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Section on International Organization Perspectives on Person-centered Medicine

World Federation for Medical Education perspectives on person-centered medicine

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Introduction

The purpose of this presentation is to explore to which extent the policy and activities of the World Federation for Medical Education (WFME) and the WFME global standards in Medical Education are consistent with the concept of person-centered medicine.

Development and implementation of the WFME global standards programme

Since 1984 the WFME has conducted an "International Programme for the Reorientation of Medical Education". An important cornerstone in this process was the Edinburgh declaration of 1988 [1], adopted by the World Health Assembly in 1989 [2]. In order to promote the programme and in keeping with its constitutional mandate, the WFME Executive Council in 1998 in a position paper launched its Programme on Global Standards [3]. The purpose was to provide a tool for quality improvement in medical education, which could be of direct assistance to institutions, organisations and national authorities responsible for education and training of medical doctors at all levels throughout the continuum of medical education.

In developing the WFME standards, the Federation set up three International Task Forces with members from all regions, selected on basis of their expertise and with geographical coverage an important consideration. The result was the WFME Trilogy of Global Standards, published in 2003 [4–6], covering all three phases, i.e. basic (undergraduate) medical education, postgraduate medical education (specialist training etc.) and the continuing professional development of medical doctors [CPD, including continuing medical education (CME)].

The global standards programme obtained clear international endorsement [7] at the World Conference in Medical Education *Global Standards in Medical Education—For Better Health Care* held in Copenhagen, March 2003. Implementation of the Global Standards Programme already started in 2000, and has comprised pilot studies of application in various institutions in all parts of the world, translation of standards into a number of languages, information in publications and at a huge number of international conferences, establishment of a WFME advisor function, and development of distance learning material to assist institutions and authorities.

An important step was the establishment in 2004 of the World Health Organisation (WHO)/WFME Strategic Partnership to improve medical education [8] with the purpose of a long-term work plan, intended to have a decisive impact on medical education in particular and ultimately on health professions education in general. The first practical result, based on a joint WHO/WFME International Task Force, was the development of the WHO/WFME Guidelines for Accreditation of Basic Medical Education, which recommended the use of the WFME standards or criteria consistent with these standards [9]. Also, the practical collaboration between the six Regional Offices of the WHO and the WFME and its six Regional Associations for Medical Education has been of increasing importance for the impact of the programme.

In 2007, a set of European specifications to the WFME global standards was published after development by a WFME/Association of Medical Schools in Europe (AMSE) Task Force [10]. This was part of the programme of the Thematic Network on Medical Education in Europe (MEDINE), running from 2004 to 2007 and sponsored by the Commission of the European Union, and was also supported by the WHO European Office. The main result of this process was to add a few references to specific European conditions, such as the EU Directives [11] and commitment to the European Higher Education Area, defined in the Bologna Declaration and Process [12], and to change the division lines between the two levels of WFME standards (see below), thus taking into account the general social and economic conditions as well as recent improvements and endeavours in quality assurance and development of medical education in Europe, which was found to allow higher standards to be set.

Based on the accumulated information collected at the WFME office, >500 medical schools in the world have now used the WFME standards as basis for institutional self-evaluation studies, peer reviews and other types of programme development, and about 100 countries are using the standards either directly or as a template for national standards in accreditation or other types of recognition of programmes. Similarly, a great number of countries are using the WFME standards for postgraduate medical education and CPD.

As part of the WHO/WFME Strategic Partnership it was decided to work for a development of the WHO Directory of Medical Schools, published since 1953. Following consultation with WFME, an agreement was signed in 2007 by WHO and the University of Copenhagen, which means that responsibility for development and maintenance of a new electronic database of medical schools and their programmes was transferred to the University with the assistance of WFME. The new database, which is intended to progressively also include education institutions for other academic health professions, is called the Avicenna Directories [13]. The vision of the WFME is that in the future, such a database could be an important instrument in quality development and international recognition of higher education institutions, allowing a kind of meta-accreditation (‘accrediting the accreditors’).

Essentials of the WFME standards

The WFME global standards programme should be seen as a tool for quality improvement of medical education and an instrument in safeguarding internationalisation of medical doctors in a world of globalisation as manifested in the increasing exchange of medical students and migration of medical doctors. The need for international standards is also intensified by the mushrooming in many parts of the world of new medical schools, many of which are established on insufficient grounds with respect to e.g. physical and manpower resources, research attainment and facilities for clinical training, and often established without adequate accreditation procedures or other types of quality assessment.

