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Lindgren, Stefan; Karle, Hans

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221 00 Lund  
+46 46-222 00 00



**Social accountability of medical education:  
aspects on global accreditation**

**Running head:** Social accountability of medical education

**Authors:** <sup>1</sup>Stefan Lindgren, <sup>2</sup>Hans Karle

**Affiliations:** <sup>1</sup> Department of Clinical Sciences, University of Lund, Sweden, President World Federation for Medical Education, <sup>2</sup> University of Copenhagen, Denmark, Project Coordinator, The Avicenna Directories, Past President World Federation for Medical Education

**Corresponding author:** S. Lindgren, Department of Clinical Sciences, Malmö, SUS Malmö, SE-205 02 Malmö, Sweden, Tel: +46 40 33 23 06, Fax: +46 40 92 32 72, email: stefan.lindgren@med.lu.se

## **Abstract**

Medical doctors constitute a profession which embraces trust from and accountability to society. This responsibility extends to all medical educational institutions. Social accountability of medical education means a willingness and ability to adjust to the needs of patients and health care systems both nationally and globally. But it also implies a responsibility to contribute to the development of medicine and society through fostering competence for research and improvement.

Accreditation is a process by which a statutory body evaluates and recognises an educational institution and/or its programme with respect to meeting approved criteria. It is a means for quality assurance, but also a strong power to reinforce the need for improvement and reforms. It must be performed through internationally recognized and transparent standards and should foremost promote quality development. The social accountability of medical education must be included in all accreditation processes at all levels.

The WFME global standards programme provides tools for national or regional accreditation but also guidance for reforms and quality improvement. The standards are used worldwide and have been adopted to local needs in most parts of the world. They are framed to specify attainment at two levels; basic standards or minimum requirements and standards for quality development. The concept of social accountability is embedded in all parts of the WFME standards documents. In 2011, a revision of the Standards for undergraduate education has been instituted. Strengthening of aspects on social accountability of medical education will be a particular concern.

## **Introduction**

Medical doctors constitute a profession, meaning that they exist for the good of others and for the welfare of society. In medicine, this means first of all medical care of sick people. Professional status is granted by society and based on expertise, ethics and the service it provides. A profession is autonomous, but this position is dependent on trust and the fundamental understanding that the interest of individual patients and societal needs are always prioritized before the interests of individual doctors. Self-regulation of professional responsibilities is a fundamental principle of a profession, as is social justice (A physicians' Charter 2002; Cohen *et al.* 2007, Van Mook *et al.* 2009). These professional responsibilities extend to all institutions that educate doctors, although no regulatory system can ever substitute for the doctor's personal professionalism. It is during the time spent in medical school that professional responsibilities and behaviours are learned. Social accountability of medical schools and other medical educational institutions is self-evident, meaning that the needs of patients and societies are fundamental in planning and delivering the curriculum (Global Consensus on Social Accountability 2010). It must be reflected in all aspects of quality development and in any accreditation process. To be efficient, the accountability to society must be evident at all levels of medical education, extended and reinforced during life-long learning. Otherwise these aspects of professional responsibility may be diminished or even gradually lost throughout the professional life of the doctor.

## **What constitutes quality in medical education?**

Accreditation should foremost promote quality development in medical education. It is therefore important to be clear about what constitutes quality in medical education (Skelton, 2005; Harden and Wilkinson 2011). Some basic components and principles are globally agreed and also expressed in the WFME global standards for quality improvement (World Federation for Medical Education

(WFME) 2003a-c). Quality in medical education is a balance between outcomes, content and the process of educational delivery. It depends on valid and reliable methods for learning and assessment, under the given circumstances, i.e. the educational context. Global and international perspectives, and the future needs of patients and health care systems should be addressed (Lindgren and Gordon 2011). In particular, social accountability of the medical school and programmes must be demonstrated in the following aspects:

