

International standards in medical education: assessment and accreditation of medical schools' – educational programmes. A WFME position paper

The Executive Council, The World Federation for Medical Education

SUMMARY

WFME has recently decided to extend its 'International Collaborative Programme for the Reorientation of Medical Education', aiming at the implementation of its educational policy at the institutional level. The first objective is to stimulate educational institutions to formulate their own plans for change and for quality improvement to align with international standards. The second objective is to establish a system to assure minimum quality standards for medical school programmes. Both objectives can be accomplished by publishing a *World Register of Medical Schools*, which will constitute an instrument of quality assurance in medical education. The Register should specify designation of a *World Register Accreditation* of medical schools, which fulfil internationally accepted and approved standards of medical education programmes. The accreditation could be differentiated in various categories.

RESHAPING THE TASK OF WFME IN THE REORIENTATION OF MEDICAL EDUCATION

Since 1984 the World Federation for Medical Education (WFME) has conducted an 'International Collaborative Programme for the Reorientation of Medical Education'. Cornerstones in this process were the Edinburgh Declaration (World Federation for Medical Education 1988), which was adopted by the World Health Assembly (WHA 1989), and The World Summit Recommendations on medical education (World Federation for Medical Education 1994), which are reflected in WHA Resolution 488 (WHA 1995).

WFME has initiated and promoted the reorientation process primarily by formulating general objectives and guidelines for the purpose of changing medical education.

The time has now come to focus the function of WFME in the direction of the individual educational

institution. The first objective is to stimulate all medical schools to identify and formulate their own needs for change and quality improvement, by assessing their own strengths, weaknesses, potentials, capabilities and needs for change and reform. The second objective is to establish a system that can assure minimal requirements of quality for medical schools worldwide as the basis for international acceptance of medical doctors and for exchange of medical students.

Central to this new strategy is the decision to give priority to the task of **specifying standards or guidelines** for medical education both in terms of **the institution** and **the educational programme of the institution**. By providing such standards, which would constitute a new framework against which schools could measure themselves, **the assessment of educational programmes** and **accreditation of medical schools** could be initiated.

The programme of reorientation is not confined to basic medical education. Similar provisions could be made in specialist training and continuing medical education. However, the task in postgraduate and continuing medical education is more complicated and not further elaborated upon in this document. We would, however, like to underline that medical education is a continuum, and that similar initiatives should be encouraged in the other phases of medical education.

The WFME project proposed in this document deals with standards, assessment, and accreditation of medical schools conducting basic medical training.

THE NEED FOR CHANGE IN MEDICAL EDUCATION – AND BARRIERS OBSTRUCTING NECESSARY CHANGES

Several recent reports (American Medical Association 1982; Muller 1984; Gastel & Rogers 1989; General Medical Council 1993; Gastel *et al.* 1995; WFME

1994) have described the need for radical changes and innovations in the structure and process of medical education. Such changes are needed to prepare doctors for the needs and expectations of society, to cope with the explosion in medical scientific knowledge and technology, to inculcate physicians' ability for lifelong learning, to ensure training in the new information technologies, and to adjust medical education to changing conditions in the health care delivery system.

The World Health Organisation has on several occasions (WHO 1991, 1995, 1996; WHA 1995) advocated the need for change. They have proposed a series of activities intended to meet the current and future requirements of society, including the importance of understanding the circumstances of doctors' function in society and the need for interprofessional collaboration.

Based on the collection of available reports and declarations, a summary of recommendations and strategies, which are in accordance with previous WMFE declarations (WFME 1988; WFME 1994), is described in Tables 1, 2 and 3.

Although the need for changes in medical education along these lines has been confirmed in many fora, development proceeds slowly. What are the reasons for this inertia? There are probably many detailed explanations, determined by political, socio-economic and cultural realities. Others must be seen as institutional or personal factors, the main obstacles to change being conservatism of faculty staff and inertia, lack of definite educational budgets, insufficient supervision of the educational programmes, lack of incentives for teaching activities and insufficient leadership and management of institutions.

