Chapter 8
Assuring Quality of Health Professions Education in the Context of Cultural Diversity

Titi Savitri Prihatiningsih and Charles Boelen

Abstract Countries with wide power distance in socio-hierarchy and collectivistic culture are mainly developing countries. Some have huge and large population with unique geographic and social environment (i.e., rural and remote areas). From the 'feasibility' and practical point of view, this kind of context tends to apply the 'quantitative' evaluation system, using numbers and statistics; and minimally applying the qualitative self-assessment & reflection in the accreditation system. Assuring quality for health profession education institutions in this kind of context is facing a dilemma due to the large numbers of institutions and study programmes, which have considerable disparities. The central and the local political decision affect the choice of the quality assurance system. This chapter discusses the definition of quality and standards in health profession education, as well as various accreditation systems in developed and developing countries. Characteristics of health profession education with social accountability values are also discussed which might influence the definition of quality.

8.1 Introduction

8.2 From health professions education to assuring its quality

In this chapter, five issues are discussed. The first is health professions education, what it is, its characteristics and its relationship with people's health. The second is defining quality in health professions education. In this section, quality in the

T. S. Prihatiningsih (✉)
Department of Medical Education and Bioethics, Faculty of Medicine, Public Health and Nursing, Universitas Gadjah Mada, Yogyakarta, Indonesia
e-mail: titi.savitri@ugm.ac.id

C. Boelen
Former Coordinator of the WHO Program (Geneva) of Human Resources for Health, International Consultant in Health System and Personnel, Geneva, Switzerland
e-mail: boelen.charles@wanadoo.fr

M. Claramita et al. (eds.), *Challenges and Opportunities in Health Professions Education*,
https://doi.org/10.1007/978-981-16-7232-3_8

industry and quality in higher education are contrasted. Looking at the characteristics of health professions education, critical questions are raised, i.e. could we use the same definition of quality or do we need to redefine the quality for health professions education. To have an appropriate definition of quality for health professions education is important because how we conceptualize quality will affect both how we formulate accreditation standards and also eventually what will be adopted in the accreditation procedures. This is explored in the third section. The fourth issue discusses the accreditation process in the context of cultural diversity in light of Hofstede's theory on cultural dimensions. Based on our conceptualization of quality in health professions education and our understanding of how cultural dimensions affect the way people work, we propose a culturally sensitive accreditation system for health professions education.

8.3 Health Professions Education

The history of medical and health professions education is as old as the history of medicine and health care. It is very much influenced and shaped by the progress and developments in health care. It can be dated back to the early centuries BC and is discovered in great civilizations which existed at the so-called 'dawn of history', such as Egyptian, Greek, Roman, Persian, Islamic and Chinese. Modern medicine started shortly after the Industrial Revolution in the eighteenth century when the way people lived and worked changed dramatically and this change affected their health risks. Scientific advancement at that time made possible many medical inventions, such as germ theory, new treatments of infectious diseases and new discoveries in public health interventions. The changes in health care and public health practices shaped the medical and health professions' education.

Before the development of the science of physical signs and the application of laboratory medicine, the physicians' relationship with their patients consisted almost entirely of dialogue between them, so that the physicians understood patients' problems comprehensively. Even now, the effectiveness of the physicians' interventions is dependent on their skills of listening and inquiring. Therefore, practicing medicine is considered a combination of art and science. The apprenticeship model of medical education that prevailed into the mid-nineteenth century provided time and space for medical students to role model the clinical consultants when caring for patients (Quintero 2014). This included how medical knowledge is applied, how clinical reasoning is exercised, how patient communication is conducted and how professional values and ethics are applied. This modeling is in line with Flexner's description of the ideal medical education which he detailed in his phenomenal report in 1910 entitled '*Medical Education in the United States and Canada'*. Flexner envisioned a clinical phase of education in academically oriented hospitals, where thoughtful clinicians would pursue research stimulated by the questions that arose in the course of patient care and they would teach the students to do the same. The academic environment has been radically transformed since the issuance of Flexner's Report. In academic

hospitals, research quickly outstripped teaching in importance. Research productivity became the measure by which faculty accomplishment is judged (Cooke et al. 2006). During those years, there was a growing complexity of medical sciences and technology. Increasing attention to quality care, patient safety and enhancement of medical practices have pushed aside the social purpose of medical education (Quintero 2014). The values of professions have become increasingly difficult to discern for medical students as clinical teachers are under intensifying pressure to increase their clinical productivity due to the implementation of quality management, evidence-based practices and the system approach in teaching hospitals. As a result, the teachers have less time available for teaching, while medical students have fewer opportunities to practice in the hospital setting when expensive and advanced medical technology has slowly replaced the 'art' of medicine. Medical care has been driven towards emphasizing the curative aspect in tertiary hospitals with sophisticated medical technology—rather than promotive and preventive care in the primary setting (Quintero 2014).

In this context, the WHO called for a 'Primary Health Care' movement in 1978, which is well known as the 'Alma Ata Declaration'. In this Declaration, the WHO reaffirms that health is a fundamental human right and the attainment of the highest possible level of health is the most important global social goal which can be achieved through the provision of primary health care. Primary health care addresses the health problems in the community, providing promotive, preventive, curative and rehabilitative care accordingly (WHO 1978).

This call still has a profound effect on how we value the medical and health professionals who have special privileges in society. There is an unwritten social contract between the profession and society. Society places their trust in this profession and they demand trustworthiness from the medical professionals who play a critical and central role as they provide health care for society. It is expected this pact will eventually bring health and well-being to all members of the society. There is a social obligation attached to them, therefore medical and health professions are considered a noble profession. Society demands health professionals who have the following virtues: compassion, empathy, helpful, caring, honesty, putting the care for patient above their own interest, righteous, high morals and competent in solving the health problems of patients, family and community, etc. As early as the fifth century BC, the Oath of Hippocrates was recited and is still read aloud during the convocation of new medical doctors. The Hippocratic Oath is the basis for medical ethics with which every medical doctor is expected to perform.

The question now is how can we—medical and health professions education institutions—be better able to deliver medical and health profession education that will produce medical doctors and other health professions with such characteristics amidst the rapid advancement in medical digital technology and the increasing application of virtual telemedicine?

The answer to this question was outlined in the WHO Document in 1995 on Defining and Measuring Social Accountability for Medical Schools. This document introduced specific social accountability values, namely relevance, quality, cost-effectiveness and equity. Boelen and Heck (1995) argued that medical schools have

social obligations to produce medical graduates who are relevant to the health needs of the society and capable to provide health care that embraces the social accountability values (Boelen and Heck 1995). This notion is strongly echoed by the Global Consensus for Social Accountability of Medical Schools in 2010 which outlined ten strategic directions for medical schools: to be socially accountable and requiring improvements in responding to current and future health needs of the society; reorienting their education, research and service in accordance with the prioritized health needs of the society; strengthening governance and partnership with stakeholders; and using evaluation and accreditation to assess their performance and impact (GCSA 2010).

"The Global Consensus on Social Accountability of Medical Schools is a landmark report, probably as important, if not more that the Flexner report published a century earlier, as it gives strategic directions to improve the quality of medical education and medical schools' governance relative to people's priority health needs and social determinants of health, particularly in a world that is endangered by climate change, unreasonable use of resources, increased health disparities within and between countries as well as health risks due to globalization".

8.4 Defining Quality in Health Professions Education

It is hard to define quality. Quality is in the eyes of the beholder. Quality is a multidimensional concept, and reducing it into one single definition is problematic. Some definitions are too specific, while other definitions are too general. On the contrary, it is easy to notice bad quality. From the industrial perspective, we can categorize how we look at quality into two perspectives, the producer and the customer. In the producer's point of view, quality is seen as meeting standards and regulations and any difference in quality leads to deviation from agreed properties. On the contrary, the customer's point of view sees quality as the ability to meet customers' needs and expectations. Quality can also mean 'excellence' and 'fitness for purpose'. We expect graduates to be "fit for the purpose", which is to bring a solution of health problems to people, not just in technical terms, but also by applying a person-centered approach (meaning considering the patient/the person in its entire context of life).

