Self-evaluation Report 2014
Faculty of Medicine, The University of Tokyo

In Accordance with Basic Medical Education
WFME Global Standards for
Quality Improvement

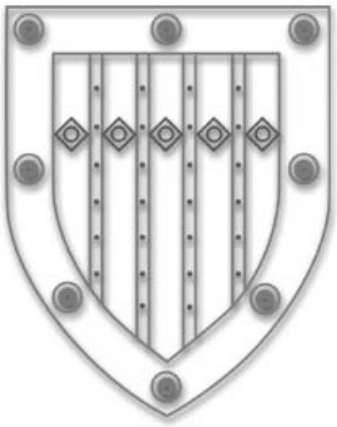


TABLE OF CONTENTS

ABBREVIATIONS

AAC: Academic Affair Committee

AAAD: Academic Affair Administrative Division

CAS: College of Arts and Sciences (basic curriculum for 1st and 2nd year students, located at Komaba campus)

CAT: Common Achievement Test (All the students who start clinical clerkships must pass CBT for knowledge and OSCE for clinical skills. Examination contents are offered by the CAT organisation, a third party)

CBEL: Centre for Biomedical Ethics and Law

CBT: computer-based testing (MCQ and extended matching items offered by CAT to assess knowledge before CC start)

CC: clinical clerkship

CDBIM: Center for Disease Biology and Integrative Medicine

CME: continuing medical education

CPD: continuing professional development

DOPS: direct observation of procedural skills

EC: elective clerkship (Additional clerkship system other than CC but some students allocate this period for research work)

EEFSU: Entrance Examination Follow-up Survey Unit

FD: faculty development

FM: Faculty of Medicine

FMUT: Faculty of Medicine, The University of Tokyo

FQ: free quarter (temporal assignment to a department for a research project)

GSM: Graduate School of Medicine

GSMUT: Graduate School of Medicine, The University of Tokyo

IR: Institutional Research

IRCME: International Research Centre for Medical Education

IRT: item response theory

MERWG: Medical Education Reform Working Group

MEXT: Ministry of Education, Culture, Sports, Science and Technology

MHLW: Ministry of Health, Labour and Welfare

mini-CEX: mini clinical evaluation exercise

OBE: outcome-based education

OIAA: Office of International Academic Affairs

OSCE: objective structured clinical examination

PBM: Professors' Board Meeting (for professors and associate professors)

PCA: Preparatory Committee for Accreditation

PGME: postgraduate medical education

SIH: School of International Health

SIHS: School of Integrated Health Sciences

SMFMUT: School of Medicine, Faculty of Medicine, The University of Tokyo

SP: simulated patient

SSU: Student Support Unit

TA: teaching assistant

UGME: undergraduate medical education

UGY1: undergraduate Year 1 (interchangeable to 2-6)

UH: University Hospital

UT: The University of Tokyo

UTH: The University of Tokyo Hospital

WG: working group

1. MISSION AND OUTCOMES

1.1 STATEMENT OF MISSION

Basic standard:

The medical school **must**

- define its mission and make it known to its constituency and the health sector it serves. (B 1.1.1)
- in its mission statement outline the aims and the educational strategy resulting in a medical doctor
  - competent at a basic level. (B 1.1.2)
  - with an appropriate foundation for future career in any branch of medicine. (B 1.1.3)
  - capable of undertaking the roles of doctors as defined by the health sector. (B 1.1.4)
  - prepared and ready for postgraduate medical training (B 1.1.5)
  - committed to lifelong learning (B 1.1.6)
- ensure that the mission encompasses the health needs of the community, the needs of the health care system and other aspects of social accountability. (B 1.1.7)

Quality development standard:

The medical school **should**

- ensure that the mission encompasses
  - medical research attainment. (Q 1.1.1)
  - aspects of global health (Q 1.1.2)

Annotations:

- *Mission* provides the overarching framework to which all other aspects of the educational institution and its programme have to be related. Mission statement would include general and specific issues relevant to institutional, national, regional and global policy and need. Mission is in this document supposed to include the institutions' vision.
- *Medical school* in this document is the educational organisation providing a basic (undergraduate) programme in medicine and is synonymous with medical faculty, medical college or medical academy. The medical school can be an independent institution or part of or affiliated to a university. It normally also encompasses research and clinical service functions, and would also provide educational programmes for other phases of medical education and for other health professions. Medical schools would include university hospitals and other affiliated clinical facilities.
- *Constituency* would include the leadership, staff and students of the medical school as well as other relevant stakeholders (see 1.2 annotations).
- *Health sector* would include the health care delivery system, whether public or

private, and medical research institutions.

- *Basic level of medical education* is in most countries identical to undergraduate medical education starting on the basis of completed secondary school education. In other countries or schools it starts after completion of a non-medical undergraduate degree.
- *Any branch of medicine* refers to all types of medical practice, administrative medicine and medical research.
- *Postgraduate medical training* would include preregistration training, vocational training and specialist training.
- *Lifelong learning* is the professional responsibility to keep up to date in knowledge and skills through appraisal, audit, reflection or recognised continuing professional development (CPD)/continuing medical education (CME) activities. CPD includes all activities that doctors undertake, formally and informally, to maintain, update, develop and enhance their knowledge, skills and attitudes in response to the needs of their patients. CPD is a broader concept than CME, which describes continuing education in the knowledge and skills of medical practice.
- Encompassing the health needs of the community would imply interaction with the local community, especially the health and health related sectors, and adjustment of the curriculum to demonstrate attention to and knowledge about health problems of the community.
- *Social accountability* would include willingness and ability to respond to the needs of society, of patients and the health and health related sectors and to contribute to the national and international developments of medicine by fostering competencies in health care, medical education and medical research. This would be based on the school's own principles and in respect of the autonomy of universities.

  Social accountability is sometimes used synonymously with social responsibility and social responsiveness. In matters outside its control, the medical school would still demonstrate social accountability through advocacy and by explaining relationships and drawing attention to consequences of the policy.
- *Medical research* encompasses scientific research in basic biomedical, clinical, behavioural and social sciences and is described in 6.4.
- *Aspects of global health* would include awareness of major international health problems, also of health consequences of inequality and injustice.

B 1.1.1 The medical school **must** define its mission and make it known to its constituency and the health sector it serves.

(A) Basic information

Mission Statement of Undergraduate Medical Education (UGME), Faculty of Medicine, The University of Tokyo (FMUT) was determined in 2000.

The University of Tokyo Faculty of Medicine serves Japan and the world by contributing new knowledge through research and providing an exemplary education to medical students who will become future leaders in the life sciences, clinical research, and the clinical practice of medicine. To prepare our graduates for the major challenges they will face, we seek to support their professional development as physicians with creative and inquiring minds, an appreciation of the principles of medical practice, and a sound foundation in both the scientific and humanistic aspects of medicine.

This mission statement is printed in the rules and regulations of the Faculty of Medicine, the homepage of FMUT (only in Japanese), syllabi and timetable of classes to inform students and faculty members.

The University of Tokyo (UT) Charter[1] was written in 2003 (effective from March 28, 2003), using elements from theMission Statement of Faculty of Medicine to prepare for privatization of corporation of UT in April 2004.

(B) Analysis and self-evaluation

Both students and faculty members will know the mission statement from various sources listed above.

(C) Current action

Currently the mission statement written in 2000 is not regarded as old. Therefore, in this process of accreditation, the mission statement above is used to evaluate the education in School of Medicine, Faculty of Medicine, the University of Tokyo (SMFMUT).

(D) Plan for future improvement

In the near future, the mission statement may possibly change to promote educational reform.

B 1.1.2 The medical school **must** in its mission statement outline the aims and the educational strategy resulting in a medical doctor competent at a basic level.

(A) Basic information

Two main components of "The Mission Statement of FMUT" are (1) creative and inquiring minds and (2) a sound foundation in both the scientific and humanistic aspects of medicine.

[1] The Charter of The University of Tokyo (http://www.u-tokyo.ac.jp/en/about/charter.html)

(B) Analysis and self-evaluation

The Mission statement covers competencies of a medical doctor at a basic level.

(C) Current action

SMFMUT as a whole should enhance its awareness for humanistic aspects of medicine. Whole person care is included in the educational outcomes of SMFMUT as determined in September 2014.

(D) Plan for future improvement

New evaluation methods must be developed to determine whether the education in SMFMUT satisfies the needs of society or the whole country. Moreover, educators' consciousness should be jncreased, especially regarding research ethics education.

B 1.1.3 The medical school **must** in its mission statement outline the aims and the educational strategy resulting in a medical doctor with an appropriate foundation for future career in any branch of medicine.

(A) Basic information

The Mission Statement of FMUT states the requirement for a sound foundation in both the scientific and humanistic aspects of medicine.

(B) Analysis and self-evaluation

SMFMUT declares a strong will to promote and develop research in biomedical, medical and practical aspects.

(C) Current action

Based on the Mission Statement, SMFMUT defined educational outcomes in September 2014.

(D) Plan for future improvement

In UGME, SMFMUT would like to strengthen the concept of whole person care.

B 1.1.4 The medical school **must** in its mission statement outline the aims and the educational strategy resulting in a medical doctor capable of undertaking the roles of doctors as defined by the health sector.

(A) Basic information

The Mission Statement of FMUT states a sound foundation in both the scientific and humanistic aspects of medicine.

(B) Analysis and self-evaluation

This mission statement emphasises the intention to solve biomedical, medical and practical issues by creative research. Many medical students learn how doctors should serve society through extracurricular or self-directed learning activities. On the other hand education for professionalism may be a weakness.

(C) Current action

Based on the Mission Statement, SMFMUT defined educational outcomes in September 2014.

(D) Plan for future improvement

In various opportunities including during faculty development (FD), faculty members should discuss the future vision of medical students.

B 1.1.5 The medical school must in its mission statement outline the aims and the educational strategy resulting in a medical doctor prepared and ready for postgraduate medical training.

(A) Basic information

Mission Statement of FMUT states the requirement for a sound foundation in both the scientific and humanistic aspects of medicine.

(B) Analysis and self-evaluation

The clinical clerkship (CC) has been enhanced since 2013, with an increased emphasis on self-directedness.

(C) Current action

Clinical education has been enhanced. For example, CC previously started from the beginning of UGY5, but since January 2013 it now starts from UGY4. Management of CC has many points to reform, therefore various improvements have been introduced.

(D) Plan for future improvement

Relation between clinical experiences in CC and competencies for PGME should be clarified by questionnaires to graduates etc.

B 1.1.6 The medical school must in its mission statement outline the aims and the educational strategy resulting in a medical doctor committed to lifelong learning.

(A) Basic information

The Mission Statement of FMUT includes developing professionals with creative and inquiring minds, which means that medical students are encouraged to pursue life sciences, clinical research and the clinical practice of medicine while continuously seeking solutions with lifelong learning strategies.

(B) Analysis and self-evaluation

Since FMUT is managed in the form of a unified organisation with the Graduate School of Medicine, The University of Tokyo (GSMUT), faculty members are continuously involved with the career development of medical students in both UGME and postgraduate medical education (PGME) to naturally accept the mission for life-long learning.

(C) Current action

Much discussion about how SMFMUT should approach life-long learning was held in four FD workshops in 2014. Although SMFMUT always advocates the importance of nurturing researchers, further consideration is needed about whether the whole curriculum is designed and implemented for such an aim.

(D) Plan for future improvement

For the future we will establish a tracking system for graduates to support better life-long learning.

B 1.1.7 The medical school must ensure that the mission encompasses the health needs of the community, the needs of the health care system and other aspects of social accountability.

(A) Basic information

Mission Statement of FMUT states "to prepare our graduates for the major challenges they will face, we seek to support their professional development as physicians with creative and inquiring minds, an appreciation of the principles of medical practice, and a sound foundation in both the scientific and humanistic aspects of medicine."

(B) Analysis and self-evaluation

The social needs, requirements related to the health and well-being of society and medical practice systems, and other social accountability issues are included in the Mission Statement.

(C) Current action

Faculty members of FMUT recognise that a description of the social aspects of medicine in the Mission Statement is relatively weak. However, we feel that social accountability issues are included in the Mission Statement.

(D) Plan for future improvement

If leadership development at the international level or national level is declared, then direct statements about the links with society will be important. Therefore, an objective to promote the social aspect of medical care should be considered.

Q 1.1.1 The medical school should ensure that the mission encompasses medical research attainment.

(A) Basic information

The Mission Statement of FMUT states "to prepare our graduates for the major challenges they will face, we seek to support their professional development as physicians with creative and inquiring minds, an appreciation of the principles of medical practice, and a sound foundation in both the scientific and humanistic aspects of medicine." Along with this, the following three projects (one course and two programmes) were developed.

A PhD-MD course in FMUT has been running since 2001 and is supported by the centennial memorial project by Tetsumon Club, the Alumni Association of SMFMUT. The MD Researcher Programme began in 2008 and the Clinical Researcher Development Programme began in 2010. In other words, SMFMUT has further strengthened the vision of enhancing researcher development.

(B) Analysis and self-evaluation

It is considered that these three projects characterise the curriculum of SMFMUT the most. One issue concerning the PhD-MD course is the low student enrollment.

(C) Current action

Those involved in these projects feel that they are functioning. Since a tracking study for graduates from the MD researcher programme has been started, data will be stored for ongoing evaluation.

(D) Plan for future improvement

In a certain period we will evaluate the course and the programmes to improve them.

Q 1.1.2 The medical school **should** ensure that the mission encompasses aspects of global health

(A) Basic information

The Mission Statement of FMUT states " to prepare our graduates for the major challenges they will face, we seek to support their professional development as physicians with creative and inquiring minds, an appreciation of the principles of medical practice, and a sound foundation in both the scientific and humanistic aspects of medicine." In addition, GSMUT has an International Health Department. The International Health Department offers classes on international community health and parasitology, and practical training for public health. Some students visit South East Asian Countries under the SMFMUT curriculum.

In addition, two full-time faculty members are placed in the Office of International Academic Affairs (OIAA)[2] and one part-time overseas faculty member is intermittently hired in the International Research Centre for Medical Education (IRCME)[3]. High attention is paid to international exchange and practical training for students.

(B) Analysis and self-evaluation

SMFMUT has various components of international health.

(C) Current action

Foundation to teach international health is sufficient.

(D) Plan for future improvement

Ongoing evaluation is needed to track how much education is offered from the viewpoint of contributions to international health including developing countries, and

[2] Office of International Academic Affair (http://koryu.m.u-tokyo.ac.jp/homepage00.html)

[3] International Research Centre for Medical Education (http://www.ircme.m.u-tokyo.ac.jp/en/)

whether faculty members in the International Health Department remain sufficiently involved in the curriculum of SMFMUT.

1.2 PARTICIPATION IN FORMULATION OF MISSION

Basic standard:

The medical school **must**

- ensure that its principal stakeholders participate in formulating the mission. (B 1.2.1)

Quality development standard:

The medical school **should**

- ensure that the formulation of its mission is based also on input from other relevant stakeholders. (Q 1.2.1)

Annotations:

- *Principal stakeholders* would include the dean, the faculty board/council, the curriculum committee, representatives of staff and students, the university leadership and administration, relevant governmental authorities and regulatory bodies.
- *Other relevant stakeholders* would include other representatives of academic and administrative staff, representatives of the community and public (e.g. users of the health care delivery system, including patient organisations), education and health care authorities, professional organisations, medical scientific bodies and postgraduate educators.

B 1.2.1 The medical school must ensure that its principal stakeholders participate in formulating the mission.

(A) Basic information

Professor Inui, a visiting professor under the International Research Centre for Medical Education (IRCME) established in 2000 (initially founded as a separate centre from the FMUT under the umbrella of the whole University of Tokyo), facilitated the discussion to develop the mission statement of FMUT in the Inui Project for the FMUT Reform Committee from July to September 2000. The committee finalised the mission statement and Professor Inui confirmed the English version. The ten members involved in the process were professors and associate professors, a director, a chief professor, an instructor in IRCME, the dean of FMUT and the director of the University of Tokyo Hospital (UTH). They had extensive discussions, finalised the final version, and endorsed the mission statement in the Professors' Board Meeting (PBM).

The discussion of the UT Charter was started December 2001 when the UT21 Committee was formulated. The nine-member committee included the president of UT, a vice president, four deans of graduate schools, a director of a research institute, and two lieutenant presidents. A draft version of the Charter was produced in November 2002, and subsequent to eliciting comments from all the departments, was endorsed in March 2003.

(B) Analysis and self-evaluation

Deans, professors and curriculum committee members were included. These faculty members had the information and experiences that were thought to reflect the voices of staff, students, executive members, related ministries and regulatory organisations.

(C) Current action

No student or faculty member has stated any opinion to revise the mission statement of FMUT.

(D) Plan for future improvement

When the mission statement is next revised, wider voices from various stakeholders will be collected.

Q 1.2.1 The medical school **should** ensure that the formulation of its mission is based also on input from other relevant stakeholders.

(A) Basic information

Those who were not involved in academic administration or postgraduate training, public or community health, education or health-related organisations and health professional associations were not directly involved in the development of mission statement.

(B) Analysis and self-evaluation

Those members involved in academic administration and management of FMUT were representing the voices from postgraduate training, representatives from public or community health, education or health-related organisations and health professional associations.

(C) Current action

Measures to ask opinions to revise the mission statement of FMUT.

(D) Plan for future improvement

Measures to ask opinions from society should be considered.

1.3 INSTITUTIONAL AUTONOMY AND ACADEMIC FREEDOM

Basic standard:

The medical school **must** have institutional autonomy to

- formulate and implement policies for which its faculty/academic staff and administration are responsible, especially regarding
  - design of the curriculum. (B 1.3.1)
  - use of the allocated resources necessary for implementation of the curriculum. (B 1.3.2)

Quality development standard:

The medical school **should** ensure academic freedom for its staff and students

- in addressing the actual curriculum. (Q 1.3.1)
- in exploring the use of new research results to illustrate specific subjects without expanding the curriculum. (Q 1.3.2)

Annotations:

- *Institutional autonomy* would include appropriate independence from government and other counterparts (regional and local authorities, religious communities, private co-operations, the professions, unions and other interest groups) to be able to make decisions about key areas such as design of curriculum (see 2.1 and 2.6), assessments (see 3.1), students admission (see 4.1 and 4.2), staff recruitment/selection (see 5.1) and employment conditions, research (see 6.4) and resource allocation (see 8.3).
- *Academic freedom* would include appropriate freedom of expression, freedom of inquiry and publication for staff and students.
- Acting in keeping with the *actual curriculum,* staff and students would be allowed to draw upon different perspectives in description and analysis of medical issues.
- *Curriculum* (see the definition in 2.1, annotation).

B 1.3.1 The medical school **must** have institutional autonomy to formulate and implement policies for which its faculty/academic staff and administration are responsible, especially regarding design of the curriculum.

(A) Basic information

The Academic Affair Committee (AAC) of FMUT and its working groups (WGs) are responsible for curricular design with enough autonomy. WGs are formulated ad hoc when the AAC demand them.

Currently, a curricular reform committee of the College of Arts and Sciences (CAS) is leading curricular reform involving all the faculties (colleges) in UT. Two members of FMUT participate in the committee as official members. A panel meeting for "reviewing Natural Sciences III" involving FMUT AAC members and CAS UT curriculum reform members has been held two times, February and May 2014. A proposal for curricular reform involving both CAS and all the faculties in UT is under discussion.

(B) Analysis and self-evaluation

Institutional autonomy of all the departments and faculty members regarding curriculum development is highly maintained.

(C) Current action

The level of knowledge and experience of all the departments and faculty members regarding curriculum development is not evaluated very well.

(D) Plan for future improvement

FMUT should discuss if they should change the system to manage the detailed content of the curriculum and educational methods.

B 1.3.2 The medical school **must** have institutional autonomy to formulate and implement policies for which its faculty/academic staff and administration are responsible, especially regarding use of the allocated resources necessary for implementation of the curriculum.

(A) Basic information

Resource allocation in FMUT is discussed and determined in the budget committee and construction committee. As for the budget, independent items are recorded for travel fees and compensation for extramural lecturers, stipends for teaching assistants (TAs), expenses for CC and extramural practicum trainings, expenses for the memorial service for dissected bodies, expenses for the MD researcher programme, and expenses for training simulated patients (SPs). Other budget items are allocated for each department including both GSM UT and FMUT.

(B) Analysis and self-evaluation

The necessary budget for education in FMUT is secured to some extent. The information necessary to determine if each department appropriately deals with their resources is not sufficient.

(C) Current action

Each department manages the resources for research, education and service provision for itself. Executive members do not manage each item of resource for each department.

(D) Plan for future improvement

FMUT should further discuss whether resource allocation is sufficient for education.

Q 1.3.1 The medical school **should** ensure academic freedom for its staff and students in addressing the actual curriculum.

(A) Basic information

Professors and associate professors have opportunities to express opinions on the curriculum because the PBM is the final meeting to endorse any proposal. Assistant professors may express opinions when the professor or the associate professor in the same department give a report about PBM contents but such an opportunity is not clearly assured.

The Students' WG for Medical Education was formed to elicit the voices of students. The WG was launched for communication between faculty members and students in FMUT regarding students' campus life and educational curriculum and was approved by AAC of FMUT in July 2010.

(B) Analysis and self-evaluation

Opportunities for faculty members and students to express opinions on the curriculum are secured.

(C) Current action

Opinions from professors and associate professors are easier to collect but more difficult from assistant professors.

(D) Plan for future improvement

The system to collect opinions from all the faculty members should be discussed further.

Q 1.3.2 The medical school **should** ensure academic freedom for its staff and students in exploring the use of new research results to illustrate specific subjects without expanding the curriculum.

(A) Basic information

Whether to use new research results or not for education in each department is arbitrary. IRCME and members in charge collect information for educational improvement and curricular change, particularly in areas where a department needs assistance in determining the extent of their involvement (e.g. clinical skill training and integrated lectures).

(B) Analysis and self-evaluation

Updated research results are sought and utilised to some extent for educational improvement for specific educational subjects.

(C) Current action

Each department seeks and utilises updated research results independently but such information is not sufficiently shared within FMUT.

(D) Plan for future improvement

The system to overview the whole curriculum in SMFMUT and to share the updated research results for educational improvement should be established in the future.

1.4 EDUCATIONAL OUTCOMES

Basic standard:

The medical school **must**

- define the intended educational outcomes that students should exhibit upon graduation in relation to
  - their achievements at a basic level regarding knowledge, skills, and attitudes (B 1.4.1)
  - appropriate foundation for future career in any branch of medicine (B 1.4.2)
  - their future roles in the health sector. (B 1.4.3)
  - their subsequent postgraduate training (B 1.4.4)
  - their commitment to and skills in lifelong learning. (B 1.4.5)
  - the health needs of the community, the needs of the health care system and other aspects of social accountability. (B 1.4.6)

- ensure appropriate student conduct with respect to fellow students, faculty members, other health care personnel, patients and their relatives. (B 1.4.7)

Quality development standard:

The medical school **should**

- specify and co-ordinate the linkage of outcomes to be acquired by graduation with that to be acquired in postgraduate training. (Q 1.4.1)
- specify outcomes of student engagement in medical research (Q 1.4.2)
- draw attention to global health related outcomes. (Q 1.4.3)

Annotations:

- *Educational outcomes*, learning outcomes or competencies refer to statements of knowledge, skills and attitude that students are expected to demonstrate at the end of a period of learning. Educational/learning objectives are often described in these terms.

  Outcomes within medicine and medical practice - to be specified by the medical school - would include documented knowledge and understanding of (a) the basic biomedical sciences, (b) the behavioural and social sciences, including public health and population medicine, (c) medical ethics, human rights and medical jurisprudence relevant to the practice of medicine, (d) the clinical sciences, including clinical skills with respect to diagnostic procedures, practical procedures, communication skills, treatment and prevention of disease, health promotion, rehabilitation, clinical reasoning and problem solving; and (e) the ability to undertake lifelong learning and demonstrate professionalism in connection with the different roles of the doctor, also in relation to the medical profession.

  The characteristics and achievements the students display upon graduation can e.g. be categorised in terms of the doctor as (a) scholar and scientist, (b) practitioner, (c) communicator, (d) teacher, (e) manager and as (f) a professional.
- *Appropriate student conduct* would presuppose a written code of conduct.

B 1.4.1 The medical school **must** define the intended educational outcomes that students should exhibit upon graduation in relation to their achievements at a basic level regarding knowledge, skills, and attitudes.

(A) Basic information

In the 1st FD for comprehensive educational reform for FMUT accreditation conducted on 30 March 2014 educational outcomes for SMFMUT were discussed. The Preparatory Committee for Accreditation (PCA) and PBM had further discussion. PBM in September 2014 endorsed the SMFMUT educational outcomes as (1) medical knowledge, (2) clinical skills, (3) communication, (4) professionalism, (5) social perspectives, (6) creative thinking, (7) team leader, (8) international leader, (9) whole person care, and (10) inspired visionary.

Outcomes (1) to (5) are basic and outcomes (6) to (10) are advanced. Basic outcomes are included in the assessment at graduation. Advanced outcomes are not concretely included in the assessment but assessed through CC and free quarter (FQ), or temporal assignments to a department for some kind of research.

(B) Analysis and self-evaluation

At the point of November 2014, summative assessment for graduation uses conventional written examinations in each department. Basic level knowledge, skills and attitudes to be achieved in UGME of SMFMUT are not presented in a form that is specifically associated with outcomes.

(C) Current action

In the 2nd FD for comprehensive educational reform for FMUT accreditation conducted on 13 June 2014, participants discussed how assessment should be improved, especially related with 10 educational outcomes. Following statements are the results of the discussions:

- Current summative assessment for graduation using only a written test should be abolished.
- CC assessment should be emphasised and made a requirement for graduation to assess in better balance all the educational outcomes
- Comprehensive written assessment and post-clerkship OSCE should be conducted to replace current summative assessment for graduation.

In August 2014, two new WGs for graduation assessment and CC assessment were launched.

(D) Plan for future improvement

For the future, a transition to outcome-based education (OBE) graduation assessment and CC assessment will be improved.

B 1.4.2 The medical school **must** define the intended educational outcomes that students should exhibit upon graduation in relation to appropriate foundation for future career in any branch of medicine.

(A) Basic information

The educational outcomes of SMFMUT include basic outcomes of (1) medical knowledge, (2) clinical skills, (3) communication, (4) professionalism, and (5) social perspectives, and advanced outcomes of (7) team leader and (9) whole person care.

(B) Analysis and self-evaluation

Whole person care is one of the advanced outcomes. Since advanced outcomes will be achieved after all the basic outcomes are achieved, assessment for outcomes (7) and (9) are not set at graduation.

Currently outcome (1) is assessed. Outcomes (2) and (3) are partly assessed by the Common Achievement Test (CAT) objective structured clinical examination (OSCE). (4) is not specifically assessed. (5) is assessed by examinations or assessment in the practicum in social medicine.

(C) Current action

When assessment for CC is improved, outcomes (2) to (5) will be more clearly assessed. The WG for CC assessment started in August 2014.

(D) Plan for future improvement

A concrete plan to improve assessment CC will promote OBE.

B 1.4.3 The medical school **must** define the intended educational outcomes that students should exhibit upon graduation in relation to their future roles in the health sector.

(A) Basic information

The educational outcomes of SMFMUT include basic outcomes of (1) medical knowledge, (2) clinical skills, (3) communication, (4) professionalism, and (5) social perspectives, and advanced outcomes of (7) team leader and (9) whole person care.

(B) Analysis and self-evaluation

Achievement of the above outcomes will assure that graduates will play a sufficient role in the health sector.

(C) Current action

When assessment for CC is improved, outcomes (2) to (5) will be more clearly assessed. The WG for CC assessment started in August 2014.

(D) Plan for future improvement

A concrete plan to improve assessment CC will promote OBE.

B 1.4.4 The medical school **must** define the intended educational outcomes that students should exhibit upon graduation in relation to their subsequent postgraduate training.

(A) Basic information

The educational outcomes of SMFMUT include basic outcomes of (1) medical knowledge, (2) clinical skills, (3) communication, (4) professionalism, and (5) social perspectives, and advanced outcomes of (7) team leader and (9) whole person care.

(B) Analysis and self-evaluation

Achievement of the above outcomes means that graduates are ready for postgraduate training.

(C) Current action

When assessment for CC is improved, outcomes (2) to (5) will be more clearly assessed. The WG for CC assessment started in August 2014. The WG for graduation assessment started in October 2014.

(D) Plan for future improvement

A concrete plan to improve assessment CC will promote OBE.

B 1.4.5 The medical school **must** define the intended educational outcomes that students should exhibit upon graduation in relation to their commitment to and skills in lifelong learning.

(A) Basic information

The SMFMUT educational outcomes include basic outcomes of (1) medical knowledge, (2) clinical skills, (3) communication, (4) professionalism, and (5) social perspectives, and advanced outcomes of (6) creative thinking, (7) team leader, (8) international leader, (9) whole person care, and (10) inspired visionary.

(B) Analysis and self-evaluation

Outcomes (6), (8) to (10) are closely related with awareness of the need for life-long learning and learning skills.

(C) Current action

Currently assessment for outcomes (6), (8) to (10) is not specifically done but will be discussed in the WG for graduation assessment.

(D) Plan for future improvement

Assessment for (6) and (10) is planned as assessment during FQ. Assessment for (8) is initially done by English skills. Educational content for (9) should be selected before assessment is discussed.

B 1.4.6 The medical school **must** define the intended educational outcomes that students should exhibit upon graduation in relation to the health needs of the community, the needs of the health care system and other aspects of social accountability.

(A) Basic information

The educational outcomes described in B 1.4.1 include advanced outcomes of (6) creative thinking, (7) team leader, (8) international leader, (9) whole person care, and (10) inspired visionary. These are linked to the health needs of the community, the needs of the health care system and other aspects of social accountability.

(B) Analysis and self-evaluation

Achievement of these advanced outcomes means that graduates are ready for postgraduate training.

(C) Current action

Currently assessment for outcomes (6) to (10) is not specifically done but will be discussed in the WG for graduation assessment.

(D) Plan for future improvement

Assessment for (6) and (10) is planned as assessment during FQ. For outcome (7) there will be further discussion regarding how to teach and assess students in CC in their role as team leader. Assessment for (8) is initially done by English skills. Educational content for (9) should be selected before assessment is discussed.

B 1.4.7 The medical school **must** ensure appropriate student conduct with respect to fellow students, faculty members, other health care personnel, patients and their relatives.

(A) Basic information

The SMFMUT educational outcomes include basic outcomes of (1) medical knowledge, (2) clinical skills, (3) communication, (4) professionalism, and (5) social perspectives,

deeply related with student conduct with respect to fellow students, faculty members, other health care personnel, patients and their relatives.

(B) Analysis and self-evaluation

Achievement of these advanced outcomes means that graduates are ready for postgraduate training.

(C) Current action

When assessment for CC is improved, outcomes (2) to (5) will be more clearly assessed. The WG for CC assessment has been started since in August 2014.

(D) Plan for future improvement

Concrete plan to improve assessment CC will promote OBE.

Q 1.4.1 The medical school **should** specify and co-ordinate the linkage of outcomes to be acquired by graduation with that to be acquired in postgraduate training.

(A) Basic information

Outcomes upon completion of two-year mandatory postgraduate training are linked with achievement objectives of postgraduate clinical training indicated by the Ministry of Health, Labour and Welfare (MHLW). Behavioural objectives of the "basic attitude necessary for health professionals" include 6 items of the (1) patient-doctor relationship, (2) team practice, (3) problem-solving ability, (4) safety management, (5) case presentation and (6) medical sociality.

If MHLW postgraduate outcomes are compared with SMFMUT graduation outcomes, consistency is observed.

MHLW postgraduate outcomes	SMFMUT graduation outcomes
(1) patient-doctor relationship	(3) communication, (4) professionalism
(2) team practice	(7) team leader, (9) whole person care
(3) problem-solving ability	(1) medical knowledge, (2) clinical skills, (9) whole person care
(4) safety management	(4) professionalism, (9) whole person care
(5) case presentation	(1) medical knowledge, (2) clinical skills, (3) communication,
(6) medical sociality.	(5) social perspectives, (8) international leader

(B) Analysis and self-evaluation

Since SMFMUT graduation outcomes cover all items of MHLW postgraduate outcomes, graduates from SMFMUT are expected to be able to work in any postgraduate training hospitals.

(C) Current action

Consistency is not complete because MHLW postgraduate outcomes have learning objectives with lower-level competencies but SMFMUT graduation outcomes do not have lower-level competencies.

(D) Plan for future improvement

SMFMUT should set up lower-order competencies of educational outcomes, to plan more concrete educational and learning objectives.

Q 1.4.2 The medical school **should** specify outcomes of student engagement in medical research.

(A) Basic information

The SMFMUT educational outcomes include advanced outcomes of (6) creative thinking and (10) inspired visionary, both related to medical research.

(B) Analysis and self-evaluation

Educational outcomes for medical research upon graduation are well defined.

(C) Current action

Assessment for outcomes of (6) creative thinking and (10) inspired visionary is not defined yet. The future plan is assessment during FQ for these.

(D) Plan for future improvement

FQ should be defined as the key component of the basics of medical research training in UGME of SMFMUT. Faculty should set the minimum target level of medical research principles that all students should experience and understand.

Q 1.4.3 The medical school **should** draw attention to global health related outcomes.

(A) Basic information

The SMFMUT educational outcomes include advanced outcomes of (8) international leader and (9) whole person care.

(B) Analysis and self-evaluation

Educational outcomes for global health are indicated.

(C) Current action

As for global health, concrete objectives are not defined. Assessment for the advanced outcomes of (8) international leader and (9) whole person care is not planned.

(D) Plan for future improvement

In UTH, the department of international practice was established in 2012. In the future, students who enter UT may experience activities related with global health, such as an overseas practicum during summer vacation.

2. EDUCATIONAL PROGRAMME

2.1 CURRICULUM MODEL AND INSTRUCTIONAL METHODS

Basic standard:

The medical school **must**

- define the curriculum model. (B 2.1.1)
- define the instructional and learning methods employed. (B 2.1.2)
- ensure that the curriculum prepares the students for lifelong learning. (B 2.1.3)
- ensure that the curriculum is delivered in accordance with principles of equality. (B 2.1.4)

Quality development standard:

The medical school **should**

- use a curriculum and instructional/learning methods that stimulate, prepare and support students to take responsibility for their learning process. (Q 2.1.1)

Annotations:

- *Curriculum* in this document refers to the educational programme and includes a statement of the intended educational outcomes, the content/syllabus, experiences and processes of the programme, including a description of the structure of the planned instructional and learning methods and assessment methods. The curriculum should set out what knowledge, skills, and attitudes the student will achieve.
- *Curriculum models* would include models based on disciplines, organ systems, clinical problems/tasks or disease patterns as well as models based on modular or spiral design.
- *Instructional and learning methods* encompass lectures, small-group teaching, problem-based or case-based learning, peer assisted learning, practicals, laboratory exercises, bed-side teaching, clinical demonstrations, clinical skills laboratory training, field exercises in the community and web-based instruction.
- The *curriculum and instructional methods* would be based on contemporary learning principles.
- *Principles of equality* mean equal treatment of staff and students irrespective of gender, ethnicity, religion, sexual orientation, socio-economic status, and taking into account physical capabilities.

B 2.1.1 The medical school **must** define the curriculum model.

(A) Basic information

The curriculum overview is described on the following page. Six years of UGME consists of two parts, 1.5 years of curriculum at CAS at Komaba Campus and 4.5 years of curriculum at SMFMUT at Hongo Campus.

Curriculum Overview of UGME

1st year (In CAS)

April	May	June	July	August	September	October	November	December	January	February	March
Preparation	College of Arts and Sciences (CAS) (Summer term) English, second foreign language, physical exercise/Health, information technology, Math, Material Science, life science		Term-end exam	Summer vacation	Term-end exam / Autumn vacation	College of Arts and Sciences (CAS) (Winter term) English, second foreign language, physical exercise/Health, Math, life science, material science, basic experiment (Physics, Chemistry)		Winter vacation	College of Arts and Sciences (CAS) (Winter) Cont'd.	Term-end exam	Spring vacation

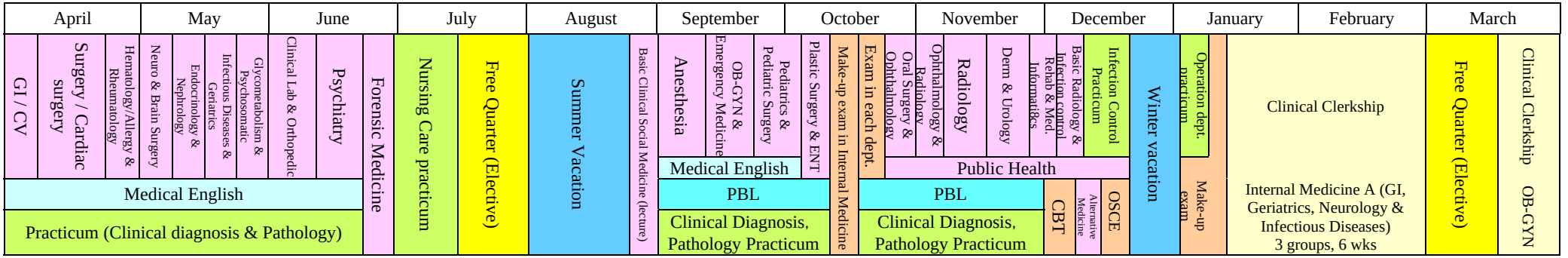
2nd year (In CAS for the 1st half, M0)

April	May	June	July	August	September	October	November	December	January	February	March
Spring vacation	College of Arts and Sciences (CAS) (Summer term) English, material science, life science, basic experiment (Biology)		Term-end exam	Summer vacation	Term-end exam / Autumn vacation	Biochemistry & Nutrition / Histology & Cell biology / "Origin of Medicine" (Lecture series given by speakers in medical and non-medical fields)	Osteology	Animal experiment & Statistics / School of medicine admission test	Winter vacation	Human genetics / Exercise in Biochemistry / School of medicine admission test	Term-end exam, College of Arts and Sciences / Free quarter (elective) / Spring vacation

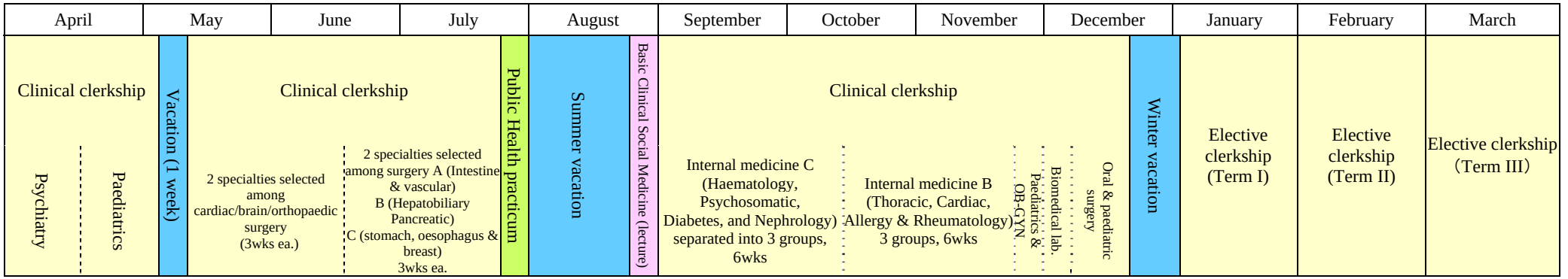
3rd year (M1)

April	May	June	July	August	September	October	November	December	January	February	March
Spring vacation	Anatomy (Macro, developmental), Immunology, Microbiology / Anatomy practicum (Macro, brain)	Physiology / Microbiology	Immunology, microbiology exercise / Term-end exam	Summer vacation	Basic Clinical Social Medicine (lecture) / Physiology / Med English / Exercise (Physiology)	Pharmacology / Medical English	Basic Medicine in Radiology	Pathology / Medical Engineering / Hygienics / Medical English	Winter vacation	Free Quarter (4 weeks required. Longer program optional)	Spring vacation

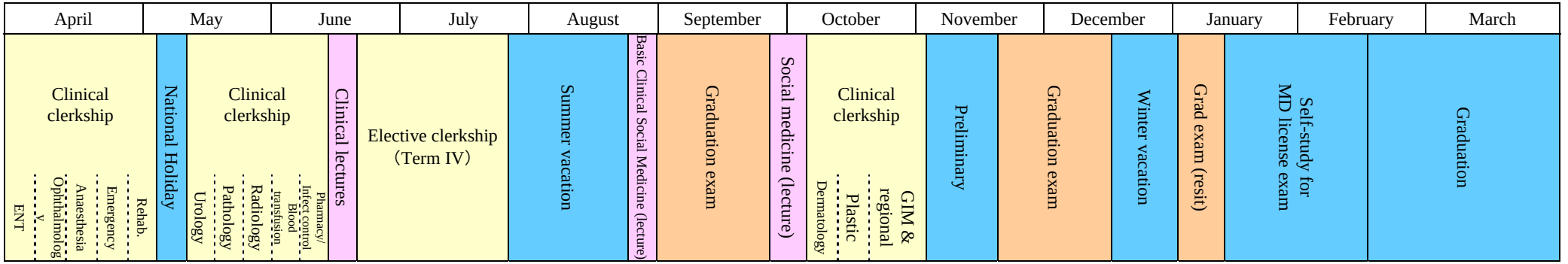
4th year (M2)



5th year (M3)



6th year (M4)



Sometimes the two components of the curriculum are called the primary and secondary phases. The secondary phase is divided into five parts. The second year of the whole UGME is designated as M0 (preparatory year for medical curricula), third, fourth, fifth and sixth year of UGME as M1, M2, M3 and M4 respectively.

