ACGME International: The First 10 Years

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A successful organization takes its mission seriously. Often, its name references those it serves. Unlike many organizations whose acronyms include the letter "A," the first letter of ACGME does not connote "American." Rather, it stands for "accreditation," the heart of the Accreditation Council for Graduate Medical Education's activities. From a traditional perspective, however, accreditation services provided by the ACGME are restricted to the United States and its territories.

In the early 2000s, a series of inquiries from other countries challenged this tradition. ACGME's system of accreditation historically has attracted attention from the global community as providing quality education that consistently produces high-quality physicians with relatively low attrition. In 2008, a request was made by the Ministry of Health in Singapore. It sought a transformational change in its graduate medical education (GME) program in order to reliably produce physicians, in greater numbers, more capable of serving their society's needs. The original request was for the ACGME to assist the Ministry of Health and associated entities to create an educational and accreditation oversight model similar to that in the United States. After considerable discussion, it was determined that the conflicts of interest inherent in a Singapore accreditation process could undercut trust in the effort. The ACGME was petitioned to provide accreditation services and parallel educational programs to transform the postgraduate system. A pilot project was formulated and approved in 2009 by the ACGME Board of Directors in response to this request.

In order to have clear separation between domestic accreditation (ACGME) and the international pilot, ACGME International (ACGME-I) was created as a limited liability corporation (LLC) of the parent organization, ACGME. Oversight rested with the ACGME Board of Directors, with a specific reporting structure to the Finance Committee to assure that no domestic funds were utilized in the development or operation of ACGME-I.

Over the next 2 years, a concerted educational program was implemented with Singapore's medical educators. Concepts such as institutional sponsorship, Graduate Medical Education Committees (GMECs), evaluations of the 6 competencies, the role and importance of the program director, accountability of the faculty for resident outcomes, and the necessity of longitudinal data acquisition and use in accreditation were introduced. It was an extraordinary undertaking by the Singaporean medical education community—a system that had evolved in the United States for over a century was being adopted in a fraction of that time.

ACGME-I modeled the international standards in a framework similar to those used in the United States.[1] Of paramount importance was the insistence that *institutional* accreditation was an essential first step. For *program* accreditation, a fundamental difference was to create a 2-step process of *foundational* and *advanced specialty* accreditation. Foundational requirements provide an educational framework similar to the ACGME Common Program Requirements. Advanced specialty requirements were those governing unique aspects of a specialty. In order to ensure implementation of the educational framework, foundational accreditation must be granted prior to consideration for advanced specialty accreditation. This 2-step process could be completed at the same time, but advanced specialty accreditation was not considered unless the foundational application demonstrated substantial compliance.

Application for initial institutional accreditation by all 3 sponsoring institutions in 2010 was successful. Shortly thereafter, the first programs were accredited by ACGME-I. These accreditation decisions were made by the founding ACGME-I Review Committee, which was comprised of senior leadership from the ACGME.

The success of the pilot program in Singapore resulted in requests for accreditation services by Qatar and United Arab Emirates. In 2011, the ACGME Board of Directors approved extension of the pilot to these countries, and in 2013 approved the continued operation of ACGME-I as a self-sufficient international accreditor of postgraduate medical education. Shortly thereafter, expansion into Oman and Lebanon (American University of Beirut) occurred. An eye specialty hospital in Riyadh, Saudi Arabia, has been added as well. Citing these

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expansions of ACGME-I into economically secure environments, the ACGME Board of Directors expressly noted its intent for ACGME-I to serve economically challenged countries as well. Currently, this commitment is manifested by extensive outreach to an institution in Haiti.

As new requests for accreditation services and expanded educational outreach occurred, so too did an expansion of ACGME-I standard-setting responsibilities. In providing accreditation services to expanded areas in different cultures and systems of health care delivery, it became apparent that these differences had 2 important lessons. The first lesson is that standards required relevance to the jurisdiction where they were being applied. This imperative to create flexibility centers on cultural, scope of practice, and societal needs. This focused effort has resulted in a gradual evolution toward truly *international* requirements, which should also be compliant with the postgraduate medical education accreditation framework proposed by the World Federation for Medical Education (WFME).[2] Elements of the original system continue to be essential to attain and maintain program quality. Most importantly, the ACGME-I requirements continue to insist on a supportive clinical learning environment with institutional accreditation required prior to any programmatic approval. On the other hand, the need for flexibility is respected. In some countries, physicians' work hours—regardless of stature or specialty—are curtailed at 35 hours, various specialists perform thyroidectomies, and age demographics influence availability of clinical experience as well as scope of practice for various specialties.

Similarly, there were lessons for the United States. Most notably, our system requiring physicians educated exclusively outside the United States to have postgraduate (GME) experience within the United States prior to licensure for independent practice (even if in ACGME-I accredited training programs) has significant wisdom. The systems of care, the culture of society, the ethical frameworks, the scope of practice, and the prevalence of disease differs from country to country, region to region. It is essential that these differences be recognized and managed through domestic training of international physicians prior to independent practice in the United States.

