the students. [Standards 2.5, 5.2, 6.2, 6.5 and 8.5]

We fully agree with the EEC that student-centred clinical education, built around meaningful student-patient interactions with clinical trainers engaging the students constructively and providing feedback, is a fundamental component of high-quality clinical training. We apply this principle in our clinical sites and we are pleased that our students have confirmed that this is indeed the case.

The configuration of certain clinical settings, such as the outpatient department with its inherent time and space constraints, may influence the teaching format. Moreover, we acknowledge that the process of training the trainers in medical education methodology is an ongoing one and we are fully committed to providing continuous support to all our clinical faculty in order to optimise the educational experience of our students. Our focus on appropriate training is exemplified by the fact that we have delivered just under 600 training sessions, with a third of them specifically delivered to clinical tutors across our clinical training sites. The following summarizes our overall approach to the training of clinical teachers. As part of the initial development of clinical sites, in-depth training is provided to clinical teachers by the Professor in Medical Education, Chair of Clinical Education and other senior academics. Some examples of training sessions delivered, that aim at ensuring that clinicians have the pedagogical knowledge needed to teach and assess students in the clinical environment, include: 1) Learning in context; 2) Teaching when time is tight; 3) Giving constructive feedback to students; 4) Introduction to the Doctor as a Professional (DAP) Domain and 5) Assessment In the clinical environment: WPBA. Other training sessions, aimed at familiarizing tutors with other aspects of the programme, and students' learning experience, such as introduction to the MD programme curriculum, student competency level at the start of clinical training and personal tutoring scheme are also delivered. Our 'train-the-trainer' strategy has further evolved to additionally offer tailored and individualized training sessions by the Chair of Clinical Education and curriculum leads, for example in relation to course-specific learning objectives and level-appropriate

delivery of assistantship-type attachments. Peer reviews also contribute to our clinical teacher support mechanisms. In addition to the comprehensive training afforded to new clinical teachers and individual guidance, we continue to deliver refresher training and emphasize the importance of student-centred learning. Our faculty development plan additionally addresses any areas for further training that may arise.

During the consultations we observed the difficulties arising from the need for translators for the students, when the practitioner and patient were speaking Greek. This caused a significant distraction away from a patient-centred consultation. [Standards 5.2, 6.2, and 6.5]
We agree with the EEC about the importance of the appropriate use of interpreters in medical education and we are committed to supporting those students whose Greek is not sufficiently developed by providing this service in relation to Greek-speaking patients. Our interpreters are specifically trained and are invaluable in supporting students in communicating with patients, primarily in the ward setting where they facilitate effective and meaningful communication and allow well-structured and complete history taking and examination. In specific circumstances, interpreters are trained to provide 'real time' translation of an ongoing clinical consultation, as is the case with patients being interviewed by psychiatrists which we understand is the example referred to by the EEC. Though this is a sensitive set up, we believe that this arrangement is least intrusive by not interrupting the doctor-patient interaction, and supports the engagement of the student with the specific type of patient history, though we will revisit the specific context and consider any necessary adaptations to ensure that patient centredness is not compromised. We are continually reviewing ways to achieve the seamless engagement of interpreters in consultations aiming for a positive experience for both students and patients and are committed to providing the relevant education and training to all involved. For example, students are trained on how to communicate with interpreters during their pre-clinical years, in preparation for their clinical years and we have plans to deliver equivalent training for clinical tutors.

We may not have observed an interactive approach that engaged the students directly with the patients, due to the vagaries of sampling but that seems unlikely since we observed 10 episodes of teaching. Alternatively, the clinical teachers may have been keen to demonstrate a well-organised session where they provided good teaching. Other possible explanations include lack of time during the consultation, language barriers, misconception of what was expected, or lack of skills amongst the educators. [Standards 5.2, 6.1, 6.2, and 6.5]
Students directly engaging with patients is an essential component of effective clinical education and we ensure that our students have ample opportunities to do so through scheduled clinical teaching sessions and time allocated to ward activity and we continually monitor the effectiveness of this approach through relevant feedback, including the end-of-attachment student feedback survey. We believe that scheduling constraints during the visit did not allow the observation of students engaging with teaching ward rounds, bedside teaching sessions or patient clerking on the wards. The majority of the interactions observed were in the outpatient setting and in the case of the Dialysis Unit, the EEC observed the Department Head introducing the students to the ward on the first day of the attachment. That said, we firmly believe that the outpatient setting also presents excellent opportunities for direct student-patient interaction, as is our experience in many of our sites. To that end, we will review the specific practical arrangements in our public hospitals to ensure that our students benefit from the use, for example, of specially-designated student rooms for parallel consultations. Moreover, we are fully committed to continuing to work with our clinical trainers to ensure that all clinical training opportunities are taken advantage of and that their clinical education approach and methodology continues to evolve. Our overall approach to training clinical teachers is described in more detail above and includes principles of teaching in the clinical

