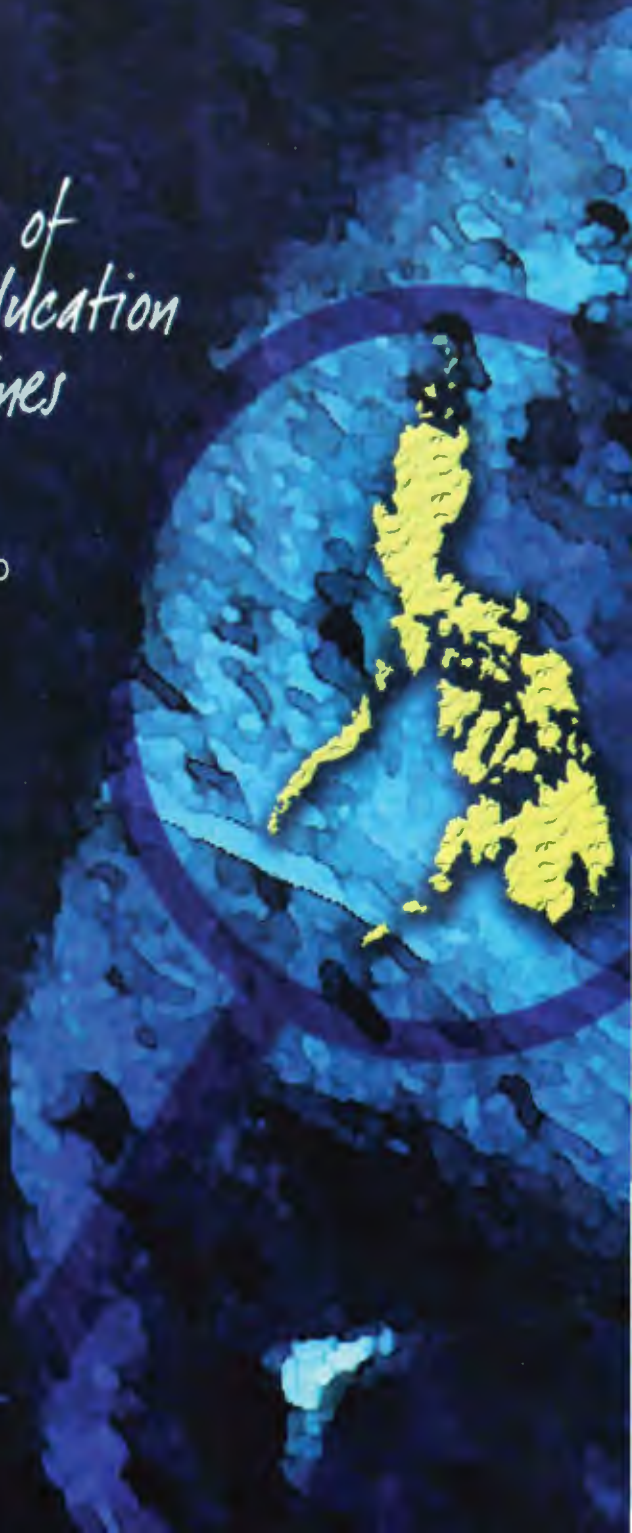
Current Status of Medical Education in the Philippines

edited by
Ramon L. Arcadio, MD, MHPEd
Acd. Perla D. Santos Ocampo, MD



The National Academy
of Science and Technology

July 2005
Monograph Series 9/2005

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ISSN 1655-4299

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July 2005
NAST Monograph Series No. 9

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Preface

In recent years, it has been noted that there is an increase in the number of medical schools in the country. Currently, the country has 36 medical schools. This phenomenon has been coupled with the fact that the national passing average for the Philippine Licensure Exam has declined remarkably over the past few years. Concerns have been raised by various sectors on whether this proliferation of medical schools has contributed to the deterioration of the quality of medical education. Thus, the National Academy of Science and Technology (NAST), in order to address these pressing issues on the proliferation of medical school, conducted a round table discussion on the state of medical education in the country which was held on 11 August 2004 at Traders Hotel in Manila.

The roundtable discussion primarily aimed to dissect the different issues concerning the setting up of medical schools—its impact on the quality of medical education and the Philippine health care system. Representatives from the Commission on Higher Education (CHED), Department of Health (DOH), Association of Philippine Medical Colleges (APMC), Professional Regulation Commission (PRC) and various medical institutions participated in the discussion.

This monograph, "Current Status of Medical Education in the Philippines", synthesizes these pressing issues and offers resolutions to address the current situation of Philippine medial education in the country. This summarizes the input from various authorities in medical education and the profession.

The paper on "Permit, Recognition and Accreditation" by Dr. Ramon L. Arcadio discusses the requirements for opening a medical degree program and the accreditation process of medical schools in the Philippines.

"Proliferation of Medical Schools" by Dr. Fernando S. Sanchez presents the trend in the number of medical schools set up in the Philippines. Dr. Sanchez raises issues on the quality of medical students and the impact of proliferation of medical schools on the quality of medical education.

In "The State of Philippine Medical Curriculum", Dr. Enriquez discusses the different teaching methods employed in Philippine Medical Schools.

The "Medical Licensure Process" by Dr. Jose S. Ramirez discusses the licensure examination process in the Philippines and the possible effect of problem-based learning on the performance of medical graduates in the medical licensure exam.

Dr. Kenneth Ronquillo, in "Medical Manpower Needs of the Country", discusses the lack of health professionals in the Philippine health care system, particularly physicians. Dr. Ronquillo offers suggestions on how to address this issue.

The paper on "Location of Practice of Medical Graduates" presented by Dr. Zorayda Leopando describes the distribution of physicians in the country from 1947-1997. It is a comprehensive study that aims to profile the Filipino medical practitioner.

The editors would like to acknowledge the efforts of the participants of the discussion, particularly Dean Angelo Manalo of the Mindanao State University (MSU) College of Medicine, who

provided great insights into the open forum; Dr. Albert Agomaa for the layout, cover design and reading of the manuscript; and Mr. Aristotle Carandang and the staff of NAST in creating this monograph.

The Editors

MESSAGE

Created in 1976, the National Academy of Science and Technology (NAST) was mandated to advise the President and the Cabinet on matters concerning science and technology, recognize outstanding achievements in S and T, engage in projects and programs that promote scientific productivity and to embark on programs that are traditionally and internationally expected of an academy of science.

The Academy is composed of outstanding members of the scientific community of the country called ACADEMICIANS. At present, there are only 49 academicians in 6 divisions: agricultural, biological, health, mathematical; chemical and physical; and social sciences.

Annually, for its work plan, the National Academy of Science and Technology identifies issues of great concern to the country. This year's scientific meeting, held last July, as the most prestigious S and T assemblage, whose resolutions and recommendations were endorsed to the President of the Philippines and appropriate agencies on: population, rice productivity, biosafety, bio-prospecting, science education , for the enhancement of the role of science in the community. Earlier, the Academy has been involved in the crafting of a water policy, applications of, and ethics-related to the human genome project, agriculture and biotechnology.

Because of the apparent concerns of various sectors of society fro science and manpower resources that includes medical and health sciences division. The Executive Council concurred that the current status of medical education in the Philippines has great importance in the face of significant economic, social, political, scientific and technological developments.

There are a number of concerns of great importance for which we seek answers. And we should keep in mind excellence and relevance as the two most salient and pragmatic consideration. A few of these pressing concerns are:

- Updated, relevant criteria for opening of medical schools
- Reasons for the proliferation of medical schools
- Mechanisms for the quality assurance and accreditation of medical schools
- What happens to medical schools who do not volunteer for accreditation
- What is the reasonable type of licensure exam that will be fair to students coming from medical schools with varied types of curricular strategies
- What curriculum structure/type is really appropriate for Philippine medical schools
- Manpower need- is it a lack or maldistribution

These are just a few of the concerns. You may add to this short list.

We would like to thank our speakers: Dr. Ramon L. Arcadio, Dr. Fernando Sanchez, Dr. Romeo Enriques, Dr. Jose Ramirez, Dr. Kenneth Ronquillo, Dr. Zorayda Leopando, Dr. Carlito S. Puno, Acad. Ernesto O. Domingo and Dr. Jaime C. Montoya, and the participants this morning who are here to help us shed light on these issues which we all know have existed as nagging questions for decades now.

Academician Perla D. Santos Ocampo, MD
President
National Academy of Science and Technology

List of Abbreviations

1. AACCUP- Accrediting Agency of Chartered Colleges and Universities of the Philippines
2. ACSCU-AAI- Association of Christian Schools, Colleges and Universities Accrediting Agency, Inc.
3. APMC- Association of Philippine Medical Colleges
4. APMCF- Association of Philippine Medical Colleges Foundation
5. ARMM- Autonomous Region of Muslim Mindanao
6. AUF- Angeles University Foundation
7. BCCM- Bicol Christian College of Medicine
8. BEME- Best Evidence-based Education
9. BOM- Board of Medicine
10. Calabarzon- Cavite, Laguna, Batangas, Quezon
11. CARAGA- Region XIII Provinces
12. CDCM- Cebu Doctors College of Medicine
13. CHED- Commission on Higher Education
14. CHED-OPS- CHED- Office of Programs and Standards
15. CHEDRO- CHED Regional Office
16. CIM- Cebu Institute of Medicine
17. CME- Continuing Medical Education
18. CMO- CHED Memorandum Order
19. COD- Center of Development

20. COE- Center of Excellence
21. CPE- Continuing Professional Education
22. CSU- Cagayan State University
23. CT- Computed Tomography
24. DLSU- De la Salle University
25. DMSF- Davao Medical School Foundation
26. DN- Dietician-Nutritionist
27. DOH- Department of Health
28. ECG- Electrocardiogram
29. FAAP- Federation of Accrediting Agencies of the Philippines
30. FEU- Far Eastern University
31. GPA- Grade Point Average
32. HEDF- Higher Educational Development Fund
33. HEI- Higher Education Institutions
34. HERO- Higher Education Regional Office
35. ICNLE -Integrated Comprehensive Nursing Licensure Examination
36. IDCM- Iloilo Doctors College of Medicine
37. IMR- Infant Mortality Rate
38. LN- Lyceum North
39. LUC- Local Universities and Colleges
40. MCU- Manila Central University
41. MD- Doctor of Medicine
42. MHO- Municipal Health Officer
43. MINSUPALA- Mindanao, Sulu, Palawan

46. MT- Medical Technology
47. NAST- National Academy of Science and Technology
48. NCR- National Capital Region
49. NMAT- National Medical Admission Test
50. OSCE- Objective Structured Clinical Examination
51. OT- Occupational Therapy
52. PAASCU- Philippine Accrediting Association of Schools, Colleges and Universities
53. PACU-COA- Philippine Association of Colleges and Universities Commission on Accreditation
54. PAFP- Philippine Academy of Family Physicians
55. PBL- Problem-based Learning
56. PGH- Philippine General Hospital
57. PHA- Philippine Hospital Association
58. PLE- Philippine Licensure Examination
59. PLM- Pamantasan ng Lungsod ng Maynila
60. PMA- Philippine Medical Association
61. PRC- Professional Regulation Commission
62. PT- Physical Therapy
63. RHU- Rural Health Unit
64. RQUAT- Regional Quality Assessment Team
65. RTR- Remedios T. Romualdez (Medical Foundation)
66. SLCM- St. Luke's College of Medicine
67. SLU- St. Louis University

68. SUC- State Universities and Colleges
69. SWU- Southwestern University
70. TCME- Technical Committee on Medical Education
71. TFR- Total Fertility Rate
72. UERMMMC- University of the East Ramon Magsaysay Memorial Medical Center
73. UN- United Nations
74. UP- University of the Philippines
75. UPCM- University of the Philippines College of Medicine
76. UST- University of Santo Tomas
77. UV- University of the Visayas
78. VMUF- Virgen Milagrosa University Foundation
79. WFME- World Federation of Medical Education
80. WHO- World Health Organization
81. WVSU- West Visayas State University
82. XU- Xavier University
83. ZMSF- Zamboanga Medical School Foundation

Permit, Recognition and Accreditation of Medical Schools

Ramon L. Arcadio, MD, MHPEd
Chair, Technical Committee for Medical Education
Chair, Technical Panel for Health Professions Education

Permit and Recognition Process

The CHED Office of Programs and Standards (OPS) is responsible for developing policies, standards and guidelines for the health professions. The Technical Panel for Health Professions Education assists the CHED-OPS in setting standards and in program and institution monitoring and evaluation. The health professions education panel is, in turn, assisted by ten (10) technical committees in various health fields, namely: medicine, nursing, optometry, dentistry, pharmacy, midwifery, medical technology, nutrition-dietetics, radiologic technology, physical therapy and occupational therapy.

The issuance of government authority (permit and recognition) for medical schools is principally governed by the "Updated Policies and Standards for Medical Education" which is embodied in CHED Memorandum Order (CMO) No. 36, Series of 2001. The issuance of government authority shall progress from: (1) permit to cover the offering of the first and second year levels; (2) permit covering the offering up to the third year level; and (3) recognition of the entire program. The issuance of the initial permit covering first and second year levels require full compli-

ance of the minimum standards (100 percent) for the whole program is required.

All applications for government authority (permit and recognition) to operate the Doctor of Medicine program shall be submitted to the CHED Regional Office (CHEDRO) for preliminary evaluation. Preliminary evaluation by the CHEDRO shall include documentary analysis and inspection by the Regional Quality Assessment Teams (RQATs), only applications that are favorably recommended by CHEDRO shall be forwarded to the Office of Programs and Standards (OPS).

The OPS through the Technical Committee on Medical Education (TCME) shall conduct the final evaluation of the applications. If favorably endorsed by the TCME, the recommendation shall be submitted by the OPS to the Commission en banc for final decision.

These procedures shall apply to all medical schools including those belonging to autonomous and deregulated higher education institutions (HEIs). In case of state universities and colleges (SUCs) and local universities and colleges (LUCs), these procedures shall be followed prior to action by their respective governing boards. The action of the CHED shall be recommendatory to the governing boards of SUCs and LUCs.

Criteria for Evaluation

The criteria for evaluation prior to the grant of government authority include the following areas: mission statement, organization and administration, faculty, curriculum, instructional

standards, library resources, research, admission requirements, residence and unit requirements.

The three (3) general criteria for the selection and identification of private higher education institutions that shall receive autonomy and deregulated status from CHED are:

1. Established as Centers of Excellence (COE) or Centers of Development (COD) and/or CHED-FAAP Level III Ac credited Programs
2. Outstanding overall performance of graduates in the li censure examinations administered by the Professional Regulation Commission
3. Long tradition of integrity and untarnished reputation.