In higher education, quality is viewed from the perspectives of multi-stakeholders, namely academicians, managers, administrators, users and students. The quality model in higher education applied internationally and nationally accommodates these multi-perspectives by commonly having the following standards, namely: vision and mission of the university, graduates' competences, curriculum (content-process-student assessment), student recruitment and selection, staffing, facilities and infrastructures, student services, governance, stakeholders' feedback, evaluation and continuous improvement. The higher education sector is seeking excellence and they define quality in higher education as achieving 'exceptional outcomes' or excellence in those standards. Higher education ranking as portrayed in the Times Higher Education Series (THES) or QS World University Ranking is created to rank higher

education institutions in accordance with how best they achieve quality indicators. Although some agencies, such as the ASEAN University Network for Quality Assurance (AUNQA) define quality as 'fitness for purpose', in addition to 'excellence', to indulge efforts made by institutions to achieve their vision and mission.

Taking into consideration the definitions of quality in business and in industry, as well as in higher education, we need to be careful when we intend to apply such definitions in health professions education. As explained above, health professions education carries social obligations and social accountability because the graduates have to serve society to attain the highest level of health. This point is to demonstrate that health as the fundamental human right embodies the provision of health care. Since the issuance of the WHO's call for Social Accountability of Medical Schools in 1995, only a very small number of medical schools across the globe—to a clear and certain extent—have implemented this concept. As a result, we still have many challenges facing our healthcare system such as poor access to primary health care, poverty and unequal access to full-service health care, maldistribution of the health workforce and lack of key health workforce personnel, low engagement of the public towards healthy life styles, widespread social injustice and high prevalence of chronic diseases (Boelen et al. 2019). Medical schools are health care stakeholders that have tremendous potentials to mobilize resources to improve population health. The special combination of education, research and service delivery missions as well as their inherent code of ethics to put the patients and the society above any partisan interests can produce enormous impacts on population health if and when they partner with stakeholders. Boelen et al. (2019) proposed the definition of quality for health professions education which is encapsulated in the following triple capacity: (1) the capacity to identify current and future health needs and challenges of citizens and society as a whole, (2) the capacity to adapt schools' mission and programmes to address those needs and challenges and (3) the capacity to monitor the effects of relevant actions on identified needs and challenges.

8.5 Standards in Health Professions Education

In the previous section, we have discussed that one definition of quality is meeting the requirements or accepted standards. Conceptions of quality will then be elaborated into standards that will be used in the external quality assessment or accreditation process. In manufacturing industries, standards are used to reduce variation because the quality of a product is measured against its meeting the expected specifications.

Grant (2018) discussed the problems of standards in the manufacturing industry which are unsuitable for higher education in general and health professions education in specific. She argues that health profession education standards that are issued by a number of agencies, such as professional organizations, association of health professions education institutions, accreditation agencies, external quality assessment bodies and governments involve several problems. The first is the industrial mindset. As discussed above, the origin of quality concepts comes from industry. The

production line as applied in the industry might not be appropriate for health profession education. Students cannot be equated with raw materials since each student is unique and has different abilities and talents. The second is atomization and isolation from complex systems. In the production line, during the process of assembly, various smaller parts that are prepared separately are put together. In health professions education, students cannot be broken down into smaller parts and then put together. The third problem is that those industry standards provide less opportunity to reflect diverse and unique realities. As we all know, all institutions of health professions education and universities, in general, have unique features. They have formulated specific vision and mission statements according to their own stakeholders. There are no two universities or faculties of health professions education that are exactly the same. The fourth is that these standards are insensitive to environmental and cultural factors and often stifle originality and creativity. Higher education institutions are well-known for their production of new knowledge and cutting-edge technology at the frontiers of science. With this in mind, the next question is 'Can we actually standardize health professions education?'.

Throughout the past two decades, after the issuance of national, regional and international standards, many professional organizations, medical authorities or governments started to question how can we assess to what extent the education programme or the health professions education institutions meet the standards? If we have standards and do not assess their compliance with these standards, then what is the use of having standards? These are some of the important questions that unconsciously may have led many leaders to adopt the 'industrial mindset' to define quality as 'meeting the standards, meeting the requirements or meeting the manufacturer's specification'.

Considering the unique characteristics of health profession education and the concept of social accountability, quality standards for health professions education have been developed which is called Conceptualization-Production-Usability. The domain 'conceptualization' involves the collaborative design of the kind of professional, which is needed and the system that will utilize his or her competences. The domain of 'production' involves the main component of training and learning. The domain 'usability' involves initiatives taken by the institutions to ensure that its trained professionals are put to their highest purpose and best use. For each domain, several requirements are identified (Boelen and Woollard 2009). This model of standards is in line with the definition of quality of health professions education as proposed by Boelen et al. (2019). Some industries nowadays care for the environment and adapt to the local needs that is why the non-fossil energy industries is flourishing worldwide. Adaptation to local context of health professions education is also highlighted in this chapter.

8.6 Accreditation of Health Professions Education in the Context of Cultural Diversity

The twenty-first century started with an explosion in the number of higher education institutions. This massive expansion shows the increasing demand for higher education. The same situation has happened around the world in health professions education. Nowadays, several systems of accreditation are used worldwide to ensure the quality of higher education and of health professions education. However, defining the term accreditation is a challenging task. Accreditation has numerous meanings in various contexts and settings.

Van Zanten et al. defined accreditation as a review of an educational programme, conducted by a governmental organization or a private entity accountable at a government level, based on publicized standards and predetermined protocols (van Zanten et al. 2012). According to Vlasceanu et al., accreditation is the process by which a (non) governmental or private body evaluates the quality of a higher education institution as a whole or of a specific educational programme in order to formally recognize it as having met a certain predetermined minimum criteria or standards (Vlasceanu et al. 2007). The results of this process are usually the awarding of a status (a yes/no decision), of recognition and sometimes of a license to operate within a time-limited validity. Cueto et al. (2006) describe accreditation as a process whereby officially appointed external regulatory bodies, accountable at the government level, evaluate educational institutions using established criteria, standards and procedures. It entails gathering data on various aspects of the educational institution and making decisions regarding compliance with the standards. This is done primarily to ensure the quality of education required to produce competent graduates. Thurston in Cassie et al. explained accreditation is a process that examines a programme in order to determine whether it: (a) has appropriate purposes; (b) has the organization and resources to accomplish its purposes; (c) can demonstrate that it is accomplishing its purposes; and (d) gives reason to believe that it will continue to accomplish its purposes (Cassie et al. 1999).

Although the above definitions have different ways of looking at accreditation, there are a number of common features. First, accreditation is an assessment or a review, or an evaluation of quality at the programme or institutional level. Secondly, it can be done by a government or a non-government organization or a private agency, but it should be external to the programme or institution being assessed. Thirdly, there are standards and procedures, which include self-evaluation and site visits by the assessors. Fourthly, the definition of quality used is complying with predetermined standards. Fifthly, there are implications or consequences for positive and negative results.

The implementation of any accreditation system is influenced by the national and organizational culture. Culture in an organization is a unique identity that sets one apart from all others. Organizations have their own distinct culture that establishes their core identity, determining what values are upheld, what norms are followed and which behaviors are expected (Schraeder and Self 2003). Unlike the concrete

nature of codified policies and procedures, culture represents the unwritten 'rules of the game'—the unspoken but widely shared assumptions that unobtrusively manipulate organizational members. Forces that are created from social and organizational culture are powerful, because they operate outside our awareness. Therefore, it is important to understand how a culture operates, or otherwise, we can become the unwitting victim of culture (Schein 2016). Hofstede offers a theory on cultural dimensions which describes six dimensions as a framework to examine how cultural differences in different countries could affect the ways an organization is operated. Hofstede's theory is applied in this section to analyze the accreditation process from the context of cultural diversity (Hofstede 2001).

The theory is based on the idea that values can be placed into six cultural dimensions. These are power (equality versus inequality), collectivism (versus individualism), uncertainty avoidance (versus uncertainty tolerance), masculinity (versus femininity), temporal orientation, and indulgence (versus restraint). Based on the calculation of the six cultural dimensions index score as explained above, the selection of countries for the analysis is from the two different groups. The first group is the Western and developed countries, and the second group is Eastern and less developed countries. For the first group, the United States of America (USA) and Canada are chosen, and for the second group, Indonesia and other South East Asia countries (such as India, Bangladesh and Thailand) are selected for the comparison.