environment, for example learning in context, engaging students and providing constructive feedback as well as individual guidance provided to tutors.

We also observed 5 sessions of structured teaching of consultations and clinical skills in the simulated setting within the medical school. These were well devised to develop skills for challenging contexts. The tutorials were very well organised and efficient; the teachers were all enthusiastic and very well prepared. The sessions appeared engaging and stimulating for the learners though there appeared too much knowledge content in the time available; for example, not all students completed the examination of the cranial nerves under observation. Teachers spoke for much of the time, particularly in the cranial nerves' session, often imparting knowledge rapidly rather than waiting for students to retrieve information and think through their own next steps in the skills processes. [Standards 2.5, 5.2, 6.2, 6.5 and 8.5]

We are grateful that the EEC noted the well-structured clinical skills sessions and deemed them to be helpful in developing skills in challenging settings. We agree that it is important that time is allowed for students to practice their skills. Our aim for each session is to provide opportunities for all students to perform the examinations/procedures under supervision and receive feedback; sessions are structured in such a way as to minimize delivery of material. In particular, students are provided with reading material prior to the teaching session to ensure that they come prepared and thus minimize the need for didactic delivery of material. This may vary depending on the content and complexity of the topic at hand and tutor teaching style. Tutor training, peer evaluations and feedback during debriefs further ensures that tutors place more emphasis on providing opportunities for practice rather than imparting of knowledge. In case not all students are able to perform the examination/procedure, students are able to practice during clinical placements or at the end-of-semester review sessions. Additionally, we make the clinical skills labs available to students for self-directed learning, which further allows them to practice their skills. We will continue to monitor teaching in the clinical skills sessions to ensure that the balance between content delivery and student engagement remain appropriate.

Following the EEC's constructive comments and to further provide opportunities for students to practice their clinical skills and obtain feedback, we have introduced formative OSCEs in Year 2 and 3 as part of the Integrated Clinical Practice (ICP) course in the Fall Semester of the current academic year i.e. 2021-2022. Summative OSCEs have been maintained for the Spring Semester. From academic year 2022-2023 onwards, in line with the revised Scheme of Assessment for new students joining the programme this year and in line with our recently revised assessment strategy, assessment in the ICP courses will place even more emphasis on formative feedback, most suitable for the learning at this stage, through role plays, observation of procedures, peer and tutor feedback and reflective practice. Formative OSCEs will be delivered in the Spring Semester of Years 2 and 3.

In communication skills, the facilitator established at the outset what the student role player most wanted feedback on and at the end, after the student shared their reflections on their own experience then all present, including the Simulated/Standardised Patient (SP), peer students, and facilitator gave focused, constructive feedback. [Standards 2.5, 5.2, 6.2, 6.5 and 8.5]
We are thankful that the EEC noted the process of providing constructive feedback, which is focused on the learner and their own learning needs, rather than taking a teacher-centred approach.

The EEC also had a brief opportunity to speak to one of the Simulated/Standardised Patients who contributes to skills training and OSCEs. She had a good understanding of what is expected of her. She reported that she was carefully and repeatedly trained for the tasks. She was also trained to give feedback according to the sandwich method. [Standards 5.2, 6.2 and 6.5]
The training, mentoring and support system that was noted by the EEC for our simulated patients reflects our approach to professional development of all involved in the training of our students, including teachers. We consider training and on-going evaluation to be one of the key components that ensures the delivery of high-quality teaching sessions.

