

# Accreditation of Graduate Medical Education Programmes

One size fits all—or does it?

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WORLDWIDE, MEDICAL EDUCATION, both at the undergraduate and postgraduate levels, is in a process of evolution. Oman has adopted outcome- and competency-based curricula in graduate medical education programmes, and is currently seeking accreditation with the Accreditation Council for Graduate Medical Education International (ACGME-I).<sup>1</sup> We believe that is the way forward. In fact, many medical schools have adopted and are currently adopting outcome- and competency-based curricula, while many others employ the time-tested methods of apprenticeship and mentorship in their graduate medical education programmes. Not only are the two models of teaching and learning different, but efforts at 'fine-tuning' have led to a whole range of different options along the spectrum. Thus, while the medical education systems vary from one country to the other, from one region to the other in the same country, and even from one medical school to the other, there are advantages in each system. It is evident that many of the 'core competencies' of medical graduates and postgraduate doctors are developed by different training methods, and stimulated by a variety of accreditation systems.

The process of refining methods in teaching, learning, and assessment in undergraduate and postgraduate education dates back to the 19<sup>th</sup> century, and is the result of either systematic reforms introduced, and/or a response to societal demands. From the 19<sup>th</sup> century apprenticeship model,

through the systems-based model introduced as a result of the Flexner report<sup>2,3</sup> in the earlier part of the 20<sup>th</sup> century, and onto the outcome-based curriculum straddling the start of the 21<sup>st</sup> century, there has been a continuous process of refinement. At the heart of the continuous desire for improvement, is the need to produce medical practitioners who can use both scientific knowledge and appropriate clinical reasoning to provide medical care with character, compassion and integrity. The strengths of the apprenticeship model, such as role-modelling and story-telling, are still important today, especially at the fellowship training level. They are considered the cornerstone for developing and polishing some very important outcomes, such as professionalism. Subsequently, the Flexner's report<sup>2,3</sup> stressed the need for formal analytic reasoning, and considered this to be one of the most important requirements for the intellectual training of physicians. The "Think much; publish little" dictum was then replaced by a 'Publish or perish' culture<sup>4</sup> in response to the then emerging standard, against which the faculty accomplishments were judged. The introduction of the discovery-care continuum in academic health institutions,<sup>5</sup> leading to the integration of research with patient care and teaching, contributed immensely to the current state of development of healthcare. Unfortunately, the pendulum swung too far in some institutions, as the medical research became increasingly molecular, leading to polarisation between clinical-teachers and top-notch researchers. Another leap

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forward that impacted medical education can be attributed to the current healthcare environment, and the need for the generation of revenue; 'clinical productivity' became a benchmark for the clinician's performance.<sup>4</sup> This necessitated the incorporation into curricula of inter-professional skills, teamwork, population health, and health service organisation. For example, 'managerial' competency is now defined as yet another important outcome in being a competent doctor.

Clearly the various competencies, as defined by the World Federation of Medical Education (WFME),<sup>6</sup> CanMEDS (from the Royal College of Physicians and Surgeons of Canada),<sup>7</sup> the UK General Medical Council (GMC) Competencies<sup>8</sup> and those from the Accreditation Council for Graduate Medical Education (ACGME)<sup>9</sup> are a reflection of the ever-changing standards of medical education. Life-long learning is more important today, as an outcome of our medical education, than ever before. Indeed most accreditation systems today insist on achieving various competencies, including life-long learning.

Whereas more and more postgraduate medical education programmes throughout the world are adopting 'structured' curricula (such as competency- and outcome-based curricula), there is still an enormous amount of variability in the way that graduate medical programmes are conducted and monitored. There appears to be a trans-Atlantic divide, with most of the postgraduate training programmes in North America being based on structured clinical teaching, compared to the vast majority of programmes outside of North America, which are still based on the apprenticeship method. However, in some of these countries, these postgraduate programmes have now begun to undergo changes and reforms. Whereas there are merits in both systems, it is difficult for one system to claim absolute superiority. *Prima facie*, the structured clinical training and competency-based curricula appear superior and seem more attractive. However, the final result is far from clear as the outcome measurement tools are still in their infancy. The residency programmes in the USA and Canada have started applying the concept of outcome-based and competency-based assessment. Utilising such assessment tools provides a level playing field for the accreditation system of residency training programmes.

The process of accreditation helps to evaluate, improve and recognise the programmes by complying with certain standards of education; it also improves healthcare by assessing and enhancing the quality of graduate resident physicians for the benefit of the public. The standards are set independently by the accrediting bodies, conformity to which helps to boost the confidence of the public in the physicians graduating from the programme. Thus, accreditation is seen to safeguard the rights of the public on the one hand, and the interests of residents on the other. Furthermore, it creates an environment conducive to research and optimal professional practice, as well as creating opportunities to integrate clinical practice, education and research. The concept of the 'discovery-care continuum'<sup>5</sup> is therefore also encouraged by accreditation. Moreover, it is a positive driver of market forces, as accredited programmes attract better residents than non-accredited programmes, and the job-market seeks graduates of accredited programmes; hence, the need for accreditation becomes clearer. The question is, which system should be adopted by Oman and other countries in the region, or by countries with health systems like Oman? Is there a choice, and what are the options?

