Observations

Reconsidering A Global Agency for Medical Education: Back to the Drawing Board?

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Abstract

Issue: The World Federation for Medical Education (WFME) was established in 1972 and in the five decades that followed, has been the de facto global agency for medical education. Despite this apparently formidable remit, it has received little analysis in the academic literature. *Evidence*: In this article, we examine the historical context at the time WFME was established and summarise the key decisions it has taken in its history to date, highlighting particularly how it has adopted positions and programmes that have seemingly given precedence to the values and priorities of countries in the Global North. In doing so, we challenge the inevitability of the path that it has taken and consider other possible avenues that such a global agency in medical education could have taken, including to advocate for, and to develop policies that would support countries in the Global South. *Implications:* This article proposes a more democratic and equitable means by which a global organisation for medical education might choose its priority areas, and a more inclusive method by which it could engage the medical education community worldwide. It concludes by hypothesising about the future of global representation and priority-setting, and outlines a series of principles that could form the basis for a reimagined agency that would have the potential to become a force for empowerment and global justice in medical education.

Introduction

Picture the scene. The date is April 1972, and the location is Mainz, Germany. A group of eight men, collectively known as the 'Planning Group', are meeting to conceptualise a new global agency for medical education. The meeting is sponsored by an American philanthropic foundation and by the end of it, a constitution for the new agency has been drafted and a conference for later in 1972 to take place in Copenhagen, Denmark has been planned to sign it off. At this conference, on 30th September of the same year, the constitution is signed by a series of 'chief witnesses' and 'distinguished witnesses' and formally deposited with the World Health Organization in Geneva, thereby recognising the World Federation for Medical Education (WFME) as the global body representing medical education worldwide.[1]

The deliberations that took place in Mainz in April 1972 were not recorded, to the best of our knowledge, in any public forum. They did, however, form the conceptual basis for WFME, which went on to become the *de facto* global agency in medical education in the five decades that followed. We propose in this article that the contributions WFME has made to medical education have not been conducive to the development of a functional and equitable global healthcare workforce and it is therefore important to understand how it was established and indeed, how the notion of a global medical education agency was justified. We cannot enter a time machine and go back to the 1972 meeting to listen to the discussions and debates that resulted in the version of WFME that emerged. We can, though, consider the historical context at this time, examine how those decisions played out through the decades that followed, and imagine how a different set of priorities might have been advanced. That is what we seek to do in this article.

We approach this work mindful of our own backgrounds and positionalities in relation to the topic. As a collective author team, our intersecting personal identities cross different linguistic, religious, and

cultural boundaries across four continents. Whilst we each hold 'scholar' and 'practitioner' roles and experience within medical education, we additionally have identities and positions in other scientific and clinical disciplines. We each work in historic institutions and hold positions of privilege within our institutions that allow us to influence policymakers, senior and junior colleagues, trainees, and students. We have previously worked jointly and individually in scholarship about equity in medical education. Although each of us has experienced medical education in both Global North and Global South settings, there are, nonetheless, important differences in our contexts and experiences. Notably, the magnitude of challenges and injustices that our peers and communities face differ considerably, from the existential to the marginal, on account of wide differences in resources and security. Across the broad networks of medical education with which we collectively connect, we encounter individuals for whom global agencies like WFME are an important factor and presence. Contrastingly, though, we also encounter very many committed and well-informed individuals in medical education who have never heard of, or thought about, a global agency in medical education.

In this article, we examine the history and functions of WFME as an illustrative case study that reflects on the broader conditions that shape global medical education. We do so using the Global critical race and racism framework as our conceptual basis, which positions racism as a fundamentally global issue that transforms across historical, political, and geographic boundaries .[2] Such an approach enables us to understand that contemporary realities are the products of deeply rooted structures and practices.

The historical context of WFME

Mainstream historical accounts of medical education usually position the 1910 Flexner report that examined medical schools in North America as the foundation of current models,[3] although its racial bias has been questioned even in the U.S. [4] The origins of academic medicine as we know it today, in fact, can be traced to a variety of peoples and cultures, including Greeks, Jews, Indians, Syriacs, and Persians.[5] Likewise, prominent histories of medicine oftentimes ignore that many African and Asian civilisations had rich and highly sophisticated traditions for healing and healthcare long before colonisers attempted to 'civilise' them by imposing Western medical models[6]

The spread of Western models of medicine and medical education was closely tied to imperialist aspirations of European nations from the 1500s onwards. [7] Even in parts of the world that resisted colonisation, missionaries set up medical schools and hospitals to support their proselytising efforts. [8] During the first half of the 20th century, Europeans essentially installed medical education systems by training medical assistants who would work under European doctors, predominantly to provide healthcare for European civil servants and military personnel. [9] The transition from medical assistants to medical graduates took place during the change from colonial status to independence.