CHED-Recognized Accreditation System

The CHED has a policy to encourage and assist medical schools which desire to attain standards of quality over and above the minimum requirements. For this purpose, the CHED encourages the use of voluntary non-governmental accreditation systems in aid of the exercise of its regulatory functions. Since the Association of Philippine Medical Colleges Foundation (APMCF) is not a recognized accrediting agency by CHED, all medical schools have, in principle, agreed to join the Philippine Accrediting Association of Schools, Colleges and Universities (PAASCU) for purposes of accreditation on a voluntary basis.

The CHED recognizes the accrediting agencies now federated under the Federation of Accrediting Agencies of the Philippines (FAAP), namely: the Association of Christian Schools, Col-

leges and Universities Accrediting Agency, Inc. (ACSCU-AAI); the Philippine Accrediting Association of Schools, Colleges and Universities (PAASCU), the Philippine Association of Colleges and Universities Commission on Accreditation (PACU-COA), and the Accrediting Agency of Chartered Colleges and Universities of the Philippines (AACCUP). Recently, the AACUP was allowed by CHED to separate from FAAP and form another federation.

PAASCU Accreditation System for Medical Schools

In 1999, the PAASCU and the Association of Philippine Medical Colleges Foundation (APMCF) started to work on an accreditation process for the Doctor of Medicine (MD) program. An accreditation instrument was developed in a year's time. In 2003, the University of the Philippines College of Medicine (UPCM) MD program became the first to receive formal accreditation (Level III for 3 years). The University of the East Ramon Magsaysay Memorial Medical Center's (UERMMMC) MD program was the second to be accredited. UERMMMC was the first private medical school to be accredited.

The PAASCU accreditation process involves the following: (1) institutional self-survey; (2) preliminary visit; (3) formal survey visit; (4) periodic re-survey. The areas to be evaluated are the following: vision-mission of the school, faculty, curriculum and instruction, clinical training / service facilities, research, students, library, administration, physical plant and resources.

Accreditation Levels

For purposes of progressive deregulation and grant of other benefits, educational programs are classified into four levels:

LEVEL I applicant status: for programs which have undergone a preliminary survey visit and are certified by the FAAP as being capable of acquiring an accredited status within two years.

LEVEL II accredited status: for programs which have been granted accredited status by any member of the agencies of the FAAP and whose status is certified by the latter.

LEVEL III accredited status: for programs which have at least been re-accredited, and have met the following additional criteria/ guidelines set by FAAP for this level. Accredited programs must satisfy the first two criteria and any other two of the succeeding ones:

(a) A reasonably high standard of instruction as manifested by the quality of its teachers

(b) A highly visible community extension program. A description of the program(s), the nature and extent of student, faculty and staff involvement, and other details shall be required documentation for this indicator.

(c) A highly visible research tradition. The following must be observable over a reasonable period of time:

1. provision for a reasonable budget
2. quality of completed outputs
3. measurable results such as publication, etc.
4. involvement of a significant number of faculty members
5. visible, tangible and measurable impact on the community

(d) A strong staff development tradition as evidenced by an appropriate budgetary allocation and/ or systematic plan for staff development programs.

(e) A highly creditable performance in licensure examinations over the last three years (Will apply only to those programs where such examinations are required).

(f) Existence of working consortia of linkages with other schools and /or agencies. Documentary evidence shall include a description of the nature, mechanism, working agreements and other details of consortia.

LEVEL IV accredited status: institutions which have distinguished themselves in a broad area of academic disciplines and enjoy prestige and authority comparable to that of international universities. These institutions must have met the following additional criteria/guideline:

(a) At least 75% of its programs must have attained Level III status for a minimum of ten years, i.e. two consecutive terms of five years each.

b) Excellent outcomes in:

1. research as seen in the number, scope and impact of scholarly publications in refereed national and international journals;

2. teaching and learning as proven in the performance of its graduates and alumni and the continuing assessment of student achievement;

3. community service and the impact of its contributions to the economic and social upliftment, on both regional and national levels.

(c) Evidence of international linkages and consortia.

(d) Well developed planning processes which support quality assurance mechanisms.

Accrediting Benefits

The following benefits for the different accreditation levels are provided:

LEVEL I
Partial Administrative Deregulation

Exemption from compliance with prescribed administrative operational requirements, such as need for approval of class and teacher's programs, trimestral or semestral submission of enrolment lists, and reports of promotion of students. Form IX may

also be submitted without the previously required documents and authority to grant teaching overload in meritorious cases.

LEVEL II

(a)Full administrative deregulation, provided that reports of promotion of students and lists of graduates are available for review by CHED at all times.

(b)Financial deregulation in terms of setting of tuition and other school fees and charges.

(c)Partial curricular autonomy which shall include the authority to revise the curricula without CHED approval provided that CHED and Professional Regulation Commission minimum requirements and guidelines, where applicable, are complied with and the revised curriculum is submitted to CHED Regional Offices.

(d)Authority to graduate students from accredited courses of programs of study in the levels accredited without prior approval of the CHED and without need for Special Orders.

(e)Priority in terms of available funding assistance for scholarships, library materials, laboratory equipment and other development activities.

(f) Priority for government subsidy for faculty development.

(g) Right to use on its publications or advertisements the word "ACCREDITED" pursuant to CHED policies and rules.

(h) Limited visitation, inspection and/ or supervision by CHED supervisory personnel or representatives.

LEVEL III

(a) All the benefits for Level II

(b) Full curricular deregulation, including the authority to offer new courses allied to existing Level III courses, without need for prior approval provided that CHED, through appropriate Higher Educational Regional Office (HERO), is duly informed before offering such new programs.

LEVEL IV

(a) All the benefits for Levels II and III

(b) Award of grants/subsidies from the Higher Educational Development Fund (HEDF) for programs of qualified tertiary educational institutions for the period or duration of its Level IV accredited status, as approved by the CHED, in accordance with the HEDF guidelines.

(c) Grant of charter or full autonomy for the duration of its Level IV accredited status of the institution.

Proliferation of Medical Schools

Fernando S. Sanchez, Jr., MD
Executive Director, Association of Philippine Medical Colleges

The Association of Philippine Medical Colleges (APMC) has always been an advocate of rationalization of the production of physicians in the country. It influenced the framing of the 1987 Philippine Constitution which mandated the State to "undertake health manpower development and research". To date, however, there is no enabling law for the actualization of this constitutional mandate.

The Medical Act of 1959 created the Board of Medical Education through which discussions among the Ministry/Department of Education, Culture and Sports; the Ministry/ Department of Health; the Philippine Medical Association and the APMC on opening of medical schools took place. The education minister/ secretary made the decision on applications to offer the medical course based on consensus of the members.

The Education Act of 1982 provided for the creation of boards for the health sciences and other fields and appropriate technical panels. The Board of Medical Education continued to function until 1986.

The Commission on Higher Education was established in 1992. The Technical Committee for Medical Education, Technical Panel for Health was subsequently created.

Opening of Medical Schools

In 1950, there were only three (3) medical schools; the population of the country was 20.3 million. Two (2) schools opened between 1951 and 1955 and another two (2) between 1956 and 1960; bringing the number to seven (7) in 1960, at which time the Philippine population reached 27.4 M.

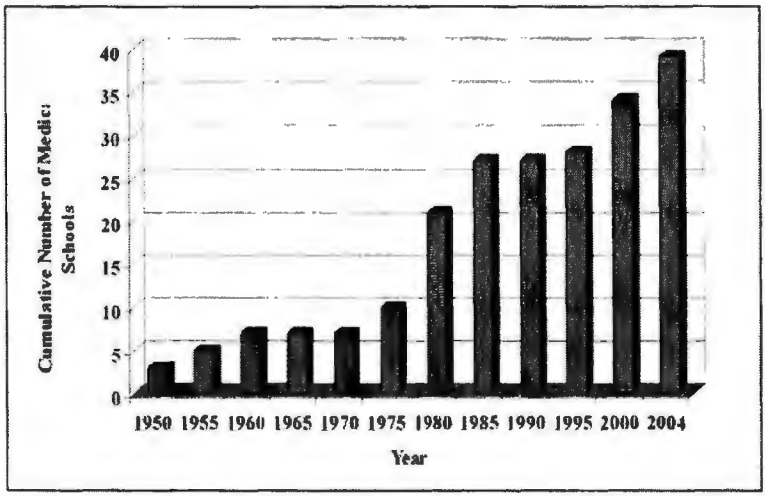
For over ten years, no medical school was established. From 1971 to 1975 three (3) schools opened and from 1976 to 1980, eleven (11) were added; the total number of medical schools became twenty-one (21). The population of the country reached 48.3 M in 1980.

Six medical schools were opened between 1981 and 1985 and none from 1986 to 1990. One school opened between 1991 and 1995, six (6) between 1996 and 2000, and five (5) after 2000. The Philippine population in 1985 was 54.6 M, in 1990 was 62.0 M, 1995 was 66.9 M and in 2000 was 76.9 M.

Number of Medical Schools Established by Period

Period	Number
Before 1950	3
1951-1955	2
1956-1960	2
1961-1965	0
1966-1970	0
1971-1975	3
1976-1980	11
1981-1985	6
1986-1990	0
1991-1995	1
1996-2000	6
2001-2004	5

Cumulative Number of Medical Schools by Year



In the period 1971-1980, the establishment of medical schools was encouraged by local governments, because of the lack of doctors in many parts of the country. Doctors were permanently being lost by migration to the USA (an estimated 40% of all doctors had been lost by 1975). Many schools were opened in the provinces, many of which were opened where there were already existing medical schools. There is today clustering of medical schools: 12 in NCR / Metro Manila, 2 in Baguio, 4 in Metro Cebu, 3 in Iloilo, 2 in Leyte and 2 in Calabarzon. CHED central office does not have data on several schools.

Number of Medical Schools by Location, 2004-05

NCR / Metro Manila	12 (1 had closed)
Metro Cebu	2
Iloilo	4
Leyte	3
Calabarzon	2 (1 had closed)
Pangasinan	2
Bicol	2
Mindanao	1 (1 had closed)
Samar	4
Pampanga	1
Vigan	1
Tuguegarao	1
Total	36

Together with the virtual closure of the USA to foreign doctors in 1975, the opening of medical schools improved the doctor-population ratio as well as the geographic distribution of physicians but the quality of the medical education suffered. The passing rate in the licensure examination went down from 70-80% to below 60%. The reasons were:

- There was lack of competent faculty members
- Academically unqualified students were admitted to the new schools
- Many new schools did not have adequate facilities including their own hospital

The lack of faculty members led the pirating of faculty members from the old schools and the emergence of so-called "flying doctors". Both still exist today and are bad for medical education.

Only nineteen (19) medical schools have their own teaching hospital. The provision for this has been ignored.

In 1995, the Board of Medical Education imposed the National Medical Admission Test (NMAT) with a cut off/passing mark. The number of applicants to the medical schools dropped. Many of the schools complained of financial difficulties.

In 1992, the education secretary adopted a policy on school opening based on market forces: "Schools can open and compete in the market; those who cannot survive should close". He also removed the passing mark of the NMAT, giving the medical schools a short-lived relief from the dwindling number of students. The number of students interested in medicine has declined in the last few years despite the expanding population of the country. The total freshmen quota of the thirty-six existing medical schools is over 5500. The number of NMAT takers for this school year (2004-2005) was 4,351, a big proportion of whom scored below the 45th percentile (the suggested cut-off). Thus, many schools cannot fill up their quotas. Only schools with strong arts and sciences programs and government schools with low tuition fees have not suffered marked declines in enrollment in the last five to ten school years.

Number of Takers of the National Medical Admission Test (NMAT) for the Indicated School Year

School Year	Number
1995-1996	5,064
1996-1997	5,209

1997-1998	6,139
1998-1999	5,707
1999-2000	5,974
2000-2001	6,158
2001-2002	6,408
2002-2003	6,274
2003-2004	5,414
2004-2005	4,351

In 2001, CHED promulgated a new policy which allows autonomous and deregulated universities and colleges to offer any academic program. The authority to grant permission to open new programs was also transferred to regional offices. Six (6) new schools had since opened, one of which closed after two years.

The APMC asked CHED through several position papers to impose a moratorium on the opening of new medical schools until a thorough study of the situation has been made. Our request was not granted. CHED agreed, however, not to restore a planned NMAT cut-off grade because of the objections of medical schools.

CHED acknowledged in CMO No. 2 series of 2004 the following:

1. There is a proliferation of medical and nursing schools in the country.

2. Philippine Licensure Examinations (PLE) administered by the Professional Regulation Commission (PRC) indicate the deterioration of the quality of medical and nursing

education.

3. There is a dearth of qualified faculty, deans and teaching hospitals which are important factors to be considered in the offering of medicine and nursing.

They modified the policy and procedure of granting authority for schools to offer programs in medicine and nursing. After the Regional Quality Assessment Team and the CHED Regional Office recommend approval, the Office of Programs and Standards has to conduct a final evaluation of the application. The recommendation is submitted to the Commission en banc. The policy and procedure apply to all institutions including autonomous and deregulated schools. The CMO No.2 series of 2004 is silent on state universities and colleges.

The State of the Philippine Medical Curriculum

Romeo Enriquez, MD
President, Association of Philippine Medical Colleges

For me to give an overview of the Medical Curriculum in the Philippines, I would like to start off with a quotation from the Edinburgh Declaration, 1988:

> *"The aim of medical education is to produce doctors who will promote the health of the people—not merely deliver curative services to those who can afford it, or those for whom it is readily available. That aim is not being realised in many places".*

As all educators know, over the past several years some medical schools, with or without encouragement from the Association of Philippine Medical Colleges (APMC), have started innovations in their curricula, mostly out of a need for reforms in the delivery of medical education. The reforms were mostly needed to change the strategy of teaching as well as the administrative aspects of running a medical school.

As a backgrounder, reforms have been encouraged at an international level with initiatives coming from the World Federation of Medical Education (WFME). In 1984, the WFME was called upon to reform medical education internationally. A Planning Commission in 1986 compiled the famous Six Major Themes Document of the WFME. The document consisting of 32 key ques-

tions which highlighted key issues, was translated into many languages and sent to the deans of all medical schools in the world. Throughout 1986, the responses received from the deans in each country were compiled into a National Report.

In 1987- 1988, six Regional Conferences analyzed the national reports and came out with six regional reports from which a world report was compiled at the World Conference on Medical Education in Edinburgh (1988) from which the Edinburgh Declaration came about.

