The Need for Accreditation in Medical Education to be based on Regional and National Health Priorities

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Introduction

In this paper, we argue that it is time to review the relationship between global ideas about the quality of medical education and actual local need. We suggest that a conversation is needed to rebalance the focus of activity from international to regional, and to take control of quality and its accreditation within our own contexts.

The medical profession has the privilege of being among the most trusted of all professions (Wellcome Trust, 2019; Ipsos, 2021). Trust in the individual physician, as well as healthcare institutions and systems, is essential to optimizing the health of patients and communities, as it is associated with timely access and better compliance with healthcare (Hall et al., 2002; Gille et al., 2015). Conceptual models of trust in physicians contain elements of competence and ethical practice including good practical, decision making and interpersonal skills as well as prioritizing the welfare of the patient (Hall et al., 2002). The first step in developing a good medical practitioner involves ensuring the appropriate quality of medical education. The relationship between medical education and the quality of healthcare remains to be established (Chahine et al. 2018), possibly because the quality of healthcare is fundamentally dependent on the state of the healthcare service itself. Nonetheless, the responsive role of medical training for supporting the healthcare service has been passionately argued for since the publication of the landmark report by Abraham Flexner (Flexner, 2010; Quintero, 2014; Sarwar et al., 2014). The public too has the right to receive healthcare from well-trained medical practitioners.

Medical education also owes medical students a duty of care. Thus, the primary responsibility of a medical school is to ensure the quality of education and training to produce graduates who are competent, clinically skillful, and maintain the highest standards of ethics and professionalism. Medical educational institutions need to establish, develop, and constantly maintain the quality of their educational programmes in order to achieve this goal. One way of demonstrating this is through accreditation.

Current Accreditation Practices in Medical Education

In 2005, the World Health Organization (WHO)/ World Federation for Medical Education (WFME) Strategic Partnership published the WHO/WFME Guidelines for Accreditation of Basic Medical Education aiming for an effective, independent, transparent, and criterion-based process (WHO/WFME, 2005; Karle, 2006; Van Zanten et al., 2008). According to this, accreditation was described

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as a process where an educational programme or institution is cyclically reviewed and evaluated by a designated authority using clearly specified criteria and procedures identified by the regulator (Boulet & van Zanten, 2013; Frank et al., 2020).

The core aims of the accreditation process would be producing competent healthcare professionals and ultimately optimization of patient care and patient outcomes (WHO/WFME, 2005; Davis & Ringstead, 2006). even though a brief search of the literature demonstrates that patient outcomes are determined by many more powerful variables than the education of medical students. There is also a lack of robust evidence on the direct role of accreditation in ensuring the quality of medical education programmes or positively impacting patient care (Boulet & van Zanten, 2013; Frank et al., 2020; Akdemir et al., 2020). Nonetheless, accreditation has been accepted as a necessary tool for quality assurance and quality improvement in medical education, and is an integral component in many medical education systems.

Even though accreditation is now an accepted process, there is little consensus about how to do that or what its effects are. A review by an international consensus consortium identified different trends and conflicts in the formation and processing of health professions education program accreditation (Frank et al., 2020). A principal disagreement among accreditation organizations across the globe is whether to have a summative or a formative accreditation process. Further, continuation of the accreditation cycle is subject to resource availability and funding from accrediting agencies and accreditives. Methods adopted by accreditation agencies often vary based on the weightage given to document reviews versus interviews and onsite inspections. Depending on the availability of resources and funding, different accreditation organizations may employ a combination of both. In contrast, it is argued whether accreditation should be conducted as a peer-reviewed process or with the accreditation experts acting as reviewers. There is no evidence to help us settle these issues.

Globalization and Medical Education Accreditation

The Global Strategy on Human Resources for Health Workforce 2030, implemented by the World Health Assembly (WHO, 2016), encouraged all countries to have accreditation for medical and other health training programs by 2020. Another non-governmental player, the WFME, has no legal or statutory basis but is affiliated with the WHO and serves as an umbrella organization for its six regional medical education associations around the world. WFME has two separate quality-related initiatives: the global standards for each stage of medical education, and the recognition programme for medical education accreditation agencies.

The WFME global standards are optional and can guide the design of medical education in any particular context.

The decision to establish global standards for medical education was based on the view that a rapid increase in the number of new medical schools was accompanied by a decline in quality (Karle, 2006). However, as the standards are entirely voluntary, how often and by whom they are used is unknown. The 2015 standards for basic medical education are detailed and prescriptive (WFME, 2015), while the 2020 version simply sets out principles for local adaptation, where schools or agencies decide to use them (WFME, 2020).

In parallel with the development of standards, and despite the lack of evidence of effectiveness, the last 20 years have shown a significant increase in medical education accreditation worldwide (Ahn, 2020). It has been emphasized that although many countries have certain undergraduate accreditation systems in place, the majority do not use medical education-specific standards unique to their particular countries (Bedoll, van Zanten & McKinley, 2021). The broader nature of either general or unmodified global standards may not adequately account for the needs of graduates of a particular region. Therefore, using global or general standards to positively or negatively evaluate a program attempting to cater to a

contextually specific region and programme may not be justifiable.

The WFME Recognition Programme

As part of its Recognition Programme, WFME conducts a voluntary and paid-for evaluation of accrediting agencies' compliance with a set of predefined criteria (WFME, 2020). Since 2005, the Foundation for Advancement of International Medical Education and Research (FAIMER) has published a list of accreditation agencies, contained in the Directory of Organizations that Recognize / Accredit Medical Schools (DORA) (FAIMER, 2020). As recorded in DORA, most countries with medical schools have a national process to accredit medical education programs, with substantial differences in the extent of authority and degree of enforcement (van Zanten et al., 2008). The establishment of a separate accreditation system for medical education is often regarded as important in addition to aggregate accreditation systems that review the entire university system. Comparing and contrasting healthcare discipline-specific accreditation systems with general higher education accreditation processes have led authorities to recommend a country-specific quality assurance process focused on health professions (Bedoll, et al., 2021). Although this makes intuitive sense, there is no evidence to support the difference that this might make.

