

Accreditation of medical education institutions

Report of a technical meeting

Schæffergården, Copenhagen, Denmark, 4–6 October 2004

WHO-WFME Task Force on Accreditation



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Contents

Introduction	1
WHO and WFME commitment to quality improvement of medical education.....	1
Status of accreditation: needs and uses	2
Viewpoints from the regions	2
Africa.....	2
Americas.....	3
Europe	4
Eastern Mediterranean.....	5
South-East Asia	8
Western Pacific.....	9
Accreditation/recognition systems: concepts and delineation	10
Presentation of established systems	10
Liaison Committee on Medical Education	10
Integration of WFME standards with national accreditation in Switzerland	11
Working groups – developing international guidelines for accreditation systems. Session I. Guiding principles	12
Accreditation/recognition systems: organization and procedures.....	13
The Australian/New Zealand experience	13
Working groups – developing international guidelines for accreditation systems. Session II. Procedures: foundations of an accreditation system	14
Values of accreditation/recognition systems	15
Significance for quality improvement of medical education.....	15
Significance for assessment of educational qualifications	16
Working groups – developing international guidelines for accreditation systems. Session III. Procedures (continued): decision-making in accreditation	16
Accreditation/recognition systems: the role of WHO and WFME	17
Accreditation/recognition systems: planning of WHO–WFME engagement: actions and organizations.....	18
Working groups – developing international guidelines for accreditation systems. Session IV. Organizational structure of an accreditation system	18
Conclusion: future directions of the WHO/WFME partnership	18

Introduction

In 2004, the World Health Organization (WHO) and the World Federation for Medical Education (WFME) established the international Task Force on Accreditation in Medical Education. In October 2004, 26 members from 23 countries covering all six WHO–WFME regions assembled for three days at a seminar in Copenhagen to discuss how WHO and WFME could contribute to the establishment of sustainable accreditation systems with the purpose of ensuring medical education of high quality.

WHO and WFME commitment to quality improvement of medical education

(The following is a summary of presentations by Hugo Mercer and Hans Karle.)

The World Health Organization's commitment to medical education is of long standing. It originates from the Organization's Constitution, adopted in 1948 when WHO came into being. Establishing international standards for the education and qualifications of the health workforce – and fostering improvement in the quality of education and qualifications – are integral to the Organization's mandate.

WHO's strategic partnership with the World Federation for Medical Education is based on a network of engaged partners with a long-term sharing of values and standards as the link between health professions education and health needs of the society. This meeting is the first activity of the WHO/WFME strategic partnership of 2004.

The World Federation for Medical Education, too, has a well-established history of involvement in improving the quality of medical education, marked by the International Collaborative Programme for the Reorientation of Medical Education of 1984, cornerstones of which were the Edinburgh Declaration of 1988 and the recommendations of the World Summit on Medical Education, Edinburgh, in 1993. The WFME Global Standards Programme in Medical Education for Better Health Care was launched in 1997; it covers basic (undergraduate) medical education, postgraduate medical education and continuing professional development (CPD) of physicians. Implementation of the programme is based on information, translation of standards and validation of standards in pilot studies, as well as institutional self-evaluation and peer review and an advisory function for WFME. Its imminent goal is incorporation of global standards in national standards and accreditation procedures and in the development of guidelines for accrediting agencies.

In the ongoing pilot study of global standards in institutional self-evaluation, 11 schools in eight countries had confirmed the value of the standards being tested. A further 24 schools had been brought into the study, for which information had been received for all but the final two schools.

The purpose of accreditation and quality improvement in medical education is to adjust medical education to changing conditions in the health care delivery system and to prepare doctors for the needs and expectations of society. Accreditation and quality improvement are expected to ensure training in the new information technologies in order to help doctors cope with the explosion in medical and scientific knowledge and technology, and inculcate in them the ability for lifelong learning.

Status of accreditation: needs and uses

Viewpoints from the regions¹

Africa

(The following is a summary of presentations by Akpa Gbary and J.P. de V van Niekerk.)

Africa has experienced a big increase in the number of private medical schools. Many African doctors migrate internationally; this situation is unlikely to change in the near future.

Health professions schools in Africa have an undeveloped culture of evaluation: although some have been evaluated by regional institutions such as the *Conférence Africaine des Doyens des Facultés de Médecine d'Expression Française*: African Conference of Deans of French-speaking Medical Schools (CADMEF), most have gone several decades without evaluation; the schools perceive no link between evaluation and educational reform. An evaluation of four nursing schools in 2004 found that although there was good clinical exposure, the quality and quantity of lecturers was inadequate and the infrastructure and equipment were obsolete.

It is believed that systematic external evaluation should be carried out at least every 10 years, with the assistance or direct participation of international organizations such as WHO and WFME and regional or subregional organizations such as CADMEF or the Association of Medical Schools in Africa (AMSA). The way forward is to build or strengthen partnerships; to increase awareness among countries and partners of the benefits of accreditation of health sciences training institutions; and to mobilize more resources for this core component of education and training.

The WHO African Region is largely sub-Saharan. The per capita income in middle-income African countries, such as Botswana and South Africa, is less than one tenth of that in developed countries, such as Australia, the United Kingdom and the United States of America; the per capita income in a more typical African country is perhaps one tenth of that in the middle-income countries, or less than one one-hundredth of the per capita income in the USA. The proportion of income spent on health is correspondingly low, yet Africa bears a massively disproportionate disease burden, particularly because of poverty, HIV/AIDS and trauma in young people. There are more than 100 medical schools in Africa, most of which were established after 1970.

Accreditation is a risk-reduction strategy; it is not an end in itself, but is more like a biopsy, which provides a diagnosis on the condition of the institution. The value of accreditation is that it provides for a process of improvement and development of the system. Standards and indicators must be identified, but achieving consensus on standards is the greatest challenge.