The whole curriculum is constructed in keeping with the mission statement of SMFMUT. Educational outcomes of SMFMUT have been just approved and will become the basis for the reform of the curriculum in the near future.

The model of the current curriculum is based on ologies. Most classes use didactic lectures and practicums. Problem-based learning (PBL) is offered 11 times (3 hours each) in three months in the fourth year.

(B) Analysis and self-evaluation

SMFMUT intends to use ologies for the basis for the curriculum.

(C) Current action

In the FD in March 2014, the direction of educational outcomes of SMFMUT was determined and the final proposal was approved by PBM in September 2014. In the FD held in August 2014, faculty reviewed curriculum integration for CC, particularly the lectures and practicums within the CC curriculum for 4th year for medical students. For the basic science curriculum, the faculty participants confirmed that they should maintain the current structure.

(D) Plan for future improvement

In the process of change into OBE, SMFMUT may need to discuss the future curriculum model.

B 2.1.2 The medical school **must** define the instructional and learning methods employed.

(A) Basic information

As for basic sciences and social medicine, main instructional and learning methods are lectures and practicums. Some classes, such as biochemistry in M0, use small group teaching.

Percentages of the practicum are 56% and 40% for M1 and M2. Clinical diagnostic practicums in M2 are offered two times every week from April to December, 43 times (3 hours each), including practicums in a skills laboratory and SP experiences.

Clinical practicums were changed in January 2013 to include 71 weeks, 54 weeks of CC and 17 weeks of elective clerkship (EC). A community-based practicum was started in

November 2013 for half of students to visit clinics and welfare facilities in the Kashiwa area for two weeks.

(B) Analysis and self-evaluation

Currently, the balance between lectures and practicums is appropriate. Some preparatory clinical experiences are offered before starting CC.

On the other hand, time for lectures dominates in M2, probably because the policy for educational methods is unclear and because governance is weak so that each department decides educational content and methods arbitrarily in SMFMUT.

(C) Current action

AAC intends to expand educational and learning methods other than lectures. This accreditation process has stimulated motivation for educational reform, for example four FDs were conducted in 2014.

(D) Plan for future improvement

More discussion should be continued in the curriculum reform WG to increase learning methods other than lectures.

B 2.1.3 The medical school **must** ensure that the curriculum prepares the students for lifelong learning.

(A) Basic information

Currently each department makes its own decisions about educational content and assessment methods. PBL is a noteworthy method to prepare for life-long learning. PBL, offered 11 times from September to November of M2, provides the trigger for small group discussion and self-directed learning for ethical issues.

(B) Analysis and self-evaluation

PBL provides well-constructed case scenarios and facilitates self-directed learning very much. However, the time span may be too short to lead to preparation for life-long learning.

(C) Current action

A panel meeting for "reviewing Natural Sciences III" involving some of FMUT AAC members and CAS curriculum revision committee members was held twice in February and May 2014. At that meeting, revision of PBL was agreed upon. PBL is regarded as an important method to prepare students for self-directed learning. Therefore, the panel feels that students should experience PBL earlier and include students from various

divisions in CAS. Students in Natural Sciences III can interact with students from different divisions in the 1st year.

(D) Plan for future improvement

When PBL is implemented in the CAS curriculum, more diverse students are expected to participate because students other than Natural Sciences III may take PBL. However, tutor training is indispensable to obtain skills to motivate students.

B 2.1.4 The medical school **must** ensure that the curriculum is delivered in accordance with principles of equality.

(A) Basic information

In 2008, as an organisation under direct control of the dean of FMUT, a gender equality committee was launched. After a questionnaire survey in 2009, a designated resting room for female graduate students and a website of the committee were created. This committee has also started an annual networking event for career support since 2012.

Another system is the tutor system under the control of AAC FMUT. From M1 to M4 a tutor is assigned for every student to deal with specific issues regarding life and health.

(B) Analysis and self-evaluation

Systems of gender equality and tutors are regarded as good.

(C) Current action

In 2014, the Student Support Unit (SSU) was established in FMUT. The Steering committee of SSU consists of the director (a committee member of AAC), a vice-director (physician in the psychiatry department or specialising in mental health), an AAC committee member in charge of M1, an expert in family nursing and a FMUT faculty member in developmental psychology. Both a barrier-free support unit and a student advisory network also cooperate with SSU. In November 2014, a certified psychiatric social worker was accepted into the position of a fixed-term full-time assistant professor.

(D) Plan for future improvement

SMFMUT expect SSU to support students as much as possible through discussion among different parties.

Q 2.1.1 The medical school **should** use a curriculum and instructional/learning methods that stimulate, prepare and support students to take responsibility for their learning process.

(A) Basic information

FQ is a curriculum for a student to delve deeply into a theme in a research department selected by him/herself. 4 weeks in M1 is required and 2 weeks in M0, 6 weeks in M1 and 4 weeks in M2 are elective periods.

Other interest groups consisting of some students supported by a faculty member, such as diagnostic reasoning using New England Journal of Medicine, have been a tradition of SMFMUT for many years.

(B) Analysis and self-evaluation

Time frames for FQ are long enough for some students to conduct research work sufficient to present at a conference or to publish a paper in a scientific journal that will connect to their later career. On the other hand, the student assessment system is not well determined. Since products of some students are not so high, the FQ system needs to be enhanced.

(C) Current action

In the FD held on 4 November, discussion involved the curriculum for nurturing future researchers. Concrete plans to improve FQ became more obvious; (1) the goal of FQ should be clearer, (2) the required length of FQ should be longer, and (3) assessment should be more standardised such as defence for the master degree.

(D) Plan for future improvement

Further revision should be repeated to set goals/objectives, to expand required FQ, and to assess students.

2.2 SCIENTIFIC METHOD

Basic standard:

The medical school **must**

- throughout the curriculum teach
  - the principles of scientific method, including analytical and critical thinking. (B 2.2.1)
  - medical research methods. (B 2.2.2)
  - evidence-based medicine. (B 2.2.3)

Quality development standard:

The medical school **should**

- in the curriculum include elements of original or advanced research. (Q 2.2.1)

Annotations:

- To *teach the principles of scientific method, medical research methods and evidence-based medicine* requires scientific competencies of teachers. This training would be a compulsory part of the curriculum and would include that medical students conduct or participate in minor research projects.
- *Elements of original or advanced research* would include obligatory or elective analytic and experimental studies, thereby fostering the ability to participate in the scientific development of medicine as professionals and colleagues.

B 2.2.1 The medical school **must** throughout the curriculum teach the principles of scientific method, including analytical and critical thinking.

(A) Basic information

In the primary phase of the curriculum at Komaba Campus, principles of the scientific method including analytical and critical thinking are learned through a variety of natural science content. More specifically, subjects in the primary phase curriculum are divided into basic subjects, general subjects and thematic subjects. Students select these three types of subjects by themselves.

Basic subjects are mandatory. Students in Natural Sciences divisions must take lectures of bioscience and physical science and practicums in basic physics/chemistry experiments and basic bioscience experiments. Especially in practicums students are expected to learn analytical thinking skills through getting actual data, analysing and reporting them.

The goal of general subjects is to touch a wide academic field with a good balance. General subjects include (A) thought and arts, (B) world and community, (C) society and systems, (D) humans and the environment, (E) materials and life, and (F) mathematics and information. Students may select not only biomedical subjects but also wider areas of natural science subjects.

Thematic subjects include three types, thematic lectures, whole campus free research seminars (small group), and whole campus experiential seminars (visit research institutes etc.). SMFMUT provides whole campus experiential seminars for those who wish to enter SMFMUT to understand medical principles.

(B) Analysis and self-evaluation

The curriculum for principles of the scientific method in the primary phase is sufficient and appropriate. Continuity between primary and secondary phases should be investigated further to check for duplication and the proper order of content.

(C) Current action

The curriculum in the primary phase is under review for further quality improvement from the viewpoint of whole faculties. Some faculty members from FMUT attend the meeting to improve continuity between the primary and secondary phases, and to improve the curriculum related with medical content in the primary phase.

(D) Plan for future improvement

Periodic round-table meetings are held for CAS and SMFMUT to review the continuity and integration of the content. The proposal to improve the curriculum in SMFMUT should be utilised to improve the continuity.

B 2.2.2 The medical school **must** throughout the curriculum teach medical research methods.

(A) Basic information

In the primary phase of the curriculum at CAS, mathematical and natural sciences are taught for students to understand medical research methods.

In the secondary phase, students learn various medical research methods through historical viewpoints, current situations and updated research topics in basic science lectures. In the practicums, students have opportunities to experience various research methods in biosciences and basic sciences, and to understand thinking methods through analysis and interpretation of the data. In lectures for clinical medicine and social sciences, teachers use diagnoses or therapies of diseases or social medicine issues to let students understand how research is conducted.

FQ is a required 4-week period (further weeks are optional) for students to learn medical research methods. Many students start to be involved in presentations at a conference or writing a journal article based on the activities in FQ.

(B) Analysis and self-evaluation

Not only in SMFMUT but also in CAS students can learn medical research methods continuously. Moreover through ology-based lectures and practicums, students are able to understand the general principles and specific way of thinking in each ology.

On the other hand basic science teachers do not have sufficient opportunities to discuss how new research areas or methods should be adopted into the current curriculum.

(C) Current action

Previously, measures to improve basic science education were discussed in FDs. Measures to improve FQ were one of the main topics in FD November 2014.

(D) Plan for future improvement

Further discussion in AAC will be needed to implement specific measures to improve FQ.

B 2.2.3 The medical school **must** throughout the curriculum teach evidence-based medicine.

(A) Basic information

EBM is taught in the following curriculum.

- M2: lectures in public health (clinical epidemiology, EBM)
- M2: lectures in medical informatics (utilization of medical data)
- M2: clinical diagnostics (small lecture in clinical reasoning)
- M2: adding EBM understanding item to CC assessment sheet in 2014
- M3: CC in clinical research support centre
- Elective Clinical Researcher Development Programme (clinical epidemiology translational research lecture, 7 hours)

(B) Analysis and self-evaluation

EBM is dealt with in different classes during and after M2. However, duplication or lack of content is not systematically checked. Learning opportunities to apply EBM to CC settings are insufficient.

(C) Current action

Further discussion will be needed to decide the level and the objectives to teach EBM.

(D) Plan for future improvement

Level and objectives and assessment to teach EBM should be improved.

Q 2.2.1 The medical school **should** in the curriculum include elements of original or advanced research.

(A) Basic information

To develop students with a research mind, elective programmes for researcher development have been provided.

- PhD-MD course: This is the programme to be able to earn a PhD degree in

graduate school in the middle of the SMFMUT curriculum. The course was started in 2006. After finishing, PhD students have two options to return to SMFMUT to take a medical licence or to be a researcher directly.

- MD researcher development programme: The goal of the programme is for students to obtain the knowledge, skills and culture needed for researchers. The programme has been running since 2008 for M1 to M4. Approximately 20 students have participated in the programme after entering SMFMUT.
- Clinical researcher development programme: The goal of the programme is to motivate attention to clinical research. The programme has been running since 2010. Lecture series, small group seminars and practicums are combined.

(B) Analysis and self-evaluation

Several programmes exist to achieve outcomes with methodologies and goals unique to each programme. Only a few students are involved in the PhD-MD course but most of them are highly motivated for research. Some have written papers in international leading journals even when they were PhD candidates. Many participants can interact with each other in the MD researcher development programme. Since the clinical researcher development programme allows a higher degree of freedom, some courses have many participants but others have fewer.

SMFMUT should track students who finished these programmes to improve the programme further.

(C) Current action

In the MD researcher development programme, follow up studies of graduates from these researcher development programmes are being conducted, so that the data can be tracked over time.

(D) Plan for future improvement

Research evidence should be collected to determine the strengths of the researcher development programmes and used for improvement.

2.3 BASIC BIOMEDICAL SCIENCES

Basic standard:

The medical school **must**

- in the curriculum identify and incorporate
  - the contributions of the basic biomedical sciences to create understanding of scientific knowledge. (B 2.3.1)
  - concepts and methods fundamental to acquiring and applying clinical science.

(B 2.3.2)

Quality development standard:

The medical school **should**

- in the curriculum adjust and modify the contributions of the biomedical sciences to the
  - scientific, technological and clinical developments. (Q 2.3.1)
  - current and anticipated needs of the society and the health care system. (Q 2.3.2)

Annotation:

- *The basic biomedical sciences* would - depending on local needs, interests and traditions - include anatomy, biochemistry, biophysics, cell biology, genetics, immunology, microbiology (including bacteriology, parasitology and virology),molecular biology, pathology, pharmacology and physiology.

B 2.3.1 The medical school **must** in the curriculum identify and incorporate the contributions of the basic biomedical sciences to create understanding of scientific knowledge.

(A) Basic information

The following curricula are required for the basic science area.

- Primary phase in CAS: “Exposure to medical jobs” and human general sciences are required subjects to enter SMFMUT.
- Second semester of the 2nd year: cell biology, anatomy (histology and osteology), biochemistry/nutrition science, human genetics, statistics and laboratory animal resources.
- M1: Macro anatomy, neuroanatomy, physiology, pathology, pharmacology, hygienics, microbiology, immunology, parasitology, legal medicine, medical technology basics, radiology basic sciences.

Elective curricula for the basic science area follow.

- Primary phase in CAS: “basic medical biology” and “journal club for Molecular Biology of the Cell” are opened to students other than Natural Sciences III in CAS. These act as early exposure to basic sciences.
- M0 and M2: Elective FQ is offered to participate in research in basic sciences or clinical medicine.
- M3-M4: EC is provided. Not only within the campus but also in foreign institutes for both clinical or research work.

(B) Analysis and self-evaluation

Required curricula for basic sciences are wide in variety. Many curricula are high level to fully understand the basic principles. Curricula are devised to smoothly evolve from general biology to specialised basic sciences. Upon starting basic science subjects in October M0, overview lectures enable students understand the whole area. The degree of freedom for the basic science elective curriculum is high depending on students' interests and level of understanding.

For future improvement, percentages for genome medicine, systems biology and embryology/regeneration medicine are less and scattered. FQ is fascinating for students interested in research but not so motivating for students less interested in research. The entire curriculum is so congested that the length of time for FQ is insufficient and too scattered to achieve the goal.

(C) Current action

Faculty members specializing in genome medicine and systems biology should participate in basic science teaching. Embryology and regeneration medicine should be taught better in the current time frame of anatomy and biochemistry.

To relate to the curriculum reform across the whole UT, the secondary phase of the UT curriculum is also being reviewed in both the AAC and curriculum reform WG.

(D) Plan for future improvement

Curriculum reform for the whole UT is planned for 2015. After 2015, effects and issues from the reform will be examined.

B 2.3.2 The medical school **must** in the curriculum identify and incorporate concepts and methods fundamental to acquiring and applying clinical science.

(A) Basic information

Bridges in mandatory classes are as follows.

- M0: General principles of medicine are taught by series of lectures 7 times. Basically, content includes professionalism or social medicine and international health, but one important area for learning is basic sciences to enhance clinical medicine.
- For M1 to M4 integrated lectures for basic sciences/basic science, clinical and social medicine are provided in 5 days in August. Two AAC members in charge supervise the whole programme by adding some expectations from students. Themes of the five-day lectures for 2014 were (1) mystery of embryology and regeneration, (2) from clinical medicine to drug discovery, (3) Japanese health care visualised from international comparison, (4) global environment and medicine, and (5) clinical dietetics in modern medicine. A professor played the role of coordinator for each day. Various speakers from basic scientists to clinicians deliver a speech for listeners to feel the connection between basic sciences and

clinical medicine.

- Application of basic sciences to clinical medicine is achievable not only through pharmacology, microbiology, immunology and basic science radiology but also biochemistry (congenital metabolic abnormality, adult life-style diseases, malignant tumours, genome medicine and metabolic abnormality), genetics of homo sapiens (human genetics, chromosomal abnormality, genome medicine), physiology (respiration, cardiovascular system, etc.). Support from faculty members of clinical medicine is positively expected in some basic science subjects, e.g. in physiology, nephrology faculty have lectures for physiology of the kidney.

In the clinical researcher development programme, students can select from lecture series or more than 10 consortium programmes. The programmes are managed by the collaboration between clinical medicine and basic science departments, such as basic science research related to a disease mechanism.

(B) Analysis and self-evaluation

Relevance between basic sciences and clinical medicine is always considered in both mandatory and elective programmes. However, the ways in which collaboration occur between basic science and clinical medicine depends on how each department perceives the relevance, and methods are not shared across departments. Therefore, uniform understanding of the whole curriculum among different departments is not yet achieved.

(C) Current action

Discussion about "origins of medicine" and "integrated lectures for basic sciences/basic science, clinical and social medicine" is regularly done to choose themes. A first-line faculty member works as coordinator to assure the quality.

(D) Plan for future improvement

As for the educational content in integrated lectures for clinical medicine, faculty members should have discussions about the need for collaboration between basic science and clinical medicine departments.

Q 2.3.1 The medical school **should** in the curriculum adjust and modify the contributions of the biomedical sciences to the scientific, technological and clinical developments.

(A) Basic information

The SMFMUT Curriculum is developed and revised in AAC. The structure and class hours are revised every year based on scientific, technical and clinical progress. Latest content is dealt with in integrated lectures in August for M1 to M4.

In FQ students can directly be exposed to scientific, technical and clinical progress in each research department. Motivated students can select the researcher development programme/course to experience cutting edge research.

(B) Analysis and self-evaluation

Since each faculty member takes a role in front line research and holds freedom to decide educational content, he/she can provide education that reflects the progress in research. AAC revises the details of the curriculum every end of fiscal year based on the progress.

Motivation and ability to teach depend on faculty members. FD for all departments has not been sufficient.

(C) Current action

In FDs or medical education seminars, how to incorporate scientific, technical and clinical progress into educational content is taught and discussed. AAC discusses how to assure the content of "origins of medicine" and "integrated lectures for basic sciences/basic science, clinical and social medicine."

(D) Plan for future improvement

Educational opportunities for teachers should be enhanced. How to disseminate examples of good education within SMFMUT and how to evaluate educational scholarship should be considered.

Q 2.3.2 The medical school **should** in the curriculum adjust and modify the contributions of the biomedical sciences to the current and anticipated needs of the society and the health care system.

(A) Basic information

In "origins of medicine" in M0, topics such as how developed countries manage aging populations, how to deal with untreatable diseases, and future transplantation medicine are incorporated. In medical engineering in M1, a lecture on basics of medical engineering is provided.

To cope with an aging society both basic scientists and clinicians are asked to have lectures on the biochemistry and physiology of aging and life-style related diseases. M2 students visit nursing care facilities in a "nursing care practicum" class.

(B) Analysis and self-evaluation

Updated education is provided to meet the needs of an aging society. Education for aging itself is relatively less, though neurological degenerative diseases are taught in pathology.

(C) Current action

AAC revises the curricular content every year to accommodate the changes of health needs.

(D) Plan for future improvement

Curriculum for aging and life-style related diseases that rapidly expanded should be continuously improved to include content needed by society.

2.4 BEHAVIOURAL AND SOCIAL SCIENCES AND MEDICAL ETHICS

Basic standard:

The medical school **must**

- in the curriculum identify and incorporate the contributions of the:
  - behavioural sciences. (B 2.4.1)
  - social sciences. (B 2.4.2)
  - medical ethics. (B 2.4.3)
  - medical jurisprudence. (B 2.4.4)

Quality development standard:

The medical school **should**

- in the curriculum adjust and modify the contributions of the behavioural and social sciences as well as medical ethics to
  - scientific, technological and clinical developments. (Q 2.4.1)
  - current and anticipated needs of the society and the health care system. (Q 2.4.2)
  - changing demographic and cultural contexts. (Q 2.4.3)

Annotations:

- *Behavioural and social sciences* would - depending on local needs, interests and traditions - include biostatistics, community medicine, epidemiology, global health, hygiene, medical anthropology, medical psychology, medical sociology, public health and social medicine.
- *Medical ethics* deals with moral issues in medical practice such as values, rights and responsibilities related to physician behavior and decision making.
- *Medical jurisprudence* deals with the laws and other regulations of the health care delivery system, of the profession and medical practice, including the regulations of production and use of pharmaceuticals and medical technologies (devices, instruments, etc.).

- The *identification and incorporation of the behavioural and social sciences, medical ethics and medical jurisprudence* would provide the knowledge, concepts, methods, skills and attitudes necessary for understanding socio-economic, demographic and cultural determinants of causes, distribution and consequences of health problems as well as knowledge about the national health care system and patients' rights. This would enable analysis of health needs of the community and society, effective communication, clinical decision making and ethical practices.

B 2.4.1 The medical school **must** in the curriculum identify and incorporate the contributions of the behavioural sciences.

(A) Basic information

Curricula for behavioural sciences are offered as part of classes in psychosomatic internal medicine, palliative care and psychiatry. Students will learn how to apply knowledge and skills in human mentality and behaviours for medicine and health care (including clinical medicine and social medicine) based on psychology, sociology and anthropology.

- M2: psychosomatic internal medicine (50 mins x 6 times)
- M2: diagnostic practicums -- medical interview practicums
- M3: integrated lectures for clinical medicine -- psycho-oncology, clinical psychology
- M4: social medicine intensive lectures -- palliative medicine
- M4: integrated lectures for clinical medicine -- family, society and culture

(B) Analysis and self-evaluation

A certain level of education is provided as to behavioural sciences integrated with clinical medicine. Contribution from different departments enables the implementation.

(C) Current action

In connection with transition to OBE, revision of behavioural science curricula will be needed to address the outcome of "social perspectives."

(D) Plan for future improvement

More systematic and integrated curricula for behavioural sciences should be considered. Especially basics for behavioural sciences related to health care should be taught in M1 or earlier.

B 2.4.2 The medical school **must** in the curriculum identify and incorporate the contributions of the social sciences.

(A) Basic information

Social medicine classes are provided in hygienics, public health, forensic medicine, etc. Classes are listed below, except for forensic medicine that is described in medical jurisprudence.

- M0: statistics
- M1: hygienics (environmental health, industrial health, infectious diseases, life-style related diseases, etc.)
- M2: public health (epidemiology, health care system, community health, etc.)
- M2: internal medicine (health management)
- M3: practicum of public health (5 days)
- M4: intensive lectures for social medicine (public health, genetics for homo sapiens, patient safety management)

For the M3 public health practicum, students can select the topic.

(B) Analysis and self-evaluation

Education for social medicine is provided in the name of hygienics, public health, forensic medicine, etc. with enough number of hours.

(C) Current action

Since some practicum sites require fees for transportation, compensation from SMFMUT will improve the quality.

(D) Plan for future improvement

There is room to improve educational content and curricula, e.g. collaborative education with clinical medicine.

B 2.4.3 The medical school **must** in the curriculum identify and incorporate the contributions of the medical ethics.

(A) Basic information

Contents for medical ethics are incorporated with the curriculum by the name of following areas.

- M2 PBL: All three scenarios are related with medical ethics ("brain death and

organ transplantation," "fertility treatment, antenatal diagnosis and artificial abortion" and "researchers' ethics and misconduct.")
- M3: Psychosomatic internal medicine (small lectures, 60 mins x twice), EC in medical ethics department (several students/year)
- M4: Integrated lecture for clinical medicine: medical ethics (90 mins)

(B) Analysis and self-evaluation

Education for medical ethics is provided in a form integrated with clinical medicine. Departments providing this content have sufficient experience and abilities, such as the Centre for Biomedical Ethics and Law (CBEL) and IRCME.

(C) Current action

Currently, across the medical ethics content it is not specified at what level and what depth the various components are taught.

(D) Plan for future improvement

How to teach clinical ethics should be continuously improved from the viewpoint of OBE.

B 2.4.4 The medical school **must** in the curriculum identify and incorporate the contributions of the medical jurisprudence.

(A) Basic information

In the lectures of forensic medicine in M2, one whole week, 35 hours, are allocated for unusual deaths and related rules and regulations. Medical jurisprudence is taught in the social medicine intensive course in M4.

(B) Analysis and self-evaluation

The forensic medicine department teaches laws and regulations related to individual physicians, such as Medical Practitioners Act, Penal Code, laws related with unusual death, etc. The public health department teaches laws and regulations related to the health care system, such as the Medical Service Act, various kinds of Health Insurance Acts, and laws related with industrial health.

(C) Current action

SMFMUT considers that classes of medical jurisprudence have no major issues currently.

(D) Plan for future improvement

The way to teach medical jurisprudence should be continuously improved from the viewpoint of OBE.

Q 2.4.1 The medical school **should** in the curriculum adjust and modify the contributions of the behavioural and social sciences as well as medical ethics to scientific, technological and clinical developments.

(A) Basic information

SMFMUT updates the curricular content of the behavioural sciences, social sciences and medical ethics every year to reflect progress in medical research. CBEL provides education and conducts research on ethical, legal and social issues brought from life science and health care technologies from the international viewpoints.

(B) Analysis and self-evaluation

AAC has a member from social medicine who updates the content every year.

(C) Current action

No member from CBEL participates in AAC.

(D) Plan for future improvement

More collaboration is considered with CBEL for the way to revise the curriculum.

Q 2.4.2 The medical school **should** in the curriculum adjust and modify the contributions of the behavioural and social sciences as well as medical ethics to current and anticipated needs of the society and the health care system.

(A) Basic information

Among departments in the social science system educational curricula for behavioural sciences, social sciences and medical ethics are always checked to update.

(B) Analysis and self-evaluation

Social science system departments always revise the curriculum for students to achieve knowledge and skills needed in the future.

(C) Current action

SMFMUT would like graduates to become leaders inside and outside of the country of Japan as stated in the mission statement and educational outcomes of SMFMUT. One of the educational outcomes is social perspectives but its lower-level competences have not been listed yet.

(D) Plan for future improvement

In the process to implement OBE, improvement measures will be planned within the OBE scheme.

Q 2.4.3 The medical school **should** in the curriculum adjust and modify the contributions of the behavioural and social sciences as well as medical ethics to changing demographic and cultural contexts.

(A) Basic information

Home care for the aged, public administration by MHLW and family, society, and culture are taught in classes of public health.

(B) Analysis and self-evaluation

Classes to deal with demographics and cultural changes are provided.

(C) Current action

There are a few classes but consideration is needed to tell if the time is enough.

(D) Plan for future improvement

Continuous checking will be needed to monitor the time allocation for classes on these topics.

2.5 CLINICAL SCIENCES AND SKILLS

Basic standard:

The medical school **must**

- in the curriculum identify and incorporate the contributions of the clinical sciences to ensure that students
  - acquire sufficient knowledge and clinical and professional skills to assume appropriate responsibility after graduation. (B 2.5.1)
  - spend a reasonable part of the programme in planned contact with patients in

relevant clinical settings. (B 2.5.2)

- experience health promotion and preventive medicine (B 2.5.3)

- specify the amount of time spent in training in major clinical disciplines. (B 2.5.4)
- organise clinical training with appropriate attention to patient safety. (B 2.5.5)

Quality development standard:

The medical school **should**

- in the curriculum adjust and modify the contributions of the clinical sciences to the
  - scientific, technological and clinical developments. (Q 2.5.1)
  - current and anticipated needs of the society and the health care system. (Q 2.5.2)
- ensure that every student has early patient contact gradually including participation in patient care. (Q 2.5.3)
- structure the different components of clinical skills training according to the stage of the study programme. (Q 2.5.4)

Annotations:

- *The clinical sciences* would - depending on local needs, interests and traditions -include anaesthetics, dermatology, diagnostic radiology, emergency medicine, general practice/family medicine, geriatrics, gynaecology & obstetrics, internal medicine (with subspecialties), laboratory medicine, medical technology, neurology, neurosurgery, oncology & radiotherapy, ophthalmology, orthopaedic surgery, oto-rhino-laryngology, paediatrics, palliative care, physiotherapy, rehabilitation medicine, psychiatry, surgery (with subspecialties) and venereology (sexually transmitted diseases). Clinical sciences would also include a final module preparing for pre-registration-training/internship.
- *Clinical skills* include history taking, physical examination, communication skills, procedures and investigations, emergency practices, and prescription and treatment practices.
- *Professional skills* would include patient management skills, team-work/team leadership skills and inter-professional training.
- *Appropriate clinical responsibility* would include activities related to health promotion, disease prevention and patient care.
- *A reasonable part* would mean about one third of the programme.
- *Planned contact with patients* would imply consideration of purpose and frequency sufficient to put their learning into context.
- *Time spent in training* includes clinical rotations and clerkships.
- *Major clinical disciplines* would include internal medicine (with subspecialties), surgery (with subspecialties), psychiatry, general practice/family medicine, gynaecology & obstetrics and paediatrics.
- *Patient safety* would require supervision of clinical activities conducted by

students.

- *Early patient contact* would partly take place in primary care settings and would primarily include history taking, physical examination and communication.
- *Participation in patient care* would include responsibility under supervision for parts of investigations and/or treatment to patients, which could take place in relevant community settings.

B 2.5.1 The medical school **must** in the curriculum identify and incorporate the contributions of the clinical sciences to ensure that students acquire sufficient knowledge and clinical and professional skills to assume appropriate responsibility after graduation.

(A) Basic information

Learning for clinical medicine mainly consists of preclinical (M2) and clinical (M2-M4) curricula. Preclinical education is composed of lectures by clinical department and clinical diagnostic practicums.

1st year of clinical clerkship is from January (M2) to November (M3) in groups of six members each, consisting of 18 weeks of internal medicine, 12 weeks of surgery (general surgery, neurosurgery, thoracic surgery and orthopaedics), 2 weeks of obstetrics/gynaecology (OB/GYN), 2 weeks of paediatrics, and 2 weeks of psychiatry. 2nd year consists of 18 weeks for ophthalmology, dermatology, otolaryngology, anaesthesiology, urology, radiology, pathology, rehabilitation medicine, transfusion, plastic surgery, infection control, emergency department and community medicine.

In total 17 weeks are allocated for EC in which students can enhance what they learned in CC. Students can select off-campus facilities to conduct EC.

(B) Analysis and self-evaluation

Clinical skills that students are required to learn are listed in the syllabus and taught appropriately.

(C) Current action

A new assessment system using a CC assessment sheet developed by AAC was started in the school year of 2014. Improvement in standard setting is planned for the school year of 2015.

(D) Plan for future improvement

Continuous reform of the CC content should be demanded from the viewpoint of OBE.

B 2.5.2 The medical school **must** in the curriculum identify and incorporate the contributions of the clinical sciences to ensure that students spend a reasonable part of the programme in planned contact with patients in relevant clinical settings.

(A) Basic information

The following programmes have planned contact with patients.

- 1st year: 8-9 day “Exposure to medical jobs” is conducted as early exposure to clinical medicine. Some students in clinical departments may have contact with patients.
- M2: 1-week nursing care practicum is offered.
- M2-M3: 36-week CC is offered.
- M3-M4: 18-week CC and 17-week EC are conducted.

(B) Analysis and self-evaluation

The new CC system was implemented in January 2013. A total of 71 weeks are achieved with CC plus the EC period.

(C) Current action

Two months are spent for graduation assessment in the current curriculum but it will become shorter when an integrated examination is implemented. At that time clinical programmes will be changed.

(D) Plan for future improvement

The plan to make “Exposure to medical jobs” mandatory for all the students who come to SMFMUT is considered.

B 2.5.3 The medical school **must** in the curriculum identify and incorporate the contributions of the clinical sciences to ensure that students experience health promotion and preventive medicine.

(A) Basic information

As for health promotion and preventive medicine, students will learn in lectures of hygienics (M1), public health (M2) and infection control (M2) and gain experiences in the operation department (M2) and public health (M3). In radiology basic science, hazards from and prevention of radiation is taught.

For students to deepen the perception of health promotion and preventive medicine, they have to record the results of their own antibody examination and if necessary they must receive vaccination of measles, rubella, varicella, mumps and hepatitis B.

(B) Analysis and self-evaluation

As for health promotion and preventive medicine, students are able to experience them at a certain level as well as obtain knowledge. However, since a practicum for a health check is not provided, learning might be not sufficient from the viewpoint of primary prevention.

(C) Current action

From the viewpoint of health promotion and preventive medicine, it should be clarified what content should be learned and at what level.

(D) Plan for future improvement

In light of the outcome "social perspectives," objectives or competencies for health promotion and preventive medicine should be considered.

B 2.5.4 The medical school **must** specify the amount of time spent in training in major clinical disciplines.

(A) Basic information

Currently CC in M2-M3 consists of 18 weeks of internal medicine, 12 weeks of surgery (general surgery, neurosurgery, thoracic surgery, and orthopaedics), 2 weeks of OB/GYN, 2 weeks of paediatrics and 2 weeks of psychiatry. CC in M3-M4 include 2 weeks of general practice (emergency care) or community medicine, 1 week of emergency department, OB/GYN or paediatrics.

(B) Analysis and self-evaluation

CC for surgery adopted an elective system, and therefore the period for the practicum for each department became 3 weeks, used for improving the practicum programme. CC for internal medicine is still 2 weeks each for each department.

(C) Current action

For CC in important departments, especially in internal medicine, the length of the practicum for each department should be reviewed for improvement.

(D) Plan for future improvement

In the school year of 2016, the length of days for graduation assessment will be shortened. Consideration to improve practicums should be continued.

B 2.5.5 The medical school **must** organise clinical training with appropriate attention to patient safety.

(A) Basic information

In clinical diagnostic practicums, M2 students learn the medical interview of patients and basic skills for physical examination. Physical examination and phlebotomy training with simulators are also combined. From the school year of 2014, M2 students must pass CAT OSCE to be promoted to M3. M2 students also have lectures and practicums of infection control to learn infection prevention measures in the hospital. In the operation department, students learn hand washing and gown technique to learn skills of infection control in an operation. M4 students have a special lecture for patient safety management.

In CC students carry out medical practice under the teaching and supervision of senior physicians, following medical practice standards stated in the CC guideline issued by the Ministry of Education, Culture, Sports, Science and Technology (MEXT) research group. Students are alerted to confidentiality for individual patient information.

In influenza season, sick students are told not to participate in CC. As a basic measure for infection prevention in CC, students are taught hand washing. Students must enroll in insurance for medical accidents.

UTH issues the pocket manual for patient safety to all the staff including medical students. Before participating in CC, M2 students are handed the certificate of student doctor in a ceremony. This ceremony is one of the opportunities to raise the consciousness of professionalism. Students take an oath that they are prepared for CC in the ceremony.

(B) Analysis and self-evaluation

Basic clinical skill training, confidentiality management for patient information and preparation for infection control/medical practice are contained in the necessary training.

(C) Current action

In the process to upgrade CC in the near future, patient safety measures should be updated continuously.

(D) Plan for future improvement

E-learning for patient safety or interpersonal communication for hospital staff is not yet offered. Implementation for such e-learning should be considered.

Q 2.5.1 The medical school **should** in the curriculum adjust and modify the contributions of the clinical sciences to the scientific, technological and clinical developments.

(A) Basic information

Each clinical department updates its lecture for clinical medicine. As for clinical diagnostic practicums, faculty members in charge and IRCME update the content continuously. Students are able to listen to integrated lectures for clinical medicine or mini-lectures in CC to obtain up-to-date information.

(B) Analysis and self-evaluation

Faculty members always update the content for teaching. However, sharing information about who teaches what might be not sufficient.

(C) Current action

Since the transition to OBE has been decided, educational content should be re-organised especially when lower-order competencies are specified.

(D) Plan for future improvement

Not only sharing educational content of teachers but also utilising students' log books to confirm and update the educational content.

Q 2.5.2 The medical school **should** in the curriculum adjust and modify the contributions of the clinical sciences to the current and anticipated needs of the society and the health care system.

(A) Basic information

In the future in Japan, it will be necessary to provide health care that will address a super-aging society. A one-week nursing care practicum in M2 is provided for that purpose. In geriatrics CC, M3 students learn how to diagnose and treat senior patients with more than one disease, and care for aged patients with physical disorders or dementia (even after discharge) in a comprehensive manner. In the community medicine practicum, M3/M4 students see aged patients and may provide care in clinics or nursing care facilities.

(B) Analysis and self-evaluation

Students achieve objectives that faculty members are targeting in CC in geriatrics and community medicine. However, currently both CC programmes are electives, chosen by only half of students.

(C) Current action

There is a possibility to consider and change the content and strategies of CC to adopt more societal needs into the curriculum.

(D) Plan for future improvement

FMUT should consider methods to learn about health economics in Japan. Educational resources in the School of Public Health should be utilised more. It is also necessary to organise education for interprofessional cooperative care.