The WFME standards are not defined to be used for assessment of individual competencies of medical graduates, but are organised at the institutional and educational programme level of medical schools and other institutions and organisations. They comprise the ‘universe’ of medical education in dealing with a broad set of categories including the structure and organisation of the institutions, the process of education, including the content or syllabus of the curriculum, the educational conditions as determined by facilities, resources and the educational environment, and the outcome described in generic terms.

The standards in all three parts of the Trilogy are structured in nine areas, defined as broad components of structure and process, and each area again divided in 36–38 sub-areas corresponding to performance indicators. For the standards in basic medical education, the areas are: mission and objectives; educational programme; assessment of students; students affairs; academic staff/faculty; educational resources; programme evaluation; government and administration; and the continuous renewal. The two other set of standards include similar areas with minor, relevant changes in the wording. For each sub-area, a number of standards are defined at two levels of attainment: (a) basic standards, meaning that the standard must be met from the outset of the programme, and being especially relevant for accreditation purposes; and (b) standards for quality development, meaning that the standard is in accordance with international consensus about best practice, and that fulfilment of—or initiatives to fulfil—some or all of such standards should be documented, and being especially relevant for programme reforms.

The global standards should be considered a template for definition of regional, national and institutional standards with adequate specifications. They have the advantage of recognising national and institutional differences, allowing different profiles of the programmes, and respecting reasonable autonomy of institutions. They aim at function-

ing as a lever for change and reforms, encouraging quality development and recognising the dynamic nature of medical education.

Measuring an institution and its programme against the standards means ensuring

- that the education provided is the best available (*educational needs*)
- that the school fulfils its mission in relation to the public (*social needs*)
- that the professionals maintain their own development and consistent performance (*professional needs*)
- quality by using accreditation or other systems of recognition based on agreed standards (*regulatory needs*).

WFME standards and the person-centered medicine concept

Do the WFME standards take into account the concept of person-centered medicine (PCM)? There is no doubt that the standards comprise the whole person in dealing with the medical curriculum and other sides of the programme. This is clearly confirmed by the description of requirements to the programme, which should include not only the disciplines of the basic bio-medical sciences, but also the behavioural and social sciences and medical ethics. Furthermore, it is outlined that all the major disciplines and skills must be included in the clinical education and training, including e.g. psychiatry.

It is thus stated in the annotations made to the sub-area on *behavioural and social sciences and medical ethics* that these topics will—depending on local needs, interests and traditions—typically include medical psychology, medical sociology, biostatistics, epidemiology, hygiene, public health and community medicine, etc., and that these disciplines should provide the knowledge, concepts, methods, skills and attitudes necessary for understanding socio-economic, demographic and cultural determinants of causes, distribution and consequences of health problems.

The PCM principle is also implicitly covered by the criteria for definition of mission and objectives of institutions and by the expected competencies of graduates, expressed in broad professional terms regarding knowledge, skills, attitudes and behaviours, as well as in stated requirements for appropriate, effective and compassionate patient care comprising all health-related problems, including disease prevention, rehabilitation and health promotion.

The WFME standards will encourage medical schools to develop an integrated programme—in theory and practice—of the bio-medical, clinical, behavioural and social sciences, including medical ethics, medical psychology, medical sociology and public health. The standards also emphasise use of a broad category of settings for clinical training, including not only academic teaching hospitals, but also other relevant hospitals and institutions and community-based settings (including specialist practices), clinics, nursing homes and primary health care stations.

Finally, the WFME in the standards advocate early patient presentation in the curriculum leading to ‘person to person’ contact and involvement.

Barriers to achievement of PCM

Most medical schools and also organisations responsible for postgraduate education of doctors would—many rightfully—argue that requirements determined by the PCM concept are adequately fulfilled in their educational programme. However, it is obvious that there are problems in some countries and institutions. Among the barriers to achievement of adequate PCM we must consider the reality in some programmes of:

- insufficient impact of medical ethics
- insufficient emphasis on communication skills
- insufficient training in medical psychology and psychiatry
- insufficient education in medical sociology and public health disciplines
- reduction in general training and too early specialisation
- consequences of some realignments in the health care sector with negative influence on the educational environment.

The concept of PCM is certainly not new, but medical educators and other responsible for quality education should be aware of trends in the development and management of medical education, which negatively would influence the outcome and deviate education from following PCM principles.

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