Furthermore, evaluation does not have to be an all-or-none process; it can be applied so as to enable all schools to be accredited, but at different levels. More time may then be spent helping those that are most in need of improvement.

¹ The regional designations used in this paper are those of WHO, which are also used by WFME. WHO Member States are grouped into six regions: Africa, the Americas, the Eastern Mediterranean, Europe, South-East Asia and the Western Pacific. These regions are organizational groups that, while they are based on geographical terms, are not synonymous with geographical areas. The WHO regions are not the same as those of the United Nations.

The WHO Regional Office for Africa has accepted WFME standards in principle, and intends to evaluate all the medical schools in Africa. It is expected to provide leadership in regional accreditation.

Comments

It was observed that the following represented opportunities to advocate accreditation: the conference of South African health science deans, to be held in Botswana in August 2005; the IAMRA (International Association of Medical Regulatory Authorities) meeting (harmonizing registration of health professionals); and in Malawi, an opportunity for persuasion with regard to medical education.

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Americas

(The following is a summary of presentations by Pablo Pulido and Emery A. Wilson.)

The current situation in Latin America and the Caribbean includes the following factors: medical education as a whole, including clinical research, must be improved; there is a lack of surveillance for quality; and health systems engender high costs (but of the 900 million people in Latin America, some 200 million live in poverty). In addition, there has been a proliferation of new medical schools in the last 35 years: in Argentina, Brazil, Colombia, Ecuador, Mexico, Peru and Venezuela, for example, the number of schools has increased from 98 in 1969 to 574 in 2004.

Medical schools in the Americas have looked to WFME and WHO for institutional standards. Leadership in establishing hemispheric standards has been provided by the Panamerican Federation of Associations of Medical Schools (PAFAMS) and by PAHO; regional or national standards have been provided by national associations of medical schools, the North American Free Trade Agreement (NAFTA), Mercosur and others.

The aim in the Americas is to improve the professionalism and quality of medical education and, as a consequence, improve the quality of health service delivery, through a pilot programme to measure the level of training and education given by the medical schools affiliated with PAFAMS; and to improve medical education and clinical research through a pilot programme and adaptation and application of the Global Minimum Essential Requirements (GMER), developed by the IIME Core Committee. Techniques in e-health and e-learning will be applied as widely as possible.

The strategies to achieve this will include alliances between institutions with similar interests; instituting institutional accreditation; work on professional certification and recertification of primary care physicians and specialists; and use of defined educational instruments with accreditation standards, in areas such as continuing medical education, continuing professional development, e-learning and distance and interactive learning.

Accreditation of medical schools has existed in Canada and the United States of America since Abraham Flexner's 1910 report, *Medical education in the United States and Canada*, to the Carnegie Foundation for the Advancement of Teaching. All 126 medical schools in the USA, and indeed all higher education institutions, are accredited – either by professional accrediting organizations or by regional entities.

Accreditation improves the quality of education and of health care; serves the interests of the public; ensures general competences in preparation for graduate medical education; establishes a foundation for lifelong learning; and indirectly limits the number and size of medical schools (by questioning whether adequate resources are available to open a school or teach more students). Medical schools look on it as a measure of quality; it is a source of pride for those schools with no areas of non-

compliance, and schools tend to go further than the standards, so that the standards stimulate innovation. Accreditation is the basis for quality assurance, and serves to reassure the public.

Comments

It was observed that contrary to responses to physician needs in other countries, the LCME accreditation process and standards are so well accepted that it is unlikely that standards would change if there were a shortage of physicians. In fact, there is now a projected shortage of physicians in the United States, and schools are planning to increase enrolment and new medical schools are being planned.

Many students now in residencies are US citizens who have been educated offshore – that is, in medical schools outside the United States. The number of such graduates and schools will likely increase. There is no difference in standards for the non-locally educated students. More medical students are desired; the schools see medical students as a revenue stream and as indicators of quality. It was noted that the site visits and standards have brought government attention to accreditation of education in general, not just medical education.

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Europe

(The following is a summary of presentations by Galina Perfilieva, Albert Oriol-Bosch and Mikhail A. Paltsev.)

There are 442 officially-recognized medical schools in Europe, although more schools exist, especially in eastern Europe. The curricula of these schools were approved by local bodies, such as rectorates. In western Europe, medical schools in the 25 countries of the European Union must comply with EU standards; no such regional standards apply in eastern Europe. The establishment of accreditation standards is thus very important. A major problem is the mismatch between the content of medical education and actual community needs.

Credentialling provides signals of understanding within a society. It is related to the drive for accountability, which is related in turn to empowerment of the population and the movement towards quality improvement. The Bologna Declaration of June 1999 calls for the establishment by 2010 of a coherent, compatible and competitive European Higher Education Area, attractive to European students and to students and scholars from other parts of the world. The European ministers of education identified the following lines of action:

- adoption of a system of easily readable and comparable degrees;
- adoption of a system essentially based on two cycles;
- establishment of a system of credits;
- promotion of mobility;
- promotion of European cooperation in quality assurance;
- promotion of the European dimension in higher education;
- lifelong learning;
- involvement of higher education institutions and students;
- promoting the attractiveness of the European Higher Education Area.

In 2000, a group of European universities took up the Bologna challenge collectively and designed a pilot project called "Tuning educational structures in Europe". During the project's first phase (2000–2002), it emphasized generic competences, subject-specific competences and the role of the European Credit Transfer System. In Spain, for example, universities have proactively established standards in anticipation of attempts by the government to do so. During the project's second phase (2003–2004), it

is giving special attention to the role of learning, teaching, assessment and performance in relation to quality assurance and evaluation. This phase includes a special focus on nursing as an example of a field of applied science.