Despite this overall reluctance to adopt radical changes, it is fair to say that, during the last two decades, new approaches to medical education have been implemented in many countries and at many schools.

THE CONTEXT OF QUALITY ASSESSMENT IN MEDICAL EDUCATION

International standards

Universities and other institutions of higher education have not customarily been questioned about the relevance, efficiency or quality of their own educational programmes. Institutional autonomy has been a fundamental principle with each institution formulating its

own goals and creating its own educational programme. Diversity of educational programmes has even been considered an independent goal.

In North America, a system of assessment and accreditation of medical schools has been in operation during most of this century (Kassebaum *et al.* 1997a; Association of American Medical Colleges & American Medical Association 1997). Some countries in Europe, for example the United Kingdom, Holland and the Nordic Countries, have established agencies for the systematic evaluation of medical school programmes. Furthermore, Australia and New Zealand have a well-developed accreditation system (Australian Medical Council 1998), and a process of national accreditation has been initiated in Mexico (Cordova *et al.* 1996) and other Latin American countries and Malaysia.

It is difficult to conduct international comparisons between programmes in medical education, yet common core standards exist. One part of such core standards arises from the common scientific basis; another is the global task of educating with the purpose of solving health care problems.

In most countries, evaluation of the results of the educational process is restricted to internal examinations based on academic criteria. The use of external examiners in the examination systems in some countries is a modest modification of the tradition that medical education is not evaluated in a wider context.

An important aspect of measuring outcome in medical education is the use of comparison. One way of doing this is the utilization of national board examinations as a licensing instrument, for example, the US Medical Licensing Examinations. At the same time as allowing comparison, it is a means of quality assurance requiring each individual school to meet minimum standards of quality.

The World Federation for Medical Education has long emphasized that medical education must be viewed in the context of health care delivery, and that health needs should be considered more seriously in the planning of medical educational programmes. WFME has thus taken the same position as WHO, UNESCO, and UNICEF. However, social accountability is still insufficiently reflected in the programmes of medical schools (Boelen & Heck 1995).

The specific health care needs of the national population differ around the world. Although this statement is generally accepted and supported by many

Table 1 WFME recommendations on aims and content in medical education

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- Academic and practical professional competencies must be balanced. Skills, attitudes, communication abilities, and judgements in clinical work are just as important as the understanding of the basic biological mechanisms.
 - In order to prevent curriculum overload a core curriculum should be defined and the content supplemented by options.
 - Medical education should in its programme, besides leading to acquisition of the basic biomedical, psychosocial and clinical knowledge and skills that are necessary to care for the ill, also contribute to the prevention of diseases and promotion of health of the well.
 - Health needs of the society should be given higher priority than today in the planning of the educational programme.
 - Medical education must adapt to changes in the spectrum of diseases, changes in demography, and changes in the health care system. A part of the curriculum must take place in the primary health care sector.
 - Introduction in research methodology and electives must be part of the curriculum.
 - Future doctors should be trained in teamwork.
 - The various phases of medical education, i.e. basic, research, general postgraduate, specialist, and continuing medical education, must be coordinated.
 - In medical schools, teaching skills of faculty staff should be given the same credit as research, and indicators of educational competence must be identified.
 - Deans, associate deans and others with responsibility for the medical curriculum must prove from their own attitudes and behaviour that medical education has the same high priority and status as research.
 - Medical faculties must establish a central curriculum committee responsible to the dean with the right to form an integrated curriculum and select methods of education and examination.
 - Medical education should have its own defined budget with expenses related to specific areas in the same way as funds are allocated for research.
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forces, appropriate and relevant strategies and methods that can reflect this connection have not been widely used and it is still not clear how local health needs are taken into consideration in curriculum planning in medical schools. The impact of these efforts has been small on an international scale. Government regulation of higher education has only influenced the medical curriculum in very general terms; and the division of responsibility between ministries of education and ministries of health can result in profound gaps in the political governance of medical education.