8.6.1 Accreditation in the Western and Developed Countries (USA and Canada)

The USA is selected because it has a long history of accreditation and it is there that the accreditation concept was first developed and practiced. The accreditation in USA and Canada for medical education share the same history, until in 1979 Canada established its own accreditation agency, although it still maintains a strong link with the USA.

The idea of reviewing medical education programmes started in 1847—when the American Medical Association (AMA) was established as a voluntary organization. AMA started to look into the curricula of medical schools in the USA which at that time the medical education was heterogenous in setting and quality (Dezee et al. 2012). Between 1830 and 1845, the number of medical colleges in the USA has doubled, creating a tough competition unrestricted by the professionals. The majority of medical schools during this time period were small, for profit schools with wide ranging, non-standardized curricula and educational goals (Irby 2011). This condition created major concerns among medical professionals. In 1844, there was a resolution promulgated by the Medical Society of New York regarding the quality of medical education. The first was that a four-month course for getting a medical degree was too short to include all branches of medical sciences, the second is the standards of premedical and medical education was too low and the third

is the union between teaching and licensing powers within medical colleges was susceptible to be abused (Eagle 2017).

Association of American Medical Colleges (AAMC) was established in 1847 by 250 delegates with the main purpose 'to elevate the standards of medical education'. Only until 1878, the then American Medical College Association adopted the resolution that medical schools had to have public recognition on the medical school's compliance to standards which then become a requirement to be included in the list of the member of the Association. However, the number of medical schools exploded to 133 by 1890. Between 1893 and 1903, representatives of medical colleges in the USA developed a register for medical colleges that met certain agreed standards. In 1905, the AMA established its own council on medical education, which produced a ten-category system for rating medical schools. The first list of medical schools accepted by the AMA was published in 1907 (El-Khawas 2001). Until the turn of the twentieth century, medical schools were closely inspected by two organizations, namely the AMA through its Council on Medical Education (CME) and AAMC. To follow up the resolution in 1844 that the granting of medical licensure should not be done by the medical college, in 1890 the National Confederation of State Medical Examining and Licensing Boards (NCSMELB) was established. Since then, there were three organizations safeguarding the quality of medical education, namely AMA, AAMC and NCSMELB. These three organizations—although rivalry was acknowledged—promulgated the agreed medical education standards to all medical colleges (Eagle 2017).

At the beginning of the twentieth century, the number of medical colleges remained growing rapidly and in 1904 the number was 166. The market of medical graduates had saturated. The AMA started to classify the medical colleges after deciding to do on-site inspections in 1906 using 10-point standards, where each school could receive 1 to 10 on each of the items of the 10-scale. The schools were grouped into A to F based on the attainment of the scores. Schools scoring 50–70 were deemed worth recognizing if they made improvements that could elevate the scores over 70. Concerned with the results of the schools' inspection where many medical schools scored under 50, AMA turned to the Carnegie Foundation for the Advancement of Teaching to seek assistance. The Carnegie Foundation sponsored Abraham Flexner to conduct an independent evaluation of medical schools in the US and Canada. One of the aftermaths of Flexner's report is the closure or merger of 37 medical schools with the score under 50 which were considered unacceptable (Eagle 2017).

After almost 40 years of increasing competition and rancor between AMA and AAMC, instead of having cooperation and collaboration, World War II began to draw them back together. In 1942, AMA and AAMC agreed to avoid duplication of efforts in evaluating the quality of medical schools by conducting a joint inspection of medical schools. A new committee was set up in 1942 sponsored by AMA and AAMC, which was called Liaison Committee for Medical Education (LCME). LCME was considered the formal accreditation agency for medical schools in the US and Canada. Their purpose is to establish and maintain educational standards by

surveying and assessing the relative rating of participating medical schools (Kassebaum 1992). Over the course of 75 years, LCME developed various guidelines, tools, instruments for the functioning of an accreditation agency in safeguarding the quality of medical education and for quality improvement (Eagle 2017).

Since the awakening of concerns regarding the quality of medical doctors and medical education in the nineteenth century, which was manifested in the establishment of two important organizations, AMA and AAMC in 1847, medical schools in Canada were always included in the conversation and site visits, including during the Flexner's independent inspection in 1908. Canadian medical schools have enjoyed a special relationship with the US medical education system for over a century as Canadian medical schools have furnished many medical practitioners in various states in the US. The AMA continued to include Canadian medical schools in its annual listing of approved medical schools in the Journal of American Medical Association (JAMA) (Eagle 2017). The most notable change in the relationship between LCME and Canada was in 1979 with the formation of the Committee on Accreditation of Canadian Medical Schools (CACMC). The reason why Canada established its own committee on accreditation was the decision to appoint a US Government representative to the LCME Board. With the involvement of the US Government in the LCME board, it has strengthened the role of LCME as the accreditation body for medical schools within the jurisdiction of the US. This situation created an unfavorable condition for Canadian medical schools (Shilliday 1983).

CACMS still maintains strong ties with the LCME by having an LCME member sits in CACMS Boards and the accreditation decisions are accepted by both bodies. All Canadian medical schools are automatically accredited by both LCME and CACMS. The standards, procedures, instruments and other tools for accreditation are the same. The accreditation report is sent to members of CACMS and LCME and other 45 independent reviewers. When CACMS makes a final accreditation decision, they always take into account the LCME recommendation (Shilliday 1983). In 2013, the sponsors of CACMS (CMA and AFMC) and the sponsors of LCME (AMA and AAMC) signed a Memorandum of Understanding to further codify the relationship between both accreditation bodies. This agreement provides CACMS a greater independence in decision making, standard setting and modification of accreditation procedures to align Canadian medical education programmes with their social accountability approaches (CACMS 2014).

One distinct feature of the Canadian medical education system is its commitment towards social accountability. By embracing this concept, Canadian medical schools are prepared to respond to the changing needs of the community by developing a formal mechanism to maintain awareness of these needs. Canadian medical schools work together and in partnership with their affiliated health care organizations, the community, other professional groups, policy-makers and governments to develop a shared vision of an evolving and sustainable healthcare system for the future. This social accountability concept is adopted in the accreditation standards and procedures (Cappon et al. 2001).

8.7 Characteristics of USA and Canada Accreditation System

The USA and Canada accreditation system stand out in three dimensions, namely: (1) accreditation is a non-governmental, self-regulatory, peer review system; (2) nearly all of the work is done by volunteers; and (3) accreditation relies on the candor of institutions to assess themselves against a set of standards, viewed in the light of their mission, and to identify their strengths and concerns, using the process itself for improvement (Brittingham 2009). Accrediting associations were established as membership organizations, supported by dues and fees (and occasional private grants), providing the foundation for self-regulation and the independence that has helped accreditation preserve the autonomy of institutions (Brittingham 2009). It has taken almost 150 years from when the concern for the quality of medical education emerged in 1844 due to the wide variation of medical education programmes and the lack of external inspection (Eagle 2017).

Standards have moved from quantitative to qualitative, from prescriptive to mission-centered, and from minimal to aspirational. The general trend in accreditation has been a movement from focusing on inputs or resources to processes and outcomes or effectiveness. Every institution finds dimensions on which it wishes to improve and promotes productive engagement in the accreditation process. As accreditation developed, it embraced many of the essential elements of American higher education, including the role of the governing boards, the place of general education in the curriculum, the centrality of academic freedom for faculty and students, and opportunity for student development outside as well as inside the classroom (Brittingham 2009).

8.8 Analysis of the USA and Canada Accreditation System Using Hofstede's Cultural Dimensions

Although USA and Canada have many similarities due to their shared long border and languages (though in Canada they have English and French as official languages), differences can be found between these two nations. Both countries are multicultural and both are meritocracies; the concept of the 'American dream' applies just as strongly in Canada; the belief that anybody can be anything, regardless of background, ethnicity, gender or sexual orientation (Hofstede et al. 2010). Canadians are closer to the British culture where they value relationships and speaking in turn. On the other hand, Americans value problem-solving and entrepreneurship, to a certain extent they are more aggressive and straightforward. They also believe in the ability of the individual to achieve a self-identified goal.