It has taken 10 years for European universities to reach 1 million exchanges of students, whereas in the USA there are some half-million foreign exchange students each year. The Transnational European Education Project is now looking at master's degrees; it will be a long time before medical education comes under study. The Tuning project does not yet cover medicine and law. For these reasons, Europe represents an opportunity for action from WFME and WHO in standards and accreditation.

In Russia, medical institutes are under the jurisdiction of the Ministry of Health. The Ministry of Science and Education is responsible for university medical schools, and for foreign medical students.

For students from the ex-Soviet Union, a diploma does not equal a license except in Armenia. Students with Russian citizenship can practise in Russia. The mandatory medical curriculum is uniform in all Russian medical schools, although each region can add subjects to meet local needs.

Comments

It was observed that EU countries set standards but do not necessarily meet them, yet these standards are used as reasons to exclude countries that aspire to join the EU. With regard to the question of medical schools as good sources of revenue: If government ministers are shareholders in private medical schools, does this not constitute a conflict of interest? (Partly for that reason, there are no private medical schools in South Africa.) It was noted that there are 10 private medical schools in Russia, and they are accredited.

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Eastern Mediterranean

(The following is a summary of presentations by Ghanim Mustafa Alsheikh, Ibrahim H. Banihani and Azim Mirzazadeh.)

For the 22 countries in the Eastern Mediterranean Region, there are more than 210 medical schools, or one school for around 2.1 million people. These schools were traditionally established according to British, American, French and Italian models. Until the 1970s – after which the number of schools became too great – they were recognized by the UK's General Medical Council and the Association of American Medical Colleges and included in WHO's *World directory of medical schools*. Now the WHO *World directory* is the only tool used to recognize medical schools. (Schools are included in the *World directory* only with the authorization of the relevant government.)

The WHO Regional Office for the Eastern Mediterranean (EMRO) has advocated the development of global standards for accreditation of medical schools, from which regional standards (stressing the use of local languages and establishing unified certifying examinations, for example) were derived and national standards were agreed upon and adopted. The process for bringing such standards into use started with the governing bodies of WHO, proceeded to national governments, then to educational institutions and finally to medical professionals.

At the regional level, action has involved a Regional Consultative Committee, the Regional Committee (including the ministers of health of the Member States) and the Expert Group on Health Professions Education Reform. There have been regional consultative meetings, joint biennial programmes between regional offices and Member States, national task forces and the contribution of consultants.

The WHO Regional Director interacts with heads of state, heads of government and government ministers. WHO and regional Member States have jointly identified partners; assembled national task forces to promote awareness and formulate national standards, regulations and frameworks; identified national accrediting bodies; endorsed regulations; supported schools in self-assessment; and supported schools undergoing accreditation.

These efforts have resulted in regional guidelines on the following: rules and procedures on accreditation, including practical ways to derive global, regional and national standards; effective learning methods – critical pathways for reform to meet standards; a regional undergraduate core curriculum to attain essential competences; mechanisms for integrating education within health systems; optimum capacity building (how and who); and networking medical institutes (a regional database and a web site).

EMRO Member States, organized in four groups, have carried out or soon will carry out the following activities: the nine countries in group 1, which have adopted national systems, will introduce and test their systems in 2004–2005; the three countries in group 2 will revise their existing systems to adopt global/regional/national standards by 2005; the ten countries in group 3 will prepare to introduce standards towards establishing national systems in 2005; and in group 4, all countries in the region will collaborate with the Arab Board of Medical Specialization and national boards of medical specialization in accrediting postgraduate medical programmes.

What is important is what a school and country do to improve quality after accreditation. WFME has done impressive work in helping establish standards, but countries must implement them. WHO has the capacity to bridge between "having" the global standards and "establishing" national systems of accreditation based on adapted regional or national standards under the umbrella of the global standards. The typical, practical steps that EMRO followed and that both WHO and WFME can adopt to support countries include the following:

- Setting standards through establishing a national task force; holding seminars and meetings with representatives of all partners; reviewing global or regional standards; accepting and adopting national standards and later recommending regulations or legislation; and discussing and approving rules and procedures of accreditation, including unified examinations.
- Establishing the accreditation body through identifying or creating a national appropriate body; setting clear legal functions and rules; ensuring independent status; and producing and disseminating accreditation documents.
- Setting a plan of action to develop a timetable to accredit schools; and setting dates for organizing national unified examinations.
- Supporting schools to conduct self-evaluation studies.
- Planning and implementing unified national medical examinations through establishing scientific committees; organizing national question banks; and establishing central and local implementation committees.
- Implementing and maintaining accreditation.

In the Eastern Mediterranean countries, with the exception of Iran, the ministry of higher education governs all universities, which in turn govern the medical schools, most of which are publicly funded. Private medical schools are very profitable, but it is fairly complex to establish a new school. The central university curriculum committee oversees the medical school curriculum, although a school's curriculum committee also has a voice. Admission to medical schools is very competitive and is based on performance in the general national high school examination, but is also subject to the political will of the government and the financial resources of the university. The schools have been characterized

by poor faculty development and a recent inequity in admissions; the tendency has been to admit more students, but without an increase in infrastructure.

What is required is an independent national accreditation bureau to ensure high-quality education programmes through the use of standards and rigorous evaluation criteria; stimulate institutions towards higher quality and efficiency; and provide a system for public trust and accountability. WFME's international standards could be used as a tool for quality assurance and development of basic medical education.

The Islamic Republic of Iran, with a population of more than 60 million, has 40 public medical schools and 550 residency training units and accommodates nearly 2000 medical students and 1300 residencies per year. In response to concerns about the quality of medical education, policy-makers in recent years have focused on quality improvement and have paid more attention to accreditation as a tool. Several programmes have been organized to establish accreditation systems for different levels of education in medicine and dentistry. The first and best-established accreditation system in Iran is the evaluation and accreditation system for graduate medical education.