Accreditation of graduate medical education started in the USA in the 1940s for individual programmes such as surgery. It gradually became popular and, nearly 40 years later, the ACGME<sup>9</sup> was established in the 1970s. More recently, the ACGME piloted the international provision of accreditation, to programmes outside the USA and thus ACGME-I<sup>1</sup> was created in 2009, almost a further 40 years later.

In Canada, the Royal College of Physicians and Surgeons of Canada, since its inception in 1929, has accredited only the Canadian medical residency training programmes.<sup>7</sup> In 2009, the Royal College Canada International (RCCI)<sup>10</sup> was established; however, it still does not accredit residency programmes outside Canada. We wonder what the delay is. Why not share what they have with developing countries, where there is a dire need for an accreditation system? The GMC monitors the quality of training, etc., of the residency programmes in the UK deaneries but not international programmes as yet.<sup>8</sup> The Australian Medical Council<sup>11</sup> accredits only the residency-training programmes in Australia and

New Zealand. A great majority of specialists and healthcare managers in countries like Oman have been trained in Canada, the UK, Australia or New Zealand, and hence the healthcare systems in some developing countries have much in common with those systems. The ability to choose from the validated accrediting programmes of those systems could be immensely helpful.

The concept of training doctors in specialties and subspecialties using 'structured training' and 'measurable outcomes' is relatively recent in many countries, and hence full acceptance by all trainers and trainees might be slow. Accreditation is a good stimulus for acceptance of change and unification amongst staff and students.

The basic mandate of ACGME-I<sup>1</sup> is to provide a strategic overview and make recommendations of standards for international accreditation similar to the ACGME standards, albeit modified by removing those standards required by US government policies, and after accommodating for regional differences in types of diseases, their prevalence and burden, etc. As a result, the requirements to comply with the standards are not less rigorous, but may be somewhat different. At the level of the educational programme, the standards seek to ensure an adequate number and quality of faculty and facilities, as well as a structured curriculum and learner-centered environment providing a humanistic experience and patient-centered care which takes into account local culture and patient safety. At the institutional level, however, the standards seek to develop a resident-centered learning environment, prioritising education, but balancing this with the provision of service. These demanding standards of ACGME-I<sup>1</sup> are clearly beneficial for graduate medical training, but can all healthcare systems comply with them? Or should they? Is that what we want—for all international graduate medical education to be almost identical in all countries? Clearly, what is needed is a choice to suit the varying needs and requirements, and that could be provided by competing accrediting bodies. One size may not fit all—and it is not necessary that it should do so!

The strength of the ACGME/ACGME-I<sup>1,9</sup> is that the system has been running in the USA for several years, is validated, and is well-received by the stakeholders. Importantly, the programmes need to comply with competency- and proficiency-

based structured training programme even though the length of training experience or the number of procedures performed during training do not equate to proficiency. Rather, each resident's competency needs to be assessed using multiple tools and various methods of assessment. The challenge outside the USA is to align the training programmes with the accreditation standards, especially where the programmes are still heavily dependent on apprenticeship and when change is not always easy or readily accepted. There needs to be a change in culture in the medical field in many developing countries. In Oman, we have adopted a structured training system in the residency programmes, even before inviting an accreditation agency, and the Oman Medical Specialty Board (OMSB)<sup>12</sup> has also recently adopted competency-based training. Thus, it is reasonably easy to comply with the ACGME-I Accreditation Standards for possible accreditation, and for now the ACGME-I may be an appropriate choice. However, specialist training is provided in six different hospitals across the capital, and these places have strong, long-standing institutional cultures, especially the priority of the provision of clinical services. It is the responsibility of the trainees and the trainers to meet the requirements for certification, with respect to achieving the required competencies, but also to keep in mind the philosophy of the institution, and the constraints of resources. Accreditation involves acceptance of change and readiness to compromise!

Whereas it may be possible to make the graduate programmes compliant with the requirements of ACGME-I, it would be difficult to change the institutional culture over a short period. The change needs to be accepted and embraced not only by residents, but also by the faculty and the leadership, i.e. the affiliated institutions, and that amounts to a paradigm shift. We believe that one size may not fit all. While accreditation is the need of the hour, it is imperative to assess the culture of the individual institution, and its state of readiness for change. The alternative would be to create an accreditation programme which is conducive and aligned to the prevalent culture. Such a development, however, would involve several built-in stages with multiple checks and balances, in order to comply with the concept that an ideal accreditation system should be structured, valid, reliable and have measurable outcomes. The time is ripe for developing countries

to have a choice of accreditation agencies. Developed countries owe it to the world of medical education.

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