Table 2 WFME recommendations on the learning process in medical education

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- Medical education should develop analytical abilities and prepare the doctor for self-directed life-long learning.
 - The students should be active and personally responsible for their learning process. Lectures must be diminished in number to allow for active learning in small group settings, one example being problem-based learning.
 - Medical education must to the greatest possible extent integrate basic and clinical disciplines with a focus on key principles. Students should meet patients early on.
 - Teachers in medical education must have a reasonable level of teaching skills and sufficient time to supervise and teach, as well as to function as mentors to individual students.
 - Teachers' knowledge of other disciplines must be increased in order to assure an integrated curriculum.
 - An essential part of medical teaching should be given by teachers with a background as medical doctors.
 - Medical education must offer instruction in the use of information technology in scientific as well as in clinical practice so that the students can learn to use bibliographic databases, computer-assisted decision making, etc.
 - Internationalization such as exchange programmes or electives at foreign medical schools should be part of the programme.
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The outcome of medical education, seen in relation to specific health care issues, will be different in various parts of the world. At the educational level, there are great variations due to differences in economic conditions (such as physical equipment, learning materials and manpower resources), academic tradition, and culture. Also, at the level of organization of health care, there are fundamental differences from region to region

Table 3 WMFE recommendations on assessment methods in medical education

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- Examinations should reflect the curriculum regarding biomedical knowledge, clinical skills, attitudes and judgements.
 - Both formative evaluation and summative examination methods are necessary.
 - The number of examinations should be limited in order to prevent overload of the curriculum.
 - Integration of the curriculum should be stimulated by the examination process.
 - Changes introduced in medical education must be evaluated. Quality control includes evaluation of the outcome in relation to the function as a doctor and the needs of society.
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of the world. The organization of health care delivery has its own influence on the conditions for, and the settings of, medical education.

Medical education and practice have always been international in focus and scope. Significant influence on the development of medical education has come from international communication among scientists and clinicians in the medical world (Stevens 1995). The 'industry' of medical communication, ranging from world conferences with international participation, to smaller meetings at a local level, and written and electronic communication through scientific journals and newspapers, all contribute to the internationalization of standards in medical education.

Another feature is the migration of students and doctors throughout the world. This phenomenon, which might increase in the next century, contributes to setting standards in the practice of medicine, and raises demands of migrating doctors to meet relevant minimum competencies.

In this connection, the value of a '**global core curriculum**' in medical education should be investigated. However, such core elements should be considered at different levels. Globally, the core can only contain the most fundamental theory and practice of medicine such as elements from the basic biomedical, behavioural and social sciences, general clinical skills, clinical decision skills, communication abilities and medical ethics. This set of core elements should be **modified or supplemented according to regional, national and institutional needs** in keeping with differences in culture, teaching traditions, disease distribution, health care delivery and resource provisions. At the institutional level, the core will then be supplemented by a **set of options** determined by factors such as local health problems, local institutional strengths and student choices.

The balance between core and options is not a fixed equation, and the balance will vary from region to region. It is likely that there will be more options in better developed regions and a core-dominated curriculum in less developed areas. For example, the present balance of 60% core and 40% options at Harvard medical school (personal communication) may not be appropriate everywhere.

An attempt to describe common guidelines in undergraduate medical education has been made in the European Community where the establishment of a quality control assessment system (Advisory Committee on Medical Training 1992) is also advocated.

What is certain is that the medical community is engaged with the need for definition of criteria of medical competence and with regulations for recognition of doctors educated in other countries. A future global standard could facilitate adequate worldwide migration, and, at the same time, set limits on the migration of those physicians who do not meet acceptable professional standards.