The USA has a considerably low power distance which is characterized by decentralization, where the gaps between subordinate and superior are small, because hierarchy exists for the purpose of getting the job done effectively and efficiently.

Accreditation in the USA relies fundamentally on volunteers to carry out the work, volunteers are at the core of the work: teams are composed of volunteers, and it is volunteer peer reviewers who serve on the policy- and decision-making bodies. Americans also believe in self-improvement, an activity requiring self-evaluation and identification of areas that could benefit from enhancement. However, the government recognizes and trusts the results of accreditation activities conducted by the accrediting agencies set up by professional organizations such as AMA and the AAMC. In this instance, the government who has the governing power does not exercise the power in a dominant, authoritarian and centralized way. The Constitutions (state and national) and the Supreme Court have provided an equitable ecosystem that imparts autonomy to universities and higher education institutions. The Government respects this autonomy and leaves the quality assurance initiatives to the professional associations and associations of higher education institutions. Being granted trust by the government, these associations are motivated to develop an accreditation system that embraces and embodies the principles of good governance.

With a score of 39 on this dimension, Canadian culture is marked by interdependence among its inhabitants and there is a value placed on egalitarianism (Hofstede 2020). This is also reflected by the lack of overt status and/or class distinctions in society. Hierarchy in Canadian organisations is established for convenience. It can be understood that when the US Government was involved in the LCME through its representative, Canada chose to set up its own accreditation committee, despite its long history with the US.

As for the individualism-collectivism dimension, the USA has a high score for the individualism index, i.e. 91 (Hofstede 2020). Individualist societies value social achievement as individual goals. In schools, students are expected to individually speak up in class. Therefore, it is common in the USA to see people who are assertive and are willing to express their ideas freely in formal and informal forums. Hiring and promotion decisions for staff members are based on skills and tenure rules without involving personal or group interests. The relationship between employer-employee is based on the contractual arrangement. Completion of tasks is supremely important and prevails over relationships. In this context, occupational mobility is higher, with little or no lifelong contract (Hofstede 2020). In the accreditation practices, these characteristics of an individualist society can easily be observable. The implication of being an individualist society is that medical schools take serious and genuine action to meet the LCME standards. The accreditation status granted by LCME is considered an individual achievement of the medical school and creates a sense of pride.

An example is the John A. Burns Medical School who has recently received continued full accreditation for the maximum period of eight years. The process for preparing for the LCME site visit began two years before and included an extensive effort from the faculty, staff, students, and community participants. Activities included the completion of LCME's Data Collection Instrument (DCI), an Independent Student Analysis (ISA), an Institutional Self-study (IS) evaluation, and many hours of preparation for all the site visit participants. Conforming to national or international accreditation organizations ensures (both for the students and public)

that the highest quality education is being delivered and that commonly shared standards in medical education are being addressed in all areas of medical education. These include teaching and curriculum development, administration, faculty, finances, learning environment, facility resources and student services (Connolly et al. 2017).

Canada scores 80 on this dimension (its highest dimension score) and can be characterized as an Individualist culture (Hofstede 2020). This is similar to the US although the Canadian score is lower. This is in line with the result of qualitative research on the impact of accreditation on medical schools' processes where medical schools developed a system to distinguish from relying on a single individual to establish tasks.

The USA has a high masculinity index. In masculine societies, appreciation towards work is higher. People are willing to spend long hours of work and put tremendous energy into work completion, because they highly value their work production. The purpose of living is to work, to get higher pay, to have security and to have interesting jobs. Work is highly competitive; therefore, managers are demanded to be more aggressive, decisive and ambitious (Hofstede 2020). The USA is well-known for the best medical schools in the world producing Nobel prize winners, new inventions in medical technology and cutting-edge sciences which are applied all over the world. This spirit of competitiveness is reflected in their medical education standards. After more than 150 years of struggle to have an established accreditation system, they highly value the accreditation process as the leverage for quality improvement and as the platform to showcase their achievements. Because of this focus on outcomes, in the LCME accreditation report, the strengths of a medical education programme are highlighted.

Canada scores 52 on this dimension and can be characterized as a moderately 'Masculine' society. While Canadians strive to attain high standards of performance in both work and play (sports), the overall cultural tone is more subdued with respect to achievement, success and winning, when compared to the US. Similarly, Canadians also tend to have a work-life balance and are likely to take time to enjoy personal pursuits, family gatherings and life in general (Hofstede 2020). This explains why for almost 100 years, Canada relied on the LCME to accredit their medical schools and still until now share the same accreditation standards, procedures and formats with LCME.

For the uncertainty avoidance index, the USA society has a low score, which is 46. A low uncertainty avoidance society is comfortable with risk, uncertainty and unpredictable situations (Hofstede 2020). The accreditation system for medical education in the USA has been evolving for 150 years to reach its present level of maturity and it took almost 100 years to get established. This reflects the dynamics of reaching a consensus among stakeholders, i.e. the medical colleges, the medical professions, and the Government. The uncertainty and the unpredictable situations are reflected in the struggle and the debate among medical colleges to agree on certain specific requirements as the foundation for running a medical education programme, such as the total number of study hours (4,000 h or 3,700 h).

Canada has a score of 48 for the uncertainty avoidance index—almost similar to the US. Canadian culture is more 'uncertainty accepting'. This is indicative of the easy acceptance of new ideas, innovative products and a willingness to try something new or different, whether it pertains to ideas, technology, business practices or consumer products (Hofstede 2020). Canadians are also tolerant of ideas or opinions from anyone and allow the freedom of expression. This is demonstrated by the acceptance of the social accountability concept for the vision of the medical schools. In other countries, social accountability is still a utopia.

The LCME as an accreditation agency is recognized by the US Department of Education and initially by the Canadian Government until they decided to have their own CACMS. Medical education programmes leading to the MD degree must first have institutional accreditation to be eligible for initial full accreditation and for continuing accreditation by the LCME and CACMS. In summary, the LCME accredits educational programmes (i.e. leading to the MD degree) and regional accrediting agencies in the U.S. (e.g. the Southern Association of Colleges and Schools) accredit their sponsoring institutions (e.g. universities). LCME and CACMS accreditation are a voluntary, peer-reviewed process of quality assurance that determines whether the medical education programme meets established standards. The process also fosters institutional and programmatic improvement. This is concordant with low uncertainty avoidance characteristics where innovators are less constrained by rules. By having accreditation as a voluntary process, it is within the control of the medical school and the university to decide whether to apply for the accreditation or not. This option gives a medical school a more relaxed presentiment to pursue innovations. When they do apply for the accreditation, it is driven by their internal motivation to perceive accreditation as the vehicle for continuous improvement.

As for the long-term orientation versus short-term orientation index, the US society has a low score for long-term orientation, meaning that they tend to focus on the near future and short-term success. Similarly, Canada scores 36 in this dimension, marking it as a normative society. People in such societies have a strong concern with establishing the absolute Truth; they are normative in their thinking. They exhibit great respect for traditions, a relatively small propensity to save for the future, and a focus on achieving quick results (Hofstede 2020). Therefore, having an accreditation status is considered a short-term achievement as it gives some direct benefits, such as recognition from the Government for funding eligibility, and qualification to perform the USLME for the graduates. For the Canadian medical schools, being accredited by both LCME and CACMS means greater opportunities to work in the USA. To achieve and maintain accreditation, a medical education programme must meet the LCME accreditation standards contained in the LCME document entitled, *The Functions and Structure of a Medical School*. Programmes are required to demonstrate that their graduates exhibit general professional competences that are appropriate for entry to the next stage of their training and that serve as the foundation for life-long learning and proficient medical care. Graduates of LCME-accredited schools are eligible for residency programmes accredited by the Accreditation Council for Graduate Medical Education (ACGME). CACMS share the same 'The Functions and Structure of a Medical School'. Blouin et al. identified pragmatic and negative

attitude towards accreditation among deans and other educational leaders of Canadian medical schools (Blouin and Tekian 2018). They perceive accreditation as being costly, dragging the medical staff's time and energy which may lead to low morale, stressful and accreditation burnout. Performance on accreditation might affect the medical school's reputation, from funding to the quality of applicants. This explains that participating in accreditation is for short-term gains of not losing the medical school's reputation. As the Canadian accreditation system (CACMS) system is identical to the US system (LCME), having the same low score for long-term orientation might lead to having this attitude in the Canadian medical schools.