Regional Accreditation Initiatives

In South-East Asia, efforts have been made in a limited capacity to draw on the contextual understanding within the region into assisting quality improvement. However, accreditation, quality assurance, and implementation of minimum standards within the region are complex and greatly varied (Bedoll et al., 2021).

In 2022, the Indonesian Accreditation Agency for Higher Education in Health (IAAHEH) held the Asia Quality Forum for Medical and Health Profession Education with the aim of supporting the WHO Global Strategy on Human Resources for Health 2030 and improving the quality of medical and health professional education in order to meet global demands (SEARAME, 2022). The IAAHEH is committed to assisting the quality improvement of medical and health professional education in the region and is intended to expedite the preparation of a Mutual Recognition Agreement (MRA) for the health professions as a part of the ASEAN Economic Community. The establishment of an accreditation mechanism that covers all health professional degree programs in Indonesia and a strong quality assurance program in Thailand are milestones in medical education accreditation in the region (Mustika et al., 2019). India legally enacted minimum standards for medical education in the late 1990s. Medical Councils in countries such as India, Sri Lanka and Bangladesh play a vital role in regulating medical education in their respective countries. Minimum standards for medical education have been in place in Sri Lanka since 2006 (Medical Council of India, 1999; Sri Lanka Medical Council, 2022).

Regional capacities are being gradually developed but are limited in their purview and may operate under a mix of global and regional quality improvement principles. Moving ahead, the focus should shift towards collaboration within the region to develop more robust regional accreditation systems and modification and improvement of the existing regional frameworks for context-oriented quality improvement. Further, it would be productive to support and develop intra-regional cooperation in ensuring that they are effective and mutually recognized.

In the South-East Asian Region (SEAR), the implementation of regional frameworks faces several challenges in the form of commodification of medical education, malpractices, and political manipulation. These challenges to implementation must be accounted for in the design and delivery of potential systems of accreditation and regional collaboration should focus on measures to mitigate external influences on the accreditation process.

An Alternative, Regional Model for Quality Development

It is neither inherent nor inevitable for medical

education accreditation or quality development to be conceptualized or operationalized at a global level. Indeed, the arguments for such a global approach tend to focus on standardization, which does not adequately emphasize the contextual importance of definitions of quality and social accountability. A regional model for accreditation should shy away from trying to achieve uniformity with a graduate or educational practice from another region but rather focus on the outcome of producing graduates who are sensitive to the regional situation and needs.

International accreditation goes hand in hand with cross-boundary recognition of qualifications (Lindgren & Karle, 2013), a prerequisite for the migration of medical professionals, students, and teachers. Therefore, if global accreditation is a measure to cope with internationalization (Lindgren & Karle, 2013) of the medical profession it is reasonable to question whether standardization of medical education under guidance of global accreditation systems has a positive feedback effect on encouraging further migration of medical professionals from lower income countries by promoting their employability to healthcare systems of the higher income countries. This is concerning to middle- and lower-income countries where brain drain continues to widen inequalities to healthcare access. In addition, if the design and delivery of home programs are according to generalized concepts of quality, those graduates who remain within the region too may not be adequately equipped to respond to the needs of the region.

Privatization of Medical Education

There has been a rapid increase in the number of private medical schools in Asia, a majority of which are for profit institutions. The largest number of private medical schools are found in India followed by Pakistan (Shehnaz, 2011). Many new medical schools are substandard and have insufficient resources, inadequate clinical training, poor research attainment (Karle, 2006) and shortages of faculty (Shahnaz, 2011). Driving forces for privatization of medical education in Asia are multiple and include increasing demand for healthcare and suboptimal physician density but also vested political interests in profitability of such schools and loose regulations. With the increasing demand from developed countries for overseas qualified medical professionals, increasing the number of medical graduates is ideal for creating a market for medical professional exportation (Shehnaz, 2011) as producing physicians in excess of the capacity of the country to employ is a recognized push factor for migration (Bach, 2004). For schools established with an objective of producing graduates for supplying this demand, accreditation from an international body is essential. However, it is debatable whether the interest in accreditation extends to actual quality improvement or stops at receiving the rubber stamp of approval. The broad principles set forth by global accreditation guidelines are easily misused to receive accreditation despite failing to meet necessary standards. Deceptive tactics such as short-term appointment of teachers despite prevailing faculty shortages for the purpose of accreditation have been described (Shahnaz, 2011). A global body is simply inadequate to respond to the situation in the region with respect to the proliferation of medical schools. A regional body of accreditation that has an interest in maintaining its presence throughout the process of education and providing a dynamic assessment of the quality is far better suited. In addition, such medical schools are unlikely to be interested in incorporating the needs of the region into the curricula and would likely prefer adhering to the basic generalizable requirements for accreditation, potentially generating graduates within the region with poor knowledge of the regional situation and needs.

Conclusion

The focus thus far has been on developing mechanisms for applying the broader concepts of accreditation and minimum standards to country-specific situations (Karunathilake, 2016). However, what is needed is perhaps a new approach that starts with notions of quality rooted in the needs of the region and achievable within the socio-cultural context and

healthcare structures of the region (WFME, 2015). Regional partnerships should be established and the development and implementation of accreditation systems should be collaborative. The goal of quality improvement in medical education within a region should focus primarily on producing graduates to serve regional needs rather than on implementing quality improvement measures with the intention of gaining international accreditation.

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