#### *Research based education*

All medical education should be research based, meaning that it should build on scientific evidence supported by high quality research. It also means that the educational process should be based on best available evidence regarding methods for teaching and assessment. The medical school should be active in research in important areas of the curriculum, in order to be able to demonstrate a scientific approach to teaching and to involve students in research activities and implement a critical and scientific approach of inquiry to their own learning and future practice. However, it does not demand active research in all aspects of the curriculum delivered, which would basically be impossible for most schools if high quality is demanded, and it does not mean that all teaching must be delivered by researchers active in that field. In poor countries, research attainment must in some institutions be ensured by recruitment of teachers with a former research background at another institution.

#### *Adequate facilities*

High quality requires adequate facilities both for learning activities and for practical clinical education. This may differ from region to region, but the facilities must be able to support the learning of the students and enable them to reach the expected outcomes. Unrestricted access to

Information and Communication Technology is necessary. The availability of clinical platforms and an adequate exposure to patients with major health problems is of particular importance.

### *Scholarship*

Scientifically and pedagogically competent teachers constitute the most important resource. The level of qualification of teachers and an academic staff sufficient in number to support the students learning is of fundamental importance for the quality of medical education. In order to be socially accountable, a medical school must also recruit teachers from the health care areas where the needs of the population are largest, i.e. in most parts of the world from the primary care level. These teachers will be important role models for the students and thus help society to direct its future human resources to areas where the need is largest. In addition they guarantee that the curriculum puts emphasis on health problems that constitute the major threats to the population served.

### *Alignment*

Curriculum alignment between expected learning outcomes, assessment of competence, the actual teaching and the learning process of the students is necessary to achieve high quality. This does not mean that specific methods for teaching and assessment must be used. Rather, methods that adequately meet the needs of the students to enable them to achieve the learning outcomes should be selected. The educational process can be varied according to available resources and conditions. Consequently, assessment should be designed to make sure that every student has demonstrated expected results in all aspects of professional competence specified in the curriculum plans. Then the quality of the educational process is transparently demonstrated and certified. It is also necessary that the structure for progression of the student's professional competence is clearly visible and realistic in the curriculum. In the alignment perspective, the primary focus is on the

achieved outcomes of the students. These must be clearly defined and understood by all students, teachers and other stakeholders. Every part of the curriculum should contribute to the overall outcomes achieved by graduates. However, these outcomes alone do not provide much help in planning the curriculum structure. Therefore the educational process and context is still in focus in most accreditation procedures. Basically there are no contradictions between the outcome and process perspectives –without a process there will be no outcomes (Grant 1999; Christensen *et al.*, 2007).

### *Management*

The leadership of medical schools and other medical educational institutions is of utmost importance for the long-term quality development of medical education. Quality is built from the bottom, but must be supported from above, with a clear long-term vision for reform and development. In a scholarly perspective, the management must demonstrate adequate competence in leadership in medical education and understanding of fundamental pedagogic principles. The management is responsible for the overall quality of the programme and to its principals and thus to society. Therefore medical educational programmes cannot be built in isolation by universities, but in close contact and collaboration with societal bodies and stakeholders. This is an absolute prerequisite for social accountability of medical education.

### *Internationalisation*

According to UNESCO, the most important obligation of all university education is to contribute to the international higher education community and to global development, through international cooperation. Social development shall be globally sustainable, encompassing the population's level of education/skills, economics, democracy, human rights, public health and the environment.



Internationalisation in university education builds on international cooperation that entails development opportunities for all parties involved.

In medicine this includes to be aware of health care and basic resource needs in different parts of the world and to achieve a global perspective on health care delivery and development. Thus, not only the needs of the population served can be in focus, particularly in richer countries. Instead resources must be used with potential global health benefit in mind, and not consumed by richer countries only. Medical education of high quality must demonstrate awareness of these global perspectives (Scott 2006), to be socially accountable. It can be manifested by global exchange programs of students and teachers, by international co-operations etc. However, to be of high quality, an exchange program must include preparation at home for the students, exposure to health problems at a level not above their expertise and reflections on the health care problems confronted and how they can be reduced. This may be demonstrated through written and oral reports, shared by fellow students and assessed by teachers at home after the study period abroad, and not least, shared by the educational and health care community in the receiving country.