The endeavour to investigate standards of medical education worldwide faces problems, due to the educational differences among countries and regions at both undergraduate and postgraduate level. One well-known example is the difference in duration of undergraduate medical education programmes and the different criteria for selection of students.

With the explosion in the number of medical schools occurring in the last half of the 20th century, in total now exceeding 1400 worldwide, the differences in institutional structure, curriculum content, and teaching methods have increased greatly. To offer medical education at a sufficiently high level is expensive in terms of both money and manpower. Medical schools must have a certain time to draw up and consolidate their educational programme, and the continuation of this 'high-quality product' is dependent on a well-established research environment. Many of the new schools have been established too 'thinly', without adequate academic, institutional and financial resources, the foundation often being driven by political influence and personal ambitions. A new trend has been the rise of commercialized medical education in the form of 'for profit' medical schools, the main goal of which is the easy and convenient production of graduates. These schools particularly attract students who are academically unqualified to enter well-established schools, but who are affluent. Besides the disruptive effect of this development on the quality of medical education, it also interferes with attempts to rationally plan medical manpower in a country or region.

The need to document quality and to describe the expected outcome of medical education is underlined by public expectations and demands specified and expressed by the media and politicians. This development is closely connected with a general rise in the level of education in the population. It is also connected to the societal demand for value for money from the health care system and from investors in medical education.

Methodology

Methods for systematic evaluation of higher education have been developed in recent years. Internationally, different principles have been adopted by various countries and the results obtained have been wide-ranging.

The variety of interests in this field have to be kept in mind. **Governments** need some kind of steering mechanisms for monitoring the increasingly decentralised field of higher education, which in many countries is heavily supported by state funding. National or international evaluation agencies can monitor programmes and institutions and thereby provide some indications of the quality level of higher education in the country.

With the existing autonomy of **institutions of medical education** the presidents, deans and governing boards are often faced with difficult decision making. Systematic evaluation can provide institutions with data about their study programmes, reflecting institutional goals and realities, which can be useful in planning and setting priorities.

Students and health care institutions also need insight into the strengths and weaknesses of study programmes and in the professional qualities of graduates (the product). Students gain a basis from which to choose the appropriate school, and employers obtain information about the competencies of their medical workforce.

In many countries, it is the tradition for institutions offering medical education to be based on high research attainment. It should be carefully considered whether evaluation of medical education in a particular school should include evaluation of the contribution of research to teaching and learning in order to secure a high level of scholarship of future doctors.

Important **targets** for conducting evaluation are shown in Table 4.

The focus for evaluation can be specified as follows.

Programme evaluation measures only the quality of educational programmes within an area or group of disciplines, often on a national basis. Normally the research aspect is left out.

Institution or faculty evaluation measures the quality of total structure and activities of institutions, including administration, economics, other resources, research, education facilities and quality assurance mechanisms.

Auditing or Higher Education Quality Control is a method which intends to evaluate to what extent relevant mechanisms for assuring quality have been

Table 4 Targets for the conduction of evaluation of medical education programmes

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- Mission for the institution.
 - Objectives for the education being offered.
 - Structure of the educational programme.
 - Content of the programme.
 - Oedagogical principles.
 - Teaching methods.
 - Learning material.
 - Skills acquisition (laboratory and clinical training).
 - Assessment means.
 - Outcome measurements.
 - Physical facilities (libraries, lecture halls, group rooms, laboratories, etc.).
 - Capacity for clinical teaching (hospitals, general practice, ambulatory settings, etc.).
 - Learning environment (service and student culture).
 - Information technology and networking.
 - Management of the programme in terms of administration and decision making.
 - Admission criteria; number of students.
 - Teacher qualifications.
 - Student support and counselling.
 - Ongoing mechanisms for quality control.
 - Internationalization (exchange of students, etc.).
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established and how effective they are. This method also investigates whether measurement of quality is part of the institutional culture and development of the product.

Over time, all three strategies of evaluation should complement and support each other.

