

**This thesis is submitted for the degree of Doctor of Medicine (Research)**

Dr Mohammed Ahmed Rashid MBChB MSc MRCGP SFHEA

UCL Medical School

**Global Approaches to Medical School Regulation: A Critical Discourse  
Analysis**

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**Declaration Statement**

I, Mohammed Ahmed Rashid, confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

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## Abstract

Although medical school regulation is ubiquitous, the extent to which it should be based on global principles is unclear. In 2010, the Educational Commission for Foreign Medical Graduates (ECFMG), announced that from 2023, overseas doctors would only be eligible for certification to practise in the United States if they had graduated from a medical school that was accredited by a 'recognised' agency. This policy empowered the World Federation for Medical Education (WFME) to create a recognition programme for regulatory agencies around the world, despite a lack of empirical evidence to support medical school regulation. In this study, I employ critical discourse analysis, drawing on the theoretical perspectives of Michel Foucault and Edward Said, to identify discourses that enabled this 'globalising' policy decision to take place. The dataset includes a series of documents gathered around three key events: the Edinburgh declaration by WFME in 1988, the first set of global standards for medical schools by WFME in 2003, and the ECFMG ruling about medical school accreditation in 2010. Two discourses, *endorsement* and *modernisation*, were dominant throughout this entire period, and framed the move to globalise medical school regulation in terms of altruism and improving medical education worldwide. A discourse of *resistance* was present in the earlier period of this study but faded away as WFME aligned itself with ECFMG. Two further discourses, *protection* and *control*, emerged in the later period of this study, and framed the ECFMG ruling in terms of nationalism and protecting American interests. This study introduces Said's 'contrapuntal' analysis to the field of medical education, synthesising it with Foucauldian principles to propose a new conceptualisation of the relationship between ECFMG and WFME. It goes on to consider the implications of this association for the legitimacy of WFME as an organisation that represents all of the world's medical schools.

## **Impact Statement**

This thesis is primarily centred on the study of globalisation in the context of medical school regulation. Historically, medical education has been slow to embrace cross-cultural thinking and examine impacts of globalisation, despite medicine having a long history of being cosmopolitan as a profession due to the extensive migration of doctors. However, a new generation of medical education scholars are signalling an intention to think more critically about how the profession should respond to the more interconnected world we live in. I contribute to this shift by critically examining a policy decision that has the potential to have a symbolic and material effect on medical schools and professionals around the world.

This research examines historical events that led up to the World Federation for Medical Education (WFME) establishing a recognition programme for agencies that regulate medical schools and identifies the discourses that enabled this programme to come into existence. Although this recognition programme has already led to financial exchanges that go into millions of dollars, often paid by low and lower middle income countries, not to mention countless other indirect costs, it has yet to be examined in a scholarly way. Indeed, as WFME approaches its 50<sup>th</sup> anniversary as an organisation, there is an absence of any critical examination of its purpose or function from medical education scholars, despite its apparently global remit in the field.

As a discipline, medical education has in recent years started to recognise the importance of language and power relations, meaning that methodologies like critical discourse analysis, employed in this study, have started to emerge. Whilst the theoretical work of Michel Foucault has also started to have an impact on the discipline in the more recent past, postcolonial theorists like Edward Said have received less attention. In that this study uses Saidian 'contrapuntal' analysis, it introduces an approach not previously used in medical education, and one that could be applied to various subject areas other than regulation, which has been the focus of this study. As postcolonialism gains prominence, this may also have resonance in other healthcare and professional education fields.

This research will be presented at conferences and published in peer-review journals. It has the potential to disrupt thinking about globalisation in medical education and to prompt policymakers to engage more critically in global practices relating to medical school regulation. It can do this by acting as a springboard for medical education scholars to reimagine a global medical education community through a lens of possibility. Ultimately, it seeks to challenge medical education practitioners and leaders to think critically about organisations that seek to represent them, and to prioritise policies and practices that best serve the needs of doctors and patients.

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## Glossary

AMEE	Association for Medical Education in Europe
CBME	Competency-Based Medical Education
CDA	Critical Discourse Analysis
COVID19	A highly contagious respiratory disease caused by the SARS-CoV-2 virus
ECFMG	Educational Commission For Foreign Medical Graduates
FAIMER	Foundation for Advancement of International Medical Education and Research
GMC	General Medical Council
IAMRA	International Association of Medical Regulatory Authorities
IFMSA	International Federation of Medical Students Associations
IMG	International Medical Graduate
LCME	Liaison Committee on Medical Education
PBL	Problem-Based Learning
UHC	Universal Health Coverage
UNDP	United Nations Development Programme
UNESCO	The United Nations Educational, Scientific and Cultural Organization
UNICEF	United Nations Children's Emergency Fund
WFME	World Federation for Medical Education
WHO	World Health Organisation
WMA	World Medical Assembly

## **1. Introduction**

### **1.1 Regulating the world's medical schools**

How should medical schools be regulated? This question has long occupied medical educators and policymakers, mindful of the crucial role that doctors play in healthcare systems and society (Fulton, 1953). Given that professional responsibility is an established social norm, academic accountability is an established educational norm, and patient safety is an established healthcare norm, the idea that medical schools should be regulated is broadly accepted (McGaghie, 2013). Despite the widespread practice of regulation, though, there remains little empirical research to guide how medical schools should be regulated, and much tension about how it can best be approached (Tackett et al, 2019).

One particular area of dissonance relates to the extent to which a global approach can be applied to the regulation of medical schools. Those arguing for such an approach draw on the issues of competence and standardisation (Karle, 2006), as well as the impacts of globalisation and the requirement for qualifications to be transferrable to allow medical professionals to move between countries (Gordon and Karle, 2012). Those raising concerns about global approaches, meanwhile, draw on the sociocultural differences in healthcare and education practices around the world (Hodges et al, 2009), as well as concerns about imperialism and homogenisation (Bleakley et al, 2008).

Globally, there is growing demand and competition for doctors (Frenk et al, 2010). As Crisp and Chen (2014) note, the contrasting forces of the market and the social drive for health equity create a complex global medical workforce pattern, with large differences among countries and regions in numbers of doctors, as well as inequitable distribution within most countries, as remote and rural areas often struggle to attract or retain doctors. The United States (U.S.), for example, has just 4% of the world's population, it has over 8% of doctors. Despite having this disproportionately high proportion of the world's doctors, though, the U.S. has considerable physician shortages and these are projected to worsen significantly in the next decade (Zhang et al, 2020).

The Educational Commission for Foreign Medical Graduates (ECFMG) is a private, non-profit, non-governmental organisation that is authorised in federal regulations to serve as the certifying agency for international medical graduates (IMGs) entering the United States (U.S.) physician workforce (Cassimatis, 2013). The ECFMG was established in 1956 to meet the need of hospitals to ensure that IMGs—then known as 'foreign-alien' physicians—were properly 'vetted' (Hallock and Kostis, 2006). Since it began credentialising IMGs in 1958, ECFMG has had systems for assessing applicants' medical schools. Notably, ECFMG requires applicants to have graduated from a school listed in its official database, including schools that have been approved by an appropriate local authority, such as an accrediting agency or government ministry.

Although it is responsible for credentialising IMGs, ECFMG is not involved in licensing. In the U.S., licensing is not done nationally but rather on a state-by-state basis by state medical boards (Cassimatis, 2014). However, in evaluating individuals for licensing, regulatory bodies may consider legitimate international credentials issued on the basis of established international standards. ECFMG consider that the 'essential element for credentials' validation' is primary source verification and have an International Credentials Service (EICS) to assist international medical regulatory authorities in evaluating credentials of applicants' educations within their jurisdictions (Cassimatis, 2014). EICS certifies a variety of credentials, including medical school transcripts, certificates of license, medical school diplomas, and certificates of post-graduate medical training. As well as the Federation of State Medical Boards in the United States, its clients for this service include regulatory agencies around the world, including medical councils in Singapore, Australia, and the UK (ECFMG-EPIC, 2021).

On 21<sup>st</sup> September 2010, the ECFMG announced that "effective in 2023, physicians applying for ECFMG Certification will be required to graduate from a medical school that has been appropriately accredited" (ECFMG, 2010 p.1). They went on to clarify that this means only graduates from schools that achieved accreditation by an authority that follows standards and procedures comparable to those used by the U.S. medical school regulatory agency, Liaison Committee on Medical Education (LCME), or the World Federation for Medical Education (WFME), or other 'globally accepted' criteria would be eligible for ECFMG certification.

WFME is a not-for-profit, non-governmental organisation, registered under English and Welsh law, with small offices in London and France (WFME, 2020a). It was established in 1972 and describes itself as 'the' global organisation concerned with the education and training of doctors. Its mission is 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. Its current priorities include the promotion of accreditation, raising the standards for basic and postgraduate medical education and continuing professional development through the publication of expert consensus standards, and maintaining the World Directory of Medical Schools (WFME, 2020a).

In response to the ECFMG statement in 2010, WFME launched a recognition programme in 2012. ECFMG anticipated such a process would result in "a meaningful, universally accepted system of accreditation for undergraduate medical education outside the United States and Canada" (ECFMG, 2010, p.3). Prior to this recognition programme and even the ECFMG announcement, WFME had already published a set of 'global standards' for undergraduate medical education in 2003, and these standards have since been updated in 2012, 2015, and 2020. The WFME recognition programme includes analysis of a regulatory agency's standards and procedures and on-site verification of

compliance with pre-defined recognition criteria. Recognition by WFME confers the understanding that an agency has credible policies and procedures to ensure the quality of medical education in the schools that it regulates.

The establishment of the WFME recognition programme was an important moment because it was the first time that global regulation in medical education was systematically and institutionally enabled (Tackett, 2019). Although it is inextricably linked with the ECFMG ruling, it has clear consequences beyond migration of doctors to the U.S. The opportunity for accreditation agencies and medical schools to credentialise and receive what may be perceived as an international mark of distinction is also a realistic motivation for, and consequence of, WFME recognition. Indeed, a 'global mark of recognition' is listed as the first 'benefit' of the recognition programme on the WFME webpage (WFME, 2020b).

It is noteworthy that a decision taken by an agency in one country, the U.S., quite directly led to a fundamental policy change in medical school regulation across the world. In light of the aforementioned concerns about globalisation being linked to homogenisation and imperialism, a policy directive that is driven by a Western country, and that predominantly affects Eastern countries, given that this is where most of the world's medical schools are, is potentially problematic. Although the ruling by the ECFMG, and the subsequent establishment of the WFME recognition programme, both clearly empower a global approach to regulation, the extent to which they will influence medical education globally remain as yet unclear. As of February 2021, only 23 agencies have been recognised by WFME. The COVID19 pandemic may have contributed to some delays in agencies gaining recognition, and ECFMG announced in 2020 that they would move the deadline for their ruling from 2023 to 2024 as a result (ECFMG, 2020).

In order to understand the importance of the ECFMG ruling, one needs to consider the possible consequences when it comes into effect in 2024. In response to the ECFMG ruling, the WFME recognition programme established a model of 'accrediting the accreditor', whereby accreditation agencies, which must be recognised by the government in the country (or countries) in which they operate, are assessed and given 'recognition' status, which "confers the understanding that the quality of medical education in its accredited schools is at an appropriate and rigorous standard" (WFME, 2020b). After 2024, if a doctor has graduated from a medical school that has not been accredited by a recognised agency, they will not be eligible to gain ECFMG certification, and thus will not be eligible to migrate to the U.S. for postgraduate medical training. For example, the UK accreditation agency, the General Medical Council, has not applied for WFME recognition, and should they not do so by 2024, no UK-trained doctor would be eligible for ECFMG certification.

As Martimianakis and Rafferty (2013) show, the completion of postgraduate medical training in the U.S. is prestigious and desirable, and reflected as a mark of quality by many countries in the world, especially those seeking to advertise themselves for 'medical tourism'. The prestige of having trained in the U.S. means that not only is it attractive to individual medical students and doctors, but also to medical schools, for whom the ability to send their graduates to the U.S. is an important quality 'badge', as well as an important promise to bolster their appeal to prospective new students. In addition, there is also an appeal for accreditation agencies themselves, which are most typically national, governmental agencies, to seek this 'recognition'. Partly, this may relate to the perceived national 'need' to be able to send doctors to the U.S. for further training, and partly it may relate to the prestige of having the 'badge' of WFME recognition. Indeed, on the WFME webpage about its recognition programme, the very first item under the section 'benefits of recognition status' is that it is a "global mark of recognition" and an "indicator to the medical education community" (WFME, 2020b).

The apparent advantage of this form of regulation is that it offers standardisation, but this also imposes a single, predominantly Western, approach to all countries of the world. Although WFME does not anywhere suggest that its standards or its recognition programme are designed to standardise medical schools (WFME, 2020a; 2020b; 2020c), the existence of a single set of statements that can be applied globally inherently implies this and its authority as an organisation is supported by its apparently global mandate, emphasised by the presence of 'world' in its title.

The cost of applying for WFME recognition includes a \$60,000 fee and the travel and accommodation costs of the team completing the site visit (WFME, 2016). Whilst this is a tiny sum for many high income countries of the world, it represents a significant sum for many lower income countries. Most countries tend to have a single, national regulatory agency but the process, and therefore the costs, are the same irrespective of the size of the agency and the number of medical schools it regulates. In other words, whether a country has hundreds of medical schools or just a handful, it has to go through the same process and pay the same amount of money. There are also a huge number of hidden costs that need to be recognised. Preparation for regulatory inspections is known to take considerable time including from senior individuals within an organisation, and it is difficult to capture what other healthcare or educational activities this may divert attention away from (Hasan, 2010; Ho et al, 2014). In short, engaging with the WFME recognition programme has both financial and opportunity costs, and thus a strong and meaningful rationale is needed for it, especially for the many low and middle income countries who have so far engaged.

If global approaches to medical school regulation are questionable from an ideological basis, in the extent to which they marginalise local contexts and impose values from dominant countries, and additionally questionable from a financial and human resource perspective, I would argue that there needs to be a firm body of empirical evidence showing that regulation is itself effective at improving the quality of medical schools. That is not, however, the case. A small number of studies have shown indirect associations, such as changes to medical schools' processes rather than outcomes (Blouin et al, 2018), and improved postgraduate examination performance in graduates who attended accredited medical schools (van Zanten, 2015). These studies, though, far from show any causative association. Substantial, well designed studies demonstrating sustained positive outcomes as a result of regulatory interventions do not exist, and furthermore, cost effectiveness analyses demonstrating that the investment spent on regulation and its preparation is worthwhile are also notably absent from the literature. As Tackett et al (2019) note in a scoping review of regulation in undergraduate medical education, 'limited evidence exists' to support current practices.

The fact that the WFME recognition programme is clearly established, and that ECFMG remain committed to the ruling, may suggest that a global approach has prevailed. However, regulatory agencies in a number of countries, including the UK and many others, have not yet engaged with the WFME programme, which I believe is a real threat to its legitimacy. Approaching this work, I could recognise both potential benefits and harms of applying a global approach to medical school regulation and my aim in this research was to examine the way in which discourses made these ECFMG and WFME policies possible, in order better understand how their decisions had been justified, and how the global approach in medical school regulation had gained apparent dominance in the policy domain.

My overall research question was: what are the dominant discourses that made it possible to 'globalise' approaches to medical school regulation? The following three sub-questions structured my analysis of key historical events to help answer this overall question:

- How did medical educators in different parts of the world respond to the first international consensus statement on medical school quality, known as the 'Edinburgh Declaration', in 1988?
- How were the first set of WFME standards in 2003 conceptualised and how were they received?
- How did U.S. policymakers justify the ECFMG ruling about medical school regulation in 2010, and what were the responses to this announcement?