The US and Canadian society have a high score in the indulgent versus restraint index. This index reflects to what extent a society can control their impulses and desires. This shows that people have more extroverted personalities and higher optimism (Hofstede 2020). This is expressed in the formulation and revision of LCME Standards. The LCME regularly reviews the content of the standards and elements, and seeks feedback on their validity, importance and clarity from members of the medical education community, including its sponsoring organizations. Changes to existing standards and elements that impose new or additional compliance requirements are reviewed by LCME's stakeholders and are considered at a public hearing before being adopted. During the public hearing, stakeholders are allowed to express their disagreements, their concerns and suggest any revisions freely. The public hearing is conducted every year, therefore the LCME standards are revised every year. Once approved, new or revised standards are published in *The Functions and Structure of a Medical School* and in the relevant version of the Data Collection Instrument (DCI), which will indicate when the changes become effective. Such periodic review may result in the creation or elimination of a specific standard and/or element, or a substantial reorganization of *The Functions and Structure of a Medical School* (LCME 2020).

8.8.1 Accreditation in the Eastern and Developing Countries (Indonesia and South East Asian Countries)

Indonesia and South East Asian countries are selected to represent the group from Eastern and developing countries, because Indonesia and South East Asian countries have several unique characteristics, which include having the complexities of a diverse culture, encountering challenging problems in health professions education and have high numbers of study programmes and health professions education institutions, which according to the latest figure in July 2020, there are 3,054 study programmes in health profession in Indonesia (Chatibwarsa 2020).

Indonesia is known as the largest archipelago, situated between the Asian and Australian continents, and bordering on the Indian and Pacific oceans. Indonesia is located in an area of the world that experiences regular natural disasters, such as earthquakes, tsunamis, floods, severe droughts and volcanic eruptions. Most of the

population lives on the large island of Java. Diverse ethnicities exist, although most Indonesians are Javanese (40.1%), followed by Sundanese, Malay, Batak, Madurese, Betawi, Minangkabau and other ethnic groups which are around 1,300 according to the latest census, making Indonesia the most ethnically diverse society in the world. Furthermore, 730 languages are spoken and various religions exist, including Islam which is the religion observed by the majority of the population (80%), followed by Christianity, Buddhism, Hinduism and several others (Central Bureau Statistics of Indonesia 2016). Other South East Asian Countries also share diverse culture and natural disasters, such as in India, Sri Lanka and Bangladesh which have regular floods and typhoons.

Indonesia was a Dutch colony for 3.5 centuries and declared its independence on August 17, 1945 after being occupied by Japan for 3.5 years. The long history of colonialism influenced both the education system and also the health system in Indonesia. During the past decade, Indonesia has emerged as a relatively stable country, economically and politically (Mustika et al. 2019). In 2014, the government launched a National Health Insurance Program and a plan for universal health coverage in 2014 (Marzuki 2016). Other South East Asian countries were also under colonization of British rules (such as India, Bangladesh and Sri Lanka) and French rules (Vietnam and Cambodia).

The accreditation system in Indonesia started first in the higher education sector as part of the Higher Education Long-Term Development 1985–1995. In this period, the quality standard became one of the higher education pillars. The National Accreditation Board for Higher Education as the sole accreditation agency for all study programmes was established in 1994. Since its establishment in 1994, the National Accreditation Board for Higher Education (NABHE) has conducted accreditation for thousands of higher education institutions and programmes. In 2020, the number of higher education institutions is 4,741 of which 91.5% are private and 8.5% are public. The number of study programmes is more than 28,000. In 2016, the National Accreditation Board restructured its organization, separating the policy-making from the accreditation process. Since then, the Board of Accreditation is responsible for policy-making and the Executive Board is responsible for conducting the accreditation programmes. As a consequence of the Higher Education Law No. 12/2012, independent accreditation agencies can be established by an association of professions and associations of education institutions of a specific professional field. Effectiveness evaluation on the implementation of the accreditation system by the National Accreditation Board in 2017 generated the results showing that the emphasis was still on input and process. Several correlations between accreditation status and the results of the national exam, with levels of research productivity, have been calculated, and the results showed there is no significant relationship between accreditation status and research productivity (Moeliodihardjo et al. 2017).

As part of the World Bank-funded Health Profession Education Quality Project (HPEQ) in 2009–2014, strengthening policies and procedures for the accreditation of health professions education was the first component. The main goal of this component is to set up an independent accreditation agency for health professions education. To achieve this goal, the project team conducted benchmarking to the Liaison

Committee for Medical Education (LCME) in the USA and recruited international consultants. It took three years to discuss and debate intensively about the independent accreditation system that would be developed. Eventually, seven professional associations from seven professions (medicine, dentistry, midwifery, nurse, public health, nutrition and diploma nursing) and seven education institutions from the seven professions mentioned signed a declaration to set up an independent accreditation agency for higher education in health in 2011.

The Independence Accreditation Agency for Higher Education in Health (IAAHEH) or *Lembaga Akreditasi Mandiri Perguruan Tinggi Kesehatan* (LAM PTKes) is the first accreditation agency that was established by Non-Government organizations and associations on February 3, 2014 based on the Minister of Law and Human Rights of the Republic of Indonesia Decree No. AHU-30.AH. 01. 07. 2014. However, to have the legal standing for the results of accreditation by the IAAHEH, this agency needed to have recognition from the Indonesian Government which is stated in the Minister of Education and Culture of the Republic of Indonesia Decree No. 291/P/2014 dated on October 17, 2014, on the Recognition of the Establishment of IAAHEH. To be able to fully function, IAAHEH had to have permission from the Government through the following decree, The Minister of Research, Technology, and Higher Education of the Republic of Indonesia Decree No. 46/E.E3/KL/2015 dated on February 2, 2015, on the Operationalization of IAAHEH. To date, IAAHEH has accredited more than 3,000 study programs in health professions and it has obtained a World Federation of Medical Education (WFME) Recognition for the period of eight years (2018 to 2026) upon completion of the recommendations.

Although IAAHEH is supposed to be an autonomous accreditation body with its own legal status, IAAHEH must comply with the accreditation standards and procedures developed by the National Accreditation Board for Higher Education (NABHE). This agency also supervises the IAAHEH. This mechanism has limited the IAAHE to innovate and develop accreditation standards and procedures suitable for health professions education. Medical schools inevitably must abide by two standards, i.e. Standards of Competence and Standards of Medical Profession Education from the Indonesian Medical Council (which are derived from the World Federation for Medical Education) and Accreditation Standards from the IAAHE.

On the other hand, with its huge number of population, India has one of the largest and diverse education systems in the world. The Medical Council of India was set up in 1934 under the Indian Medical Council Act, 1933. This Act was repealed and a new Act, The Indian Medical Council Act, 1956, was enacted. This latter Act was further amended in 1964, 1993 and in 2001. The objectives of the Indian Medical Council, as per the Act, are as follows: (1) maintenance of uniform standards of medical education, both undergraduate and postgraduate; (2) recommendation for recognition/de-recognition of medical qualifications of medical institutions of India or foreign countries; (3) permanent registration/provisional registration of doctors with recognized medical qualifications; (4) reciprocity with foreign countries in the matter of mutual recognition of medical qualifications. The accreditation for medical schools involves both the Government and Non-Government agencies. The National Assessment and Accreditation Council (NAAC) was established in 1994 as

an autonomous institution of the University Grants Commission (UGC) with its headquarters in Bengaluru. NAAC also accredits medical education programmes only compulsory for those funded by the UGC and the rest are voluntary. Medical Council of India conducted the accreditation for the whole medical education programmes and was considered compulsory. The standards and guidelines were later developed by the NAAC to comply with the National Education Policy (Cueto et al. 2006).