Accreditation can be targeted towards the institution as a whole or towards the three areas of function: research, education and service. The method requires identification and definition of a number of minimal requirements relating to the standards. Accreditation of educational programmes comprises issues such as numbers and qualifications of teachers, financial circumstances and teaching facilities and material as well as the educational programme in terms of curriculum content, teaching methods, assessment methods, etc.

The standards defined are often derived on the basis of consensus between educators, students, professional organizations, and governmental and public interests. The overall goal is to define competent doctors, who can serve the needs of the society. In this connection there is a need for better methods and more extensive use of outcome measurements. Is the doctor adequately prepared for the task?

In medicine, accreditation of educational programmes signifies that national standards for structure, function and performance are met by a medical

Table 5 Themes to be covered by the accreditation process

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- Representation and characterization of major decision makers.
 - Committee structures.
 - Review processes, evaluation and feed-back.
 - Staff appraisal.
 - Allocation of support to individual teachers and departments.
 - Management and development strategies.
 - Financial control and business planning process.
 - Infra and inter departmental communication.
 - Social accountability and integration with the community.
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education institution's programme leading to the MD degree (undergraduate medical education, in some countries MB) or qualifications as a specialist in one of the recognized medical specialities (postgraduate training).

The process of accreditation normally involves the following elements: (1) data collection about the institution (Table 5); this may encompass questionnaires to various groups, for example students and/or recent candidates; (2) a self-evaluation process conducted by the leaders, educators, administrators and students of the institution; (3) institution visit by external experts; (4) the production of a report by the evaluation body, and (5) final decision by a duly constituted authority on accreditation.

INTERNATIONAL REGISTRATION AND ACCREDITATION AS A TOOL TO IMPLEMENT QUALITY

An overview of medical education in the late 20th Century (Sajid *et al.* 1994), covering a large part of the world, is a valuable source in comparative studies.

Until now, the only global registration of medical schools is the *World Directory of Medical Schools* (WHO 1986). In the latest edition, medical education institutions and programmes are presented in a very condensed and standardized form based on information delivered by national authorities. Detailed information about objectives, curriculum content, balance of disciplines, teaching methods, evaluation methods, or outcome and results of the education programme are not provided. Furthermore, the information has not been controlled and the programmes not subjected to any quality assessment. The next edition of the *World*

Directory of Medical Schools, now under preparation on the basis of a more elaborate questionnaire, will include information about existing national assessment and accreditation systems.

A more versatile way of collecting information on medical school curricula has recently been presented by Eysenback *et al.* (1998) using data compiled and made accessible via the World Wide Web.

The intention of this WFME background paper is to describe the need to develop instruments to document the quality of medical education which should not only give basic information, but, in addition, should provide qualitative descriptions of school programmes based on assessment and an international accreditation system.

It is a general experience that change and development can be initiated more easily when outside experts are consulted. This principle is often used by governments calling upon international agencies. Limited experience with evaluation of higher education seems to indicate similar value of external peer reviewers used in relation to self-evaluation procedures. In fact, the mere decision to start an evaluation process seems to initiate a climate for initiatives to be taken by the responsible leaders of the institutions.

A lasting gain of any accreditation procedure is the systematic data collection related to the management of the educational programme. This is useful for the continuing quality measurement in the individual institution.

It should be emphasized that quality does not imply accordance with a single formula. One concern with accreditation systems could be the risk of uniformity of educational programmes. However, experience shows that accreditation does not lead to identical programmes, but to the underlining of different profiles of education within the defined standards.

To supplement the qualitative profile, a quantitative dimension can be added in the form of grades ranging from excellent to not acceptable. This can help students in their choice of medical school to which to apply.

The real value of accreditation is **not control**, but the initiation of formative processes which results in quality improvement on the institutions' own premises. Experiences with evaluation of medical school programmes show that the process has started a profound discussion and interest in self-evaluation in individual schools. This has very often led to substantial changes, carried out by the school independently of the final assessment report.