The students we met, now use a well-structured electronic portfolio and members of the EEC were able to review some of these with the students' consent. The portfolios evidenced a good range ofclinical skills having been signed off using rubrics and we noted that almost all were rated 'excellent'.There was no constructive feedback on how to improve on the samples we saw. Students told us that although clinicians gave them verbal feedback there was no time for the teachers to write in their portfolios and students were not permitted to do so. Students told us about a reflective overview section of their portfolio which they shared with us; this comprised a comprehensive log of activities with little reflection on their achievements and future learning needs. [Standards 2.4, 2.5, 3.2, 5.2, 6.2, 6.5 and 8.5]

In line with our aspirations to further utilize technology in our processes, with the ultimate aim of improving operational efficiency and the students' learning experience, we have introduced the e-portfolio *MyProgress* in the clinical years in the current academic year, with further implementation planned for the pre-clinical years in 2022-2023. *MyProgress* allows students to maintain a single electronic access point for all DAP-related activities, including WPBA, as noted by the EEC. We are very pleased that the EEC considered the e-portfolio well-structured and noted the good range of clinical skills that students have to complete. While students receive extensive verbal feedback, we consider the provision of written feedback to be an essential component of reflective learning and a very valuable learning resource. We continue to deliver refresher training to our WPBA assessors and emphasize the importance of written feedback. In addition to real time training provided by the DAP Lead and Professor in Medical Education, recognizing the challenging circumstances of the pandemic, we have also provided our assessors with videos on assessment of mini-CEX, CBDs and DOPS, which they can complete at their own time. Moreover, we are making the inclusion of written feedback mandatory for the successful submission of the WPBAs. This will be implemented on a pilot basis for Semester 8 in Spring, 2022, with full implementation in Years 5 and 6 in the academic year 2022-2023.

In regard to the reflective portfolio, following the EEC's constructive comments, we have now introduced a reflective portfolio in all six years of the MD programme, as part of the DAP assessment domain. We acknowledge that further work needs to take place for the reflective portfolio to reach its full potential. Similar to the quality assurance processes for any new developments in the MD programme, we have carefully formulated an implementation and monitoring plan. The DAP Lead delivered briefing sessions to students to introduce the e-portfolio, reflective practice and how to make the most of the reflective portfolio. Students are expected to move beyond simply describing what happened, to analysing why it happened, what they felt and thought, what they have learned as a result and how this impacts on their future practice. Additionally, students have been provided with written guides to support them to make the most of their reflective portfolios and the forms that students have to complete have been structured in such a way to explicitly require students to reflect on these experiences, rather than to simply state them. Finally, students are required to discuss their reflective pieces with their personal tutors in pre-clinical years and their clinical lead during clinical years to ensure maximum insight is gained from

learning opportunities in the classroom and clinical environment. As part of on-going monitoring, the reflective portfolio is discussed at the MD programme committee, which receives reports from the DAP lead, and we also receive valuable feedback from our external examiners, who receive samples of the students' portfolios, including WPBA and the reflective accounts. Additionally, student feedback informs any changes. Actions are clearly set to address any areas for improvement.

Role modelling of excellent clinical practice was limited; it was not clear to what extent various factors contributed including small rooms without curtained off examination couches, language barriers, use of a translator for teaching, lack of experience of clinical teaching that engaged the teacher, student, and patient, or cultural influences on clinical practice. We observed a doctor-centred, paternalistic approach, rather than patient-centred clinical practice. There is a concern that the good work done in simulation sessions may decay very quickly if clinicians do not have the facilities, time, and training to demonstrate and teach using patient-centred practice. [Standards 2.5, 5.1, 5.2, 6.1, 6.2, 6.5 and 8.5]

We agree with the EEC that the application of patient-centredness in clinical practice is an essential component of the delivery of high-quality clinical education and we are pleased to note that the EEC considers the skills training at the Medical School to provide a good basis for such an approach. The participation of clinical trainers in School-based skills teaching provides such continuity and we aim to expand this scheme appropriately. Moreover, additional 'train-the-trainer' activities will illustrate best practice in that respect.

We fully agree with the EEC about the importance of role models and we receive, throughout the academic year, multiple references to members of the healthcare team as providing excellent teaching through student feedback. Following the EEC's constructive comments, we have additionally included a new question for students to note the names of clinical teachers they consider as role models. Furthermore, we have more recently introduced the Student-Led Excellence Awards (SLEAs) for Teaching and Administration. This is an awards scheme exclusively led by students and recognizes excellent performance of both administrators and teachers, including those in the clinical years. This further encourages our clinical teachers to continue working towards further improvement of the student learning experience.