Historians of medicine and medical education have noted that the 1950s and 1960s were characterised by efforts to export what was then considered the 'best' of western medical training.[10] Although in this period there was no global agency for medical education, there was a global agency in healthcare and public health – the World Health Organisation (WHO). The steps taken by WHO in this period reveal a desire to take a holistic and equitable approach to improving medical education worldwide. For example, they conceded that training for physicians in 'developing' countries should differ from those in high-income countries and take account of the local healthcare needs.[11] Likewise, WHO sent individuals and teams to institutions in lower income countries with a focus on training local staff and providing teaching equipment and medical literature.[12] In 1969–1971, WHO and UNICEF jointly undertook a comprehensive assessment of their assistance to education and training

programmes in nine countries and noted serious shortages of healthcare workers. Moreover, migration from Global South to Global North countries was also recognised in this report and highlighted as serious threat.[13]

The period of the early 1970s then, when WFME came into existence, was characterised globally in medical education as a period when many formerly colonised countries were seeking to overcome the material and ideological oppressions they had faced, and moreover, were further challenged by ongoing 'brain drain' caused by the mass exodus of healthcare workers who were paradoxically often migrating to coloniser countries.[14]

Key WFME Landmarks

WFME was admitted into official relations with WHO in 1974, as a Non-Governmental Organisation (NGO), thereby recognising it as the agency representing medical education and medical schools at the global level.[1] The Federation was also listed by the Economic and Social Council of the United Nations as a related NGO, with similar relations to other UN bodies concerned with health, notably UNESCO, UNICEF, and the UNDP. The relationship between WFME and the World Medical Association (WMA) was ratified at the first Assembly of WFME at Stockholm 1974, with WMA an ex-officio member of the WFME Executive Council and WFME of the WMA Council. Its proclaimed mission was to *"strive for better health care, by high scientific, ethical and social standards in the education of medical and related personnel, toward provision of competent medical and health services globally."*[1]

In its first 50 years, WFME has had six presidents and four offices. Astonishingly, none of these presidents have been in, or from, Asia or Africa despite the fact that this is where the overwhelming majority of medical education actually takes place.[15] In fact, all six have been white men. The offices, meanwhile, have been in the U.S. (1972-1983), the U.K. (1983-1996), Denmark (1996-2010) and

France (2010-date) .[1] This strikes a problematic image in light of the aforementioned impacts of colonial rule that had been troubling the global medical education comunity in the period leading to its establishment.

Although WFME has a 50-year history, it would be wrong to assume that its activity and influence has been stable or even rising in any graded way. Rather, it seems to have had spikes of activity and then a quite sudden and dramatic rise in the last decade. In its first two decades, for example, there appears to have been little activity. Its first significant event occurred in 1988 when it hosted the World Conference on Medical Education in Edinburgh, UK and used it to publish a document about quality of medical schools in the world that became known as the Edinburgh Declaration.[16] It has been noted that language used in this statement was criticised as being overly grandiose, and that it contrasted different regions of the world according to modernity and development.[17] It was, however, framed as reformative in a 30-year anniversary commemoration,[18] although it has rarely been cited or celebrated other than at this juncture.

The next major landmark for WFME was the development of global expert standards, which were first conceptualised in 1998,[19] first published in 2003,[20] and subsequently updated in 2012, 2015, and 2020.[21] WFME state that these standards "provide a template for medical schools and other providers of medical education, and the agencies which accredit them to define institutional, national, and regional standards, and to act as a lever for quality improvement" .[21] Although WFME recommend that they should be adapted locally, this is not always the case in reality,[22] and they are often conceived of as authoritative and a 'gold standard' to aspire to.[23] They have also been the subject of critique, including on the basis of them legitimising standardisation and 'Westernisation' in medical education,[24] on the basis of them 'encouraging Western values,'[25] on the basis of the fostering 'a predominantly developed world paradigm of basic medical education.'[26] Drawing on ideas of

globalisation and how they apply in medical educatiom, Hodges et al. (2009) ask the following probing question in the context of the WFME standards:

> *Is it possible to consider global accreditation without reverting to colonialism and all of the problematic baggage associated with homogenization and cultural dominance?* [27 (pg. 915)]

Although the Edinburgh Declaration and WFME standards were noteworthy spikes of activity, it was not until 2012 that WFME had its most significant moment of prominence, when it launched a recognition programme for medical school accreditation agencies directly in response to a policy decision by the U.S. agency, the Educational Commission for Foreign Medical Graduates (ECFMG). This accreditation system charges $60,000 dollars plus travel and subsistence costs for a visiting team and has been taken up by a number of low- and middle-income countries.[21] As well as being directly linked to 'compliance' with the U.S. ruling, it was also developed in close collaboration with a U.S. agency, the Foundation for the Advancement of International Medical Education and Research (FAIMER) ,[28] which is closely linked to ECFMG. In other words, this WFME programme exists directly because of a U.S. decision and was designed with a U.S. agency. In contrast to these Global North origins, the impact of this programme is firmly in the Global South, given that this is where most of the world's medical schools are.[15] Moreover, despite the programme being in existence for over a decade, there has been no formal, or indeed informal, evaluation of it to date.