The influence of a national accreditation system is documented by Kassebaum *et al.* (1997b). A correlation was shown between the criticisms appearing from the accreditation results and curriculum renewal. This renewal process was supported by grant funds from national foundations promoting reforms. Accreditation works because of the process of evaluation, including the establishment of national goals for medical education and national standards for accreditation; it includes (1) a process of internal (self-) assessment; (2) on-site peer review by a panel of experts, and (3) decision making by a national accreditation commission.

RECOMMENDATIONS FOR FUTURE ACTIONS. THE ROLE OF WFME

Only a minority of the more than 1400 medical schools worldwide have been subjected to external assessment and accreditation procedures. This gives rise to major concern about quality when seen in relation to the well-documented need for reforms in medical education. The explosion in the number of new schools adds to the problem.

The arguments presented demonstrate that undergraduate medical education from an international perspective is in need of the introduction of a quality-assuring instrument. Two main purposes should be fulfilled. One is to facilitate the implementation of the changes and innovations which have been advocated by international organizations and leading educators, but which for many reasons have been insufficiently incorporated in education programmes. The second is to safeguard and enhance the quality of medical education to ensure that the increasing internationalization in medicine can continue by supplying national authorities, and potential students, with valid information about the realities of medical education programmes in other countries.

Although it might be controversial to use a ranking system allowing individual schools to compare with each other, WFME believes that comparing medical school educational programmes to internationally approved standards, and publishing the results, would stimulate individual schools to work more dynamically with educational reforms. In addition to the accreditation result, the dialogue among teaching staff at the individual medical school and the site visitors conducting their investigation will be valuable.

Institutional self-evaluation of education programmes has potential for demonstrating the demand for reforms and should be used systematically as a quality-assuring instrument. With respect to measurement of quality in medical education, guidelines for self-assessment with a focus on the need for adjustments of medical education programmes to health needs have been presented (Boelen *et al.* 1992).

Regarding internationalization, the authorities at present generally have limited documentation for their evaluation of the educational background of foreign medical students who are seeking access to continue undergraduate medical education, and of foreign medical doctors who want to obtain a license to practise medicine or the opportunity to enter postgraduate training. Great variation is seen in the ways in which national authorities tackle this situation. The most elaborated system is in the United States, in which systematic evaluation of visiting physicians has been developed during the last 40 years by the Educational Commission for Foreign Medical Graduates (ECFMG) (Gary *et al.* 1997).

In countries other than the USA, the methods followed to assure the necessary competencies of foreign applicants are generally less systematic and safe, and to a great extent subjected to variations determined by traditions and specific knowledge about the education systems in other countries. Documentation regarding medical education and certification will normally be supplemented by requirements to pass examinations in at least some disciplines of medicine as well as a language test when relevant.

From the point of view of guarantee to the authorities regarding sufficient competencies of doctors educated abroad, systems presently in use are not adequate for control and local assessment of applicants. On one hand, it is not documented what is obtained by adding new examination requirements in biomedical and clinical medicine to those already fulfilled at international medical schools of equal standard and comparative programmes. On the other hand, even the most scrupulous administrative practice with respect to the achievement of documentation from other countries will not safeguard against deficiencies in competencies, a problem which is only partly solved by examinations that mainly measure theoretical knowledge.

WFME considers that there is a great need for an **International Register of Medical Schools**. In this

context the possibility of developing the *World Directory of Medical Schools* into an effective quality information document in international medical education should certainly be considered. The World Register should continue with the present method of listing all medical schools based on basic information obtained from national authorities. The information provided, which serves as a foundation for foreign students and authorities in other countries, could well be extended to give information about addresses, names of relevant contact persons, etc. The development proposed implies that, in addition, those medical schools fulfilling internationally approved criteria for medical educational programmes could be designated as a **'medical school with an accredited medical education programme'**.