Q 2.5.3 The medical school **should** ensure that every student has early patient contact gradually including participation in patient care.

(A) Basic information

1st year students experience settings for medical work in "exposure to medical jobs." Before CC, M2 students have opportunities to interview SPs and to conduct physical examinations with peers or simulators in clinical diagnostic practicums. Moreover, M2 students have nursing care practicums.

(B) Analysis and self-evaluation

Students are exposed to medical work in the first year just after admission to be motivated to learn medical subjects. Just before CC, clinical diagnostic practicums facilitate the adoption of clinical practice. However, there is no opportunity for M0 and M1 students to have contact with patients.

(C) Current action

Analysis of the experiences in "exposure to medical jobs" for the first year is needed.

(D) Plan for future improvement

Discuss if more patient contact is possible in M0 and M1.

Q 2.5.4 The medical school **should** structure the different components of clinical skills training according to the stage of the study programme.

(A) Basic information

Through clinical diagnostic practicums, M2 students will be ready with minimum medical interview skills, physical examination skills and basic attitudes as physicians.

An OSCE is conducted to assess students, and if the result is not sufficient, individual remedial training and retesting is provided.

In CC from M2 to M4, minimum physical examination skills are learned between students or with real patients. In addition to the required CC, 8-17 weeks of EC have been added. Thus, motivated students are able to do sub-internships in the departments they select.

(B) Analysis and self-evaluation

Basically, the education planning process is structured to align the level of student skills and performance with the educational programme.

(C) Current action

Evaluate the time frame and content for clinical diagnostic practicums in the M2 curriculum.

(D) Plan for future improvement

Consider construction of a system to share and revise the CC curriculum among different departments.

2.6 CURRICULUM STRUCTURE, COMPOSITION AND DURATION

Basic standard:

The medical school **must**

- describe the content, extent and sequencing of courses and other curricular elements to ensure appropriate coordination between basic biomedical, behavioural and social and clinical subjects. (B 2.6.1)

Quality development standard:

The medical school **should** in the curriculum

- ensure horizontal integration of associated sciences, disciplines and subjects (Q 2.6.1)
- ensure vertical integration of the clinical sciences with the basic biomedical and the behavioural and social sciences. (Q 2.6.2)
- allow optional (elective) content and define the balance between the core and optional content as part of the educational programme. (Q 2.6.3)
- describe the interface with complementary medicine. (Q 2.6.4)

Annotations:

- Examples of *horizontal* (concurrent) *integration* would be integrating basic

sciences such as anatomy, biochemistry and physiology or integrating disciplines of medicine and surgery such as medical and surgical gastroenterology or nephrology and urology.

- Examples of *vertical* (sequential) integration would be integrating metabolic disorders and biochemistry or cardiology and cardio-vascular physiology.
- *Core and optional (elective) content* refers to a curriculum model with a combination of compulsory elements and electives or special options.
- *Complementary medicine* would include unorthodox, traditional or alternative practices.

B 2.6.1 The medical school **must** describe the content, extent and sequencing of courses and other curricular elements to ensure appropriate coordination between basic biomedical, behavioural and social and clinical subjects.

(A) Basic information

From M0 to M1 basic sciences, behavioural sciences and social medicine are taught based on ologies. Since these will become the basis for clinical medicine, students are expected to learn all the content before CC.

Systematic lectures are offered for clinical medicine from April to December of M2, then CC starts in January. After CC starts, not only lectures in each department but integrated lectures for clinical medicine and integrated lectures for basic sciences/basic science, clinical and social medicine are provided to organise clinical medicine knowledge with basic sciences, behavioural sciences and social medicine.

(B) Analysis and self-evaluation

Elements of the curricula are specified by syllabus to students. The syllabus is able to work as an advanced organiser because it contains details of classes and practicums with references. Goals and objectives are also stated. The extent of education is wide and high.

However, the curriculum for the first 1.5 years is so filled with liberal arts subjects that students have to learn much content in a short period until CC starts.

(C) Current action

The AAC and CC support team hold meetings with students and faculty members to get input to improve the structure of the curriculum. FMUT was able to change the curricular content for the second half of M0, though it was difficult because CAS previously had initiatives.

(D) Plan for future improvement

Discussion to include medical subjects into CAS curricula should be continued.

Q 2.6.1 The medical school **should** in the curriculum ensure horizontal integration of associated sciences, disciplines and subjects

(A) Basic information

Integrated lectures are provided as follows: For M1 to M4—in basic sciences, clinical and social medicine; and for M3 and M4 in clinical medicine. Several departments are involved in one lecture theme to nurture integrated perspectives for students.

In FD held on 25 August 2014, participants discussed the M2 curriculum, such as,“organ-system-based or generation-based integration (such as combining content for children or aged people)”, and “assessment for each subject should be integrated”. However, participants agreed that ologies should still remain the focus, and that they should study how to reorganise and integrate the exams for each department, taking into consideration student load.

(B) Analysis and self-evaluation

Horizontal integration seems OK.

(C) Current action

Assessment for integrated lectures for basic sciences, clinical and social medicine and integrated lectures for clinical medicine is not specified, so information as to how much students have achieved is lacking. The contents of these programmes are changing every year, so the extent of improvement is not clear.

(D) Plan for future improvement

Discuss the system to continuously improve students’ outcome and curriculum.

Q 2.6.2 The medical school **should** in the curriculum ensure vertical integration of the clinical sciences with the basic biomedical and the behavioural and social sciences.

(A) Basic information

All the clinical medicine, basic sciences and social medicine faculty members share the updated information to provide integrated lectures for basic sciences, clinical and social medicine started in 2001. The theme and contents for the integrated lectures are determined by not only faculty members but also students to meet the students’ need.

(B) Analysis and self-evaluation

Student committee members participate in planning the lecture content of the integrated lecture programme. The programme runs for five days from morning to early evening. Contents range from mathematical modeling to light catalysts.

After determining the theme, student committee members and a coordinator faculty member discuss who should be lecturers. From M1 to M4, students can participate in this process to integrate the contents vertically.

(C) Current action

Since only some of the students are involved, there might be an imbalance or duplication of themes or content that can be improved.

(D) Plan for future improvement

Lack of assessment for students and insufficient attendance rate are the issues for future improvement.

Q 2.6.3 The medical school **should** in the curriculum allow optional (elective) content and define the balance between the core and optional content as part of the educational programme.

(A) Basic information

Students can select the following option curricula.

- FQ: 4 weeks are required but 1 week in M0, 6 weeks in M1, and 2 weeks x twice in M2 are all elective.
- Medical English III: Offered for M3 students who plan to participate in research or clinical EC in foreign countries.
- EC: 4 weeks x 3 times in M3 and 5 weeks in M4 are allocated.
- Researcher development programme: PhD-MD course, MD researcher and clinical researcher development programmes are included.

Those involved in the PhD-MD course or MD researcher development programme are allowed to decrease on-duty hours in CC to avoid interference with research activities.

(B) Analysis and self-evaluation

There are various opportunities for electives for students to learn about career options and professional attitudes toward their future jobs. Researcher development programmes especially enable students to be involved in full-fledged research activities from studentship, and are helpful in the development of basic and physician scientists, one of the main missions of UT.

On the other hand, balance with CC that requires long hours is an issue. The main activities of the clinical researcher development programme are lectures and reading sessions of scientific papers. Further improvement is necessary and is underway.

(C) Current action

FQ and EC should be continued because these promote highly recommended practicums outside of the campus to broaden students' horizons. The clinical researcher development programme started in 2010 and continues to improve.

(D) Plan for future improvement

More cooperative facilities outside of the campus should be added for FQ and EC to meet the needs of different students. Seminar-type lectures should be opened if student needs are high, besides Medical English III.

As for the PhD-MD course and MD researcher development programme, content should be enhanced after evaluation of graduates, products and direct feedback from those involved. As for the clinical researcher development programme, it also should obtain student feedback and suggestions to enhance existing content and introduce new topics.

Q 2.6.4 The medical school **should** in the curriculum describe the interface with complementary medicine.

(A) Basic information

One representative of complementary alternative medicine programmes is Kampo medicine in Japan (Chinese medicine imported previously and modified in Japan). Oriental medicine/complementary medicine is offered 3 times x 50 minutes to teach the basic concept of Kampo medicine, several diseases for which Kampo is a good choice and where there is integration of oriental and western medicine. Other types of complementary medicine are not included in the curriculum.

(B) Analysis and self-evaluation

Only a short period is provided for Kampo medicine though clinicians widely use Kampo drugs for some chronic diseases without specific evidence of the mechanism or effectiveness. If the mechanisms become more scientific, pharmacology will teach this area in the future.

(C) Current action

No plan to change the curriculum for complementary medicine.

(D) Plan for future improvement

Discuss the need to add more complementary and alternative medicine other than Kampo.

2.7 PROGRAMME MANAGEMENT

Basic standard:

The medical school **must**

- have a curriculum committee, which under the governance of the academic leadership (the dean) has the responsibility and authority for planning and implementing the curriculum to secure its intended educational outcomes. (B 2.7.1)
- in its curriculum committee ensure representation of staff and students. (B 2.7.2)

Quality development standard:

The medical school **should**

- through its curriculum committee plan and implement innovations in the curriculum. (Q 2.7.1)
- in its curriculum committee include representatives of other relevant stakeholders. (Q 2.7.2)

Annotations:

- *The authority of the curriculum committee* would include authority over specific departmental and subject interests, and the control of the curriculum within existing rules and regulations as defined by the governance structure of the institution and governmental authorities. The curriculum committee would allocate the granted resources for planning and implementing methods of teaching and learning, assessment of students and course evaluation (see area 8.3).
- *Other relevant stakeholders* would include other participants in the educational process, representation of teaching hospitals and other clinical facilities, representatives of graduates of the medical school, other health professions, who are involved in the educational process, or other faculties in the University. Other relevant stakeholders might also include representation of the community and public (e.g. users of the health care delivery system, including patient organisations).

B 2.7.1 The medical school **must** have a curriculum committee, which under the governance of the academic leadership (the dean) has the responsibility and authority for planning and implementing the curriculum to secure its intended educational outcomes.

(A) Basic information

AAC is the only permanent committee responsible for education in SMFMUT. Issues approved in AAC are reported to and endorsed by PBM before implementation. Major issues for educational revision become agenda items in PBM for discussion before endorsement.

Some educational issues or detailed plans demanding more time for discussion are sent to specific WG, such as curriculum reform. Each WG makes a report to be endorsed in AAC.

Other meetings related to education consist of the CC curriculum WG, CC support team, electronic chart WG, vaccination inoculation meeting, graduation assessment WG and CC assessment WG.

(B) Analysis and self-evaluation

The system for implementation and continuous improvement of curriculum works well in the form that AAC governs many WGs and other meetings.

(C) Current action

As for career support after graduation no organisation related to postgraduate training or the research career pathway has been set up. Such a function will be needed in SMFMUT.

(D) Plan for future improvement

Plans for improvement should be discussed for the current system to function better. Consider the need for career support of graduates.

B 2.7.2 The medical school **must** in its curriculum committee ensure representation of staff and students.

(A) Basic information

The representatives of students have opportunities to deliver opinions to AAC but is not an official member of AAC. The students' WG for Medical Education (SWGME) may participate in AAC meetings as observers.

(B) Analysis and self-evaluation

Sufficient numbers of faculty representatives are on the AAC. Representatives from students are not official members of AAC.

(C) Current action

Consider how student representatives participate in AAC.

(D) Plan for future improvement

The way to welcome student representatives in AAC as official members should be discussed.

Q 2.7.1 The medical school **should** through its curriculum committee plan and implement innovations in the curriculum.

(A) Basic information

The curriculum reform WG under AAC analyses curricular problems and how to improve them. Discussion in FDs or opinions from IRCME are also utilised to improve the situation. As for improvement of the CC curriculum reform WG, the CC support team and CC support centre collaborate in organizing the plans for improvement. Implementation of the plan is conducted by AAC.

(B) Analysis and self-evaluation

Very active discussion on the medical education curriculum is being done prior to the accreditation team visit. For the researcher development programmes, new approaches are always being discussed, designed and implemented to enrich to the CC.

(C) Current action

Objective data and information should be evaluated for further improvement. Such a system for continuous improvement is needed.

(D) Plan for future improvement

Discussion to establish the system of continuous improvement by AAC should be promoted. Consider setting up an IR department to help this system.

Q 2.7.2 The medical school **should** in its curriculum committee include representatives of other relevant stakeholders.

(A) Basic information

More than 20 members are involved in AAC as committee members. Two members join in AAC from IRCME to offer advice to improve medical education curriculum.

(B) Analysis and self-evaluation

No one from training hospitals or other clinical facilities, representatives of graduates, health professionals other than physicians, or faculty members from other faculties participates in AAC. Opinions from such stakeholders are reported via members of the curriculum reform WG or IRCME.

(C) Current action

Contact person should be clear to collect information from such stakeholders.

(D) Plan for future improvement

How to obtain opinions from training hospitals, graduates, and other health professionals should be discussed by the general education centre and IRCME. The curriculum reform WG should collect information from other faculties.

2.8 LINKAGE WITH MEDICAL PRACTICE AND THE HEALTH SECTOR

Basic standard:

The medical school **must**

- ensure operational linkage between the educational programme and the subsequent stages of training or practice after graduation. (B 2.8.1)

Quality development standard:

The medical school **should**

- ensure that the curriculum committee
  - seeks input from the environment in which graduates will be expected to work, and modify the programme accordingly. (Q 2.8.1)
  - considers programme modification in response to opinions in the community and society. (Q 2.8.2)

Annotations:

- The *operational linkage* implies identifying health problems and defining required educational outcomes. This requires clear definition and description of the elements of the educational programmes and their interrelations in the various stages of training and practice, paying attention to the local, national, regional and global context. It would include mutual feedback to and from the health sector and participation of teachers and students in activities of the health team. Operational linkage also implies constructive dialogue with potential employers of the graduates as basis for career guidance.
- *Subsequent stages of training* would include postgraduate training (pre-registration training, vocational training, specialist training) and continuing professional development (CPD)/continuing medical education (CME).

B 2.8.1 The medical school **must** ensure operational linkage between the educational programme and the subsequent stages of training or practice after graduation.

(A) Basic information

The following curricula are provided to make UGME and PGME seamless.

- Clinical diagnostic practicums

  Basic clinical skills and attitudes which should be learned before CC are provided 43 times x 3 hours (at the pace of twice a week). All the departments and IRCME participate in small group practicums.

  Physical examination should be learned during the diagnostic process. HDPE is such a physical examination technique where diagnostic reasoning is learned at the same time; offered in October to December M2.

  Basic clinical skills taught with simulators are offered from May to October and address patient safety issues. Medical interview practicums are also offered to teach better communication between physician and patient. Students conduct role-playing with SPs, and through videotape review receive feedback in small groups.

- CC

  All the clinical departments provide CC in both UTH and hospitals outside of UT. Comprehensive administration and management is provided by the CC support centre and CC support team.

- PBL

  In M2 for three months, PBL is provided 11 times once a week. Not only acquisition of knowledge but also learning skills are emphasised. Administration and management is offered by IRCME.

- OSCE

  Clinical skills necessary for CC are assessed by the OSCE program offered by CAT. No OSCE is offered after CC.

- Community medicine practicum

  The community medicine practicum was implemented in November 2013 for M3 or M4. Half the students go to clinics, home care and nursing care facilities.

(B) Analysis and self-evaluation

Linkage between UGME and PGME is provided. In UTH, since attendings for PGME also work for UGME, the linkage is clearer. In other hospitals or CC in foreign countries such linkage might be unclear. Each clinical department has initiatives to offer CC but some might have problems to manage them in the real settings.

(C) Current action

FMUT should consider how to bridge UGME and PGME in the current programme after hearing from graduates.

(D) Plan for future improvement

More discussion is needed for better linkage between UGME and PGME and to consider continuous and integrated program development.

Q 2.8.1 The medical school **should** ensure that the curriculum committee seeks input from the environment in which graduates will be expected to work, and modify the programme accordingly.

(A) Basic information

Graduates from UT work in various facilities across the whole country besides UTH. Numbers of UT graduates who entered a UT postgraduate programme were 29, 35 and 42 in 2012, 2013 and 2014 respectively. In the third year after graduation numbers of UT graduates working in UT were 68, 53 and 57 in 2012, 2013 and 2014 respectively. As such information from UT graduates who work in UT are always available.

Graduation	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
UT	59	46	46	47	46	43	39	45	29	35	42
Others	71	84	94	101	84	87	91	85	102	91	84
Total	130	130	140	148	130	130	130	130	131	126	126

(B) Analysis and self-evaluation

Regarding house officers working in UTH continuous information and problems are collected through meetings with the hospital director and questionnaire surveys to give feedback to UGME. The information about UT graduates working in other hospitals is limited.

(C) Current action

A systematic follow-up system for data from graduates or alumni should be discussed.

(D) Plan for future improvement

A systematic follow-up system for data from graduates or alumni should be discussed such as with the Institutional Research (IR) division.

Q 2.8.2 The medical school **should** ensure that the curriculum committee considers programme modification in response to opinions in the community and society.

(A) Basic information

In CC, a “community medicine” practicum was started to provide experiences in clinics, home and nursing care facilities.

Internationalization of students is promoted through EC abroad, foreign EC is promoted. Many students go abroad for basic science and clinical medicine practicums. Some of these facilities or universities have official agreements with UT for such practicums.

(B) Analysis and self-evaluation

Opinions from community and society are incorporated into the programme.

(C) Current action

SMFMUT should consider how to further adjust the educational curriculum ~~is adjusted~~ to the needs expected from community and society.

(D) Plan for future improvement

For the internationalization of the entire UT campus and its students, foreign practicums should be promoted further. Formal contact channels to adopt opinions from community and society should be discussed.

3. ASSESSMENT OF STUDENTS

3.1 ASSESSMENT METHODS

Basic standard:

The medical school **must**

- define, state and publish the principles, methods and practices used for assessment of its students, including the criteria for setting pass marks, grade boundaries and number of allowed retakes. (B 3.1.1)
- ensure that assessments cover knowledge, skills and attitudes (B 3.1.2)
- use a wide range of assessment methods and formats according to their "assessment utility" (B 3.1.3)
- ensure that methods and results of assessments avoid conflicts of interest (B 3.1.4)
- ensure that assessments are open to scrutiny by external expertise. (B 3.1.5)

Quality development standard:

The medical school **should**

- document and evaluate the reliability and validity of assessment methods. (Q 3.1.1)
- incorporate new assessment methods where appropriate. (Q 3.1.2)
- use a system for appeal of assessment results. (Q 3.1.3)

Annotations:

- *Assessment principles, methods and practices* would include consideration of number of examinations and other tests, balance between written and oral examinations, use of normative and criterion referenced judgements, and use of special types of examinations, e.g. objective structured clinical examinations (OSCE) or mini clinical evaluation exercise (MiniCEX).
- *Assessment methods* would include the use of external examiners with the purpose of increasing fairness, quality and transparency of assessments.
- *"Assessment utility"* is a combination of validity, reliability, educational impact, acceptability and efficiency of the assessment methods and formats.
- *Documentation and evaluation of reliability and validity of assessment methods* would require an appropriate quality assurance process of assessment practices.

B 3.1.1 The medical school **must** define, state and publish the principles, methods and practices used for assessment of its students, including the criteria for setting pass marks, grade boundaries and number of allowed retakes.

(A) Basic information

Requirements for the primary phase are stated in the CAS UT handbook with rules for course enrolment and assessment. Requirements for the secondary phase are stated in

the SMFMUT handbook including rules for promotion, examination, assessment, graduation and resit examination.

There are two phases for students to be promoted from CAS to SMFMUT. In total, 110 students are promoted to SMFMUT; in the first phase 77 (64 from Natural Sciences III, 10 from Natural Science II and 3 from other divisions) and in the second phase 33 (all from Natural Science III). To be promoted to SMFMUT, students have to take one of the required bioscience subjects (2 credits) by the first half of the second year.

Examination results are divided into A, B, C, D and F; pass for D and better, or fail for F. Assessment is done using examination points B for 100-80, C for 79-70, D for 69-60 and F for 59 or below. A is offered to those with B who are approved high performers (only those who are in the top 10th percentile).

In the SMFMUT rules, required subjects are listed. Those who are promoted to M2 must take all the basic science subjects in M0 (anatomy, histology, osteology, biochemistry, dietetics, introduction to medicine, statistics, homo sapiens genetics and experimental animal resources) and other basic science subjects in M1, then pass the examinations (at most 2 subjects might be delayed until the end of M2). Those who are promoted to M3 must take all the required subjects, and then pass all the examinations and CAT-CBT/OSCE.

Resit is possible for all the examinations only once. The graduation assessment also has a resit. If a student fails equal to or more than 9 subjects, they lose the capacity to take resit examinations. If they pass a resit, their assessment converts to 60 (D).

Standards for CAT-CBT are discussed by AAC even if AAC refers to the item response theory (IRT) cut-off score of 43. Resit for CAT-OSCE is only conducted for stations with failed students, and the pass-fail decision is made by a group of faculty members.

Those who are promoted to M4 must take equal or more than 80% of credits offered in CC in M3.

The above information is announced to students through the handbooks of CAS and SMFMUT. As for the CAT-CBT, starting from December 2014, the cut-off score was decided as the IRT standard score of 43 and announced to students.

(B) Analysis and self-evaluation

Principles, methods and implementation of student assessment including written tests and reports are defined and announced to students through handbooks. For assessment for CC in M3 and M4, however, the relationship between assessment and the requirements for promotion or graduation is not documented in the handbooks or syllabi. The cut-off score for CAT-OSCE is also unclear.

(C) Current action

SMFMUT has begun revisions towards OBE with defined educational outcomes, and is developing assessment tools appropriate for each outcome. In FDs conducted in March, June, August and November 2014, many faculty members in SMFMUT participated in the discussion about educational outcomes and assessment tools. AAC is using the

results of the discussion for assessment revision plans to be implemented in the near future.

(D) Plan for future improvement

Current tools for assessment focus on knowledge, such as written assessments or reports. In the future, SMFMUT should change to OBE using comprehensive assessment tools to prove that educational outcomes are achieved by competency-based assessment. Two WGs for graduation assessment and CC assessment have specified the plan for a better assessment system so that implementation will be the issue.

B 3.1.2 The medical school **must** ensure that assessments cover knowledge, skills and attitudes

(A) Basic information

The relationship between different subjects and various assessment tools is listed in the table in the following pages. For each lecture and practicum, assessment including knowledge, skills and attitude is carried out. Details are listed in the syllabus booklets for CAS and FMUT.

In the FMUT handbook, use of OSCEs is documented. Before entering CC, students must pass CAT-CBT and CAT-OSCE in M2.

Attitude is mainly assessed in practicum programmes. One item in the CC assessment is specifically for attitude.

(B) Analysis and self-evaluation

For all the lectures and practicums, knowledge, skills and basic attitude are assessed.

(C) Current action

The validity of assessment for knowledge, skills and attitudes should be confirmed for lectures and practicums to make assessment methods more effective.

(D) Plan for future improvement

Implementation of a post-clerkship OSCE should be an addition to the current assessment tools for knowledge, skills and attitude.

Assessment Methods for Each Subject

	Subject	Attend-ance	Report	Written Exam	Small Quiz	Viva	Attitude	Presen-tation	Chart	Global rating
M0	Origins of Medicine	x	x							
	Anatomy (histology, osteology)		x	x						
	Biochemistry/Dietetics		x	x						
	Homo sapiens genetics			x						
	Statistics	x		x						
	Experimental animal resources			x						
M1	Neuroanatomy		x	x	x					
	Anatomy			x	x	x				
	Physiology	x	x	x				x		
	Pathology		x	x	x					
	Pharmacology	x	x	x			x	x		
	Hygienics	x		x	x					
	Microbiology		x	x						
	Immunology	x	x	x	x					
	Parasitology		x	x						
	Medical engineering basics	x		x						
	Radiology basic sciences	x	x	x						
M2	Clinical Diagnostic Practicum	x		x			x			
	Public Health			x			x			
	Radiology Basic Sciences			x						
	Gastroenterology	x		x						
	Gastroenterology CC	x	x			x				x
	Health Management	x		x						
	Cardiology			x						
	Cardiology CC	x				x	x			x
	Respitology			x						
	Respitology CC	x					x	x	x	x
	Neurology			x						
	Neurology CC	x					x	x		x
	Haematology/Oncology	x		x	x					
	Haematology/Oncology CC	x	x			x		x		x
	Nephrology			x						
	Endocrinology			x						
	Nephrology/Endocrinology CC	x	x			x				x
	Diabetes/Metabolism CC	x	x			x				x
	Allergy/Rheumatology	x		x	x					

M2	Allergy/Rheumatology CC	x				x	x	x		x
	Gerontology	x		x						
	Gerontology CC	x				x		x		x
	Psychosomatic medicine	x		x	x					
	Psychosomatic medicine CC	x	x				x			x
	Infectious diseases	x		x						
	Infectious diseases CC	x	x			x				x
	Surgery	x		x	x					
	Surgery (oncology/vascular) CC	x	x			x				x
	Surgery (hepatobiliary, pancreatic/transplantation) CC	x	x			x	x		x	x
	Surgery (upper GI/mammo) CC		x			x		x		x
	Neurosurgery		x	x		x				
	Neurosurgery CC						x	x		x
	Thoracic surgery	x	x			x				x
	Lung surgery	x		x	x					
	Cardiovascular surgery	x		x						
	Orthopaedics			x						
	Orthopaedics CC	x	x			x	x	x	x	x
	OB/GYN			x						
	OB/GYN CC	x	x			x				x
	Paediatrics			x						
	Paediatrics CC	x	x			x	x	x		x
	Ophthalmology			x						
	Ophthalmology CC	x								
	Dermatology			x						
	Urology	x		x	x					
	Psychiatry			x						
	Psychiatry CC		x			x				x
	Otolaryngology	x		x						
	Radiology			x						
	Plastic surgery	x		x						
	Clinical pathology	x		x						
	Oral surgery			x						
	Paediatric surgery	x		x						
	Emergency medicine	x		x						
	Infection control			x						
	Infection control CC	x	x							
	Pathology	x		x	x					
	Operation department	x								
	Rehabilitation medicine			x						x

M2	Medical informatics		x							
	Oriental/complementary medicine			x						
M3	Integrated lectures for clinical medicine	x								
	Internal medicine (gastroenterology) CC	x	x			x				x
	Internal medicine (respitology) CC	x					x	x	x	x
	Public health (practicums)	x	x				x	x		
	Neurology CC	x					x	x		x
	Internal medicine (haematology/oncology) CC	x				x				x
	Internal medicine (infectious diseases) CC	x	x			x				x
	Internal medicine (gerontology) CC	x				x		x		x
	Internal medicine (allergy/rheumatology) CC	x				x	x	x		x
	Internal medicine (cardiology) CC	x				x	x			x
	Internal medicine (diabetes/metabolism) CC	x	x			x				x
	Internal medicine (nephrology/endocrinology) CC	x	x			x				x
	Internal medicine (psychosomatic medicine) CC	x	x				x			x
	Internal medicine (haematology/oncology) CC	x	x			x		x		x
	Surgery (oncology/vascular) CC	x	x			x				x
	Surgery (hepatobiliary, pancreas/transplantation) CC	x	x			x	x		x	x
	Surgery (upper GI/mammo) CC		x			x		x		x
	Thoracic surgery CC	x	x			x				x
	Neurosurgery		x	x		x				
	Neurosurgery CC						x	x		x
	Orthopaedics CC	x	x			x	x	x	x	x
	Orthopaedics EC	x					x	x		x
	OB/GYN CC	x	x			x				x
	OB/GYN new CC	x	x			x				x
	Psychiatry CC		x			x				x
	Paediatrics CC	x	x			x	x	x		x
	Paediatrics new CC	x	x			x	x			x
	Radiology CC	x		x		x				x
	Radiology new CC		x			x		x		x
	Clinical pathology new CC	x				x				x
	Rehabilitation medicine new CC	x	x				x	x		x
	Oral surgery CC	x	x			x	x			x
	Plastic surgery CC	x	x	x						x
	Paediatric surgery new CC	x				x	x		x	x
	Ophthalmology CC	x	x			x		x		x
	Emergency medicine CC	x		x						x
	General practice CC									x
	Otolaryngology CC	x	x			x				x

	Urology/male care new CC	x				x	x		x	x
	Dermatology new CC	x	x				x			x
	Pathology CC	x	x				x			x
	Anaesthesiology/pain centre new CC	x	x			x	x			x
M3	Pharmaceutical department CC	x	x							x
	Transfusion department CC	x	x			x				x
	Infection control department CC	x					x			x
	Clinical research support centre new CC	x				x	x			x
	Community medicine new CC	x	x					x		x
	Integrated lectures for clinical medicine	x								
	Public health			x						
	Social medicine – palliative care	x								
	Neurosurgery		x	x		x				
	Orthopaedics EC	x					x	x		x
	OB/GYN new CC	x	x			x				x
	Dermatology			x						
	Dermatology new CC	x	x				x			x
	Radiology CC	x		x		x				x
	Radiology new CC		x					x		x
	Transfusion department CC	x	x	x		x				x
	Rehabilitation medicine new CC	x	x				x	x		x
	Oral surgery CC	x	x			x	x			x
	Plastic surgery CC	x	x	x						x
M4	Paediatric surgery new CC	x				x	x		x	x
	Ophthalmology CC	x	x			x		x		x
	Emergency medicine CC	x		x						x
	General practice CC							x		x
	Otolaryngology CC	x	x			x				x
	Paediatrics new CC	x	x			x	x			x
	Urology/male care new CC	x				x	x		x	x
	Pathology CC	x	x				x			x
	Anaesthesiology/pain centre new CC	x	x			x	x			x
	Pharmaceutical department CC	x	x							x
	Transfusion department CC	x	x			x				x
	Clinical pathology new CC	x				x				x
	Infection control department CC	x					x			x
	Clinical research support centre new CC	x				x	x			x
	Community medicine new CC	x	x					x		x

CC: Clinical Clerkship, EC: Elective Clerkship

B 3.1.3 The medical school **must** use a wide range of assessment methods and formats according to their "assessment utility"

(A) Basic information

In the first and second year in CAS, the main assessment tools are written examinations (not specified in detail so not listed in the table).

For basic sciences in M0 and M1, not only written examinations but also attitude and degree of understanding are confirmed in detail and are reflected on the assessment ratings of their comprehensive assessment results.

For the lectures on clinical medicine in M2, clinical diagnostic practicums are key. For medical interviewing and physical examination skills, CAT-OSCE is the main assessment tool currently conducted in December in M2.

For CC from M2 to M4, each department assesses basic knowledge, skills, diagnostic reasoning, clinical planning, case presentation, attire and communication with patients. If a student fails the CC assessment, that student cannot take the graduation examination. If the CC assessment is on the borderline, some departments offer an additional practicum programme. The graduation examination mainly uses written assessment. A post-clerkship OSCE has not yet started.

(B) Analysis and self-evaluation

Each subject uses various tools of assessment for knowledge, skills and attitudes. Examination for graduation or promotion has not been changed drastically yet, but some summative assessment uses more valid methods.

The transition process to OBE just started in September 2014, so the assessment system will be revised soon after accreditation in February 2015.

(C) Current action

CC started in January 2013 and is changed every year. In 2014, FD has been regularly held to enhance the ability of faculty members to assess students. Educational outcomes were finalised in September 2014 and future improvement is expected.

(D) Plan for future improvement

SMFMUT has started discussion for revision of the curriculum into OBE with 10 outcomes. An assessment system for continuous improvement based on assessment data should be established.

B 3.1.4 The medical school **must** ensure that methods and results of assessments avoid conflicts of interest

(A) Basic information

Rules of UT state that "learner assessment is determined by each faculty/department's rule," so avoidance of conflict of interest is an issue that needs to be defined in SMFMUT rules. However, no rule addresses conflict of interest for assessment in SMFMUT. For example, if a student's relative assesses the student, currently no rule regulates such conduct.

As for harassment issues, several documents including general harassment, sexual harassment and academic harassment are available on the web of UT. There is a harassment counseling centre for the whole UT open to any student.

As for compliance issues (adherence to laws and regulations, rules in the university, ethics for education and research, and other regulations), basic regulation for compliance defines responsibilities of faculty members and students to prevent compliance problems. If students have concerns, how to contact the person in charge is clearly specified.

(B) Analysis and self-evaluation

No issue was discussed about the conflict of interest of faculty members with their relatives. However, such cases should be considered, to revise the rules and result in improvement.

SMFMUT does not ask students for any donation to the university, which may influence the assessment system. The fact that contact information is clear about harassment and compliance issues, and a tutor system is easily accessible to students should be appreciated.

(C) Current action

AAC is starting to discuss the system for an examinee's relative to avoid the role of examiner. SMFMUT rules should have such an item.

(D) Plan for future improvement

Issues of conflict of interest should be continuously improved by collecting information from actual cases, such as how to deal with harassment or compliance issues.

B 3.1.5 The medical school **must** ensure that assessments are open to scrutiny by external expertise.

(A) Basic information

Regulations or operations for assessment should be specified to students through each syllabus for external experts to critically appraise the system. However, currently the syllabae are not open to those outside of SMFMUT.

The syllabae list assessment methods, such as written examinations, reports, etc. but do not specify concrete assessment criteria or the assessment process. Sometimes the connection between assessment and a promotion decision is unclear.

(B) Analysis and self-evaluation

Currently accountability and transparency of assessment is not sufficient. Sharing information about assessment tools and standard setting should be promoted.

(C) Current action

Assessment tools and standard setting should be clarified in the syllabus for all the subjects. Moreover, the process leading up to a promotion decision should be clarified to avoid mistrust.

(D) Plan for future improvement

The criteria and process for assessment should be checked and evaluated and should be disclosed.

Q 3.1.1 The medical school **should** document and evaluate the reliability and validity of assessment methods.

(A) Basic information

The CAT organisation maintains appropriate quality assurance regarding the assessment process for CAT-CBT and CAT-OSCE. Reliability and validity of such examinations are clarified. It is difficult to evaluate the validity and reliability for assessment tools used in SMFMUT. One index is the pass rate for medical licence examination offered by MHLW.

Table. Graduation assessment and medical licence examination pass rates

	Graduation assessment		Medical Licence Examination Pass Rates	
	Average	Standard deviation	Pass rates for all	Pass rates of new graduates
2013	79	5.20	89.2%	91.6%
2012	79	3.96	94.4%	99.0%
2011	78	4.91	92.7%	94.1%
2010	82	4.57	92.2%	96.7%
2009	80	4.06	90.4%	93.2%
2008	80	4.94	92.5%	92.4%
2007	81	5.46	90.7%	92.6%
2006	78	7.33	99.0%	99.0%
2005	78	5.50	90.3%	92.9%

For these eight years pass rates have exceeded 90%, especially rates limited to fresh graduates which are maintained at 92-93%. Predictive validity between CAT-CBT and the graduation examination has been from 0.52 to 0.68 in terms of the correlation coefficient. Furthermore, graduation assessment points were significantly different between those who passed or failed the medical licence examinations (80.2 vs 72.2, $P<0.001$).

Assessment for lectures and practicums or how to develop and use assessment for the graduation assessment depends on each department. In general, it is not possible to assure validity and reliability. CC assessment used in M2 to M4 has an assessment guide for faculty members to share. CC assessment outside of campus is done by faculty members inside of the university, based on assessment from outside faculty members. Students with problems during CC are reported to the CC support centre, then AAC addresses each case as necessary.

(B) Analysis and self-evaluation

CAT's CBT and OSCE are considered quality assured with reliability and validity. However, examination by each department for CC assessment and graduation assessment have low validity and reliability. AAC should clarify the ratings, range, methods and process of assessment; as well as check for reliability, convergence and discriminatory correlations with oth assessments and standard setting.

(C) Current action

Regarding CC assessment, the CC support team has regular meetings to avoid biases in the different departments and to explain criteria for assessment and results of global ratings in each department. The CC assessment sheet consists of various components, and validity is always discussed among faculty members in charge of CC and AAC committee members.

(D) Plan for future improvement

In the future, SMFMUT will need to establish a "general assessment committee," which will continuously and consistently discuss, manage and improve all assessment. Appropriate assessment for assessing competencies at graduation and assessment in each subject or department should be considered and discussed.

SMFMUT will need more FDs for assessment development, blueprinting, consistent assessment with goals/objectives, etc. For the graduation assessment, relevance to the medical licence examination or graduation outcomes should be considered.

Q 3.1.2 The medical school **should** incorporate new assessment methods where appropriate.

(A) Basic information

In PBL in M2, in addition to the faculty's assessment, self-assessment and peer assessment are conducted.

For CC in M2-M4, portfolio learning was introduced and organised for future assessment. In CC, the assessment sheet includes not only global ratings but also detailed items.

Written examinations and reports are major assessment methods but some practicums use other assessment tools such as presentations or discussions. Some departments use viva, presentations and medical charts as assessment targets to make them multidimensional.

(B) Analysis and self-evaluation

Some multidimensional assessment tools are adopted in PBL and CC. More balanced assessment include skills and attitudes. Current graduation assessment uses only written assessment, but skills and attitudes should be included in the future.

(C) Current action

The CC support team and AAC continue discussion to adopt multidimensional assessment especially in CC.

FD in June 2014 participants discussed reform for the graduation assessment. Beginning in the school year of 2016, assessment should be changed from written assessment only to adoption of a post-clerkship OSCE. The graduation assessment WG is promoting a concrete plan to make the reform.

(D) Plan for future improvement

Regarding OBE perspectives, multidimensional assessment methods should be adopted to ensure appropriate assessment of outcomes at graduation; especially adoption of a post-clerkship OSCE, work-based assessment including mini-CEX or DOPS in CC, and use of portfolios.

Q 3.1.3 The medical school **should** use a system for appeal of assessment results.

(A) Basic information

If an examinee has any concern or doubt about an assessment or other results, they can consult with faculty members. FMUT rules have pages for marking schemes etc.

(B) Analysis and self-evaluation

When a student would like to file an appeal against an assessment, the contact person will be a faculty member or member of the academic affair administrative division (AAAD), but AAC members or chairperson will deal with the issue. However, an

official body to deal with an actual appeal or its concrete process is not yet documented or systematised.

(C) Current action

No problem is found in the appealing system for assessment results.

(D) Plan for future improvement

Consider establishment of an appealing system including a contact person, method for appeal, etc. Discussion is also needed to address the issue that there is no official body for dealing with problems on the students' side, such as cheating.

3.2 RELATION BETWEEN ASSESSMENT AND LEARNING

Basic standard:

The medical school **must**

- use assessment principles, methods and practices that
  - are clearly compatible with intended educational outcomes and instructional methods. (B 3.2.1)
  - ensure that the intended educational outcomes are met by the students. (B 3.2.2)
  - promote student learning. (B 3.2.3)
  - provide an appropriate balance of formative and summative assessment to guide both learning and decisions about academic progress. (B 3.2.4)

Quality development standard:

The medical school **should**

- adjust the number and nature of examinations of curricular elements to encourage both acquisition of the knowledge base and integrated learning. (Q 3.2.1)
- ensure timely, specific, constructive and fair feedback to students on basis of assessment results (Q 3.2.2)

Annotations:

- *Assessment principles, methods and practices* refer to assessment of student achievement and would include assessment in all domains: knowledge, skills and attitudes.
- *Decision about academic progress* would require rules of progression and their relationship to the assessment process.
- *Adjustment of number and nature of examinations* would include consideration of avoiding negative effects on learning. This would also imply avoiding the need for

students to learn and recall excessive amounts of information and curriculum overload.