## **1.2 Background**

My interest in this area came about as a result of my own work as a medical educator. For the last five years, I have been involved in projects to develop and build capacity in medical schools in various parts of the world, principally in Africa and Asia. Through this work, I have encountered many contrasting opinions about WFME in general and the consequences of the ECFMG ruling for medical schools and regulatory agencies specifically. I have been struck by the enormous impact this policy has had on 'frontline' medical educators and how it has often resulted in talented and thoughtful education leaders prioritising 'global' over 'local' in order to comply with what they conceptualised as 'best practice' and 'international standards', which in turn marginalises important local priorities. This preoccupation with WFME and the ECFMG policy in medical schools in Africa and Asia was in stark contrast to my medical education colleagues in the UK, who mostly had not even heard of WFME. I was keen to examine how this policy came about, and how it was justified and empowered to create this effect.

## **1.3 My Positionality**

As a medical educator, it was crucial that I recognised my position as an 'insider' in this research. As for any qualitative researcher, this recognition of the impact of my own background and perspective would allow me to be reflexive about my own position within this work. As Berger (2015) has described, reflexivity can be described as the "turning of the researcher lens back onto oneself to recognize and take responsibility for one's own situatedness within the research and the effect that it may have on the setting and people being studied" (p.220).

As a practising doctor and an academic staff member at a medical school, I am a professional 'insider' within medical education, and this affects the way I approach this work. I have a particular interest in the regulation of medical schools and have contributed to this field as a practitioner and scholar (Rashid et al, 2020a), for example as an accreditation reviewer on behalf of Ministries of Education in the Middle East.

As described above, I have had the privilege of working in over 10 different countries outside the UK, where I am based, and have engaged in scholarly work about international medical education (Rashid et al, 2019; Rashid et al, 2020b). Importantly, this work has principally been on behalf of my university, which is ranked amongst the top universities in the world in most league tables, meaning that there is inevitably a power imbalance in the institutional relationships that I contribute to, given that most organisations I have worked with are either new or relatively low in ranking on conventional league tables, and from lower income countries than in the UK, where I am based. Moreover, there is often

a commercial element to these relationships, with monies moving to my institution in exchange for services and educational materials, which causes additional power dynamics. It is important, therefore, for me to recognise the significant tensions between my professional activities and institutional ties and my approach to this research.

The conversations I have had with medical educators from various different countries, who have differed in their views on globalisation in medical education and specifically on WFME and ECFMG policies and practices, have invariably shaped my own thinking. Importantly, though, the ECFMG is an American organisation, and in that I have never studied, practised medicine, or taught in the U.S., I am in that way an 'outsider' to the U.S. medical education system.

Lastly, in light of this work being about global policies, it is important for me to consider my own personal background. Although I was born and educated in the UK, where I have spent my entire professional life as a doctor and educator, my family heritage is from South Asia. I am a Muslim, with an Arabic name, I speak and read Urdu as well as English, and I spent a year of my childhood living in a remote village in the mountains of Kashmir. My personal background is, therefore, not straightforward, and I do not fit neatly into boxes of either 'East' or 'West'.

Conducting this research, I was mindful of these mixed experiences that closely link me with the world I am studying.

#### **1.4 Organisation of thesis**

Following this introduction, I examine the literature on globalisation in medical education in chapter 2, analysing the positions that have been taken in the field in order to situate the topic of regulation specifically. Chapter 3 then describes my methodology, theoretical framework, and data collection approaches. In chapter 4, I provide a brief summary of my findings and in chapters 5 to 9, I provide an analysis of the five discourses that I identified: *endorsement*, *modernisation*, *resistance*, *protection*, and *control*.

Chapter 5 provides an analysis of the discourse of *endorsement* and argues that alignment with recognised agencies and ideas was used to promote notions that regulation should be 'globalised' in medical education. Chapter 6 describes the discourse of *modernisation*, which was used to portray global approaches as reformative and progressive. Both of these two discourses were present throughout the entire period of this study. Chapter 7 examines the discourse of *resistance*, which was used to challenge global approaches on both technical and ideological grounds, and was prominent in the earlier period of this study. The final two discourses were present in the later period of this study. Chapter 8 explains the discourse of *protection*, which presented global regulatory approaches as a



means to manage a threat posed by foreign doctors, drawing on ideas from healthcare to project a focus on 'safety'. Chapter 9 examines the discourse of *control*, which problematises international variation and projects global regulation as a means to 'manage' this variation.

In chapter 10, I propose the implications of these discourses, linking them together and providing an explanation for their use and interplay. Chapter 11 concludes with some final reflections.

## **2. Globalisation in Medical Education**

### **2.1 Introduction**

Although the notion of globalisation has been pervasive and dominant in the early 21<sup>st</sup> century, its origins are in fact relatively recent. The term originated in the field of economics, coined by Theodore Levitt in 'The Globalisation of Markets' (Levitt, 1983). It was, though, very quickly popularised by writers from a variety of different disciplinary backgrounds, intensely debating its intended and unintended consequences for nations, organisations, and individual citizens. Although definitions have varied according to the field and topic of interest, it fundamentally deals with "the widening, deepening and speeding up of worldwide interconnectedness" (Held et al, 1999 p.2). Given that this thesis seeks to identify the processes which enabled global policies in medical school regulation to be enacted, this chapter critically reviews the literature on the impacts of globalisation on the field of medical education and briefly summarises the literature on medical school regulation in order to contextualise the position of global regulation specifically.

This review identified relevant literature primarily using a database search, which was carried out in January 2020 using a combination of search terms linked to 'globalisation' and 'medical education'. For practical reasons, only English language papers were included. Although multilingual scholars have generally expressed positive views about publishing in English (Martin et al, 2014), it has been noted that the texts of these scholars may elicit biases against the writers themselves in the responses of journal editors and reviewers (Lillis and Curry, 2011). The selection of only English literature therefore limits this review to a worldview expressed predominantly by Western authors, and through platforms controlled by Western actors. The implications of this are that the perspectives of those in dominant positions are likely to have been more prominent than those from marginalised groups, whose views and experiences may not be expressed as candidly in English language texts.

According to the German sociologist Beck (2003), globalisation is one of the most widely used and misused keywords in modern parlance. He argued that it has a familiarity that is changing everyday lives and compelling everyone to adapt and respond in various ways, removing barriers wittingly and unwittingly to create transnational lifestyles where people across separate worlds act and live together. Globalisation is a process of both interaction and integration, essentially making the world a 'smaller' place (Tan and Macneill, 2015). As Beerkens (2004) points out, the distinction between globalisation and internationalisation is an important one. He suggests that globalisation can be understood as a process that makes countries more integrated, whereas internationalisation is a process of countries that makes them more connected. This is important in medical education as it distinguishes global policies as those that seek to capture the entirety of medical schools in the world,

as opposed to international policies, which may selectively link some, but not all, medical schools or nations.

Although those who first described globalisation mostly saw it as a positive force, this view was quickly challenged. American political commentator Thomas Friedman is one of the most widely cited authors on globalisation. He argued that there is an unstoppable global integration process underway and that with freer movement of goods, services and ideas, the opportunities increase for everyone (Friedman, 2007). This view has been challenged by economist Richard Florida, who has argued that as globalisation proceeds, wealth creation and innovation are actually not becoming more evenly distributed around the world and that the reverse is true. He writes that the world is actually concentrating resources in a few locations and becoming not flat but 'spiky' (Florida, 2005).

Because of the volume of globalisation research and the number of disciplines from which it arises, scholars from across the social sciences have identified three key perspectives in globalisation theory – hyperglobalist, sceptical, and transformationalist (Holton, 2005). These three perspectives were first identified as 'schools of thought' by political scientists (Held et al, 1999) and they subsequently been widely used to provide a framework for thinking about globalisation. Given the popularity and utility of this framework across multiple sectors, I will first describe each of these perspectives, and then summarise the published literature in medical education using this analytical framework.

## **2.2. Globalisation perspectives**

Globalisation theory is widely seen to have started in the 1980s and was characterised in this early period by admiring accounts of the globalisation of economy, politics and culture and the sweeping away of the significance of territorial boundaries and national economies, states and cultures (Martell, 2007). In simple terms, it argued that if governments allow organisations the freedom to 'do business', wealth will be generated, which will trickle down to everyone. Japanese organisational theorist and author of the popular book 'The Borderless World' (1990), Kenichi Ohmae is often picked out as an example of this wave in globalisation theory. He argued that cities and regions, like Hong Kong and Silicon Valley, have become more important than nations. This perspective is described by Holton (2005) as 'hyperglobalist' in that it argues that national governments have much less socio-political influence, or even none at all. International organisations such as the United Nations and International Monetary Fund are also argued to be increasingly important (Gill, 2000). Other hyperglobalist 'realities' in the modern world include multinational corporations, international sports events like the Olympic games, and the 'spread' of democracy after the second world war. As Held et al (1999) point out, this perspective is generally 'economistic', neoliberal, and celebratory of the global economy as a 'harbinger' of human progress. It sees globalisation as a unique, entirely lawful, and progressive

process of unification. It conceptualises globalisation as a 'leveller' that helps to create economic and social opportunities that would otherwise have not existed. It also views the emergence of patterns of global governance and global cultural homogenisation as evidence of a 'radically new world order' and ultimately helping to move towards a 'global civil society' (Keane, 2003).

A more sombre set of accounts reacted against this with scepticism and argued that globalisation is neither new nor progressive. This 'sceptical' perspective is concerned with the abstract nature of globalist ideas, which seem to be thin on empirical substantiation and make sweeping claims about processes as if they affect all areas of the world evenly and with the same responses (Martell, 2007). It draws on evidence of the continuing role of nations and the ongoing importance of national borders. Sceptics have sought to test the claims of globalism against evidence, and when they have done so have sometimes found them wanting. Indian-American economist Ghemawat (2017), for example, points that although technology allows individuals to interact with billions of others around the world, they tend to do so only with a small number of friends and family who tend to live close by, leading him to coin the term 'globaloney'. Sociologists Beck et al (2003) have also highlighted that cultural globalisation essentially refers to the overwhelming dominance of one culture, that of the U.S., as they argue in their exploration of the term 'Americanisation'. The sceptical perspective also highlights that the world has seen greater, rather than lesser, nationalism in many places, often in response to the perceived and real threats of globalisation (Milner, 2020). Seabrook (2004), meanwhile, argues that, by definition, globalisation makes all other cultures local, and, by implication, inferior. He suggests that globalisation alludes to a superior, civilised mode of living that consequently diminishes and marginalises local cultures. He argues that integration into a single global economy is a 'declaration of cultural war' upon other cultures and societies and that it often results in profound social disruption. The sceptical perspective, then, challenges the consequences, ubiquity, and sustainability of globalisation.

A third perspective recognises some validity of both the hyperglobalist and sceptical perspectives that emerged in the earliest periods of globalisation analysis. This 'transformationalist' perspective has sometimes been referred to as the 'third wave' of globalisation theory (Martell, 2007). It suggests that whilst a critical assessment of the claims of globalisation are needed, one should not 'throw out the baby with the bathwater' (Held and McGrew, 2003). The outcome of this has been a departure from some of the conclusions of sceptics and instead a recognition of a more complex picture of globalisation, as described by the prominent sociologist, Anthony Giddens (1990). This perspective recognises the global media as beneficial because it is primarily responsible for diffusing different cultural styles around the world and creating new global hybrid styles in fashion, food, music, and lifestyle. It is argued that in the global, postmodern world, such cultural diversity and pluralism is

becoming the norm. Globalisation is seen as occurring but without just sweeping all away before it, as hyperglobalists might have it. Randeria (2007) proposes that through this process, a new and complex social order is appearing in the world. The transformationalist perspective frames the process of globalisation as uneven and uncertain, and insists on its multidimensionality.

In the following sections, I will examine the medical education literature according to these three perspectives, arguing that it has moved from being predominantly hyperglobalist and sceptical, to a point where it is now predominantly transformationalist.

### **2.3 Hyperglobalist perspectives in medical education**

Hyperglobalist perspectives have been manifest through approaches to what is taught, how it's taught, and the products of, medical education. Perhaps unsurprisingly, teaching about global health has been analysed in the context of globalisation, although much of this has come from the global health community and not the medical education community, as reflected in the appearance of these ideas in general medical and global health journals (Bateman, et al, 2001). For example, a collaborative statement from several global health agencies urges medical schools to dedicate the necessary resources to 'embrace' international health (Evert et al, 2006), projecting it as a progressive and morally right course of action. There has also been a call for an international consensus on what constitutes core competencies in global health (Brewer, 2009), portraying a hyperglobalist idea of a single statement that could capture what would be important in global health education irrespective of local culture and context.

In recent decades, medical schools in Western countries have moved towards a student-centred learning model that has fundamentally changed both the philosophical basis of, and the practical implementation of, undergraduate medical education (Lemos et al, 2014). Problem-based learning (PBL) was a particularly widely adopted example of this new educational paradigm (Wood, 2003). Although it began as a Western model of teaching medicine, it was adopted by medical schools in all parts of the world with great enthusiasm (Ju et al. 2016). Much of this adoption was based on hyperglobalist ideas, including the apparent ubiquity of medical school education environments. Early adopters from Eastern countries suggested that PBL could be used just as effectively in Asian countries as it could in the West (Khoo, 2003).

The English language has also been promoted in a hyperglobalist way in the context of medical education. Wang (2004) encourages the use of English in China, arguing that it is needed in order to allow scholars in the country to 'contribute' their share to globalisation. Huang (2009) argues along

similar lines in the Japanese context, presenting data that shows the dramatic move towards publication of textbooks and articles in English over two decades.

Technology has also been a part of the hyperglobalist perspective in medical education. Harris et al (2001) celebrated how their 'academic centre in an English-speaking country' could use the internet to provide low-cost medical training to doctors around the world. The potential of the internet to specifically help developing countries has also been suggested (Edejer, 2000) and Carr-Chellman (2004) argued that the 'lure' of flexible learning and the financial benefits of online learning means it will prove 'irresistible' for the world. The 'eViP' (electronic Virtual Patients) project, which involves interactive computer programs that simulate real life clinical scenarios for educational purposes (Smothers et al, 2008), can also be considered hyperglobalist, in that it seeks to enable the 'exchange' of virtual patients across countries.

Given its considerable impact across many sectors and communities, including medicine, social media has unsurprisingly emerged in the medical education literature in recent years, much of it with a hyperglobalist perspective. A systematic review has highlighted the vast popularity of Twitter-based journal clubs as free, time-efficient, and publicly accessible means to facilitate international discussions between medical faculty members (Roberts et al, 2015). As well as the more obvious potential for networking and collaboration, Bolderstone et al (2018) show that such activities can directly inform participants' clinical and educational practices. One particularly hyperglobalist movement is Free Open Access Medical Education (FOAMed), which attracts medical students and doctors from all around the world sharing advice and resources through various social media platforms. During the COVID19 global health crisis, this social media community shared technical knowledge as well as social and moral support (Rashid et al, 2021), suggesting an integrated global medical community that transcends geographical and hierarchical barriers.

Another popular idea in medical education in recent decades has been 'outcomes-based education', where the orientation moves from process to 'product'. In 2002, the Institute for International Medical Education developed a set of core competencies which represent the minimum essential core competences that all physicians must have (Schwarz and Wojtczak, 2002). As a widely cited editorial by Harden (2002) from this time makes clear, there was great excitement about the prospect of the learning outcomes developed by this project being widely used by countries in the 'East and West'. Harden (2006) later develops this further, quoting Friedman's vision of globalisation 'flattening' the world and using it to suggest not only universally agreed learning outcomes, but also a 'transnational' approach to the entire medical school curriculum, culminating in his vision of a truly hyperglobalist idea: an 'international virtual medical school'.