By a special Act of the national parliament in 1973, the Iranian Council for Graduate Medical Education was established as the competent authority to supervise graduate medical education in the country. Under the Council are the Accreditation Commission and what will ultimately be 24 Specialty Review Committees.

To date, 15 Specialty Review Committees have been established; in addition to general residency programme standards, which are common to all residency programmes, standards have been developed for residency programmes in nine specialties. Residency programmes are starting to implement the standards by self-review. The plan is for the Specialty Review Committees to conduct formal external evaluation of the residency programmes before starting the summative evaluation, which will lead to determination of their accreditation status.

The standards developed have been oriented more towards input and process than towards outcomes. Most of the standards are considered "musts", some are "should" and a few are "desirable".

There are many challenges in the field of accreditation in Iran. There has been some misunderstanding of the meaning and characteristics of accreditation (e.g., interpreting it as a system of ranking), as well as difficulties in developing valid and credible standards. There has also been a shortage of resources for the activities of the accreditation systems.

Development of international guidelines or standards will be quite valuable to the Islamic Republic of Iran. Such guidelines must address the scope, organization, standards and procedures of accreditation systems. They may be used solely as guidelines, or as a tool with which to evaluate and recognize accreditation systems.

Comments

The least-developed countries without sufficient resources should consider the distribution between physicians and other health professionals. International standards for training of physicians should be maintained.

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South-East Asia

(The following is a summary of presentations by P.T. Jayawickramarajah and Arjuna P.R. Aluwihare.)

The 11 countries of the South-East Asia Region are the home of one fourth of the world's population. There are some 261 medical schools spread unevenly in eight countries of the region.

The medical education movement that arose in the region in the 1960s and continues to this day gave rise to a declaration calling for an Equivalence Committee intended to: facilitate the movement of medical professionals; ensure graded evaluation from high school to intermediate level, bachelor's degree level, postgraduate degree or diploma level, to the doctoral level; and provide certificates, transcripts and registration by professional bodies to be used as indicators for comparison. The Equivalence Committee is to advise national medical councils on issues including: admission criteria, programme design or curriculum, the duration of courses, programme delivery, pedagogical tools, assessment methods, criteria by which to judge performance, and profiles of teaching staff.

There is regional equivalence of the MBBS, or basic medical degree; the postgraduate medical degree (MD or MS); and other postgraduate degrees (MPH, MPhil and PhD). One of the outcomes of a conference on accreditation in public health, held in Chennai, India, in 2002, was to appropriately adapt the WFME recommendations on standards in medical education as a framework for accreditation of public health institutes and programmes.

The specific results expected in this region in 2006–2007 include the development of strategies, tools and standards for accreditation and support for equivalence of qualifications and degrees for medical, dental, nursing and allied health education.

Countries in the region are characterized by the double burden of infectious disease and chronic conditions, and much of the population is rural and impoverished. Physical access to the health care system is difficult; the system is short-staffed and often short of other resources, and the balance between generalists and specialists is problematic. Although English is widely spoken and is the language of instruction in medical schools in much of the region, there are also many indigenous languages in the region.

The demand for places in the region's medical schools is huge, as medical education is seen as the passport to a better life. This demand leads to the existence of institutions of variable standards. Student selection is normally by competitive examination. The academic standards, skill levels and attitudes of students and teachers are an issue in accreditation.

Other issues are: the balance between public medical schools and private ones; the need for job descriptions, in order to match outcomes to needs and thus to ensure appropriate accreditation standards; and both intra-country and international brain drain.

What purposes does accreditation serve? Job satisfaction for the educators? A safeguard for patients? Is it primarily for local consumption? International mobility? Also, we must explain why brain drain is not the *raison d'être* of accreditation standards.

Each school desiring accreditation must be recognized by the medical council or equivalent body of the country concerned. If not, national health priorities and the rights of patients may be jeopardized by the requirements of individual schools.

Resolution WHA 57.19 recommends, among other things: "...facilitating dialogue and raising awareness about migration of health personnel and its effects, including examination of modalities for receiving countries to offset the loss of health workers, such as investing in training of health professionals.

Western Pacific

(The following is a summary of presentations by Michael J. Field, Cheng Boji and Ichiro Yoshida.)

The Western Pacific Region is diverse in population, resources (including gross domestic product), health challenges and medical school numbers and standards. There are 371 medical schools for a population of 1.7 billion.

The Australian Medical Council (AMC) has accredited Australian and New Zealand medical schools since 1985. In 1992 the AMC introduced its own guidelines, then revised them in 1998 to reflect worldwide developments. In 2002 the guidelines were revised again to align with the WFME guidelines.

Accreditation in Australia and New Zealand serves as a vehicle for quality assurance – recognition of standards for local medical registration of graduates – and quality improvement – as a stimulus for growth, change and development. All the schools accredited say they have benefited from the accreditation process and in consequence produce physicians of better quality.

The principles of accreditation in Australia and New Zealand are: regular external peer review against published standards; self-examination and self-directed improvement; respect for university autonomy and encouragement of diversity; support for educational initiatives; and mutual exchange of ideas. The 14 schools accredited between 1989 and 2004 include two new schools: the Australian National University and James Cook University.

The AMC is an active member of the Association for Medical Education in the Western Pacific Region (AMEWPR). It involves colleagues from neighbouring countries in assessment visits in Australia and New Zealand. Regional visitors are invited to AMC retreats. The AMC provides pilot accreditation (via the AMEWPR) of regional schools, notably in Fiji and Papua New Guinea. It is considering taking responsibility for accrediting offshore campuses of Australian medical schools.

China has no accreditation system, although the Ministry of Education has conducted evaluations of medical schools or educational programmes since 1995. For further development of medical education, China must establish a quality assurance system; it should be in line with developing trends of medical education elsewhere in the world.