We acknowledge that the EEC have encountered a small sample of training activity where the engagement of the clinical trainers could be improved. It is important, however, to point out that there is ample evidence that our students are truly inspired by clinical trainers, who have a wealth of experience. This is continually evidenced through student feedback and surveys and the outstanding success of our graduates overall at the Medical School with virtually all of them (99.8%) working in more than two hundred medical centres around the world including some of the world's leading institutions. Additionally, evidence from graduate surveys, demonstrates overwhelmingly that our alumni feel prepared for their clinical roles, making very good use of their undergraduate training and are keen to continue to engage with the School and provide support to current students. We were pleased to note that 100% of our recent MD graduates would recommend the University of Nicosia Medical School to their friends and relatives.

That said, our aim is for a more consistent experience for our students and we continue to work towards that end, as described above. In terms of the issues of facilities and time availability, we continue to work with our partners in the SHSO to factor educational considerations into current and planned development work and with our site Academic Leads and Hospital leadership to facilitate the teaching commitments of clinical trainers.

Strengths

1. **Highly motivated, well informed academic and clinical teachers who are respectful of their students and keen to help them learn. [Standard 5.1]**

   The EEC's positive comments about our teachers, both in the classroom and in the clinical environment, are appreciated. We are committed to providing both academic and pastoral support to our students to help them excel in their studies and future practice.

2. **High quality estate and facilities in the Medical School and University of Nicosia. [Standards 6.1, 6.2 and 6.3]**
   We consider our state-of-the-art infrastructure to be of the utmost importance in the delivery of high-quality education and we are pleased that this was ratified by the EEC.

3. **An excellent University of Nicosia Medical Centre with potential to develop holistic primary (and specialist) care within Cyprus, and to educate students on this approach. [Standards 6.1, 6.2, 6.4 and 8.5]**
   The EEC's comments are very much appreciated. Our aspirations for our own Medical Centre are to provide patient-centred care within the auspices of the national healthcare system for the benefit of the community, which also serves as a model teaching centre for our medical students. The healthcare team is multidisciplinary and also includes nurses, a pharmacist, a dietician, a laboratory assistant, administrative staff and our medical students. It is thus ideally placed to support student clinical training in general and in IPL more specifically.

4. **Effective use of teaching in the simulated setting (clinical skills and communication) with well-trained Standardised Patients. [Standards 2.5, 6.2 and 6.5]**
   We pride ourselves in the way we deliver teaching in clinical and communication skills, following the latest pedagogy in medical education and ensuring our teachers and simulated patients are appropriately trained, and it is gratifying that this was noted by the EEC.

5. **Feedback in role play sought from all present including self, peers, and the Standardised Patient, with the facilitator asking the student about their required focus for feedback. [Standards 3.2 and 6.5]**
   As mentioned above, this reflects the School's student-centred approach that we continue to enhance in all aspects of our teaching.

6. **Enthusiastic students, very supportive of the School and its community. [Standards 2.1, 2.7, 4.3, 6.2]**
   We place great emphasis on engaging the students in all processes and this has been important in helping us further improve the MD programme. We rely on the students' support and enthusiasm and we are pleased to note that this was evident in the interactions of the EEC with our students.

7. **Quality processes that regularly evaluate the courses and programme, and faculty responsive to students. [Standards 7.1, and 7.2]**
   We consider quality assurance at all levels - School, Department and programme - to be critically important. Feedback from all stakeholders is carefully considered in informing decisions. We strive to deliver the curriculum in a supportive learning environment and faculty members provide extensive

support to students, as acknowledged by the EEC.

Areas for improvement and recommendations

1. **Developments in the hospital must take account of the needs of clinical teaching. [Standards 6.1, 6.2 and 8.5].**

   We agree with the EEC that developments in the hospital must consider the needs of clinical teaching. In reference to physical facilities, as highlighted previously, we continue to work very closely with the SHSO in the plans for improvement in the infrastructure of the public hospitals we utilize for clinical training. The Medical School has in fact already taken the initiative to upgrade the library facilities and fully equip a designated clinical skills room at Limassol General Hospital to further improve the student learning experience and ongoing work at Paphos General Hospital will provide student access to an onsite clinical skills lab.