In the early part of the 21<sup>st</sup> century, the Medical Professionalism Project sought to “promote an agenda for the profession of medicine that is universal in scope and purpose” (Medical Professionalism Project, 2002). In their *Physician’s Charter*, the project team argued that despite wide variations in the practice of medicine, they were able to identify ‘fundamental principles’ as a set of definitive professional responsibilities. This homogenisation of the professionalism of medicine is hyperglobalist in that it seeks to transcend national and cultural differences. In a report of an international medical education conference meeting, Cruess et al (2010) suggested, similarly, that only ‘minor differences’ exist between countries and cultures, and that professionalism is ultimately universal. Jha et al (2015) also suggest that that it would be both possible and desirable for the medical education community to develop a framework of professionalism as a ‘global construct’. Work exploring apparently ‘international’ programmes has also raised similar suggestions. A study that investigated the experiences of curriculum developers of ‘international’ medical school programmes in Hungary, the Netherlands, and Malaysia, found a clear desire in the group to produce doctors who were ‘universal’ professionals who could practice anywhere in the world after graduation (Brouwer et al, 2020).

One apparent benefit of globalisation is its ability to bring people together to form hitherto unattainable connections, networks, and communities. Within medical education, some scholars have explored the extent to which these opportunities for ‘global’ engagement have been, and indeed should be, taken. In some regards, the perception of the medical education community as small and fledgling has perpetuated thinking about globalisation. For example, Eva (2009) suggested that because medical educators are motivated by enthusiasm and dedication, they should prioritise ‘co-operation and collegiality’ over and above competition. Similarly, McClean (2013) argues that all medical educators fundamentally have a shared goal to ‘advance humankind’, irrespective of the specific settings in which they operate. Whilst these ideas of a shared community may help to promote the field of medical education generally, the significant number of new journals and conferences in the field suggest it is no longer a niche field. In the sense that these perspectives assume generalisability and promote an idealised shared endeavour, they fit within the hyperglobalist position.

#### **2.4 Sceptical perspectives in medical education**

There are also many examples of sceptical perspectives in the medical education literature. The migration of doctors is a politically contentious topic because of the implications for healthcare services as well as medical education systems. In critical reviews of medical education in India (Banerji et al, 1981; Solanki and Kashyap, 2014) and Pakistan (Zaidi, 1987; Shaikh and Humayun, 2012), the

Western influence has been problematised by local educators. Not only does the dominance of the English language cause doctors to become alienated from ‘the masses’ of local populations (Banerji et al, 1981), the focus on hospital-based teaching limits interaction with rural communities (Zaidi, 1987), and the overall effect is to cater either for the elite of the country or to maintain foreign standards by assisting migration to the West (Banerji et al, 1981; Zaidi, 1987; Solanki and Kashyap, 2014). Experiences in Sub-Saharan Africa are similar, as healthcare worker shortages remain critical (Wilcox et al, 2015), and at one stage, there were found to be more Malawian doctors practising in the city of Manchester in the UK than in the whole of Malawi (Broadhead, 2002). This is an example of ‘medical brain drain’, a term which has been used to describe doctors moving from developing countries to developed countries, and has been argued to be profoundly impactful across all health professions (Pang et al, 2002). This scholarship is particularly important for this study, given that countries in Asia and Africa have been amongst the first to engage with the WFME recognition programme. Moreover, it fits within the sceptical perspective in that it focuses primarily on the harms that globalisation causes to local communities.

Although Segouin et al (2007) and later Hodges et al (2009) lament the lack of cross-cultural research within the field of medical education, a small collection of studies have explored impacts of globalisation in a critical way. For example, Xu et al (2007) describe noticeable incongruence between Chinese beliefs and Western concepts, so much so that they argue that adopting Western practices could be both harmful and unethical. Meanwhile, Gao (2015) challenges the motives of promoting the notion of a global medical education ‘community’, suggesting that the pursuit of networks or connections by elite research universities is likely to be in order to achieve academic accolade. A systematic review of medical education articles published between 2006 and 2014 showed that only 8.7% of medical education research takes place in non-Western countries, although the overwhelming majority of education practice occurs in these settings (Gosselin et al, 2016). The authors of this review argue that the resource differences that lead to such disparities may be further compounded by the tendency of non-Western stakeholders to be hesitant to express disagreement. In challenging the motivations and assumptions of a global medical education ‘community’, these studies fit within the sceptical category.

Given that the term originated in field of economics, it comes as little surprise that globalisation in medical education has been examined in economic terms. Reductions in governmental funding for medical schools have been cited as a key reason for the rapid development of ‘academic capitalism’ in medical schools (Slaughter and Leslie 1997). An early and oft-discussed example is Weill-Cornell Medical School’s branch campus in Qatar, which was established in 2005. As Green (2007) noted, this was conceptualised from the outset as a ‘revenue stream’, and as Marginson and van der Wende



(2007) note, this new venture took place amidst a perfect storm of factors that led to the 'global marketisation' of higher education. In a seminal paper outlining the influence of economic discourses in medical education, Hodges et al (2009) unpicked the trends towards commercial dominance in the field. They noted, for example, the now routine conceptualisation of physicians being 'imported' and 'exported', and the packaging and trading of educational materials as commodities. Martimianakis and Rafferty (2013), meanwhile, demonstrate that in efforts to attract medical tourism, institutions are keen to advertise the fact that their physicians have trained in the U.S., suggesting that such marketing promotes the idea that only Western education connotes quality. In focusing primarily on the harmful consequences of globalisation, these views can all be classed as sceptical.

Further sceptical viewpoints can be seen in studies that explore international medical education collaborations. In the context of Sub-Saharan Africa, for example, Alemu (2014), has outlined how more powerful universities quickly adopt the role of 'supplier' of knowledge, leaving weaker and poorer institutions with no choice but to be 'consumers'. Tan and Macneill (2015) have also challenged the business activities of medical schools in Western countries, who commercialise branding and prestige, and for whom often "the main driver is to maximise profitability across national boundaries rather than concern for human well-being" (p.850). It is not just medical schools that have been examined with a sceptical outlook though. Khan et al (2017) have outlined concerns about Western medical students potentially representing 'destructive forces' when conducting overseas electives, echoing concerns previously raised about this model contributing to a medical education 'inverse care law' (Edwards, 2004).

Using a case study of the Pakistani medical school circuit, Zaidi (1987) drew parallels between the economic dominance of developed countries over developing ones, and the ideological dominance that takes place within medical education. She noted that such dominance, which is often by an ex-Colonial country, typically overshadows the different disease patterns and resource limitations of developing countries. Marginson and van der Wende (2007) highlighted that such power imbalances are commonplace and result from a desire from some countries to match the apparent superiority of others. Hong et al (2010) pointed out the great 'esteem' that Chinese medical educators hold for any Western education research, Nemr et al (2012) noted that medical schools in Lebanon want to 'keep up' with practices in Europe and North America, and Huggan et al (2012) mourned that the most pressing question in medical education in Singapore is whether the British or American system is more suitable for adaptation. Each of these articles express concerns about the intellectual harms caused by globalisation and thereby fit into the sceptical category.

## 2.5 Transformationalist perspectives in medical education

As outlined earlier in this chapter, the transformationalist perspective recognises arguments from both sceptical and hyperglobalist perspectives. In the context of medical education research, it has been the most widely adopted viewpoint. It is perhaps most clearly embodied in a Canadian literature review that argued that both 'standardisation' and 'contextualisation' each have a role in the design and delivery of medical education systems, which in turn should seek to fulfil both global and local needs (Bates et al, 2019).

As described in the 'hyperglobalist' section of this chapter, PBL became a popular method in Western medical education that was initially thought to be widely transferrable. Although earlier views of it were hyperglobalist, these soon changed to a more transformationalist position, with the recognition that challenging peers or tutors, a key element of PBL practice, was 'culturally inappropriate' in some settings (Hussain et al, 2007). A study that used empirical case studies of PBL adoptions at medical schools in the Netherlands and Jamaica noted that people do not just 'naturally' work well together and that the import of instructional designs to different cultures requires deep reflection and adaptation (Stevens and Goulborne, 2012). Indeed, Jippes et al (2008) have shown that the propensity of a country to adopt PBL curricula actually correlates quantitatively with national culture, as defined by various numerical cultural parameters.

The idea of learner-centred pedagogy has also been challenged on the basis of both values and technical grounds. It has been suggested, for example, that such strategies are underpinned by neoliberal ideologies that are deemed important for the operation of free market economies (Tabulawa, 2003), and rely strongly on western ideals of democracy, individualism, and egalitarianism (Greveson and Spencer, 2005). It has also been argued that such approaches ignore the importance of 'losing face' and the focus on achievement and competition that characterises some non-Western cultures (Frambach et al, 2012). Although much of the literature has focussed on the export and replication of educational approaches, a British study of Asian international medical students' learning styles' suggested that they were not just rote learning as stereotyped, but rather adopting a Confucian-inspired, effort-focussed, learning attitude (Tavakol and Dennick, 2010). These studies all point out the complexities of implementing teaching and learning approaches across different cultures, emphasising the inherent complexity of this process. In that they still ultimately argue that such adjustments are possible, they are transformationalist rather than sceptical in their outlook.

The outcomes-based educational approach outlined in the hyperglobalist section of this chapter was the ideological basis for another movement known as 'competency-based medical education' (CBME), with a focus on 'competence' and 'competencies' that need to be achieved (ten Cate, 2017). CBME

has become widely popular over the last two decades. Perhaps nowhere has it been more dominant than in Canada, where the launch of the CanMEDS framework in 2005 cemented a clear move towards conceptualising physician practice, and therefore training, in terms of distinct roles (Whitehead, 2011). Although some have framed this as the ‘modernisation’ of medical education (Stevens and Goulborne, 2012), the movement has also been met with criticism. Grant (1999), for example, described the way in which it can oversimplify and depreciate the profession of medicine. Whitehead et al (2013) also exposed unintended consequences of competency frameworks, especially in their compartmentalisation of the role of a physician and marginalisation of the importance of values. In the adaptation of the Canadian CanMEDs framework for Saudi Arabia, resulting in the SaudiMEDs framework, adaptations were needed although it did not differ ‘significantly’ (Zaini et al, 2011). In noting the challenges but possibilities of such modifications, this outlook can be seen as transformationalist.

In the hyperglobalist section of this chapter, I described how at an international medical education conference workshop in 2009, it was decided that professionalism was ultimately universal with only ‘minor differences’ between cultures (Cruess et al, 2010). Just a year later, a second such conference workshop, this time focussing on the assessment of professionalism, had a very different conclusion. It suggested that there were likely to be multiple different ways of conceptualising the idea of professionalism around the world, and suggested a move towards a ‘multi-dimensional, multi-paradigmatic approach’ to account for these differences (Hodges et al, 2011). The contrast between the findings of these workshops is stark, as it seems unlikely that the differences between the teaching and assessment of professionalism could explain such opposing conclusions. It is noteworthy in that it demonstrates both the limitations of such consensus statements, and also the differences in opinion from amongst the medical education ‘community’. Whilst the former was hyperglobalist in outlook, the latter is firmly transformationalist.

In the decade since these two conference workshops on professionalism, the medical education literature has taken on a transformationalist perspective on this topic, noting that universal definitions of professionalism are problematic. Ho et al (2011) produced a country-specific professionalism framework for Taiwan, grounded in Confucian cultural traditions, and challenging the ‘universal applicability’ of the Western framework. Similarly, Al-Eraky et al (2012) adapted a North American framework for the Arabian context, and later used a Delphi method to propose a ‘four gates model’ for Arabian medical professionalism, which includes as one of the four gates, a series of Islamic faith-based principles about accountability to God (Al-Eraky et al, 2014). Comparable studies have developed professionalism frameworks in Japan (Nishigori et al, 2014) and China (Pan et al, 2013), both producing models that differ from the Western, Hippocratic tradition. These ideas about

professionalism are transformationalist, rejecting both the universal definition of professionalism promoted by hyperglobalist scholars, as well as the notion from sceptical scholars that the adaptation of western frameworks is invalid.

The rector of King Fahd University in Saudi Arabia once said: “some countries have sacrificed the soul of their culture in order to acquire the tools of Western Technology. We want the tools but not at the price of annihilating our religion and cultural values” (Reynolds, 1980). Although culture is of relevance to globalisation in the broadest sense, it is explicit within parts of the medical education literature. In a study examining medical students’ anxieties about peer examination, it was found that Middle Eastern students characterised more body regions as intimate than their Western counterparts (Rees et al, 2009). Similarly, a study comparing residency programmes in Canada and Thailand found that although the technical and scientific basis of education was very similar, its enactment was significantly influenced by ‘culture and context’ (Wong, 2011). In China, meanwhile, a study noted that the profession of medicine was itself evolving due to the fusion of Western and Eastern cultures, and that medical schools should match this by promoting exchanges, both of students and of ideas, in order to reach ‘harmonisation’ (Fan et al, 2013). Given that these studies portray culture as a consideration and not as an insurmountable barrier to globalisation, they can be framed as transformationalist.

Whilst social media has clearly had an impact on medical education, not all studies have been celebrated its potential and impact in a hyperglobalist way. As Alruwaili (2019) highlighted, digital activity is bound by cultural expectations and interactions, and communities may not always be as diverse as they may seem. This is demonstrated by the fact that the predominant group offering advice to newly qualified UK doctors on social media, were doctors and medical educators from within the UK itself (Rashid et al, 2018). Likewise, in the context of the COVID19 pandemic, a social media discussion that sought to explore medical students’ responses, and concerns was predominantly taken up by students from the same country as the organisers (Huddart et al, 2020). Reflecting on an ‘international’ social media event in medical education, Sherbino (2015) noted that although virtual participation ‘enriched’ the discussion, communication and engagement before and after the event was much more limited. Whilst recognising the potential for global engagement and the benefits it may bring, these articles portray a measured, transformationalist outlook overall.

As was established in the hyperglobalist section of this chapter, much of the economic language in medical education has focussed on international relationships that have been transactional in nature. There are, though, examples of activities that buck this trend. The Toronto Addis Ababa Academic Collaboration is a longstanding, wide-ranging partnership that is framed entirely in terms of respectful

and reflexive engagement (Whitehead et al, 2018). The international work that I am engaged in also seeks to recognise cultural differences and complexities and form educational partnerships and relationships that are grounded in respect and building local capacity (Rashid et al, 2019; Rashid et al, 2020c). There are, then, transformationalist perspectives in the context of international education partnerships as well as the hyperglobalist ones outlined previously.

As with cultures and traditions, the languages of the world influence the process of globalisation. International scientific publishing is one important aspect of this, and English is widely considered the 'lingua franca' of academic publication (Steger, 2017). In a nuanced analysis of potential 'trade-offs' between local and international publication, Flowerdew and Li (2009) noted that there are important ideological implications of writing in English. Within medicine, the use of English as a language of instruction is widespread, and as a number of scholars have highlighted, potentially problematic. Zaidi (1987) highlighted the important consequences this has on selection, as a preference for English shows a bias towards the elite and westernised urban based minority. Not only does it limit the diversity of students, but it further entrenches the differences between them and the largely illiterate public that they are training to serve. As Yang and Xi (2009) point out, studying in English may also mean that additional effort is needed to understand the language, distracting from the content of the medical curriculum itself. Al Kadri (2013) found that the use of English added an additional layer of complexity, as faculty members were making adjustments and taking more lenient views when teaching and assessment was done in English rather than Arabic. Whilst each of these articles draw attention to some of the disadvantages of using English, they do all recognise some benefits, primarily related to accessing medical knowledge. In acknowledging this complexity, they fit within the transformationalist category of thinking on globalisation.