The quality assurance system in China aims to be based on standards, internal quality survey and control, self-assessment and external evaluation for accreditation. Further, standards and accreditation methods should be developed according to the practical circumstances in China; that the educational process and its outcomes should be considered; and that national standards should be in keeping with the global standards of WFME.

National standards for medical education in China should cover the operation of schools (10 areas) and essential requirements for undergraduates in ethics and professional attitude, and skills and knowledge upon graduation.

A quality assurance system was designed in line with the standards and guidelines of WFME, the WHO Western Pacific Region, the Global Minimum Essential Requirements of the Institute for International Medical Education, Australia, Japan, the United Kingdom and the United States.

A survey was conducted to test the validity of a proposed quality assurance system; the survey questionnaire was sent to 53 experts in medical education, 101 medical schools and 100 students from six medical schools. All respondents verified that the proposed standards conform to the circumstances

in China and in particular to medical education in China, and that the standards are in line with the global standards of WFME.

If the proposal to be submitted to the Ministry of Education is approved, four medical schools will participate in a pilot study of accreditation. Accreditation of medical education will be the topic of the Eighth Medical Education Conference, to be held in Hong Kong in 2005.

The 80 medical schools in Japan produce some 7500 graduates per year. There is no national accreditation system, but the government conducts site visits at irregular intervals. Schools are required to produce a self-evaluation report every five years. Two national tests serve to measure educational outcomes.

The well-established schools tend to be very conservative and resistant to change. A programme of liberalization of the medical curriculum was instituted in 1991; a new national core curriculum came into effect in 2001. Currently there is active debate about whether to include traditional medicine in the otherwise allopathic medical curriculum.

2004 will see the privatization of all national universities and the implementation of a new rule for postgraduate clinical training. A system of quality assurance and accreditation is needed to help improve medical education in Japan. In September 2004, the Ministry of Education announced that it would introduce an accreditation system in the near future.

Comments

It is not desirable to develop a common degree or certification to practice anywhere, since this would tend to encourage a drain from countries needing graduates to countries that need them less. Are there guidelines for final examinations by medical schools? There should be guidelines for the number of students to be given entry to medical education: should these be included in global standards, or should local agencies formulate their own guidelines?

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Accreditation/recognition systems: concepts and delineation

Presentation of established systems

(The following is a summary of presentations by Emery A. Wilson and Karl Zbinden-Baertschi.)

Liaison Committee on Medical Education

The Liaison Committee on Medical Education (LCME) was established in 1942 to combine the separate accreditation programmes of the American Medical Association (AMA) and the Association of American Medical Colleges (AAMC). It is the accrediting agency authorized by the US Department of Education to serve the interests of the public. As such, it accredits medical education programmes leading to the Doctor of Medicine degree in the United States and Canada (with the Committee on Accreditation of Canadian Medical Schools, CACMS) by judging the compliance of medical education programmes with nationally accepted standards of educational quality.

LCME accreditation is voluntary, takes place through a peer-review process, has no system of ranking, lasts for eight years, encourages innovation and adheres to non-prescriptive standards. Accreditation takes into account the institutional setting, the educational programme for the MD degree, the students, the faculty and the educational resources.

The standards include "musts" – for which meeting the standard is obligatory – and "shoulds" – for which compliance is expected unless there are extenuating circumstances. Standards are reviewed every two years; they can be changed after a public hearing and approval of the two parent organizations.

If a school is not accredited, its students may not be eligible for federal loans and cannot take the US Medical Licensing Examination; its graduates cannot enter residencies; and the school itself may not be eligible for certain federal funds.

The accreditation process includes institutional self-study; an institutional site visit, with an exit report to the school's dean and president; and the LCME's decision – provisional accreditation, accreditation, continued accreditation, probation or withdrawal of accreditation. The LCME submits a final report to the university president that can be made public; it includes the school's perceived strengths, areas of non-compliance and areas in transition (for example, a substantial decrease in financial resources that could affect the medical education programme in the future and should be monitored).

The site visit team includes five members, one of whom is a representative of a school about to undergo an internal evaluation; in the past, international participants have been allowed to observe the LCME accreditation process. A school has two years during which to come into compliance and be re-evaluated.

The LCME consists of 17 members: six professional members appointed by the AMA; six professional members appointed by the AAMC; one professional member appointed by the CACMS; two medical students; and two public members. The LCME has offices at AMA headquarters (Chicago) and AAMC headquarters (Washington, DC).

Issues proposed for discussion by the participants were: authorization for the accrediting agency; consequences of not being accredited; disclosure of accreditation status to the public; duration of time in which to correct areas of non-compliance; costs of accreditation; the role of accreditation in educational improvement versus meeting minimum standards; the accrediting processes versus outcomes; country versus regional accreditation; and accreditation in conjunction with licensure and certification.

Integration of WFME standards with national accreditation in Switzerland

In Switzerland, the accreditation process is carried out by an independent body, the Center of Accreditation and Quality Assurance of the Swiss Universities (OAQ).

In basic medical education, the standards used for self-evaluation and peer review include all the WFME basic standards and selected quality-development standards. The standard set is complemented by additional generic standards of national provenance and a link to the national catalogue of discipline-specific learning objectives. The Swiss national guidelines for accreditation, supplemented by profession-specific extracts of the WFME standards, provide the legal basis for the accreditation decision. Accreditations of Swiss faculties of medicine and their curricula are due in 2005–2006.

In postgraduate medical education the Swiss Medical Association (FMH) provides for 44 specialty programmes. Current legal requirements call for only unguided self-evaluation for each discipline. In 2003–2004, subsequent to a compromise negotiated between the FMH, Ministry of Health and OAQ, self-evaluation based on WFME quality standards was introduced. The self-evaluation documents are being assessed by independent international experts and will – together with a final report of the OAQ – provide the basis for the accreditation decision by the Federal Council in May 2005. Legislation

anticipated for 2008 will require full three-step accreditation (self-evaluation, peer review and an accreditation decision).