- *Encouragement of integrated learning* would include consideration of using integrated assessment, while ensuring reasonable tests of knowledge of individual disciplines or subject areas.

B 3.2.1 The medical school **must** use assessment principles, methods and practices that are clearly compatible with intended educational outcomes and instructional methods.

(A) Basic information

Educational outcomes of SMFMUT were just approved in September 2014. Discussion of educational and assessment methods to achieve OBE has just been started.

(B) Analysis and self-evaluation

For basic educational outcomes, medical knowledge, clinical skills and communication might be addressed by current educational and assessment methods. Other basic outcomes, professionalism and social perspectives, or even advanced outcomes including creative thinking, team leader, international leader, whole person care and inspired visionary are more difficult to teach and assess.

(C) Current action

Two WGs for graduation assessment and CC started discussion for future OBE.

(D) Plan for future improvement

After CC assessment, integrated graduation assessment and the post-clerkship OSCE are implemented the data should be organised to improve the system.

B 3.2.2 The medical school **must** use assessment principles, methods and practices that ensure that the intended educational outcomes are met by the students.

(A) Basic information

Among educational outcomes of SMFMUT, medical knowledge, clinical skills and communication are assessed by written examinations for basic sciences and clinical medicine, and CBT and OSCE offered by CAT.

For social perspectives, the nursing care practicum at M2, public health practicum at M3, and community medicine practicum at M3-4 are carried out to improve student awareness of community health and the social accountability of physicians.

As to professionalism, a ceremony for student physicianship is conducted just before CC starts at M2 to raise awareness of being a professional.

For creative thinking and being an international leader, assessment is conducted through presentations at FQ and/or the MD researcher development programme and clerkship assessment in EC in foreign institutes.

(B) Analysis and self-evaluation

Educational outcomes were proposed and approved in 2014, but the system to assess all the outcomes has not been established yet.

(C) Current action

To specify the objectives to assess all the outcomes, two WGs for CC assessment and graduation assessment were started for discussion.

(D) Plan for future improvement

After the two WGs complete concrete plans for assessment of the outcomes, continuous improvement is planned.

B 3.2.3 The medical school **must** use assessment principles, methods and practices that promote student learning.

(A) Basic information

To facilitate students' learning, syllabi including objectives and their levels, overview of classes, format of classes, assessment methods, message from faculty members and textbook/references are provided. Assessment is provided along with attendance through small quizzes, written examinations, viva and/or group presentation as stated in the syllabi.

Assessment results in CC and CAT-OSCE are given as feedback to students to let them understand what should be reviewed. The CC assessment is submitted to the CC support centre after the dean of each department has had a discussion with attendings to finalise the global ratings. The result of the CC assessment is delivered to each student. The result of CAT-OSCE is given as feedback to each student, too.

If the result for a student is not sufficient to promote them to the next stage, AAC identifies the student and appoints an individual tutor to consult and lead him/her. Normally tutors have a first meeting with the tutee in May of each school year (school year starts in April) with a few more meetings during the year if the tutee does not have any issue. If the tutee experiences a resit, long-term leave, or economic or psychiatric problems, the tutor contacts the tutee as many times as possible and refers him/her to the Head of Year or head of tutors. At all the meetings, tutors generate records with the

tutees. All the tutor/tutee meeting records are submitted to the Head of Year by the end of February every year.

(B) Analysis and self-evaluation

For almost all the curricular units, comprehensive assessment is well conducted including attendance, quiz, final written test, viva and group presentation. Feedback after CC and CAT-OSCE works effectively.

The tutor system augments the assessment system by individual level support to teach and lead each student.

(C) Current action

CC assessment is not very rigorous, consequently, some students do not work very hard during CC.. The CC assessment WG is discussing how CC learning should be enhanced.

(D) Plan for future improvement

After discussion by the two WGs for CC assessment and graduation assessment, concrete plans should be improved continuously.

B 3.2.4 The medical school **must** use assessment principles, methods and practices that provide an appropriate balance of formative and summative assessment to guide both learning and decisions about academic progress.

(A) Basic information

Balance between formative and summative assessment to help students perceive the depth of learning depends on the faculty member in charge of each class. Currently, the main assessment is considered summative.

(B) Analysis and self-evaluation

Rules for assessment and prerequisites for promotion are clearly defined. Balance between formative and summative assessment is not managed by the university but delegated to each faculty member in charge of each class. This situation results in less balance of formative assessment in some curricula.

(C) Current action

FDs in 2014 have been conducted to promote educational reform to help each faculty member perceive the importance of the balance between formative and summative assessment.

(D) Plan for future improvement

Students' opinions should be adopted to realise a better balance between formative and summative assessment.

Q 3.2.1 The medical school **should** adjust the number and nature of examinations of curricular elements to encourage both acquisition of the knowledge base and integrated learning.

(A) Basic information

Currently each department provides an examination and resit only once for basic knowledge. Assessment for integrated learning is not widely provided other than CBT and OSCE by CAT.

(B) Analysis and self-evaluation

In M1, examinations from 11 departments are provided in June-July and November-December for basic sciences. In M2, examinations from 36 departments are conducted from April to December almost every month. In M2, CBT and OSCE by CAT are also provided. The examination schedule is especially overloaded in M2 and needs to be improved.

The graduation examination is conducted by 36 departments in September and November-December, and is very congested, too.

(C) Current action

Regarding the graduation examination, FD in June 2014 reached a conclusion of (1) abolishment of the written examination from each department and (2) adoption of a post-clerkship OSCE. AWG for the graduation examination was started in August 2014 for discussion.

(D) Plan for future improvement

Regarding appropriate numbers and methods of examinations for all the school years, specific methodology should be discussed for not only basic knowledge but also integrated learning. Ideally, the assessment committee should be launched to continuously consider the best assessment methods.

Q 3.2.2 The medical school **should** ensure timely, specific, constructive and fair feedback to students on basis of assessment results.

(A) Basic information

In CC in M3-M4, global ratings from each department are delivered to each student twice a year to give students feedback. If a student is given low marks, AAC raises the issue to provide the student with special support or consultation by his/her tutor or faculty member in charge of CC.

SMFMUT has tutor system to appoint a tutor to all the students in M1-M4. For students with academic or other problems focused feedback is given. If a student's problem is critical the student's name is brought to AAC meeting to discuss how to address the problem.

(B) Analysis and self-evaluation

For students in the M1-M4 tutor system, ~~and~~ the CC assessment works well to give students appropriate feedback, but SMFMUT is not able to follow 1st year and first-half of M0 year students.

(C) Current action

More enhancement of the tutor system, including not only feedback after assessment but also career support before and after admission to SMFMUT, is being considered. As to feedback for CC assessment, the CC support team and AAC continue discussions on the appropriateness of the content, timing and frequency.

(D) Plan for future improvement

An assessment system for comprehensive and continuous feedback, career support and confirmation of achievement for all the school years should be planned.

4. STUDENTS

4.1 ADMISSION POLICY AND SELECTION

Basic standard:

The medical school **must**

- formulate and implement an admission policy based on principles of objectivity, including a clear statement on the process of selection of students. (B 4.1.1)
- have a policy and implement a practice for admission of disabled students (B 4.1.2)
- have a policy and implement a practice for transfer of students from other programmes and institutions (B 4.1.3)

Quality development standard:

The medical school **should**

- state the relationship between selection and the mission of the school, the educational programme and desired qualities of graduates. (Q 4.1.1)
- periodically review the admission policy, based on relevant societal and professional data, to comply with the health needs of the community and society. (Q 4.1.2)
- use a system for appeal of admission decisions. (Q 4.1.3)

Annotations:

- *Admission policy* would imply adherence to possible national regulation as well as adjustments to local circumstances. If the medical school does not control admission policy, it would demonstrate responsibility by explaining relationships and drawing attention to consequences, e.g. imbalance between intake and teaching capacity.
- The *statement on process of selection of students* would include both rationale and methods of selection such as secondary school results, other relevant academic or educational experiences, entrance examinations and interviews, including evaluation of motivation to become doctors. Selection would also take into account the need for variations related to diversity of medical practice.
- *Policy and practice for admission of disabled students* will have to be in accordance with national law and regulations.
- *Transfer of students* would include medical students from other medical schools and students from other study programmes.
- *The health needs of the community and society* would include consideration of intake according to gender, ethnicity and other social requirements (socio-cultural and linguistic characteristics of the population), including the potential need of a special recruitment, admission and induction policy for underprivileged students and minorities.

B 4.1.1 The medical school **must** formulate and implement an admission policy based on principles of objectivity, including a clear statement on the process of selection of students.

(A) Basic information

In the UT application guidebook and admission guidebook, prerequisites to apply and how to select students are selected and described. The first page of the application guidebook documents the UT admission policy[4].

The committee involved in admission is UT Committee for Admission Administration, whose chair person is the president and members are deans of CAS, faculty of arts, faculty of sciences and a few other faculties or research institutes. The remit of the committee is as follows.

(1) Discussion of subjects for entrance examination and admission guidebook.
(2) Policy and principles for question items and marking.
(3) Discussion and determination for important issues about admission implementation.
(4) Determination of passers.
(5) Other important issues regarding admission.

High school leavers take the entrance examination for SMFMUT but initially enter Natural Sciences III at CAS. In the midst the 2nd year almost all students in Natural Sciences III are allowed to enter SMFMUT. At the same time 10 students enter SMFMUT from Natural Sciences II and 3 from other divisions (e.g. Natural Sciences I or Humanities and Social Sciences I).

Details about admission for Natural Sciences III are as follows.

Natural Sciences III admission

- Entrance examination is discussed and determined in the UT Committee for the Admission Administration and Institution Committee. The information of whether FMUT sends a committee member or not is not disclosed.
- Interviews for the 1st round of admission for Natural Sciences III framework were adopted in 1999.
- Interview for Natural Sciences III admission was abolished in 2008. The interview was highly standardised so that preparation elevated the mark very much. Reasons for abolishment were low difference among applicants due to such preparation from preparatory schools and low cost-effectiveness for large number of applicants.

FMUT admission

- As a policy for whole UT, 30% of students should come from other divisions of

[4] Admission guide is partly readable on the comparable web page. (http://www.u-tokyo.ac.jp/en/admissions-and-programs/index.html)

CAS.

- Before the UT conflict by student activists in 1968, 90 students were selected out of 100 students in Natural Sciences III.
- After the UT conflict, 10 were selected from Natural Sciences II and 1 from Natural Sciences I.
- Since school year of 2008, the system has been changed so that 10 are selected from Natural Sciences II and 3 from other divisions.
- Follow-up study of the outcomes concerning which division each student came from has not been done.

(B) Analysis and self-evaluation

The UT Committee for Admission Administration thoroughly discusses the policy of admission and describes it in the application and admission guidebooks. The Committee for Admission Administration asks SMFMUT about any recommendations for improvement.

(C) Current action

The Admission Administration committee regularly monitors the consistency between the admission process and policy for admission. From 2016, admission through a recommendation system will be implemented, and SMFMUT will select 3 students through it.

(D) Plan for future improvement

In the near future, interviews for admission to SMFMUT will be in discussion again.

B 4.1.2 The medical school **must** have a policy and implement a practice for admission of disabled students

(A) Basic information

Guidebooks for applicants and admission describe the preliminary consultation and its criteria for applicants with disabilities.

(B) Analysis and self-evaluation

There is a policy for disabled applicants for admission.

(C) Current action

Current measures do not have major issues to be solved.

(D) Plan for future improvement

Follow up study for those who entered with a disability to SMFMUT should be considered.

B 4.1.3 The medical school **must** have a policy and implement a practice for transfer of students from other programmes and institutions

(A) Basic information

UT has another admission process for students to move from CAS to a more specialised faculty. SMFMUT accepts 10 students from Natural Sciences II and 3 students from other divisions. This admission process is described in detail and follows standard procedures for admission.

Each faculty in UT has a postbaccalaureate admission system to select applicants. SMFMUT has such a system for the 4-year programme to accept at most 2 students only from graduates from the School of Integrated Health Sciences, Faculty of Medicine, UT.

(B) Analysis and self-evaluation

The policy for admission from CAS or postbaccalaureate admission from the School of Integrated Health Sciences is well defined.

(C) Current action

For school year 2015, reform for the admission system from CAS is planned. Currently, the curriculum reform team under UT is discussing the details.

(D) Plan for future improvement

SMFMUT will follow the plan to revise the admission system from CAS.

Q 4.1.1 The medical school **should** state the relationship between selection and the mission of the school, the educational programme and desired qualities of graduates.

(A) Basic information

UT expects students to become “civil elite with global perspectives” as described in the admission policy. Students need to obtain wide perspectives and highly specialised knowledge. For this purpose, admission uses results of both the National Centre Test for University Admissions and the UT academic examination with 7 subjects. Weight for

both results is 1:4. The foreign language subject for the UT academic examination allows selection of one from English, German, French, Chinese or Korean.

(B) Analysis and self-evaluation

The UT application guidebook documents the basic admission policy. Furthermore, what UT would like students to learn is detailed for each subject that comprises the admission examination.

For future improvement, a detailed follow-up survey for the medical licence examination results etc. will be needed.

(C) Current action

UT sets up various committees regarding admission to discuss the content and methods to meet the needs of UT and society.

(D) Plan for future improvement

SMFMUT will develop its unique curriculum policy and diploma policy to clarify the educational processes and goals/objectives. After these policies are specified the system for continuous improvement including curriculum and diploma policies should be established. Interviews for admission should be resumed for UT admission and SMFMUT admission.

Q 4.1.2 The medical school **should** periodically review the admission policy, based on relevant societal and professional data, to comply with the health needs of the community and society.

(A) Basic information

The admission policy is specified and the special admission process for Natural Sciences III is offered for foreign graduates, but only one entered through this process during these past three years.

(B) Analysis and self-evaluation

The UT admission policy is ready for flexible revision in accordance with changes in the social environment. Since the percentage of those who come from outside of Tokyo prefecture is approximately 60% in FMUT, graduates working outside of Tokyo prefecture might be as many. With this shift in student intake, the contribution to community medical care should be enhanced. When graduates finish the first two years of required residency training, we plan to assess whether we accomplished the initial purpose.

(C) Current action

To address economically-challenged enrollees, an exemption for tuition and a scholarship award is currently done. In the future, further enhancement of the scholarship system that better measures parents' economic challenges can avoid interfering with the enrollees' study at the university.

In the future more foreign applicants will come for admission as medical education is internationalised, so assessing Japanese language ability should be considered.

(D) Plan for future improvement

Based on changes in social need and academic standards for FMUT, the admission policy should be regularly revised. According to the environment surrounding FMUT such as globalisation of medical education, it is important to flexibly renew and manage the admission policy.

It is also necessary for FMUT to organise the system for information collection, and tracking the career of graduates.

Q 4.1.3 The medical school **should** use a system for appeal of admission decisions.

(A) Basic information

If applicants ask for disclosure of the mark of the entrance examination it is possible. No protest has been recorded.

(B) Analysis and self-evaluation

The admission administration office of UT is the contact for appeals regarding determination of admission.

(C) Current action

No problem is identified.

(D) Plan for future improvement

Necessity of a checking system for such an appeal should be discussed.

4.2 STUDENT INTAKE

Basic standard:
The medical school **must**

- define the size of student intake and relate it to its capacity at all stages of the programme. (B 4.2.1)

Quality development standard:

The medical school **should**

- periodically review the size and nature of student intake in consultation with other relevant stakeholders and regulate it to meet the health needs of the community and society. (Q 4.2.1)

Annotations:

- Decisions on *student intake* would imply necessary adjustment to national requirements for medical workforce. If the medical school does not control student intake, it would demonstrate responsibility by explaining relationships and drawing attention to consequences, e.g. imbalance between intake and teaching capacity.
- *Other relevant stakeholders* would include authorities responsible for planning and development of human resources in the national health sector as well as experts and organisations concerned with global aspects of human resources for health, e.g. shortage and mal-distribution of doctors, establishment of new medical schools and migration of doctors.
- *The health needs of the community and society* would include consideration of intake according to gender, ethnicity and other social requirements (socio-cultural and linguistic characteristics of the population), including the potential need of a special recruitment, admission and induction policy for underprivileged students and minorities.

B 4.2.1 The medical school **must** define the size of student intake and relate it to its capacity at all stages of the programme.

(A) Basic information

The admission policy for the entire UT is described on the first page of the UT applicant guidebook. It specifies the image of students expected in UT, “civil elite with global perspectives (as in the UT Charter),” and three basic policies in admission. Moreover, the applicants for Natural Sciences III are expected to apply to SMFMUT, as indicated in the Mission Statement of SMFMUT. In the third year, we welcome 110 students in SMFMUT.

The actual numbers of passers and enrolees for Natural Sciences III are as follows for the past five years. No data for the male/female ratio is disclosed.

Year	2010	2011	2012	2013	2014
Passers	100	100	100	100	100
Enrolees	100	100	99	100	100

Following is the list of passers and enrolees from each division to SMFMUT

		HSS I	HSS II	HSS III	NS I	NS II	NS III	Total
2014	Passers	0	0	0	1	12	97	110
	Enrolees	0	0	0	1	12	96	109
2013	Passers	1	0	0	2	10	97	110
	Enrolees	1	0	0	2	10	97	110
2012	Passers	0	0	0	3	10	97	110
	Enrolees	0	0	0	3	10	96	109
2011	Passers	0	1	1	1	10	97	110
	Enrolees	0	1	1	1	10	97	110
2010	Passers	0	0	1	1	11	87	100
	Enrolees	0	0	0	1	11	87	99

*HSS: Humanities and Social Sciences, NS: Natural Sciences

Results for postbaccalaureate admission into SMFMUT are as follows.

Year	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Applicants	5	2	4	2	3	5	4	1	0	1	0	2
Passers	0	0	0	0	0	1	1	0	--	1	--	1

Students numbers in Natural Sciences III CAS and SMFMUT are following.

2014	Total number			PBA		Repeat		TW	
	M	W	total	M	W	M	W	M	W
NS III 1	87	18	105			3	1	1	0
NS III 2, M0	85	17	102			4	1	0	0
M1	102	16	118	0	0	9	0	2	0
M2	99	17	116	0	1	9	2	3	0
M3	84	26	110	0	0	7	0	4	1
M4	91	18	109	0	0	5	0	1	0

2013	Total number			PBA		Repeat		TW	
	M	W	total	M	M	W	total	M	M
NS III 1	87	18	105			2	1	1	0
NS III 2, M0	85	14	99			3	0	0	0
M1	102	16	118	0	1	7	1	4	0
M2	88	27	115	0	0	8	1	2	1
M3	94	18	112	0	0	8	0	5	0
M4	91	17	108	0	1	12	1	2	0

2012	Total number			PBA		Repeat		TW	
	M	W	total	M	M	W	total	M	M
NS III 1	86	15	101			1	1	1	0
NS III 2, M0	87	14	101			3	0	0	0
M1	93	27	120	0	0	9	0	1	0
M2	93	19	112	0	0	5	1	2	1
M3	89	16	105	0	1	10	1	4	0

M4	88	18	106	0	1	9	1	4	1

2011	Total number			PBA		Repeat		TW	
	M	W	total	M	M	W	total	M	M
NS III 1	85	15	100			0	0	0	0
NS III 2, M0	83	21	104			2	0	0	0
M1	110	7	117	0	0	7	0	2	0
M2	97	7	104	0	1	6	1	1	1
M3	98	9	107	0	1	9	0	5	0
M4	91	16	107	0	0	10	1	1	1

2010	Total number			PBA		Repeat		TW	
	M	W	total	M	M	W	total	M	M
NS III 1	82	21	103			1	0	0	0
NS III 2, M0	89	13	102			4	1	0	0
M1	88	16	104	0	1	4	0	2	0
M2	91	18	109	0	1	7	1	2	1
M3	91	16	107	0	0	8	1	5	0
M4	81	16	97	0	0	6	0	3	1

(NS: Natural Sciences, M: Men, W: Women, PBA: Postbaccalaureate admission, TW: Temporary withdrawal)

Following is the number and percentage of graduates who were able to graduate in six years.

	SMFMUT graduates	Number of graduates in six years	Percentage of graduates in six years
2013	99	94	94.9%
2012	102	95	93.1%
2011	92	89	96.7%
2010	103	94	91.3%
2009	106	95	89.6%

(B) Analysis and self-evaluation

For all the programmes in CAS and SMFMUT sufficient numbers of departments and faculty members address education. The intake number for Natural Sciences III and SMFMUT is strictly regulated by MEXT so no issue was identified.

(C) Current action

No issue is found for this matter.

(D) Plan for future improvement

When the intake to CAS or SMFMUT changes, SMFMUT should check and change the capacity to ensure a sufficient teaching system.

Q 4.2.1 The medical school **should** periodically review the size and nature of student intake in consultation with other relevant stakeholders and regulate it to meet the health needs of the community and society.

(A) Basic information

The UT Committee for Admission Administration discusses issues related to admission and refers details to subcommittees. Regarding the intake number and educational content of the curriculum for physician development, the committee has regular contact with MHLW and MEXT, other faculties and deans in different medical schools.

According to the request from authorities to UT, the intake of SMFMUT was changed from 100 to 108 in 2009 and from 108 to 110 in 2010.

(B) Analysis and self-evaluation

Students entering Natural Sciences III are only the high performers in the entrance examinations. Only limited students with top performance in CAS can enter SMFMUT from divisions other than Natural Sciences III. Such students coming to SMFMUT take a variety of liberal arts classes and real-setting practicums to acquire appropriate abilities to become physicians.

On the other hand, some students with high academic performance in written examinations might not be very appropriate for clinical jobs. SMFMUT should confirm if enrolees to Natural Sciences III are skewed towards those from economically rich families or limited to domestic students.

(C) Current action

Since 2001, academically high performances of enrolees to the SMFMUT PhD-MD course enable students to take the PhD course of graduate school in the middle of medical studies. 11 students were accepted to the PhD-MD course during the past 10 years. Since 2008, the MD researcher development programme accommodates 20 students every year to become basic scientists just after medical curricula. For enrolees to Natural Sciences III who are not so appropriate for clinical jobs, pathways to other divisions are available.

(D) Plan for future improvement

The system related to intake and the admission policy is always discussed and revised among stakeholders every year. SMFMUT will continue to address health-related requests from the community and society, enhance the relationship with collaborators in related fields, and regularly review the number and characteristics of intake.

Furthermore SMFMUT will accept high performers and try to educate them to disseminate medical development.

4.3 STUDENT COUNSELLING AND SUPPORT

Basic standard:

The medical school and/or the University **must**

- have a system for academic counselling of its student population. (B 4.3.1)
- offer a programme of student support, addressing social, financial and personal needs. (B 4.3.2)
- allocate resources for student support. (B 4.3.3)
- ensure confidentiality in relation to counselling and support. (B 4.3.4)

Quality development standard:

The medical school **should**

- provide academic counselling that
  - is based on monitoring of student progress. **(**Q 4.3.1)
  - includes career guidance and planning. (Q 4.3.2)

Annotation:

- *Academic counselling* would include questions related to choice of electives, residence preparation and career guidance. Organisation of the counselling would include appointing academic mentors for individual students or small groups of students.
- Addressing *social, financial and personal needs* would mean support in relation to social and personal problems and events, health problems and financial matters, and would include access to health clinics, immunisation programmes and health/disability insurance as well as financial aid services in forms of bursaries, scholarships and loans.

B 4.3.1 The medical school and/or the University **must** have a system for academic counselling of its student population.

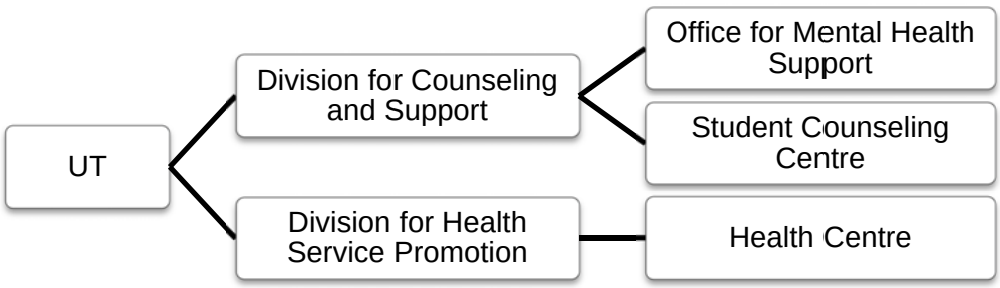
(A) Basic information

SMFMUT has been managing the tutor and Head of School Year systems. For those with health problems the Division for Health Service Promotion[5] and for those with harassment issues the Harassment Counseling Centre are installed as organisations for

[5] Division for Health Service Promotion (http://www.hc.u-tokyo.ac.jp/en/index.html)

the whole UT. Problems can be brought to these facilities by students or referred to them by tutors or Heads of Year in some cases.

As shown in the following diagram, the administration bureau of the whole UT has two Divisions for Counseling and Support and Health Service Promotion for learning problems. The Division for Counseling and Support[6] consists of the Office for Mental Health Support[7] and the Student Counseling Centre[8]. The Division for Health Service Promotion has the Health Centre under it. Students can consult physicians of internal medicine, surgery and psychiatry in the Health Centre.



Some cases have been pointed out that the tutor system does not work very well due to the relationship between a tutor and a student or to the specialty of each tutor. Since April 2014, the plan to set up a Student Support Unit (SSU) in FMUT was enforced and since November 2014 one certified clinical psychology expert has started work there.

Many students who had learning problems were suffering from difficulty in maintaining motivation or from insufficient interpersonal skills in practicums. Previously, when learning problems were suspected by various members in UT, it was not easy to communicate information with the AAAD in FMUT. The new SSU in FMUT maintains a close relationship with the Division for Counseling and Support. Therefore, when the AAAD perceives any student problem they can smoothly refer to the SSU and the Division for Counseling and Support to obtain the best support.

(B) Analysis and self-evaluation

The student support system in FMUT has been maintaining appropriate role sharing between FMUT and the whole UT to provide sensible care, but some issues were remaining. The new SSU seems to be a better system for students to be able to consult on various issues.

(C) Current action

The function of the SSU has been just started since November 2014.

---

[6] Division for Counseling and Support (http://dcs.adm.u-tokyo.ac.jp/en/)
[7] Office for Mental Health Support (http://mhs.adm.u-tokyo.ac.jp/english-page.html)
[8] Student Counseling Centre (http://scc.u-tokyo.ac.jp/about/index-e.html)

(D) Plan for future improvement

Needs for learner support is increasing compared with before. Currently the unit is mainly managed by a part-time assistant professor only three times a week. If the workload is more than expected, a full-time faculty member should be appointed to the position.

B 4.3.2 The medical school and/or the University **must** offer a programme of student support, addressing social, financial and personal needs.

(A) Basic information

For students with economic challenges, a reduction or exemption of the admission and/or tuition fee, and an exemption of the dormitory fee are available. Various scholarship schemes and part-time jobs are also offered.

UT has a health centre under the Division for Health Service Promotion that is set up for consults when health problems or concerns happen. Students have to have a health check-up upon admission and every following year. If any health problems are noted, the health centre asks such students for detailed examinations or specialist consultations. Before the CC starts, students are checked for antibody values of measles, rubella, varicella and mumps and are inoculated with additional vaccinations as needed. The health centre provides influenza vaccination, too.

Social career support for women physicians related to delivery and childcare has become an urgent need to support a sufficient workload from physicians qualitatively and quantitatively. FMUT has established the Committee for Gender Equality to facilitate career support for women physicians and to hold a regular tea party for medical career support.

(B) Analysis and self-evaluation

Currently, many students are at a certain economic level with a relatively small percentage depending on income from part-time jobs to sustain academic work. However, some of them have difficulty to continue studies at the university. FMUT should promote support for such students.

Some students suffer from psychiatric conditions. The tutor system is helpful for discovering such problems.

CC attending physicians also try to discover such issues to give sufficient support.

(C) Current action

Enhancement of the tutor system, regular activities in the Committee for Gender Equality, and the appointment of an educational specialist in CC is expected.

(D) Plan for future improvement

Whether such a student support programme or system meets the needs of students should be evaluated to further develop it.

B 4.3.3 The medical school and/or the University **must** allocate resources for student support.

(A) Basic information

101 faculty members are involved in the tutor system and each member cares for 1 to 6 students. From M0 to M4 Heads of Year are in charge of each school year and one AAC member is in charge of the whole tutor system.

The Division for Counseling and Support is set up and directly supervised by the Presidents' Office as a student support system, consisting of the Director, one planner, five members from the Student Counseling Centre, six members from the Office for Mental Health Support, five members from the Communication Support Room, and four members from the General Counseling Room. Moreover, the Career Support Unit, Barrier-free Support Unit, Women Researcher Support Room, and Komaba Student Counseling Unit have several members each. All these accept students without any fee.

If any student has difficulty in paying the admission or tuition fee due to financial problems, such fees may be reduced or exempted. Dormitory board can be provided for students depending on the financial situation. Scholarship information from public or private foundations, such as the Japan Student Services Organisation, is also provided.

UT has a junior TA system that provides a scholarship for participation in UT official activities. The UT Satsuki-Kai scholarship is targeted for female students.

For foreign studies, the UT project pays a scholarship for students who satisfy a certain level of criterion (60-100 thousand yen/month). Moreover, other public or private scholarship information is provided. In SMFMUT Otsubo Osamu Tetsumon Fellowship supports the travel fee for EC in foreign countries (50-500 thousand yen for each).

As health support, the Division for Health Service Promotion (Health Centre) carrys out a health check-up for entering students and returning students once a year. The Health Centre has full-time physicians to provide students with health counseling or consultation (internal medicine, dentistry, oto-rhino-laryngology, psychiatry, orthopaedics and dermatology). Health service fees are lower than normal consultation fees. Vaccination is also provided though it is a charging programme. To prepare for CC at SMFMUT, the Health Centre offers free antibody laboratory tests for hepatitis B, measles, rubella, varicella and mumps, and inoculation of vaccine if the antibody value is below the standard. For CC in the winter season, students are highly recommended to receive influenza vaccination at a minimal charge. UT pays for casualty and accident insurance for student education and research covering all students.

(B) Analysis and self-evaluation

The tutor system has a sufficient number of faculty members to provide finely tuned education and consultation for individual problems. The student support system in the whole UT appoints a sufficient number of members to address the various issues within different units/departments/centres.

On the other hand, some issues such as personal issues are difficult for a tutor or the Head of Year to deal with, so lack of a student's self-directed action results in difficulty in obtaining support from whole university. It is necessary to provide active support for medical students and counseling by experts.

Financial support by UT is limited but an exemption scheme and scholarship are offered.

Health support is given in the form of regular health check ups and general consultation with minimal charge by the Health Centre.

(C) Current action

SSU in FMUT has been set up, and one part-time faculty member has begun to work to achieve a better counseling system for medical students. Financial support is given by foundations such as "Go Global scholarship."

(D) Plan for future improvement

AAC and other departments continue to discuss how to offer student support and how to improve the system.

B 4.3.4 The medical school and/or the University **must** ensure confidentiality in relation to counselling and support.

(A) Basic information

Rules to assure confidentiality of personal information dealt with during counseling and support are addressed by UT rules for personal information disclosure and UT rules to appropriately manage personal information. These rules are organised based on laws regarding protection of confidential information stored by an independent administrative agency. Counseling and support is given in line with these rules.

(B) Analysis and self-evaluation

Confidentiality during counseling and support seems assured by the well-prepared rules.

(C) Current action

It is necessary to check how confidentiality is kept in the settings for counselling and support currently.

(D) Plan for future improvement

Any improvement of confidentiality should be planned based on the data obtained from counselling and support.

Q 4.3.1.The medical school **should** provide academic counselling that is based on monitoring of student progress.

(A) Basic information

Tutors hold regular counselling sessions for students' attendance, academic performance and issues or concerns in everyday life. Faculty members from each phase, M1 to M2 faculty members in basic sciences or M3 to M4 clinical medicine members, become tutors. Such student and faculty membership alignment makes monitoring easier.

(B) Analysis and self-evaluation

The tutor system for each student is remarkable for its regular counselling and cooperative structure with the Health Centre. Insufficient training such as FD for quality assurance of tutors is the issue to be improved.

(C) Current action

Some tutors may be rewarded by Best Teacher's Award from AAC to maintain motivation of tutors.

(D) Plan for future improvement

For tutors FD with counselling experts and case study opportunities with difficult cases are to be planned.

Q 4.3.2 The medical school **should** provide academic counselling that includes career guidance and planning.

(A) Basic information

For the whole UT, the Career Support Unit addresses guidance and planning. In FMUT, AAAD is in charge. No specific career support unit is in FMUT.

Each tutor provides counselling for the career pathway for each tutee and appropriate advice if necessary. Tutors for M1 to M2 are faculty members in basic sciences, and tutors for M3 to M4 are clinical medicine members. Such membership makes monitoring easier.

(B) Analysis and self-evaluation

It is unclear how well the UT Career Support Unit functions for medical students.

The tutor system is useful for individual support but there can be a mismatch. For example, students with an interest in clinical medicine from M0 or M1 may not have contact with clinical faculty to access such information.

(C) Current action

So far, career support has depended on how each faculty member works. More discussion is needed for a better system.

(D) Plan for future improvement

In particular, FMUT should plan how to address students who repeated a school year or who failed the licence examination.

4.4 STUDENT REPRESENTATION

Basic standard:

The medical school **must**

- formulate and implement a policy, that ensures participation of student representatives and appropriate participation in the design, management and evaluation of the curriculum, and in other matters relevant to students. (B 4.4.1)

Quality development standard:

The medical school **should**

- encourage and facilitate student activities and student organisations. (Q 4.4.1)

Annotations:

- *Participation of student representatives* would include student self governance and representation on the curriculum committee, other educational committees, scientific and other relevant bodies as well as social activities and local health care projects (see B 2.7.2).
- To *facilitate student activities* would include consideration of providing technical and financial support to student organisations.

B 4.4.1 The medical school **must** formulate and implement a policy, that ensures participation of student representatives and appropriate participation in the design, management and evaluation of the curriculum, and in other matters relevant to students.

(A) Basic information

FMUT has a student organisation managed by current students, SWGME. It has been active since 2010 with the main goal being to serve as the contact for communication regarding campus life and the curriculum between faculty members and students. SWGME is approved by AAC. Participation is voluntary, with M3 students assuming the leadership, supported by M2 and M4 students. As of November 2014, SWGME consists of 13 members, six M4, four M3 and three M2 for management.

As a main activity, they conduct a questionnaire evaluation of M1-M4 students. They submit the report, and request to present and discuss the results with the AAC. In one medical education FD, students presented their results, including issues to improve curricula. Student evaluations have led to curricular improvement, such as changes in the examination schedule, small-group learning activities, implementation of CC and adoption of intra-hospital personal handyphone services.

Activities of SWGME are supported by AAAD, including the printing and distribution of the questionnaires and collation and electronic documentation of results. All the results are saved as electronic data in AAAD and disclosed depending on the need.

(B) Analysis and self-evaluation

Opinions from students are directly and accurately conveyed to faculty members through student participation in AAC as observers and the students' questionnaire, and are utilised to improve the quality of curricula.

However, since SWGME consists of only voluntary members, administrative or funding support might not be sufficient. Also, there is a tendency for faculty to take the survey results as comments and reference only.

(C) Current action

More proactive participation is expected from the student side for curricular development and evaluation.

(D) Plan for future improvement

To promote more appropriate participation from students for curricular development and evaluation, the extent of how students are involved in AAC discussions should be discussed. The response to the need for administrative and/or funding support for student involvement should be planned.

Q 4.4.1 The medical school **should** encourage and facilitate student activities and student organisations.

(A) Basic information

FMUT has had Tetsumon[9] club as the organisation for alumni of FMUT since 1899. The President and executive members are graduates but student members perform the actual management and administration. The main goal is to enrich relationships among students and graduate members and to provide settings to meet one another. Tetsumon club also collects membership fees and donations, provides budgets for student clubs and circles, and sets up opportunities for students and graduate members to meet in the Tetsumon general meeting and Tetsumon tour. Tetsumon club also introduces outside hospitals for EC.

(B) Analysis and self-evaluation

FMUT facilitates free student activities.

(C) Current action

Activities and management of Tetsumon club are not comprehensively discussed from the viewpoint of education or learning.

(D) Plan for future improvement

Students and faculty members should have more discussions about what kind of support students need and how FMUT should provide such support.

[9] Tetsumon literally means “iron gate” as a symbol of FMUT and its graduates. The “iron gate” was the nickname of the clinic for smallpox vaccination founded in 1858, the origin of FMUT.

5. ACADEMIC STAFF/FACULTY

5.1 RECRUITMENT AND SELECTION POLICY

Basic standard:

The medical school **must**

- formulate and implement a staff recruitment and selection policy which
  - outlines the type, responsibilities and balance of the academic staff/faculty of the basic biomedical sciences, the behavioural and social sciences and the clinical sciences required to deliver the curriculum adequately, including the balance between medical and non-medical academic staff, the balance between full-time and part-time academic staff, and the balance between academic and non-academic staff. (B 5.1.1)
  - addresses criteria for scientific, educational and clinical merit, including the balance between teaching, research and service qualifications. (B 5.1.2)
  - specifies and monitors the responsibilities of its academic staff/faculty of the basic biomedical sciences, the behavioural and social sciences and the clinical sciences. (B 5.1.3)

Quality development standard:

The medical school **should**

- in its policy for staff recruitment and selection take into account criteria such as
  - relationship to its mission, including significant local issues. (Q 5.1.1)
  - economic considerations. (Q 5.1.2)

Annotations:

- The *staff recruitment and selection policy* would include consideration of ensuring a sufficient number of highly qualified basic biomedical scientists, behavioural and social scientists and clinicians to deliver the curriculum and a sufficient number of high quality researchers in relevant disciplines or subjects.
- *Balance of academic staff/faculty* would include staff with joint responsibilities in the basic biomedical, the behavioural and social and clinical sciences in the university and health care facilities, and teachers with dual appointments.
- *Balance between medical and non-medical staff* would imply consideration of sufficient medical orientation of the qualifications of non-medically educated staff.
- *Merit* would be measured by formal qualifications, professional experience, research output, teaching awards and peer recognition.
- *Service* functions would include clinical duties in the health care delivery system, as well as participation in governance and management.
- *Significant local issues* would include gender, ethnicity, religion, language and other items of relevance to the school and the curriculum.
- *Economic consideration* would include taking into account institutional conditions for staff funding and efficient use of resources.