## **2.6 Literature on medical school regulation**

The earliest records of quality assurance processes in medical education relate to the regulation of individual practitioners rather than schools or programmes, such as examinations for prominent physicians in Baghdad as early as 700 AD (McGaghie, 2013), and licensure being introduced in Britain in the 16<sup>th</sup> century by the first Medical Act of Henry VIII (O' Malley, 1970). The literature on medical school regulation published in English is unsurprisingly dominated by the experiences of Western countries. In the US, for example, the American Medical Association and American Association of Medical Colleges have each been reviewing medical school quality since the mid-19<sup>th</sup> century, eventually joining in 1942 to form the Liaison Committee for Medical Education, which continues to lead medical school evaluations until now (Kassebaum, 1992). The UK medical regulator, meanwhile, formed in 1858 (Irvine, 2006), although it has been described as "silent and essentially reactive"

(p.205) for much of that time, until it took a more proactive role in medical school regulation from 1968 onwards.

Regulatory authorities in other parts of the world have been influenced by the UK and US. Countries in the British Commonwealth, such as India, Pakistan, and Nigeria, were likely influenced by the UK approach as they established their regulatory activities for medical schools in the 1960s (Cueto et al, 2006). Canada formalised its own accreditation system in partnership with the LCME in 1979 (Chen et al, 2020), and the North American model influenced the creation of the regulatory agencies in both Australia in 1985 and New Zealand in 1992 (Geffen, 2014). A survey in 2020 showed that although only 49% of the 186 countries with medical schools have accreditation systems that use medical-specific standards, the majority of World Bank regions experienced the greatest increase in medical education accreditation agency establishment since the year 2000 (Bedoll et al, 2021). Despite the growing trends towards formal accreditation of medical schools, the volume of evidence linking it to improved outcomes remains low, and the quality of research that does exist is poor (Tackett et al, 2019).

## **2.7 Summary**

The academic literature examining globalisation in the field of medical education is highly variable in its form, content, coverage, and findings. Notably, there is a growing body of evidence that is comparative, reflexive, and grounded in empirically tested hypotheses. This work has particularly been generated in the last decade, and has been predominantly transformationalist in its perspective. The medical education literature has then, mirrored the broader literature across the social sciences, in moving over time from hyperglobalist and sceptical positions, towards a 'third wave' of globalisation thinking that is transformationalist in its perspective.

Hyperglobalist ideas that suggest and promote universality and homogenisation have been proposed, as have sceptical ideas that reject them. What is noteworthy, though, is that these ideas have generally not come to fruition from a policy and practice perspective. For example, the notion of using universal learning outcomes across medical schools in the world has not been realised, less still the idea of an 'international virtual medical school', which seems even more remote an idea now, 15 years after it was first suggested, despite the advances in technology that may make it seemingly more possible to implement. Despite its potential to improve communication channels, social media has not been the 'game changer' for medical education that advocates had suggested, and nearly 20 years after the '*Physician's charter*', the world's medical schools do not have a universal definition of medical professionalism to base their curricula and assessments on.

In the same way, many sceptical ideas have not been realised. The suggestion that western educational approaches cause outright harm in eastern countries is not consistent with the fact that many years on, approaches like PBL continue to be enthusiastically used all around the world, albeit often with adaptations. Likewise, sceptical criticisms about the transactional and financial basis of medical education international partnerships have not led to the end of these relationships. In fact, they seem to be getting more popular, although as mentioned in the transformationalist section of this chapter, the nature of them is changing. English language also continues to be widely used in medical education throughout the world despite the sceptical challenges about its sustainability outside of the English-speaking regions of the world.

What is also clear from this literature, though, is that there have been no major policy decisions that have successfully 'globalised' medical education. The movement of ideas and practices has instead been more organic and more uneven, fitting more with Florida's 'spiky' world than Friedman's 'flat' world. Where ideas and practices have moved, they have done so through choices made by individual educators and institutions rather than through compulsion, and have been tempered by sceptical, and eventually transformationalist, perspectives. Particularly in the more recent past, notions of universality have been widely challenged and there is a recognition of the need for medical education to be grounded in local context.

As outlined in the previous chapter, this thesis seeks to identify discourses that have enabled policies that 'globalise' medical school regulation. In the context of the literature analysed in this chapter, the ECFMG requirement for medical school regulation is an unfamiliar event in the field of medical education. Previous changes in the global landscape of medical education have been smaller in scale and ambition and crucially, have not led to a material policy change. The ECFMG ruling is also noteworthy in the context of this literature review, as it seems to have happened at the approximate time that the medical education literature moved from the hyperglobalist and sceptical perspectives to a more transformationalist outlook towards globalisation. This may explain why the ruling is problematic, in that it is grounded in a set of ideas to globalisation that had already started to evolve and have continued to do so in the decade since it was announced.

In summary, the medical education literature has responded to globalisation with a range of opinions and outlooks that eventually moved from more polarised positions to a more moderate perspective. Importantly, though, the literature describes a plethora of small scale changes and experiments to globalise, confirming that the ECFMG ruling that this study will examine, is an unusual event in this field and one that has no clear parallel. In the following chapter, I will build on these findings by outlining the methodology I use to explore this ruling in greater depth.

### **3. Methodology and Data Collection**

#### **3.1 Introduction**

This chapter describes the methodology used in this research. I describe my theoretical approach and outline my reasons for using critical discourse analysis and drawing on the work of Michel Foucault and Edward Said. I describe critical discourse analysis and elaborate on key concepts from the work of Foucault and Said that I use in this research, although these descriptions continue into future chapters to explain how the two scholars dealt specifically with ideas linked to the discourses identified in this research. Lastly, I lay out the steps I took to gather my archive and explain the rationale for the data set I used.

#### **3.2 Theoretical Overview**

Mills (1997) outlines the differences in the use of the term 'discourse' in different contexts and disciplines, including linguistics, sociology and psychology. In general, it relates to language, texts and the contexts in which language and texts are used and put into practice (Kuper et al, 2013). It is important for the creation and reproduction of knowledge as it enables certain statements to be prioritised over others by legitimising them and portraying them as more important than others. Discourses shape our experience of what is 'real', and "the way we speak and write reflects the structures of power in our society" (Lather, 1991, p. 25). In practice, people are seldom aware of 'participating in a discourse' and "may simply regard their words as 'the way one talks' on this sort of occasion" (Davies & Harré, 1990, p. 49).

Discourse analysis helps to show the connection between various statements and ideas that may not at first appear related. Given that the focus of this study is a series of documents that are intrinsically based on expert knowledge and are intimately linked to influential and bold policy decisions with far-ranging impacts, discourse analysis, with its attention to knowledge, power, and language, offered a suitable approach.

Phillips and Hardy (2002) outline how forms of discourse analysis can be categorised as focusing more on constructivist or critical approaches, depending on whether they highlight social construction processes or power dynamics. Types of discourse analysis can be further classified according to whether they focus more on text or on context (Phillips & Hardy 2002). Drawing on these classifications, Kuper et al (2013) position critical discourse analysis (CDA) in this schema as a critical, context-focused approach, in that it focuses primarily on the relation of language and practices and power. Although a variety of discourse analysis traditions could be applied, this study will draw on CDA to historically account for the present day discourse surrounding global regulatory policies in



medical education, as well as critically interrogating the way power relations are distributed in this field. This fits within a tradition that Kuper et al (2013) term 'making strange', that they describe as follows:

This is a way of gaining new, even startling, perspectives about things that we would otherwise accept as 'normal', because they are so familiar, so engrained in routine, so naturalized, that it becomes difficult to imagine that the world could be organized in any other way (p.e849)

This research employs CDA and draws on the work of two scholars who were both interested in the relationships between language, power, and knowledge, and whose ideas have been widely used by discourse analysts. Although Michel Foucault and Edward Said differed in their disciplinary backgrounds and in their areas of research focus, they were both fundamentally attracted to how power is enacted through discursive practices to understand how marginalisation and exclusion from mainstream standards occur (Racevskis, 2005). They also both proposed theoretical approaches to critically analyse historical events. As Racevskis (2005) notes, there is much congruence between the work of these contemporary theorists, and as Moosavini et al (2019) describe, Said explicitly expresses the similarity between his work and Foucault's discourse theory. Whilst the work of Foucault has been widely used in medicine and medical education, Said has been comparatively less cited. One possible explanation for this is that medical education has focussed on 'inward' rather than 'outward' challenges and been slow to apply global lenses. Taylor (2003) has noted that medicine has been guilty of acting as though it has 'one culture' and Segouin et al (2007) question the lack of comparative cross-cultural research in medical education, although this has gradually increased in the last decade (Hodges et al, 2019). In the next section of this chapter, I outline key theories from the work of Foucault and Said that I draw on in this study. As both of these scholars dealt directly with the key discourses identified in this study, I continue to discuss their theoretical perspectives in the results chapters of this thesis, linking them to my analysis.

### **3.3 Foucault**

As Bleakley and Bligh (2009) note, "engaging Foucault critically is not straightforward — his work is full of paradoxes and open to multiple readings" (p.369). Indeed, Foucault did not offer a unified theoretical approach but instead provided a number of concepts and theoretical lenses which "open up spaces for acting and thinking differently about our relation to ourselves and to others" (Ball, 2019, p.133). The concept of discourse was described by Foucault as 'a way of speaking' or 'the system or rules by which certain statements appear and not others' (Foucault, 1972). Foucault aimed to study that which appears obvious or self-evident. In his examinations of madness, prisons, and hospitals, he demonstrated that these arise as a result of the existence of particular discourses that make them

possible and that their nature and functions change as discourses change, assume dominance and disappear (Hodges, 2009).

Foucault was specifically interested in the social and historical circumstances that allowed certain statements to be considered 'truths' (Foucault, 1972). He argued that, given that discourses are linked to power and that the distribution of power is complex and dynamic, language use can lead to either the reproduction of existing discourses or the production of new ones (Foucault, 1972). Discourses can therefore be a means to build or sustain certain power relations by establishing the social boundaries of what it is possible to say and believe at any given time. In simple terms, Foucault was interested in what could, and could not, be said at any given historical moment, and why. Two Foucauldian concepts that are particularly important in this research are archaeology and genealogy.

Foucault's concept of archaeology can be broadly understood as an analytical tool for uncovering alternative and disturbed histories of systems of knowledge. By taking an archaeological approach, changes in the kinds of statements that are being made become extremely important, as these signal a shift in ways of thinking and in the rules governing discourse production (Kuper et al, 2013). Foucault's concept of archaeology is helpful as it focuses attention on the way our ideas of 'truth' have been embedded in the different language that has been used in different ways in different times. It also requires us to analyse our current assumptions about accepted forms of knowledge since, for Foucault (2000), 'truth' is to be understood as a system of ordered procedures for the production, regulation, distribution, circulation, and operation of statements.

It is notable that Foucault applied this 'archaeological' approach specifically to medicine and medical education in *The Birth of the Clinic* (2003), analysing the historical development of modern medicine. He argued that diagnostic medical practice in the modern period, beginning at the transition from the 18th to the 19th century, was characterised by an active mode of simultaneous 'seeing' and 'saying'. 'Seeing' is not simple description, but ascription – making sense of what is there through a conceptual scheme of disease categories coded in a specialist language ('saying'). Novices must be taught how to 'see' by acquiring this language (Bleakley et al, 2003). The way that the doctor makes sense of illness, or gives meaning to symptom, is shaped by a certain cultural framework at a historical moment.

Foucault also used history as a means of critical engagement with the present, expressed in his conceptions of 'genealogy' or 'history of the present' (Garland, 2014). Whereas archaeology describes the specific discourses and their elements as they exist at particular points in time, genealogy is a study of the evolution of these discourses and the ebbs and flows of their relationships to each other. These ebbs and flows are not random. Rather, they are animated by shifts in how power is enacted. Power is taken to be a force that is present in every interaction, communication, and moment, and so

does not lie in particular individuals or institutions. Using a particular discourse perpetuates a particular arrangement of power linked to that discourse, which in turn perpetuates the discourse itself. Genealogy thus examines the relationship between power and discursive practices, providing a 'history of the present' (Foucault 1979).

Foucault breaks apart the concept of power and explains differences in various modes of power. His mode of 'sovereign' power is easy to recognise and understand because it most closely resembles forces of domination with which society is familiar, such as the central authority of an autocratic ruler (Fendler, 2010). As Howley and Hartnett (1992) describe, though, two other Foucauldian modes of power are more relevant to educational settings. 'Pastoral' power seeks to encourage the individual to favour the collective approach in a 'complicated interplay of coercion and freedom' that diffuses power throughout the community and may be more effective as a continual control device (Howley and Hartnett, 1992). 'Disciplinary' power, on the other hand, is a more overt form of social coercion that has a range of techniques which encourage conforming to the social norm (McHoul and Grace, 1997). Many of these play out in medical education, including 'surveillance', seen in the pre-occupation with raising concerns about peers, 'normalisation', seen in the comparison of medical trainees against pre-defined standards, 'exclusion', seen in the focus on questioning fitness for professional practice, and 'classification', seen in the differentiation and ranking of students and trainees according to their performance. Foucault's notion of disciplinary power is particularly relevant to the discourses in this study and is elaborated on further in this thesis.

### **3.4 Said**

Said described a process by which colonisers determined how the colonised were thought about, talked about, and understood. He was concerned with how European colonisers 'gazed' upon the Orient and created knowledge about it, thereby legitimising and consolidating colonial power. In his landmark book *Orientalism*, Said (1979) demonstrated how a sustained discursive effort was used in historical and contemporary texts to construct an image of the East that suited colonial undertakings. He revealed how European culture was able to manage, and even 'produce', the Orient (Dallmayr, 1996). Portrayals of the Orient were invariably as backward nations and peoples, in stark contrast to the 'superior' Occident. Said demonstrated how this promoted a binary representation of East and West, where East was feminine and West was masculine, East was barbaric and West was civilised, and where the East could not thrive or function without the West. Said pointed out that Western societies and values such as individualism, rationality, libertarian democracy, or the free press, are presumed to be superior to Eastern cultures or concepts (Gunaratne, 2005; 2009). Politically, it is a "Western style for dominating, restructuring, and having authority over the Orient" (Said, 1979, p.3).

In *Culture and Imperialism*, Said (1993) takes ideas about orientalist discourses a step further by conducting what he described as a 'contrapuntal' analysis. He highlights that without the power of culture, the institutional, political, and economic operations of imperialism would not be possible. He therefore analysed the 'general worldwide pattern' of imperial culture that develops to both justify and reinforce the establishment and exploitation of empire (Chowdhry, 2007). Said's contrapuntal reading of texts goes against the way the author intends the document to be read, thereby challenging underlying assumptions. For example, questioning the fact that the Orient is indeed 'backward'. Unlike univocal readings in which the stories told by dominant powers become naturalised and acquire the status of 'common sense', a contrapuntal reading thus employs what Said (1993) describes as "a simultaneous awareness both of the metropolitan history and of those other histories against which (and together with which) the dominating discourse acts" (p.51). In other words, a contrapuntal analysis involves reading a text in the context of its spatial and political relations to empire, as well as in the 'counterpoint' to this position that colonised or marginalised people themselves produced in response to domination.