Comments

It was suggested that countries could exchange observers and members of accreditation/evaluation teams. It was also noted that students could – and did – provide valuable input to the review process.

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Working groups – developing international guidelines for accreditation systems. Session I.
Guiding principles

Requirements of an accreditation system

The accreditation system should be: based on standards (such as those of the WFME); supported by a legislative instrument; independent; transparent; non-profit-making; accountable; representative of, but independent from, all major stakeholders; and efficiently administered. The system should have national legitimacy and should have the authority both to accredit and to sanction. It should include both self-assessment and external review, including a site visit. The results of accreditation should be reported to the institution undergoing review; with an opportunity for response. The system should have adequate human, material and financial resources, including a core budget that is publicly financed. The accreditation system itself should be periodically evaluated so that its standards, procedures and organization remain optimal.

Desirable qualities of accreditation

Accreditation should be time-limited; voluntary (with incentives), but probably virtually compulsory – due to professional and market pressure – in the long run; acceptable to all stakeholders; credible; feasible for a given socioeconomic, political and cultural situation; relevant; valid and reliable; and comparable and transportable.

Stakeholders in accreditation

The stakeholders include: the public, in general and as patients; government at all levels; health regulators; health services entities; funding agencies; students; licensing bodies; the teaching staff; universities; and other health professionals.

Uses of accreditation

Accreditation can be used to ensure and improve the quality of medical education – for example, by ensuring the acquisition of core competences; to improve cost-effectiveness; to serve as a lever for reform; to foster respect for the health system; and to assist in resource mobilization. The long-term purpose of accreditation is to improve the health status of the population.

Comments

Self-evaluation of medical schools should be based on the WFME guidelines. Listing only accredited schools in WHO's World directory may be an incentive. We must promote licensing of health care professionals and accreditation of schools for all health care professionals.

Should we pursue recognition of existing national standards? This would encourage consistency with global guidelines. But how are we to accredit the accreditors? Global guidelines are broad in order to be adapted to national and local needs; national standards will be more detailed. Guidelines would be derived and modified at regional level in conjunction with national representatives. The process of establishing accreditation systems will take time.

We view accreditation as a tool for protecting and improving the health of the population as well as for improving the quality of education. Accreditation should be compulsory, be based on a legal instrument, be nonprofit and transparent, include the ability to sanction, be accountable, have national legitimacy, represent all major stakeholders, have adequate and dependable financing and be efficiently administered. The accreditation process should include a process for appeal.

The accreditation process should be based on: standards, self-assessment, a site visit (by a team of at least two, but involving all the local stakeholders) and a report (there was debate as to whether it should be public). It should be time-limited, and there should be follow-up and review.

To protect the public, each country must have a mechanism to accredit schools and license health care providers. Assessment teams must be extensive enough to ensure a credible result. If all stakeholders can be persuaded of the utility of accreditation, it may be easier to foster the establishment of accreditation systems.

Self-assessment is fundamental, but must be validated by a site visit by a team of perhaps three members. If the self-assessment process is emphasized and checked, the rest of the accreditation process may go more easily.

It might be helpful to have a World Health Assembly resolution urging that all WHO Member States undertake accreditation of health professions educational institutions. Such a resolution must come from the Member States themselves. A draft resolution could be introduced through a regional committee. For example, the Eastern Mediterranean countries could propose a resolution to the Regional Committee for the Eastern Mediterranean. We could perhaps aim for a proposal to the Executive Board in January 2006 for a draft resolution to the Health Assembly in May 2006.

This process would parallel that of WFME. It would be from the ground up: from national associations or governments, to regions, and then to the Executive Board and the World Health Assembly. The wording of the resolution should specify that institutions be accredited: "in order to appear on a register". The WFME could perhaps help draft the resolution.

We would also need a development plan to supplement guidelines for accreditation systems.

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Accreditation/recognition systems: organization and procedures

The Australian/New Zealand experience

(The following is a summary of a presentation by Michael J. Field.)

The Australian Medical Council meets twice a year; the Accreditation Committee meets three times a year; assessment teams are set up as they are needed; there is a full-time staff of two, plus general office support. The Accreditation Committee chair contributes the equivalent of one day a week. Assessor training workshops are organized as needed. The AMC covers the cost of its infrastructure; the medical schools cover the cost of assessment.

Eighteen months before an anticipated accreditation visit, a school submits its application, based on its self-assessment; medical students prepare a separate submission. A year in advance, the AMC selects a site-visit team of six or seven members, consisting of clinicians, scientists, educationists and other stakeholders. The team is given a handbook and briefed on the accreditation process, and the dates are determined.

Six months before the visit, the team meets to discuss the school's submission and plan the visit. The members request additional information if necessary, and assign report-writing roles. The chair and secretary make a preliminary visit. The school briefs its staff and stakeholders. For new courses and new schools, an additional preliminary submission is required, and there are visits by the chair and secretary and possibly also by a small working party to advise on accreditation requirements.

During the five days of the visit, the team meets daily to develop the report. A draft report is given to the school within five weeks. The school may request corrections of fact.

The revised report is presented to the Accreditation Committee and published; the accreditation decision is approved by the Council. Subject to satisfactory periodic reports, accreditation can be granted for 10 years, or for shorter periods with reassessment, or refused. Conditional accreditation has been given on occasion, primarily because of poor relations with hospitals or poor clinical teaching facilities, funding and resources, or curriculum design problems.

The school submits an annual or biannual report, which is reviewed by a member of the assessment team. There is a formal review process if the report is considered unsatisfactory.