The responsibility for setting these standards continues to rest with the peer-driven, volunteer review committees. The original review committee comprised of ACGME staff has been replaced. By 2014, the community of international educators had grown to a point where a truly international review committee was possible. This evolution continues to include US representatives; these members are specialty-specific experts with accreditation experience. There are now 2 Review Committees International—one which renders accreditation decisions for institutions and medical-based specialty programs, and the other for surgical and hospital-based specialty programs. With 2 face-to-face meetings annually, accreditation decisions are made in a rigorous manner analogous to program reviews in the United States with careful deliberation, full participation, and recusal of any members with perceived or actual conflicts of interest. Requirements are crafted with public input, specific task forces are formed as needed to address flexibility issues, and thoughtful decision-making skills are practiced by all committee members in a process of international peer review. Prevailing all decisions is the desire to maintain high standards while allowing flexibility where local needs are warranted.

ACGME-I's services have not been widely broadcast. Growth since 2014 has been attributed to partnerships among medical educators across oceans and continents. Interest in international medicine and global connectedness can be found in virtually every university; the availability of international education is a high priority for new physicians seeking GME. Mobility of patients, impact of climate change, and medical tourism represent other trends, which have highlighted the value that ACGME-I accreditation might offer. However, requests to ACGME-I for accreditation services is due in large part to a country's or region's desire to enhance postgraduate medical education and produce quality physicians to serve their populations. There is an undeniable link between quality education and retention of a physician workforce. In large part, relationships with US accredited programs or other stakeholders familiar with ACGME sparked this development. These relationships have led to new accreditation relationships with additional institutions in Haiti and Panama, as well as in Shanghai, China. Relationships have matured in the United Arab Emirates and Qatar, which have connectedness to US institutions. Substantive discussions are also occurring with institutions in Kenya, Pakistan, Guatemala, East Jerusalem, and Hong Kong. Each of these significant interests has stemmed from partnerships with US stakeholders.

Outcomes

As of June 2019, ACGME-I currently accredits 15 sponsoring institutions, which sponsor 149 programs. A total of 9 different relationships for accreditation services are in place with international responsible parties, including ministries of health, governmental

authorities for education, university systems, and single institutions. There are 4022 approved positions in accredited programs, of which over 75% are currently filled. More than 1000 individuals have graduated from ACGME-I accredited programs.

ACGME-I accredits programs in 21 primary specialty residencies. As institutions apply for accredited programs, the primary care specialties (internal medicine, family medicine, pediatrics, obstetrics and gynecology, and general surgery) are in the initial wave of applications, followed by emergency medicine, orthopedic surgery, and psychiatry in the second wave. The third wave usually includes anesthesia, surgical specialty fields, radiology, radiation oncology, dermatology, and neurology. There are also 11 subspecialty fellowships, with the preponderance being those which represent subspecialties of internal medicine. Recently, a relationship with a pediatric specialty hospital has prompted the development of multiple pediatric fellowship requirements in anticipation of the institution's desires for accreditation.

Perceived Benefits of ACGME-I Accreditation

The importance attached to ACGME accreditation by the US Congress as well as the 2 main certifying entities, the American Board of Medical Specialties and the American Osteopathic Association, provide significant motivation for sponsors and programs to seek ACGME accreditation in the United States. In the international sphere, there is no similar requirement. ACGME-I is contacted when there is a perceived need for quality improvement, desire for international recognition, or another institutional motivation. Though perhaps not articulated, each of these reasons connect directly to the needs of patients and society.

Administrative and governmental leaders seek a healthier society and a physician workforce that provides both quality and access to its people. These highly desirable outcomes manifest as improved morbidity and mortality, affordability of health care, effective distribution of the workforce, and adequate specialists and generalists. These goals cannot be achieved solely through production of a well-prepared physician workforce. However, it is highly unlikely that these goals can be achieved in the *absence* of a well-prepared physician workforce.

We noted benefits that have become obvious early in this process. Medical education leadership and faculty noted enhanced effectiveness in their roles with greater authority accompanying specific responsibilities.[3] Acquisition of additional faculty, staff, and equipment has been reported, as has an improved institutional awareness of the value of education as manifested by protected time to teach and enhance scholarly activity. Faculty have taken ownership of responsibilities within the construct of GMECs, Clinical Competency Committees, and Program Evaluation Committees. Program faculty and leadership report that this added activity creates a greater sense of ownership and engagement by the faculty in the educational process. The importance of quality improvement and resident participation in quality-of-care initiatives has been highlighted by both medical education leadership and faculty. Requirements for scholarly activity have increased research activities and expanded professional responsibilities beyond direct patient care. A shift to a competency-based model of education has strengthened education in the competency domains of professionalism, communication, systems-based practice, and practice-based learning and improvement. As the shift of education has transitioned from one designed by individual trainees that typically incorporated sequential 6-month rotations, the structured and supervised training has also emphasized the importance of continuity of care.

