Making a greater impact on society as a mark of excellence in the accreditation of medical schools

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Summary. With challenges societies are facing to establish and maintain efficient, equitable and sustainable health care delivery systems, all key stakeholders are urged to question how they can best contribute. Likewise, academic institutions, medical schools particularly, must review the concept of excellence to include the capacity to make a more significant contribution to health system performance and people's health. The continuing adaptation of education, research and service delivery missions to respond to evolving health needs of society should be enhanced by the use of appropriate accreditation standards and mechanisms. Accreditation standards of the Liaison Committee for Medical Education (LCME), of the World Federation for Medical Education (WFME) and the Conférence Internationale des Doyens et des Facultés de Médecine d'Expression Française (CIDMEF) have been reviewed in this context. It is observed than they mainly concentrate on medical education content and processes. It is therefore recommended that their standards be revisited and new ones added to better reflect the concept of social accountability, which is illustrated by the three tier engagement: to identify present and future health needs of the population, including health determinants, to adapt missions accordingly and to the ensure anticipated effects have occurred on people's health status. To initiate change, a course of future actions is proposed.

Key words. Academic excellence. Accountability. Accreditation standards. Health system. Medical school. Social.

Conseguir un mayor impacto en la sociedad, como indicador de excelencia en la acreditación de las facultades de medicina

Resumen. Dados los retos a los que se enfrenta la sociedad de establecer y mantener sistemas de prestación de servicios de salud eficientes, equitativos y sostenibles, se debe instar a todos los agentes implicados a preguntarse cómo pueden contribuir mejor a ello. También las instituciones académicas, y las facultades de medicina en particular, deben revisar el concepto de excelencia para incluir la capacidad de contribuir de forma más significativa al funcionamiento del sistema de salud y a la salud de las personas. La adaptación continua de las misiones de la educación, la investigación y la prestación de servicios para responder a las necesidades de salud en evolución de la sociedad debería reforzarse mediante el uso de estándares y mecanismos de acreditación adecuados. Los estándares de acreditación del Liaison Committee for Medical Education (LCME), de la World Federation for Medical Education (WFME) y de la Conférence Internationale des Doyens et des Facultés de Médecine d'Expression Française (CIDMEF) han sido revisadas en este contexto. Se observa que se concentran principalmente en los contenidos y los procesos de la educación médica. Por lo tanto, se recomienda revisar estos estándares y que se añadan estándares nuevos que reflejen mejor el concepto de responsabilidad social, que se ilustra mediante el compromiso en tres niveles: identificar las necesidades en salud de la población actual y futura, incluidos los determinantes de la salud; consecuentemente, adaptar las misiones y asegurarse si los efectos anticipados se han producido en el estado de salud de las personas. Para iniciar el cambio, se propone una serie de acciones futuras.

Palabras clave. Estándares de acreditación. Excelencia académica. Facultad de medicina. Responsabilidad social. Sistema de salud.

Defining excellence

Preventing from health hazards, reducing suffering, readapting to a productive life have always been fundamental guiding principles for health professionals and for institutions set to educate them and regulate their practice. Today, an emerging paradigm is also being progressively referred to, namely the engagement for an enhanced contribution to efficient, equitable and sustainable health systems.

A number of opportunities and challenges in the health sector call for greater commitments from the part of stakeholders: the increase of life expectancy requiring to generalize inter-professional ser-

vices, greater expectations of citizens coupled with a quest for more cost-effective interventions, fairer distribution of health resources to ensure universal coverage, comprehensive action on health determinants by improved coordination of multiple players, greater emphasis on the first level of care including community empowerment. In such a rapidly evolving context, what is the optimal set of competencies for the future health professional? How should education, research and service missions of academic health institutions be adjusted? What kinds of incentives should be proposed to undertake the necessary reforms? How can a revisited accreditation system of medical schools help guiding change?

Regarding medical schools, the interest for linking medical education to health system development is not new, as witnessed by the Edinburgh Declaration on medical education in 1978 [1]. More recently, in 2011, the Global Consensus for Social Accountability of Medical Schools suggested a set of strategies enabling medical schools to make a greater impact on the health system and on society's health status [2]. Since 1995, the World Health Organization has defined the social accountability of medical schools as: 'the obligation to direct their education, research, and service activities toward addressing the priority health concerns of the community, the region, or nation they have a mandate to serve. The priority health concerns are to be identified jointly by governments, health care organizations, health professionals and the public' [3]. It is understood that society's health concerns are extended beyond medical care to encompass economic, cultural, social and environmental determinants of health, many of which play a major role in maintaining the 'complete state of well being, physical mental and social' as WHO defines health.