But Internationalisation is not only exchange. Internationalisation at home means a process that aims to integrate international, intercultural and global perspectives into the aims, organisation and provision of higher education. Among other things, this means integrating international students and international teachers in the curriculum. Internationalisation at home also has a societal perspective, being the universities contribution to social development, higher education based on the needs of society and research- based social debate, i.e. the social accountability of medical education.

## **Essentials of accreditation in medical education**

Accreditation of higher education, defined as the process by which a statutory body investigates, evaluates and recognises an educational institution and its programme or curriculum with respect to meeting approved criteria for providing the intended educational services, is considered the golden standard as a means of quality assurance. It is increasingly being used around the world, but the methods vary much from country to country and sometimes within countries. Both governmental and non-governmental agencies are in operation, sometimes with overlapping responsibilities for provision and quality assurance of education. Some systems are voluntary, others obligatory. In some countries only public institutions are covered. Furthermore, most countries have a common system for all types of higher education, but some use evaluation based on a combination of general higher education and profession-specific education criteria. Another problem is that most systems only cover national providers leaving out of control the increasing number of cross-border education providers.

Within the framework of the WHO/WFME partnership to improve medical education (WHO/WFME 2004), an international task force on accreditation of basic (undergraduate) medical education was established in 2004. Based on this work, Guidelines for Accreditation (WHO/WFME 2005), define components of proper accreditation (Table 1).

### **Table 1 in here**

The standards to be used should either be the WFME Global Standards for Quality Improvement or a similar set of standards. The standards in use must cover medical profession relevant issues.

Medical education is not only a university enterprise, but highly dependent on the health care sector, which in most countries is governed by other authorities.

Proper accreditation implies not only an element of quality control, but has the important potential of offering opportunities for institutions to analyse their own situation and conduct necessary reforms. It is self-evident to stress that the criteria in use must be based on the principles of social accountability of the educational institution and its programme.

### **WFME global standards programme and social accountability**

The main intention of the WFME global standards in medical education (WFME 1998), was to provide means by which medical schools and other institutions responsible for medical education could be stimulated to identify and formulate their own needs for reforms and quality improvement, in assessing their strengths, weaknesses, potentials, capabilities and needs for change. However, it was from the outset emphasised that the WFME standards would also have a status as an accreditation instrument.

The standards cover all three phases of medical education (WFME 2003a-c). They were designed to enable medical education institutions at various stages of development, and with different educational, socio-economic and cultural conditions, to use them as a template for development of national and regional standards, and as a lever for reform. The WFME standards cover 9 areas (Table 2) and are framed to specify attainment at two different levels: (a) basic standards or minimum requirements, specifically useful for recognition/accreditation purposes; and (b) standards for quality development, of central value for institutions in reform processes. For Europe (Quality Task Force, MEDINE 2007), a change of the division line between the two levels was proposed.

## **Table 2 in here**

Although favouring harmonisation of medical education in order to cope with the increasing internationalisation of the medical profession, the intention was not uniformity. It also allowed social accountability of institutions in their dispositions with respect to curriculum development, student recruitment, interactions with the health care sector, etc.

The concept of social accountability is embedded in all parts of the WFME standards documents. It is surprising how often medical schools are established without clear formulation of their mission and objectives. The WFME standards stimulate medical schools to encompass social accountability when making mission and objectives clear to their constituents. Societal needs, as the foundation for curricular developments, the involvement of a broad range of stakeholders in mission/objectives formulation and programme evaluation, the importance of behavioural and social sciences and medical ethics, collaboration with partners in the health sector, and the needs of community involvement as basis for decisions on admission of students are only a few examples of the social accountability dimension.