   Our governance structures ensure that developments in the hospital take into account the needs of clinical teaching. The existing high-level management structure of the Steering committee is responsible for the smooth implementation of the legally-binding Student Training Agreements between the Medical School and the clinical education providers. To further strengthen the governance structures for clinical training at the operational level, curriculum leads will oversee and coordinate clinical training across the MD programme.

2. **The Portfolio should be developed further, with more focus on constructive feedback and students' reflections; written feedback should be explicit. [Standard 2.8, 3.2, 5.2, 6.2, and 6.5]**

   We agree that constructive feedback is an important aspect that facilitates student development in key areas such as history taking, clinical reasoning and clinical skills. As ratified by the EEC, verbal feedback is provided. In regard to written feedback, as explained above, we are implementing mandatory written, specific and constructive feedback for WPBA submission for Semester 8 in Spring 2022, with full implementation planned for Years 5 and 6 in the new academic year 2022-2023.

   In regard to the reflective portfolio, as described above, we acknowledge the need for further development of the reflective portfolio, which is in its first year of implementation. We have carefully formulated an implementation and monitoring plan, which will allow us to identify what is working well and areas for improvement to further increase the utility of both the reflective portfolio and *MyProgress* for the following academic year.

3. **The School must continue to develop a systematic and longitudinal faculty development programme for both academic and clinical teachers that includes the following: patient-centred communication and clinical practice; clinical teaching that encourages student-patient interactivity, and moves away from a didactic approach; working with a translator in the consultation; feedback to learners using a modern framework; collaborative learning amongst students; student-teacher interactivity; and use of the 'flipped classroom', especially where the session with experts should focus on application of knowledge such as skills and communication sessions, revision quizzes and problem-solving workshops. [Standards 2.5, 2.8, 3.2, 5.2, 6.5 and 8.5]**

   In line with the EEC's constructive recommendations, we have invested much time and effort in

further supporting our faculty's personal and professional development to support student-centred learning. Specifically, the Medical Education team at the Medical School, in association with the Pedagogical Support Unit (PSU) of the University of Nicosia, has provided access to a number of in-house and external training sessions, including those organized by the internationally recognised, Association for Medical Education in Europe (AMEE). Tutors have received training on student-centred learning, interactivity in large group audiences, flipped classroom and team-based learning, which allows for collaborative learning. The training topics were selected to address faculty needs as reported through the annual peer review and evaluation systems, and to ensure access for faculty to recent developments in higher education, including the methodologies recommended by the EEC, for example flipped classroom. Further, the Medical Education team has made several resources, ranging from teaching on how to enhance PowerPoint slides for improved student engagement to sharing tips for classroom management strategies and techniques, available on Moodle.

We agree with the EEC's comments that the communication and clinical skills sessions should utilize the flipped classroom methodology and this is in fact the primary mode of delivery, whereby students are provided with reading/recorded material prior to the session and teaching contact time is focused on addressing questions and allowing students to practice. As noted by the EEC, the balance of didactic teaching and student engagement in such sessions may vary, for example due to the complexity of the topic at hand. It is also acknowledged that revision and problem-solving quizzes are well-placed to support the flipped classroom methodology and we have in fact embedded this in all pre-clinical years in the MD programme this academic year.

In regard to the EEC's comment about providing feedback to learners, using a modern framework, we are pleased to clarify that we no longer use the 'sandwich' methodology. Instead we use the Agenda-Led Outcome-Based Analysis (ALOBA) model. More specifically and as noted by the EEC during the communication skills sessions, in line with this model, the student is first asked to discuss which aspects they would like to focus on before the role play. The SP, other students and finally the tutor provide feedback, after the student reflects on their own performance. Students also provide written feedback for the observed student. To further support all students to improve the way they provide feedback, the observed student is asked to indicate on the back of the form if the feedback from their peers was 'Very helpful', 'Somewhat helpful' or 'Not helpful' and provide additional comments, if needed. With this exercise we intend to help students improve their feedback skills and also further recognize the importance of providing constructive feedback. As we shift the focus towards constructive, formative feedback in other courses, the ALOBA methodology can be further implemented, including in the clinical environment.

