Relevance of the WFME global standards in medical education to the South East Asian region

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Globalisation of medicine, as manifested by the growing number of migrating doctors and cross-border education providers, is increasing and new medical schools of dubious quality are proliferating, accentuating the need to define and use standards in medical education to introduce effective and transparent accreditation systems, and to find procedures for international appraisal.

The WFME global standards program, launched in 1998, is now being implemented all over the world. The standards are used as a basis for improving medical education throughout its continuum and as a template for national and regional accreditation standards.

A recent development of adapting the WFME global standards to the specific needs in the European region implies that only a few specifications and supplements were necessary. A similar process is recommended to be achieved for the South East Asian region.

Only a minority of countries have quality assurance systems based on external evaluation, and most of these use only general criteria for higher education. The WHO/WFME guidelines on accreditation in basic medical education, the first practical result of the World Health Organization (WHO)/World Federation for Medical Education (WFME) strategic partnership to improve medical education, recommend the establishment of effective, independent and transparent accreditation systems based on criteria specific to medical education.

Promotion of national accreditation systems will influence future international recognition of medical education. Information about accreditation status or other quality assurance mechanisms will be an essential component of the future Global Directories of Health Professions Education Institutions (GDHPEI) which will be a foundation for international "meta-recognition" of institutions and programs ("accrediting the accreditors").

WFME welcomes the SEARAME JOURNAL

On the occasion of this inaugural issue, it is a great honour and pleasure, on behalf of the World Federation for Medical Education (WFME), to welcome the SEARAME journal among international journals concerned with medical education. The new journal will cover the interests of medical educators and other partners in the South East Asian region, an area comprising 11 countries, a total population of more than 1.6 thousand millions and more than 770,000 physicians.

The new journal appears at a time when international collaboration in higher education, including education and training of medical doctors at all levels, is becoming of highest importance, and the journal could be an essential instrument in exchange of scientific results and ideas related to medical education.

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Need for standards in medical education

The increasing internationalisation of the medical profession raises the question of safeguarding the practice of medicine and the use of the medical workforce.

Within the framework of globalisation and cross-border education, we have observed pronounced migration of medical doctors. As a consequence of this development, commercialisation and privatisation and even a for-profit approach of education providers have become realities. Medical education thus follows the conditions of other parts of higher education, becoming a trade commodity with the risk of compromising quality. This fact has brought about renewed interest in quality assurance mechanisms, exemplified in greater concern about standard setting and establishment of accreditation systems, and a number of international organisations and agencies are now working with these issues.

The need to define global standards in medical education arises from the implications of this globalisation process, but also from an attempt to meet national problems and challenges due to institutional conservatism and insufficient management and leadership.

One paramount world-wide problem is the mushrooming of new medical schools of about 100 per year over the last 10 years. This development has serious consequences in many new medical schools due to unclear mission statements, insufficient educational resources, lack of clinical training settings, and limited research attainment. The lack of accreditation procedures or other quality assurance mechanisms in many countries adds to the disquiet.

The WFME global standards programme

The WFME launched its ambitious programme on international standards in medical education in a WFME executive council position paper published in 1998 (WFME, 1998).

The working process consisted of three international task forces with all together 76 experts representing all five continents. Members of the Task Forces were selected on the basis of their expertise.

The trilogy of global standards for quality improvement in medical education, covering basic medical education (BME), postgraduate medical education (PME) and continuing professional development (CPD) of medical doctors and published in 2003 (WFME, 2003) was the essential background material for the 2003 WFME world conference in medical education entitled: Global standards in medical education for better health care. The conference resulted in consensus worldwide on the standards programme (van Niekerk, 2003; van Niekerk *et al., 2003)* and gave WFME a renewed mandate. The implementation process has been ongoing since 2001, comprising pilot studies, translation (the BME Standards have been translated into more than 20 languages), basis for self-evaluation and external reviews of educational institutions and incorporation in national standards and accreditation systems around the world. More than 250 medical schools have used the standards directly and more than 60 countries use the WFME standards as a reference in national standard setting.

In defining global standards, dissimilarities between regions and countries regarding the basic conditions and management of medical education must be taken into consideration. The WFME task forces also discussed the “pros” and “cons” of standard setting. Among the advantages enumerated were incentive for improvement, basis for national evaluation, formulation of curricular essentials (core), opportunity for education research, facilitation of reforms, instrument for funding, facilitation of exchange (students/teachers/programmes) and foundation for accreditation. On the other hand, reservations were also expressed, the most important ones being interference with autonomy, focus on minimum requirements, risk of conformity, sense of control, lack of common relevance, disregard of local differences, equation of “global” and “western” and the risk of increasing brain drain. Balancing these views, the task forces came to the conclusion that time was ripe for common global standards for medical education to be explored.

Specifying global standards in any restricted sense could exert insufficient impact, and indeed such standards have the potential to lower the quality of medical education in some places. Thus, a lever for change and reform had essentially to be incorporated. This was the background for the concept of the WFME Standards to be framed to specify attainment at two levels.

(a) Basic standards to be met from the outset and useful for accreditation

(b) Standards for quality development in accordance with international consensus about best practice and essential in reform processes.

The WFME standards are formulated at the institutional and educational programme level dealing with all relevant aspects of structure and organisation of the institution, the curriculum, its content and the process of education, the learning environment, the outcome competencies and the management of education. They are structured in nine areas (each with around 35 sub-areas) for each of the three phases of medical education (Table. 1).