The WFME standards influence medical education in more than half of the world's medical schools, facilitated by translation into a number of languages. WFME has recently decided to revise the standards for basic medical education by the assistance of an international group of experts. Adoption to societal needs and aspects relevant for social accountability will be a particular concern in the revision process.

## **International recognition**

Internationalisation of medical education is evident from the migration of the medical profession, movement of students and teachers, developments in programmes and campuses and distance learning. It has created a need for systems of international recognition of medical schools and their programmes and similarly for programmes for postgraduate medical education. This need is accelerating due to the explosion in the number of new medical schools. Factors such as privatisation of educational institutions, the concept of for-profit education and the increasing use of cross-border providers illustrate why quality of medical education is under pressure. The trend to establish small, proprietary institutions of questionable quality with low research attainment and inadequate access to clinical training facilities is a warning of the risk of a return to “pre-Flexnerian” conditions for medical education in some countries (Karle, 2010).

Presently, there are no mechanisms in place for international recognition, but initiatives to address this question can be seen in bi-and multilateral agreements to ensure quality, such as international conventions like the EU-Directive of the European Union (EU Directive 2005) and similar systems in other parts of the world, establishment of common accreditation systems, and collaboration between regulatory agencies. WFME promotes establishment of national and regional proper accreditation as the most effective quality assurance instrument we have at the moment. However, we should be aware of potential pitfalls in such mechanisms. The independence of accreditation councils and objectivity of assessors can sometimes be questioned and experts may show conflicts of interest. Judgements may be wrong, or the system can be under political pressure. Reliability of the information provided to assessors or the selection of what is demonstrated during site visits may

be biased. Another problem is costs, which prevents many countries from introducing proper accreditation.

One approach, which in the future will simplify international recognition, is through provision of extensive information about medical schools and their programmes showing more openness and transparency of all affairs of educational institutions. This is the idea behind the new Avicenna Directory of medical schools, established as a project according to an agreement between the World Health Organization and the University of Copenhagen with the assistance of WFME (Avicenna Directories 2007). The new database contains information collated from medical schools through an extensive questionnaire, and the web-based presentation is arranged in different sections with information on: name, addresses, contact persons and type of diploma, affiliations of the school, admission requirements and production figures, staff number and student affairs, programme characteristics, educational facilities and recognition/accreditation procedures in function. Inclusion in the database does not indicate formal recognition by WHO or WFME as is often the misunderstanding. Even more detailed information about the programme will be relevant for presentation of social accountability of the institutions.

The database is easy to access and will be regularly updated. It will help regulatory bodies in taking decisions regarding licensing of doctors with educational background from a foreign country, emphasizing the social accountability of that particular medical school.

It is the view of the Avicenna Directory that medical schools in a competitive world, through exposure to comparison, commentaries, critics and complaints, will be stimulated to keep quality of

their programmes at a high level, and that information received from users of the database can be of help in correcting information and thereby indirectly promote reforms.

At the same time, responses could guide accrediting agencies on where to concentrate their limited capacity. The database will thus provide a basis for meta-recognition of medical schools and programmes.

To further improve international coverage, negotiations have been initiated with ECFMG/FAIMER to merge the Avicenna Directory and the International Medical Education Directory (IMED) of FAIMER.

### **The role of WFME in global accreditation**

WHO and WFME are not accrediting agencies, but they should support and assist existing national or regional systems and promote establishment of accreditation systems in countries without sufficient quality assurance. To this purpose, the WFME has formulated a programme on Promotion of Accreditation of Basic Medical Education, in which a package for assistance is offered, including development of national specifications to the WFME Standards, conduction of institutional self-evaluation and external review as well as development of accreditation systems.