> *"It proved to be a mandate for reform of medical education; its validity came from its having started from enquiry at national level, subsequently endorsed regionally, and finally adopted globally; it was globally agreed by medical educators by international consensus; it became formally accepted by governments and approved by the world health parliament; it reflects the convictions of medical teachers, medical students, doctors and other health professionals, and the general public around the globe; its parallel goal is improvement of health care for all the populations."*

Professor Henry Walton

The following were the principles from the Declaration:

ACTIONS WITHIN THE MEDICAL SCHOOL

1. Widen educational settings
2. National health needs as the context for curricula
3. Active learning methods (tutorial, self-directed and inde-

pendent) for continuity of learning throughout life

4. Require professional competence (not mere knowledge recall)
5. Train medical teachers as educators
6. Prevention of illness and health promotion
7. Integration of science and clinical practice
8. Selection of applicants, for non-intellectual as well as intel lectual attributes

REQUIRES WIDER INVOLVEMENT

9. Coordination of medical education and health care systems
10. Balance in production of categories of medical staff and other health professions
11. Multiprofessional training and teamwork
12. Provision for continuing medical education

These basic principles have been the basis for most medical schools in the Philippines and abroad for working aggressively into developing innovations in the delivery of medical education in their respective institutions.

At the international level, the WFME have gone further to ensure the implementation of reforms. It has embarked on developing International Standards in Medical Education. In 2003, the final drafts of the WFME Trilogy of Standards were presented at the WFME Congress in Copenhagen. These include WFME Global Standards for Quality Improvement in Basic, Postgraduate and Continuing Medical Education. These tools can provide a basis for medical schools for self-evaluation in terms of minimum requirements as well as parameters for quality.

In the Philippines, medical schools maintain standards at different levels. The minimum standards are set by the government through the Commission on Higher Education (CHED) through a series of CHED Memorandum Orders updated periodically as recommended by the Technical Committee on Medical Education (TCME). The CHED Guidelines are based primarily on the ability of an institution to fulfill the objectives of basic medical education as follows:

1. To facilitate the Students' acquisition of core knowledge, skills and attitudes to enable him/her to assume any of the following roles:
    a. Healthcare Giver
    b. Teacher
    c. Researcher
    d. Administrator
    e. Social Mobilizer
2. To develop core knowledge needed by a primary care physician to:
    a. Promote the health of communities
    b. Prevent the onset of disease
    c. Cure disease and/or mitigate its consequences
    d. Utilize the broadest range of health intervention to achieve the foregoing
    e. Optimize the use of available resources in the treatment of disease
3. To develop skills and attitudes
    a. Critical thinking
    b. Leadership and managerial ability
    c. Communication and technical skills in giving health care and in the conduct of research

4. To develop skills and attitudes

a. Commitment for lifelong self directed learning and professional development

b. Desirable attitudes, moral values, social conscience and responsibility and ethical behavior

c. Capability to apply the holistic approach to patient care

d. Team spirit

It is important to note that CHED, in line with international calls for innovations, has developed its new guidelines and standards on the medical curriculum without being rigid in imposing specific curricular designs as well as teaching strategies. The recommended characteristics of the curriculum especially those intending to innovate are as follows:

a. Integrated, with little barrier among component courses

b. Competency based, student centered and encourages self-directed learning

c. Utilizes active learning methods such as small group discussion

d. Allocated adequate time for independent learning

The medical curriculum can best be described on four parameters: objectives, content, design and instructional methods.

Most medical schools in the Philippines, through their own mission statements, once reviewed will most likely be consistent with the aforementioned CHED-imposed objectives in medical

education. I personally believe that at this day and age, with the current situation in medical education as well as with the effect of the nursing phenomenon, the objective of making huge profits is only secondary.

The level of excellence of each medical school is based on the curricular content. Anyone who starts a school will most likely find it easy to fulfill the minimum CHED requirements. As the school continues its operations, its next objective is to make sure that its graduates pass the Physicians' Licensure Examination (PLE) satisfactorily. Therefore, in a sense, if the PLE is the final standard for certification, the curriculum should be congruent with it regardless of the teaching strategy. Technically, a "syllabus" has been released by the Professional Regulation Commission (PRC) Board of Medicine as a guide for medical schools to follow. However, apparently, it needs a lot of improvement.

For most schools complying satisfactorily with the PLE performance, additional content in the curriculum is based on minimum requirements of international agencies. Most schools will aspire to have a good passing percentage in the US Medical Licensing Examinations. Hence, they have a tendency to incorporate studies of diseases and technology that may not be relevant to the Philippine situation.

Likewise, specialty societies, non-government organizations and advocacy groups usually come to the APMC to request endorsement for medical schools to include a particular topic or competency and sometimes, even subjects into the curriculum. For this reason, the content becomes dynamic, and very varied

from school to school from their mission statements.

On top of these, the following also influence the curricular content:

a. Educational excellence of the institution
b. Recommendations by both national and international academic government and non-government organizations
c. Recommendations of stakeholders
d. Influence of social accountability

The curriculum design is the organization and the sequencing of subjects or modules based on principles of learning. It is apparent that the very basic subjects are taught first, followed by clinical subjects and finally by clinical exposure in clerkship. Recently however, variations in design have involved the organization and integration of subjects. Certain schools maintained the discipline-based nomenclature and organization such that the traditional disciplines are taught as separate subjects. This remains true for all traditional schools and for a few of those who have innovated. For most of those who have innovated completely, subjects are organized into sequential modules arranged according to organ systems.

The subjects are likewise integrated into modules. Horizontal integration means that the teaching of subjects in the same year level is integrated into modules. These modules may be organ based or specialty based, i.e., the nervous system, the respiratory system, etc. In vertical integration, organ based modules include the study of all aspects of each organ system. Everything in basic and clinical sciences related to the organ system is

discussed during the module such that, even at first year level, students will be expected to learn for example, the anatomy, physiology, biochemistry, pathophysiology as well as the prevention, clinical course, pathology and principles of management of diseases related to an organ system.

Most traditional curricula still do not integrate since the subjects are still discipline based. However, certain schools have made sure that the teaching of topics either in basic or clinical sciences is synchronized according to organ systems.

The main method of instruction in the Philippines is still the formal lecture. The formal lecture is usually teacher centered, and the entire class may vary in size ranging from 30 to 200 students. Although there is little room for interaction, some really good educators through showmanship and other innovative styles, can convert a formal lecture despite a large class into a lively and interactive teaching experience.

Some institutions make sure that lecture classes do not exceed a certain number to maintain a small class size. This has the advantage of more direct interaction between faculty and students.

The latest innovations in teaching methodology are the student-centered methods. Problem-based learning basically requires that learning for students be primarily focused on a paper case with trigger problems that can be the start of discussion among the students. Utilizing the 7 step approach, the students evaluate the problem, identify things that they have to learn to be able to understand the problem, re-evaluate the case with

knowledge gained, and identify again things they need to learn to be able to discuss the case based on learning objectives that they have set themselves. PBL therefore, is self-directed learning. The faculty becomes only a facilitator to make sure that the discussion is directed towards the right path. The faculty is not allowed to give lectures during these sessions. It is supposed to teach the students HOW to learn rather than WHAT to learn. Among Philippine medical schools, the PBL approach is being used in different degrees. Some have developed a pure PBL curriculum, while others utilize the PBL approach for small group case discussions. PBL purists have a tendency to discourage, hybrid models since they feel that giving lectures defeats the purpose of problem based learning.

One medical school in the Philippines utilizes the PBL approach to learning has the distinction of focusing the learning process on the Community. Most of its students have done very well in the Physician's Licensure Examinations.

Preceptorship as a method of learning is still used by most medical schools primarily for the teaching of interviewing and physical examination skills. Other innovations in medical education include the following:

a. Purely Self-directed
b. Web based
c. Multimedia based

Taking into consideration the opinions of the proponents as well as those of pessimists on problem-based learning, it is my opinion that problem based learning is a good teaching strategy

by itself. However, the design of the curriculum will strongly depend on the profile of the faculty, the student population and most importantly, the mission of the school

In summary, the medical curriculum is dynamic. Medical schools must conform in content to national and local standards in curriculum development. Curriculum design must be based on the institutional, faculty and student profile. There should be emphasis on encouraging the student to develop skills and enthusiasm for self directed and lifelong learning.

Taking into consideration the current state of the Philippine medical curriculum, I present the following recommendations:

1. The CHED Technical Committee in Medical Education should take a very active role in the following:
    a. Upgrading the minimum standards for medical education
    b. Require all schools to submit proposals for curriculum change, regardless of autonomous status
    c. The development of detailed guidelines on the content and delivery of medical education similar to the UK GMC document "Tomorrow's Doctors"

2. The APMC and the PRC Board of Medicine should work together to ensure congruence of the medical curriculum and the Physician's Licensure Examination.

The Medical Licensure Process

Jose S. Ramirez, MD
Chairman, Board of Medicine
Professional Regulation Commission

Introduction

The licensure examination for physicians, as well as medical education and the practice of the profession in the Philippines, is governed by the Medical Act of 1959. The examination currently is given twice a year, in August and in February, in Manila and, depending on the number of applicants in Cebu and Davao, also in these venues. The examination is guided by a syllabus, available from the PRC, which is congruent with the medical educational process as offered in schools or colleges of medicine in the country.

Characteristics of the examination

The examination is given in English, and covers twelve primary subjects: anatomy and histology, physiology, biochemistry, microbiology and parasitology, pharmacology and therapeutics, pathology, medicine, obstetrics and gynecology, pediatrics and nutrition, surgery and ophthalmology, otolaryngology and rhinology, preventive medicine and public health, and legal medicine, ethics and jurisprudence. Examinees may elect to take a preliminary examination covering only the first four subjects listed above. Currently, 100 multiple choice questions are given for each of the twelve listed subjects. Where possible, especially in clinical subjects, case-based problem-solving items are formu-

lated. Actual questions for a given examination are extracted by computer from a question bank of unused items formulated by the Board members concerned; these may number anywhere from 500 to 800 questions for each subject. Correction of the examinee answer sheets is done by computer, based on the answers provided by the examiners. Code numbers, not names of examinees, are written on the answer sheets. Grading is criterion-referenced, not norm-referenced and transmutation of the raw scores to final grades is done by the computer. The final passing grade for each examination is adopted by the Board collegially. The Board takes pains to ensure that examinations are valid, reliable, relevant and practicable. Security and integrity are assured.

The Board of Medicine

The Board of Medicine (BOM) consists of a maximum of six members, one of whom serves as the chairman. Board members are appointed by the President of the Philippines from a list of candidates recommended by the Philippine Medical Association (PMA), and vetted by the Professional Regulation Commission (PRC). Currently, no academic experience is required for appointment to the Board. Five of the present members of the Board are graduates of the University of Santo Tomas and one is a graduate of the University of the Philippines. When fully constituted, with six members, the Board assigns two subjects to each member. Members may not serve as faculty or on the governing body of any medical school. Each member is appointed for a term of three years and may not be reappointed right after his term is completed. However, a member may continue to serve the Board (as hold-over) until he or she is specifically re-

placed by a new appointee. The Board undertakes serious measures to assure that the quality of the examination remains high and, to this end, it has conducted evaluation seminars and workshops. The last one was held in Clark in April this year.

Results of recent examinations

The Board has noted with increasing concern that the passing percentage for each succeeding examination has declined each year. From August 2001, when the passing percentage was 64.3%, to August 2003, when it was 55.6% and to February this year, when it went down to 51.97%, there has been a continuing relentless slide. The Board worries that the quality of medical education in our country may have deteriorated in recent years, influenced by the unchecked proliferation of medical schools and the pirating of faculty members from established schools. There may also have been deterioration in the quality of students, and in the admission process.

The impact of the introduction of Problem Based Learning on the passing percentage in the licensure examination

Whereas it is rather early to make definitive conclusions regarding this matter, the Board has noted with concern that the passing percentage achieved by PBL graduates has been remarkably lower that that achieved by graduates of the same institutions before the introduction of PBL. For instance, in one school, with graduates obtaining 40-60% passing, the passing percentage for its first PBL graduates was 21%. In yet another and larger school, where the passing percentage was in the nineties previously (actually 100% as recently as 8-9 years ago), the

percentage declined to 66% in August 2003 and 69% in February 2004. The Board feels that there is nothing intrinsically wrong with PBL but that the problem may lie with the implementation of its teaching strategy by academicians who are not committed to it or do not recognize the requirements for successful implementation. The Board has noted with gratification that small schools employing the PBL have produced graduates who have done well in the examination. Minimum standards for PBL have not been defined in our country. Abroad, there is increasing recognition that PBL does not produce graduates who are more knowledgeable or more clinically competent than graduates of other educational processes. There is a fact a shift from the so-called pure or even hybrid PBL to BEME, which is Best Evidence Based Education.

Where are we and where should we be?

The Board is the first to admit that the examination process is imperfect. The technology available for upgrading the exam items is yet to be installed. We cannot, for example, print ECG tracings, x-ray photographs, CT scans, etc. as integral parts of examination items. In the United States, a third step in the licensure examination process has been started, essentially a form of OSCE (objective structured clinical evaluation). We are so far behind we can only dream about such things. As for the Board of Medicine itself, half-humorously, I have suggested that vetting of prospective appointees should include an IQ exam and if that is passed, also an examination on principles of evaluation and question formulation. The job of the a Board member is very demanding and not particularly rewarding, except in the satisfaction of knowing that one contributes to the quality of

medical care in the country. The Board, for those who are unaware of it, also investigates charges if gross negligence or malpractice or immorality lodged with the PRC. As for medical education, why, a whole series of seminars and workshops should be held so that the educational process can be upgraded and not be exclusively Flexner-based or PBL? Surely a marriage of the best features of both may be expected to improve the educational process. It appears that medical education in the Philippines, now struggling with the various forms of PBL and traditional curriculum, needs not only innovation but reformation. The country and its citizens deserve no less from educators and health care providers. The academe should work in concert with CHED, the Board of Medicine and other interested parties to achieve this goal. Unfortunately, the Board of Medicine is not represented in the CHED Technical Panel for Health Professions Education—the BOM member chosen and nominated by the PRC has not been appointed to this Panel. Similarly, the BOM has not been invited (it used to be before the change of the leadership at the APMC) to participate in the yearly conventions of the APMC. It seems now to prefer to work in isolation. Meanwhile, medical educators wade through this quagmire, guided or misguided by self-proclaimed gurus, hoping for the best.

A new medical act intended to replace the antiquated Medical Act of 1959 has been on the drawing board since 1999. The crafting of this new Act reached an advanced stage in Congress last year but since it was not finalized and passed in spite if numerous hearings, it must be introduced this year. We desperately need a new law, but even the last draft that was almost completed last year still contained imperfections.

Conclusion

The licensure process for physicians, medical education and the practice of medicine itself need to be upgraded. We should all work together, or we will sink together. In the meantime, all that the Board of Medicine can do is to ensure, with the resources available to it, that the licensure examination for physicians, to the extent possible, is valid, reliable, relevant and practical.

The Health Workforce of Today

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In any country, health is of utmost importance. One of the vital factors that affect the level of health is the disbursement of health services by health professionals. The Human Capital Theory states that the extent of human capital investments in individuals translates to the capabilities and productivity of human resources which can consequently determine the performance of the organization where the worker is employed in. As such, the Human Resources for Health in the Philippines aims to ensure the availability of different health personnel needed to deliver health services; train different health personnel; and deploy, utilize and maintain health personnel in a way that could achieve the goals of the health system. Mirroring today's health crisis, we face a national crisis of the health workforce. Issues on imbalances in overall numbers, skills or skills mix, as well as distribution have to be addressed.