8.9 Characteristics of the Indonesian and Indian Accreditation System

In this part, the discussion will be focused on Indonesian and Indian Accreditation System. The main feature of the Indonesian accreditation system is that it is initiated by the Government. In India, accreditation for medical colleges started far ahead of Indonesia, which was in 1934. India copied the British System of having a medical regulatory body, namely Medical Council of India which is a Government body. Both countries make use of accreditation as a policy instrument that is used by the Government to monitor and evaluate the medical education institutions and programs. Since the reform movement in 1998, Indonesia has shifted from a highly centralized Government during the New Order Era to a more decentralized public management. All the laws and regulations related to higher education after the reform are very much dominated by the central idea of giving autonomy to each university to manage their own affairs. This policy is also affected by the international trend, especially in the developed countries where university autonomy is seen as the panacea for improving the quality of higher education and to enhance the performance of the university. Until recently, higher education in India is highly centralized and institutions have very limited autonomy, regardless of their public or private status. Universities have some substantive autonomy in theory while private institutions have more leeway in terms of procedural autonomy. The concept of university autonomy has been debated almost for the past four decades.

Accreditation is compulsory and it is the Government that has the mandate to conduct accreditation on behalf of the public as stipulated in the National Education Law No.20/2003 and Higher Education Law No.12/2012. Therefore, the National Accreditation Board for Higher Education (NABHE or *Badan Akreditasi Nasional Perguruan Tinggi*/BAN PT) has been acknowledged as the single national accreditation agency that is responsible for the accreditation of all universities and all study programs all over Indonesia. BAN PT has also been given a mandate to develop a national accreditation system, accreditation standards, procedures and instruments. Since its establishment in 1995, the accreditation instruments have relied heavily on quantitative input measurements. The weighting for the completed instruments (supporting data) is 90%, leaving only 10% for the self-evaluation conducted by the study programme. This approach has pushed many universities and study programmes to focus on completing the accreditation instruments and providing

the documents and data that are required, rather than implementing the quality improvement process.

Although India has a long history of medical school accreditation which is compulsory by the Medical Council in India, when an independent accreditation agency (NAAC) was set up by the University Grants Commission (UGC) in 1994, it becomes a voluntary process and the final outcome of the process is an overall grade on a multi-point scale and a detailed assessment report, valid for a period up to five years.

Only after there was a sharp increase in the number of higher education institutions (almost 3,000) and study programmes (almost 15,000), did the Government and NABHE decide to provide opportunities for professional organizations to set up independent accreditation agencies. This change was reinforced by the outcry of the academic community who had to have a long queue to obtain accreditation or reaccreditation after passing the due date. This delay was caused by the imbalance between the capacity of NABHE and the rapid increase in the number of higher education institutions and study programmes. However, through the Decree of Ministry of Research, Technology and Higher Education No. 32/2016 on Accreditation and renewed by the Decree of Ministry of Education and Culture No 5/2020 on Accreditation, the Indonesian Government, through the Ministry of Education and Culture, still maintains the discretion to regulate any independent accreditation agency. For example, all of the standards and procedures must be approved by the NABHE. In this context, IAAHEH must abide by the policy of the national accreditation system from NABHE, including the accreditation standards, the procedures and the instruments. This recent development raises the important question: 'What exactly do we mean by an independent accreditation agency?'.

The development in India demonstrated a radical change. The Medical Council of India which was the Government agency was established in 1934. The Medical Council of India (MCI) has its written constitution to deal with medical colleges and hospitals and medical professionals in India. The amendment in the MCI act was also made subsequently in 1964, 1993 and 2001 to ensure the proper functioning of the council. However, in 2006, there was a movement to change the Medical Council Act, along with the findings that the elected members had declined, corruptions and abuse of powers, inefficiency, arbitrariness and lack of transparency (Cueto et al. 2006).

In 2016, a Standing Committee on Health and Family Welfare was set up to investigate the Medical Council of India (MCI). Their reports identified that all members of MCI were only medical doctors, no other representatives from other government and non-government organizations. The Committee observed that the present requirements for establishing a medical college are based only on physical space, infrastructure and rigid faculty requirements and MCI was the sole agency that had the mandate to give permission to set new medical colleges. The fact that MCI also conducted compulsory accreditation for all medical colleges led to a conflict of interest. The Committee observed issues related to corruption in the MCI. Further, it noted that autonomy should be balanced with accountability. As MCI is funded by the government, therefore it should enforce accountability on the MCI.

After a long debate, eventually the decision was approved by most states and after its approval by the Prime Minister, National Medical Commission (NMC) Bill was passed by parliament and approved by President on August 8, 2019. NMC is a new regulatory body to replace MCI with its main function is laying down policies for regulating medical institutions and medical professionals. The membership of NMC includes representatives from various stakeholders, namely Undergraduate Medical Education Board, Postgraduate Medical Education Board, Medical Assessment and Rating Board, Ethics and Medical Registration Board, Directorate General of Health Services, Indian Council of Medical Research, Ministry of Health and Family Welfare. In addition to this, 22 members representing experts, Medical Union and Medical Advisory Council. This new NMC is no longer involved in the accreditation of medical colleges (Doddaiah et al. 2020).

8.9.1 Analysis of the Indonesian and Indian Accreditation System Using Hofstede's Cultural Dimensions

Based on Hofstede's cultural dimension index, Indonesia scores high on the power distance dimension (score of 78) which means that the following attributes characterize the Indonesian cultural style, namely being dependent on hierarchy, unequal rights between power holders and non-power holders, power is centralized, communication is indirect and negative feedback is hidden (Hofstede 2020). It is understandable that although IAAHEH has a strong legal standing as an independent accreditation agency, it is still not as independent as it should be. In terms of accreditation standards, IAAHEH must comply with the formats from NABHE, although health professions have their own standards. An example is the medical profession. The Indonesian Medical Council legally has the authority to approve Standards of Competences and Standards of Medical Profession Education. Both Standards are formulated by a national task force whose members represent the Indonesian Medical Associations and the Association of Medical Education Institutions. The medical profession also has an international organization, namely the WFME, which is a WHO partner aimed to improve the quality of medical education. WFME also issues global standards in basic medical education, postgraduate education and continuing education which are used as references in developing national standards by many countries. Although the Indonesian Medical Council already approved the Standards of Medical Profession Education in 2006 and 2012 which referred to the WFME standards, still the accreditation standards used by IAAHEH are the ones developed by NABHE. Consequently, the accreditation instruments follow the standards that are used, and must be approved by NABHE as well.

India has a similar score of power distance which is 77. It is clear that Indians are dependent on the boss or the power holder for direction (Hofstede 2020). The dissolution of the Medical Council of India in 2019 demonstrated the high power of the

Government and the diminishing power of civil society represented by the professional organization. The Indian Medical Association (IMA) has not been directly involved in medical regulation, albeit its long-standing existence since 1928. They are also not represented in the New National Medical Commission (NMC). Other professional organizations accept the unequal rights between the power-privileged and those who are not. Real Power is centralized and lay in the Ministry of Health and Family Welfare.

From the above cases, we can observe how the power distance in Indonesia has diverted the true intention of having a quality assurance system. This follows the explanation at the beginning of this chapter that a quality assurance system is defined as 'fitness for purpose'. In the context of health professions education, the 'purpose' is to improve the health status of the community which has been mandated. Health professions education institutions—having been granted at least an academic autonomy by the Higher Education Law—are supposed to have the freedom to gear their vision and mission to meet the society's health needs, and to develop education, research and community services in accordance with their own vision and mission. Having a high score of power distance where leaders are the main directive and power is centralized, the health professions education institutions tend to obey—or even demand the ministerial decrees—to direct and to guide them in almost every aspect of academic activities. Perceiving that higher education institutions are subordinates of the Ministry of Education and Culture, they consciously choose to accept being controlled by the higher authority. Similarly, the Ministry of Education and Culture with its own bureaucratic powers tends to maintain tight controls over the academic life of higher education institutions. A number of guidelines, directives and instructions issued by the Ministry of Education and Culture reflect this relationship of superior-subordinate. In this high-power distance culture, the regulations established concerning university autonomy and academic freedom are practically ambiguous.

Since the MCI was dissolved in 2019, accreditation of medical colleges is conducted by National Assessment and Accreditation Council (NAAC) which was established in 1994 by the UGC. At the programme level, accreditation by NAAC is voluntary, including for medical education programmes; but for higher education institutions it is mandatory. The instruments used are mostly quantitative measures with a scoring system.