B 5.1.1 The medical school **must** formulate and implement a staff recruitment and selection policy which outlines the type, responsibilities and balance of the academic staff/faculty of the basic biomedical sciences, the behavioural and social sciences and the clinical sciences required to deliver the curriculum adequately, including the balance between medical and non-medical academic staff, the balance between full-time and part-time academic staff, and the balance between academic and non-academic staff.

(A) Basic information

UT defines the positions of academic and administrative staff in the basic organisational rules. As of May 2013, numbers of all the staff are as follows.

	Title	Men	Women	Total
Academic	Professor	1,201	66	1,267
	Associate professor	804	97	901
	Lecturer[10]	221	34	255
	Assistant professor[11]	1,109	217	1,326
	Instructor	23	21	44
	Teacher	27	15	42
Administrative	Academic	--	1	1
	Clerical	867	603	1,470
	Technical	459	131	590
	Health professional	222	1,545	1,767
	Others	5	3	8
Grand total		4,938	2,733	7,671

CAS has 488 staff including both academic (164 professors, 123 associate professors, 9 lecturers, 78 assistant professors and 3 instructors) and 111 administrative staff.

Organisational rules for SMFMUT define that education and research in the Faculty of Medicine is carried out with the cooperation from the Graduate School of Medicine. Employment of faculty members is limited to the numbers for full-time staff determined in SMFMUT and UTH. Numbers of faculty members are as follows (as of April 2014). Meantime, the dean of each clinical department in SMFMUT also works as the director of the same clinical department.

	Basic Science	Social Medicine	Clinical Medicine	Total	Men	Women	Medically qualified
Professor	29	17	35	81	78	3	67
Associate Professor	18	10	46	74	66	8	54
Lecturer	16	11	90	117	101	16	94
Assistant Professor	56	27	1	84	55	29	15

[10] Lecturer is a title in Japan between associate and assistant professors and usually tenured. In UT lecturers do not attend PBM.

[11] Assistant professor has been a new title defined by the School Education Act since 2007.

Total	119	65	172	356	300	56	230

Here in GSMUT only tenured faculty members are counted. GSMUT employs 197 non-tenured faculty members (8 specially appointed professors, 37 specially appointed associate professors, 13 specially appointed lecturers, 75 specially appointed assistant professors and 64 specially appointed research fellows) working for 39 endowed departments, 4 social cooperation programmes and 4 research units (3 related with MEXT and 1 related with MHLW)

Clinical faculty members in GSMUT also play a role in training for UTH. There are other faculty members directly employed by UTH.

	Total	Men	Women	Medically qualified
Assistant Professor	327	249	78	304
SA Professor	10	10	0	7
SA Associate Professor	35	31	4	30
SA Lecturer	7	6	1	4
SA Assistant Professor (HAL)	38	34	4	35
SA Assistant Professor	84	57	27	54
Total	501	387	114	434

* SA: specially appointed, HAL: hospital-appointed lecturer

These faculty members work for 12 specialty areas of GSMUT ((1) Molecular Cell Biology; (2) Functional Biology; (3) Pathology, Immunology and Microbiology; (4) Radiology and Biomedical Engineering; (5) Neuroscience; (6) Social Medicine; (7) Internal Medicine; (8) Reproductive, Developmental and Aging Sciences; (9) Surgical Sciences; (10) Health Sciences and Nursing; (11) International Health; and (12) School of Public Health, as well as Divisions in UTH (Clinical Divisions, Central Clinical Facilities and Clinical Research Division) and the Centre for Disease Biology and Integrative Medicine a collaboratory organisation with the Faculty of Engineering. Moreover IRCME with the mission to enhance medical education inside and outside of Japan and OIAA to support international collaboration and facilitation of foreign (mostly English) languages are managed to effectively implement comprehensive medical education.

Each department asks front-line researchers as adjunct faculty members to incorporate highly specialised content and newest findings into education. For integrated lectures for basic sciences/basic science, clinical and social medicine SMFMUT invites many researchers outside of UT depending on the themes for each year in order to enhance educational.

(B) Analysis and self-evaluation

Strengths of UGME in SMFMUT consist of (1) maintenance of the primary phase curricula in CAS and (2) fulfillment of the secondary phase curricula in SMFMUT to emphasise ologies and to maximally utilise the specialties of each faculty.

As for (1), liberal arts education ranging from humanities and social sciences to natural sciences taught by a variety of faculty members is the basis to provide required and elective classes. Such a rich liberal arts education contributes to the formation of each individual's foundation and intellectual activities to realise the mission of SMFMUT.

As for (2) faculty members with expertise corresponding to each ology are appointed to each department and are in charge of lectures and practicums depending on their specialties. Moreover, FMUT consists of SMFMUT and the School of Integrated Health Sciences. Collaboration of departments in the latter with social medicine departments covers behavioural and social medicine areas including hygienics, public health, and social medicine in a balanced manner.

From the above information, it can be concluded that SMFMUT maintains the tradition of emphasising liberal arts and provides systematic curricula by specialised areas for three balanced areas including basic sciences, social medicine and clinical medicine.

In contrast, a few negative aspects are found, (1) the primary phase curricula in CAS delays the start of medical subject curricula and (2) collaboration between the primary and secondary phases is weak. How to overcome such issues while UT upholds its strengths will be a future challenge.

(C) Current action

Current prioritised issues are (1) steps to stop the decrease in the number of students who target basic science research and (2) enhancement of CC. For (1), SMFMUT has established the MD Researcher Development Programme, appointed a lecturer and an assistant professor, conducted planning and execution of a special curriculum for students who receive an orientation to basic science research, and given counseling to students.

For (2), SMFMUT has started a new system since 2012 to select and appoint SMFMUT clinical trainers with the criteria of at least 7 years of clinical experience and of basic area specialists or subspecialty specialists defined by the Japan Medical Specialty Board to promote CC in affiliated hospitals outside of the campus. To effectively implement CC, the CC support centre was established; one specially appointed assistant professor was appointed, and has been trying to enhance effectiveness of a participatory practicum with the CC support team. To assure the quality of a new system and organisation, the establishment of an appropriate project cycle for continuous improvement is essential.

(D) Plan for future improvement

The biggest challenge of medical education in SMFMUT is the divided implementation of curricula for the primary and secondary phases by CAS and SMFMUT, respectively. UT currently promotes whole-university-level educational reform and maintains discussions on (1) early exposure opportunities from admission, (2) participation of SMFMUT in the curriculum of CAS and (3) transmission of CAS contents to SMFMUT. SMFMUT has been exchanging opinions and sharing information with CAS faculty members.

Opinion exchanges and information sharing between CAS and SMFMUT have been enhanced, and consideration for the development of a new curricula with the collaboration of the both primary and secondary phases has been started. Through such close and continuing collaboration and cooperation, medical education will be appropriate for our university goals and mission to nurture international leaders.

B 5.1.2 The medical school **must** formulate and implement a staff recruitment and selection policy which addresses criteria for scientific, educational and clinical merit, including the balance between teaching, research and service qualifications.

(A) Basic information

When recruiting professors, associate professors, lecturers and assistant professors in SMFMUT, the rule says that competition or selection is needed and that employees have to submit curriculum vitae, a residence certificate and other documentation demanded by the university corporation. All the faculty members must have necessary qualifications for teaching, research and clinical services in each specialty area.

When recruiting and promoting faculty members, the Board of Representatives Meeting, PBM or each department conducts the selection process depending on academic rank. When selecting a professor, the Board of Representatives Meeting chooses selection committee members for that specialty to discuss candidates. The selection committee nominates approximately 100 candidates for that specialty, chooses 3 or less members, discusses the characteristics of those members, and elects one by voting. When selecting an associate professor, the selection committee is designated to compile a list of candidates, with discussion and voting in the Board of Representatives Meeting to make a decision. When selecting a lecturer, a candidate is nominated by the specialty department, with voting in PBL to make a decision. When selecting an assistant professor, each specialty department can make a decision. Currently, all faculty members have a certain term of years. The decision for reappointment is discussed in the reappointment committee based on expected products and outcomes of the nominee.

(B) Analysis and self-evaluation

Faculty members are selected based on experience and qualifications from academic, educational and clinical work. The evaluation of research products is based on acceptance data managed by each university. Each faculty member enters information into databases. One such database is the Research Map. Currently, research products especially English-language papers, acquisition of competitive funding, and history of awards are emphasised.

In the professor selection process, applicants have to understand the direction of education and research in SMFMUT. No quantitative criteria are specified. Education and clinical service provision in that specialty is needed. In surgical departments, a previous number and/or skills of operations are also asked.

When selecting, promoting and reappointing an associate professor or a lecturer, no criteria for education and clinical service provision are determined, but approval by the Board of Representatives Meeting and PBM requires proof of a certain level. When selecting an assistant professor, each department assures the level of education or clinical work. To maintain the quality of faculty members, the reappointment system has a certain level of meaning.

The current system to select faculty members seems to be functioning. However, it is a concern that some members within the organization itself of SMFMUT may not keep up with the increasing sophistication and complexity of medicine.

(C) Current action

When selecting a faculty member, the criteria of academic, educational and clinical work should be clarified.

(D) Plan for future improvement

Normally, the balance of the different types of workload should be self-evaluated. Evaluation of faculty members should be based on quantitative as well as qualitative data. Currently no qualitative data is collected. For clinical departments, quantitative and qualitative indices for clinical work should be established. For surgical departments, qualitative data for operational skills are not reflected. For education, the morale of faculty members is facilitated at the department level and individual-level awards, but qualitative data should be more utilised.

B 5.1.3 The medical school **must** formulate and implement a staff recruitment and selection policy which specifies and monitors the responsibilities of its academic staff/faculty of the basic biomedical sciences, the behavioural and social sciences and the clinical sciences.

(A) Basic information

AAC discusses Curricula in SMFMUT, confirms the balance among basic sciences, behavioural sciences, social medicine and clinical medicine, controls the contents in horizontal programmes and appoints faculty members for each curriculum. Each department determines the role of each faculty member depending on the curriculum. Each curricular component is well communicated with each department by syllabus.

SWGME conducts questionnaire surveys about whether education by each faculty and/or each curricular component was good or not and presents the results in AAC. Such opinion exchange between students and AAC committee members becomes an important base to improve the curriculum.

(B) Analysis and self-evaluation

Curricula and roles of faculty members are well defined and delivered to each department by syllabi. Management and administration is provided by collaboration of each department with the AAAD and AAC.

(C) Current action

Enhancement of the motivation of faculty members to maintain a good learning environment is important. To evaluate activities in educational work, the Best Teacher's Award was created. Evaluation is done by teaching portfolio. Winners of the award will have an opportunity for presentations and appreciation in PBM.

(D) Plan for future improvement

A more comprehensive evaluation system should be set up for overall supervision and efficient resource allocation as much as possible since the advancement of human resources and utilisation of information technologies will result in further development of the system.

Q 5.1.1 The medical school **should** in its policy for staff recruitment and selection take into account criteria such as relationship to its mission, including significant local issues.

(A) Basic information

To fulfill the mission stated in B1.1.1, SMFMUT continues a faculty selection process that complies with the core educational organisation emphasising ologies, and appoints faculty members in a flexible way for the Center for Disease Biology and Integrative Medicine (CDBIM) and endowed departments using external funds. To carry out whole person care, attending physicians in affiliated hospitals outside of the campus have been appointed as "clinical teachers of SMFMUT" in CC. UT keeps a tradition to emphasise a broad liberal arts education and to provide a primary phase education including natural sciences and humanities/social sciences in CAS, because liberal arts are the basis for exploring new research areas or for practicing whole person care. Furthermore, for the mission to develop international leaders, faculty members who can enhance students' international experiences should be selected. IRCME and OIAA have faculty members with foreign backgrounds.

An essential issue for the community where UT is located includes measures or support to the areas damaged by the Great East Japan Earthquake. UTH began the aid just after the earthquake on 11 March 2011; dispatched interprofessional teams there for a long time (in total 48 teams, 138 members), procured medication and food, and continued effective activities with other teams from different governmental universities.

(B) Analysis and self-evaluation

FMUT maintains a certain level of international presence. In the world university ranking issued by Times Higher Education 2013-2014, UT ranked 23rd, and the clinical and pre-clinical and health area ranked 31st (both 1st rank in Asian countries). The item of "teaching" was as high as "research" by itemised rank, so FMUT takes pride in a high standard adequate for academic leadership in Asian countries.

Among six evaluation items, on the other hand, "international outlook" was lower than other items. Points to improve should be selection of faculty members and a system to support them. In the report in UT in 2013 where it states "comprehensive reform of undergraduate education -- for actualisation of world-class higher education," it comments on insufficient international experiences and a delay in steps for globalisation of the whole university undergraduate education.

(C) Current action

As for globalisation, FMUT should actively support student practicums in foreign countries in EC or FQ period, increase foreign adjunct professors, and enhance the system to strengthen global education by the collaboration between the School of Medicine and School of Integrated Health Sciences.

(D) Plan for future improvement

Mid-and-long term action plans of FMUT are specified in "Action Scenario -- FOREST 2015[12]." In the revision issues outlined in 2014, a measure for globalisation was specified, as well as educational reform using a new timetable and preparing for accreditation. FMUT says that it fosters curricula strengthening in FQ, CC and experiential learning in medical and research settings from the first year, fulfilling student-driven curriculum such as integrated lectures for clinical medicine, and creating a medical research ethics education programme. It also says that resource expansion to make learning more efficient, such as the new formation of the SSU in FMUT, expansion of the CC support centre and more comprehensive student support by faculty and administrative members.

Q 5.1.2 The medical school **should** in its policy for staff recruitment and selection take into account criteria such as economic considerations.

(A) Basic information

For academic staff recruitment and selection, the history of grant success is emphasised. The selection of professors, associate professors and lecturers depends on not only publications but also research grants. Furthermore, endowed departments or social cooperation programmes are promoted, and specially appointed faculty members are

[12] FOREST 2015 has an English version but the faculty-specific part is only Japanese.

accepted. UT does not increase the number of tenure positions, but uses specially appointed members to reinforce the educational and research system.

Subsidy from the government is allocated for newly accepted members to start their education and research. Specially-appointed members are allocated external funds. Acquiring further competitive grants is highly emphasised to smoothly progress to later research activity.

(B) Analysis and self-evaluation

Faculty members maintain a certain level of external grant funding to assure the quality of education and research. So far, many specially appointed faculty members have been employed through endowed departments and social cooperation programmes.

(C) Current action

Since the governmental subsidy is decreasing (3% every year after corporatisation in 2004), faculty members must focus more on acquisition of external grants. If the necessary budget is to be allocated from university resources to provide undergraduate education and to support young researchers, then the AAC, departments, and committees in the graduate school must evaluate the levels and efficiency.

(D) Plan for future improvement

Economic support for faculty members should be reconsidered to satisfy the needs from each faculty member and to maximise the whole system of the faculty.

5.2 STAFF ACTIVITY AND DEVELOPMENT POLICY

Basic standard:

The medical school **must**

- formulate and implement a staff activity and development policy which
  - allows a balance of capacity between teaching, research and service functions. (B 5.2.1)
  - ensures recognition of meritorious academic activities, with appropriate emphasis on teaching, research and service qualifications. (B 5.2.2)
  - ensures that clinical service functions and research are used in teaching and learning. (B 5.2.3)
  - ensures sufficient knowledge by individual staff members of the total curriculum. (B 5.2.4)
  - includes teacher training, development, support and appraisal. (B 5.2.5)

Quality development standard:

The medical school **should**

- take into account teacher-student ratios relevant to the various curricular components. (Q 5.2.1)
- design and implement a staff promotion policy. (Q 5.2.2)

Annotations:

- The *balance of capacity between teaching, research and service functions* would include provision of protected time for each function, taking into account the needs of the medical school and professional qualifications of the teachers.
- *Recognition of meritorious academic activities* would be through rewards, promotion and/or remuneration.
- *Sufficient knowledge of the total curriculum* would include knowledge about instructional/learning methods and overall curriculum content in other disciplines and subject areas with the purpose of fostering cooperation and integration.
- *Teacher training, support and development* would involve all teachers, not only new teachers, and also include teachers employed by hospitals and clinics.

B 5.2.1 The medical school **must** formulate and implement a staff activity and development policy which allows a balance of capacity between teaching, research and service functions.

(A) Basic information

To achieve the educational aim of FMUT, each faculty member must have sufficient research activity in each area. Faculty members in clinical departments must provide whole person care in their clinical practice. Faculty members must perform administrative work such as management of SMFMUT or UTH, and make a social contribution through their expertise or specialised clinical skills. Each faculty member determines time allocation or work-life balance. If he/she contributes to external work with compensation, he/she must submit its information within the predetermined time or price. Each can manage the effort rate for education within his/her discretion.

Faculty members are able to take a sabbatical to recover from physical and/or psychological fatigue or to ensure research time that tends to be insufficient with competing work.

(B) Analysis and self-evaluation

All faculty members work for research products and clinical faculty members also work for clinical activity. However, the time purely for research is relatively declining even in UT, as time increases for administrative work, applications for research grants, and tasks for hospital management. More individual effort is demanded to achieve the goals. Regarding effort rate, questionnaire surveys were conducted twice, in 2009 and 2013, to the department heads in UTH. Results indicate that expected percentages for education among practice/research/education were 25% for both years but actual percentages were

16% in 2009 and 20% in 2013. Since a small increase was observed, the consciousness of educational goals was promoted.

(C) Current action

No regular discussion is conducted on the balance among practice/research/education. Since the actual data was less than expected, many faculty members must feel the necessity to increase the education percentage.

(D) Plan for future improvement

Necessity for the discussion on the balance among practice/research/education should be considered for the future.

B 5.2.2 The medical school **must** formulate and implement a staff activity and development policy which ensures recognition of meritorious academic activities, with appropriate emphasis on teaching, research and service qualifications.

(A) Basic information

The Tokyo Journal of Medical Sciences (both Japanese and English[13]) is annually issued to publish the information about the activities in each department including education/research/clinical practice. UTH has its own statistics for disclosure. In terms of the educational activities of individual faculty members, the Best Teacher's Award was created to recognise faculty members who contribute to educational work. AAC determines the awardees by strictly evaluating teaching portfolios and commending them in PBM. Awardees are given an opportunity to present their educational activities in PBM and are given a predetermined research allowance.

Regarding CC, the Best Clinical Department is selected by student evaluation results and has a similar opportunity to present the activity in PBM. UTH has a Best Staff Award to commend faculty and/or administrative staff who contributed to education.

From the above activities, each faculty and administrative staff is assessed by the rules of UT or UTH, which are reflected on their appraisals including remuneration. In UTH, assistant professors who are approved to have sufficient skills in clinical education and practice are given a specially appointed lecturer (hospital) title, and those who are approved to have sufficient contributions to hospital management as well as clinical education and practice are given a hospital professor title.

(B) Analysis and self-evaluation

---

13 The Tokyo Journal of Medical Sciences -- http://www.m.u-tokyo.ac.jp/AnnualReport/2013/127eng.pdf

Currently, performances of education/research/clinical work vary greatly depending on the department. Comprehensive assessment in a form that can be widely accepted is not easy. Anyway, through a combination of the submission of educational activity portfolios and evaluation by students and peer faculty members, FMUT is achieving the goal to confirm educational quality and facilitate faculty motivation.

On the other hand, since not all members are required to submit an educational portfolio, only teachers with recommendations are included in the selection process for all the awards. Additionally, opportunities to share experiences/best practices of high performers to all faculty members are not sufficient.

In the future, these reward systems should include not only the awards for excellent individuals but also dissemination of such excellent teaching experiences to all faculty members. Furthermore, though the educational burdens are increasing amidst limited human and other resources, the reward system for the burdens is quite weak.

(C) Current action

Various reward systems are positively adopted to acknowledge educationally excellent faculty members. As educational tasks are diversified, educational burdens are also perceived in all the departments, resulting in the increase in the numbers of educationally appointed faculty and administrative staff.

(D) Plan for future improvement

Ultimate evaluation of the faculty members' educational activities should be done by the graduates' contribution to the society. In addition to various evaluation methods, graduates' career information should be combined to establish a better system to enhance the education of FMUT further.

B 5.2.3 The medical school **must** formulate and implement a staff activity and development policy which ensures that clinical service functions and research are used in teaching and learning.

(A) Basic information

In CAS, "Exposure to Medical Jobs" is provided for all students who intend to proceed to FMUT in order to experience activities in various departments such as cutting edge medical research and practice.

FQ is prepared as an individual elective curriculum to explore cutting edge research activities depending on the student's interest.

EC is provided for M3-M4 students to be trained by specialists in various clinical departments. CC has been reformed since 2013 January for most clinical departments to provide participatory practicums.

(B) Analysis and self-evaluation

Students have sufficient opportunities to experience developments in biosciences, medical sciences and practice, and international contributions. After completion of the early exposure programmes, many students continue to participate in elective research programmes.

Popularity of three research programmes is stable (MD Researcher Development Programme 20 students, Clinical Researcher Development Programme 20-30 students, and PhD-MD course 1-2 students every year). Early exposure to clinical and research activity is realised. Some students go abroad for EC. On completion of the MD Researcher Development Programme, students are recommended to write English papers. Some papers are as good as master's level.

(C) Current action

Since 2008, "Basic Medical Biology" has been started in addition to "Exposure to Medical Jobs" to promote early exposure programmes in SMFMUT. To enhance CC more, a specially appointed assistant professor is appointed in the CC Support Centre to communicate with both students and departments.

(D) Plan for future improvement

Better collaboration between FMUT and GSMUT should be realised to promote globalisation of clinical medicine through continuous early exposure to CAS students, experiences of clinical or research activities in the early stages of SMFMUT, and more global clinical experiences in EC.

B 5.2.4 The medical school **must** formulate and implement a staff activity and development policy which ensures sufficient knowledge by individual staff members of the total curriculum.

(A) Basic information

For the 6 years of the programme, the syllabi for CAS, basic sciences, clinical medicine, etc. are edited and printed. Syllabi describe all the faculty members' names, schedule and educational content. Every year syllabi are reviewed for upgrading. Syllabi are distributed to all the departments to share the curricular content of other departments.

Since 2013, an improved CC has been implemented mainly led by AAC. Since that time, each specialised area shares its aims, revised content, objectives, etc. regarding the new CC system through a faculty member in charge of education in every department. The Medical Education Reform WG discusses future education for the whole FMUT.

(B) Analysis and self-evaluation

Curricular information is well distributed to all faculty members through syllabi and FDs. Some faculty members might not know the educational content in other departments very well. Some content is duplicated in different departments (e.g. related internal medicine and surgical departments teach the same diseases). More information exchange is needed to stay current with disease structure and therapeutic progresses.

Another issue is the weak connection of educational content among basic sciences, social medicine and clinical medicine. Some faculty members do not have sufficient understanding about the connection among different subjects in medicine.

(C) Current action

Four FDs in 2014 opened eyes to the curricula provided by different departments and to the importance of knowing the curricular framework, especially areas that more than one department might teach.

In the future, efforts to disseminate the educational content to different departments should be continued. Development of the current role of integrated lectures will enhance the understanding of the relationship among different areas of curricula.

(D) Plan for future improvement

Syllabi are indispensable to understand curricula. An electronic version of syllabi is planned but only the top page was set up and there is no content there. Adoption of electronic syllabi should be considered.

Continuous FD will deepen the understanding of curricula from different departments with one another. Since OBE will be more enhanced in the near future, information of its progress should be shared.

Some curricular reforms are linked with curricular reform of the whole university (e.g. implementation of four-term system).

B 5.2.5 The medical school **must** formulate and implement a staff activity and development policy which includes teacher training, development, support and appraisal.

(A) Basic information

Departments in charge of classes in basic sciences, behavioural/social medicine and clinical medicine are linked with divisions in GSMUT. In the division meeting, faculty members discuss the educational content or methods of SMFMUT.

Regarding educational issues, FMUT has held FDs since IRCME was established in 2000. Faculty members discuss issues in small groups in FDs, and come to conclusions that will produce changes in the current system.

IRCME regularly holds “medical education seminars” to convey updates on issues in medical education to participants inside and outside of the campus. The contents are

also broadcasted by web-based movie, so that those who cannot attend the lecture can watch the seminar at the same time through the Internet or later by streaming. IRCME has also started a medical education basic course as a FD for practical skills of medical education for young faculty members.

Some clinical departments hold their own FDs (e.g. paediatrics). The CC support centre also holds FD workshops 2 or 3 times a year.

(B) Analysis and self-evaluation

Educational opportunities for faculty members are provided at a certain level. Conclusions in FD are utilised to revise the curriculum.

(C) Current action

The support system for young faculty members is well constructed, but such training has not been made obligatory yet.

(D) Plan for future improvement

Obligatory training opportunities should be discussed.

Q 5.2.1 The medical school **should** take into account teacher-student ratios relevant to the various curricular components.

(A) Basic information

The number of faculty members for each type of class is as follows.

- Lecture: one for 110 students
- Basic sciences practicums, clinical diagnostic practicums and PBL: one for 6-7 students
- FQ: 1 on 1
- CC: In outpatient one for 1-2 students. In inpatient one student is in each practice team (1-3 faculty members and 1-3 residents/physician staff).

(B) Analysis and self-evaluation

For all classes, measures for improvement are ongoing and an appropriate number of faculty members are allocated to respond to evaluations from students. Many adjunct faculty members are invited from the School of Integrated Health Sciences, other research institutes, other hospitals or universities to vitalise classes.

(C) Current action

After the number of weeks for CC was expanded, the number of faculty members needed for CC was increased. Physicians outside of the university are invited as “clinical teachers of SMFMUT” to teach students. This system should be strengthened.

(D) Plan for future improvement

As medical practice and medical education progresses, the teacher-student ratio should be reconfirmed, and efficiency should be further pursued.

Q 5.2.2 The medical school **should** design and implement a staff promotion policy.

(A) Basic information

In FMUT, when any position of lecturer or higher becomes vacant, PBM will select another lecturer, and for associate professors and professors the Board of Representatives Meeting will select one. Promotion criteria use this same process.

(B) Analysis and self-evaluation

When a faculty member is brought to promotion, strict screening and discussion is done. Screening is mainly based on research products, but evaluation for other areas of performance might be inadequate.

(C) Current action

As an index of evaluation for individual faculty members, the degree of educational contribution should be appropriately quantified. Such measures will produce a better system to select faculty members with a good balance among research/practice/education.

(D) Plan for future improvement

Based on the mission statement of FMUT, indices to assess the educational skills of faculty members should be developed. Measures to check if the promotion process is appropriately performed or not should be discussed.

6. EDUCATIONAL RESOURCES

6.1 PHYSICAL FACILITIES

Basic standard:

The medical school **must**

- have sufficient physical facilities for staff and students to ensure that the curriculum can be delivered adequately. (B 6.1.1)
- ensure a learning environment, which is safe for staff, students, patients and their carers. (B 6.1.2)

Quality development standard:

The medical school **should**

- improve the learning environment by regularly updating and modifying or extending the physical facilities to match developments in educational practices. (Q 6.1.1)

Annotations:

- *Physical facilities* would include lecture halls, class, group and tutorial rooms, teaching and research laboratories, clinical skills laboratories, offices, libraries, information technology facilities and student amenities such as adequate study space, lounges, transportation facilities, catering, student housing, on-call accommodation, personal storage lockers, sports and recreational facilities.
- *A safe learning environment* would include provision of necessary information and protection from harmful substances, specimens and organisms, laboratory safety regulations and safety equipment.

B 6.1.1 The medical school **must** have sufficient physical facilities for staff and students to ensure that the curriculum can be delivered adequately.

(A) Basic information

Medical students learn on Komaba Campus in the first year and a half, and then move to Hongo Campus in the latter half of the second year (M0) and afterwards till sixth year. On Hongo Campus from M0 to December of M2 they mainly learn in classrooms or practicum rooms, and move to UTH practicums (CC) afterward.

Komaba Campus has 9 buildings with more than 100 lecture rooms, auditoria, laboratories, etc. It also has audiovisual facilities. The library on Komaba Campus has 8,600 square meters with approximately 600,000 books or journals. The library has 1,100 seats with LAN (local area network) cable, and facilities for group learning.

Facilities of FMUT are listed in the following table. The Internal Medicine Auditorium is under construction currently.

Name	Seats	Location	Floor
2nd Bldg, large auditorium	160	2nd Bldg	3F

2nd Bldg, small auditorium	152	2nd Bldg	1F
1st Bldg, 3F auditorium	212	1st Bldg	3F
1st Bldg, 1F auditorium	143	1st Bldg	1F
3rd Bldg, N101 lecture room	54	3rd Bldg	1F
3rd Bldg, S101 lecture room	42	3rd Bldg	1F
3rd Bldg, S102 lecture room	42	3rd Bldg	1F
Internal Medicine auditorium	260	Internal medicine Bldg	2F
Dissection practical room	120	2nd Bldg	3F
2nd Bldg, practical room commons	120	2nd Bldg	2F
1st Bldg, 1st practical room	120	1st Bldg	BF
1st Bldg, 2nd practical room	120	1st Bldg	BF
3rd Bldg, practical room	120	3rd Bldg	1F
Pathology dissection room		2nd Bldg	1F
Forensic Medicine dissection room		2nd Bldg	BF
Medical Library Bldg 333 room	120	Library Bldg	3F
Tetsumon Memorial Auditorium	280	Research/education Bldg	14F

*BF: basement floor

The Medical Library[14] is open to any students and staff (including graduates or previous staff). Its construction was renewed to enhance earthquake safety in 2008. Some reading rooms (up to 35 members) and small group learning rooms (up to 7 members) have computers provided for private usage. Hours are from 8:45 to 20:00 weekdays and 8:45 to 17:00 on Saturday, but application for extra usage hours may be accepted to utilise the library from 20:15 to 23:30.

UTH has 1,163 beds for normal hospitalisation and 54 beds for the psychiatry department. Students come to the hospitals for observation for “exposure to medical jobs,” CC and EC. A simulator room is prepared for students to undergo exercises for emergency training or other skills. UTH has 3 restaurants, 2 coffee shops and 3 kiosks (1 with a convenience shop). Each floor has a students’ room and a conference room for student seminars. Three meeting rooms are in inpatient areas and three more in practice areas for student seminars and lectures.

In the basement of tutorial rooms for PBL, clinical diagnostic practicums and OSCE are organised. 20 rooms have a table, 7-8 chairs, a white board, reference books and a computer with an Internet connection.

(B) Analysis and self-evaluation

Facilities and equipment seem sufficient for all the school years.

(C) Current action

No classroom has an electronic response system currently. Similarly more enhancement of audiovisual aids will enable more effective education.

(D) Plan for future improvement

[14] Medical Library (http://www.lib.m.u-tokyo.ac.jp/eng/guide.html)

More enhancement of audiovisual aids for education should be considered. To promote collaboration between FMUT and UTH, an educational facility in UTH should be discussed.

B 6.1.2 The medical school **must** ensure a learning environment, which is safe for staff, students, patients and their carers.

(A) Basic information

UT has a Division for Environment, Health and Safety and each faculty has an Environment, Health and Safety Unit to address student and staff safety issues. The dean of GSMUT is responsible for FMUT facilities and the director of UTH is responsible for facilities in UTH for safety and improvement.

UTH has a Risk Management Committee managed by the Medical Safety Management Centre, a Nosocomial Infection Control Committee managed by the Infection Control Centre, and a Radiation Safety Committee managed by the Radiology Department to continuously manage a safe learning environment. Both the Medical Safety Management and Infection Control Centres regularly check if any problems occur. Any claims from patients or their caregivers are addressed by the Patient Relations and Clinical Ethics Centre.

(B) Analysis and self-evaluation

Safety management organisations are well designed for the whole university. Various committees have systems to conduct safety trainings but the attendance rate is not always high. Content for such training courses should be improved.

(C) Current action

Dates and timing should be improved to increase attendance rates. E-learning content for medical safety measures should be enhanced.

(D) Plan for future improvement

Based on the needs from society, regular checks for a safe learning environment should be assured.

Q 6.1.1 The medical school **should** improve the learning environment by regularly updating and modifying or extending the physical facilities to match developments in educational practices.

(A) Basic information

The UT Campus Overview Plan was enacted in March 2014 and implemented in the following month for an upgrade of facilities. As for the Komaba Campus, the plan says that a unique environment for academism should be created to facilitate the interaction and collaboration between academism and society. In June 2014, construction of 21 KOMCEE (21 Komaba Centre for Educational Excellence) with studio classrooms and an open stadium to support a new type of liberal arts education was completed.

Facility improvement on the Hongo Campus has progressed along with the vision of the "Human Hospital" developed in 1996. After environmental changes around UTH, the new vision of an "Integral Hospital" was formulated. The Integral Hospital consists of six requirements: (1) comfortable spaces and structures, (2) correct diagnostic systems, (3) a health care environment to address community/society needs, (4) tight structural and organisational connections between new and old buildings to wield comprehensive strength, (5) enhancement of practice functions for research, and (6) enhancement of clinical education functions to integrate the three fields of practice/education/research.

In 2012, the basic improvement plan of the inpatient building for phase II was issued as a construction plan. Currently two visions are being developed. One is the "UT Clinical Research Centre Vision" to propose a clinical medicine research centre to integrate disease research to study the etiology and incidence mechanisms of diseases, clinical epidemiology research to develop and confirm new diagnostic and therapeutic methods, and translational research. The other is the "UT Medical Town Vision" to collaborate and integrate the UT Clinical Research Centre with UTH based on the origin of clinical medicine research both from bedside to bench and from bench to bedside.

Construction of the inpatient building for phase II started in 2014 and further building planning for the whole UT is proceeding.

(B) Analysis and self-evaluation

All the chairmen in FMUT, such as the dean of GSMUT (FMUT) and the director of UTH, organise opinions about the status quo and issues for facilities from each department.

(C) Current action

The master plan of construction and renovation for UTH is formulated, and its milestones and budget should be regularly checked to ensure appropriate progress.

(D) Plan for future improvement

Renewal and expansion of facilities/equipment is based on the master plan of construction and renovation for UTH to improve the learning environment, particularly small group learning rooms, facilities/equipment for skill training and skill assessment (including OSCE).

6.2 CLINICAL TRAINING RESOURCES

Basic standard:

The medical school **must**

- ensure necessary resources for giving the students adequate clinical experience, including sufficient
  - number and categories of patients. (B 6.2.1)
  - clinical training facilities. (B 6.2.2)
  - supervision of their clinical practice. (B 6.2.3)

Quality development standard:

The medical school **should**

- evaluate, adapt and improve the facilities for clinical training to meet the needs of the population it serves. (Q 6.2.1)

Annotations:

- *Clinical training facilities* would include hospitals (adequate mix of primary, secondary and tertiary), ambulatory services (including primary care), clinics, primary health care settings, health care centres and other community health care settings as well as skills laboratories, allowing clinical training to be organised using an appropriate mix of clinical settings and rotations throughout all main disciplines.
- *Evaluation of facilities for clinical training* would include appropriateness and quality for medical training programmes in terms of settings, equipment and number and categories of patients, as well as health practices, supervision and administration.

B 6.2.1 The medical school **must** ensure necessary resources for giving the students adequate clinical experience, including sufficient number and categories of patients.

(A) Basic information

The number of beds of UTH is 1,217 (general 1,163 and psychiatry 54), gross number of inpatients in 2013 was 392,823 (1,077 average/day); and outpatients were 760,563 (3,117 average/day). UTH has various stratifications of patients including tertiary emergent patients and encompasses Clinical Divisions including Divisions of Internal Medicine (12 subspecialties), Surgery (13 subspecialties), Sensory and Motor System Medicine (7 subspecialties), Paediatrics, Perinatal and Women's Medicine (3 subspecialties), Neuropsychiatry and Radiology, and Central Clinical Facilities including the Surgical Centre, Emergency Service, Intensive Care Unit, Department of Blood Transfusion, Pathology, etc.

SMFMUT prepares opportunities for practicums to learn medical practice in other major hospitals besides UTH. For instance, there is an opportunity to experience a community-based medicine practicum to learn home care around the focal point of

community care in Kashiwa City where a new campus of UT exists. Another learning opportunity to experience the emergency setting is to ride an ambulance car in collaboration with the fire department next to the Hongo Campus.

(B) Analysis and self-evaluation

Regarding advanced medical care, such as secondary/tertiary care or care for intractable diseases, sufficient case experiences are available in UTH. Regarding primary care, experiences in the emergency department of UTH and major hospitals are available. However, case experiences might be variable among students. Community medicine with home care and general practice in the emergency department are elective, so students cannot experience both unless they learn such areas in EC. Currently, whether all the students cover a similar variety of diseases, signs/symptoms and pathophysiologies is not confirmed. Opportunity to learn preventive medicine is not sufficient.

(C) Current action

A survey of students' experiences of diseases, signs/symptoms and pathophysiologies is necessary. The schedule for CC should be checked for all the students to experience both community medicine and general practice. The balance between experiences of UTH and other major hospitals should be also checked.

(D) Plan for future improvement

Discuss the settings for students to learn preventive medicine. Confirm how many diseases, signs/symptoms and pathophysiologies all the students experience in CC and continuously check if balanced learning opportunities are provided.

B 6.2.2 The medical school **must** ensure necessary resources for giving the students adequate clinical experience, including sufficient clinical training facilities.

(A) Basic information

There are various types of clinical training facilities: (1) clinical skills laboratory, (2) UTH (primary, secondary and tertiary care), (3) major hospitals in and around Tokyo, (4) other facilities for community-based care, (5) epidemiology and preventive medicine (health check up), and (6) nursing care facilities in and around Tokyo.

The clinical skills laboratory is located in the 3rd floor in the previous central practice building of UTH and open from 8:30am to 5:00pm on weekdays. Staff in UTH, and staff and students in GSMUT and FMUT are allowed to use it. The first room has mainly simulators for cardiopulmonary resuscitation and the second room has simulators for training for physical examinations, ultrasound, phlebotomy and urethral catheterisation.

UTH has 1,217 beds for primary, secondary and tertiary care. Each clinical department has outpatient and inpatient consultation rooms, a laboratory room, a conference room, a student practicum room and operation theater for discussion among students and self-directed learning in CC.

Practicums in major hospitals in and around Tokyo are set up to learn medical care outside of UTH. Moreover, as an opportunity to experience community-based care, practicums in home care are provided around the focal point of community care in Kashiwa city. There is also a nursing care practicum in a nursing care home or facility in and around Tokyo. There is no opportunity to experience epidemiology and preventive medicine in UTH.

(B) Analysis and self-evaluation

The clinical skills laboratory has many simulators but limited opening hours might be a reason for insufficient usage by students. Equipment for CC has improved including lockers and computers for students, but some departments do not provide them. Experiences outside of UTH are appropriately provided. Clinical training facilities for areas such as epidemiology and preventive medicine or a health maintenance centre to learn preventive and primary health maintenance is insufficient.

(C) Current action

Since the frequency of usage for the clinical skills laboratory is currently limited, regular seminars will be planned to use it more. Opening hours are limited, but such management should be reviewed. Space for CC should be improved by the cooperation between the CC support unit and CC support team in each clinical department.

(D) Plan for future improvement

When completed, the second phase of the inpatient building will have a larger simulation laboratory and meeting rooms for seminars to make it a better simulation education facility. Discussion is planned for learning opportunities for preventive medicine and health maintenance in the epidemiology and preventive medicine department or health centre.