Let us first look into the status of health in our country. It is often said that improvement of the health status of Filipinos is slower compared to our Asian neighbors. In 1970, the Filipinos had a life expectancy of 57 years. By 2001, our life expectancy had risen to 70 years. Infant mortality rate (IMR) in the Philippines had fallen, from 57 (per 1,000 live births) in 1990 to 29 in 2001. However, it had fallen at a slower rate compared again to our Asian neighbors. Under-five mortality rate fell from 80 per

1,000 live births in 1990 to 38 per 1,000 live births in 2001. The Millennium Development Goal for under 5 mortality targets a reduction by two-thirds by 2015. Our Maternal Mortality Rate (MMR) has barely improved compared to other Southeast Asian nations. From 190 per 100,000 live births in 1970, our MMR fell slightly to 170 per 100,000 in 1998. We have a long way to go to reach our goal of 52 per 100,000 by 2015, which is the target of the Millennium Development Goal. Our population growth averaged 2.7% through the 1970s, dropped to 2.3% in the 1980s and was measured at 2.1% for the decade 1990-2001. Our current Medium Term Philippine Development Plan has set a target of 1.9% population growth rate. Our total fertility rate (TFR) was at 7.0 in 1960, 4.4 in 1990 and 3.4 in 2001.

Clearly, we are behind most Southeast Asian countries in terms of these basic health determinants. In addition, we are experiencing a double burden of disease because of the high threat of infectious diseases and the increasing burden of degenerative diseases.

Using year 2000 data, a human resources for health workforce study was undertaken to project and forecast human resources for health needs in a 20 year period. Key planning assumptions include the following: a gradual reduction in acute and communicable diseases and increase in chronic diseases; faster growth to private sector than public sector; faster growth to health expenditures than to public health expenditures; faster growth to personnel expenditures than to non-personnel and capital expenditures; more emphasis to prevention and public health services than curative services; more emphasis to primary care than higher level care; more emphasis to ambula-

tory care than to in-patient care; more emphasis to the needs of rural population than to urban population, and gradual increase in the technical level of health personnel.

Demographic estimates and assumptions show that with an average annual percent change in population of 2.4, within a 20-year period, population increases by 67.82 percent. Further, urban and rural residency increases and decreases by 6 percent respectively. Economic changes also show that if gross domestic product is maintained at its current average annual percent change of 3.5 and per capita income at 1.1 percent. a sustainable average annual percent change in personnel expenditure can be sustained at 5.3 within the 20 year period.

It has been difficult to accurately establish the stock and distribution of health workers in the Philippines. The projections and forecasts are a result of information interwoven from Philippine human resources for health production patterns gathered form the Commission on Higher Education, Professional Regulation Commission, the Philippine Overseas Employment Authority, and the Department of Labor and Employment. Attempts to gather information and later, validation from the professional organizations and other stakeholders on human resources for health did not prosper simply because a database was not available or readily available. Moreover, only health professions regulated by PRC was inputted into the projection model.

Estimated production patterns in 2000 show that nurses are amongst the most numerous health worker category produced whereas occupational therapists and dietician/nutritionists have the smallest number. The estimated production trends are the

following:

- Nurses (5800/year) from 150 nursing colleges
- Midwives (2800/year) from 188 schools
- Physical Therapists (2400/year) from 60 PT colleges
- Doctors (2200/year) from 30 medical schools
- Medical Technologists (1900/year) from 40 MT colleges
- Pharmacists (1700/year) from 20 pharmacy colleges
- Dentist (1100/year) from 20 dental schools
- Dietician Nutritionists (400/year) from 60 DN colleges
- Occupational (400/year) from 15 OT colleges

(PRC, 2000, CHED, 2000)

Granting that key planning assumptions, demographic estimates, and economic changes are constant, it is projected that there will be shortages in human resources for health as seen below. It should be emphasized though that such data be verified and validated especially when assumptions and estimates change significantly over the 20 year period.

With regard to the medical profession, recent data reveal that the number of students interested in medicine has declined in the last few years despite the expanding population of the country. The total freshmen quota of the thirty-six existing medical schools is over 5500. The number of National Medical Admission Test or NMAT takers for school year 2004 - 2005 was 4351, a big proportion scored below the 45th percentile (which was the suggested cut-off) of whom close to 2500 have been enrolled as first year medical students.

The records show that as of 2003, there is a cumulative

number of 101,489 doctors registered with the PRC, who graduated from 36 accredited medical schools. Twelve percent opt to serve in the government sector; 60 percent in the private sector, while 28 percent leave the country. Of those serving in the government sector, 74 percent prefer hospital practice while the 26 percent go to the local government units for community practice.

We experience a certain degree of maldistribution of doctors in different parts of the country - with most preferring to enjoy training and employment in Metro Manila and other urban centers and lesser number of physicians going to the provinces and far-flung communities. The current ratio of doctor to population is one doctor per 9,727 people as against a 1974 study by the World Health Organization recommended ratio of 1 doctor to 20,000 population, for the Philippine health system.

One grave problem in the health system is the increasing physician migration in the last five years. More recent outflows are disturbing because our doctors are training to become nurses so they can leave the country. Medical practitioners becoming nurses come from all kinds of specialties. Their age ranges from 25 to 72 years old. Years of practice as physicians range from zero to 35 years. In June 2004, 3.5% or 458 of 13000 nursing board examinees were doctors; in December 2004, there were 10% or 1,183 doctors from 12,000 nursing board examinees. Since year 2000, over 4000 Filipino doctors left our country as nurses. In December 2003, 515 more took and passed the ICNLE.

Doctors in droves trying to earn their nursing caps and diploma for abroad are not surprising since new MDs receive only

slightly more than $200 per month. For some, the opportunity to immigrate is a plus factor.

Actions must be pursued over a certain period for human resources for health and implemented through action alliances. Policies for human resources for health development calls for a more assertive compliance to the Magna Carta for health workers; changes in the curriculum that is multi-track, step ladder continuum, integrates career pathways, interfaces services with training, flexible to regional and local requirements; rationalization of the number of science schools and the type and quality of health students; registration and licensing that could determine the acquisition of required competencies; career opportunities and attractive compensation and benefits. In the long haul, quality healthcare delivery is brought about by having the right person, with the right skills and attitude, at the right time, in the right place, with the right motivation and the right cost.

Location of Practice of Medical Graduates

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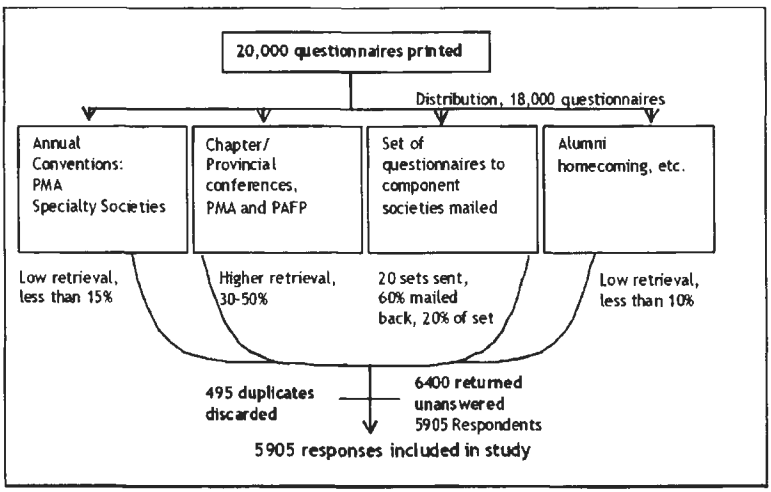
UP College of Medicine

A study was done to track medical graduates from 1947 to 1977. According to the report of the Health Human Resource Development in 1994, 50-70% of health professionals are in urban areas. Why is this so? There are several factors that may affect the choice of place of practice: lifestyle preference, working environment, need for professional growth, opportunities for medical advancement, proximity to relatives, family expectations, home area and financial considerations. The choice of what specialty to pursue on the other hand was affected by: personality, social relevance, good income prospects, family expectations, need for professional advancement and practicality.

To determine the training and practice profile of medical graduates, a study was conducted from 1999 to 2000. It aims to describe the demographic characteristics of medical graduates in the Philippines and to determine the reason for the choice of specialization and location of practice. The research method involved the administration of questionnaires to 20,000 physician respondents during the annual convention of the Philippine Medical Association (PMA) and the different specialty and component societies as well as to attendees in conferences conducted by chapters of the PMA and the Philippine Academy of Family Physicians. One of the problems encountered by the study is the absence of a comprehensive and accurate list of physicians who

are still in active practice in the country. Both the PMA and the PRC do not have an updated list.



There were a total of 5900 respondents who answered the questionnaire . The mean age of respondents was 42.4 years, 84% belonged to the age group of 26-55, 64% were women, 70.2% were married and 51.8% graduated from medical schools in Metropolitan Manila. In terms of location of practice, the regions with the highest percentage of respondent doctors were from the National Capital Region followed by Region IV and Region VI. The three autonomous regions, Cordillera, ARMM and CARAGA and regions II, VIII and XII were the regions with the least number of doctors.

Region	Frequency	Percentage	Rank
I	283	4.8	6
II	125	2.1	14
III	530	9.0	4
IV	718	12.2	2
V	178	3.0	10
VI	592	10.0	3
VII	255	4.3	8
VIII	134	2.3	12
IX	250	4.2	9
X	272	4.6	7
XI	411	7.0	5
XII	148	2.5	11
CAR	125	2.1	13
ARMM	37	0.6	16
CARAGA	96	1.6	15
NCR	1652	28.1	1
No Answer	97	1.6	
TOTAL	5905	100.0	

In terms of location of practice, 21.8% were in metropolitan cities. These include Cebu, NCR, Metro Cebu and Metro Davao. 21.8% were in rural areas and 9.8% were in the smaller cities with the rest with no answers. In terms of area of practice in relation to the area of origin, 82.7% of those who came from the rural area tend to practice in the rural area where they originated from. 53.5% of those who practice in metropolitan areas of NCR, Cebu and Davao did not come from these areas.

Distribution of respondents according to areas of practice as to development (rural-urban)

	Frequency	Percentage
t= 115.221 df= 4361 p= 0.0000		
Rural	1980	33.6
NCR, Metro Cebu, Metro Davao	1287	21.8
Urban	580	9.8
No Answer	2058	34.8
TOTAL	5905	100.0

What factors determine or affect the choice of place of practice? Based on the study, the most important factor is place of residence. Next is place of origin followed by family consideration and convenience. Those who stayed in the rural areas did so because it's their place of residence, it's convenient and also because of family considerations while those who stayed in the metropolitan area said it is because of residence and place of origin and income consideration.

Distribution of respondents according to reason for choice of area of practice

Reason	Frequency	Percentage
Residence	1601	27.1
Place of Origin	525	8.9
Family Consideration	472	8.1
Convenience	471	8.0
Income Consideration	436	7.4
Area of employment	320	5.4
Service	197	3.3
Demand for specialty	103	1.7
Access to hospital	68	1.2
No Answer	1712	29.0
Total	5905	100.0

Comparing males and females who stayed in rural areas, 26% of male respondents came from rural areas and practiced in rural areas whereas 44% of female respondents came from rural areas who also practiced in rural areas. On the other hand, those who stayed in metropolitan areas 26.7% of the male respondents did not originate from these (metropolitan) areas and 63.6% of female respondents practicing in metropolitan areas where likewise not from these same areas. I think this is expected in Philippine culture because usually females follow where the husbands come from.

In terms of specialization, 14.8 % were in Family Medicine, 11.8 % in Pediatrics, 11.2 % in Internal Medicine, 6.9 % in Surgery and 6.8 % in Obstetrics and Gynecology. The leading preferences for specialization for males were surgery, family medicine, internal medicine, pediatrics and anesthesia, while for females, the leading specialty was pediatrics, then family medicine, internal medicine, obstetrics and gynecology, and dermatology. 52.3% of the respondents were in private practice; 27.6% were in government. Based on focus group discussions conducted with some of the respondents, the location of undergraduate training and residency affected the choice for the location of practice. In terms of choice of specialty, the respondents indicated that if the specialty was pioneering in the area, then it is a good choice. Also, other factors considered were the needs of the area, return of investment and opportunities for growth.

The study, however, has certain limitations. It did not show who have permanently left the country. It also did not show the number of doctors who were working abroad. As far as sampling of respondents is concerned, the study did not involve randomization and did not include medical graduates who did not take the licensure examination. The study was also conducted during the time that doctors were not taking up nursing, unlike what is being seen now.

Specific recommendations can be made based on the results of these studies. There should be a mechanism for tracking all medical graduates in all medical schools, in terms of area of practice, reasons for choice of location of practice, choice of specialization and reasons for choice. Some medical schools are already currently implementing some form of tracking system of

their medical graduates. Since doctors who stay in the rural areas originated from the area, there should probably be a policy where all medical schools can allocate a certain percentage of their students to students from areas where doctors are needed the most. There should also be a policy limiting new medical schools only to areas which does not have one. A big number of the respondents did not have training for specialization but instead went into general practice after graduation.

In the light of the full implementation of the National Health Insurance Law, there is a need to strengthen primary care. We only have eight years for the full implementation of the National Health Insurance Law. There is a need to improve and enhance the capability of primary-care doctors in the primary-care facilities. In foreign countries, there is better patient satisfaction and better patient outcome if there are better trained doctors in the primary-care facilities. The following have been shown to provide better health outcomes and cost-effective care: equitable distribution and financing of health care; comparable of earnings of primary care physicians and specialists; comprehensive health care; provision of health care by primary care physicians and person-focused longitudinal care. There should be a body to oversee the training of primary care physicians, generalists and specialists ensuring that there is a correct mix, equitable deployment and assignment. Furthermore, development of medicine is very dynamic thus commitment to lifelong learning is an important ingredient in ensuring better quality of care.

There is also a need for the PRC to review its ruling on continuing professional education which was retracted. It used to require all doctors to submit evidence of continuing professional

education before they can renew their license. This is in line with fact that PhilHealth requires all health care providers to participate in quality improvement activities.

Based on data collected from the PRC, there are about 45,000 medical practitioners but only 25,000 are active. The highest number is in the NCR followed by Region IV. There is no accurate data on how many municipalities do not have doctors currently. In 1992 when the Doctors to the Barrios project was launched, there were 272 municipalities with no doctors.