Such a high-power distance as shown in Indonesia and India obviously has an impact on how the accreditation system is implemented. Quality—whatever definition is used—always demands autonomy because quality needs creativity and freedom to strive for the best outcome in order to achieve the vision. A program or a higher education institution needs to have a considerable discretion to be able to fully execute the Plan-Do-Check-Act (PDCA) cycle consistently, resulting in a continuous quality improvement. In Indonesia, the high-power distance has urged the adoption of an 'obedience' mentality and the acceptance of 'centralized bureaucratic power' that controls the university. This situation is similar to India.

Although by regulation, NABHE and IAAHEH are supposed to operate independently of Government intervention, still they are obliged to comply the Ministerial Decree No.32/2016 which was renewed in the Ministerial Decree No.5/2020 on Accreditation. From the perspectives of the education institutions and the study programmes, they perceive NABHE and IAAHE are representing the Government in an effort to control them. A similar situation occurs in India where the Government established National Assessment and Accreditation Council (NAAC).

Therefore, the design of the accreditation system in Indonesia as well as in India demonstrates this 'obedience or compliance' attitude. This is reflected in the accreditation standards, procedures and instruments, where the quantitative approaches have been adopted for each sub-criteria with certain weightings. In spite of the fact that the assessors have to complete the qualitative narrative for each sub-criteria before they assign a score, but due to the limited time to verify all the sub-criteria during the site visits, in order to get enough data for narrative reports, the assessors tend to focus on giving scores for about 170 sub-criteria. The Excel application calculates automatically the total scores and concludes to which category the study program or the institutions are placed. In the old system, the category of the accreditation results was A for the score of 361–400, B for 301–360 and C for 200–300. The new system replaces A with excellence, B with very good and C with good.

The 'obedience and compliance' behavior has impacted the implementation of the internal quality assurance system within both the institutions and also the study programs, which is supposed to be the basis for an external quality assurance system through accreditation. Institutions or study programs regard the accreditation as a necessary formality, and as long as they can demonstrate compliance to the criteria and sub-criteria, they can survive the accreditation. In order to get the best status they can, manipulation of data and interpretations are commonly found. In some cases, evidence and documents are created instantly for the purpose of meeting the description of the sub-criteria.

According to Hofstede's cultural dimension index, Indonesia scores (46) and is thus considered low Masculine—although it is not too low to be considered a feminine culture. In Indonesia, status and visible symbols of success are considered to be the most important. Often it is the position that a person holds which is more important to them because of an Indonesian concept called '*gengsi*'—loosely translated to mean, 'outward appearances' or 'outward reputation'. It is important that the '*gengsi*' be strongly maintained thereby projecting a different outward appearance aimed at impressing and creating the aura of elevated status. This can be seen in the proactive behavior to obtain the 'A' accreditation status as 'a *gengsi*' of the institution, rather than the 'true achievement'. India's masculine score index is 56 which is higher than Indonesia. The fact that in MCI rampant corruptions were discovered has shown that the society values material gains as the measure for success.

Concerning the uncertainty avoidance score, Indonesia scores 48. Indonesia thus has a low preference for avoiding uncertainty. This means that there is a strong preference in Indonesia towards the Javanese culture of separation of internal self from external self. When a person is upset, it is habitual for the Indonesian not to show any negative emotion or anger externally (Hofstede 2020). They will keep

smiling and be polite, no matter how angry they are inside. This attitude also means that maintaining workplace and relationship harmony is very important in Indonesia, and no one wishes to be the transmitter of bad or negative news or feedback. This kind of behavior is contradictory to the value of quality assurance where people are expected to be honest and descriptive about their achievements and what needs to be improved. Quality is about achieving the shared vision in the future which is better than the current state. Along the way during the journey moving towards the vision, it is rational to have obstacles, problems, and difficulties. But the Indonesian culture hinders people from honestly self-evaluating their achievements and identifying the true weaknesses that need to be changed, albeit the self-evaluation is very important in quality assurance—both internally and externally. Direct communication as a method of conflict resolution is often seen to be a threatening situation and one with which most Indonesians are uncomfortable. In this cultural situation, it is difficult to take self-evaluation seriously if a program or institution intends to achieve its vision, mission and objectives, even though the results of self-evaluation are used for targeting the improvement efforts. The weighting for Self-Evaluation Report for the total score which is only 10% for study programs and 15% for institutions has forced programs and institutions to disregard conducting self-evaluation sincerely. Again, self-evaluation is treated as 'a ritual' and in some cases, a puppet charade.

India's score for uncertainty avoidance is 40. Rules are often in place just to be circumvented and one relies on innovative methods to 'bypass the system'. A word used often is 'adjust' and means a wide range of things, from turning a blind eye to rules being flouted to finding a unique and inventive solution to a seemingly insurmountable problem. It is this attitude that is both the cause of misery as well as the most empowering aspect of the country. There is a saying that 'nothing is impossible' in India, so long as one knows how to 'adjust' (Hofstede 2020). This situation could be found in MCI. Although, the Medical Council Act already provided the rules on how to run the Council, these rules were bypassed resulting in corruption and abuse of power.

8.10 Reflection of Accreditation System in Different Cultural Context

From the two case studies presented, the USA and Indonesia, we can conclude that depending on the cultural context as analyzed using Hofstede's Cultural Dimension, the implementation of quality assurance concepts, the effect on the programme and institutional changes towards quality improvement, and the impact for graduates and societies can be different; yet what matters in assessing any achievement should be evidence-based. The USA and Canada, Indonesia and India demonstrate two countries with opposing cultures that have developed different accreditation systems. A comparison is depicted in Table 8.1.

Table 8.1 Comparison between the USA and Canada versus Indonesia and India accreditation system

Characteristics of the Accreditation System	USA and Canada	Indonesia and India
Initiator	Association of American Medical Colleges (AAMC) and American Medical Association (AMA)	Government
Enactment	Agreement/Consensus among member representatives	Higher Education Law and Ministerial Decrees for Indonesia Medical Council Act for India, later changed by National Medical Commission Bill
Type of Organization	Non-government	Quasi-government for Indonesia and Government for India
Answerable to	Member representatives	Government
Feature	Volunteer	Compulsory for Indonesia and India. Starting in 2020, it is voluntary for India
Assessors	Volunteer	Paid contract
Standards	Developed by the Accreditation Agency (LCME) established by the AAMC and AMA for USA Canada apply the same standards	Developed by the Indonesian Medical Council and NABHE For India, initially by the Medical Council of India, later by the NAAC
Accreditation fee	None (funding from membership fee)	NABHE is funded by the Government, IAAHEH is funded by accreditation fee (around 7,000 USD) MCI used to be funded by the Government. NAAC is funded by the Government
Direct Government control	Almost none	Very strong
Basis	Principle-based	Rule-based
Methods	Self-regulation and Peer review	Compliance-based and control
Main document for desk evaluation	Self-evaluation Report	Completed instruments for supporting data and their attachments
Data gathering approach	Qualitative narrative using open questions, asking for input, process and output	Quantitative—focusing on inputs
Purpose	Continuous quality improvement	Compliance with criteria and sub-criteria
Accreditation status	Accredited for certain years and not accredited	A, B and C (Excellence, Very Good, Good)
Post accreditation	Monitoring	Survey

(continued)

Table 8.1 (continued)

Characteristics of the Accreditation System	USA and Canada	Indonesia and India
Use	Eligibility for Government Programs and for further study	Eligibility for Government Programmes, for job requirements and for further study

The accreditation system was initially developed in the USA before spreading to all over the world. Indonesia and other countries from different cultural and historical backgrounds should adjust their concepts and procedures before deciding to apply the accreditation system.

8.11 Summary: Culturally Sensitive Accreditation System

It is important to avoid uniformity of concepts, policies and procedures when we deal with internal and external quality assurance system. The concept of Social Accountability could be taken into consideration when designing an accreditation system for a particular country. Accreditation—as an external quality assurance—is not only meant for checking the compliance against predetermined standards, but equally, the accreditation process could be aimed at higher purposes and beyond the confines of a higher education institution.