B 6.2.3 The medical school **must** ensure necessary resources for giving the students adequate clinical experience, including sufficient supervision of their clinical practice.

(A) Basic information

Each clinical department designates a CC support team member to ask staff physicians (faculty members, hospital staff and specially appointed clinical staff) and house officers to teach medical students. The CC support team meeting is regularly held to discuss issues and vision in CC.

Medical practice in CC is allowed by patient consent under the supervision of faculty members or staff members. Documentation in the electronic medical chart by CC students is checked with a counter signature by a faculty member or clinical staff.

(B) Analysis and self-evaluation

The CC system is well constructed, but the actual education for students varies depending on departments. There are timing issues that limit student training due to the overwhelming tasks of faculty members and clinical staff. Many clinical departments have not established team-based practice yet. More reform should be incorporated into the educational settings.

(C) Current action

There are FDs for CC trainers. Those who complete the FD are expected to be supervisors. More facilitation is needed for faculty members and clinical staff who teach in CC to participate in the FD. Team-based practice should be enhanced in each department.

(D) Plan for future improvement

Count graduates from FD for CC trainers in each clinical department and assure sufficient numbers of faculty members and clinical staff for teaching. Construct the system to supervise and evaluate CC education and organisation in each department.

Q 6.2.1 The medical school **should** evaluate, adapt and improve the facilities for clinical training to meet the needs of the population it serves.

(A) Basic information

Transformation of CC using more participatory methods and more involvement in patient practice facilitates not only medical knowledge but also organisation of such knowledge for practical use. Facilities to accept CC have been increased dramatically (refer to B6.2.3). There are several seats for EC in foreign facilities with financial support.

(B) Analysis and self-evaluation

Adoption of simulation-based training and learning contracts depending on a student's level and expectation enables student-centred education and students' high satisfaction with the system.

However, practice management follows the philosophy of patient-centred care and sometimes a mismatch with students' schedules result in inefficient usage of time.

For procedural skills training, active usage of simulators to mimic actual clinical settings is important to decrease the concern of patients. The clinical skills laboratory

has a variety of simulators, but students cannot use them easily. A more accessible environment should be established. The CC support team should modify such activities for more efficient use.

(C) Current action

The CC support team and AAAD collaborate to obtain student feedback and lead unified measures for requests from students. To maximise the effectiveness of students' learning time other than time for patient care, space for self-directed learning and an environment for preparation of materials are being considered.

Moreover, the importance of a portfolio to visualise students' achievement in CC and to improve teaching is acknowledged. Currently, students are recommended to document what kind of practice they have conducted.

(D) Plan for future improvement

Set the achievement levels for students regarding procedural skills, amount of knowledge and non-technical skills (ability for application and emergency care) and improve education through assessing students. Goals and objectives should be clearly articulated and shared among departments.

The CC support team is constructing a system to deliver and share student information to consider individual situations. Portfolios are being considered for a tutor to check the achievement of each student.

6.3 INFORMATION TECHNOLOGY

Basic standard:

The medical school **must**

- formulate and implement a policy which addresses effective use and evaluation of appropriate information and communication technology in the educational programme. (B 6.3.1)

Quality development standard:

The medical school **should**

- enable teachers and students to use existing and exploit appropriate new information and communication technology for
  - independent learning. (Q 6.3.1)
  - accessing information. (Q 6.3.2)
  - managing patients. (Q 6.3.3)
  - working in health care delivery systems. (Q 6.3.4)
- optimise student access to relevant patient data and health care information

systems. (Q 6.3.5)

Annotation:

- A policy regarding e*ffective use of information and communication technology* would include consideration of the use of computers, internal and external networks and other means. This would include coordination with library resources and IT services of the institution. The policy would include common access to all educational items through a learning management system.

  Information and communication technology would be useful for preparing students for evidence-based medicine and life-long learning through continuing professional development (CPD)/ continuing medical education (CME).

B 6.3.1 The medical school **must** formulate and implement a policy which addresses effective use and evaluation of appropriate information and communication technology in the educational programme.

(A) Basic information

In the primary phase, CAS curriculum, “Information” as a required subject and “Information Science” as a semi-required subject are provided to learn the basics of information and computer technology. The Medical Library and Informatisation Promotion Unit provide new-enrolee guidance and seminars about computer and network usage, seminars and web-based information for literature search methods, seminars and web-based information to use MATLAB (statistical software) in FMUT. For the whole UT, the Division for Information and Communication Systems provides seminars and web-based support for network usage, database and literature searching, and security measures; and prepares computers for the tutorial rooms and multimedia corner in the Medical Library. The Medical Library and Informatisation Promotion Unit provide an online literature search service and lend software for research support and education. UTH has 25 computers for students for CC.

(B) Analysis and self-evaluation

Guidance and seminars about information and communication technology are always crowded. Public relations activities should be promoted to expand usage of information and computer technologies.

(C) Current action

The schedule for guidance and seminars is on the webpages of the Medical Library and Informatisation Promotion Unit, Division for Information and Communication Systems, UMIN Centre (University Hospital Medical Information Network Centre), etc.

(D) Plan for future improvement

Measures to promote public relations activity should be considered by appraising past records.

Q 6.3.1 The medical school **should** enable teachers and students to use existing and exploit appropriate new information and communication technology for independent learning.

(A) Basic information

For self-directed learning, the Medical Library and Informatization Promotion Unit has 20 computers in tutorial rooms, 30 computers for information searching or document formulation, an ink-jet printer for large-sized paper, 4 computers with scanners for presentation materials, and 5 computers with statistical software (SPSS, SAS, MATLAB, Mathematica and Stata) in the multi-media corner. Public spaces and lecture rooms have WiFi access points for portable terminals to connect to the Internet. In UTH, after an application for use, personal mobile terminals can be connected to the Internet through WiFi or LAN cable.

(B) Analysis and self-evaluation

Facilities and equipment for tutorial rooms and the multi-media corner are appropriate. WiFi connection is available in various areas of the campus. Software for research support and education seem sufficient, but the number of licenses for some software should be evaluated .

(C) Current action

The Medical Library and Informatization Promotion Unit promotes public relations for the online literature search service, software for research support and education, tutorial rooms and the multi-media corner. The Division for Information and Communication Systems also works for the online literature search service and software for research support and education.

(D) Plan for future improvement

It is necessary to enhance WiFi access points in public spaces and to increase licenses for software for research support and education.

Q 6.3.2 The medical school **should** enable teachers and students to use existing and exploit appropriate new information and communication technology for accessing information.

(A) Basic information

FMUT provides a homepage for students and staff to access all the information within Hongo Campus. Literature searching is fully possible only through the on-campus LAN connection for literature databases, all the electronic books and journals, etc.

After their application is accepted, current students and staff are able to connect to the literature database and electronic journals from off-campus, too.

(B) Analysis and self-evaluation

Access to information through the information and computer technologies by students and staff is sufficiently guaranteed.

(C) Current action

Database and electronic materials should be continuously monitored to consider modification for the future. To prevent unauthorised access to the network, it is necessary to consider constructing a high security system.

(D) Plan for future improvement

The internet environment on the campus should be continuously improved depending on the surrounding conditions.

Q 6.3.3 The medical school **should** enable teachers and students to use existing and exploit appropriate new information and communication technology for managing patients.

(A) Basic information

For the management of patients, all the documentation, laboratory data and images are saved in the electronic medical chart system for faculty members and students to use. Students are able to access the electronic chart by ID and password given before CC starts. From the viewpoint of protecting patients' personal information, students can view the information of only limited patients as allowed by faculty members.

Students are able to use computer terminals installed in outpatient and inpatient practice settings or the Central Clinical Facilities and Clinical Research Divisions. Hospital staff has priority to utilise such terminals, but 25 terminals installed in students' practical rooms etc. are prioritized for students in CC.

Such an electronic medical chart system was constructed as a result of discussions by the CC electronic medical chart implementation WG in November 2012.

(B) Analysis and self-evaluation

Staff and students are able to be involved in patient management with utilisation of information and computer technologies. Students are also able to make entries in

medical charts specifically constructed for students, and after a faculty member's signature the student's chart becomes visible to other health professionals.

Computer terminals for students have been developed over several years. Previously 8 computers were in the students' practical room in UTH but 17 were added from November 2013 to January 2014. Students' learning opportunities are limited because students are able to view a patient's record only during the period of CC (if a faculty member allows the student to view the information). Since student authorisation must be given by staff, it is sometimes not so convenient.

(C) Current action

Faculty members should take care of enabling students to view patients' charts more easily. The issues of students' limited viewing authorisation and how students actually need to use medical charts should be discussed with the CC support centre, Department of Planning, Information, and Management and all the appropriate departments for students to obtain the information necessary for practice.

(D) Plan for future improvement

The CC support centre and Department of Planning, Information, and Management should collaborate for students to obtain the necessary information in CC. Depending on the necessity, the electronic chart system should be continuously changed. Since some students are frustrated by the current rule of patient registration (number of patients and length of period), relaxation of the rule is being considered while being attentive to personal information security.

Q 6.3.4 The medical school **should** enable teachers and students to use existing and exploit appropriate new information and communication technology for working in health care delivery systems.

(A) Basic information

The Division for Health Service Promotion and the Health Centre under it is responsible for health maintenance of all the students and staff in FMUT. Since a shared health care database system was adopted including Hongo, Komaba and Kashiwa Campuses, students promoted from CAS are provided continuous health maintenance and support. Students are given regular health check ups with the legal basis from the School Health and Safety Act and its Ordinance for Enforcement. A mental health interview is performed for all new enrolees. SSU was set up to take care of medical students and a new specially appointed faculty member has come to SSU since November 2014. For faculty members, a normal health check up for staff, special health check, health check for radiation handlers, etc. based on the Industrial Safety and Health Act are provided. The practice division in the Health Centre consists of internal medicine, psychiatry, dentistry, otorhinolaryngology, etc. and contributes to the health maintenance of students and staff collaborating with UTH.

(B) Analysis and self-evaluation

The health maintenance system in the organization of the university is considered sufficient, but some students are still suffering from psychiatric problems. In the future, prevention of, early detection of and early therapeutic intervention for psychiatric problems are the issues for faculty members of FMUT, SSU and the Division for Health Service Promotion.

(C) Current action

Before CC in hospitals, vaccination for students is sufficiently provided but vaccination for staff should be strengthened. A web-based health check up database is constructed for students and staff to read but it is not utilised much. Publicity and more usage is expected.

SSU has just been opened since November 2014. Collaboration with the Health Centre is expected in the future.

(D) Plan for future improvement

Developing a collaborating system between the SSU and Division for Health Service Promotion is expected to prevent and provide early detection of learning disorders resulting from psychiatric problems and to connect students with early therapy.

Q 6.3.5 The medical school **should** optimise student access to relevant patient data and health care information systems.

(A) Basic information

Students are able to read all the medical records registered by faculty members for 4 weeks, and document on the "CC record for medical students" in the electronic medical chart system.

(B) Analysis and self-evaluation

It seems appropriate for students to access the electronic chart only for the patients that they are responsible for.

(C) Current action

The CC support team regularly discusses the issues of the electronic medical chart documented by students.

(D) Plan for future improvement

More discussion should be done on whether to relax restrictions for viewing the electronic chart, because relaxation of restriction would affect student learning.

6.4 MEDICAL RESEARCH AND SCHOLARSHIP

Basic standard:

The medical school **must**

- use medical research and scholarship as a basis for the educational curriculum. (B 6.4.1)
- formulate and implement a policy that fosters the relationship between medical research and education. (B 6.4.2)
- describe the research facilities and priorities at the institution. (B 6.4.3)

Quality development standard:

The medical school **should**

- ensure that interaction between medical research and education
  - influences current teaching. (Q 6.4.1)
  - encourages and prepares students to engage in medical research and development. (Q 6.4.2)

Annotation:

- *Medical research and scholarship* encompasses scientific research in basic biomedical, clinical, behavioural and social sciences. Medical scholarship means the academic attainment of advanced medical knowledge and inquiry.

  The medical research basis of the curriculum would be ensured by research activities within the medical school itself or its affiliated institutions and/or by the scholarship and scientific competencies of the teaching staff.

  Influences on current teaching would facilitate teaching of scientific methods and evidence-based medicine (see B 2.2).

B 6.4.1 The medical school **must** use medical research and scholarship as a basis for the educational curriculum.

(A) Basic information

GSMUT consists of 116 specialty departments under 12 departments, 9 research divisions under 2 centres, 40 endowed departments, 4 social cooperation programmes and 5 research units. These are responsible for research in basic sciences, social medicine and clinical medicine. Each department, division and research unit continues efforts to maintain excellent faculty members, and promote research and top-level research products from the viewpoint of international competition.

(B) Analysis and self-evaluation

UGME consists of basic sciences, social medicine and clinical medicine with all the specialty departments. Moreover, faculty members in CDBIM, endowed departments, social cooperation programmes and research units are involved in UGME. Some departments or units are not involved in UGME very much.

(C) Current action

More active involvement is asked of all the faculty members in FMUT. Unequal situations in the curricula should be reviewed and rectified.

(D) Plan for future improvement

Each department and unit should find better faculty members.

B 6.4.2 The medical school **must** formulate and implement a policy that fosters the relationship between medical research and education.

(A) Basic information

All the faculty members in FMUT are working for both research and education. The way to include research findings into education depends on the intention of each faculty member.

In the MD Researcher Development Programme, Clinical Researcher Development Programme, etc. faculty members give consideration to education aligned with medical research.

(B) Analysis and self-evaluation

Collaboration between research and education is more emphasised than before.

(C) Current action

Further improvement of the programmes and students' more active participation in the Researcher Development Programmes are expected.

(D) Plan for future improvement

Insufficient areas in the current programmes should be reviewed and improved from new perspectives.

B 6.4.3 The medical school **must** describe the research facilities and priorities at the institution.

(A) Basic information

As described in the Prospectus 2013 – 2014, each department in GSMUT conducts independent and high-level research.

UT has become a university mainly managed by its graduate school since 1997, and FMUT rule says that its education is provided by the cooperation from teachers in GSMUT. FMUT's organisational rule says that "GSMUT sets up CDBIM and IRCME as affiliated centres for education and/or research" and "items necessary for the organisation and management of affiliated facilities are described in detail in another document." Other affiliated facilities are (1) Medical Library, (2) OIAA, (3) MD Researcher Development Programme Unit, (4) Museum of Health and Medicine, (5) Office for Research Ethics Support and (6) Life Sciences Research Equipment Support Unit.

(B) Analysis and self-evaluation

Facilities and equipment for research are managed to accommodate departmental independence.

(C) Current action

The Clinical Research Centre will be completed in the future and more collaboration among basic sciences, clinical medicine and social medicine is expected.

(D) Plan for future improvement

To enhance clinical research and translational research in GSMUT, more collaboration for the whole graduate school is expected.

Q 6.4.1 The medical school **should** ensure that interaction between medical research and education influences current teaching.

(A) Basic information

In CAS, "Basic Medical Biology" is provided prior to medical specialty education. In "Exposure to Medical Jobs," small groups of students visit departments in GSMUT to experience the atmosphere of medical jobs or bioscience research before being promoted to FMUT. Just after promotion to FMUT, students can learn from many researchers in clinical medicine and basic sciences during the lecture series "Origins of Medicine." Integrated lectures for basic sciences/basic science, clinical and social medicine are open to M1-M4 students. Integrated lectures for clinical medicine are open to M3 and M4 students. All the lectures are provided by first-line researchers.

As an elective program, the MD Researcher Development Programme is for students who wish to pursue basic science research and the Clinical Researcher Development Programme is for students who wish to pursue clinical medicine research. In these programmes, students conduct research in the departments they choose and participate in seminars, presentations, English presentation training, short-term study abroad, etc. These programmes enable undergraduate students to experience basic training as researchers to become future researchers.

(B) Analysis and self-evaluation

The above programmes are on-going and quite positive, and further development is expected.

(C) Current action

The current curriculum, MD Researcher Development Programme and Clinical Researcher Development Programme should be further improved.

(D) Plan for future improvement

Further development of the curriculum should be considered.

Q 6.4.2 The medical school **should** ensure that interaction between medical research and education encourages and prepares students to engage in medical research and development.

(A) Basic information

FQ is the portion of the curriculum where students deepen their study in self-selected themes in each department. 4 weeks in M1 are mandatory. Other FQ, such as 2 weeks in M0, 6 weeks in M1, and 4 weeks in M2, are elective.

To develop future researchers, the following three programmes are provided and managed. Though only 1-2 students are enrolled in the PhD-MD course, the MD Researcher Development Programme has 20 enrolees a year, and the Clinical Researcher Development Programme has 80-100 enrolees for the lecture course and 50 enrolees for the small-group course in total, so the impact on the whole student body is considerable.

	PhD-MD course	MD Researcher Development Programme	Clinical Researcher Development Programme
Year started	2001	2008	2010
Target	M2-3	M1-4	M1-4, house officers
Aim	Developing basic	Developing basic	Developing clinical

	scientists	scientists	researches
Characteristlics	After completion of M2 or M3, students stop undergraduate learning and enter the PhD course. Appropriate for students who wish to concentrate on research. After graduation from the PhD course, students are allowed to resume the MD course.	Parallel to FMUT curriculum students learn skills needed for basic science research. Programme consists of both (1) individual research activity and (2) activity of all the participants (small group seminars, English, retreat, short-term study abroad, etc.	Students learn importance of research in medicine and way of thinking as clinical researchers. The programme provides weekly lecture series, small group courses (journal club, mini-lecture, practicum, etc.) and opportunities for discussion between faculty members and students. As advanced content, they can participate in research in a clinical department.

(B) Analysis and self-evaluation

FQ and the three researcher development programmes are regarded as the core to plan the relationship between research and education. Students are facilitated to positively get involved in medical research development. The environment for that purpose is organised.

(C) Current action

More enhancement of and more number of participants in these curriculum should be expected.

(D) Plan for future improvement

Continuous improvement based on the evaluation of the outcomes of graduated students should be conducted.

6.5 EDUCATIONAL EXPERTISE

Basic standard:

The medical school **must**

- have access to educational expertise where required. (B 6.5.1)
- formulate and implement a policy on the use of educational expertise
  - in curriculum development. (B 6.5.2)
  - in development of teaching and assessment methods. (B 6.5.3)

Quality development standard:

The medical school **should**

- demonstrate evidence of the use of in-house or external educational expertise in staff development. (Q 6.5.1)
- pay attention to the development of expertise in educational evaluation and in research in the discipline of medical education. (Q 6.5.2)
- allow staff to pursue educational research interest. (Q 6.5.3)

Annotations:

- *Educational expertise* would deal with, processes, practice and problems of medical education and would include medical doctors with research experience in medical education, educational psychologists and sociologists. It can be provided by an education development unit or a team of interested and experienced teachers at the institution or be acquired from another national or international institution.
- *Research in the discipline of medical education* investigates theoretical, practical and social issues in medical education.

B 6.5.1 The medical school **must** have access to educational expertise where required.

(A) Basic information

Organisations that specifically work for education and accept consultations about education are IRCME (three full-time faculty members), the MD Researcher Development Programme (two), the General Education Centre (two) and the CC Support Centre (one).

IRCME regularly has adjunct professors with medical education expertise from abroad. IRCME also collaborates with four other universities (Keio, Yokohama City, Tokyo Medical Dental and Chiba) to develop core competencies at the graduation level for educational experts to exchange information.

(B) Analysis and self-evaluation

Educational expertise inside and outside of the campus is always accessible on demand.

(C) Current action

IRCME was converted from the whole university centre to the FMUT centre in April 2013. Commitment to UGME is planned to be enhanced. The quality of medical education should be regularly checked for improvement with the General Education Centre and the CC Support Centre.

(D) Plan for future improvement

Far wider expertise should be sought further.

B 6.5.2 The medical school **must** formulate and implement a policy on the use of educational expertise in curriculum development.

(A) Basic information

Curriculum development is mainly done by AAC. Curriculum reform is done by faculty members mainly selected from AAC members. Faculty members from IRCME are always involved in AAC or the curriculum reform WG. It means that curriculum development is done by faculty members who are experts in medical education.

(B) Analysis and self-evaluation

Regarding curriculum development, regular advice from educational experts is available.

(C) Current action

AAC, the CC Support Centre, General Education Centre and IRCME are involved in curriculum development but more external experts should be more involved. Curriculum evaluation by IRCME should be enhanced.

(D) Plan for future improvement

A system for continuous improvement of the curriculum based on the evaluation data should be considered.

B 6.5.3 The medical school **must** formulate and implement a policy on the use of educational expertise in development of teaching and assessment methods.

(A) Basic information

The General Education Centre and IRCME lead the development and implementation of new educational and assessment methods. Faculty members in IRCME actively participate in administrative work in CAT to construct the system of the whole country and to advise on UGME at SMFMUT.

(B) Analysis and self-evaluation

A policy for regular advice from educational experts about the development of teaching and assessment methods is formulated and implemented.

(C) Current action

Learn from and adopt new educational methods introduced in domestic or international conferences and scientific journals, teach faculty members and attendings in FMUT, and improve teaching and assessment methods with cooperation from students. Strengthen the function of IRCME and develop the methods for assessment.

(D) Plan for future improvement

In the future, a division for the development of assessment methods should be separated from the division for education.

Q 6.5.1 The medical school **should** demonstrate evidence of the use of in-house or external educational expertise in staff development.

(A) Basic information

UT maintains IRCME that has played a cutting-edge role in medical education in Japan and that is staffed with faculty members with medical education expertise. IRCME was the centre under the umbrella of the whole university but converted to the centre under the umbrella of the Graduate School of Medicine in April 2013. IRCME's contribution to education in SMFMUT was increased after the conversion.

IRCME regularly holds a UT Medical Education Seminar (almost monthly) and UT Medical Education Basic Course (monthly) as a FD activity. Furthermore, the CC Support Centre holds training of CC trainers with the support of IRCME. Such FD activities are announced in the e-mail list of FMUT.

(B) Analysis and self-evaluation

By IRCME's webpage, experts inside and outside of the campus are utilised to enhance the educational skills of faculty members.

(C) Current action

Since the mission of IRCME has not been revised even after the status was converted, IRCME's contribution to FMUT is not prioritised in the mission. If IRCME contributes to FMUT, a demarcation between AAC and IRCME should be considered.

(D) Plan for future improvement

The description of IRCME's role to contribute to FMUT should be more concrete after IRCME's mission is revised. One idea is that IRCME will have a role as the institutional research unit to collect data related with medical education and to suggest improvement plans by analyzing such data.

Q 6.5.2 The medical school **should** pay attention to the development of expertise in educational evaluation and in research in the discipline of medical education.

(A) Basic information

All the meetings related with implementation and reform of medical education, such as in AAC and the medical education reform WG, must involve faculty members from IRCME to adopt updated information.

(B) Analysis and self-evaluation

The current way to promote medical education is appropriate.

(C) Current action

An attitude to take opinions about medical education from foreign visiting professors in IRCME was active around 2000, during the Inui Project, but not so active afterward.

(D) Plan for future improvement

The kind of preparation that should be done toward the next (2nd) accreditation review will be discussed together with revision of IRCME's mission statement.

Q 6.5.3 The medical school **should** allow staff to pursue educational research interest.

(A) Basic information

IRCME and other departments are specifically working in educational research and try to involve other faculty members. Research products are listed in a different document.

(B) Analysis and self-evaluation

There is a specialised department for medical education research. Dissemination of such research activity to all faculty members should be enhanced.

(C) Current action

Specialised departments for educational research become the core to involve faculty members and students in such research work.

IRCME has started a Medical Education Basic Course to teach practical skills of education to young scholars as a part of FD since 2011.

(D) Plan for future improvement

Educational findings should be applied to practice to check the outcomes. Faculty members and facilities for educational departments should be strengthened. Consider a system to promote educational research.

6.6 EDUCATIONAL EXCHANGES

Basic standard:

The medical school **must**

- formulate and implement a policy for
  - national and international collaboration with other educational institutions. (B 6.6.1)
  - transfer of educational credits. (B 6.6.2)

Quality development standard:

The medical school **should**

- facilitate regional and international exchange of staff and students by providing appropriate resources. (Q 6.6.1)
- ensure that exchange is purposefully organised, taking into account the needs of staff and students, and respecting ethical principles. (Q 6.6.2)

Annotations:

- *Other educational institutions* would include other medical schools as well as other faculties and institutions for health education, such as schools for public health, dentistry, pharmacy and veterinary medicine.
- A *policy for transfer of educational credits* would imply consideration of limits to the proportion of the study programme which can be transferred from other institutions. Transfer of educational credits would be facilitated by establishing agreements on mutual recognition of educational elements and through active programme coordination between medical schools. It would also be facilitated by use of a transparent system of credit units and by flexible interpretation of course requirements.
- *Staff* would include academic, administrative and technical staff.

B 6.6.1 The medical school **must** formulate and implement a policy for national and international collaboration with other educational institutions.

(A) Basic information

So far, FMUT has entered into academic collaboration agreements with many foreign medical schools and has sent many medical students (from 15 to 25 yearly) for clinical or research EC to foreign universities, schools of medicine and hospitals. OIAA

mediates such exchange programmes. Moreover, several students in either the MD or Clinical Researcher Development Programme have made presentations in conferences.

Every year, 20 to 30 letters requesting elective clerkships are received from foreign medical students but only around 5 are actually accepted. A major reason is the high tuition. Another issue is the limited number of faculty members who can teach such foreign students.

There is no regular programme to accept students from other domestic institutes.

(B) Analysis and self-evaluation

The number of students who go abroad for EC ranges from 15-25, and the number of students who apply for this programme is stable. A major reason is more strict conditions to accept students for EC in medical schools abroad. Therefore, an increasing number of students give up the dream to go abroad due to insufficient scores on USMLE step 1 or TOEFL. Lately, less students come to OIAA for foreign practice. This trend is similar to the so-called "introspective mindset" of recent young people and students.

(C) Current action

As financial support, the Otsubo Osamu -- Tetsumon fellowship has been created since 2008. Approximately 15 students have been given this fellowship every year. Students are able to apply for a scholarship for the UT international academic exchange activity facilitation programme, not only for a foreign programme of more than three months but also for shorter programmes from 2013. 8 students were given the scholarship in 2013. For public relations regarding preparation for a foreign practicum or its contents, reflective reports of foreign practicums are anonymously disclosed on the web. Students who desire foreign practicums refer to the reflective reports for preparation. Furthermore, students in the MD Researcher Development Programme or Clinical Researcher Development Programme are financially supported when presenting a paper abroad.

(D) Plan for future improvement

The percentage of students in FMUT who experienced a practicum abroad is much higher than any other faculties in UT. Students who desire a practicum abroad understand its strengths and weaknesses very well, make a full financial plan, submit a document for scholarship, and undertake special practice in English. OIAA provides sufficient information and replies to the questions from the students. Such student aspirations should be maintained by future support. Academic exchange agreements with other medical schools in the US and European countries are planned to be increased.

B 6.6.2 The medical school **must** formulate and implement a policy for transfer of educational credits.

(A) Basic information

When UT students are dispatched to foreign facilities or foreign medical students come to FMUT, a certificate of completion of a practicum is issued to be approved as a credit in each medical school.

(B) Analysis and self-evaluation

The medical school that accepts a student from another medical school issues the certificate of completion of the practicum to smoothly approve the credit. No problem case has occurred.

(C) Current action

A credit transfer programme with foreign medical schools is allowed at a certain level, but no such programme is approved for domestic medical schools.

(D) Plan for future improvement

The necessity of expansion of the credit transfer system should be discussed.

Q 6.6.1 The medical school **should** facilitate regional and international exchange of staff and students by providing appropriate resources.

(A) Basic information

Faculty members and researchers frequently visit foreign universities and research institutes for academic exchanges, but the total number of visits is not monitored. International exchange of medical students is described in B6.6.1 and B6.6.2. There is no clear documentation regarding domestic academic exchange but students often go to domestic conferences. Students are able to participate in frequent seminars by researchers from inside or outside of Japan.

(B) Analysis and self-evaluation

One major problem when foreign faculty members or researchers visit UT is accommodation. In foreign institutes, accommodation for faculty members and researchers is available at a modest price. When a student visits foreign institutes with an exchange agreement, he/she can often live in the dormitory. On the other hand, UT has too few accommodations for foreign students to stay at a dormitory of UT. Foreign students suffer from an enormous economic burden when they stay in Tokyo for a practicum due to the high costs for lodging and eating.

(C) Current action

When a student participates in an international or domestic conference, or seminar at UT, students are advised to talk with faculty members and researchers from foreign countries and research institutes. Before or after international conferences, visits to the local foreign universities or research institutes is recommended for academic and research exchange.

(D) Plan for future improvement

UT plans to construct houses for faculty members and researchers for the future. A dormitory might be constructed at the same time. In that case, temporal stays at the dormitory should be allowed and for that purpose change of the corresponding rule is planned, too.

Q 6.6.2 The medical school **should** ensure that exchange is purposefully organised, taking into account the needs of staff and students, and respecting ethical principles.

(A) Basic information

OIAA works as the office in charge of foreign studies of students, considers the demands and needs of students, supports the selection of foreign universities and institutes mainly from the schools with agreements, and try to develop meaningful and safe practicums. Moreover, OIAA supports accepted foreign students for better exchange programmes.

(B) Analysis and self-evaluation

There are many foreign exchange programmes with meaningful activities. An increased number of exchange programmes should be considered.

(C) Current action

OIAA regularly discusses evaluation, issues and the mission for foreign practicums.

(D) Plan for future improvement

OIAA should discuss whether official agreements should be made with foreign medical schools which have accepted students from SMFMUT, based on the actual outcomes of past data of students' exchange. Recruitment of new medical schools to send students should be considered too.

7. PROGRAMME EVALUATION

7.1 MECHANISMS FOR PROGRAMME MONITORING AND EVALUATION

Basic standard:

The medical school **must**

- have a programme of routine curriculum monitoring of processes and outcomes. (B 7.1.1)
- establish and apply a mechanism for programme evaluation that
  - addresses the curriculum and its main components. (B 7.1.2)
  - addresses student progress. (B 7.1.3)
  - identifies and addresses concerns. (B 7.1.4)
- ensure that relevant results of evaluation influence the curriculum. (B 7.1.5)

Quality development standard:

The medical school **should**

- periodically evaluate the programme by comprehensively addressing
  - the context of the educational process. (Q 7.1.1)
  - the specific components of the curriculum. (Q 7.1.2)
  - the overall outcomes. (Q 7.1.3)
  - its social accountability (Q 7.1.4)

Annotations:

- *Programme monitoring* would imply the routine collection of data about key aspects of the curriculum for the purpose of ensuring that the educational process is on track and for identifying any areas in need of intervention. The collection of data is often part of the administrative procedures in connection with admission of students, assessment and graduation.
- *Programme evaluation* is the process of systematic gathering of information to judge the effectiveness and adequacy of the institution and its programme. It would imply the use of reliable and valid methods of data collection and analysis for the purpose of demonstrating the qualities of the educational programme or core aspects of the programme in relation to the mission and the curriculum, including the intended educational outcomes. Involvement of experts in medical education would further broaden the base of experience for quality improvement of medical education at the institution.
- *Main components of the curriculum* would include the curriculum model (see B 2.1.1), curriculum structure, composition and duration (see 2.6) and the use of core and optional parts (see B 2.6.3).
- *Identified concerns* would include insufficient fulfilment of intended educational outcomes. It would use measures of and information about educational outcomes, including identified weaknesses and problems, as feedback to conduction of interventions and plans for corrective action, programme development and

curricular improvements.

- *The context of the educational process* would include the organisation and resources as well as the learning environment and culture of the medical school.
- *Specific components of the curriculum* would include course description, teaching and learning methods, clinical rotations and assessment methods.
- *Overall outcomes* would be measured e.g. by results at national license examinations, benchmarking procedures, international examinations, career choice and postgraduate performance, and would, while avoiding the risk of programme uniformity, provide a basis for curriculum improvement.
- *Social accountability* (see the definition in 1.1, annotation).

B 7.1.1 The medical school **must** have a programme of routine curriculum monitoring of processes and outcomes.

(A) Basic information

AAC with approximately 30 members is in charge of regular curriculum monitoring of SMFMUT. AAAD supports implementation and assessment tasks without any delay. Concrete curriculum monitoring mechanisms are explained as follows.

- CAS

  AAC in CAS develops and monitors the curriculum for the 1st year and first half of the 2nd year. FMUT sets the curriculum required for the students who are promoted to FMUT. All the performance and outcome data are calculated by the UTask Web system. At the final class of each course, an evaluation sheet compatible with optical mark reader is distributed, collected and analysed to give feedback to all the faculty members.

- Preclinical education in SMFMUT

  SWGME formulates a questionnaire every autumn and asks AAAD both to conduct evaluation using the questionnaire and to sum up the results. Students subjectively analyse the results and present the report to AAC in February or March.

- Clinical education in SMFMUT

  The CC Support Centre regularly conducts evaluation surveys. Feedback is given in CC support team meetings two or three times a year.

(B) Analysis and self-evaluation

AAC is the core mechanism to develop and monitor the curricula, so the basic feedback system is functioning. The new CC curriculum started in January 2013 and the CC Support Centre was established at that time to address detailed issues. This revision of the CC system changed the continuous monitoring system to enable better supervision of the whole curriculum better than before.

For preclinical curricula, SWGME and AAAD conduct the questionnaire survey for evaluation once a year. Due to less frequent evaluation, continuous curriculum monitoring, dissemination of the evaluation results and correlation of monitoring results with curriculum improvement might be less timely than with other curricula.

(C) Current action

Regarding the continuous monitoring of the curriculum and dissemination of the results to the faculty members, it is important to appreciate autonomy of the students and to revise the monitoring system into more continuous system. Monitoring results should be opened not only to AAC but also to PBM for all the professors and associate professors to share.

(D) Plan for future improvement

As a longitudinal issue, it is important to comprehensively monitor the curriculum from M0 to M4 and to continuously evaluate UGME. Regarding the accreditation process this time, IRCME has been playing an important role. For the future, IRCME will continuously monitor the curriculum, analyse if "monitoring results are used for curriculum improvement," and improve the whole system.

B 7.1.2 The medical school **must** establish and apply a mechanism for programme evaluation that addresses the curriculum and its main components.

(A) Basic information

As for the process of reform of the FMUT curriculum and its components, WGs and sub-committees propose a draft plan, and AAC and PBM revise and approve it. In these past 20 years, 4 major revisions have been made.

- 1998: UGME curriculum reform
- 2000: UT Inui Project
- 2004: Medical Education Reform
- 2009: Medical Education Reform by education reform WG

In these curricular reforms, the clear goals of SMFMUT were set as “human resources to originate new ideas in the medical field (physician researchers) whether basic science or clinical medicine,” and enhanced educational content and methods to realise such a goal.

(B) Analysis and self-evaluation

Thus far, the curriculum in FMUT has been developed by a relatively small number of faculty members involved in AAC. This has resulted in AAC's passive attitude to

decrease some lectures or practicums because such a reform might be seen as a disadvantage for specific departments. Thus, the whole curriculum has tended to become more congested step by step, with students becoming more passive learners.

(C) Current action

To solve the issues above, curriculum reform in SMFMUT is progressing through the MERWG (chairman: Professor Kurihara) that is working to adopt a 4-term system for the whole UT. To decide the direction of curricular reform of SMFMUT, four FDs were conducted in March, June, August and November 2014. Consensus was obtained regarding the issues (1) determination of educational outcomes, (2) abolishment of a written test for each clinical department for the graduation assessment, (3) adoption of a new integrated graduation written test and post-clerkship OSCE, (4) improvement in CC management and assessment, etc. These examples illustrate FD's function in suggesting medical education reforms and skill enhancement for medical education.

Previously, AAC had undertaken all the roles of planning, implementation and evaluation of the curriculum. Currently, the faculty members hold the control to discuss grand design and evaluation of the whole curriculum.

(D) Plan for future improvement

For all areas from B7.1.2 to B7.1.4, AAC or WGs under AAC currently conduct both planning/implementation and evaluation of the curriculum. Valid evaluation for overseeing the whole curriculum is not sufficient. To solve this issue, an IR division is being considered to continuously evaluate the curriculum.

B 7.1.3 The medical school **must** establish and apply a mechanism for programme evaluation that addresses student progress.

(A) Basic information

FMUT tracks the progress of each student by assessing the results of the entrance examination, tests in CAS, the SMFMUT admission examination, test results in M0/M1/M2, CAT-CBT and OSCE, CC assessment and the graduation assessment.

The Entrance Examination Follow-up Survey Unit (EEFSU) stores all the data of the entrance examination, CAS test results and SMFMUT admission. AAAD of FMUT stores all the test results in M0/M1/M2, CAT-CBT and OSCE, CC assessment and the graduation assessment. Sampling surveys were conducted regarding the transition of test results after SMFMUT admission, CAT-CBT and OSCE, CC assessment and the graduation assessment.

(B) Analysis and self-evaluation

Methods to follow students' progress are not sufficient but trends can be grasped at a minimum. Currently no system works to connect the entrance examination and results during SMFMUT.

(C) Current action

Since either EEFSU or AAAD at FMUT stores all the assessment results for all medical students, it would be possible to analyse those data if necessary. Currently it is not defined what kind of data would function as outcomes indices, nor which examination data is appropriate to measure the outcome indices.

(D) Plan for future improvement

SMFMUT is expected to strengthen the storage of basic data, horizontal analysis and longitudinal analysis, and to establish an IR division. For the future, it should be considered to a develop database of longitudinal test results and longitudinal data analysis.

B 7.1.4 The medical school **must** establish and apply a mechanism for programme evaluation that identifies and addresses concerns.

(A) Basic information

Regarding UGME, analysis of test results after SMFMUT admission, analysis of the questionnaire survey, and a hearing system to check the weak points of the curriculum are organised for evaluation. Horizontal analysis of the test results for each department is connected to the feedback to the faculty members in charge of the examination contents. The CC Support Centre conducts an evaluation survey, delivers the results to each department, or the person in charge of the curriculum in each department. For each student one faculty member is assigned. If a test result is insufficient to meet the pass level, a tutor has to conduct a hearing for such a student. One faculty member is in charge of the whole school year to organise tutors. One supervisor, from AAC members, oversees all the faculty members in charge of each school year. Thus issues are addressed by different members but if the issue is still not sufficiently addressed, it will come up to AAC for further discussion.

(B) Analysis and self-evaluation

The basic mechanism for programme evaluation that identifies and addresses concerns is organised by analysis of academic performance in each department after admission to FMUT, analysis of the questionnaire survey mainly by the CC Support Centre, and a hearing for each student through the tutor system as needed. Currently, evaluation by the questionnaire survey is limited to part of the curriculum e.g. CC. Since student hearings are triggered only with students who are marked very poor in the summative assessment, identifying issues with other students might be insufficient.

(C) Current action

The current mechanism for programme evaluation that identifies and addresses concerns through academic performance, the questionnaire survey, and student hearings should be maintained. Moreover, the system to specify issues from the students' viewpoint should be enhanced.