In reference to the training offered to clinical teachers, our systematic, longitudinal approach to training is described previously in more detail, with training firstly provided at the planning stage prior to teachers engaging with clinical teaching, including principles of teaching and assessing in the clinical environment. This includes sessions specifically designed to address the need for learning in context and when time is tight, engaging students in meaningful student-patient interactions, providing constructive feedback to learners and work-place based assessment. The one-on-one follow up training sessions with the Chair of Clinical Education or curriculum leads, provide additional tailored guidance that are attachment-specific and are a key component of our training activities. Refresher training reinforces the principles of effective clinical education and we are currently planning for the delivery of additional training sessions to address demonstrating patient-centredness and interactive learning. Moreover, we will enhance peer review of clinical training and provide more tailored support to our clinical faculty. We will also introduce specific training for clinical trainers aimed

at optimising the interaction with interpreters in clinical consultations, which will further support the learning of our students. Training needs are assessed on a continuous basis and these are taken into consideration as part of our faculty training plan. .

4. **The School should consider embarking on interprofessional education in the clinical setting. [Standards 2.4, 2.5 and 2.8]**
The importance of IPE in the clinical setting is an important objective in our IPL strategic development plan, which we have previously shared with the EEC. The plan sets out goals, objectives and milestones over the next three years. In addition to classroom-based activities, as described above, for the current academic year, activities in the clinical environment are planned, utilizing the University of Nicosia Medical Centre for the upcoming Spring Semester. Further implementation is planned for academic years 2022-2023 and 2023-2024 in Years 5 and 6, respectively. For example, our plans include building on learning with students from other healthcare fields, including nutrition, nursing and physiotherapy students, who also complete their training in public and private hospitals used for the training of our medical students.

5. **The School should consider requiring students to be able to speak Greek to their patients, even if the teaching is in English. [Standards 2.4, 2.5 and 2.8]**

The language of teaching, clinical instruction and clinical supervision is English and the fact that English is widely spoken in Cyprus, with up to 80% of the population using English as a second language, facilitates English-language consultations. That said, we acknowledge that students interact with Greek-speaking patients and as mentioned above, Medical School-appointed interpreters facilitate effective interaction and completion of programme requirements in English. We remain committed to maximizing their usefulness, with minimal disruption to the patient-doctor interactions and patient-centred consultations. They are each provided with training by our Clinical Communications team as well as onsite training by the Chair of Clinical Education.

While students are not required to speak Greek, they are strongly encouraged to join Greek language classes offered by the Medical School for free, throughout the duration of their programme. These are scheduled at times to best fit with the students' schedules and are delivered online to increase accessibility to all students in Years 1-6. Additionally, we deliver online sessions specifically catering to the needs of students in their clinical years twice a week. We agree that knowledge of the Greek language could enrich the students' learning experience in some settings and we will continue to review the effectiveness of current practice and consider whether speaking Greek in the clinical environment could become a requirement.

UPDATE TO COMPLIANCE SCALES

The committee has reviewed all the compliance decisions submitted in the October 2020 report; all remain accurate except for Sub-area 6.1 and 6.2 which have been updated from *Not applicable* to *Partially compliant*, as shown below.

Sub-area		***Non-compliant/Partially compliant/Compliant/Not applicable***
6.1	Physical facilities	Partially compliant
6.2	Clinical training resources	Partially compliant
6.3	Information technology	Compliant
6.4	Medical research and scholarship	Partially compliant
6.5	Educational expertise	Partially compliant
6.6	Educational exchanges	Compliant

We would like to express our gratitude to the Rector of the University, the Dean of the Medical School, and the MD Programme Director, along with the many members of staff at the University, Limassol and Paphos General Hospitals, and the University Medical Centre, as well as the students, patients, and other stakeholders, who have all engaged with the visit so constructively and who have given their time generously to help us observe and learn so much during our short visit.

We remain very grateful for the insightfulness shown by the EEC and wish to thank them for their considerable time during what has been a very challenging period. We are confident that implementation of the EEC's recommendations has further improved the MD programme.

The External Evaluation Committee
6 November 2021

Signatures of the EEC who visited on 4 and 5 October 2021

Name	***Signature***
Professor Helen Cameron	Helen Cameron
Professor Reinold Gans	R. Gans
Professor Matthias Siebeck	[signature]
Dr Philippos Stylianou	
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