The overall outcomes of accreditation across the system as a whole are seen as: better-integrated curricula; greater focus on student-centred learning (especially problem-based learning); greater focus on teaching communication skills and early clinical contact; more diverse assessment strategies; more focus on population health and evidence-based medicine; explicit attention to personal and professional development; a stronger role for general practice; better use of information technology in courses; and more equitable admissions processes.

The challenges are seen as: responding to workforce demands (the need for training in rural, remote and outer metropolitan areas); the cost of accreditation; the changing mix of schools (from 11 now to perhaps 15 or more within three years); equivalence of training in different clinical contexts; and internationalization.

Comments

Annual reports would be required if any unresolved issues remained. The Liaison Committee on Medical Education in the USA requires an annual report devoted largely to financial issues. In South Africa, the assessment board covers the expenses of the assessments; the school pays if there are persistent problems or repeat visits. Recently there had been political input.

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**Working groups – developing international guidelines for accreditation systems. Session II.
Procedures: foundations of an accreditation system**

Authority for accreditation

The accreditation system must have authority, however that authority is derived or ascribed.

The accreditation process

The accreditation process should include: self evaluation; conveying the results of the self-evaluation to the accreditation body; an audit – possibly including a site visit – by the accreditation body to verify the self-evaluation and obtain any additional information needed; a preliminary report to the institution by the accreditation body; opportunity for the institution to correct errors of fact; and the accreditation decision. The accreditation process itself should undergo periodic review; it should accommodate input from all stakeholders for the maintenance and updating of its policies, standards and procedures.

Standards for accreditation

Standards can be: global; regional and transnational; national; subnational, such as state or provincial; or institutional. They serve to measure outcomes and define competences. They must be clearly stated.

Data for accreditation

The types of data for accreditation may include those on: the mission and objectives of the programme or institution; the renewal or revision of the programme or institution; admissions criteria; the number

of students, and their characteristics; procedures and results of student assessment; the educational programme; the number, nature and circumstances of teaching sites (clinical or didactic) and other physical facilities; information resources; teaching and learning methods; the presence of other programmes; the population and diversity of patients; the governance structure; the number and qualifications of teaching staff; the number and composition of administrative staff; and the amount and sources of financial resources.

Values of accreditation/recognition systems

(The following is a summary of presentations by Peter Rubin and Thanyani J. Mariba.)

Significance for quality improvement of medical education

The Education Committee of the General Medical Council (GMC), United Kingdom, was established by Parliament to protect the public by promoting high standards of medical education and by coordinating all stages of medical education. The GMC Education Committee has statutory power to: determine the content and outcomes of the medical course; determine the standards of qualifying examinations; determine the content and outcomes of the pre-registration (internship) year; inspect any aspect of the teaching and assessments of any body wishing to confer a primary medical qualification; and the power to recommend that a body should no longer confer a primary medical qualification, or that new institutions be given the power to confer a primary medical qualification.

The Quality Assurance of Basic Medical Education (QABME) assessment programme of the Education Committee gives guidance by – and receives guidance from – the following documents: *Tomorrow's doctors* (1993 and 2003), *The new doctor* (1997 and 2004), *Good medical practice* (2001) and *Continuing professional development* (2003).

The quality assurance process has four parts: an annual report to the GMC from each medical school, describing any significant changes from the last report; a visit to each school by the GMC Education Committee at least twice in every 10 years, culminating in a report by the visiting team; special arrangements if a school is proposing major curriculum changes; and, for new schools, three or four targeted visits per year, through to the graduation of the first cohort of students.

The functions of the GMC Education Committee, including the QABME programme, are paid for by physician registration fees. Site visitors are recruited after public advertisement and a rigorous selection process. The 100 visitors include medical and non-medical personnel and students; they are formally trained, in a process that features 360° appraisal.

The QABME programme includes an external evaluator to help assure its quality. Feedback from the schools and the visiting teams serves as part of the input to this continuing quality assurance.

The GMC Education Committee's plans for the future include: a Research Board, to evaluate the effectiveness of the Committee's guidance on medical education and practice; and a Futures Project, to identify trends that will shape medical practice in the future and to prepare doctors to meet future needs. The Committee will also consider: the benefits and disadvantages of a national assessment; student registration with the GMC; diversity and access; and future themes for its guidance.

Significance for assessment of educational qualifications

An accreditation body verifies and evaluates: the physical facilities of the institutions it reviews; at a minimum, the undergraduate curriculum; the educational and training processes employed; the educational methods and techniques employed; and the evaluation process and criteria of the end product of education and training.

The accreditation process seeks: to identify qualifications that will satisfy the minimum acceptable standards; to protect both the student and the public from programmes of poor quality; to exercise control over the quality of education and training; and to serve as proof of the standard of performance of individuals who graduate from an institution so accredited.

Qualifications can be verified by checking the WHO *World directory of medical schools* or the *International medical education directory* of the Foundation for Advancement of International Medical Education and Research (FAIMER), which is a non-profit foundation of the Educational Commission for Foreign Medical Graduates (ECFMG). A medical school is listed in either of these directories only upon confirmation from the ministry of health or other appropriate agency that the medical school is recognized by the ministry or other agency.

The ECFMG verifies the qualifications of international medical graduates by sending the individual's medical diploma to the issuing medical school for verification, and by requesting the final medical school transcript. This is part of the certification process that must take place before international medical graduates can enter US residency and fellowship programmes accredited by the Accreditation Council for Graduate Medical Education.

Working groups – developing international guidelines for accreditation systems. Session III. Procedures (continued): decision-making in accreditation

Accreditation should encourage and support the programme or school in endeavours to improve; the accreditation process must consider the context in which the programme or school exists.