(D) Plan for future improvement

In a short time, an additional questionnaire survey to evaluate each class after the summative assessment (e.g. M0, M1, M2 etc.) will identify more issues from the students' viewpoints.

The IR division should be established as an organisation to conduct and analyse the evaluation data and to suggest issues and improvement plans to AAC (or MERWG as its subordinate organization).

B 7.1.5 The medical school **must** ensure that relevant results of evaluation influence the curriculum.

(A) Basic information

Based on the reports from AAC and MERWG, the system to carry out large-scale curriculum reform is well managed. In FMUT, related departments get together to form a specialty area, and a meeting for the specialty area is held monthly. Curricular change in each department is decided in the specialty area meeting based on the evaluation results.

(B) Analysis and self-evaluation

The basic system to change the curriculum is organised, on a small scale by each department or on a larger scale by AAC and MERWG. However, since MERWG is a temporary organization, sustainability is not assured.

(C) Current action

The current structure enables continuous curricular change by each department. However, the structure to change the curriculum on a larger scale by AAC and MERWG should be further strengthened. Detailed curricular changes by each department should be collected and reorganised for MERWG supervised by AAC to oversee the entire curriculum.

(D) Plan for future improvement

From B7.1.2 to B7.1.4 it is stated that the IR division will conduct systematic evaluation and suggest a reform plan for the evaluation process. Based on such a plan, AAC will

decide what changes should be made. The Evaluation Committee formed by members inside and outside of FMUT should oversee and advise on the system.

Q 7.1.1 The medical school **should** periodically evaluate the programme by comprehensively addressing the context of the educational process.

(A) Basic information

In AAC, MERWG and AAAD, the context of the educational process and its background is regularly checked, and lecture and practicum programmes are comprehensively evaluated.

(B) Analysis and self-evaluation

Currently, the comprehensive evaluation system by AAC and MERWG on the educational process and its background is effectively functioning. However, opinions or feedback from part of the students are collected but not from all the students. No department or centre to do such tasks in a short time has been organised. Especially feedback to basic science programmes are relatively less.

(C) Current action

Occasionally, opinions about the educational system and its background have been collected from as many students as possible to address programme development. Many students gave opinions about overly congested curricula. The CC Support Centre collects opinions from faculty members to revise the evaluation questionnaire and to improve it. The CC Support Centre also conducts questionnaire surveys to students to consider how the programme should be revised.

(D) Plan for future improvement

Web-based evaluation methods are under discussion to enable more comprehensive and faster collection of opinions from students. Such a web-based evaluation system should be utilised by faculty members, too. Such information should be analysed in an integrated manner to support more speedy and relevant programme improvement. For that purpose, a new organisation to sufficiently collect and analyse the information, such as IR division, is expected.

Q 7.1.2 The medical school **should** periodically evaluate the programme by comprehensively addressing the specific components of the curriculum.

(A) Basic information

In many classes including CC, evaluation data from students are collected to evaluate the educational methods. AAC and the CC Support Centre manage the evaluation. Opinions from students about educational and learning methods are obtained by counseling in the tutor system.

(B) Analysis and self-evaluation

Every year curricular content like CC are revised every year in the current system. So far in CC, practicums are revised for students to participate in real patient settings, and two levels of learning objectives are selected by students (basic or advanced) depending on their own need. The comprehensive evaluation system for the programme seems to be effectively functioning. The CC Support Centre was newly established and a full-time faculty member was assigned. Regarding assessment methods, besides CAT-OSCE, there are only knowledge tests for each department and CC assessment.

(C) Current action

As determined in the June 2014 FD, implementation of the post-clerkship OSCE and reform of the graduation assessment format and content are under discussion. Through these reforms it is expected that students' motivation will be improved and the amount of knowledge increased.

(D) Plan for future improvement

SMFMUT plans computerisation of teaching materials and syllabi, and quick calculation of student evaluation results and feedback to students from those data to improve the educational programme. One division in charge of such tasks should be charged to set assessable objectives for each school year, to specify those in each syllabi and to assess students based on such standards. Assessment or examination of more essential knowledge should be considered.

Q 7.1.3 The medical school **should** periodically evaluate the programme by comprehensively addressing the overall outcomes.

(A) Basic information

In September 2014, PBM officially approved SMFMUT educational outcomes. SMFMUT now is ready to correlate some data from admission to graduation.

EEFSU is conducting correlational analysis for Natural Sciences III between the entrance examination and FMUT admission. Such raw data are not shared with FMUT. Since EEFSU is supervised by the UT Committee for Admission Administration, whether information sharing with specific faculty (e.g. FMUT) is possible or not is uncertain.

(B) Analysis and self-evaluation

SMFMUT is starting the transition to OBE but the UT organization has impediments to evaluate the whole outcome. The biggest issue is the separate administration of academic performance data between CAS and FMUT to analyse the correlation.

For the whole university, the Centre for Research and Development of Higher Education has a large amount of information about IR. Before starting the discussion of IR for SMFMUT, the difference from IR for the whole university should be discussed.

(C) Current action

To begin with, a follow-up survey for graduates should be started in order to develop the system of IR after admission to SMFMUT.

(D) Plan for future improvement

An educational improvement system to measure content related with outcomes should be constructed.

Q 7.1.4 The medical school **should** periodically evaluate the programme by comprehensively addressing its social accountability.

(A) Basic information

In the educational outcomes of SMFMUT, information about advanced outcomes (creative thinking, team leader, international leader, whole person care and inspired visionary) should be collected with higher priority. Currently from the SMFMUT alumni (Tetsumon Club) name list, information about current jobs and social status can be collected and analysed.

(B) Analysis and self-evaluation

In the hospital directors' meeting for the Tetsumon Club with directors or vice-directors of any hospitals, a questionnaire survey was conducted to extract impressions, strengths and weaknesses of graduates from SMFMUT. Results said that communication skills with patients or other health professionals were lower than other graduates.

(C) Current action

In the future, such information collection for graduates should be continued and at the same time Tetsumon Club should be enhanced.

(D) Plan for future improvement

Data collection from graduates of SMFMUT as a basis for evaluation should be established.

7.2 TEACHER AND STUDENT FEEDBACK

Basic standard:

The medical school **must**

- systematically seek, analyse and respond to teacher and student feedback. (B 7.2.1)

Quality development standard:

The medical school **should**

- use feedback results for programme development. (Q 7.2.1)

Annotation:

- *Feedback* would include information about the processes and products of the educational programmes. It would also include information about malpractice or inappropriate conduct by teachers or students with or without legal consequences.

B 7.2.1 The medical school **must** systematically seek, analyse and respond to teacher and student feedback.

(A) Basic information

Firstly, faculty members' feedback for the curriculum is described. MERWG has conducted questionnaire surveys for the curriculum of basic sciences and social medicine (lectures and practicums) related with the whole UT educational reform in February 2014. Evaluation for CC is regularly done with a questionnaire to faculty members and the results are reported and analysed by the CC Support Team.

Secondly, student feedback is described as stated in B7.1.1. As for M1, SWGME conducts a questionnaire survey for basic science lectures and practicums, and FQ. As for M2, SWGME conducts the questionnaire survey for clinical diagnostic practicums, PBL, nursing care practicums, clinical medicine lectures and assessment, and analyse the results for clinical diagnostic practicums and clinical medicine lectures and assessment. AAC distributes and collects the questionnaire for integrated lectures for basic sciences/basic science, clinical and social medicine but no systematic analysis is done. As for CC, the CC Support Team conducts regular questionnaire surveys and produces evaluation results for each department and attending physicians, utilised for selection of the best staff award.

Finally, there is information about medical errors and inadequate interaction in clinical practice. Luckily, no report for a medical accident has been reported. Information about misconduct in assessment, etc. has been shared as strictly confidential information only in AAC.

(B) Analysis and self-evaluation

Faculty members' feedback on the curriculum was collected for curriculum reform for basic science and social medicine. Continuation of this feedback survey is uncertain at this moment. The evaluation survey for CC is conducted in an appropriate manner.

Student feedback is obtained for M1 and M2, CC and integrated lectures for basic sciences/basic science, clinical and social medicine as a questionnaire survey. The results are discussed and utilised for curricular improvement and reform.

Information about misconduct in assessment, etc. has been shared as strictly confidential information only in AAC.

(C) Current action

What kind of feedback information is obtained, whether from faculty members or students, should be confirmed. If any insufficient area is found, it should be filled. Standards for such feedback information should be established. Particularly, results of analyses should be communicated to relevant faculty members and students.

(D) Plan for future improvement

The feedback system for each school year and each educational content area (practicum, lecture, etc.) for basic science, clinical medicine and social medicine should be established for both students and faculty members.

Q 7.2.1 The medical school **should** use feedback results for programme development.

(A) Basic information

Information from faculty members and students is collected as described in B7.1.1 and B7.2.1. Such information is reported to AAC to be utilised for curriculum development or improvement.

(B) Analysis and self-evaluation

AAC utilizes feedback information from programme implementation to develop curriculum. The degree of sophistication of the information has not been discussed.

(C) Current action

For each area of basic science, clinical medicine and social medicine, the way feedback from faculty members and students is connected to each school year or each educational content area should be confirmed. If any insufficient area is found, it should be filled.

(D) Plan for future improvement

Discussion should be started to establish a system to utilise feedback information for each school year and each educational content area for basic science, clinical medicine and social medicine. In such a system, IR should be central.

7.3 PERFORMANCE OF STUDENTS AND GRADUATES

Basic standard:

The medical school **must**

- analyse performance of cohorts of students and graduates in relation to its
  - mission and intended educational outcomes. (B 7.3.1)
  - curriculum. (B 7.3.2)
  - provision of resources. (B 7.3.3)

Quality development standard:

The medical school **should**

- analyse performance of cohorts of students and graduates in relation to student
  - background and conditions. (Q 7.3.1)
  - entrance qualifications. (Q 7.3.2)
- use the analysis of student performance to provide feedback to the committees responsible for
  - student selection. (Q 7.3.3)
  - curriculum planning. (Q 7.3.4)
  - student counselling. (Q 7.3.5)

Annotations:

- Measures and analysis of *performance of cohorts of students* would include information about actual study duration, examination scores, pass and failure rates, success and dropout rates and reasons, student reports about conditions in their courses, as well as time spent by them on areas of special interest, including optional components. It would also include interviews of students frequently repeating courses, and exit interviews with students who leave the programme.
- Measures of *performance of cohorts of graduates* would include information about career choice, performance in clinical practice after graduation and promotion.
- *Student background and conditions* would include social, economic and cultural circumstances.

B 7.3.1 The medical school **must** analyse performance of cohorts of students and graduates in relation to its mission and intended educational outcomes.

The mission statement of UGME in FMUT is defined as stated in B1.1.1. Educational outcomes of SMFMUT in relation to the mission statement were discussed and approved in PBM in September 2014.

Currently concrete tasks are being considered to analyse the outcomes of students and graduates based on these.

(B) Analysis and self-evaluation

Whether FMUT produces graduates suitable for the mission Statement is decided based on unsystematic information of each department.

Educational outcomes of SMFMUT were discussed in the 30 March 2014 FD based on the mission statement of UGME in FMUT. Discussion about the appropriateness of FMUT education has been occasionally done when motivation for educational reform was elevated, such as for the Inui Project in 2000.

Pass rate of graduates on the medical licence examination has been stable and mostly higher than 90%. Sufficient information regarding degree of achievement of objectives at or after graduation is not collected except for the pass rate of graduates for the medical licence examination etc.

(C) Current action

Career pathways after graduation are roughly known but not in detail. In the future, thorough information collection is expected.

(D) Plan for future improvement

In the future, items for assessing achievement of educational outcomes listed in B1.4.1 should be specifically determined, and necessary data collection methods for these assessment indices should be prepared within several years, including materials inside and outside of FMUT or additional surveys.

After concrete content and methods for assessment are specified based on the educational outcomes of SMFMUT, it is necessary to collect information and to establish the system to assess clinical and research ability in the early stages after graduation. Regarding evaluation for career pathways and outcomes long after graduation, discussion should be continued for a longitudinal system with consideration of collaboration with alumni. As for the career pathways of graduates, the progress of data collection might not be so smooth, so specific planning about the cost or person in charge will be necessary.

B 7.3.2 The medical school **must** analyse performance of cohorts of students and graduates in relation to its curriculum.

(A) Basic information

AAAD collects data for academic results for each department area, percentages of those who are promoted or repeat each school year, those who repeat any school year more than once, those who are absent from the class for a long time, etc. and share such information with AAC and PBM. Systematic information collection for evaluation is carried out by questionnaires to students and to faculty members, so the evaluation system is relatively well established. Students who need individual instruction, such as students who repeated a school year more than once, are treated by a tutor in charge.

(B) Analysis and self-evaluation

Regarding the content and evaluation of the curriculum, information is collected from students and faculty members after lectures and practicums in a timely manner. The system for an ongoing improvement cycle is established.

(C) Current action

For curriculum evaluation, how much is the collected information well organised and utilised for continuous improvement should be comprehensively confirmed.

(D) Plan for future improvement

Important items for curriculum evaluation should be considered based on the discussion in this accreditation report in Area 2.

B 7.3.3 The medical school **must** analyse performance of cohorts of students and graduates in relation to its provision of resources.

(A) Basic information

The Budget Committee evaluates the current situations of management and administration of FMUT and determines allocation of the budget every year. However, since discussion does not separate the budget between GSMUT and FMUT or between research support, education and management/administration, a clear mechanism to associate the educational budget of FMUT with the outcomes is not established.

(B) Analysis and self-evaluation

The system to evaluate the budget or facilities/equipment of FMUT from the viewpoint of educational performance has not been established yet.

(C) Current action

Necessity of the system to evaluate the budget or facilities/equipment of FMUT from the viewpoint of educational performance should start to be discussed.

(D) Plan for future improvement

Establishment of the system to evaluate the budget or facilities/equipment of FMUT from the viewpoint of educational performance should be planned.

Q 7.3.1 The medical school **should** analyse performance of cohorts of students and graduates in relation to student background and conditions.

(A) Basic information

UT conducts a student actual life status survey every year to analyse income, income of his/her household, residence, with or without part-time job, attendance rate (lectures, practicums or site visits), quota of students, student/faculty ratio, academic performance, attrition rate, rate of repeating students, evaluation for practicum teachers, pass/fail in the medical licence examination and relationship with postgraduate career pathways.

(B) Analysis and self-evaluation

Regarding the background information of students, the Student Life Status Survey Unit and the UT Student Committee analyse the following items: situation of household (address and income of the household), cost of living (spending and income), commute to school or residence (time length for commuting, expectation to live in a dormitory), life hours (part-time jobs, circle activity, study hours, etc.), scholarship (situation of recipient, exemption of tuition, income from part-time job), and current life situation as part of a massive analysis. AAAD and AAC obtain and analyse items of course selection after admission to SMFMUT, academic performance, attrition rate, rate of repeating students, evaluation of practicum teachers, and pass/fail in the medical licence examination. The Tetsumon Club and alumni of each department collect postgraduate career pathways.

(C) Current action

The database for each student should be collated among the Student Life Status Survey Unit, AAAD, Tetsumon Club and alumni of each department to analyse the relationship among the different information sources.

(D) Plan for future improvement

A one-stop organisation should be discussed to manage all the data and information of students.

Q 7.3.2 The medical school **should** analyse performance of cohorts of students and graduates in relation to student entrance qualifications.

(A) Basic information

EEFSU analyses the academic performances of the entrance examination and CAS assessment. After admission to SMFMUT, EEFSU does not have detailed information.

(B) Analysis and self-evaluation

EEFSU has developed a calculation formula for student performance using total credit hours earned and assessment results. All EEFSU does is to analyse the correlation between the entrance examination results and academic performance in SMFMUT for each category of the entrance examination (for science subject physics, chemistry, biology or geoscience) but not for individual correlation. Tetsumon Club and alumni of each department collect outcomes of graduates but do not analyse the relationship with entrance examination results.

(C) Current action

At first whether IR division is established should be is determined. For that purpose discussion with Centre for Research and Development of Higher Education, UT is also needed.

(D) Plan for future improvement

Plan the system to separate tasks, for example, the Centre for Research and Development of Higher Education should be the IR unit for the whole UT, and FMUT should have another IR for the faculty level.

Q 7.3.3 The medical school **should** use the analysis of student performance to provide feedback to the committees responsible for student selection.

(A) Basic information

FMUT gives feedback concerning academic performance of students and graduates to EEFSU so that it may consider better student selection methods.

(B) Analysis and self-evaluation

AAAD and AAC collect and analyse student outcomes, and the Tetsumon Club and alumni of each department analyse graduate outcomes, but such analysis data are not given to EEFSU.

(C) Current action

At first whether IR division is established should be is determined. For that purpose discussion with Centre for Research and Development of Higher Education, UT is also needed.

(D) Plan for future improvement

Plan the system to separate tasks, for example, the Centre for Research and Development of Higher Education should be the IR for the whole UT, and FMUT should have another IR for the faculty level.

Q 7.3.4 The medical school **should** use the analysis of student performance to provide feedback to the committees responsible for curriculum planning.

(A) Basic information

Currently AAC manages all the data for assessment results not only to decide pass or fail but also to utilise them for curriculum evaluation or planning for the following school year. However, documentation organising all the students' data (entrance examination, CAS assessment results, SMFMUT assessment results, CBT results, pass or fail for the medical licence examination, and their correlations) is not available.

(B) Analysis and self-evaluation

Currently AAC manages all the academic data and makes decisions in the current system. Regarding academic performance data no specialised analysis is conducted. One of the main reasons is that the CAS side manages the data from the entrance examination to admission to SMFMUT, so the SMFMUT side does not have access to such data.

Changes to admission to any faculty have been implemented since the 2008 school year. Those changes were expected to improve the quality of students who enter SMFMUT but no detailed analysis has been reported since then.

(C) Current action

SMFMUT tried a correlational analysis for 30 students, with subsets of 10 students each categorised by CAT-CBT results (10 high performers, 10 around average and 10 low performers) with assessment results of admission to SMFMUT, academic results for M0/M1/M2, and CBT.

This analysis showed a high correlation among the assessment results of admission to SMFMUT, academic results for M0/M1/M2 and CBT. High rankers in the assessment results of admission to SMFMUT marked high performance afterward and vice versa. Some students who pass CAS Natural Sciences III and are admitted to SMFMUT may lose their own life goals and have decreased motivation for learning.

Next, related to the change in the admission system to SMFMUT[15], performance was compared between the M2 school years of 2013 and M2 of 2008 but no difference was observed. A possible explanation is that the lowest point for admission to SMFMUT was increased once but after 2011 decreased. This is probably because even low performers in Natural Sciences III were allowed to enter SMFMUT.

(D) Plan for future improvement

In the future, installation of an IR division to save various data including background information at admission, academic performances of students, all the awards and punishments, career pathway, performance and work experiences after graduation, etc., to analyse such data, and to give feedback after analysing such data is considered. Continuous curricular improvement is expected.

Q 7.3.5 The medical school **should** use the analysis of student performance to provide feedback to the committees responsible for student counselling.

(A) Basic information

In SMFMUT, the tutor system is regarded as student counselling because a tutor has meetings with each student one on one. Tutors submit yearly meeting records to the Head of School Year by the end of February. Then the Head of School Year makes a presentation in an AAC meeting. This system positively supports details of each student not addressed with everyday classes or practicums.

(B) Analysis and self-evaluation

The tutor system to cover specific students one on one is good to address individual students with problems. Since many tutors are also AAC members, some members might have too much workload.

(C) Current action

Some faculty members say the one on one tutor system is helpful for weak students to help them to acquire learning and living habits, in addition to having a safety network such as the tutor system and Health Centre. Collaboration with SSU which started in November 2014 is also expected.

(D) Plan for future improvement

[15] Previously all the Natural Sciences III students were allowed to enter SMFMUT but after the school year of 2008, three students at most failed to enter SMFMUT.

Functions of SSU are expected to address mental health issues, low academic performance, or other problematic behaviours as a one-stop office. For that purpose collaboration with AAC, AAAD, the Health Centre, the Mental Health Support Unit, the Office for Mental Health Support, etc. is indispensable. Mental health problems and low academic performance may interact with each other to worsen the situation. These related offices should share the information to support such students, including taking an approved long leave.

7.4 INVOLVEMENT OF STAKEHOLDERS

Basic standard:

The medical school **must**

- in its programme monitoring and evaluation activities involve
  - its academic staff and students. (B 7.4.1)
  - its governance and management. (B 7.4.2)

Quality development standard:

The medical school **should**

- for other relevant stakeholders
  - allow access to results of course and programme evaluation. (Q 7.4.1)
  - seek their feedback on the performance of graduates. (Q 7.4.2)
  - seek their feedback on the curriculum. (Q 7.4.3)

Annotation:

- *Other relevant stakeholders* would include other representatives of academic and administrative staff, representatives of the community and public (e.g. users of the health care system), education and health care authorities, professional organisations, medical scientific bodies and postgraduate educators.

B 7.4.1 The medical school **must** in its programme monitoring and evaluation activities involve its academic staff and students.

(A) Basic information

To monitor and evaluate the curriculum from the faculty members' viewpoint, the MERWG was formed in 2007, conducted discussions on how the curriculum should be, and made changes until 2011.

To monitor and evaluate the curriculum from the students' viewpoint, SMFMUT did not have such functions for a long time. The FMUT Handbook described the existence and roles of the Student Union in 2009, which did not function due to influences from the student activists fight in UT in 1960s. IRCME asked several students interested in

medical education and suggested to form an organisation for students to participate in medical education. A few volunteer students from each school year participate in the organisation, and SWGME was formed and approved by AAC in September 2010. Currently SWGME conducts a yearly curriculum evaluation survey.

(B) Analysis and self-evaluation

The MERWG discusses how medical education should be in SMFMUT, to collaborate with CAS, and to promote a summer programme for foreign EC.

SWGME independently works on an evaluation survey to present to the AAC.

(C) Current action

After January 2014, the MERWG continues to work for educational reform for the whole UT. The MERWG enhances collaboration with AAAD and IRCME.

(D) Plan for future improvement

The MERWG should clarify its role as separate from AAC or IRCME. Currently it works with CAS but such function is not permanent. When the activity of the MERWG is systematised, the role should be part of the activity of AAC or IRCME.

B 7.4.2 The medical school **must** in its programme monitoring and evaluation activities involve its governance and management.

(A) Basic information

The AAC works on governance and management of medical education, too. The rule of AAC describes various governance and management activities but not medical education evaluation. What AAC discusses is regularly given as feedback to the Board of Representatives Meeting or PBM. IRCME regularly holds FD etc. to improve medical education.

(B) Analysis and self-evaluation

There is no documentation regarding the function to evaluate medical education and to improve medical education based on the results. Therefore a WG or other group arbitrarily evaluates medical education but no organisation permanently does it.

(C) Current action

The MERWG from 2007 to 2011 was doing medical education evaluation activity involving students. Such an evaluation model might be the continuous model for the MERWG for the future. FD managed by IRCME becomes a function to suggest plans for improvement in a bottom-up approach.

(D) Plan for future improvement

A division to evaluate the medical education programme and curriculum, such as IR, should be independent, and governance and management functions based on data or analysis from such a division should be enhanced.

Q 7.4.1 The medical school **should** for other relevant stakeholders allow access to results of course and programme evaluation.

(A) Basic information

In the current system of FMUT, AAC perceives the results of evaluation of the curricula and programmes and reports only important issues to PBM. Minutes of PBM can be viewed in a certain condition.

(B) Analysis and self-evaluation

Disclosure request for the PBM minutes enables viewing them.

(C) Current action

No problem occurs currently.

(D) Plan for future improvement

When the Evaluation Committee is established, a system is constructed for an external member to view the evaluation results of curricula and programmes.

Q 7.4.2 The medical school **should** for other relevant stakeholders seek their feedback on the performance of graduates.

(A) Basic information

In the current system of FMUT, AAC perceives the results of evaluation of the performances of graduates and reports only important issues to PBM. Minutes of PBM can be viewed in a certain condition.

(B) Analysis and self-evaluation

Disclosure request for the PBM minutes enables viewing them.

(C) Current action

No problem occurs currently.

(D) Plan for future improvement

When the Evaluation Committee is established, a system is constructed for an external member to view the evaluation results of curricula and programmes.

Q 7.4.3 The medical school **should** for other relevant stakeholders seek their feedback on the curriculum.

(A) Basic information

In the current system of FMUT, AAC perceives the results of evaluation of the curricula and programmes and reports only important issues to PBM. Minutes of PBM can be viewed in a certain condition.

(B) Analysis and self-evaluation

Disclosure request for the PBM minutes enables viewing them.

(C) Current action

No problem occurs currently.

(D) Plan for future improvement

When the Evaluation Committee is established, a system is constructed for an external member to view the evaluation results of curricula and programmes.

7.4 INVOLVEMENT OF STAKEHOLDERS

Basic standard:

The medical school **must**

- in its programme monitoring and evaluation activities involve
  - its academic staff and students. (B 7.4.1)
  - its governance and management. (B 7.4.2)

Quality development standard:

The medical school **should**

- for other relevant stakeholders
  - allow access to results of course and programme evaluation. (Q 7.4.1)

- seek their feedback on the performance of graduates. (Q 7.4.2)
- seek their feedback on the curriculum. (Q 7.4.3)

Annotation:

- *Other relevant stakeholders* would include other representatives of academic and administrative staff, representatives of the community and public (e.g. users of the health care system), education and health care authorities, professional organisations, medical scientific bodies and postgraduate educators.

B 7.4.1 The medical school **must** in its programme monitoring and evaluation activities involve its academic staff and students.

(A) Basic information

To monitor and evaluate curriculum from faculty members' viewpoint, MERWG was formulated in 2007, continued discussions how the curriculum should be, and made changes until 2011.

To monitor and evaluate curriculum from students' viewpoint, SMFMUT did not have such functions for a long time. FMUT Handbook described existence and roles of the Student Union in 2009, which did not function due to influences from student activists fight in UT in 1960s. IRCME asked several students interested in medical education and suggested to formulate an organisation for students to participate in medical education. A few volunteer students from each school year participate in the organisation and SWGME was constructed in September 2010 approved by AAC. Currently SWGME conducts yearly curriculum evaluation survey.

(B) Analysis and self-evaluation

MERWG discusses how medical education should be in SMFMUT to clooaborate with CAS and to promote summer programme for foreign EC.

SWGME independently works for evaluation survey to present it in AAC.

(C) Current action

After January 2014 MERWG continues to work for educational reform for whole UT. MERWG enhances collaboration with AAAD and IRCME.

(D) Plan for future improvement

MERWG should clarify its role to separate from AAC or IRCME. Currently it works with CAS but such function is not permanent. When the activity of MERWG is systematised the role should be part of activity of AAC or IRCME.

B 7.4.2 The medical school **must** in its programme monitoring and evaluation activities involve its governance and management.

(A) Basic information

AAC works for governance and management of medical education too. The rule of AAC describes various govenance and management activities but not medical education evaluation. What AAC discusses is regularly given feedback to Board of Representatives Meeting or PBM. IRCME regularly holds FD etc. to improve medical education.

(B) Analysis and self-evaluation

There is no documentation regarding the function to evaluate medical education and to improve medical education based on the result of results. Therefore WG or other group arbitrarily evaluates medical education but no organisation permanently does it.

(C) Current action

MERWG from 2007 to 2011 was doing medical education evaluation activity involving students. Such evaluation model might be the continuous model for MERWG for long. FD managed by IRCME becomes a function to suggest plan for improvement in bottom-up approach.

(D) Plan for future improvement

Division to evaluate medical education programme and curriculum, such as IR, should be independent, and governance and management function based on data or analysis from such division should be enhanced.

Q 7.4.1 The medical school **should** for other relevant stakeholders allow access to results of course and programme evaluation.

(A) Basic information

Currently follow up information for graduates is only collected by Tetsumon Club. However, since this function is not official, no current system to obtain feedback from health facilities where graduates are working. Meanwhile, range of "stakeholders" should be well defined to address the issue here.

(B) Analysis and self-evaluation

Currently no system to allow access to results of course and programme evaluation has been established.

(C) Current action

In the near future, the system to allow access to results of course and programme evaluation should be clarified.

(D) Plan for future improvement

Suggested definition of "stakeholders" includes faculty members who are not involved in teaching, Faculty member representative (e.g. Steering Committee), representatives from community, education or health management (IRCME, Safety Centre, AAAD, etc.), other health professionals (Faculty members of School of Integrated Health or Faculty of Pharmaceutical Sciences) and health facilities graduates are working (directors or responsible persons for teaching). It is necessary to establish a system to give feedback to these stakeholders about evaluation results of curriculum and academic performance. A system to disclose the database with safety or authentification check should be also attached.

Q 7.4.2 The medical school **should** for other relevant stakeholders seek their feedback on the performance of graduates.

(A) Basic information

No systematic system to seek stakeholders' feedback exists.

(B) Analysis and self-evaluation

No systematic system to seek stakeholders' feedback exists.

(C) Current action

No systematic system to seek stakeholders' feedback exists.

(D) Plan for future improvement

Feedback information about graduates career and performances should be shared not only with faculty members related with medical education but also with all the stakeholders. The system for the trainer of a graduate in the training hospital to write in his/her assessment result should be established.

Q 7.4.3 The medical school **should** for other relevant stakeholders seek their feedback on the curriculum.

(A) Basic information

No systematic system to seek stakeholders' feedback exists.

(B) Analysis and self-evaluation

No systematic system to seek stakeholders' feedback exists.

(C) Current action

No systematic system to seek stakeholders' feedback exists.

(D) Plan for future improvement

The system for the trainer of a graduate in the training hospital to write in his/her assessment result should be established.

8. GOVERNANCE AND ADMINISTRATION

8.1 GOVERNANCE

Basic standard:

The medical school **must**

- define its governance structures and functions including their relationships within the University. (B 8.1.1)

Quality development standard:

The medical school **should**

- in its governance structures set out the committee structure, and reflect representation from
  - academic staff. (Q 8.1.1)
  - students. (Q 8.1.2)
  - other relevant stakeholders. (Q 8.1.3)
- ensure transparency of the work of governance and its decisions. (Q 8.1.4)

Annotations:

- *Governance* means the act and/or the structure of governing the medical school. Governance is primarily concerned with policy making, the processes of establishing general institutional and programme policies and also with control of the implementation of the policies. The institutional and programme policies would normally encompass decisions on the mission of the medical school, the curriculum, admission policy, staff recruitment and selection policy and decisions on interaction and linkage with medical practice and the health sector as well as other external relations.
- *Relationships within the University* of its governance structures would be specified, if the medical school is part of or affiliated to a University.
- *The committee structure* would define lines of responsibility and includes a curriculum committee (see B 2.7.1).
- *Other relevant stakeholders* would include representatives of ministries of higher education and health, the health sector, the health care delivery system and the public (e.g. users of the health care system).
- *Transparency* would be obtained by newsletters, web-information or disclosure of minutes.

B 8.1.1 The medical school **must** define its governance structures and functions including their relationships within the University.

(A) Basic information

FMUT is set up with other nine faculties[16]. The basic organisational rule of UT defines that each faculty has its own PBM to discuss (1) items for developing curriculum, (2) items for students' admission, graduation and otherwise related with enrollment and conferment of academic degree, and (3) other items related with education or research in the faculty. Therefore, PBM in each faculty is entrusted with considerable authority. As for admission, curriculum, methods to take classes, assessment, graduation, conferment of academic degree, etc., shared rules and regulations among all the faculties are specified.

The rule of FMUT defines aims for education and research, admission, curriculum, assessment, academic marking, promotion and graduation. FMUT consists of SMFMUT and SIHS. SMFMUT develops medical doctors or researchers. SIHS develops researchers and practitioners in social medicine, health sciences, nursing, international health and public health.

FMUT was upgraded to postgraduate-centred status[17] in 1997. Since then the rule says that education in FMUT is provided by the cooperation from faculty members in GSMUT. GSMUT has 13 specialty areas with chair persons for each[18]. Each specialty area consists of a few larger departments and each larger department consists of a few departments. FMUT has two centres: CDBIM and IRCME. Each larger department in those centres function as a cooperative larger department to join in some specialty area in GSMUT.

(B) Analysis and self-evaluation

All the organisational structure and functions governed by FMUT are clearly defined including the status within the whole UT.

(C) Current action

Since one of the aims is to develop research-minded students, additions to the regular classes include the PhD-MD course, MD Researcher Development Programme and the Clinical Researcher Development Programme. Those students promoted to GSMUT by way of the PhD-MD course are allowed to utilise the system to receive financial support by donations from alumni. Moreover, to create the setting for students to have contact with leading researchers, the "Tetsumon lecture series" has been started since the school year of 2013 supported by donations from the 150th anniversary of FMUT and UTH. This event includes lectures by Nobel Prize winners and a tea party to have opportunities to talk with the guests. Furthermore, a curriculum for CAS students to enhance their exposure to medical subjects is under development.

---

[16] Organisational Chart (http://www.u-tokyo.ac.jp/en/about/organization/chart.html)

[17] The main structure of the university is reframed into a graduate school. In the 1990s in Japan, traditional governmental universities are converted to this status headed by UT.

[18] Graduate School of Medicine (http://www.m.u-tokyo.ac.jp/english/departments/graduate.html)

(D) Plan for future improvement

Whether the current status corresponds to the trend should be checked continually and an effort to optimise the organising structure and function should be continued. Since the rules for the MD Researcher Development Programme Unit have not been developed yet, it should be developed soon.

Q 8.1.1 The medical school **should** in its governance structures set out the committee structure, and reflect representation from academic staff.

(A) Basic information

The organisational structure of GSMUT/FMUT is defined in detail in the rules and regulations of GSMUT/FMUT. Decision making is done by the Board of Representatives Meeting and PBM whose chair person is normally the Dean of GSMUT/FMUT. In the Board of Representatives Meeting, personnel affairs of associate professors or above are discussed. The Dean is elected by voting from more than one applicant and recommended by the President of UT. In PBM rules and regulations related to education and research in GSMUT/FMUT, personnel affairs of lecturers or below, revisions of specialty areas, departments, organizations or curricula, student enrollment, certificate for graduation, disciplinary actions or conferment of academic degrees are discussed and decided. The Steering Committee and Executive Committee are set up to manage GSMUT/FMUT under the leadership of the Dean in an organised manner. In the Steering Committee, the chair person is the Dean to deliberate important issues of GSMUT/FMUT. The Executive Committee receives consultation from the Dean and submits a report for important issues concerning the education, research and administration of GSMUT/FMUT.

AAC is set up to discuss items regarding educational issues in FMUT. IRCME has the mission to promote both high quality medical education across the country and international cooperation for medical education in developing countries, and is actively involved in the medical education of FMUT. The chair person of AAC is appointed by the Dean after approval from PBM. AAC consists of faculty members from basic sciences, social medicine, clinical medicine and IRCME. Results of discussion in AAC are regularly reported to PBM to deliver the information to all faculty members.

To revise medical education in a timely manner, MERWG has been set up under AAC. MERWG tries to collaborate with CAS and obtains opinions from faculty members in FD and reflects them on the curricula.

(B) Analysis and self-evaluation

There are committees to govern the whole UT, to govern medical education specifically, and WGs organised by faculty members. There are some WGs that connect UT and FMUT. On the other hand, no cross-sectional system to collect opinions from lecturers

or assistant professors currently exists, but each department discusses educational issues separately.

(C) Current action

It is planned to have discussion about whether discussion in each department is sufficient or not, and the necessity to develop a cross-sectional system to collect opinions from lecturers and assistant professors.

(D) Plan for future improvement

System improvement should be planned to collect opinions from all faculty members.

Q 8.1.2 The medical school **should** in its governance structures set out the committee structure, and reflect representation from students.

(A) Basic information

Opinions from students are reflected on the curriculum by way of the following channels.

- SWGME is given a channel to provide feedback on class evaluation results.
- Evaluation of faculty members (Best Teacher's Award) and CC preceptors
- Active participation in planning integrated lectures for basic sciences/basic science, clinical and social medicine
- Student representative's participation in PCA (as a committee member in Area 4)

(B) Analysis and self-evaluation

Opinions from students are listened to in various ways and are reflected in changes to the education of SMFMUT. A more organised evaluation system from students should be established. Regarding the mission statement of FMUT, constructive opinions from students should be positively adopted.

(C) Current action

Discussion is planned if student representatives should be involved in AAC as regular members.

(D) Plan for future improvement

Consider student representatives' regular participation in AAC and other meetings.

Q 8.1.3 The medical school **should** in its governance structures set out the committee structure, and reflect representation from other relevant stakeholders.

(A) Basic information

IRCME invites medical education experts from North American countries as foreign visiting professors for a half or full year. He/she evaluates the educational system of FMUT from outside and suggests ideas to improve it. Such suggestions are connected to actual curricular reform through AAC. IRCME also holds monthly a Medical Education Seminar for any participants including lay people, mass media or government officials. A speaker and participants may exchange opinions through a question and answer session.

The Department of Medical Education in MEXT implements measures to enhance medical graduates with a research focus. FMUT applied for the "Basic Scientist Researcher Development Project" in 2011 with Kyoto, Osaka and Nagoya Universities and it was adopted with a budget. Currently this programme is implemented mainly by the MD Researcher Development Programme Unit with 20-30 students a year in FMUT engaged in basic science research.

A simulated patient organisation is developed and managed with Tokyo Medical Dental University. Feedback from this organisation is obtained for education for students.

FQ is conducted for M0, M1 and M2 as an elective research experience for FMUT students. The nursing home care practicum is done in July for M2. CC include external hospital experiences. EC is provided for M3 and M4. Feedback for education and research is obtained from those institutes, hospitals, etc.

(B) Analysis and self-evaluation

Evaluation and suggestions are obtained from foreign visiting professors.
Self-evaluation is high because research mind of medical students is highly enhanced.
Medical education and research is done in external institutes, hospitals and research institutes with appropriate feedback.

(C) Current action

The necessity to develop an integrated evaluation organisation to involve stakeholders of education is under consideration.

(D) Plan for future improvement

The necessity to develop an integrated evaluation organisation to involve stakeholders of education should be realised if the necessity is approved.

Q 8.1.4 The medical school **should** ensure transparency of the work of governance and its decisions.

(A) Basic information

The work of governance and decision making function of committees are specified in rules and regulations. Discussion processes are recorded in minutes. Inspection of minutes is possible under certain conditions.

(B) Analysis and self-evaluation

Currently certain level of transparency is indicated.

(C) Current action

Necessity to confirm if the transparency is sufficient regarding the work of governance and decision making function of committees should be considered.

(D) Plan for future improvement

The system to confirm if the transparency is sufficient regarding the work of governance and decision making function of committees should be considered.

8.2 ACADEMIC LEADERSHIP

Basic standard:

The medical school **must**

- describe the responsibilities of its academic leadership for definition and management of the medical educational programme. (B 8.2.1)

Quality development standard:

The medical school **should**

- periodically evaluate its academic leadership in relation to achievement of its mission and intended educational outcomes. (Q 8.2.1)

Annotation:

- *Academic leadership* refers to the positions and persons within the governance and management structures being responsible for decisions on academic matters in teaching, research and service and would include dean, deputy dean, vice deans, provost, heads of departments, course leaders, directors of research institutes and centres as well as chairs of standing committees (e.g. for student selection, curriculum planning and student counselling).