Table 1: WFME Trilogy of Standards: Areas

Basic medical education	**Postgraduate medical education**	**Continuing professional development (CPD)**
1. Mission and objectives	1. Mission and outcomes	1. Mission and outcomes
2. Educational program	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. Program evaluation	7. Evaluation of training process	7. Evaluation of methods and competencies
8. Governance and administration	8. Governance and administration	8. organization
9. Continuous renewal	9. Continuous renewal	9. Continuous renewal

Adaptation to Regional requirements

A European task force under the thematic network MEDINE, sponsored by the European Union, recently came to the conclusion that there is presently no need for a separate set of European standards in medical education. The increasing collaboration between countries, a spectrum of diversity of medical education comparable to other regions of the world, the regional perspectives in a broader global context and type of standards needed in medical education, all led to rejection of a concept of separate standards for Europe as an intermediary level between global and national standards in the region.

The only thing needed would be to add regional specifications for the WFME global standards. Elements of such specifications were the changing of division lines between basic standards or minimum requirements on one site, and standards for quality development on the other site. Supplements necessitated by the special European conditions as consequence of e.g. the EU directives on medical education or determined by commitment to the European higher education area, including the so- called Bologna process or other initiatives, were also added.

Based on this work, European specifications for the WFME global standards for quality Improvement of medical education were recently published (WFME, 2007) and are thought to be usable as a template for national standards in the region.

Obviously, a similar argumentation could be utilised in the South East Asian region, and I would encourage the SEARAME to take responsibility for exploring the relevance of a process of adaptation of the global standards to the needs of this Region. The examination recently conducted with European spectacles has demonstrated that the WFME standards, although now being more than 5 years old, do not need a revision at the moment.

Use of standards and the concept of accreditation

The primary intention of WFME was to provide a new framework against which medical schools and other educational institutions and providers could measure themselves in institutional self-evaluation and self-improvement processes. Such procedures should be further developed by inclusion of evaluation and counselling from external peer review committees.

However, from the beginning, it was also stated that global standards could be used as a template for national and regional standards with the necessary specifications as mentioned above, to be used as criteria for agencies dealing with recognition and accreditation of medical schools and other educational institutions and their programmes.

Quality assurance and accreditation systems for higher education based on external review are presently adopted in somewhat more than 70 countries. The existing systems vary from country to country and sometimes even within countries. For example, some countries only have one system for all higher education, whereas others use a combination of evaluation based on general higher education criteria and profession-specific education criteria. A new problem is that most systems only cover national providers leaving cross-border education providers outside any control.

Recommendations for proper accreditation systems can be found in the WHO/WFME guidelines for accreditation in basic medical education, published in 2005(WHO & WFME, 2005) as a result of an international task force with broad representation from all regions. This was the first practical result of the 2004 strategic partnership between the World Health Organization (WHO) and the WFME to improve medical education (WHO & WFME, 2004). Another result of the WHO/WFME task force was the recommendation, that accreditation should foremost be considered a national responsibility, the exemption being countries with only one or a few medical schools, entailing difficulties regarding the independence and externality of experts. Such conditions would require affiliation with an accreditation system in a neighbouring country or establishment of regional or sub-regional accreditation systems.

The WHO/WFME guidelines are formulated as flexible recommendations and cover fundamental requirements, the legal framework, the organisational structure, the standards or criteria to be used, the process and types of decision, the question of public announcement and comments on the benefits of using accreditation. Accreditation systems must be trustworthy and recognised by all, i.e. the medical schools, students, the profession, the health care system and the public. Trust must be based on the academic competence, efficiency and fairness of the system and the system must possess a high degree of transparency.

Within the framework of the WHO/WFME strategic partnership, WFME recently formulated a programme for promotion of accreditation (WFME, 2005). Essential in this development was the definition of a WFME advisor function by an international task force (WFME, 2005).

International recognition of medical education programmes

International recognition of medical education programmes will be beneficial to medical students, medical teachers, medical schools/colleges and health care authorities, at local, national and international levels, and will safeguard the interests of the public.

Further debate is needed on how to achieve reliable and valid international recognition of medical education institutions and programmes. In some parts of the world, accreditation of education is still not an accepted procedure and other means of quality assurance is used, e.g. central evaluation of programmes without institutional self-evaluation or site visits. Quality issues are also controlled by selection procedures, entrance examinations, centrally regulated curricula, self-evaluation and inspections organised by the institution itself, use of external examiners and national examinations before licensure.

In conclusion, apart from quality assurance of medical education through national accreditation other mechanisms for international recognition of medical education programmes are needed.

Over the last years, WHO has considered the future of the World Directory of Medical Schools (WHO, 2003) and has now decided that new Global Directories for Health Professions Education Institutions (GDHPEI) should be developed. One objective is to establish and strengthen national accreditation and to increase the amount of information about institutions and programmes, including number of admissions and graduates, attrition rate, ownership, management and funding sources, and, most important, to add quality related information, e.g. about accreditation status (operating agency, the criteria used, type of procedure, etc) or other quality assurance mechanisms.

In August 2007, an agreement was signed between WHO and the University of Copenhagen in Denmark, which implies that the responsibility for developing and running this database will be taken over by the University of Copenhagen with the assistance of the WFME.

The plan described will automatically lead to a system of meta-recognition of accredited medical schools. The approach of "accrediting the accreditors" will stimulate establishment of national accreditation systems, respect the work already being done by existing reliable accreditation agencies, and avoid unnecessary bureaucracy.

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