At present, there are no directly comparable organisations to WFME. Although there are other medical education agencies that claim a global remit, including FAIMER[29] or the American Board of Medical Specialties,[30] they have clear financial, staffing, and governance links to a single country – in both of these cases, the U.S. Moreover, although these agencies claim to have global agendas, they do not claim to be globally representative by including individuals and agencies from around the world in their structures.

Who is being prioritised in priority-setting?

We contend that the version of WFME that has existed in the last half a century did not occur by accident or default but rather came about through a series of decisions taken by individuals and groups at different historical time points, as summarised above. It is neither inherent nor inevitable. This is particularly apparent when contrasting the history of WFME with the period that preceded its establishment. In that period, as highlighted above, there was a recognition that formerly colonised countries were facing significant challenges and required a celebration of difference and support to maintain contextual authenticity. There is little in the history of WFME that helps these countries. Rather, the overwhelming messages that emerge from the organisation are of standardisation, the promotion of Global North ideas and values, and supporting Global North policy positions. This mismatch was not inevitable and could have been avoided if WFME had followed an alternative path.

At the heart of the mismatch described above, between the apparent global need in medical education and the policies of WFME, is a misalignment of priorities. Indeed, the challenges faced by countries in the Global South are not expressly prioritised in the policies or publications that have emerged from WFME in the last fifty years. Rather, the priorities seem to be those of Global North countries. Perhaps the clearest example of this is seen in the movement of healthcare workers.

As previously stated, concerns about 'brain drain' and the impact of this on Global South countries was evident even before WFME was established. Yet throughout its existence, the WFME's main priorities and programmes have facilitated medical migration. Both the WFME standards programme,[31, 32, 33] and much more expressly the WFME recognition programme,[34, 35, 36] have been linked directly to facilitating migration to the U.S. In contrast, there is an absence of attention given

to the impacts on countries losing doctors to migration. Considering this, the WFME appears to prioritise advancing a Global North agenda.

In the UK in 2004, a non-profit organisation called The James Lind Alliance (JLA) was established that had a clear mission to rethink how decisions can be prioritised in medicine.[37] These decisions related not to medical education but rather to health research funding. The JLA brings together patients and clinicians in priority-setting partnerships to help identify unanswered questions or evidence uncertainties that they agree are the most important, so that health research funders are aware of the issues that matter most to the people who need to use the research in their everyday lives. In other words, the JLA democratises decision-making about where research monies go, shifting the power from a few senior individuals to those who have the most lived experience of the problems and most to gain from the outputs. This is just one example and other organisations, including the The Patient-Centered Outcomes Research Institute (PCORI), have developed similar approaches.[38]

Transposing the JLA model to WFME may allow us to see how a different agenda could have been shaped, where the power to decide was not with a small number of 'leaders' in Europe but rather, with those working at the frontline of medical education. Considering this in a proportionate way, the greater number of medical schools in the Global South would therefore mean that these voices would carry the most influence. Given the structural dominance of Global North in medical education scholarship[39] and journal editing,[40] amongst other areas, this could be an important mechanism to redress these balances through a radical, proportionate, and equitable prioritisation system.

Although we argue for a more democratic method to inform the agenda of a global organisation for medical education, like WFME, here we propose possible avenues that could be pursued. We recognise that these are just a few of an endless number of priority areas that individuals and groups in medical education may choose to sponsor and propose. Indeed, we recognise that there may well

be interest in keeping aspects of the current WFME portfolio, including the global standards, which have been embraced positively in different settings around the world, including in Pakistan,[41]Germany,[42] Iran, [43]and Sudan.[44] We also recognise that there will continue to be varied priorities across nations and regions. Global consensus may rarely be possible; rather, acknowledging and managing tensions between a plurality of global perspectives might be a productive focus moving forward. Welcoming respectful conversations about contentious topics could be a way for WFME to broaden representation and provide a global space for discussion. Importantly, we also suggest that the current focus of WFME on regulation is not inevitable, and that it could choose to focus instead or in addition, on any other possible areas where it might make valuable and ethically sound contributions.