### **3.5 Critical discourse analysis**

CDA examines the way that discourse makes certain statements appear inevitable and closes off challenge or debate (Fairclough, 2013). As described by Rogers et al. (2005), CDA is characterised by the "movement from description and interpretation to explanation of how discourse systematically constructs versions of the social world" (p. 371). Epistemologically, CDA takes knowledge to be socially constructed, and it explores instances of language to understand how these influence what individuals within a socio-political and cultural context understand as, or consider to be, 'known' (Wodak, 2011). CDA probes the question of how certain knowledge claims are beyond dispute at particular historical time periods, and it pays attention to the contradictions within and among discourses that become visible when the probing of this 'common sense' occurs (Wodak and Meyer, 2015). However, CDA goes beyond a simple description of patterns, seeking to understand the implications of particular discourses for the legitimacy and power they bring to different institutions and ideas (Haddara and Lingard, 2013). As Hodges et al (2008) note, one of the benefits of using CDA is that it allows one to focus on meaning in a wide-ranging way:

What underpins all variants of discourse analysis is the idea of examining segments, or frames of communication, and using this to understand meaning at a "meta" level, rather than simply at the level of actual semantic meaning. In this way, all of the various methods of discourse analysis provide rigorous and powerful approaches to understanding complex phenomena,

ranging from the nature of on-the-ground human communication to the inner workings of systems of power that construct what is “true” about health and health care (p.572)

CDA focuses on changes in language and practices (Guba and Lincoln, 2005). As such, it is a powerful tool to look at how ideas of globalisation were conceptualised and dominant ideas about it evolved in the context of medical school regulation. However, as with any methodological approach, the nature of its focus also sets limits on its functionality. By focusing predominantly on uses of language and shifts in power, it places less emphasis on building detailed social reconstructions of individual events or people, and instead focuses on trends and patterns. CDA has not been met without criticism and scholarly opponents have suggested that it is unclear of its philosophical foundations and lacks an adequately developed sociological theory (Hammersley, 1997) and is overly ambitious in ‘the task it sets itself’ (Haig, 2004). Dissecting and responding to these various critiques, Breeze (2011) highlights that they are based on misunderstandings and concludes that CDA “offers a promising paradigm for identifying and interpreting the way ideology functions in and through discourse” (p.520).

CDA enables researchers to study ideas that are accepted as ‘truths’ in order to understand how they came to gain this legitimacy. CDA seeks to problematise ‘truths’ that have been widely accepted, it is not intended to be a methodology wielded from a vantage point of unbiased objectivity (Feilchenfeld et al, 2018). The choice to use CDA in this thesis is a deliberate one, as a means to identify and interrogate dominant ideas about globalisation in the context of medical school regulation. However, this does not mean that the goal is either to promote or reject any particular policy decision or direction. Rather, in keeping with other medical education scholars who have used CDA (Kuper et al, 2013), the hope is to advance the field in constructive ways.

### **3.6 The Archive**

My first task in this research was to define and delimit my data set. As outlined in the first chapter of this thesis, my interest was primarily in the ECFMG announcement in 2010 that from 2023 onwards (modified to 2024 in light of disruption caused by the COVID19 pandemic), physicians applying for ECFMG certification will be required to graduate from a medical school that has been accredited by an agency recognised by WFME. From here on, this will be referred to as the ‘ECFMG ruling’. Given my approach of using CDA to look historically at the discourses that enabled this policy announcement to take place at this time, this start point was in fact my ‘end point’ chronologically. I therefore had to proceed ‘backwards’, drawing on Foucault’s notion of genealogy, I did so through identifying important landmarks and their impact on the status quo (rather than simply exploring the period chronologically). Given that my primary interest was in the move towards global approaches in

regulation, and that it was WFME who became responsible for ‘enacting’ this policy, I decided to use the history of WFME to consider the ideological history of this event.

The WFME recognition programme that resulted from the ECFMG ruling evaluates compliance of accrediting agencies with pre-defined criteria. This approach is not, though, in my experience, widely understood by medical educators. The reason for this is that since 2003 the WFME has also had ‘global expert consensus standards for medical schools’ that are designed to ‘guide the development and evaluation of medical education programmes’ (WFME, 2020c). In other words, the ECFMG ruling led to a recognition programme that assesses accreditation agencies, whereas the pre-existing standards were designed for use by, and assessment of, medical schools.

Given that WFME standards were first published in 2003, seven years prior to the ruling in 2010, their publication seemed an important antecedent and worthy of further examination. Although WFME was first established in 1972, there were no major programmes, meetings or publications in its early period, until the offices moved from the U.S. (Maryland) to the UK (Edinburgh) in 1983. In fact, the first major event in its history seemed clearly to be its publication of the Edinburgh Declaration at the World Conference on Medical Education in 1988. This document was published with no named individual author(s) but rather from WFME as an organisation and it asserted itself as a consensus statement about quality and development of all the world’s medical schools. In that this represents the first statement of this kind that is seemingly ‘global’ and related to quality of medical schools, I decided this would represent a suitable start point for my analysis.

I had identified, then, three distinct historical events to frame my data collection. These are shown in figure 1. Although not directly linked in policy terms, the thread that runs through them is the central role of WFME, and that they each represent a further point in the move toward global approaches to medical school regulation. Although my data set was structured around these three temporal events, my approach to gathering documents was not rigidly fixed to this time period. For example, some texts about the Edinburgh declaration, which was published in 1988, were written to commemorate its 30 year anniversary in 2018 and these were included in the corpus despite being published outside of the primary historical time period of the study. Likewise, the majority of texts that relate to the ECFMG ruling were published in the decade after its announcement in 2010. A number of documents in the data set dealt with two out of the three of these events, and a handful of documents covered all three, reaffirming the conceptual link between them.

Data sources included research articles, editorial and commentary articles, other scholarly writings from educators and policymakers, and current and historical policy and standards documents. Electronic database searches using keywords from each of the three events outlined above were

combined with manual searches of webpages and key journals. Having read key documents and articles relating to each event, I then adopted a 'snowballing' process (Greenhalgh et al, 2004), pursuing references of references and using citation-tracking software. This iterative process continued until it was clear that key documents had been located, at which point the corpus contained 250 documents in total.

Analysis was carried out using document analysis. As Bowen (2009) describes, documents are stable, "non-reactive" data sources, meaning that they can be read and reviewed multiple times and remain unchanged by the researcher's influence or research process. They can also point to questions that need to be asked or to situations that need to be observed, making the use of document analysis a way to ensure this research is critical and comprehensive. Once the data set had been defined and delimited, the texts were read and analysed to identify discourses and discursive shifts. Statements, key words, and metaphors were sought with particular attention to recurring arguments and shifts in these arguments. These discourses were also analysed with attention to practices, institutions and social relations, read through the lenses of the approaches outlined by Foucault and Said earlier in this chapter. My overall aim was to identify the ways in which discourses about the importance of the globalisation of medical school regulation became dominant, and how these in turn enabled policy decisions to establish global approaches to medical school regulation.

### **3.7 Ethics**

As this research was based on an archive of written documents that were all in the public domain, formal research ethics approval was not necessary. As mentioned in the introduction chapter of this thesis, I am to some degree an 'insider' in this research and during the period of this study, I had informal conversations with various members of the community examined in this research, including for example, whilst attending the WFME conference in Seoul in 2019. Mindful of these conversations, I deliberately attempted to base this analysis on the archive of documents, whilst acknowledging that my overall perspective is shaped by the breadth of my experiences in this field.

### **3.8 Summary**

This research employs critical discourse analysis, drawing on Foucauldian concepts of archaeology and genealogy, and Saidian concepts of orientalism and contrapuntal reading, to explore the ways in which global approaches to medical school regulation were established and promoted. It examines an archive of scholarly articles and policy documents that were structured around three key historical events: the Edinburgh declaration in 1988; the publication of the first set of WFME global standards in 2003; the ECFMG ruling in 2010.

## 4. Summary of findings

### 4.1 Outline of discourses

Overall, five discourses were identified in this study: *endorsement*; *modernisation*; *resistance*; *protection*; *control*. There are important differences in the temporality of these discourses. The discourses of *endorsement* and *modernisation*, which both serve to accelerate the globalisation of medical school regulation, are present throughout the entire time period of this study, across all three historical events described in the previous chapter. The discourse of *resistance*, though, is present in the early time period in this study, specifically around the Edinburgh declaration and immediately following the first publication of WFME standards. It fades away in the later period of the study, at which time the two remaining discourses, *protection* and *control*, emerge. These two discourses become dominant around the time of the ECFMG ruling announcement in 2010 and the period following this.

In the following chapters, I will consider each of these five discourses in turn, drawing further on the theoretical devices of Foucault and Said that have been outlined in the previous chapter. I will argue that the discourses of *endorsement* and *modernisation* are both hyperglobalist in perspective and seek to frame globalisation as unanimously accepted and an overwhelmingly positive force. Both of these discourses are dominant, marginalising the discourse of *resistance*, which is transformationalist in perspective. A discursive shift took place in the middle time period of the study, as the discourse of *resistance* faded and the discourses of *protection* and *control*, both transformationalist in perspective, became dominant. Both of these discourses frame globalisation as neither explicitly positive nor negative but rather, as a process that needs to be managed in the context of American healthcare system and workforce priorities.

I will go on to argue that two discursive strands each promote policy decisions to globalise medical school regulation through fundamentally different rationalisations – one of altruism and improving medical education globally, and one of nationalism and protecting American interests. Finally, I consider the consequences of these discourses for the authority of WFME as an organisation with an apparently global mandate and remit.



## **5. The Discourse of *Endorsement***

### **5.1 Introduction**

The discourse of *endorsement* is dominant throughout the entire corpus of texts in this study, and is used to promote and justify globalising ideas and practices. It is used to support the notion that policies that move medical school regulation in a more global direction have widespread support. It draws on the authority of respected institutions to strengthen the case for these policies, and aligns with authoritative ideas of the time to provide a sense of harmony and hint at the inevitability of globalisation.

Seen through a Foucauldian lens, one can view the entire discourse of *endorsement* to be about power relations. Indeed, Foucault (1988) argued that “the relations of power are perhaps among the best hidden things in the social body” (p. 118). He also argues, though, that it is misleading to think of power as something that some individuals or even classes possess and others lack. Power is dispersed over society and its effects are everywhere. Foucault (1980) likens power to ‘a machine working by a complex system of cogs and gears’ that no individual or group is in charge of. He also argued that power should not be thought of in exclusively negative or disciplinary terms, as it can also produce all kinds of knowledge and social realities. As I will argue in this chapter, the discourse of *endorsement* strengthens the case for a global approach to medical school regulation. This, in turn, shifts power towards global policies and practices, projecting them as unstoppable.

Said was also concerned with power as it relates to the promotion of dominant discourses. He notes, for example, that there is a ‘flat assertion of quality’ that Western policymakers have ‘by virtue of being western’ (Said, 1985). He goes on to describe this as a “statement for power and a claim for absolute authority” (p.8). In this chapter, I will explore how claims for authority relating to global approaches in medical school regulation are articulated in a discourse of *endorsement*, and in particular, how this can be seen as a means of exerting Western authority, as Said observed.

This chapter describes the discourse of *endorsement* and the ways in which it was used to validate global approaches to medical school regulation. The discourse plays out through four key ideas (consensus, alignment, implementation, and representation), and although these are all interlinked, they are each considered in turn through this chapter.

### **5.2 Endorsement by consensus**

As described in the previous chapter, the World Conference on Medical Education in Edinburgh in 1988 was the first time that a public attempt was made to agree on universal points of quality in basic medical education and was therefore an important moment in the story of how medical school

regulation came to be conceptualised and managed globally. The discourse of *endorsement* can be traced back to this point and weaves through the decades that followed, including to the announcement of the ECFMG ruling in 2010 and the reaction to it thereafter.

The Edinburgh declaration is just 664 words long and has no named individual author(s), although the mention of the title and dates of the World Conference on Medical Education at the end of it hints that it represents a consensus of all individuals present at this event. The text itself also gives an indication of consensus:

This concern... reflects the convictions of a growing number of medical teachers and medical students, medical doctors and other health professionals and the general public around the globe (WFME, 1988)

Strikingly, the final paragraph of the document changes linguistically to a much more personal style, with an emphasis on 'we' and 'us':

By this declaration, we pledge ourselves and call on others to join us in a sustained and organised programme to alter the character of medical education so that it truly meets the defined needs of the society in which it is situated. We also pledge ourselves to create the organisational framework required for these solemn words to be translated into sustained and effective action. The stage is set; the time for action is upon us (WFME, 1998)

The Edinburgh declaration was cited in the context of both the WFME standards and the ECFMG declaration, reaffirming that there is a conceptual link between these events, despite the lack of any direct policy link. Referencing back to the Edinburgh declaration provides a historical endorsement and additional source of legitimacy. In a report of the WFME conference where the first set of WFME standards was launched, van Niekerk et al (2003) describe the following:

The opening address was given by Gro Harlem Brundtland, Director General of the WHO. She noted that there has been a consistent international theme of reorientation in medical education since 1984, a notable landmark being the Edinburgh Declaration of 1988 (p.1051)

In a paper examining the ECFMG ruling, Tackett (2019) also draws a clear line between both the Edinburgh declaration and the first set of WFME standards, by way of background for his exploration of the ruling:

The WFME... first developed a series of principles to guide medical education, the Declaration of Edinburgh. Then, in 2003, the WFME developed a comprehensive set of standards intended

to serve as a template to facilitate the formal quality assurance efforts of individual schools and of national and regional authorities (p.944)

This ‘backwards’ endorsement by consensus is augmented by ‘sideways’, or contemporary, statements and claims about consensus. Indeed, WFME was clear about the importance of developing consensus when it set out to develop its first set of standards, five years prior to their eventual publication. At this time, the first step of their ‘action plan’ stated that “international discussions among experts in medical education should lead to consensus about accreditation standards” (WFME Executive Council, 1998 p.556). Once the standards were published, the importance of consensus was consistently reiterated, with descriptions including “consensus-based” standards (Hays and Baravilala, 2004), standards that are “agreed by most educators” (Gukas, 2007), and having “obtained international endorsement” (Sjostrom et al, 2019). The consensus around the standards was especially emphasised when considering their revision:

Many observers now regard the WFME standards as a source of sound, robust guidance, and there is some consensus for the proposal that mutual recognition of graduates may be facilitated across accreditation authorities (Hays, 2014 p.459)

The importance of this use of ‘consensus’ to propagate the *endorsement* discourse is highlighted by examining definitions of the word. Although the Oxford English dictionary offers a number of different definitions, of particular relevance is the definition used by international agencies. The United Nations Library, for example, states in the context of multilateral diplomacy that consensus is “understood as the absence of objection rather than a particular majority” (United Nations, 2019). This definition is striking, in that as will be outlined later in this thesis, there is sometimes very vocal objection to these standards on a number of different grounds.

An extension of the framing of consensus is the claim that such consensus provides a mandate. Discussions of mandate are particularly forceful with respect to WFME standards, but first appear in relation to the Edinburgh declaration. Professor Henry Walton was Dean at Edinburgh Medical School and given that he was President of WFME during the time of the Edinburgh declaration, it seems likely that he played an important role in its co-ordination and writing. That he was also a previous President of the Association of Medical Education in Europe, an important organisation in the medical education community, and editor-in-chief of *Medical Education*, an influential journal in the field, his authority is likely to have carried some weight. Writing three years after the publication of the Edinburgh declaration, Walton celebrates it in a long essay, and includes in his conclusion the following claim about the mandate he believes WFME has:

The World Federation for Medical Education, as a consequence of intensive international enquiry, has obtained a globally agreed mandate for reorienting all stages of medical education (Walton, 1991 p.157)

Such claims became more widespread following the publication of the first WFME standards. In a conference report written by WFME officers summarising the conference where the first set of WFME standards were launched, it was reported that “the conference strongly endorsed the evaluation process and encouraged its continuation”, in what it described as “a remarkable example of international collaboration” (van Niekerk et al, 2003). Then WFME President, Hans Karle, later described that the conference gave the WFME a ‘renewed mandate’ for its work (Karle, 2006) and provided ‘clear international endorsement’ (Karle, 2010). Of note, this conference endorsement appears only from WFME sources, and is repeated in a paper co-authored by Karle (van Zanten et al, 2009), although does not appear elsewhere in the published literature at this time.