Types of accreditation decisions

The statutory accrediting body can decide to accredit – with or without conditions – or to withhold or withdraw accreditation. The decision should be public, unless circumstances demand otherwise and there has been prior agreement for the decision not to be public; justified, not arbitrary; fair; and subject to an equitable appeal mechanism. The school should be allowed to propose how to correct deficiencies, subject to agreement or amendment by the accrediting body.

Reporting the results of accreditation

The accrediting body should present its preliminary results to the institution in writing. Any errors of fact should be resolved in writing by the institution and the accrediting body. The site-visit team should be a neutral recorder and reporter of facts to the statutory accrediting body; decisions should lie with the statutory accrediting body.

Comments

There should be communication between the accrediting body and the institution being accredited, particularly when a negative evaluation is possible. The accreditation system should provide time limits for remedies. Feedback may elicit corrections of errors of fact.

There should be verification of accreditation systems in countries, much as site-visit teams verify institutional self-evaluations.

Accreditation/recognition systems: the role of WHO and WFME

There appears to be general agreement that accreditation is a means to improve medical education and practice, and thus ultimately to improve the health status of the population. Accreditation should address consumers' needs; be a unified process; promote and adhere to high standards of quality, balancing technical excellence with social responsiveness; and be country-based. Quality of care and safety of patients are matters of public interest. Professional bodies, academic institutions and ministries of health must work together in accreditation, since the possible weaknesses of one may be canceled out by the strengths of the others.

Establishing guidelines is an appropriate role for WHO and WFME, as is identifying good practice and helping establish accreditation systems. They can also help provide meta-accreditation, either by accrediting the accrediting bodies or by formulating guidelines for accreditation.

The WFME role should be to: define or update global standards, review regional and national standards, collect and disseminate information, encourage institutional self-evaluation and establish an adviser function (for which a manual is now in progress).

Should WFME develop guidelines for accreditation systems? Should there be recognition of accreditation systems? Should there be recognition of accredited institutions?

Comments

There was strong support for a WHO/WFME role in recognizing accreditation systems. It was observed that as WHO and WFME are experienced in planning accreditation systems, they should pursue this work before others do it and do it less well.

WHO should encourage countries to establish or clarify accreditation processes and systems. A regulatory body should perform the accreditation.

Meta-accreditation is for support as well as supervision. WHO and WFME should design a system for recognition and validation of accreditation systems.

Regional mechanisms should promote global guidelines, establish national standards and recognize accreditation systems.

WHO and WFME should produce overall guidelines and support countries in using or adapting them. In the WHO Eastern Mediterranean Region, ministries identified focal points who then established working groups to set up accreditation systems.

WHO and WFME should promote the existing global standards, then develop guidelines for accreditation systems.

The point is to help institutions of medical education to improve, not to be punitive or to be oriented towards weeding out the few medical schools that do not measure up. A warning could appear in the WHO World directory that ultimately only accredited institutions would be included. It would not be feasible to suspend listings of non-accredited institutions right away.

WHO is now updating and upgrading the World directory to include more information and to include schools for other health professionals. The questionnaire for this effort will ask about accreditation. A new resolution governing the Directory is needed. WHO must work with countries to develop their own accreditation systems, and must also work with medical schools. The proposed resolution should cover both countries and schools.

WHO's method of building the Directory is well-established and sound, but medical schools exist that are not listed in it. Their governments may not have requested that they be included. In the Eastern Mediterranean Region, the Regional Office requests an update on medical schools every two years.

Participants were informed that development of human resources for health would be the theme of both World Health Day and the World health report in 2006. There would also be a Human Resources Decade from 2006 through 2015. All this was in order to increase the ground of development of human resources for health in the health policy agenda.

It was assumed that most existing medical schools would adhere to WFME standards, as would most new medical schools.

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Accreditation/recognition systems: planning of WHO–WFME engagement: actions and organizations

Working groups – developing international guidelines for accreditation systems. Session IV. Organizational structure of an accreditation system

General requirements and structure of the accreditation system

An accreditation system must have the authority, competence and resources to do its work. It derives its authority from the government, from professional organizations and from the institutions it must accredit.

The accrediting body should be an independent statutory body representative of all the stakeholders. It should be empowered to promote the required regulations and be given the means and capability to obtain the technical resources necessary to pursue its charge.

The structure of the accreditation system must be defined according to the circumstances and needs of the country and the field being accredited, but the responsibilities of each entity in the system must be clearly defined.

Comments

Could a body such as WFME perform the accreditation, in the case of a single-school country? Can international accreditation be ascribed in addition to national accreditation?

It should be noted that possessing a source of funding does not necessarily taint independence.
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Conclusion: future directions of the WHO/WFME partnership

As a result of the deliberations, consensus was achieved with respect to the future engagement of WHO and WFME in establishment of accreditation systems in medical education. The activities should:

- promote development of regional and national standards on the basis of the global standards;
- promote institutional self-evaluation and external reviews;
- formulate accreditation guidelines;
- promote the establishment of accreditation systems;
- pursue work on recognition of accreditation systems;
- develop the WHO *Directory of Medical Schools* and the new Global Database of Health Education and Training Institutions, based on quality indicators and information about accreditation;
- work towards a World Health Assembly resolution on accreditation in May 2006.

Information will be disseminated about the results of the WHO–WFME seminar in print and via the World Wide Web. A draft report will be circulated to all participants as soon as possible. The final report will be made widely available. A short version of the final report will be sent to the WHO regional counterparts, the WFME network, ministries and professional associations.

In January 2005, a report should be forwarded to the WHO–WFME Task Force on progress concerning the proposed World Health Assembly resolution.

In 2004, the World Health Organization and the World Federation for Medical Education established the international Task Force on Accreditation in Medical Education. This is the report of the first activity of that body, a seminar to discuss the establishment of sustainable accreditation systems in order to ensure medical education of high quality.

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