PMA data (2000) and various specialty organizations
Based on record: 45,000, but only 25,000 are active members Region I: 1,053 NCR: 10,000 Region IV: 2,700 Region III: 2,090 PAFP: NCR: 1,998 Luzon: 2,072 Visayas: 1,500 Mindanao: 1,196

Distribution of physicians by specialty/ specialty organizations
Obstetrics and Gynecology Majority are in NCR, followed by Region IV, then Region III
Philippine College of Surgeons 480/ 902 are in NCR
Rehabilitation Medicine 50 / 77 are in NCR
Philippine Society of Anesthesiologists 920/ 1932 are in NCR; 168 /1932 are in Northwestern Luzon
Pathology 82/ 147 are in NCR
Philippine College of Radiology 395 / 690 are in NCR
Philippine College of Physicians 1353 /2299 are in NCR

What do these statistics say? Most of the training programs for residency are in the NCR and our findings tell us that most of doctors stay where they train. It would therefore be important that there will be residency training programs for the various specialties in other regions. The DOH has a network of medical centers that unfortunately, not all its training programs are accredited by the various specialty groups. We can have at least 4 specialties- obstetrics and gynecology, surgery, medicine and pediatrics accredited (in these medical centers) and this could improve the distribution of the various specialties.

In the past, medical graduates were required to practice in a community for 6 months prior to issuance of a license. This program continued up to 1986 after which it became voluntary. And in 1992, the DOH launched the Doctors to the Barrios. In this program, they were able to integrate 40% and out of those, only 20% were retained. Retention is really a problem when it comes to practice in rural areas. However, elsewhere, community service is still a requirement for doctors who practice like in other South-East Asian countries such as Thailand and Vietnam.

Excerpts from the Open Forum

Moderated by Academician Ernesto Domingo

On Population-Physician Ratio

From the floor: Are these not the statistics, the ratio and distribution available refer to BHWs depending on the country? (referring to the WHO recommendation on population-health professional ratio)...And is there a need for us to come up with our own ratio?

Dr. Ronquillo: Regarding the ratio and distribution of medical professionals, the WHO recommendation of one physician for every 20,000 population is very general. We have to consider other factors in the country like the archipelagic nature of our country and needs for human resources for health may be different depending on location. As such, we might need a different number of physicians in island municipalities or mountainous areas where health care is lacking and this means that even if the population is just 5,000, they may need at least one physician in the area.

The WHO does not encourage us to use the 1:20,000 ratio. Instead, they encourage us to use workload indicators for staffing need. These vary depending on the area and there is no one standard for the country. We can teach people on how to come up with these workload indicators and in fact, we have been advocating its use to the PHA. However, further studies have to be done because staffing needs of different municipalities vary widely.

Dr: Leopando: I think, when it comes to workforce indicators, we have to see to it that it's a good private and public sector mix. There may be maldistribution—some regions may lack certain specialties to answer the referrals of primary health care doctors. What I would like to suggest is that each region should come up with its own need.

I would like to impart to you our experience with San Miguel. We were able to achieve two of the three goals that we were after. The first goal that we targeted was to reduce mortality (mortality across regions are not necessarily the same). We identified the leading cause of death because again, in one region it may be infectious diseases in another it may be cardiovascular disease. The second goal we targeted was reducing hospitalization and we were able to do this using a problem-oriented approach. By doing so, this could be used as a performance measure of the specific region.

The Mindanao State University (MSU) Experience

Dr. Manalo: I would just like to show what so far has happened since we opened in 1984. We have graduated 314 medical students, 32 of which have just finished internship and is in the process of taking the Boards. Twenty-six are still in their internship program leaving us with 256 graduates. Of the remaining graduates, 249 have taken the boards, or 79% of our total graduates or 97% of our 256 graduates who are qualified to take the boards.

The total number of graduates who took and passed the boards was 244 out of 249 translating to a 98% passing average. Of those who failed, there were five of them or 2 percent) of

all who took the board exam) and there were 7 who never took the board examination. Therefore, these sum up to 2.73% of our 256 graduates.

We were in the traditional curriculum until 1994 and when we shifted to problem-based, we had 135 graduates, 133 of whom took the boards. Those who passed on their first take were 103 or 74.4%. Then on the second take of the Boards, of the 27 who failed in their first take and those who did not take the board exams 27 passed, or additional 20% of the previous passing rate. One had to take it three times so that by the end of the series (of board exam taking), with the traditional curriculum, 98.49% had already passed the boards.

On the other hand, with our problem-based curriculum, we have had 121 graduates, 116 of whom took the board exams. Seventy-nine (79) passed on the first take or 68%, compared with 77% passing rate with the traditional curriculum. Thirty-three passed on the second take, or an additional 28.44% to the previous passing rate. One had to take the board exams thrice and therefore, the passing rate for all those who took the board exams was 97.41%.

And I therefore think, that percentages should be done by the PRC (given these data), because eventually these medical graduates will pass the exams. Percentages should not be taken on a per-take basis alone.

With respect to location, of our total 256 graduates, 90 or 35.15% are in private practice. Of the 90, 39 or 43.33% are in their respective specialty practice. The remaining 51 are in gen-

eral practice. Sixty-four (64) or 71% of those in private practice are in Mindanao. And that is in line with our mission-vision. However, 18.88% have transferred to the Visayas and there are 7 who are in Luzon and 2 in Palawan even though Palawan is part of our coverage area (MINSUPALA).

We have 77 or 30% in government service. Forty-eight (48) or 62% of those in government service are in public health, mostly as MHOs and rural health physicians. There are some who are also in schools and academic institutions, majority of whom are with MSU and they are in our staff although they still hold private practice. Some are with other government agencies like PhilHealth.

With respect to those who are currently in their residency training, majority of whom are PBL graduates. The 64 PBL graduates who are currently in their residency training represent 25% of our graduates who took the exam. Most of them are in Mindanao: Davao Medical Center, in Northern Mindanao, which is their favorite. Some are in the Visayas: in Cebu—Vicente Sotto Hospital and other hospitals in Cebu. Some are in Luzon—in PGH, in Jose Reyes and East Avenue. Hopefully, as evidenced by previous groups (of graduates) they will come back to Mindanao.

Two of our graduates are in Ireland, one took care-giving the other nursing. One is in Australia, because the husband works as a nurse. One is in Guam. Another one who used to work as an MHO in San Miguel in Surigao, is in Japan through a scholarship doing research,. One is in New Zealand who moved together his family. One is in Singapore undergoing training. One who used to

be a government physician in Palawan until she was recruited by the UN for about two years is in Trinidad and Tobago, but she's coming back. And one is in the US. So, summing up, 4.68% are abroad. In addition, we also have 4 who are not practicing.

Dr. Poblete: More of a comment, probably, rather than a question. We are worried about the lack of manpower that we will be facing in the future. But we do observe that many of our applicants or many of our graduates eventually leave for abroad even in spite of, I mean when you interview them, them saying that they want to serve the country. In fact, it's been a joke by some of our faculty saying, yes they want to serve the people in the USA. And this is happening because parents look for a brighter future, as far as income is concerned.

The few that we have who also stayed in rural areas are eventually being pushed to leave for abroad. They usually are our scholars. So I think there is a need to see, to review, whichever it is, to find certain people who would like to go to medicine with the view that they should be staying in the country. I think that's part of the success of Dr. Manalo, that most of his students are scholars.

Dr. Domingo: Dr. Manalo, do you think that it's a question of scholarship? They are heavily subsidized (by the government).

Dr. Manalo: Yes. But now they have removed the MOE. Since the government removed the MOE for paying tertiary education, our school in fact is becoming student managed. They draw up the budget, they determine how much they are going to pay the following year. What was left with us are the salaries. And so far it

has been worthwhile for the past two years. I don't know if it will keep doing that. But they have established a strong student council that takes care of the MOE, capital outlay and even our building fund, because we cannot expect anything from the government anymore

Effect of the Devolution of the Health Care System

Dr. Ramirez: This devolution thing that came to upon us 10 years ago, how has it affected the delivery of health care in various areas in the Philippines, especially in the outlying areas and has it also affected the training of residence in the provinces?

Dr. Ronquillo: Before the devolution, there was a continuum of direction from the National to the periphery. In fact, it was from the secretary of health to the level of the midwife or even the barangay health workers. But with the devolution, there has been a fragmentation of health services. Starting from the provincial hospitals to the municipal hospitals, RHUs, barangay health stations, they are all under the local government. District hospitals are under the Office of the Governor and the health centers and barangay health stations are under the Office of the Mayor.

So how is the DOH addressing all these issues? One is improving the staff. We have various programs on that. The most popular of which is the Doctors to the Barrios Program. So, inasmuch as the objective of the Doctors to the Barrios Program before was to deploy doctors to where they are needed, we have now provided some continuing medical education units, but

these units were never formalized into a structure. Currently, we have expanded the program which we call the *Leaders for Health Program*. The Leaders for Health Program provides the doctor who is deployed in a doctor-less area the capacity to become a leader in health specifically in the area of systems development for health. But we do not train the doctor. We see to it that the doctor is an equivalent with other stakeholders in health in the municipality or area. It is a diploma course, a Masters in Community Health Development, which is provided by the Ateneo Graduate School of Business in Health. At the same time, diploma courses are also provided for the local chief executive. Therefore, the Mayor, who serves at the boss of the physician is also given the capacity to learn more about health, governing health and managing health in a system and with community leaders. This is a tri-leader system because we are not only addressing the needs of the doctors in developing health systems, and managing health in their areas but also the needs of the local chief executive as leader in health and the needs of community leaders.

There are also other deployment programs, like the Rural Help Placement Program. However, these programs are just temporary measures in addressing the needs of the municipalities. We still have to come up with a more structured mechanism or a scheme wherein we can bring back the good relationship between the national and local governments in terms of health care delivery.

On Tracking Medical Graduates

Dr. Galvez: I'd like to share my experience at PLM. There is a

need for a timely and relevant statistics. Graduate tracking should be in place in every medical school. I admire what MSU has done and they may have done so because of the relatively small population they have. But for a school like ours, we are really having a hard time tracking our graduates though we've graduated a little over 2,000 doctors.

In PLM, we have a payback system. We have not been successful for quite some time, but I guess in the last two years, we have been improving. What we'd like to get are statistics from the PRC or maybe give us the flexibility to apply for our students for the board exams. That way, this will help track our graduates down, hold them back so that they can serve back the City of Manila. At present, our mission-vision is not just to serve the City of Manila—we also share our products to the country. If we have a good tracking system and if don't have the help of other agencies like the PRC to allow us to control where our students are going, then it would really give us problems. My point here is that the redesigning of medical education should go back to the hands of the medical school. Quality would also mean being able to assess the lack of doctors not just in the real of your jurisdiction but also elsewhere in the country. We have actually requested the PRC to help us with some form of control, not to allow any graduate to apply (for the board exam) unless there is an okay from the college. But they have not responded to this.

From the PRC: Unfortunately, currently, the law only requires a couple of things for a graduate of a medical school to apply for the licensure exam. One is the diploma, which attests to the fact that he or she has completed the medical course and, number two, is the transcript of records to show, for a fact, that he com-

plied with requirements of the graduation process. So, having those two in hand (currently, the APMC is also involved in the dispensing certificates to show that the candidate has finished the internship program), they cannot be prevented from applying to take the licensure exam.

When a new PRC bill was introduced in Congress and eventually became a law, it was supposed to contain a provision not just on CME because that is just for medicine but on continuing professional education as well, which means a certain number of units would be required before anyone could renew their registration or license. We believe that there mechanisms that will allow the PRC and the Board of Medicine to reinstitute a requirement for CPE one of which is a resolution mandating the CPE requirement that a certain number of units per year (have to be earned) before licensure can be reviewed. And the best mechanism would be for the President of the Philippine to issue a presidential decree.

On Student Selection

From the PRC: How many still put a premium on admitting students who, to your evaluation process, has a good chance of staying is better—in the country? And what is your device for detecting people like these?

Dr. Manalo: I think the biggest and strongest (factor) is the community-based immersion. Because this quotient conscienticizes them and they become advocates, especially of the poor.

In the selection process, we put a large weight on the interview. We consider three points in our admission process: the NMAT, the GPA and the interview. They are all equal, 33% each. This is essentially similar to the instrument I devised when I was regionalization liaison officer for UP. We consider their (applicants) experience in their own respective areas, family background, how committed the family is in the area. And we actually have bias for the poor—the poor is selected over the rich because we feel that well-off students can easily go to any medical school they want.

We have a student interviewer. Our interview is conducted by four people: 2 faculty members, one from the basic sciences and one from the clinical sciences; one from family medicine; and one fourth year student. The applicant rotates among them. It's not a panel type of interview and they are graded or ranked and then we average the grades.

Dean Poblete: I guess for most medical schools, you don't really have to screen in terms of who is going to stay or not because most of them (medical schools) have a quota beyond the picked applicants. That is why, like in our case, our quota is 250, but we have less than a hundred. So, I mean, anybody who wants to come in who would like to (study medicine) and who would qualify will be accepted.

On doctors shifting to nursing

Lyn Resurrecion: Regarding the new nursing phenomenon, have we quantified the number of doctors who have shifted to Nursing? How many of them (doctors) have shifted or transferred to

the other field?

Dr. San Luis: I don't have the numbers of those who are going to nursing but I know the implication of that. I was in touch with one of the students who is doing his masters degree. He had quantified the cost of a physician transferring to another field—how much we lose in terms of that. And it has been quantified to be about 800,000 pesos per doctor who had transferred to nursing. And that is only in terms of the tuition fees that the doctor had paid and the training that he had undergone. Obviously, the cost will rise higher if this physician is already at the consultant level.

From the floor: With regard to doctors going into nursing, I think they can be classified as a hidden population. It is not going to be easy for us to really determine whether one is moving into nursing or not because there are foreign hospitals that get nurses, doctor-nurses who have not yet passed the board examinations. So it's going to be an underestimation.

I think I agree with the need to consolidate our efforts to be able to determine this (number of doctors shifting into nursing), because if a single agency would just be doing this, the results would be probably an underestimation.

With regard to the screening in determining whether our applicants are willing to stay or not, I think most of us, would really have a good reason to put the best foot forward during application. I don't think it's enough that we assess our students based on the screening process—it's a nurturing process. We need to be conscious of that. While they are in their formative years, we

have to inculcate the importance of staying in the country, and to put some force into it.

From the Floor: I have a different perception of doctors shifting to nursing or doctors going out (of the country). This is the answer to our unemployment problem. We should have the government solve the unemployment problem.

My second point is that this is also the answer to our values-you will recall that there is an issue on values, national values. Our doctors who are going abroad or any Filipino going abroad can get correct values or he can be oriented to the values abroad, and they can transmit them (back to the country). And my third point is that we all know, because of our cultural heritage, they will send money back—the economy of the country will improve. So I don't see any reason why we should prevent (doctors leaving for abroad).