A final way that the discourse of *endorsement* uses ideas of consensus is in the presentation of the WFME as the ‘gold standard’. This term has its root in economics and describes a system whereby countries fixed the value of their currencies in terms of a specified amount of gold, although in medical science it represents “a consensus that a given test in a given situation is the best available test” (Versi, 1992). This notion of *endorsement* is apparent both through explicit use of the term “gold standard” in the context of WFME standards (Gordon and Karle, 2012; Tackett et al, 2016) and through the implicit treatment of WFME standards as a gold standard approach in Zambia (Banda, 2008), Malaysia (Mohamed, 2008), and in multiple countries in Sub-Saharan Africa (Girma et al, 2016). In its announcement that an applicant’s medical school must be accredited through a formal process that uses criteria ‘comparable to WFME standards’, ECFMG (2010) also contributes to this framing of WFME standards as a gold standard.

### **5.3 Endorsement by alignment**

The discourse of *endorsement* is additionally established through alignment with prominent and esteemed agencies and policies. The practice of associating WFME and ECFMG with these symbols of authority, and the frequency with which these associations are communicated, suggests it is an important way in which the *endorsement* discourse is cemented. As Foucault argued in his essay ‘The Crisis of Medicine or Anti-Medicine’, medicine is inherently social, political, and constituted in power relations (Foucault, 2004). To understand medicine as objective, neutral, and without investment in securing its own authority and legitimation, is seen by Foucault as a mistake (Hancock, 2018). As such, this enactment of seeking authority through association can be conceptualised as a means for WFME to gain and consolidate power.

The most frequently cited and vigorously argued alignment is with the World Health Organisation (WHO). To some degree, this is unsurprising, given that the WHO played a role in the establishment of WFME, although its involvement has gradually but significantly reduced since. This separation of the relationship is evident in the gradual reduction in the mention of WHO alignment across the time period of this study. As mentioned earlier in this chapter, the Edinburgh declaration has no named individual authors but rather the title and dates of the conference at which it was developed. It does, though, have a list of five organisations that it was sponsored by, of which the first is WHO (WFME, 1988). This sponsorship by the WHO was emphasised in a letter written by the WFME President (Walton, 1993), whilst Smilkstein (1990), in an article introducing a new curriculum, sets up his case by summarising the Edinburgh declaration and accentuates its importance by emphasising the WHO sponsorship.

The WHO was established in 1948 to serve as the ‘directing and coordinating authority’ in all international health matters, including the containment and eradication of infectious diseases (McCarthy, 2002). Given the post-war worldview that valued good health as the basis for international peace, the organisation was imbued with considerable authority to pursue this goal (Kamradt-Scott, 2008). Despite criticisms over its management of various health crises since its inception, it has ultimately maintained this authority and has wide recognition and respect in the medical and public health community, as demonstrated by the reaction to President Trump withdrawing from it in the midst of the COVID19 pandemic (Sridhar and King, 2020). The widespread recognition and respect of the organisation may explain the reason that alignment to it is such a crucial element of establishing the discourse of *endorsement*.

Thirty years after the Edinburgh declaration, the journal that Walton (the WFME President at the time of the declaration) once edited, *Medical Education*, published a special issue that sought to “commemorate and reflect on” its anniversary (Eva, 2018). Dr Kevin Eva, Walton’s successor as editor-in-chief at the journal, introduced the issue in his editorial and foregrounded the WHO sponsorship in his description of the declaration:

“...an international effort supported by both the World Health Organization and the World Federation for Medical Education” (p.1)

Although the WHO was the primary organisation of alignment, other international agencies were also included. Writing in a family medicine journal about the implications of the Edinburgh Declaration on the discipline, Metcalf (1989) describes its association with international agencies, suggesting that this represents the fact that “those in the higher levels of the ivory tower” have understood the realities facing frontline clinical educators:

Medical schools worldwide face a new challenge in the wake of the World Conference on Medical Education which took place in Edinburgh in August 1988. From this an action programme for reform of medical education worldwide has been set up and has won funding: moreover active cooperation and coordination has been secured between international agencies such as the World Health Organization, UNESCO, UNICEF, the United Nations Development Fund and others. For once the stimulus does not come from the bottom of the academic pecking order. (p.165)

Likewise, Vysholid and Walton (1990) celebrate the “close cooperation and support of WHO, UNICEF, UNESCO, UNDP” that led to the development of the declaration, and Walton (2001) later lists these agencies, as well as the Pan-American Federation of Associations of Medical Schools and “the National Associations for Medical Education of many South American countries” (p.14).

The alignment with the WHO persists through the period of the first WFME standards. Describing the “enthusiastic support” that the standards received at the World Conference on Medical Education, van Niekerk et al (2003) highlight that the standards had already been “accepted by the World Health Organisation (WHO) and the World Medical Association (WMA)” prior to this meeting (p.585).

As well as describing a WHO-WFME partnership at great length in a journal article, then WFME President Karle (2006) highlights that “a number of quality assurance initiatives have been taken internationally in higher education” (p.543) that he goes on to list:

Those taking such initiatives have included the United Nations Educational, Scientific and Cultural Organization (UNESCO), the Organisation for Economic Co-operation and Development, the International Association of Universities, the International Association of University Presidents, and the International Network for Quality Assurance Agencies in Higher Education (p.543)

In subsequent years, a number of other authors have used this framing of WHO and WFME being in a partnership, always referencing the original Karle (2006) editorial when doing so (van Zanten, 2009; Rezaeian et al, 2013; Ibrahim, 2015; Iqbal, 2019). As mentioned earlier in this chapter, alignment with WHO becomes less active over the time period of this study. Of note, though, alignment with the International Association of Medical Regulatory Authorities (IAMRA), an umbrella organisation that offers a ‘global community’ to medical regulators from around the world, becomes more prominent in the later period (Shiffer et al, 2019; Sjostrom et al, 2019). Established in 2004, this organisation has steadily grown in influence since, and the fact that alignment to it has commenced, may be indication that this is emerging as a new institution of authority in this field. In a sense, then, one might perceive

that WFME has aligned with the relevant authorities of the time, which was initially WHO and then moved to become IAMRA. In other words, this could be seen as WFME associating itself with whoever is the authoritative body of the time in order to legitimise itself through this association.

In parallel to the alignment with reputable international organisations, a further means of *endorsement* has been alignment with popular policies. Universal health coverage (UHC) is defined as ensuring that all people in a society have access to needed health services of sufficient quality to be effective while also ensuring that the use of these services does not expose the user to financial hardship (Reich et al, 2016). UHC has been a widely accepted target for policymakers in many countries for several decades. In medical communities, it is almost ubiquitously accepted as a ‘truth’ that UHC is a desirable goal. In the early period after the Edinburgh declaration, the document is associated with both the Alma Ata declaration (Ramalingaswami, 1989) and the WHO Global Strategy for Health for All by the Year 2000 (Hussey, 1990), which both focus on achieving UHC. This policy alignment is another means by which the authority of the declaration is seemingly enhanced. Of note, this alignment is not to a dominant policy goal in education but one in healthcare.

A further policy alignment can be seen in the period surrounding the launch of the first WFME standards in 2003. On this occasion, it relates not to healthcare policy but rather to higher education policy, the other sector that medical schools typically have to navigate. The Bologna Process describes a series of ministerial meetings and agreements between European countries to ensure comparability in the standards and quality of higher-education qualifications (Wachter, 2004). It was named after the University of Bologna, where the Bologna declaration was signed by education ministers from 29 European countries in 1999. Around the period of the first WFME standards, educators across Europe were recognising the potential relevance of this policy for medical schools, which included many features that were relevant to WFME standards in terms of ‘uniformity’, including for example, a single credit unit system to ensure courses were ‘comparable’. Given that the Bologna process was in the consciousness of medical educators and had a legal mandate in European law, alignment of WFME standards with it (Christensen, 2004; Mirecka, 2005; SImunovic, 2006; Cumming, 2007), served to give them apparent relevance and authority.

A final aspect of alignment that featured in the discourse of *endorsement* was related to the extent to which the WFME standards aligned with existing, credible, medical education standards. In a regional consultation document on the accreditation of health professions education in the Eastern Mediterranean Region (WHO, 2003), before sections on Sudan, Egypt, Jordan, Pakistan, Iran, Iraq, Bahrain, Palestine, Lebanon, Morocco, and Yemen – i.e. the countries of the region – the document first describes WFME standards, along with the standards of the UK General Medical Council and the

Australian Medical Council. It is notable that the WFME standards, which were still relatively new at this stage, are aligned with the regulatory standards of two countries that have long established and widely respected systems of regulation. Perhaps more striking, though, is how this framing sets up the standards of Eastern countries in the terms of, and context of, the standards of Western countries. This is a pattern that Said (1979) describes with countless examples. Hodges et al (2009) pick up both on the alignment of global standards with those of Western countries, and on the tension this brings in terms of framing. They propose the following:

Specific attention must be given to avoiding the imposition of standards from economically or culturally dominant countries that do not fit with the cultural, economic or health-human resources needs of other countries (p.915)

Unfortunately, not all the alignment of WFME standards with Western standards is as considered and reflexive as Hodges et al (2009) call for in this passage. WFME President Karle (2006), for example, proudly notes that the WFME standards align closely with those of the U.S. regulator, the Liaison Committee for Medical Education (LCME):

Comparison of the LCME and the WFME standards shows a high degree of congruence and mutual consistency (p.546)

The notion that the WFME standards are equivalent to European and North American standards is repeated by authors from Eastern countries (Slumonovic, 2006; Abdalla, 2014), and requires consideration. Why should it be that a global authority needs to align with national authorities in order to justify and promote its existence? Might one not expect the reverse – that is, that national authorities reaffirm themselves by aligning with an international authority? One explanation for this is that national standards and regulatory agencies have existed for many decades before the WFME and its standards. However, another explanation is that whereas national standards and agencies have a clear role and function in their own countries, the WFME and its standards are having to make a case for their existence and justify this additional layer of regulatory bureaucracy. Indeed, the decision to align with Western countries may also be interpreted as a strategic and potentially problematic pattern in light of the fact that these countries have a history of colonialism and domination of many parts of the world.

Given that the ECFMG ruling is directly linked to a single country, the U.S., the alignment to its regulator, the LCME, is perhaps unsurprising. From a U.S. perspective, alignment of the WFME with the ECFMG is an expression of the world buying in to its own vision, values, and practices. It is



important here to consider the exact wording that the ECFMG (2010) used in its ruling announcement when considering eligibility:

To satisfy this requirement, the physician's medical school must be accredited through a formal process that uses criteria comparable to those established for U.S. medical schools by the Liaison Committee on Medical Education (LCME) or that uses other globally accepted criteria, such as those put forth by the World Federation for Medical Education (WFME). (p.1)

Although the policy steps that followed, namely the establishment of the WFME Recognition Programme, meant that the eventual criteria used was in fact that of WFME rather than LCME, the fact that the ECFMG approved both is a firm message of alignment and is ultimately an important contributor to the discourse of *endorsement*. This explicitly stated equivalence of LCME and WFME has been reaffirmed elsewhere (Ranasinghe, 2015; Shankar, 2017; Dauphine, 2019) and has important implications for the overall framing of the ECFMG ruling. If WFME is so closely aligned to LCME, then the decision taken by the ECFMG can be framed as one of dominance. This is picked up in more detail in later chapters.

#### **5.4 Endorsement by implementation**

Another means by which the discourse of *endorsement* has been established is through descriptions of implementation. Assertions that the Edinburgh declaration led to changes in medical schools, that the WFME standards were widely used across the world, and that countries were responding to the ECFMG ruling by seeking WFME recognition, are all used in this discourse, and can be traced throughout the period of this study. In each of these cases, examples and trends are used selectively to illustrate this implementation rather than any systematic attempts to actually quantify the degree of implementation.

One of the means by which claims of widespread implementation were made relate to language translation. The fact that a document has been translated into different languages, the argument goes, proves that it is influential and impactful. Although this argument is never explicitly laid out in this way, it is implicit in the fact that mentions of translation are linked to adoption:

The recommendations of the World Conference are summarized in the Edinburgh Declaration, translated into all the main languages and now widely known and adopted (Vysholid, 1990 p.408)

Linking the translations of the Edinburgh declaration to its implementation is repeated elsewhere (Majumder et al, 2004; Abulrehman, 2008), although there is no mention of the specific languages, countries, or world regions this applies to. Rather, each time, there is a superficial and uncritical

acceptance that this translation is an indication of both its status and widespread adoption. Likewise with the WFME standards, translation is once again used as a discursive device to demonstrate *endorsement* through implementation. Then President of WFME, Karle (2006) makes the case for the impact that the standards have had:

Outcomes have included a number of publications, presentations at more than 100 international meetings and conferences, and translations of the standards for basic medical education into 20 languages (p.S45)

This is later repeated, this time describing the “translation of standards into a number of languages” in the same paragraph that the standards are described as having “obtained clear international endorsement” (Karle, 2010 p.14). As in the case of the Edinburgh declaration, there is no mention of the specific languages or countries that were involved in these translations, but instead an overarching statement that is discursively used to promote *endorsement*. Of note, both of the statements about the translation of the WFME standards came from the WFME President and are not corroborated elsewhere in published articles. That is not to say that the claims are false, but rather that they are not discursively useful or meaningful elsewhere in the same way they are here. Seen through a Foucauldian lens, this emphasises the use that this discourse has in promoting the agenda of WFME, namely to gain power through its global mandate.

In a statement published online by the WFME to mark the 30<sup>th</sup> anniversary of the Edinburgh declaration, it retrospectively celebrates its impact, describing it as having been:

...widely accepted by medical teachers, medical students, medical doctors and other health professionals, and the general public around the globe (WFME, 2018)

This sentence gets more grandiose and extraordinary as it progresses and in my experience does not hold water. I have worked at two leading medical schools in the last decade including with many esteemed medical teachers whose careers have spanned the thirty years between the Edinburgh declaration and this statement. When asked, not one of these colleagues had even heard of the declaration, still less ‘accepted’ it. Given that both of these medical schools are in the same part of the world as Edinburgh, it is difficult to believe that anything more than a tiny proportion of medical teachers in the thousands of schools in other parts of the world will have even heard of the declaration. Having myself been a medical student and medical doctor through this period and encountered many thousands of other students and doctors in this time, I feel confident that a miniscule percentage, if any, would know what the declaration was. The final claim, that the billions of citizens of the globe have somehow ‘accepted’ this declaration, is inexplicable. Had the claim been

that these groups were ‘impacted’ by the declaration, perhaps unknowingly, this would have been slightly more credible, although still open to significant debate. It is, therefore, clear to me that the purpose of this statement is to assert that the declaration was widely implemented, thereby supporting the discourse of *endorsement*. The use of this sweeping language is noteworthy in that it clearly demonstrates the importance that WFME place on establishing the declaration as useful and impactful, using this discursive device to gain authority and power with its stakeholders.

As mentioned earlier in this chapter, the 30<sup>th</sup> anniversary of the Edinburgh declaration was commemorated by the *Medical Education* journal. In light of the fact that the declaration is not well recognised within the practising medical education community as I have outlined, and that it has not been widely cited except in the few years following its publication, this may be seen as an unusual decision. Moreover, it is not widely recognised or cited by medical educators in the same way as, for example, the Flexner report of 1910 is (Whitehead, 2011). This apparently odd decision to have a special issue in its remembrance may be explained by the fact that Walton, who was WFME president at the time of the declaration, led this journal for 21 years, the longest tenure in the journal’s history, as celebrated by his successor who commissioned this special series (Eva, 2016). The special issue sought to provide updates on each of the 12 recommendations of the original declaration (Eva, 2018). Whilst no paper in this special issue offers an in-depth examination of the declaration, a number of papers mention it in their introductory sections, generally endorsing it as positive, although never emphatically so (Gormon et al, 2018; Stegers-Jager et al, 2018; Bandiera et al, 2018; Griffin et al, 2018; Dotters-Katz et al, 2018).