Among the ten strategic directions presented by the Global Consensus enabling medical schools to become 'socially accountable', one specifically recommends that standards currently used by accreditation systems be adapted and new ones added to better reflect the concept of social accountability. Consequently, revisited standards would explore three interdependent clusters of capacities: first, the capacity to identify current and future health needs and challenges of citizens and society as a whole; second, the capacity to adapt the school's missions and programs to address those needs and challenges; third, the capacity to ensure that undertaken actions have produced or are likely to produce the desired effects on people's health as anticipated in the first instance.

Following this approach, and taking medical education as an example, a medical school would be confronted with the following questions: Do my graduates possess all the relevant competencies to address society's priority health concerns? Have we efficiently orientated their career choice towards issues and areas where needs are the greatest? Have we established solid relationships with their potential employers, in the public and private sector, to ensure a future conducive working environment to practice all competencies acquired during their medical education program? A similar introspection would be advisable for the research and service delivery missions of the school. One may argue that a medical school practising such an evaluative approach to guide its future development demonstrates traits of academic excellence as it seeks to provide evidence that what it had publicly committed to do to improve the quality, equity and effectiveness of health services has effectively been achieved and produced expected effects at short and longer term on people's health.

Adapting standards

An estimate of the scope of work required for adapting standards can be appreciated by reviewing the ones currently used by three main accreditation systems of medical schools, namely: the LCME (Liaison Committee on Medical Education), the WFME (World Federation for Medical Education) and the CIDMEF (International Association of Deans and Francophone Medical Schools) [4-7]. A general observation is that they all concentrate on the quality of medical education processes with limited interest to explore upstream what may justify such processes –ie., which situation analysis has determined the kind of health system and physicians society requires– and with even less concern for the consequences of those processes on the performance of the health system.

In the document *Functions and structure of a medical school*, the LCME proposes 12 areas of standards. Area 1, 'Mission, planning, organization and integrity', indicates from the onset that medical schools must show measurable results of quality in its medical education programs. This fair recommendation should have been preceded by a more overarching statement outlining explicitly how the school as an institution should strategically position itself regarding society's health challenge with the assumption that such statement should condition the design of medical education programs. If users

of standards were to consider this relationship with the overall health sector as implicit, the risk is that it would be diversely interpreted, eventually misinterpreted, if not neglected.

It is only at area 6, 'Competencies, curriculum objectives and curriculum design', that the recommendation is made to ensure students acquire the expected competencies by the profession and the public, without stating clearly which are those competencies. In contrast, in area 7, 'Curriculum content' it is recommended that students should apply most recent scientific knowledge to act on individual and population health and recognize health determinants and possible impact of socio-economic and cultural factors on patients' health.

The term 'health' is used here for the first time, once relative to individuals and population and once to patients without making a clear distinction of actions pertaining to one or the other. It is also proposed the curriculum should contain instructions to identify and resolve health disparities.

While above recommendations for medical education program designers are very relevant, none suggests the school becomes an eventual contributor to address those important health issues in the health system, possibly through collaborative ventures with other with key stakeholders. In limiting the social perspective to the formal education program instead of promoting it as a real ethos for the entire institution, the opportunity may be missed to convince faculties to wrestle with similar important commitment in their real life practice and research work and so become role models for graduates in their career choices. As a matter of facts, while the title of the LCME document refers to functions and structure of a medical school, its standards strictly relate to medical education programs.

Regarding the WFME, the document *Global standards for quality improvement of medical education* states that the prime goal of medical education is the improvement of people's health. Its 106 standards are clustered into 9 areas and 35 sub-areas. After their revision in 2015 following the Global Consensus for Social Accountability of Medical Schools, the document reaffirms that the strengthening of social responsibility aspects in medical education is of particular importance. As for the LCME standards, emphasis is put on educational programs, less on the engagement of the school although it is mentioned in area 1, 'Mission and outcomes', that the medical school must respond to health needs of society and assume consequences for its relationship with health policies. Further, in area 8, 'Interaction with the health sector', the school is advised to entertain a productive interaction with key stakeholders.

A part from those general considerations in the introduction and in the conclusion, there are no specific standards in the core of the document suggesting how the school should bring evidence for its a greater impact on society's health. Standards focus essentially on the educational processes, leaving untouched issues as important as strategies to encourage career choice of graduates in respect to priority health needs and conditions to respond to those priorities in their future working environment. One would expect the document to state upfront what is precisely expected from a medical school committed to respond the health needs and challenges in society and which partnerships it should weave to have a greater influence. New specific standards should be designed, eventually supported with examples and explanations as provided for existing ones.