Bearing in mind the unique characteristics of health professions education as explained in the previous sections, it is paramount to always consider that health professions education and health services are inseparable. We cannot conduct health professions education without the involvement of health services, and by the same token, we cannot deliver proper health services without the involvement of academicians and students. The recently proposed idea of redefining quality and accreditation as proposed by Boelen et al. (2019) is very relevant in this circumstance. Medical and health professions schools are the prime health stakeholders with strong potentials to mobilize resources towards improved health community. Quality in health professions education needs to be redefined as the institutional and program capacity to identify the current and future health needs of the society, to gear their vision and mission to adjust with the health needs and to monitor the effects of relevant actions towards meeting those needs (Boelen et al. 2019).

In the cultural context of Eastern developing countries, such as Indonesia and India, for the accreditation to be fully functioning as the policy instruments for quality improvement and improvement of population health, quantitative input-based approach needs to be mitigated. All supporting data for each standard does not necessarily require re-input and is to be attached in the documents. We need to build trust that institutions and study programmes have the good intention to gather and maintain their own academic data. The accreditation system should be designed in such a way

that it allows for more dialogues, communication and feedback between the accreditation agency and the institutions or the study programs. The provision of detailed and appropriate feedback will be more meaningful for the study programs in order to gradually make changes and improvement. Self-evaluation needs to be redefined and to use the commonly expressed language in a more supportive and cogent manner. Empirically, the accreditation system should rely on the Self-Evaluation Report. The institutions and the programs are convinced that Self-Evaluation is their need and should be used in accordance with their own needs. The rigid quantitative calculation for each sub-criterion must be limited, because such methods would divert the attention of the institutions and the program from the real purpose of accreditation to only just obtaining the scores and accreditation status.

Accreditation is about regulation and regulating means controlling. It is important to have a balance of power in regulation and control. Too much leaning on the government side might disempower the civil society which is needed in modern society. On the other hand, too much power in the civil society might lead to abuse of power by strong and dominating individuals in the organization.

Concludingly, the accreditation system that is developed in developing countries with high power distance and low uncertainty avoidance should make maximum use of those motivated in adapting the accreditation standards to the priority health needs of society and incite those in a power position to facilitate the implementation of proposed changes to install new 'honor system'.

There must be a global awareness that we may all be aiming at a same goal. That is why the recently established International Social Accountability and Accreditation Think Tank (ISAATT) has set as objective to

> *"Create a momentum towards a global initiative to ensure accreditation systems of medical schools are designed and used to better respond to priority health needs and challenges of societies today and in the future."*

Key Learning Points

- Medical and health professions education has social accountability to the society they have a mandate to serve.
- Definition of quality for medical and health profession education should be geared towards fulfillment their social accountability.
- Accreditation in high power distance and low uncertainty avoidance should make maximum use of benchmarking through role modeling.

References

Blouin D, Tekian A (2018) Accreditation of medical education programs: Moving from student outcomes to continuous quality improvement measures. Acad Med 93(3):377–383. https://doi.org/10.1097/ACM.0000000000001835

Boelen C, Blouin D, Gibs T et al (2019) Accrediting excellence for a medical school's impact on population health. Educ Health 32(1):41

Boelen C, Heck J (1995) Defining and measuring the social accountability of medical schools, No. WHO/HRH/95.7. Unpublished, 1st edn. World Health Organization

Boelen C, Woollard B (2009) Social accountability and accreditation: a new frontier for educational institutions. Med Educ 43(9):887–894. https://doi.org/10.1111/j.1365-2923.2009.03413.x

Brittingham B (2009) Accreditation in the United States: how did we get to where we are? N Dir High Educ 145:7–27. https://doi.org/10.1002/he.331

CACMS (2014) The role of students in the accreditation of medical education programs in Canada. https://docplayer.net/1489273-The-role-of-students-in-the-accreditation-of-medical-education-programs-in-canada.html

Cappon P, MacDonald N, McMurtry R (2001) Social accountability: a vision for Canadian Medical Schools. Institute for International Medical Education, Ottawa. http://www.iime.org/documents/hawkins.htm

Cassie JM, Armbruster JS, Bowmer MI et al (1999) Accreditation of postgraduate medical education in the United States and Canada: a comparison of two systems. Med Educ 33(7):493–498. https://doi.org/10.1046/j.1365-2923.1999.00444.x

Chatibwarsa U (2020) Social accountability and accreditation of IAAHEH (LAMPTKES) to improve access on quality of study programme in health in Indonesia. Indonesian Accreditation Agency for Higher Education in Indonesia (IAAHEH/LAM-PTKES), Jakarta

Connolly KK, Blanchette PL, Hedges JR (2017) Medical school hotline: John A. burns school of medicine receives continued full accreditation by the Liaison Committee on Medical Education (LCME) for the maximum accreditation period of eight years. Hawai'i J Med Public Health: J Asia Pac Med Public Health 76(10):287–289

Cooke M, Irby DM, Sullivan W (2006) Medical education: American medical education 100 years after the flexner report. N Engl J Med 355(13):1339–1344. https://doi.org/10.1056/NEJMra055445

Cueto J, Burch VC, Adnan NAM et al (2006) Accreditation of undergraduate medical training programs: practices in nine developing countries as compared with the United States. Educ Health: Change Learn Pract 19(2):207–222. https://doi.org/10.1080/13576280600783570

Dezee KJ, Artino AR, Elnicki DM et al (2012) Medical education in the United States of America. Med Teach 34(7):521–525. https://doi.org/10.3109/0142159X.2012.668248

Doddaiah S, Bhat D, Hathur B et al (2020) Assessment and accreditation of a medical college by national assessment and accreditation council: an overview. Int J Adv Med 7(2):354. https://doi.org/10.18203/2349-3933.ijam20200093

Eagle RH (2017) Academic quality and public accountability in academic medicine: The 75-year history of the LCME. Association of American Medical Colleges

El-Khawas E (2001) Accreditation in the USA: origins, developmentsand future prospectsitle. https://unesdoc.unesco.org/ark:/48223/pf0000129295

GCSA (2010) Global Consensus for Social Accountability of Medical Schools (GCSA). http://healthsocialaccountability.org

Hofstede G (2001) Cultural consequences: Comparing values, behaviours, institutions, and organizatis across nations, 2nd edn. Sage Publications Inc., California, USA

Hofstede G (2020) Compare countries. https://www.hofstede-insights.com/product/compare-countries/

Hofstede G, Hofstede GJ, Minkov M (2010) Culture and organization software of the mind: Intercultural cooperation and its importance for survival, 3rd edn. McGraw Hill, New York

Irby D (2011) Educating physicians for the future: Carnegie's calls for reform. Med Teach 33(7):547–550. https://doi.org/10.3109/0142159X.2011.578173
Kassebaum DG (1992) Origin of the LCME, the AAMC-AMA partnership for accreditation. Acad Med J Assoc Am Med Coll 67(2):85–87
LCME (2020) Function and structure of medical school. https://www.aamc.org
Marzuki P (2016) Case Study 24.5: Establishing a quality assurance system of medical education in Indonesia. In: Abdurahman K, Mennin S, Harden R (eds) International handbook of medical education. Routledge, London, pp 340–342
Mustika R, Nishigori H, Ronokusumo S et al (2019) The odyssey of medical education in Indonesia. The Asia Pacific Scholar 4(1):4–8. https://doi.org/10.29060/taps.2019-4-1/gp1077
Quintero GA (2014) Medical education and the healthcare system—why does the curriculum need to be reformed? BMC Med 12(1):1–4. https://doi.org/10.1186/s12916-014-0213-3
Schein EH (2016) Organizational culture and leadership, 5th edn. John Wiley and Sons, New Jersey
Schraeder M, Self D (2003) Enhancing the success of mergers and acquisitions: an organizational culture perspective. Manag Decis 41:511–512. https://doi.org/10.1108/00251740310479359
Shilliday G (1983) Accrediting Canadian medical schools. Can Med Assoc J 128(8):985–986
van Zanten M, Boulet JR, Greaves I (2012) The importance of medical education accreditation standards. Med Teach 34(2):136–145. https://doi.org/10.3109/0142159x.2012.643261
Vlasceanu L, Grunberg L, Pârlea D (2007) Quality assurance and accreditation: a glossary of basic terms and definitions. Unesco-Cepes, Bucharest, p 25
WHO (1978) Declaration of Alma Ata. https://www.who.int/publications/almaata_declaration_en.pdf