Given that the Edinburgh declaration is a short statement that is made up of a series of broad recommendations, it is not easy to ‘prove’ that it has (or has not) had an impact. The WFME standards, however, are more comprehensive and specific, and can therefore be used in a more tangible and direct way, meaning impact can more easily be captured. An individual medical school or national accreditation agency can use these standards in an accreditation process, which is evidently not the case with the broader principles outlined in the Edinburgh declaration. One element of the discourse of *endorsement* is the widespread adoption of these standards. Responding to an article challenging the uncritical global spread of innovations in medical education, including the WFME standards, Karle et al (2008) defend the standards by claiming they are “now the national basis used for the recognition and accreditation of medical schools in numerous countries around the world” (p.957). This description of widespread adoption, which does not include any specific countries that have adopted them, suggests that countries have carefully reviewed the standards prior to adopting to them. Whilst no evidence is given to support this, there is equally no evidence that it did not take place. Irrespective, it promotes the discourse of *endorsement* and provides figurative authority to the standards.

In an overview of accreditation of medical schools around the world, van Zanten et al (2008) pronounce that the WFME standards are “being used in countries throughout the world” (p.931), referencing the Karle et al (2008) paper and providing no further details. This is repeated in van Zanten et al (2012) with the same reference. Whilst these papers are from North America, the notion of WFME standards being widely adopted has also appeared in Eastern countries, such as Iranian authors Rezaeian et al (2013) describing that them as being “on the agenda in many countries” (p.150) and an author from Saudi Arabia describing them as being in use “worldwide” (Abdalla, 2014 p.3). This *endorsement* through adoption thus becomes a universal ‘truth’ that although never substantiated with empirical evidence, is used compellingly by all these authors, who each is arguing for the importance of accreditation and thereby gains authority through this discourse.

In the period following the first publication of WFME standards, a number of pilots were carried out that sought to test the validity of the standards. In a report about the conference during which the WFME standards were launched, van Niekerk et al (2003) state that the standards have been “validated in pilot studies” (p.1050), although these studies are not described or referenced. Two years later, Grant et al (2005) describe a pilot evaluation of the WFME standards, although this appears as a two-page commentary article rather than as a full research manuscript. It concludes that “the standards were usable, adaptable and appropriate” (p.246) and that “the usefulness of the WFME global standards has been confirmed by the fact that many other medical schools are using the standards as a self-study guide” (p.246). This article represents the closest published version of a pilot and despite the overall positive conclusion, it does highlight that “disadvantages were the time commitment, cost and data collection problems” (p.246). These disadvantages are not alluded to in subsequent papers. Instead, they each frame the pilots within the discourse of *endorsement*, using them as further ‘proof’ of the validity of the standards (Karle, 2010; Karrar, 2019).

### **5.5 Endorsement by representation**

The final approach within the discourse of *endorsement* is the representation of those involved in the development of both the Edinburgh declaration and WFME standards. The argument here, although not explicitly stated, seems to be that the diversity of those involved in the development of these documents infers their validity and authority.

The issue of participation and representation has long been deliberated on, and theorised by, social scientists and policy researchers. Over half a century has passed since Sherry Arnstein’s landmark paper about citizen participation (1969), in which she describes a ‘ladder of involvement’ that moves up from manipulation, to tokenism, through consultation and partnership, up to citizen control. This seminal model has been widely influential in recent decades in both the healthcare sector, in the

context of patient involvement (Rashid et al, 2017), and in the education sector, in the context of student involvement (Jingura et al, 2018). As a field that sits between these two sectors, one might expect medical education to have been mindful of these ideas. The disenfranchisement that can result from tokenism in global health stakeholder engagement has been particularly well documented (Murphy et al, 2015; Yarmoshuk et al, 2018). The absence of any description of the manner and extent of representation related to either the Edinburgh declaration or WFME standards is, therefore, striking. Rather than any attempts to validate the representation by framing it as meaningful participation, it is instead used discursively as a means of establishing the discourse of *endorsement*.

As highlighted earlier in this chapter, the final paragraph of the Edinburgh declaration is dominated by bold statements of 'we' and 'us' (WFME, 1988). In addition to the notion of consensus discussed earlier, this also hints at representation, giving an image of a group harmoniously participating through a unified collective voice. Warren (1998), an American participant in the conference from the Rockefeller Foundation in New York, reports on the conference in *The Lancet*, and provides the most quantitative picture of representation that is publically available:

The 137 participants came from 67 different countries well distributed among the six regions of the world-Africa, the Americas, the Eastern Mediterranean, Europe, South-East Asia, and the Western Pacific. (p.462)

These numbers look reassuring, and paint a picture of a style of meeting that one might expect in the chambers of a large international agency, with purposeful and democratic involvement from representatives of these countries. A picture is also painted of the nature of representation:

Three days of deliberations in plenary sessions and working groups saw the birth of a document called the Edinburgh Declaration (Warren, 1998 p.462)

The use of the words 'deliberations' and 'birth' here is suggestive of a highly democratic and collaborative process. Beyond this rhetoric though, there is a clear absence of detail of what actually took place to allow 137 participants to agree on, and write, this document. For example, was there a co-ordinating individual or group who led the writing? Was there a process for suggesting edits? Did any votes take place? What were the mechanisms for consultation? How many drafts were needed to reach a final version? To what extent did the final version still contain areas of tension? Perhaps it is unreasonable to expect this degree of transparency in 1988 when it was less of a norm than it is today. Perhaps there was, in fact, a highly democratic and participatory mechanism in place. What is clear from the texts of this time, though, is that representation of individuals from different countries was an important discursive tool to provide authority to this document.

The WFME conference in 2003 marked the launch of the first WFME standards. Like in the case of the Edinburgh declaration five years earlier, the delegates present at this meeting were once again used discursively to promote the notion of representation:

An important element contributing to the endorsement was the nature of the Conference and the standing and influence of the delegates. The interest generated by the importance and relevance of the topic resulted in large numbers of delegates (500), representing a remarkable number of countries (88). Furthermore, an impressive array of influential leaders in the spheres of medical education, policy making, educational institutions, regulatory authorities and external agencies, such as the WHO, WMA, UNESCO and International Federation of Medical Students Associations (IFMSA), were present. Their combined opinion therefore carried considerable weight. (van Niekerk et al, 2003 p.585)

As with the Edinburgh declaration, no explanation was provided about exactly what kind of endorsement these delegates gave, nor about what, if any, involvement they had in the development of the standards. Their mere presence at this meeting is used to promote the discourse of *endorsement*. In particular, the descriptions of delegates as being ‘influential’ and ‘impressive’ is noteworthy as a discursive device that transfers the authority and power of these individuals to the standards that they apparently endorsed through their presence at this meeting. The last sentence of the above passage is worthy of particular attention. Whilst it is undoubtedly true that the opinions of such a group does carry weight, this further emphasises the complete absence in this article, or indeed elsewhere in the published literature, of any process that was systematically used to gather their opinions. It is difficult to believe that 500 individuals from such a diverse group of different backgrounds and sectors would uncritically and uniformly endorse any statement or policy decision, and yet this seems to be the suggestion.

Furthering the tributes to conference attendees, van Niekerk et al (2003) describe them as “leaders and acknowledged experts in medical education and health care delivery”. Grant et al (2005) paint a more exclusive, but still complimentary, picture in their description of those who contributed to the development of the standards (broadly rather than only through the conference) as “members of the WFME international task force and selected advisors worldwide” (p.245). Karle (2008) also refers to this “international task force” (p.1042), and provides further detail here:

In developing the WFME standards, the Federation set up an International Task Force with members from all regions, selected on basis of their expertise and with geographical coverage an important consideration (Karle, 2010 p.14)

This passage makes it clear that it is the combination of both the expertise and geographical diversity of participants in this process that gives this representation authority. This seemingly anticipates that any challenge to the authority of WFME may come either on the basis that the representatives were not credible individuals, or that they weren't taken from a sufficiently broad range of countries to collectively be a credible voice of the global medical education community.

A further question that arises from this focus on representation is one of language. As highlighted earlier in this chapter, the translation of both the Edinburgh declaration and the WFME standards into other languages after publication was given much emphasis in contemporary writing. What, though, of the language(s) used in the development of these documents? As already highlighted, the conference that led to the Edinburgh declaration was attended by individuals from 67 countries (Warren, 1988) and the conference that 'endorsed' the WFME standards was attended by individuals from 88 different countries (van Niekerk et al, 2003). There is a complete absence of the consideration of language in these conferences or documents. As mentioned earlier, the use of representation in the discourse of *endorsement* has not focussed on meaningful engagement, and the lack of consideration of language is a further example of this.

It is entirely possible that language was, in fact, sensitively and proactively considered by WFME and non-English speakers given ample opportunities to contribute meaningfully. Even if this was accepted as true, it is still notable that this explanation is not part of this discourse, and thereby not considered an important feature of the representation that has taken place from non-English speaking countries. Said (1993) discusses the supremacy of the English language, describing it as:

...the lingua Franca for metropolitan Britain: global, comprehensive, and with so vast a social authority as to be accessible to anyone speaking to and about the nation. This Lingua Franca locates England at the focal point of a world also resided over by its power, illuminated by its ideas and culture, kept productive by the attitudes of its moral teachers, artists, legislators. (p.123)

Elsewhere, in discussing the relationship between language and power, he talks of "a tremendous international display of British power virtually unchecked over the entire world" (Said, 1993 p.127). The colonial history of the UK means that the very origin name of the Edinburgh declaration and its language are relevant to the apparent or actual authority it holds. What, for example, might have been the fate of this document if it remained otherwise unchanged but was called the Delhi declaration and was published in Hindi, or the Tokyo declaration and published in Japanese, or the Cairo declaration and published in Arabic? An entirely different set of arguments may have been needed to gain

authority, and the discourse of *endorsement* could have been infinitely more challenging to articulate and sustain.

## 5.6 Summary

The discourse of *endorsement* is dominant throughout the entire time period of this study, expressed through language of consensus, alignment, implementation, and representation. Through a process described by Foucault as ‘normalisation’, this discourse encourages those who are subjects of power to “internalise expected behaviours and learn these behaviours through acceptance of a discourse” (Perryman et al, 2018). Whilst *endorsement* is very clearly promoted by, and fuelled by, successive WFME Presidents and more broadly, from ‘Western’ voices, it is clear that over time, they have also been repeated and reaffirmed by writers from Eastern countries. In promoting global approaches to medical school regulation as both accepted and widely adopted, it can be framed as clearly hyperglobalist in its perspective.

‘Argumentum ad populum’ is a Latin phrase meaning ‘argument to the people’, and in argumentation theory is recognised as a logical fallacy that occurs when something is considered to be true or good solely because it is popular (Melton et al, 1997). Whilst many popular ideas are valid, the mere popularity of an idea is not evidence of its validity (Dauer, 1996). As I have argued in this chapter, some claims of popularity in this discourse are not well evidenced or corroborated. But even if we accept the apparent popularity of ideas to globalise medical school regulation, it does not follow that they are necessarily valid, well thought through, or constructive. Nonetheless, this discourse remains dominant for a significant period of time and is a major part of the case presented in favour of these approaches.

The discourse of *endorsement* can be conceptualised as a means of exerting what Foucault described as ‘disciplinary’ power. This power is partly gained by the volume of individuals who have been involved in the development process – as argued through the notion of representation, partly gained by the numbers of countries who have engaged – as argued through the notion of implementation, and partly gained by the calibre of institutions and ideas that it is associated with – as argued in ideas of consensus and alignment. In sum, these arguments project WFME and ECFMG as popular and authoritative forces within the world that command the respect of key individuals and institutions in the medical education community. It also projects them as being ‘on trend’ with influential organisations and ideas of the time, using this association to support their own position and policies.

Foucault’s approach allows us to understand why “a particular experience arises at a certain historical moment and not another” (Stoller, 2009, p.708). Foucault (1979) argued that subjectivity is



constituted through complex relations of discourse and power. In this context, power is productive, or generative. When considering the discourse of *endorsement* through this lens, it is clear that it is generating a position of authority for these policies and creating a set of circumstances in which it is difficult to argue against them. Put simply, the discourse of *endorsement* is shaping a view of global regulation as inevitable and as enjoying widespread support and a clear mandate. Seen through the lens of Foucauldian 'disciplinary' power, the discourse of endorsement is classically 'normalising' in that it exerts control by creating a persuasive image of a social structure (Perryman et al, 2019).

Said (1979) outlines how he sees 'discursive formations' to be constituted by a collective body of texts that each support one another:

The unity of the large ensemble of texts I analyze is due in part to the fact that they frequently refer to each other: Orientalism is after all a system for citing works and authors. (p.23)

He goes on to give an example in which French writer Gérard de Nerval cites the work of the authoritative figure Edward William Lane, and states about Nerval's motives: "it is to use Lane's authority to assist him" (p.23). In other words, Said, like Foucault, recognises that authority and power are borrowed from others through association. Said specifically links this to imperialism, and the way in which this is sustained by practices of writers endorsing each other through citations. One might argue that the discourse of *endorsement*, outlined in this chapter, is an example of this, in that it associates various dominant western ideas together and forms what Said described as a 'discursive formation' of interlinked ideas and practices.

## **6. The discourse of *modernisation***

### **6.1 Introduction**

Like the discourse of *endorsement* covered in the previous chapter, the discourse of *modernisation* is dominant throughout the entire time period of this study, and is similarly used to promote and justify globalising ideas and practices.

Modernisation has been extensively studied and theorised. Giddens (1990) has been a notably influential contributor to this scholarly debate, and describes modernity as the institutions and modes of behaviour established in post-feudal Europe. He describes a complex interplay of factors that contribute to this new form of society, including the type and nature of modern institutions. Giddens (1990) highlights that standardisation and globalisation have been important components of modernisation as they have allowed more seamless interaction between people.

In contrast to Giddens' ideas of modernisation as a phenomenon that emerges in Europe due to particular economic and social circumstances, Said (1993) sees it as part of the more sinister impact of Orientalism on the Western mindset. He conceptualises modernity as a means for Westerners to disassociate the East with normalcy and civilisation. In seeing themselves as modern, he argues that Western countries have been able to lay claim to acts of 'civilising' and 'modernising' the rest of the world. As McCain (2017) highlights in his biography of Said, imperialism has 'scarred the world' in such a way that we must actively remind ourselves that modernisation is not synonymous with 'westernisation'. It is Said's, and not Giddens' conceptualisation of modernity that shape my analysis in this chapter.

This chapter describes the discourse of *modernisation* and the ways in which it was used to validate global approaches to medical school regulation. The discourse plays out through three key ideas (reform, development, harmonisation), and although these are interlinked, they are each considered in turn through this chapter.

### **6.2 Modernisation by reform**

According to Pollitt and Bouckaert (2011), reforms are deliberate changes to structures and processes of organisations with the objective of improving their performance in some way. Although modernisation is sometimes used to mean the outcome of reform, the two terms are often used synonymously, including in influential publications within medical education (Ten Cate, 2007; Patricio and Harden, 2010).