Closing Remarks

Catherine Castañeda, PhD
Director, Office of Programs and Standards
Commission on Higher Education

Good afternoon. Let me settle some issues raised in the entire discussion: First, on autonomous and deregulated schools, they are free to open, practically everything that they would like to get into. This includes freedom to open distance learning programs and freedom to also to increase their tuition fee. The only difference between deregulated and autonomous (schools) is that the former has to pass through the Commission on Higher Education. But both enjoy similar benefits.

Second, we have made many schools autonomous and deregulated and now, we take the risk of not monitoring quality and excellence. But we believe in the medical profession and this is one area we would like to work for greater autonomy. We would like to have minimum supervision in the medical and law fields because other fields have so many problems. For example, there are 305 nursing schools and 200 applied this year. We only approved 25, but for some reason, it went to more than 60. We have set the deadline for nursing schools to comply with all the requirements, by September. Such that, if we find out that these schools do not have a base hospital, then we have to close them.

Third, CHED recognizes PBL as a good approach to medical

education but it is the position of the commission that we are not ready for it. However, the Commission cannot stop schools from using PBL, especially if the school is autonomous and deregulated. We have completed a survey of autonomous and deregulated schools and we have noted that there have been many new programs created by these schools and we have become wary because there are some schools that have actually been downgraded.

We in the Commission implement what you would like to happen. We do not have a say on the technical content of the different professions. As for recommendations, we elevate these to the Commission en banc for decision. Soon, there may be a moratorium on the opening of medical schools as there is, presently a moratorium on nursing schools.

On behalf of Bro. Rolando Dizon, the Commission would like to thank everyone. This is a type of dialogue that we need. And I think, other professions should also have this type of discussions. Thank you very much.

Summary of the Open Forum

Academician Ernesto O. Domingo, MD
Chair, Health Sciences Division-NAST
Moderator

Jaime C. Montoya, MD
Infectious Diseases Unit
UP-Philippine General Hospital
Rapporteur

1. The ideal physician : population ratio of 1: 20,000 is based on the 2000 data derived by the WHO. But we have to realize that this ratio will vary depending on the country's geography. For example, an archipelago like the Philippines, an island with 5,000 inhabitants may require a doctor. The WHO recommends that for countries like the Philippines, the parameter that we should use is the workload indicator which will vary from area to area. There is a need, therefore, for a Philippine study to determine the required physician : patient ratio for the country based on workload indicators.

The NAST should embark on a scientific study to determine the workload indicators in the health sector in the Philippines so as to identify the ideal physician : population ratio for an island archipelago like the Philippines. This information will serve as the basis for implementing human resource retention strategy to address the problem of migration of health care workers.

2. There is also a need to evaluate the impact of devolution on the delivery of health care services. According to Dr. Kenneth Ronquillo, there has been a fragmentation of health services.

The DOH supervises only tertiary hospitals that include medical centers and regional hospitals. From the level of the provincial hospitals to municipal hospitals, RHUs and the barangay health stations; these are all under the local government. Provincial hospitals are under the office of the governor while the rest (of the hospitals) are under the municipal mayors.

To counteract the loss in administrative powers of the DOH, programs such as the "Doctors to the Barrios Program" and the "Leaders for Health Program" were instituted. The latter provides a doctor who is deployed in a doctorless area the capacity to become a leader in health and most specifically in systems development for health. This diploma course is being provided by the Ateneo Graduate School of Business in Health. The diploma may lead to a Masters in Community Health Development. Diploma courses and certificate courses are also offered to the local chief executives. There are also deployment programs like the Rural Health Placement Program. But these are all temporary measures in addressing the needs of the municipalities.

The DOH, in cooperation with the private sector, should further strengthen these programs to incentivize and motivate health care workers serving in government, particulary those in far-flung and underserved areas. There is also a need to develop and implement a more structured and efficient health delivery mechanism that is equally shared by the national and local governments.

3. There is a need to develop better and more reliable ways of determining who among the applicants to medical schools will most likely to stay in the country after graduation. Based on the

MSU experience, getting graduates from underservedcommunities and students from lower economic strata are associated with higher retention rates. Community immersion as an integral and important part of the medical curriculum has also been associated with higher retention rates of students. This is attributed to making the students more socially aware of community needs and existing realities and the critical role that they will play (in the community).

4. Adoption of a regionalization program by medical schools that will help identify graduates who can best serve the most underserved areas in the country. This will involve getting students from the underserved areas who apply on their own or are recommended by the local government unit. They are given full benefits of medical scholarship and upon graduation, they return to the region where they will serve.

5. There is a need for medical schools to develop a tracking mechanism for their graduates: where they will eventually practice after graduation and training. This will provide critical data to the medical school as to retention rates of medical graduates and possible measures to address maldistribution.

6. There is a need to reinstitute a return of service scheme particularly for graduates of state universities and colleges. This will also help reduce the loss of medical graduates to foreign lands.

7. There is a need to reinstitute the CME unit requirements for physician renewal of licenses through a resolution by the PRC at the minimum or a Presidential Decree.

Resolutions

Roundtable Discussion on the Current Status of the Medical Education in the Philippines
National Academy of Science and Technology

Resolved as it is hereby resolved that the National Academy of Science and Technology submit the following recommendations to the agencies involved:

1. Improve the quality of medical education:

   1.1 Conduct seminars and workshops on the reformation of the medical curriculum to focus on the best features of both innovative and traditional curriculum

   1.2 Revive a national cut-off score in the National Medical Admission Test (NMAT)

   1.3 Implement the freshman admission quota for each medical school

   1.4 Suspend the issuance of permits for the opening of new Doctor of Medicine (MD) Programs

   1.5 Require faculty to attend medical education seminars prior to the grant of tenure

   1.6 A medical school dean should preferably have a health professions education degree (MHPEd) or any equivalent masters degree

   1.7 The curriculum chair must preferably have an MHPEd or education degree or at least 18 units of curriculum design.

   1.8 Request the University of the Philippines and other capable Universities to offer a distance course in Master

of Health Professions Education (MHPEd) for medical school faculty

1.9 Require medical schools to have its own base teaching hospital accredited by the Association of Philippine Medical Colleges (APMC)

1.10 Encourage all medical schools to apply for voluntary accreditation by the Federation of Accrediting Agencies of the Philippines (FAAP) and the Philippine Accrediting Agencies of Schools, Colleges and Universities (PAASCU).

1.11 The CHED and the APMC shall monitor and assist in the improvement of the academic programs of low performing medical schools in the licensure examination.

1.12 Medical schools with percentage passing below the national passing rate shall institute remedial measures like the opening of tutorial, remedial and formal review classes.

2. Improve the quality of the licensure examination

2.1 Amend the Medical Act of 1959 to include:

a. Revised qualifications for membership in the Board of Medicine

- Academic experience with clinical practice
- For pure academicians: involvement in teacher training
- Require an age limit

b. Provisions for organ system integration of curricular offerings and subjects for licensure examination

c. Provisions for the congruence of medical education and the licensure examination

2.2 The licensure examination must be guided by commonly agreed terminal competencies of medical educa-

tion.

2.3 Prepare better written tests by

a. Using a test blueprint for each subject

b. Improving test questions construction

c. Include more application (problem-solving) and comprehension questions compared to recall

d. Provide larger pool of questions to improve randomization

e. Improve the encoding and computer selection of questions

2.4 The examination should test the competencies of a general, basic or primary physician rather than those of a specialist.

2.5 Install the appropriate technology to upgrade examination items.

3. Issues on Health Services

3.1 Increase the compensation and incentives for government and privately employed physicians.

3.2 Create a National Body to study Health Human Resource Development (number and distribution of doctors)

3.3 Medical, nursing and other health professional schools shall be encouraged and given incentives to conduct highly visible community health programs particularly in areas where there is a lack of health care professionals.

3.4 Improve the hostile environment in the practice of medicine, e.g. malpractice bill, malpractice insurance, HMO rates, BIR coverage and PhilHealth coverage.

4. Meeting the Nursing Phenomenon

4.1 There should be a multi-sectoral, multi-agency National Coordinating Body to draft and implement a national policy on this issue.

4.2 Bilateral dialogues and agreements should be drafted between the Philippines and countries importing nurses and other Filipino health professionals in order to rationalize departure regulations and implement ethical recruitment policies for foreign countries.

5. Increase enrollment in medical schools and residency programs

The commission on Higher Education (CHED), Association of Philippine Medical Colleges (APMC), Philippine Hospital Association (PHA), Department of Health (DOH) and the Philippine Medical Association (PMA) should develop a program of attraction for young students to enroll in medicine and for medical graduates to train in the specialties (residency ahd fellowship programs). This shall include measures like:

a. Shorten the medical curriculum

b. Student loan (study now, pay later), network with banks/ funding agencies for support

c. Relax the limitations (quota and visa requirements) for prospective foreign medical students.

The Editors

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APPENDIX

Freshmen Quota, Medical Schools
CHED Memorandum Orders:
No. 36 Series of 2001
No. 02 Series of 2004
No. 01 Series of 2005

Freshmen Quota and Enrollment, Medical Schools

1995-96, 2001-02 and 2004-2005

	Quota	1995-1996	2001-2002	2004-2005
NCR				
UP		167	167	160
UST	410	430	421	440
MCU	210	219	148	54
FEU	360	332	379	248
UERM	360	205	309	200
PLM	160	183	160	135
SLCM	120	129	128	76
CAR				
SLU	160	121	112	64
Region 1				
LN	160	36	57	19
VMUF	160	62	68	24
Region II				
CSU	80	21	33	19
Region III				
AUF	150	78	72	30
Region IV				
DLSU	200	274	257	117
Region V				
BCCM	160	32	25	19
Region VI				
WVSU	160	86	99	100
IDCM	160	92	78	20
Region VII				
CIM	260	99	118	77
SWU	210	117	138	78
CDCM	200	131	120	99
UV	160	66	80	40
Region VIII				
RTR	80	50	73	30
Region IX				
ZMSF	80	25	30	33
Region X				
XU	100	47	55	63
Region XI				
DMSF	160	100	88	100
Region XII				
MSU	80	36	42	54

CHED Memorandum Order No. 36 Series Of 2001

Republic of the Philippines
OFFICE OF THE PRESIDENT
COMMISSION ON HIGHER EDUCATION

CHED MEMORANDUM ORDER (CMO)
No. 36
Series of 2001

SUBJECT: UPDATED POLICIES AND STANDARDS FOR MEDICAL EDUCATION

In accordance with the pertinent provisions of Republic Act No. 7722, otherwise known as the "Higher Education Act of 1994", all Presidents/Heads of Higher Education Institutions (HEIs) concerned are hereby directed to comply with the following "Updated Policies and Standards for Medical Education."

ARTICLE I
AUTHORIZATION

SECTION 1. Only schools, colleges and universities, duly authorized by the Commission on Higher Education shall be allowed to operate medical education programs.

SECTION 2. All curricular programs in medical education must have proper authorization from the Commission on Higher Education prior to the offering of such programs.

ARTICLE II
MISSION STATEMENT

SECTION 1. The main purpose of basic medical education is to produce physicians and thereby satisfy the health human resource needs of the country.

It shall:

1) provide students with the knowledge, skills, and attitudes in consonance with the concept of a primary care physician;
2) prepare medical students for post-graduate study, research, teaching and specialty training;
3) inculcate in the students an appreciation of the use of community and indigenous resources to promote health;
4) promote the integration of health services into the training of medical students; and

5) develop in the students such habits and attitudes that will enable them to engage in lifetime continuing medical education responsive to changing needs and developments.

The graduate shall, furthermore, be capable of embracing on further training in any field of medicine, including research, teaching, community development and administration.

ARTICLE III
ORGANIZATION/ADMINISTRATION

SECTION 1. The program in medical education leading to the Doctor of Medicine (M.D.) degree shall be conducted in an environment that fosters intellectual challenge and spirit of inquiry as characterized by the community of scholars that constitutes a college/university. A medical school and its teaching hospital shall be incorporated as one under the Corporation Code, as a non-stock, non-profit corporation. When the school does not own its training hospital, it shall be required to enter into an affiliation arrangement with an accredited hospital in the same geographic area and shall be responsible for planning, controlling and monitoring/evaluation of the activities of its students therein.

SECTION 2. A medical school shall be governed by its Board of Trustees/Regents in accordance with its incorporation papers.

SECTION 3. The functions of the Board of Trustees/Regents in addition to those provided by law are:

a) to set the policies for the medical school and teaching hospital;
b) to approve the budget for the medical school and its teaching hospital as submitted by the President/Chief Executive Officer (CEO) upon the recommendation of the Dean;
c) to confirm the appointment or separation of administrative personnel and faculty members submitted by the President/CEO, upon the recommendation of the Dean;
d) to approve the rules and regulation of the medical school and its teaching hospital as proposed by the President and the Dean; and
e) to insure the viability of the medical school.

SECTION 4. The medical school shall be under the immediate administration and supervision of a Dean, who acts as its Chief Academic Officer and who, by training and experience, is capable to interpret the prevailing standards in medical education and possesses sufficient authority to implement them.

SECTION 5. The qualities and qualification of the Dean:

a) must be a licensed doctor of medicine with a minimum teaching experience of five (5) years in a college of medicine and holds at least the rank of Assistant Professor;

b) must have leadership qualities;
c) must have experience in administrative positions; and
d) must possess professional standing commensurate with the position.

SECTION 6. The duties and responsibilities of the Dean:

a) to prepare and recommend the annual budget of the school for the consideration of the Board of Trustees;
b) to recommend the appointment of the medical and teaching personnel of the medical school and its teaching hospital;
c) to supervise the admission of students as recommended by the committee on admission which screens applicants based on criteria proposed by the faculty and approved by the Board of Trustees/Regents;
d) to periodically review the curriculum and make the necessary recommendations for its improvement;
e) to plan the organizational structure of the college of medicine and to recommend the appointment of the secretary of medical school and the other assistance that may be deemed needed for the consideration of the Board of Trustees;
f) to approve assignments of the faculty members as recommended by the corresponding department heads/chairpersons;
g) to recommend disciplinary actions on erring faculty members and other school personnel after observing the due process required by law;
h) to promote faculty development;
i) to initiate, upgrade and promote research, upgrade library and laboratory facilities;
j) to establish scholarships and professorial chairs; and
k) to secure/obtain endowments/grants and the like, for research and/or educational purposes.

SECTION 7. The Dean shall be appointed by the Board of Trustees/Regents or by the President/CEO of the college/university.

SECTION 8. The tenure of the Dean shall be determined by the Board of Trustees/Regents.

Academic Organization

SECTION 9. The President/CEO shall recommend to the Board of Trustees/Regents the organization of academic units which shall serve as the academic structure necessary to attain the aims of medical education.

SECTION 10. The Unit Head or Department Chairman shall hold the rank of at least Assistant Professor and shall have the following duties and responsibilities:
a) to supervise all activities in the unit/department;

b) to organize the unit/department towards the attainment of the objectives of medical education in accordance with the policies set by the Board of Trustees/Regents;
c) to evaluate and select the staff of the unit/department and recommend their appointment/promotion/separation to the Dean based on set criteria;
d) to prepare the budget for the unit/department for recommendation to the Dean;
e) to review periodically or upgrade the curriculum as well as teaching methods and evaluation techniques; and
f) to encourage the faculty staff to participate in research activities.