Such a **'World Register Accreditation'** of a medical school programme awarded by an **International Board of Accreditation** would be a guarantee that the programme has been assessed by an international expert committee and found to fulfil minimal requirements and meet accepted standards. Such recognition will signify that the international reform programme either has been incorporated or that serious initiatives to do so have been taken. Consequently, the Register could catalyse the WFME reorientation programme.

Accreditation could be further differentiated as **'excellent'**, **'good'** or **'acceptable'**.

Knowing that the definition of minimum standards can have a levelling effect on quality, all evaluations should include guidance on how the programme could be improved – even the excellent ones. In this way, the aim would be towards excellence in medical education, not for a minimum standard. To obtain further information, individual schools could be encouraged to add information about particular curricular features, educational strategies or innovative approaches.

World Register Accreditation must be based on **voluntary assessment**. In a world influenced by market mechanisms, external approval might attract grants and facilitate student recruitment to the school. The development of an international accreditation system, as proposed, will be a demanding and challenging process, which WFME and its Regional Associations must commit itself to in close collaboration with other relevant partners in international medical education. These parties include WHO, UNESCO, the World Medical Association (WMA), the Network of Community-Oriented Educational

Institutions for Health Sciences and the International Federation of Medical Students Associations (IFMSA); foundations concerned with the promotion and quality of medical education. In this connection, it will be important to build on the experiences already gained by agencies around the world which have been involved in assessment and accreditation of medical schools. It should be emphasized that **existing national or regional accreditation systems of high quality should be adopted** by the International Board of Accreditation of the World Federation for Medical Education.

ACTION PLAN

- **The first phase.** International discussions among experts in medical education should lead to consensus about **accreditation standards**. Such standards would be formulated **globally** in accordance with the recognition that science and practice of medicine, despite their variability around the world, are founded on a core of concepts. The need for **regional and national additions, exceptions and modifications** will be taken into consideration. The intention is emphatically **not** to apply one uniform set of standards leading to any single prototype of doctor in the whole world.
- **The second phase** will be communication of the emerging accreditation criteria through an **international debate** utilizing conferences, workshops, journals, newsletters, and the Internet, with the purpose of achieving general acceptance of such standards among schools, authorities and organizations.
- **The third phase** will be establishing experiments with accreditation procedures in the form of **pilot studies** in all six regions of WFME. These will include initiation of institutional self-evaluation and the appointment of national and regional expert panels to undertake institutional surveys.
- The main intention of **the fourth phase** will be the establishment by WFME of an **International Board of Accreditation** with the responsibility of evaluating accreditation reports and making decisions regarding designation of **'World Register Accreditation'**. The Board should be broadly based with members representing medical schools, medical educators, health authorities, the practising profession, and medical students. The accreditation

Table 6 Protocol for the WFME collaborative project: International Standards in Medical Education. Assessment and accreditation of medical schools' educational programmes

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- Preparatory inquiries will be initiated with international authorities in health and higher education, such as WHO and UNESCO, as well as other relevant organizations and institutions.
 - Political and financial partners for the project will be sought.
 - Experience from existing assessment and accreditation systems will be incorporated.
 - A procedure for definition of global and regional standards for medical education programmes will be initiated, addressing the need to establish a national consensus for educational standard setting, assessment, and accreditation. In this process WFME will act as the catalyst.
 - International communication and discussion of results from WFME initiatives will establish regional and national consensus about standards.
 - Accreditation pilot projects will be conducted in the six WFME regions based on institutional self-evaluation and peer reviews by expert panels.
 - An International Board of Accreditation will be established with responsibility for evaluation of reports and designation of a 'World Register Accreditation'.
 - A central or mobile secretariat of evaluation experts will be established to ensure quality in the accreditation programme.
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will be conducted based on **voluntary** request from the institutions concerned.

WFME proposes a **Protocol** for the process that will require the Federation to undertake a number of steps (Table 6).

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