B 8.2.1 The medical school **must** describe the responsibilities of its academic leadership for definition and management of the medical educational programme.

(A) Basic information

The management and administration of the whole FMUT and curriculum organisations are explained in B8.1.2, and the ultimate person with responsibility is the Dean of FMUT/GSMUT. The Dean appoints the chairperson of AAC and delegates tasks of curriculum development, promotion, graduation, etc. The Director of UTH cooperates and supports clinical medical education. The Dean of CAS is responsible for the education in the 1st and 2nd years, and the "UT Education Steering Committee for the Primary Phase Curriculum Member" selected by FMUT keeps close contact with CAS regarding educational content.

Regarding Vice Deans, the rule says that "Faculty appoints a few Vice Deans. Vice Deans help the job of the Dean." but no specific tasks of education is given, such as a Vice Dean in charge of education.

The capacity of the Dean for education is described as "The Dean supervises the job of the faculty, organises PBM for the faculty and manages faculty members," with only general statements in the FMUT rule.

(B) Analysis and self-evaluation

In the current system, all the educational leadership to define and manage the curriculum comes from the Dean. Because the quality and quantity of clinical medical education is rapidly increasing, leadership for all the stakeholders should be properly managed directly and comprehensively.

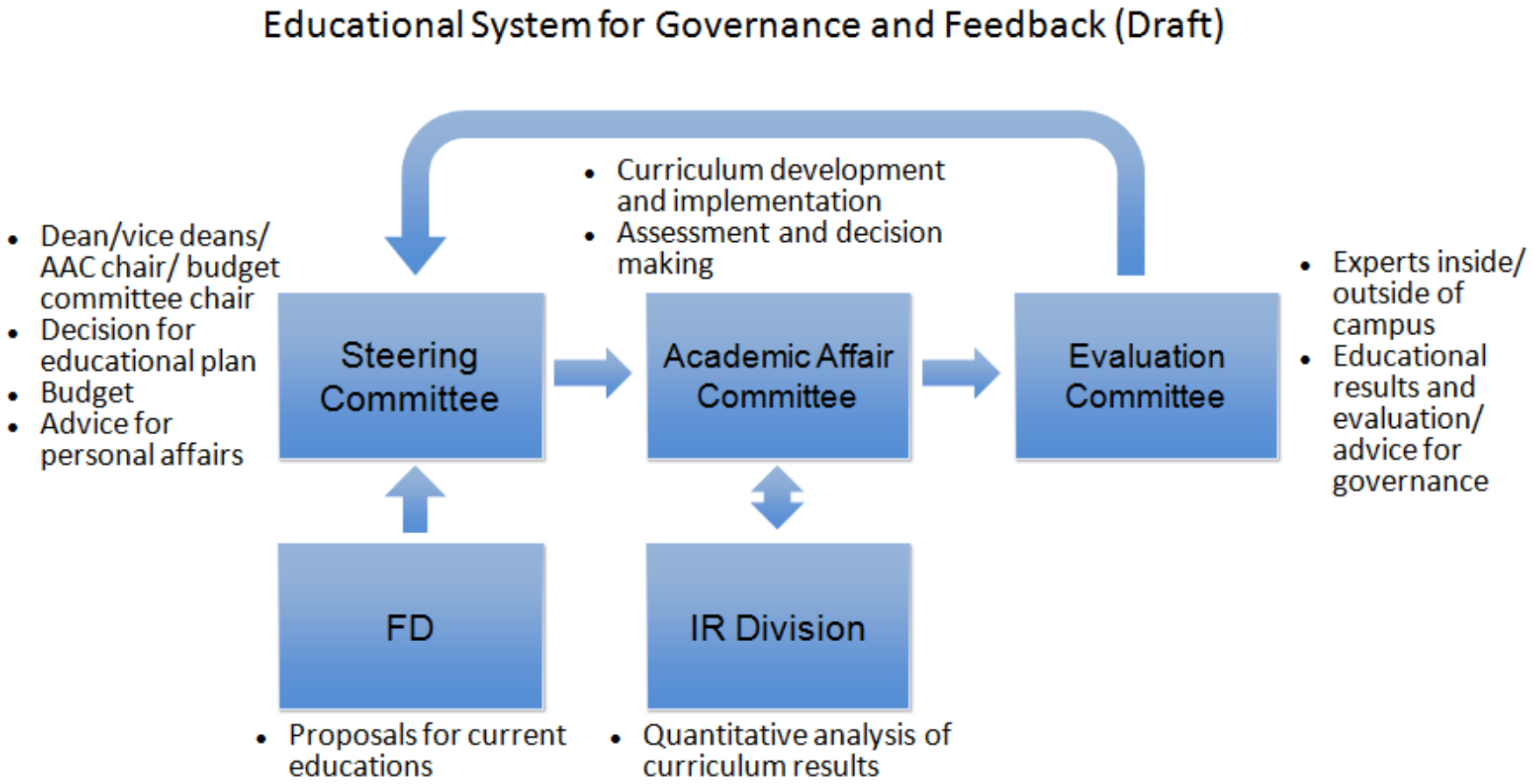
Under the Dean, a responsible person to take charge of revising the curriculum and planning future directions should be designated. Currently three Vice Deans support the Dean, but no Vice Dean is in charge of education.

(C) Current action

The system to give educational leadership to one of the three Vice Deans is starting to be discussed. Another system to separate the planning, implementation and evaluation of the curriculum should be considered, too. Documentation of the role of the Dean of education should be cautiously appraised.

(D) Plan for future improvement

Besides AAC implementing the curriculum, the IR division to evaluate the curriculum and a new committee to plan the basic direction of the curriculum under the Vice Dean in charge of educational affairs are being considered (see the figure in the next page).


Educational System for Governance and Feedback (Draft)
Dean/vice deans/ AAC chair/ budget committee chair
Decision for educational plan
Budget
Advice for personal affairs
Curriculum development and implementation
Assessment and decision making
Steering Committee
Academic Affair Committee
Evaluation Committee
Experts inside/ outside of campus
Educational results and evaluation/ advice for governance
FD
IR Division
Proposals for current educations
Quantitative analysis of curriculum results

Q 8.2.1 The medical school **should** periodically evaluate its academic leadership in relation to achievement of its mission and intended educational outcomes.

(A) Basic information

As described in B8.2.1, the Dean is ultimately responsible for education and research in FMUT but no specific documentation is found for the educational responsibility of the Dean. The Mission Statement of FMUT was set in 2000 and the educational outcomes were determined in September 2014 but no evaluation of the leadership was conducted besides the institutional accreditation of UT conducted in 2009. The Mission Statement and outcomes have not been checked.

(B) Analysis and self-evaluation

Regarding the academic leadership by the Dean and Vice Deans, evaluation is obtained from students concerning educational programmes and curricular content, but evaluation from experts inside or outside of the faculty/university is not obtained. For evaluation of the results of the curriculum, responsibility by the Dean is not specified.

(C) Current action

Consideration of a system to establish the position of a Vice Dean in charge of education and to accept evaluation from experts inside or outside of the faculty/university has been started.

(D) Plan for future improvement

Leadership and responsibility of the Dean and the Vice Dean in charge of education should be clearly defined. An evaluation system by faculty members and experts inside/outside of the university should be considered.

8.3 EDUCATIONAL BUDGET AND RESOURCE ALLOCATION

Basic standard:

The medical school **must**

- have a clear line of responsibility and authority for resourcing the curriculum, including a dedicated educational budget. (B 8.3.1)
- allocate the resources necessary for the implementation of the curriculum and distribute the educational resources in relation to educational needs. (B 8.3.2)

Quality development standard:

The medical school **should**

- have autonomy to direct resources, including teaching staff remuneration, in an

appropriate manner in order to achieve its intended educational outcomes. (Q 8.3.1)

- in distribution of resources take into account the developments in medical sciences and the health needs of the society. (Q 8.3.2)

Annotations:

- *The educational budget* would depend on the budgetary practice in each institution and country and would be linked to a transparent budgetary plan for the medical school.
- *Resource allocation* presupposes institutional autonomy (see 1.3, ann.).
- Regarding *educational budget and resource allocation* for student support and student organisations (see B 4.3.3 and 4.4, annotation).

B 8.3.1 The medical school **must** have a clear line of responsibility and authority for resourcing the curriculum, including a dedicated educational budget.

(A) Basic information

The educational budget for FMUT is funded by the UT operation cost subsidy. The President of UT distributes the budget to the Dean of FMUT and the Dean implements the budget as the person in charge. The distributed budget to FMUT is discussed by the budget committee headed by a Vice Dean and administrated by the Financial Affairs Administrative Division. Regarding the overview of the budget, the Vice Dean in charge of the budget committee makes a report about the implementation plan in PBM.

(B) Analysis and self-evaluation

The yearly budget distribution plan is well addressed but plans for longer periods should be considered. This matter will be described further in B8.3.2.

(C) Current action

The Executive Committee started discussions regarding how to implement a long-range educational budget.

(D) Plan for future improvement

The position of the Vice Dean in charge of education should be established. The Vice Dean should develop the long-range educational budget, and request from the Dean more consideration in the budget committee.

B 8.3.2 The medical school **must** allocate the resources necessary for the implementation of the curriculum and distribute the educational resources in relation to educational needs.

(A) Basic information

Among the educational budget items, administrative costs for the Medical Library and the Animal Experiment Laboratory, part of the cost for student practicums e.g. dissection for anatomy, and the cost for adjunct professors are paid as shared costs. Part of the budget is distributed to each department depending on the number of faculty members or students. Cost for lectures and practicums in each department is paid from such budgets.

After CC was converted from an observation-based CC to a more participatory CC starting in January M2, the increase in CC outside of UTH and the delegation of attending physicians resulted in higher costs.

(B) Analysis and self-evaluation

Current methods to distribute the budget is good to address yearly lectures and practicums but difficult to manage longer term issues. For example, facilities and equipment for practicums will become obsolete and older unless they are renewed or renovated every 5 years. However, such longitudinal planning is not taken into account. Cost for practicums conducted by each department is paid from the operation cost subsidy for each department, but costs for practicums without a specific responsible department, such as clinical diagnostic practicums or simulation education, tends to be insufficient, so attention should be paid to these areas.

(C) Current action

The Executive Committee has started discussions on methods to implement the educational budget from longitudinal perspectives.

(D) Plan for future improvement

In the future, the educational budget from longitudinal perspectives should be organised by the Vice Dean in charge of education, submitted to the Dean, and discussed in budget committee.

Q 8.3.1 The medical school **should** have autonomy to direct resources, including teaching staff remuneration, in an appropriate manner in order to achieve its intended educational outcomes.

(A) Basic information

Since UT is a national university corporation, the salary of faculty members basically conforms to the scale of national public employees. However, some assistant professors in UTH are using an annual salary system. Given that the degree of freedom for salaries

is not so high, there is a system where faculty contributions to FMUT are reflected in reappointment, promotion or bonuses.

For the system of the Best Teacher's Award, a research grant distributed from the budget at the Dean's discretion is provided as an extra prize. In UTH, assistant professors in charge of education spend 50% effort for education, and educational outcomes are evaluated.

(B) Analysis and self-evaluation

There is no ability to change the framework given by the national university corporation, but FMUT has appropriate autonomy for the decision to allocate salary and educational resources.

(C) Current action

The system to confirm whether the current given autonomy is fully wielded should be considered.

(D) Plan for future improvement

When the salary scheme for the national university corporation is changed, the methods to address resource issues should be reconsidered.

Q 8.3.2 The medical school **should** in distribution of resources take into account the developments in medical sciences and the health needs of the society.

(A) Basic information

The reallocation system for the number of possible faculty recruitments has been administered to self-check and reorganise since 2007. FMUT/GSMUT makes every department release 1% of positions every year, and requests reallocation of 0.75% of all the positions collected, and reallocates certain positions. GSMUT and UTH suggest reallocation requests and make changes in the positions. Several departments or units take advantage of this system, such as the MD Researcher Development Programme Unit to enhance student research, the Department of Child Neuropsychiatry to address developmental disorders whose progress in research is delayed, the CC Support Centre, etc.

Faculty members of endowed departments and social cooperation programmes, opened to conduct various research and education for evolution of medicine and social health needs, are able to participate in medical education.

(B) Analysis and self-evaluation

The reallocation system for the number of possible faculty recruitments is effective to allocate educational resources to new areas to address evolving medicine and social health needs. However, since 1% of positions are reduced every year, it is unavoidable that necessary positions for medical education might be downsized and be difficult to refill again. If this system is utilized, the total number of faculty members will continue to decrease because only three quarter of positions downsized are reallocated. In light of this situation, it is necessary to increase the number of faculty positions through budget requests or to recruit specially appointed faculty members by other sources of funding.

(C) Current action

An increase in faculty members is requested of the government when needed. Recruitment of specially appointed faculty members through donated funding is carried out depending on the situation.

(D) Plan for future improvement

Currently, specially appointed faculty members are not involved in the discussion, evaluation or decision making of UGME of FMUT. Such a system should be also reformed in the future.

8.4 ADMINISTRATIVE STAFF AND MANAGEMENT

Basic standard:

The medical school **must**

- have an administrative and professional staff that is appropriate to
  - support implementation of its educational programme and related activities. (B 8.4.1)
  - ensure good management and resource deployment. (B 8.4.2)

Quality development standard:

The medical school **should**

- formulate and implement an internal programme for quality assurance of the management including regular review. (Q 8.4.1)

Annotations:

- *Administrative staff* in this document refers to the positions and persons within the governance and management structures being responsible for the administrative support to policy making and implementation of policies and plans and would - depending on the organisational structure of the administration - include head and staff in the dean's office or secretariat, heads of financial administration, staff of the budget and accounting offices, officers and staff in the admissions office and heads and staff of the departments for planning, personnel and IT.

- *Management* means the act and/or the structure concerned primarily with the implementation of the institutional and programme policies including the economic and organisational implications i.e. the actual allocation and use of resources within the medical school. Implementation of the institutional and programme policies would involve carrying into effect the policies and plans regarding mission, the curriculum, admission, staff recruitment and external relations.
- *Appropriateness of the administrative staff* means size and compostion according to qualifications.
- *Internal programme of quality assurance* would include consideration of the need for improvements and review of the management.

B 8.4.1 The medical school **must** have an administrative and professional staff that is appropriate to support implementation of its educational programme and related activities.

(A) Basic information

The administrative division in charge of activities related with the curriculum is AAAD in the administrative department of GSMUT/FMUT. AAAD works for admission, long leave, re-enrollment, withdrawal, graduation, curriculum, administration of enrollment and academic performance, tuition and scholarship, management of auditorium and class rooms. One Vice Director in charge of academic affairs supervises the administrative tasks. The top person for the administrative division is the Director, whose remit includes not only academic affairs but also administrative work related to the Dean's office and PBM, and collaboration with other committees.

AAAD in CAS supports educational programmes in CAS. Education and Research Related Affairs of the Administrative Bureau supervises all the administrative academic work and supports educational improvement in each faculty. AAAD of FMUT closely collaborates with those offices.

The Administrative Bureau provides training in academic affairs for 2 days a year for administrative staff who work for academic affairs. The Examination Planning Office is in charge of administrative work for the entrance examination.

(B) Analysis and self-evaluation

Administrative staff are appropriately appointed as well as professional staff. A strength is that they keep close contact with AAC. A point for improvement is that they sometimes do not address issues in a timely manner since the amount of work increases every year. Administrative staff are part of the national university corporation and are always rotated to other positions every few years.

(C) Current action

Since administrative staff are managed by the personnel affairs system that originated from the previous system for government servants, it is difficult for FMUT to improve the system.

(D) Plan for future improvement

Since the Action Scenario of UT specifies the vision statement to develop "staff with high ability and specialty," concrete measures should be discussed.

B 8.4.2 The medical school **must** have an administrative and professional staff that is appropriate to ensure good management and resource deployment.

(A) Basic information

To fully implement administrative tasks, the Division of General Affairs administers PBM and other meetings; the establishment, revision or abolition of rules/regulations; management of official seals, etc. To fully implement resource allocation, the Division of Financial Affairs is set up in the administrative department to administer budgeting and book closing, accounting audits, claims and incomes, etc. One Vice Director each is appointed in charge of general and financial affairs to govern tasks. The Director of the administrative department governs all the administrative tasks.

(B) Analysis and self-evaluation

Administrative staff are appropriately appointed as well as professional staff. Leadership of the Director of the administrative department fully administers appropriate management and resource allocation.

(C) Current action

Regular training sessions are held for administrative staff who work for general affairs and resource allocation.

(D) Plan for future improvement

As surrounding situations of the university are largely changing, e.g. administrative work has expanded and become more complicated, while the operation cost subsidy has decreased, further support structures should be considered.

Q 8.4.1 The medical school **should** formulate and implement an internal programme for quality assurance of the management including regular review.

(A) Basic information

Regarding education and research, the organisational management and facilities/equipment in the university, FMUT regularly checks the status of job performance. The Evaluation Support Unit for the whole UT collects/analyses evaluation information and organises statistical surveys, e.g. "institutional accreditation" by the accreditation body every 7 years (or shorter) and the "national university corporation appraisal" by the National University Corporation Appraisal Council. The Evaluation committee of FMUT discusses items related to evaluation for FMUT including administration and management.

(B) Analysis and self-evaluation

Regular self-evaluation is conducted through "institutional accreditation" and the "national university corporation appraisal." Regarding administration and management, the system for quality assurance functions effectively.

(C) Current action

Progress for a yearly plan to target achievement of mid-term goals and plans is being analysed.

(D) Plan for future improvement

Job performance thus far will be analysed and discussed, and what should be improved will be discussed to prepare for the mid-term review planned in 2016.

8.5 INTERACTION WITH HEALTH SECTOR

Basic standard:

The medical school **must**

- have constructive interaction with the health and health related sectors of society and government. (B 8.5.1)

Quality development standard:

The medical school **should**

- formalise its collaboration, including engagement of staff and students, with partners in the health sector. (Q 8.5.1)

Annotations:

- *Constructive interaction* would imply exchange of information, collaboration, and organisational initiatives. This would facilitate provision of medical doctors with the qualifications needed by society.
- *The health sector* would include the health care delivery system, whether public or

private, and medical research institutions.

- *The health-related sector* would - depending on issues and local organisation - include institutions and regulating bodies with implications for health promotion and disease prevention (e.g. with environmental, nutritional and social responsibilities).
- To *formalise collaboration* would mean entering into formal agreements, stating content and forms of collaboration, and/or establishing joint contact and coordination committees as well as joint projects.

B 8.5.1 The medical school **must** have constructive interaction with the health and health related sectors of society and government.

(A) Basic information

Some faculty members from UT participate in various council meetings for MEXT or MHLW as members or witnesses.

FMUT set up the Museum of Health and Medicine in 2011 to interact with community people through sharing medical education, health and medical knowledge. The number of visitors reached 55,000 in three years. Various project exhibitions, showcasing of research departments, seminars and exchange meetings are directed to community people twice a year.

FMUT has nursing care practicums for M2 students in nursing care facilities in the community.

UTH dispatchs house officers to community hospitals in core cities for a year, not only in Tokyo prefecture but also Ibaraki, Fukushima, Kanagawa, Chiba, Saitama, Shizuoka and Nagano prefectures as cooperative facilities for postgraduate clinical training. One month community-based training is also offered for all the house officers in hospitals providing rural or community medicine. To make the collaborating relationship closer, a training management committee meeting is held twice a year to determine directions of training, to exchange information and to collaborate with other professionals.

UTH holds FD for clinical trainers every year for attendings in FMUT, UTH and affiliated hospitals to teach young physicians/house officers. As a hub collaborating hospital for cancer treatment certified by MHLW, UTH holds training session for palliative care for the physicians involved in cancer treatment in the community. Furthermore, for the staff in national, public and private university hospitals, there is training for health professionals/workers, such as pharmacists, clinical research coordinators, clinical pathologists, dietitians, radiation technologists, etc. For administrative staff in governmental university hospitals across the whole country, administrative training is also held to strengthen the ability of middle managers for hospital administration.

The Tetsumon hospital directors' meeting offers a setting to exchange information from various hospitals.

(B) Analysis and self-evaluation

There are many settings to interact with community or health-related departments in the government. However, no specific discussion is held concerning the supply of the physician human resource needed for the society.

In line with the Mission Statement, FMUT should establish discussions for physician human resource needs not only in Bunkyo-ku or Tokyo Prefecture but also across the whole country or world.

(C) Current action

A system to discuss the physician allocation issue for the whole country or the world should be considered.

(D) Plan for future improvement

Systematic measures for discussion with MEXT or MHLW, or collaboration with the World Health Organisation should be considered.

Q 8.5.1 The medical school **should** formalise its collaboration, including engagement of staff and students, with partners in the health sector.

(A) Basic information

In FMUT, curriculum health professional staff or researchers other than physicians are invited to provide classes concerning health promotion, disease prevention and interprofessional practice. To develop physicians who can effectively collaborate with other health professionals, nursing research symposiums were held three times to promote collaborative research with health related divisions in university hospitals and interprofessional discussions for sharing research findings. The Centre for Home Care Medicine was set up in 2014 as a MEXT-budgeted "future medical research human resource development project" for students to experience community-based practice and home visits and welfare. To develop human resources who can conduct translational research with Faculties of Pharmaceutical Sciences and Engineering, seminars are held for medical students and house officers.

UTH provides community health clinical training with the National Public Health Institute for house officers to learn knowledge and skills in public health. That training consists of training in the National Public Health Institute, observational tours in MHLW, training abroad (WHO or infectious disease control), the National Institute of Infectious Diseases, and the National Institute of Health and Nutrition. Students in other health-related universities, colleges or schools are accepted as practice students and taught in collaboration with teachers from those educational facilities. Health professionals are also accepted for professional practicums and education from health related colleges, national/public/private hospitals, the Tokyo Fire Department, etc. In collaboration with the Legal Training and Research Institute, training for judges is

provided to experience actual situations of medical practice settings and to understand medicine more deeply.

(B) Analysis and self-evaluation

FMUT tries to develop physicians with communication skills and flexible ideas necessary for interprofessional team clinical care and research. For that purpose, UGME emphasises collaboration with faculty members of SIHS, health professionals in UTH, home visit nurses outside of campus, or researchers in other fields.

UTH exchanges and collaborates with other facilities by dispatching staff to other institutes/hospitals or accepting staff/students from other facilities. Evaluation results after such practicums are good. However, the number of staff/students accepted to some training programmes is limited.

(C) Current action

Regarding health promotion, disease promotion and interprofessional practice, the educational outcomes of FMUT determined in September 2014 also include "social perspectives" and "teamwork." As for interprofessional education, it should be confirmed that the current education has a certain level of effect.

(D) Plan for future improvement

Longitudinal interprofessional education should be provided through practice in community settings after promotion of interprofessional practice in community settings supported by the Centre for Home Care Medicine.

9. CONTINUOUS RENEWAL

Basic standard:

The medical school **must** as a dynamic and socially accountable institution

- initiate procedures for regularly reviewing and updating its structure and functions. (B 9.0.1)
- rectify documented deficiencies. (B 9.0.2)
- allocate resources for continuous renewal. (B 9.0.3)

Quality development standard:

The medical school **should**

- base the process of renewal on prospective studies and analyses and on results of local evaluation and the medical education literature. (Q 9.0.1)
- ensure that the process of renewal and restructuring leads to the revision of its policies and practices in accordance with past experience, present activities and future perspectives. (Q 9.0.2)
- address the following issues in its process of renewal:
  - Adaptation of mission statement and outcomes to the scientific, socio-economic and cultural development of the society. (Q 9.0.3) (see 1.1)
  - Modification of the intended educational outcomes of the graduating students in accordance with documented needs of the environment they will enter. The modification might include clinical skills, public health training and involvement in patient care appropriate to responsibilities encountered upon graduation. (Q 9.0.4) (see 1.4)
  - Adaptation of the curriculum model and instructional methods to ensure that these are appropriate and relevant.(Q 9.0.5) (see 2.1)
  - Adjustment of curricular elements and their relationships in keeping with developments in the basic biomedical, clinical, behavioural and social sciences, changes in the demographic profile and health/disease pattern of the population, and socioeconomic and cultural conditions. The adjustment would ensure that new relevant knowledge, concepts and methods are included and outdated ones discarded. (Q 9.0.6) (see 2.2 - 2.6)
  - Development of assessment principles, and the methods and the number of examinations according to changes in intended educational outcomes and instructional methods. (Q 9.0.7) (see 3.1 and 3.2)
  - Adaptation of student recruitment policy, selection methods and student intake to changing expectations and circumstances, human resource needs, changes in the premedical education system and the requirements of the educational programme. (Q 9.0.8) (see 4.1 and 4.2)
  - Adaptation of academic staff recruitment and development policy according to changing needs. (Q 9.0.9) (see 5.1 and 5.2)
  - Updating of educational resources according to changing needs, i.e. the student

intake, size and profile of academic staff, and the educational programme. (Q 9.0.10) (see 6.1 - 6.3)

- Refinement of the process of programme monitoring and evaluation. (Q 9.0.11) (see 7.1 – 7.3)
- Development of the organisational structure and of governance and management to cope with changing circumstances and needs and, over time, accommodating the interests of the different groups of stakeholders. (Q 9.0.12) (see 8.1 – 8.5)

B 9.0.1 The medical school **must** as a dynamic and socially accountable institution initiate procedures for regularly reviewing and updating its structure and functions.

In 2009, UT conducted institutional accreditation, carried out self-evaluation and received external evaluation by the National Institution for Academic Degrees and University Evaluation. In the external evaluation report, UT was acknowledged for: "Liberal arts education offered in CAS is one specific strength of the university concerned. Student achievement is not confined to specialties based on the philosophy of late specialisation", "Considering the importance of bioscience education, permeating the curriculum from faculties to graduate schools, the Comprehensive System for Life Science Education was established and materials are actively developed to implement bioscience education" and "one cancer professional development plan was accepted."

However, no department or committee is in charge of the self-evaluation study for FMUT. FDs have been held for continuous improvement but the frequency and themes were determined arbitrarily. For this medical education accreditation, PCA was initiated in March 2014.

(B) Analysis and self-evaluation

The system for evaluation or improvement is well organised for the whole UT, but insufficient at the level of FMUT. This opportunity for medical education accreditation was a trigger to identify the necessity of such a system.

(C) Current action

The fact that medical education accreditation will be held every several years should be understood, and the need to conduct regular evaluation and improvement through an IR division should be considered.

FD is conducted and the theme is selected depending on the important issue at that time. This is a kind of rapid response to respond to immediate needs every time.

(D) Plan for future improvement

The system to plan and implement regular evaluation and improvement through an IR division should be secured.

As for FD, the system to plan and implement using longer perspectives should be established.

B 9.0.2 The medical school **must** as a dynamic and socially accountable institution rectify documented deficiencies.

(A) Basic information

No system to conduct continuous evaluation has been established regarding the educational system for the medical school level. So far, when a problem becomes manifest, the AAC, the Dean, PBM or Board of Representatives Meeting addresses it. For continuous improvement, FD is conducted but the frequency and themes are determined arbitrarily.

(B) Analysis and self-evaluation

Since no division of labour has been specified regarding evaluation or responsibility for medical education, all the faculty members have a common perception that every one commits to medical education at a certain level. On the other hand, expertise in medical education has not been so high.

(C) Current action

It should be discussed how evaluation and responsibility for medical education should be shared. FD is not well planned in advance.

(D) Plan for future improvement

In the future, the system to share evaluation and the responsibility for medical education should be considered. Regarding FD, long-range planning will be needed to establish the system.

B 9.0.3 The medical school **must** as a dynamic and socially accountable institution allocate resources for continuous renewal.

(A) Basic information

The ordinary income for the whole UT consists of an operation cost subsidy provided by the government, tuition, income from UTH, externally-raised capital, etc. Resource allocation for continuous renewal is implemented by the system accounting for 30% of collaborative research grants, contracted research grants, and donation funds. Since the fund from the system includes education and research components, whether the resource allocation to education is sufficient is not well evaluated.

(B) Analysis and self-evaluation

FMUT/GSMUT takes pride in the high evaluation of research, but education evaluation is uncertain. For example, resources for long-term maintenance of facilities for practicums, or simulation education for diagnostic practicums, are not sufficiently allocated and depend on the resource allocation from the government in an unsystematic manner.

(C) Current action

For continuous improvement of education, the way to allocate resources for certain settings should be discussed.

(D) Plan for future improvement

For continuous improvement of education, the way to allocate resources for certain settings should be discussed.

Q 9.0.1 The medical school **should** base the process of renewal on prospective studies and analyses and on results of local evaluation and the medical education literature.

(A) Basic information

Currently no prospective study, analysis or self-evaluation study is conducted for medical education. Literature for medical education has been checked for improvement or revision.

(B) Analysis and self-evaluation

Generally medical education reform has been carried out along with the reform in western countries. In the future, the direction of improvement should be obtained from the prospective study, analysis or self-evaluation study. For that purpose, a permanent division or committee to do such studies may be needed.

(C) Current action

The current medical education accreditation process is the opportunity to reaffirm the importance of prospective study, analysis and self-evaluation.

(D) Plan for future improvement

Establishment of a division or committee to continuously evaluate medical education should be discussed.

Q 9.0.2 The medical school **should** ensure that the process of renewal and restructuring leads to the revision of its policies and practices in accordance with past experience, present activities and future perspectives.

(A) Basic information

Regarding the history of medical education in FMUT, the medical education reform through the Inui Project in 2000 was noteworthy. Previously, reform directed by the medical student curriculum committee in 1970 was well-known.

New curricula started in this period included FQ and integrated lectures for basic sciences/basic science, clinical and social medicine in 1970, and the mission statement of FMUT and PBL in 2000. Thus, medical education in FMUT does not change rapidly, but once FMUT finds the way to improve, the new direction is well followed with sustainability.

The reforms of FMUT described in both documents, Kaga's paper in 1970 and Inui Project report in 2000, may be seen as limited.

(B) Analysis and self-evaluation

Educational reform in FMUT thus far has been somewhat slow but sustainable. Movement of medical education reform was not so powerful nor so professional to be led from inside.

(C) Current action

Reform in 1970 was largely influenced by the student activist movement closely related with FMUT then. Reform in 2000 was mainly led by the installment of IRCME in April 2000. Currently, reform was stimulated by the accreditation process of medical education.

(D) Plan for future improvement

The direction of reform has been made by external pressure, but such direction should be changed. A system to produce sustainable improvement should be considered.

Q 9.0.3 The medical school **should** address the following issues in its process of renewal Adaptation of mission statement and outcomes to the scientific, socio-economic and cultural development of the society. (see 1.1)

(A) Basic information

The mission statement and educational outcomes of FMUT were made with a high sense of value to lead the science, society, economy and culture in Japan.

(B) Analysis and self-evaluation

The mission statement and educational outcomes of FMUT were conceptually very progressive, but further discussion might be needed for difficulty in assessing, etc.

(C) Current action

In the future, educational outcomes should be related with assessment and assessment with yearly milestones for further refinement.

(D) Plan for future improvement

In the future, outcome-based education should be more established but scientific, socioeconomic and cultural development should be applicable, too.

Q 9.0.4 The medical school **should** address the following issues in its process of renewal modification of the intended educational outcomes of the graduating students in accordance with documented needs of the environment they will enter. The modification might include clinical skills, public health training and involvement in patient care appropriate to responsibilities encountered upon graduation. (see 1.4)

(A) Basic information

Training for clinical skills and public health and practicums including participation in patient care are currently implemented. Educational outcomes include clinical skills, social perspectives and whole person care.

(B) Analysis and self-evaluation

Currently, clinical diagnostic practicums for clinical skills, public health practicums for public health, and 1st-year exposure to medical jobs, nursing care practicums in M2 and CC in M2-M4 are provided. Before educational reform is conducted, individual curricular components should be reviewed with newly defined educational outcomes and critically appraised from the perspective of balanced content.

(C) Current action

Educational outcomes were approved in September 2014 but assessment methods and their association with outcomes are discussed in WGs for CC and for graduation assessment.

(D) Plan for future improvement

For mid-term or long-term, whether the current medical education system is able to achieve educational outcomes should be evaluated to identify where to make reforms.

Q 9.0.5 The medical school **should** address the following issues in its process of renewal adaptation of the curriculum model and instructional methods to ensure that these are appropriate and relevant.(see 2.1)

(A) Basic information

The relationship between the curricular model and instructional methods is delegated to each department. Such relevance is evaluated by students. Currently, the class evaluation depends on the students' self-directed activity and it is unclear if the system leads to continuous improvement.

(B) Analysis and self-evaluation

For educationally motivated faculty members, the system to give autonomy gives a higher degree of freedom. However, less motivated faculty members might provide classes without sufficient preparation of the curricular model or instructional methods.

(C) Current action

It should be discussed if FMUT should check the curricular model and instructional methods. For class evaluations, student opinion should reflect on the curricular model and instructional methods.

(D) Plan for future improvement

It should be discussed if FMUT should check the curricular model and instructional methods. For class evaluations student opinion should reflect on the curricular model and instructional methods.

Q 9.0.6 The medical school **should** address the following issues in its process of renewal adjustment of curricular elements and their relationships in keeping with developments in the basic biomedical, clinical, behavioural and social sciences, changes in the demographic profile and health/disease pattern of the population, and socioeconomic and cultural conditions. The adjustment would ensure that new relevant knowledge, concepts and methods are included and outdated ones discarded. (see 2.2 - 2.6)

(A) Basic information

Currently some curriculum renewal is corresponding to situational changes. For example, FD in 2003 discussed clinical diagnostic practicums and PBL. FD in 2008 selected the theme of the development of the research mind. Since 2013, community medicine practicums and general practice practicums were implemented (currently each student selects either of them).

(B) Analysis and self-evaluation

The timing of curriculum reform is consistent with changes of society.

(C) Current action

So far, FD has been conducted to correspond to major curriculum reform. Essentially, FD should be held to disseminate medical education information and upgrade educational skills. It might be possible that meetings for curricular reform should be held with the name of "education reform forum."

(D) Plan for future improvement

Future plans of how to hold meetings for educational reform should be determined.

Q 9.0.7 The medical school **should** address the following issues in its process of renewal development of assessment principles, and the methods and the number of examinations according to changes in intended educational outcomes and instructional methods. (see 3.1 and 3.2)

(A) Basic information

Regarding learner assessment, a specific WG was set up in July 2014 to discuss the direction of medical education reform.

(B) Analysis and self-evaluation

In the current learner assessment system, each department decides the assessment method, marking scheme and standard setting, so the responsibility of pass-fail decisions by each department is a heavy task. Issues such as this have been made apparent by this accreditation and have led to setting up the WGs.

However, there is no system to continuously discuss learner assessment. In the future, the necessity of such system should be discussed.

(C) Current action

Reform for learner assessment was discussed by a WG in November 2014.

(D) Plan for future improvement

There is no system to permanently discuss learner assessment. To determine the direction and the necessity of such a system should be discussed.

Q 9.0.8 The medical school **should** address the following issues in its process of renewal adaptation of student recruitment policy, selection methods and student intake to changing expectations and circumstances, human resource needs, changes in the premedical education system and the requirements of the educational programme. (see 4.1 and 4.2)

(A) Basic information

An admission policy was set up and disclosed the UT Committee for Admission Administration determines the student recruitment policy by themselves. The Director of CAS, Dean of Faculty of Arts, and Dean of Faculty of Science are members of the UT Committee for Admission Administration but whether the Dean of FMUT is included depends on the direction of the President. As for the number of student enrollment, slight changes are made with the direction of MEXT. It seems that such changes are following requests from society.

(B) Analysis and self-evaluation

The admission policy of UT does not change very much. UT takes pride in its steady policy toward the students who like to learn in UT.

(C) Current action

FMUT keeps seeking the best methods of student selection. It abolished interviews for applicants.

(D) Plan for future improvement

The best methods of student selection should be sought, including adopting opinions or expectations from various stakeholders.

Q 9.0.9 The medical school **should** address the following issues in its process of renewal adaptation of academic staff recruitment and development policy according to changing needs. (see 5.1 and 5.2)

(A) Basic information

As for the policy for academic staff recruitment, autonomy of each department is relatively strong. FD has two areas of discussion for educational reform and skill training for young faculty members.

(B) Analysis and self-evaluation

As for the policy for academic staff recruitment, assessment in the whole FMUT might be insufficient. The necessity of FD or young faculty members' obligation of FD has not been discussed.

(C) Current action

It should be discussed whether the governance of academic staff recruitment should be further enhanced or not. FMUT should review the direction and necessity of FD.

(D) Plan for future improvement

The system to collect opinions about FD's direction, content and strategy should be considered.

Q 9.0.10 The medical school **should** address the following issues in its process of renewal updating of educational resources according to changing needs, i.e. the student intake, size and profile of academic staff, and the educational programme. (see 6.1 - 6.3)

(A) Basic information

The student intake for Natural Sciences III was 100 in 2008 and before, 108 in 2009 and increased to 110 in 2010 and thereafter. Since the increase was only 10%, no additional educational resources have been needed. In the future, experiences outside of the campus should be increased, such as community medicine practicums. To ask for such practicums at affiliated hospitals, more educational resources might be needed.

(B) Analysis and self-evaluation

Every department takes measures to renew educational resources, but the total and continuous management for the whole FMUT is not so sufficient.

(C) Current action

Construction of a system to check the adequacy of current educational resources and to identify mid-term or long-term reform needs beforehand should be considered by the AAAD.

(D) Plan for future improvement

Though the direction of educational resource renewal is unpredictable, the development of such a system should be considered.

Q 9.0.11 The medical school **should** address the following issues in its process of renewal refinement of the process of programme monitoring and evaluation. (see 7.1 – 7.3)

(A) Basic information

Currently, the functions to check and evaluate the curriculum are concentrated in the AAC.

(B) Analysis and self-evaluation

Since the AAC mainly plans the educational programme and implements it, another organisational body is expected to evaluate and provide an overview of the curriculum.

(C) Current action

Discussions for establishing an IR division to evaluate and provide an overview of the curriculum was started.

(D) Plan for future improvement

Discuss the system in which an IR division will evaluate and provide an overview of the curriculum.

Q 9.0.12 The medical school **should** address the following issues in its process of renewal development of the organisational structure and of governance and management to cope with changing circumstances and needs and, over time, accommodating the interests of the different groups of stakeholders. (see 8.1 – 8.5)

(A) Basic information

The governance of FMUT heavily depends on the Dean's perception. The Dean is ultimately responsible for education but has all the responsibilities for how to balance education with research and service, which compete with education. It is difficult for the Dean to evaluate and to make decisions specifically for education.

(B) Analysis and self-evaluation

No system to check the governance of FMUT is specified.

(C) Current action

Regarding the governance of FMUT, to make specific evaluation and decision making for education possible, discussions for creating the position of a Vice Dean in charge of education was started.

(D) Plan for future improvement

It is expected that discussions for developing the system for a Vice Dean in charge of education will be conducted to consider governance of FMUT from the educational perspective.