Heads of clinical units/departments shall have the following additional responsibilities:

g) to head the corresponding clinical department/services in its own teaching/affiliated hospital;
h) to supervise the staff and student activities in the corresponding services of affiliated hospitals; and
i) to develop and maintain an accredited residency training program.

ARTICLE IV
FACULTY

SECTION 1. The medical school shall have a component teaching staff. Appointment to the faculty shall be based on academic and professional qualifications, teaching ability and/or research potentials.

For the authority to operate, a medical school shall submit a list of qualified faculty members in subjects they intend to teach.

SECTION 2. Nominations of faculty appointments shall originate from the concerned unit/department head and submitted to the Dean. The Dean subsequently transmits the necessary recommendation together with the proposed designation or rank of appointee to the appointing authority. In the absence of duly constituted departments, the Dean will nominate and directly recommend faculty members for appointment.

SECTION 3. Recommendations for promotion of faculty members shall be based on : teaching ability, research productivity, academic and professional development/potentials, dedication/commitment to duty and responsibility, abiding interest in work, moral integrity and good personal character and conduct, and peer acceptance.

SECTION 4. Each faculty member shall enjoy academic freedom within the purview of institutional policies and other rights and privileges granted by law.

SECTION 5. The academic ranks and their corresponding minimum qualifications, in addition to existing rules and regulations of the institution, specifically, on pedagogic skill, are as follows:

a) Instructor - A licensed Doctor of Medicine or a graduate of a relevant or related discipline with at least a Master's Degree;
b) Assistant Professor - At least three (3) years successful tenure as Instructor;
c) Associate Professor - At least three (3) years successful tenure as Assistant Professor or an equivalent training and experience and must be a co-author of at least one publication in a peer reviewed scientific journal.
d) Full Professor - At least three (3) years successful tenure as Associate Professor or an equivalent training and experience, and must have shown outstanding achievement in scholastic and research as evidence by being author of at least three (3) scientific papers published in a peer reviewed scientific journal or book.

SECTION 6. The appointment of faculty member at any level of the academic ranks may be made without passing through antecedent ranks if warranted/ justified by the applicant's training, productivity including research publications, demonstrated ability, maturity or eminence in the particular field or study without violating existing college/university regulations.

SECTION 7. Each Department shall have a chairman/head and a complement of faculty members necessary to effectively implement the curriculum. In general, the faculty-student ratio (total full time and part time-total student enrolment) is 1:4.

SECTION 8. The definition of full-time faculty shall be left to the institution; provided however, that a minimum of twenty (20) hours per week, including administrative functions is regularly rendered. At least one faculty member shall be full-time in each department.

A faculty member who teaches or occupies regular positions as full-time in more than two (2) medical schools shall not be allowed.

SECTION 9. The Dean and Assistant Dean, shall confine themselves to teaching and performing administrative function in their own medical school.

SECTION 10. Heads of departments/units shall not be allowed to hold administrative positions in any other education institution although they may be allowed to teach in the latter.

ARTICLE V
CURRICULUM

SECTION 1. The objectives of the undergraduate curriculum are:

a) To provide students with the core knowledge needed by a primary care physician to:
    1) promote the health of communities
    2) prevent onset of disease
    3) cure disease and/or mitigate its consequences
    4) utilize the broadest range of health interventions to achieve the foregoing
    5)

b) To develop in the students the following skills/attitudes:
    1) critical thinking and problem-solving skills
    2) decision-making and leadership ability
    3) communication and technical skills
    4) commitment for the life long self-learning and professional development
    5) desirable attitudes, moral values and ethical behavior including love of country, social responsibility, honesty, integrity and justice, and sensitivity to the world of the patient
    6) capability to use the holistic approach to patient care
    7) team spirit and ability to work with other health personnel and community workers

SECTION 2. The curriculum shall have the following characteristics:

a) competency-based and student-centered
b) promotes learning of principles and processes rather that mastery of facts
c) encourages self-directed learning
d) utilizes evidence-based medicine, promotes research and allows students to choose electives
e) allocates adequate time for both theory and practice

SECTION 3. The curriculum shall be at least four (4) years, the fourth year of which shall be a full clinical clerkship.

SECTION 4. The following disciplines shall be included in the curriculum:

a) Human Anatomy (including Gross and Microscopic Anatomy, and Developmental Anatomy)
b) Anesthesiology (including Pain Management)
c) Biochemistry, Molecular Biology, Genetics, and Nutrition
d) Legal and Forensic Medicine, Health Economics and Bioethics
e) Internal Medicine
f) Microbiology, Parasitology and Immunology
g) Neurosciences (basic and clinical)
h) Obstetrics-Gynecology (including Women's Health)
i) Ophthalmology and Otorhinolaryngology

j) Pathology (Clinical and Anatomic)
k) Pediatrics (including Child Protection)
l) Pharmacology and Therapeutics (including Alternative Medicine)
m) Physical Medicine and Rehabilitation
n) Human Physiology
o) Family and Community Medicine (including Preventive Medicine)
p) Behavioral Medicine (Psychiatry)
q) Radiological Sciences (including Imaging Modalities)
r) Surgery
s) Research and Clinical Epidemiology

SECTION 5. The teaching-learning activities shall be held in variety of appropriate settings. These shall include adequately lighted, ventilated and equipped classrooms and laboratories, ambulatory care clinics, hospital wards and other units., community and family settings, etc. Overcrowding in the classroom, laboratory and other venues for instruction, needless to say, is not conducive to learning, and must not be allowed. For practicum on the clinical departments and Community and Family Medicine, the setting shall be as similar as possible to actual intended future places of practice.

Medical Schools may affiliate with hospitals and health facilities/clinics accredited for undergraduate medical education by the Technical Committee for Medical Education.

SECTION 6. Clinical instructions shall be primarily case-based utilizing the problem solving approach and emphasizing direct patient care under the guidance of a preceptor.

SECTION 7. No rigid curriculum for accomplishing the aforesaid objectives can be prescribed. On the contrary, it is essential that there shall be a continuous study of the curriculum by the faculty and school administration with the introduction of modifications and new methods and materials to take proper cognizance of the advances in medical sciences and medical education including the changing pattern of medical practice. The existence of a functioning Curriculum Committee or its equivalent is highly desirable.

SECTION 8. In schools utilizing innovative teaching-learning strategies (e.g. PBI, IMC, etc.), the curriculum will cover as extensively as possible the whole field of medical knowledge as enumerated in Section 4 hereof.

ARTICLE VI
INSTRUCTIONAL STANDARDS

SECTION 1. The medical college shall maintain a high standard of instruction, utilizing a variety of appropriate instructional methods which contribute to the total effectiveness of medical students preparation for future professional practice.

SECTION 2. A system of supervision shall be instituted and implemented for the purpose of evaluating medical competence of students.

SECTION 3. The institution shall provide for a systematic plan of evaluation of student progress through a grading system that is consistent and congruent with the educational objectives set by the institution. Methods of formative and summative assessments including clinical examinations shall be developed and validated for this purpose.

The Institutional policies shall be made known for the medical students to serve as their guide in preparing for their courses. The grade or rating of a student in each course shall be fair and just and shall reflect proficiency in the subject based on reasonable rules and standards of the school.

SECTION 4. The school must implement its clinical training program in at least a secondary care hospital with a minimum capacity of 100 beds, and where the four (4) major clinical departments—Internal Medicine, pediatrics, Obstetrics and Gynecology and Surgery—functionally exist.

SECTION 5.

A. Traditional

For every 100 students, there must be at least one (1) full-time faculty member who must be specialty board certified in each of the four (4) major clinical departments.

For the various teaching-learning activities, the maximum faculty-student ratio is as follows:

Lectures - 1:100
Laboratory Sessions - 1:25
Small Group Discussions (SGD) - 1:15

B. PBL (Problem-Based Learning)

For a maximum of ten (10) students there must be at least one faculty facilitator.

SECTION 6. Clinical materials shall be provided by the out-patient services with a load of at least fifty (50) patients per day and in-patient services of one (1) occupied hospital bed per clinical clerk (4th year student) at any given time.

SECTION 7. To provide for more clinical materials, other duly accredited hospitals formally affiliated with the medical school may be utilized. However the clinical program in such affiliated hospitals must conform with the course objectives set forth by the medical school. Faculty members or clinical coordinators shall be assigned to supervise the clinical clerks.

SECTION 8. In Obstetrics, at least ten (10) maternity cases shall be followed through to delivery by each clinical clerk who must have actual charge of these cases under the supervision of a clinical preceptor.

SECTION 9. The medical school shall provide extension services for instruction of medical students in Community Medicine either independently or in cooperation with the Department of Health or other agencies.

SECTION 10. The medical school shall provide an adequate number of appropriate teaching facilities and equipment which are necessary to assure the attainment of its educational objectives.

ARTICLE VII
LIBRARY RESOURCES

SECTION 1. The medical school library shall have journals, textbooks, and other reference materials adequate to meet the curriculum and research needs of its students and faculty.

SECTION 2. Computer based reference systems shall be provided and Internet access shall be made available to students for at least a minimum of twenty (20) hours per semester.

ARTICLE VIII
RESEARCH

SECTION 1. The medical school shall actively engage in research activities which must be supported by the administration through funding, providing requisite facilities, special privileges and other benefits for the faculty such as reduced teaching load, protected time and/or their equivalent.

SECTION 2. The school shall inculcate in the students n attitude of inquiry and desire to test theory against scientific evidence.

SECTION 3. The school shall require the students to do research. The student research outputs shall be widely disseminated by means of publication and/or oral presentation. Faculty generated research must be submitted for publication in peer-reviewed local or international journals.

ARTICLE IX
ADMISSION REQUIREMENTS

SECTION 1. Students seeking admission to the medical education program must have the following qualifications:

a) holder of a bachelor's degree in the sciences or arts (AB/BS).
b) Must have taken the National Medical Admission Test (NMAT) and have obtained a score the percentile cut-off set by CHED as recommended by the Technical Panel for Medical Education on a yearly basis.

SECTION 2. The applicant shall submit the following documents on CHED:

a) birth certificate and certificates of good moral character from two (2) professors in college
b) official transcript or records showing completion of a degree course
c) for graduates of private schools, the transcript of records is validated by a Special Order from CHED while graduates of public schools, the diploma or certificates of graduation must be presented
d) Certified true copy of NMAT score

SECTION 3. On the basis of the foregoing documents, CHED will issue the appropriate certificate of eligibility for medicine (CEM) which the applicant shall submit to the medical schools which he/she is seeking admission.

SECTION 4. The medical schools shall admit only transfer students with certificate of honorable dismissal.

SECTION 5. The Commission through its Technical Panel of Medical Education shall set a freshman quota for each medical school based on its faculty resources and adequacy of teaching facilities available.

ARTICLE X
RESIDENCE AND UNIT REQUIREMENTS

SECTION 1. No degree shall be conferred upon a student unless the last two (2) curriculum years of the medicine course was taken in the college which is to confer the degree.

SECTION 2. Guidelines of pre-requisites shall be made part and parcel of the academic policies of the school. The rules on pre-requisite courses shall be strictly observed by medical institutions. No student shall be permitted to take up any subject until the pre-requisite courses are passed.

SECTION 3. No student shall be promoted to the next year level in case of an outstanding deficiency in the current year level. On a case to case basis and at the discretion of the Dean, a student who failed in a major subject may be given additional advanced minor loads, provided that the rules on pre-requisites are strictly observed.

SECTION 4. A student who fails in forty percent (40%) or more of the total annual academic load, in hours, at any year level shall be dismissed from the college. A

medical student who fails in the same subject/course twice at any year level shall be automatically dropped from the rolls.

Medical schools may, however, prescribe a more stringent policy on dismissal due to academic deficiency.

SECTION 5. New students shall be accepted only in the first semester of the academic year.

SECTION 6. If a student obtains a grade of "Incomplete," no credit shall be given for the subject unless such incomplete grade is satisfactorily removed within one (1) year from the date it was obtained. The incomplete grades removed within one year shall be recorded and submitted immediately on a supplementary form (Form IX).

ARTICLE XI
MISCELLANEOUS PROVISIONS

SECTION 1. CHED encourages innovation in medical education for relevance.

SECTION 2. As provided for in Batas Pambansa 232, otherwise known as the "Education Act of 1982", medical schools must release the diploma, transcript of records and all other credentials upon request of a student within thirty (30) days after completion of all requirements for graduation.

SECTION 3. The foregoing requirements/provisions in this "Updated Policies and Standards" shall serve as basis for determining existence of minimum standards which shall justify the issuance of a Certificate if Recognition.

ARTICLE XII
EFFECTIVITY

SECTION 1. This set of Policies and Standards for Medical Education shall take effect beginning school year 2001-2002.

SECTION 2. This Order supercedes all previous issuances concerning medical education which may be inconsistent or contradictory with any of the provision hereof.

Pasig City, Philippines, November 28, 2001

ESTER ALBANO-GARCIA
Chairperson

CHED Memorandum Order No. 2 Series of 2004

Republic of the Philippines
OFFICE OF THE PRESIDENT
COMMISSION ON HIGHER EDUCATION

CHED MEMORANDUM ORDER
No. 02
Series of 2004

To : All CHED Regional Directors
Presidents of State Universities and Colleges (SUCs)
Administrators of Local Government Colleges and Universities
Presidents of Private Higher Education Institutions

SUBJECT : **NEW PROCEDURES IN THE PROCESSING OF APPLICATIONS OF GOVERNMENT AUTHORITY TO OPERATE DOCTOR OFMEDICINE AND BACHELOR OF SCIENCE IN NURSING PROGRAMS**

In accordance with the pertinent provisions of Republic Act No. 7722, otherwise known as the "Higher Education Act of 1994" and by virtue of CHED en banc Resolution No. 492-2003 on the operation of medical and nursing programs, new procedures shall be implemented in the processing of applications of government authority to operate Doctor of Medicine (MD) and Bachelor of Science in Nursing (BSN) programs.

Studies conducted by the CHED Technical Committees for medical and Nursing Education and medical and nursing professional associations, show the following:

1. There is a proliferation of medical and nursing schools in the country.

2. Philippine Licensure Examination (PLE) administered by the Professional Regulations Commission (PRC) indicate the deterioration of the quality of medical and nursing education.

3. There is a dearth of qualified faculty, deans, and teaching hospitals which are important factors to be considered in the offering of medicine and nursing programs.