As already outlined in this article, the problem of 'brain drain' is one that has long affected the global medical system. Given the severe health human resource shortages across the world, the medical education community must contribute to finding solutions to ensure global access to healthcare. Issues of medical migration are complex and although migration to the Global North is considered desirable[45] and can be undertaken for a variety of reasons,[46] its unidirectional pattern can widen inequalities and harm healthcare systems.[47] It is not an area that current WFME policies have confronted. Indeed, one could argue that they have instead worsened them. What, then, could WFME do to tackle this in a more equitable way? It could, for example, be a global advocate for rural and remote medical education, strengthening local postgraduate training opportunities, brokering equitable global partnerships to develop contextual and sustainable medical education development, and advocate governments and policymakers to consider creative new solutions to incentivise physicians towards the areas of greatest need.

Another problem already alluded to in this article is the dominance of the Global North in knowledge production in medical education. In fact, other than a few scattered editorial articles and letters to

journals from successive WFME presidents, there has been almost no contribution to the academic literature from the organisation since its inception, less still a structured mechanism to promote or develop it. By exploiting Global North expertise and skills and supporting an equitable and accessible model of redistributing it to emerging Global South scholars, WFME could play its part in creating a more balanced medical education literature that draws on some of the rich talents and experiences that are currently being missed because of structural inequalities.

Engagement, democracy, and representation

Aside from rethinking the areas of policy focus, there are a number of other ways in which a global organisation for medical education, like WFME, could be structured to make it more engaged, democratic, representative, and ultimately, more connected to the medical education communities it seeks to serve.

Firstly, there is a clear lack of transparency in WFME, which is evident from the lack of detail it publishes about how it makes decisions, manages finances, or ensures appropriate governance. An example of this is that a commissioned report of WFME that took place between 2020 and 2022 that led to 'over 50 recommendations' has been celebrated on the WFME webpage[17] but a copy of the report has not been published and was not made available on direct contact and request by members of this author team. Likewise, in 2022, WFME elected a new President and Vice President, although there are no public traces of the candidates who were put forward, the voting processes that led to the eventual outcomes, or the manifestos or proposals of individual candidates. We suggest that in order to be credible, a global agency should uphold the highest levels of transparency in order that those it serves can hold it to account and get behind it.

Secondly, the only platform for engagement in WFME is the Executive Council, which has just a single representative from each region of the world. We believe that a global agency in medical education

should strive to bring together members of the medical education community at all levels, to foster the building of relationships across a variety of areas and topics, determined as ever in a democratic way by medical teachers and students from around the world rather than a small group of policymakers. There is an opportunity for a global agency like WFME to be seen as 'us' and not 'them' but this is only possible if it is seen as open, with multiple, accessible opportunities for people to participate in meaningful and enriching ways according to their own interests and priorities.

Thirdly and finally, an organisation like WFME has to be governed according to a set of principles that champion a truly global philosophy. In other words, WFME cannot be seen to be, and indeed cannot, align itself with any particular country or region of the world. Given its historical links to Global North countries and the inherent geopolitical power imbalances that exist, this is especially the case should such alignment be to the Global North. Rather, it should seek to adopt an inclusive, advocative, and benevolent organisation that models itself not just on equality, but rather on equity. Simply put, existing and historical injustices and burdens should be clearly accounted for and not ignored.

The issues we uncover through examining a global agency in medical education are aligned with many important issues that are currently being debated in medical education more broadly. As we have outlined in this article, WFME has positioned itself as an agency concerned with regulation of medical education and in recent times, other studies have deconstructed this global quality agenda[48, 49, 50, 51]. Likewise, scholars have also interrogated other aspects of medical education using lenses that take into account the power and politics of globalisation and colonialism. This has included, for example, deconstructions of Western influences on global education trends,[52] patient involvement in medical education,[53] training about Aboriginal Peoples and health equity,[54] professional identity formation,[55] and bioethics.[56] We hope that approaches from postcolonialism and related areas continue to be applied empirically to global equity issues in medical education to help answer some of the important questions raised in this article.

Conclusion

Medical education, like all fields, exists in a series of political, social, economic, and cultural contexts around the world. A global organisation that seeks to represent it, then, cannot embrace ignore this. In this article, we conducted a historical case study analysis to examine how WFME was conceptualised and examined its contributions to medical education in the decades since it was established. Examining the historical development of organisations and institutions provides insights into ways they can be adapted going forward to increase representation and inclusivity. As the medical education community has recently developed greater collective awareness of its colonial history, we are perfectly positioned to act decisively to make change.

Global organisations for medical education must be relevant and beneficial to members of this community. The current structures and functions of global agencies are not meeting this goal. Through a comprehensive and accessible engagement exercise and a structural review, though, such organisations could aim to serve global medical education through principles of equity, justice, and empowerment.

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