The document of the CIDMEF intends to propose a wider scope of standards for education, research and service missions of a medical school. In its 2013 revised list of standards, chapter 1, 'Mission and objectives', clearly states that the school must contribute to improve the quality, equity, relevance and effectiveness of health services. This commitment is further elaborated in chapter 2, 'Governance and administration', by indicating a school must share responsibilities in the management of a health care delivery system in a given territory to demonstrate continuing consistency of its programs with health needs of people living in this territory. In so doing, it is anticipated that the school will make a more substantial contribution, for instance, in encouraging a larger proportion of graduates to settle in underserved areas and embrace primary care specialties. It also states that the school must avail of a leadership able to conduct the school to behave as an important health system actor. It is obvious that in advocating those guiding principles, CIDMEF intents to recognize excellence in the social engagement of the entire institution. Nevertheless, standards should be explicitly enunciated and coherently ordered throughout the nine chapters, assorted with definitions and illustrations to enable fair translation of principles into concrete recommendations.

In summary, the LCME, WFME and CIDMEF all admit to various degrees the need for medical schools to better adapt to evolving health needs of society and seem open to adjust their accreditation systems accordingly. Consistently, their current standards should be revisited, new ones added and presented

in a way that gives greater visibility to their ambition for a greater impact on health of the public.

Perspectives for future action

There is a growing opinion that medical schools should become more socially accountable and accreditation systems evolve. However, recommendations remain largely theoretical and limited to medical education programs. Standards must be clearly formulated to guide users in making the necessary adaptation.

Advocacy for socially accountable accreditation

While countries are urged to avail medical schools with a well-organized accreditation mechanism, equally pressing is the updating of standards to reflect principles of social accountability. Inspiration to design such standards can be found in the 10 strategic directions of the Global Consensus document [2] as well as in frameworks for evaluating the social accountability of medical schools, such as the ones proposed in the CPU model [8], the THEnet [9] and ASPIRE [10]. A panel of international experts should review the state of the art and make recommendations.

Beyond peers

Currently, teams visiting medical schools for their accreditation are essentially made of peers. To warrant more independent views on how schools fulfill their social obligation, teams should also be composed of representatives of key stakeholders such as potential employers of graduates, health professional associations, health care organizations and communities. Specific arrangements should be tested for their practicality and feasibility.

Global harmonization

The search for excellence in academic institutions is a universal quest, as is the aspiration for free circulation of ideas, talents and resources. Therefore, a certain degree of harmonization of the different accreditation systems for medical schools should be envisaged. Not for the purpose of uniformization as a greater impact on society can only be achieved by making specific choices and using optimally local resources, but for a stronger commitment towards a more relevant, efficient and equitable health system.

References

1. Edinburgh Declaration on Medical Education. Med Educ 1988; 22: 481.
2. Global Consensus for Social Accountability of Medical Schools (GCSA); 2010. URL: http://www.healthsocialaccountability.org.
3. Boelen C, Heck J. Defining and measuring the social accountability of medical schools. Geneva: World Health Organization; 1995.
4. Liaison Committee on Medical Education (LCME). Function and structure of a medical school. Standards for accreditation of medical education programs leading to the MD degree; 2015. URL: http://www.lcme.org/publications.htm.
5. WHO/WFME Guidelines for accreditation of basic medical education. Geneva/ Copenhagen: WFME; 2005. URL: http:// www.wfme.org/accreditation/whowfme-policy/28-2-who-wfme-guidelines-for-accreditation-of-basic-medical-educationenglish/ file.
6. World Federation for Medical Education (WFME). Accreditation 2005. URL: http://wfme.org/accreditation.
7. Conférence Internationale Francophone des Doyens et des Facultés de Médecine d'Expression Française (CIDMEF). Le Conseil d'Évaluation. Normes. 2012. URL: http://www. cidmef.ubordeaux2. r/?q=structures/conseil-evaluation.
8. Boelen C, Woollard R. Social accountability and accreditation: a new frontier for educational institutions. Med Educ 2009; 43: 887-94.
9. The Training for Health Equity Network. THEnet's social accountability evaluation framework version 1. Monograph I. THEnet. 2011. URL: www.thenetcommunity.org.
10. Fenoll-Brunet M, Harden R. La excelencia en educación médica: ASPIRE. Educ Med 2015; 16: 109-15.