The most immediate effect of ACGME-I accreditation has been felt by the trainees themselves. In some places, this manifests as an emphasis on clinical experience and graduated responsibility, as opposed to service obligations that carry little educational value. Much of the benefits to residents can be summarized as *structure*—with a road map and milestones to knowing what a person is to learn, when supervision is necessary, where to turn when help is needed, and how to resolve grievances with program or institutional leadership. Residents become valuable team members and learn the value of team-based care. Graduating from an ACGME-I accredited program has also led to eligibility, in many circumstances, for subspecialty training when not available in one's own country.

As summarized by an educator from Singapore who analyzed the transition to ACGME-I accreditation: "The strength of the new obstetrics and gynecology residency lies in having a structured, competency-based, closely supervised approach to training with standardized evaluations, timely feedback, and a committed faculty."[4]

Challenges of ACGME-I Accreditation

With any change, difficulties arise. Almost universally, faculty resist converting to a new way of educating physicians. Many were not actively involved in the

decision-making process resulting in this change; others justifiably believe the way they were educated worked "just fine." Responsibilities of data collection and extensive evaluation, coupled with required committee activity, seem unnecessary additions to people who are already busy.

On occasion, the existing program requirements conflict with local cultures, scope of practice, and societal needs. These issues surface in the accreditation process itself. Though initially perceived as a challenge, resolution of such issues results in a concerted assessment of these differences by the Review Committees International.

As service needs shift toward greater educational focus, existing paramedical personnel assume more work, and new personnel are often required. Responsible medical educators such as program directors and other educational staff create additional financial burden to institutions.

Limitations Faced by ACGME-I

One limitation is that accreditation focuses on creating effective programs for educating physicians. It sets the methods used to evaluate individual trainees. It does not, however, judge each graduate's performance. Board certification validates individual readiness to care for patients independently. There is no recognized international board-certifying agency. As the Review Committees International reflect on faculty qualification, for instance, it seeks verification via a process which is an independent entity from the educational process, avoids conflict of interest in its process, and is used by local and regional institutions to judge suitability for medical staff membership. The words "accreditation" and "certification" as used internationally often conflate these 2 distinct processes. ACGME and ACGME-I continue to work with ABMS and other entities that recognize individual accomplishments to create reliable and accepted methods to achieve this goal internationally.

Second, the creation of ACGME-I was predicated on the premise that it would fund international activities solely from revenue generated from international activity. As such, it faces constraints common to start-up entities. ACGME-I is committed to and looks forward to serving countries that face significant economic challenges. Expenses inherent in the educational efforts as well as processes for accreditation reflect the cost of providing education to faculty and administration transitioning to a new model. Most prominent among these is the cost of international travel for ACGME faculty and staff. We are expanding our reliance on alternative means of distance learning, and look forward to achieving a critical mass of a community versed in accreditation, permitting regional delivery of educational and accreditation services. Our goal is to be able to provide these educational and accreditation services to countries and institutions of all economic means, with a goal of enhancing health and health care through improvement of physician preparation through accreditation.

The Future of International Accreditation

The World Health Organization has placed as its top priority the accreditation of health care education, with the creation of new entities or the strengthening of existing ones. Through the WFME, Global Standards for Postgraduate Medical Education[2] have been defined and most recently revised in 2015. These standards are intended to assist others in creating or improving accreditation systems. Both process and principles are addressed in the defined areas of mission and outcomes, educational program, trainee assessment, trainee activity, trainers, governance, and continuous renewal. WFME specifically does not itself "accredit" nor does it desire to do so. It encourages the development of regional authorities to "accredit," with specific attention to the development of suitable standards for each specialty

In this context, ACGME-I strives to be a truly international accreditation system, adaptable to regional needs, with authority for accreditation granted to a peer group of individuals without conflict of interest and with a growing awareness of needed flexibility. At the same time, it seeks to keep standards set to the highest level in anticipation that globalization trends of patients, physicians, and disease demographics will continue.

Summary Comments

Entering its tenth year, ACGME-I has developed an international accreditation model in which high standards are enforced and flexibility for cultural and societal norms is embraced. When institutions transition to this system of education, there are benefits and challenges. The mission ACGME-I serves "to improve care by improving the quality of education through accreditation" can be met. As globalization embraces the medical community, it is hopeful that demonstrated outcomes of improved quality of care, with enhanced clinical judgment and cost containment, will ensue. These outcomes are only achievable through transformational change led by responsible authorities, passionate medical educators, and students eager to provide the best for their patients throughout their careers.

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