From time to time pressure is put on the WFME to be more directly engaged in accreditation, eventually in collaboration with its six Regional Associations for medical education and the six WHO Regional Offices. It is evident that over the last 10 years WFME has been more strongly involved in accreditation, e.g. in evaluating and recognizing national/regional accreditation systems in some parts of the world. As long as this is based on request from national authorities, such a

model of “accrediting the accreditors” is not violating the principle of not having the authority as the responsible agency.

### **Concluding remarks**

Social accountability of medical education institutions means the ability and readiness of the institution to adjust to societal needs. Thereby it can provide the health care systems locally and globally with the competence needed for the best care of patients and support development of medicine and society through research and improvement. Sometimes, the debate becomes too simplistic. A common critic is that medical schools, due to engagement in biomedical research and high technology clinical services in tertiary university hospitals, are setting aside accountability to societal needs. An isolated public health perspective does not take into account the responsibility of medical education to societal and global needs of future development of medicine and society. In the richer parts of the world, this means that even highly sophisticated clinical service, and the research and educational background for it, could be a sign of social accountability.

Social accountability of medical schools not only means to be accountable for what is within the power of the leadership of the school, but also to try to influence matters, which presently are beyond the capability of the school, but rather determined by political or financial priorities. Accreditation of medical schools and other medical education institutions must be attentive to this responsibility.



### **Practice points**

- The willingness and ability of medical education to adjust to societal needs must be reflected in accreditation processes
- Accreditation offers medical education institutions the possibility to formulate their own needs for reforms and quality development
- Accreditation and recognition of medical education should be based on internationally accepted and transparent standards and accreditation processes
- The WFME global standards programme has an internationally accepted status as accreditation instrument and at a second level of attainment provide support for quality development

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## **Declaration of interest**

The authors report no declarations of interest.

## **Notes on contributors**

**Stefan Lindgren** MD, PhD, FACP, FRCP, FEFIM (hon) is professor of medicine and gastroenterology at Lund University in Sweden, and senior consultant in gastroenterology at the University Hospital MAS in Malmö. He is the current president of the World Federation for Medical Education. His former appointments include Dean of Education at the Medical Faculty, Lund University.

**Hans Karle** MD, DMSc, Dhc, FRCP is a retired hematologist from Herlev University Hospital, University of Copenhagen. He is Past President of the World Federation for Medical Education and currently Project Coordinator of the Avicenna Directories in Copenhagen.

**Table 1**

**Components of Proper Accreditation in Medical Education**

- Authoritative mandate
- Independence from governments and providers
- Trustworthiness and recognition by stakeholders
- Transparency
- Predefined general/discipline specific criteria
- Use of external experts
- Procedure using combination of self-evaluation and site visits
- Authoritative decision
- Publication of report and decision

**Table 2**  
**WFME Trilogy of Global Standards in Medical Education: Areas**

| <b>Basic Medical Education</b>   | <b>Postgraduate Medical Education</b>          | <b>Continuing Professional Development (CPD)</b> |
|----------------------------------|--|--|
| 1. Mission and Objectives        | 1. Mission and Outcomes                        | 1. Mission and Outcomes                          |
| 2. Educational Programme         | 2. Training Process                            | 2. Learning Methods                              |
| 3. Assessment of Students        | 3. Assessment of Trainees                      | 3. Planning and Documentation                    |
| 4. Students                      | 4. Trainees                                    | 4. The Individual Doctor                         |
| 5. Academic Staff/Faculty        | 5. Staffing                                    | 5. CPD-Providers                                 |
| 6. Educational Resources         | 6. Training Settings and Educational Resources | 6. Educational Context and Resources             |
| 7. Programme Evaluation          | 7. Evaluation of Training Process              | 7. Evaluation of Methods and Competencies        |
| 8. Governance and Administration | 8. Governance and Administration               | 8. Organisation                                  |
| 9. Continuous Renewal            | 9. Continuous Renewal                          | 9. Continuous Renewal                            |