The issuance of government authority shall progress from: 1) permit to cover the offering of the 1st and 2nd year levels; 2) permit covering the offering up to the 3rd year level; and 3) recognition for the entire program. The issuance of the initial permit covering the 1st and 2nd year levels shall require full compliance of minimum standards for the first three years of the program. In the 2nd year of operation, application fro the 3rd year level

shall be made. For issuance of government recognition, full compliance of the minimum standards (100 percent) for the whole program is required.

All applications for government authority (Permit and Recognition) to operate MD and BSN programs shall be submitted to the CHED Regional Offices for preliminary evaluation. Preliminary evaluation by the CHEDRO shall include documentary analysis and ocular inspection by the Regional Quality Assessment Teams (RQATs). Only applications that are favorably recommended by the CHEDRO shall be forwarded to the Office of Programs and Standards through the Executive Office.

The OPS through the Technical Committees (TC) shall conduct the final evaluation of the applications. If favorably endorsed by the Technical Committees, the recommendation shall be submitted by the OPS through the Executive Office to the Commission en banc for final decision. The action taken by the Commission en banc with corresponding CHED Resolution shall be forwarded by the Executive Office to the CHEDRO for issuance of government authority if action is favorable. If not favorable, the HEI is informed by the CHEDRO of the disapproval.

These new procedures shall apply to all HEI including the autonomous and deregulated higher education institutions (HEIs). In the case of state universities and colleges (SUCs) and local universities and colleges (LUCs), the above procedure shall be followed prior to action by the governing board. The action of the CHED shall be recommendatory to the governing boards.

This CMO shall take effect beginning January 2004 and shall remain in force and effect until otherwise revoked or superseded.

Wide dissemination of this CMO is desired.

ROLANDO RAMOS DIZON
Chair

CHED Memorandum Order No. 01 Series of 2005

Republic of the Philippines
OFFICE OF THE PRESIDENET
COMMISSION ON HIGHER EDUCATION

CHED MEMORANDUM ORDER
No. 01
Series of 2005

Subject : **REVISED POLICIES AND GUIDELINES ON VOLUNTARY ACCREDITATION IN AID OF QUALITY AND EXCELLENCE IN HIGHER EDUCATION**

In accordance with the pertinent provisions of Republic Act (RA) No. 7722, otherwise, known as the "Higher Education Act of 1994" the Commission on Higher Education hereby promulgated the Revised Policies and Guidelines on Voluntary Accreditation in Aid of Quality and Excellence in Higher Education for the information and guidance of all concerned:

Article I
Statement of Policies

1. It is the declared policy of the State to encourage and assist, through the Commission on Higher Education (CHED), higher education institutions (HEIs) which desire to attain standards of quality over and above the minimum required by the State.

2. For this purpose, the CHED encourages the use of voluntary non-governmental accreditation systems in aid of the exercise of its regulatory functions. The CHED will promote a policy environment, which support the accreditation's non-governmental and voluntary character and protects the integrity of the accreditation process.

3. The CHED acknowledges the pioneering work and efforts of the accrediting agencies now federated under the Federation of Accrediting Agencies of the Philippines (FAAP), namely the Association of Christian Schools, Colleges and Universities Accrediting Agency, Inc. (ACSU-AAI), the Philippine Accrediting Association of Schools, Colleges and Universities (PAASCU), and the Philippine Association of Colleges and Universities Commission on Accreditation (PACU-COA).

4. Further, the CHED acknowledges the existence of the National Network of Quality Accrediting Agencies (NNQAA), now made up of Accrediting Agency of Chartered Colleges and Universities of the Philippines (AACCUP) and the Association of Local Colleges and Universities Commission on Accreditation (ALCUCOA).

5. The CHED shall authorize federations/networks of accrediting agencies which shall certify to CHED the accredited status of programs/institutions granted by their member accrediting agencies and in accordance with their own standards, as accepted by the CHED, for granting benefits to institutions/programs at various accredited levels, and as contained in Article No. V of this CHED Memorandum Order (CMO).

6. The CHED shall recognize one federation/network largely serving the public sector educational institutions and one for the private sector educational institutions, without restricting the freedom of any educational institution, public or private, to choose an accrediting agency for various educations programs which may belong to either federation/network.

7. The CHED demands responsibility and accountability from federations/ or networks for their certification of the quality of education offered in accredited programs/ institutions.

Article II
Institutional and Program Accreditation

1. Accreditation is a process for assessing and upgrading the educational quality of higher education institutions and programs through self-evaluation and peer judgment. It leads to the grant of accredited status by an accrediting agency and provides public recognition and information on educational quality.

2. Program Accreditation refers to the evaluation of individual programs of a higher education institution.

3. Institutional Accreditation refers tot eh evaluation of a whole educational institution of which the guidelines and standards shall be formulated in collaboration with the existing federations/networks of accrediting agencies to be approved by CHED.

Article III
Federations/Networks of Accrediting Agencies

1. Accrediting agencies shall join either of the above-mentioned federations/networks; the federation/network must have procedures and guidelines in accepting accrediting agencies as members, following this CMO.

2. Federations/networks of accrediting agencies shall have the following functions:

    a. Accept and recognize its member accrediting agencies. The applicant accrediting agency must be required to have the following:

        - standards for accreditation which are adequately rigorous, competitive and reflect current acceptable practice;

- appropriate survey and assessment instruments and processes;
- effective mechanism for assessing compliance of programs/institutions with its own standards;
- policies and procedures for the grant, suspension or revocation of accredited status of programs/institutions, in accordance with the federation/network policies and procedures;

Furthermore, the accrediting agency shall submit required annual reports and documents to the federation/network.

b. Monitor the operations of member agencies, including their processes and procedures, and training and selection of accreditors;
c. Certify to CHED the accreditation status of programs/institutions accredited by its member agencies;
d. Assure the comparability of standards of member accrediting agencies;
e. Upgrade and update standards, procedures and criteria for accreditation;
f. Contribute to quality education through the enhancement and development of the accreditation movement;
g. Establish procedures for addressing complaints by higher education institutions regarding procedures and processes of accrediting agencies;
h. Maintain a valid and reliable data management and analysis system relating to their member accrediting agencies;
i. Submit annual reports to CHED on its operations, especially programs/ institutions accredited.

3. Federations/networks seeking CHED recognition should show evidence acceptable to CHED that they are able to undertake the functions as indicated in Article III, Section 2 of this CMO;

   a. Federations/networks seeking recognition shall submit application to CHED and should include the following:
      1. SEC Registration, Articles of Incorporation and approved By-Laws
      2. Listing of officers and members of the governing board
      3. Board resolution authorizing the submission of application for CHED recognition
      4. Short history of the organization and its works
      5. Listing of the member accrediting agencies
      6. Description of accreditation process as done by member agencies
      7. Full set of accreditation instruments used by its member agencies
      8. Sample self-evaluation reports and sample of Chairman's report of actual survey
      9. Description of training processes and procedures of accreditors of its member agencies
      10. If a network/federation is new and has not functioned yet, it should submit documentations to show CHED that it is able to do functions specified in Article III, Section 2

b. Within two (2) months from application and submission of all the required documents, CHED for valid reasons may grant provisional recognition to federation/network subject to annual review.

c. The federations/networks recognized by CHED shall be subject to periodic review every five years after recognition or as the need arises;

d. Federations/netorks found not conforming with the policies and guidelines of this CMO shall be required by CHED to comply within six (6) months after notification;

e. After due process is observed, CHED may limit, suspend or withdraw recognition of a federation/nework.

Article IV
Accreditation Levels for Program Accreditation

1. For purposes of receiving benefits, educational programs are classified as candidate and one of four (4) accredited levels.

   a. Candidate status: for programs which have undergone a preliminary survey visit and are certified by the federation/network as being capable of acquiring accredited status within two years;

   b. Level I accredited status: for programs which have been granted initial accreditation after a formal survey by the accrediting agency and duly certified by the accreditation federation/network, effective for a period of three years;

   c. Level II re-accredited status: for programs which have been re-accredited by the accrediting agency and duly certified by the accreditation federation/network, effective for a period of three or five years based on the appraisal of the accrediting agency;

   d. Level III re-accredited status: for programs which have been re-accredited and have met the additional criteria/guidelines set by the federation/ network for this level.

   Level III re-accredited undergraduate programs must satisfy the first two of the following criteria and two others of the succeeding ones:

   i. A reasonably high standard of instruction;

   ii. A highly visible community extension program. A description of the programs, the nature and extent of student, faculty and staff involvement, and other details shall be required documentation for this indicator;

iii. A highly visible research tradition. The following must be observable over a reasonable period of time:
- provision for a reasonable budget
- quality of completed outputs
- measurable result such as publication, etc.
- involvement of a significant number of faculty members
- visible, tangible and measurable impact on the community.

iv. A strong faculty development tradition evidenced by an appropriate budget allocation and/or systematic plan for faculty development programs.

v. A highly creditable performance of its graduates in licensure examinations over the last three years. (will apply only to those programs where such examinations are required)

vi. Existence of working consortia or linkages with other schools and/or agencies. Documentary evidence shall include a description of the nature, mechanism, working agreements and other details of consortia.

vii. Extensive and functional library and other learning resource facilities.

Level III accredited graduate programs must satisfy I and III and any two (2) of II, iv, v, vi and vii above.

The institutions should submit pictorial and documentary evidence to support its claims.

Only programs that have been granted "clean" re-accreditation, meaning that no progress report or interim visit is required within the five-year accreditation period, may apply for Level III status.

e. Level IV accredited status: accredited programs which are highly respected as very high quality academic programs in the Philippines and with prestige and authority comparable to similar programs in excellent foreign universities.

These programs must have met the following additional criteria/guidelines:

Excellent outcomes in -

- Research as seen in the number, scope and impact of scholarly publications in refereed national and international journals;
- Teaching and learning as proven in excellent performance of graduates and continuing assessment of student achievement;
- Community service and the impact of contributions to the economic and social upliftment, on both regional and national levels.
- Evidence of international linkages and consortia;

- Well developed planning processes which support quality assurance mechanisms.

HEIs should provide adequate documentation in support of application for Level IV accredited status.

Article V
Benefits for Program Accreditation

The following benefits for the different accreditation levels shall be provided:

A. For Private Sector Institutions:

a. Level I/Level II

i. Full administrative deregulation, provided that reports of promotion of students and lists of graduates are available for review by CHED at all times.

ii. Financial deregulation in terms of setting of tuition and other school fees and charges.

iii. Authority to revise the curriculum without CHED approval provided that CHED and Professional Regulation Commission minimum requirements and guidelines, where applicable, are compiled with and the revised curriculum is submitted to CHED Regional Offices.

iv. Authority to graduate students from accredited courses or programs of study in the levels accredited without prior approval of the CHED and without need for Special Orders.

v. Priority in the awards of grants/subsidies or funding assistance from CHED-Higher Education Development Fund (HEDF) for scholarships and faculty development, facilities improvement and other development programs.

vi. Right to use on its publications or advertisements the word "ACCREDITED" pursuant to CHED policies and rules.

vii. Limited visitation, inspection and/or supervision by CHED supervisory personnel or representatives.

b. Level III

i. All the benefits for Level I/II.

ii. Authority to offer new courses allied to existing Level III courses without need for prior approval, provided that the concerned CHED Regional Office (CHEDRO), is dully informed.

iii. Privilege to apply for authority to offer new graduate programs, open learning/distance education, extension classes and to participate in the transnational education.

c. Level IV

i. All the benefits for Levels 1, II and III.

ii. Grant of full autonomy for the program for the duration of its Level IV accredited status.

iii. Authority to offer new graduate programs allied to existing Level IV courses, open learning/distance education and extension classes without need for prior approval by CHED provided that the concerned CHEDRO is duly informed.

B. For Public Sector Institutions

a. Though public sectors institutions already possess most if not all of the benefits related to curricular and administrative deregulation granted to private sector institutions at various accreditation levels, accreditation level will be used by the CHED and Department of Budget and Management in recommending budgetary allocation for public sector institutions.

b. As for accredited private sector institutions, accredited public sector institutions shall also enjoy priority in terms of available funding assistance from CHED for scholarships and faculty development, facilities improvement and other development programs.

c. Right to use on its publications or advertisements the word "ACCREDITED" pursuant to CHED policies and rules.

Article VI
Transitory Provisions

1. Pursuant to the Article III, Section 3, FAAP, a recognized federation by CHED, shall submit to CHED documents on their existence, membership, procedures, accredited programs and summary on how the federation/network is able to do Article III, Section 2, Parts d, e, f, g, and h within three (3) months of the effectivity of this CMO for re-certification by CHED.

2. Likewise, pursuant to the Article III, Section 3, NNQAA, a network that has not been recognized by CHED, shall submit to CHED documents on their existence, membership, procedures, accredited programs and summary on how the federation/ network is able to do Article III, Section 2, Parts d, e, f, g, and h within three (3) months of the affectivity of this CMO for certification by CHED.

3. Accreditation levels recognized by CHED on the basis of certifications by federations/ networks under the previous CHED Order No. 31, s. 1995 shall remain in effect until their defined/prescribed expiration period.

4. All programs accredited by AAACUP as of the date of issuance of this CMO shall be deemed recognized by CHED upon submission of a list of such programs by AAACUP within thirty (30) days upon issuance of this CMO.

5. Programs accredited by AAACUP after the date of issuance of this CMO shall be recognized by CHED only after all requirements shall have been fulfilled as required by this CMO. AAACUP should therefore seed recognition from a recognized federation/network.

Article VII
Effectivity

This CMO supercedes CHED Order No. 31, s. 1995 and shall take effect immediately.

Pasig City, Philippines, February 15, 2005.

FR. ROLANDO V. DE LA ROSA, OP
Chairman

ABOUT NAST

The National Academy of Science and Technology (NAST) Philippines is the country's highest advisory body to the government and the science community on matters related to science and technology. It also has the mandate to recognize outstanding achievements in science and technology made by Filipino scientist in all fields of science.

VISION, MISSION AND MANDATE

The National Academy of Science and Technology Philippines, founded in 1976, continues to stand today with a firm resolve to faithfully pursue:

Its **VISION**: **A PROGRESSIVE PHILIPPINES ANCHORED ON SCIENCE**

Its **MISSION**:

1. To recognize exemplary science and technology achievements among the young and among peers
2. To encourage individual Academy members to continue their scholarly pursuits thereby making the Academy the principal reservoir of scientific and technological expertise in the nation
3. To provide independent and science-based advice on problems facing the nation and the world
4. To link with like-minded institutions and individuals in promoting scientific achievement in the Philippines and abroad
5. To promote a strong science culture in Philippine society

Its **MANDATE**:

1. To recognize outstanding achievements in science and technology as well as provide meaningful incentives to those engaged in scientific and technological researches (PD 1003-A).
2. To advise the President and the Cabinet on matters related to science and technology (EO 818).
3. To engage in projects and programs designed to recognize outstanding achievements in science and promote scientific productivity (EO 818).
4. To embark on programs traditionally expected of an academy of science (EO 818).

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