The Edinburgh declaration was the first attempt to define universal aspects of quality in basic medical education and makes it clear that it seeks to bring about reform:

Reform of medical education requires more than agreement; it requires a widespread commitment to action, vigorous leadership and political will (WFME, 1988)

Ramalingaswami (1989) mirrors this language, talking about “the reforms defined in the Edinburgh Declaration” (p.328), as does Warren (1988), who describes it as a “campaign to reform medical education” (p.462), and Menken (1991), who frames the measures as “desirable for reform” (p.361). These examples, though, are the exception, as the vast majority of texts from this time did not describe the declaration as being reformative. This idea did re-emerge, though 30 years later, as the Edinburgh declaration was commemorated in a dedicated special issue of the journal *Medical Education*. Here, descriptions of the declaration as reformative resurface and are particularly prominent. In his editorial introducing this special issue, the editor-in-chief of the journal firmly sets this tone:

The city of Edinburgh’s reputation and influence is highly disproportionate to its size. Known, among other things, as the site of the world’s largest annual international arts festival and for its architectural and geographical beauty, Auld Reekie or the Athens of the North has a long and rich history of promoting developments in science, literature and engineering. It should come as no surprise then that Edinburgh played a central role in efforts to modernise and improve medical education. In this issue we commemorate and reflect on the 30th anniversary of the Edinburgh Declaration (Eva, 2018 p.1)

Several other contributors to this issue also frame it as a historic moment of reform that had a profound impact on the field. Sargeant et al (2018) refer to the recommendations that are “listed in the Edinburgh Declaration’s call for reform” (p.126), whilst Nair and Fellmeth (2018) describe a “commendable transformation” (p.25) of medical education, although extending this reforming agenda to the Flexner report. Irby and O’Sullivan (2018) meanwhile, despite urging education scholars to go further than they have already, still feel that the goal is to “achieve the vision articulated in the Edinburgh declaration” (p.64).

2018 also saw the first commemorative publication about the Edinburgh declaration by WFME, describing the declaration as “ground-breaking” (WFME, 2018):

The Edinburgh Declaration was followed by a surge of reform worldwide greater than any since the start of the 20th century, and the Declaration remains an essential basis of reform and reorientation of medical curricula worldwide. (WFME, 2018)

An important consideration here is the causative assumption made in this sentence. The suggestion is that all reform that happened in the years following the Edinburgh declaration can be attributed to it. A basic and fundamental principle of all scientific enquiry is that association does not equal causation. In other words, the fact that changes took place in the years following the publication of this document is not evidence that this document led to those changes. A considerable number of influences dictate change in medical education, including those from within healthcare, from higher education, from scientific research, and beyond. As no attempt is made to reference or justify this statement, this claim seemingly serves to advance the discourse of *modernisation* by tying the declaration to contemporary changes in medical education policy and practice.

It is worth examining these reformatory claims about the Edinburgh declaration made in 2018 in the context of how it has appeared in the academic literature. In the years following its publication in 1988, there were a few dozen publications that cited the Edinburgh declaration, including a significant subset that were outspokenly critical of it. It was then cited extremely infrequently for almost three decades until this 30-year anniversary point. This is in stark contrast, for example, with Flexner's report on the state of medical education in 1910, which had significant and tangible effects on medical schools and has been cited many thousands of times, and more consistently, since its publication (Whitehead, 2011). Of course, it is true that not all discussion includes citations and not all of medical education practice is captured in academic writing, so it is not possible to quantify the 'real' impact of the Edinburgh declaration. What is clear, though, is that the declaration seems to have been somewhat forgotten in the scholarly literature until this renaissance in 2018. Notably, since 2018, references to it have once again subsided. This suggests that it has not, in fact, been as impactful as asserted by WFME.

Moving on now to consider the first set of WFME standards and reform, and although these were published in 2003, plans to develop them were first published in a paper five years earlier (WFME, 1998). After describing the Edinburgh declaration as a "cornerstone" (p.549), the paper, authored by the Executive Council of WFME, sets out the next step of this journey:

The time has now come to focus the function of WFME in the direction of the individual educational institution. The first objective is to stimulate all medical schools to identify and formulate their own needs for change and quality improvement, by assessing their own strengths, weaknesses, potentials, capabilities and needs for change and reform. (p.549)

This is the backdrop under which it launches the idea of "international standards" (p.550), arguing especially about measurement and "use of comparison" (p.550) between countries. Reform, then, is a clear and stated goal of these standards from even before work on them had begun. Although

explicit language of reform is less prominent when the standards are eventually published, they nonetheless state they want to “stimulate... change and improvement in accordance with international recommendations” (van Niekerk et al, 2003 p.1050). Bezuidenhout (2005) uses similar language, describing WFME standards as “a lever for change and reform” (p.74), and in their report of a pilot evaluation of the standards, Grant et al (2005) also describe “reform” (p.245) as an aim of the standards programme. Writing about a “wave of reform in medical education” (p.101) in Ireland, Finucane and Kellett (2007) call the WFME standards “rigorous and highly structured” (p.102), celebrating their influence on the Irish medical regulator. Writing in an Iranian medical journal, Rezaeian et al (2013) link the WFME standards with reform on multiple occasions, including at one point predicting that they “will have a central role in reform processes and in promotion of efficient and transparent national accreditation systems worldwide” (p.153).

Language of reform also extends to the third period of this study, centred on the ECFMG ruling in 2010. Writing about the impacts of the ruling, Japanese authors Jego and Amengual (2017), for example, describe how the ECFMG ruling had “a major impact on medical education reform in Japan” (p.1101). Writing in an international medical journal, Akiyama et al (2020) corroborate this, describing how the ECFMG ruling “accelerated the reform of medical education in Japan” (p.172). Onishi (2018) paints a clearer picture of why this idea of reform in Japan is so strong, explaining that the ECFMG ruling directly resulted in the Japanese ministry of education appointing a “project team to promote and reform universities” (p.290) that would eventually establish a brand new accreditation agency to comply with the ruling.

Whilst still acknowledging the significant reform in Japan as a direct result of the ECFMG ruling, Saiki et al (2017) provide a more critical perspective on whether this reform is desirable. They draw on the Japanese philosopher, Uchida:

Therefore, Uchida considers that Japanese usually accept new global trends and concepts with an open mindset (without criticisms), to catch up with international standards (p.1016)

They consider a number of areas in medical education and dissect how global influences have taken effect in Japan, including the ECFMG ruling directly leading to the establishment of a new accreditation agency in Japan. Their conclusion includes the following noteworthy sentence:

As knowledge, educational terms, and models of medical education, which are mainly generated in the English-speaking countries surely contributes to the global progression of medical education, another view and wisdom should be produced and exported from non-English speaking countries for the equal collaboration (p.1021)

This stands out as it is a notable exception. Contemporary writing of this time is generally descriptive, using the language of reform to uncritically describe a series of events that took place outside of Japan, and led to significant activity within it. Although the two quotations highlighted above are themselves exceptions in that they are swimming in the sea of a seven page article that is otherwise completely technical in its content and descriptive in style, they are nonetheless important. As Said (1993) outlines, the purpose of contrapuntal analysis is to highlight and amplify voices of opposition. Whilst still acknowledging the reformative nature of this U.S. policy decision on Japan, the authors offer a gentle and understated challenge against it.

### **6.3 Modernisation by development**

As well as language of reform, the discourse of *modernisation* also contains language and ideas of development. In the post-war period, development has been the guiding policy principle in developing countries, especially in economics and politics (Omar, 2012). Throughout this time, a plethora of advisors and organisations have been mobilised to help these countries achieve the ‘promised land’ of economic growth and security. The development ‘grand narrative’ describes a pervasive assumption that this development would only be possible through the intervention of the developed world (Rigg, 2009).

In recent decades, there has been much criticism of the entire development enterprise. Escobar (2000) points out that the consensus around it gradually began to erode due to the rise of movements that questioned its rationality, as well as intellectual criticism that used post-structuralist arguments to cast serious doubt not only on the feasibility but also on the desirability of development.

In the context of Said’s *Orientalism* (1979), the dichotomy of development and underdevelopment has determined most interactions between the West and other regions, in which the West defined itself as the contrasting image of the underdeveloped world in the same way in which the Orient was constructed as Europe’s spatial Other. As Omar (2012) highlights, like the orientalist discourse, development is another style of Western knowledge designed for dominating, restructuring and having authority over the underdeveloped world. Said charged the discourse of development with excessive Eurocentrism, questioning its continued relevance to the study of non-Western societies. He understood this as part of a strategy to preserve Western hegemony, rationalise relationships of exploitation, and ignore external determinants of ‘underdevelopment’ (Mirsepassi, 2000).

The very first sentence of the Edinburgh declaration contains imagery of underdevelopment:

Thousands suffer and die every day from diseases which are preventable, curable or self-inflicted and millions have no ready access to health care of any kind. Such facts have

produced a mounting concern in medical education about equity in health care, the humane delivery of health services, and the cost to society (WFME, 1988)

The descriptions of inadequate healthcare access and delivery that is not 'humane' does not seem to take aim at the local healthcare provision in the city of Edinburgh, where the declaration was made, and where the UK National Health Service provides equitable healthcare services to the local population. Rather, it seems to allude to more distant lands, such as those in the East, that require development to reach these heights of civilisation. Text from further on has a similar effect:

The aim of medical education is to produce doctors who will promote the health of all people – not merely deliver curative services to those who can afford it, or those for whom it is readily available. That aim is not being realized in many places despite the enormous progress that has been made during this century in the biomedical sciences (WFME, 1988).

Here again, the focus on affordability and on contrasting the scientific 'progress' of the West with the lack thereof elsewhere, accentuates the gulf between developed and underdeveloped world regions. Through this emphasis on biomedical sciences and universal health coverage, there is what Mirespassi (2000), drawing on Said's work, describes as a new identity being 'seized by means of contrast' and later calls 'the dark side' of modernity, both intellectually and politically. In listing its recommendations, of which there are eleven in total, the declaration uses the word "improvements" (WFME, 1988). In the context of the background text that contrasts different world regions in terms of 'progress' and development, the inference here is that these improvements are really needed in, and designed for, underdeveloped countries. The fact that this declaration is named after a city in Britain and is calling for these 'improvements' furthers the notion that the intention is to support countries to 'catch up'.

Of the eleven 'improvements' that the declaration suggests, eight "can be achieved by actions within the medical school itself", whilst the remaining three "require wider involvement" (WFME, 1988). Within the eight targeted at medical schools themselves, five are what might be considered as structural, in that they suggest changes to placements, admissions, and curriculum coverage. A further three, though, deal with more fundamental educational approaches:

[Improvement #2] Ensure continuity of learning throughout life by shifting emphasis from the didactic methods so widespread now to self-directed and independent study as well as tutorial methods.

[Improvement #3] Build both curriculum and examination systems to ensure the achievement of professional competence and social values, not merely the retention and recall of information.

[Improvement #7] Integrate education in science and education in practice using problem solving in clinical and community settings as a base for learning. (WFME, 1988)

What is notable about each of these three ‘improvements’ is their alignment with Western educational norms. It is widely acknowledged that education methods reflect cultural and ideological values (Wong, 2011). The three ‘improvements’ listed above, when read together, speak to moves towards a ‘self-directed’ method of education that prioritises ‘problem solving’, and moves away from ‘recall of information’. Problem-based learning (PBL) is an educational approach that gained prominence in medical education in the decade prior to the Edinburgh declaration (Neame, 1981; Barrows, 1989) and aligns almost perfectly with these three ‘improvements’. It differs from more ‘traditional’ approaches to teaching in that the participants are encouraged to use self-directed learning skills (placing emphasis on a person’s ability to seek out and assimilate relevant information) to analyse a given clinical scenario, formulate and prioritise key learning objectives within that scenario, and collect whatever additional information they think will be needed to address those objectives (Kilroy, 2004). Crucially, all this takes place within a group setting, so that each individual member of the group contributes to the learning process at every stage. As Frambach et al (2012) highlight, the widespread adoption of PBL has not been universally successful, and they summarise a growing number of studies that have examined this:

Rooted in Western culture, student-centred, problem-based methods may not be of a truly international nature and their compatibility with non-Western cultures has been questioned (p.739)

Bleakley et al (2008) highlight why this is a problem:

There is a danger, as the universalising agenda is pushed forward, that proponents of certain learning methods (particularly problem-based learning [PBL]) and certain educational frameworks (such as competence) will increasingly see them as ‘essential’ and unquestioned parts of the curriculum. As this tendency becomes widespread throughout medical education, these key aspects of the Western curriculum will become, like the Big Mac, ubiquitously present (p.268)

Seen in hindsight, one may interpret this to mean that the Edinburgh declaration promoted the widespread adoption of an educational practice that proved to be detrimental to some in the East.



Seen through a Saidian lens, this could be interpreted as Western knowledge being used to restructure the underdeveloped world. Rather than pay attention to the cultural values of the East and examine the suitability of 'spreading' such a method from West to East, or even suggest that further research is required to explore the potential consequences of such adoption, it is instead formalised in a ceremonial declaration that has used the various discourses outlined in this study to give it authority. In this case, with the widespread adoption of PBL internationally and the subsequent harms that come with this, this apparent developmental activity may actually have had a net effect of worsening, rather than improving, the state of medical education worldwide.

Clearly, this critique of the Edinburgh declaration is only possible in hindsight, and as Hodges and Segouin (2008) point out, international, comparative research in medical education was almost completely non-existent at that time. Indeed, at the time of its publication, there was much excitement about the developmental potential of the Edinburgh declaration. Sudanese authors Abdel Rahim et al (1992), for example, are hopeful that it will help them to try out new innovations:

It will mark the first step in a long road to win the minds in traditional circles and consequently the main stream of the medical profession. (p.234)

This enthusiasm for adopting a Western version of 'truth' is worthy of attention. Drawing on Said's work, Rizvi and Lingard (2006) provide an explanation for this:

It points to the powerful role that hegemony plays in processes of colonial subjugation, which requires, at a general level, the consent of the colonized people, expressed through their general acceptance of the hegemonic discourses. It underlines the importance of understanding such discourses within the broader context of the power configurations that they often help reproduce. (p.298)

It therefore follows that in order to understand why these authors apparently naively accepted the developmental promises of the Edinburgh declaration, one must understand the overall power dynamics at play here. As outlined in this study, a number of powerful discourses beyond the one described in this chapter are used to give authority to the Edinburgh declaration. As Foucault (2003) makes clear:

Power cannot function unless knowledge or rather knowledge apparatuses, are formed, organized and put into circulation (p.33)

In particular, he sees the 'centralisation' of knowledge as an important mechanism for gaining this power as it allows the distribution of knowledge to be controlled (Farrell and Lillis, 2013). Seen through this Foucauldian lens, one might argue that the mandate that WFME built, as discussed in the previous

chapter, is a means of 'centralising' knowledge about medical education through the Edinburgh declaration, moving it from individual countries to one single organisation. This centralisation provides a great deal of power to a small number of individuals and marginalises all other voices, including those that did not have the time, resources, or interest to visit Edinburgh and contribute to this process. In the context of Foucault's idea of 'disciplinary' power, this centralisation is also a means of 'exclusion' (Hook, 2007), in that it creates social barriers to those who are considered as legitimate arbitrators of 'truth' in the field of medical education.

Language about development continues to feature in texts published in and around the launch of the first set of WFME standards. Writing in a Singaporean medical journal, WFME President at the time of their publication, Karle (2008) sets out one of the key problems that necessitates these standards:

Some new medical schools... do not have clear missions and objectives of programmes, and often have insufficient resources, inadequate settings for clinical training and poor research attainment. (p.1041)

It is significant that the areas he has outlined here align with the key section headings present in contemporary education standards in Western countries. In other words, the fact that medical schools do not align with Western standards is problematised as an area for development. This is also furthered by U.S. authors Rizwan et al (2018) who instead of problematising low quality medical schools, take issue with "the quality and competency of these physicians" (p.1).

In a textbook on medical accreditation, Saudi Arabian author Abdalla (2012) advises that the WFME standards should "be used primarily as a tool for the development" (p.15), and Armenian authors Markosyan and Kyalyan (2008) also frame them as a means to help them in a 'transformation' project that the standards themselves have partly necessitated. However, it is once again the case here that this language finds its roots further West, as the idea of the standards being developmental had been suggested much earlier by Scottish authors Lilley and Harden (2003):

Standards are not primarily regulatory tools but they can be seen as a means of improving the quality of medical education in response to globalisation. (p.350)

Australian author Prideaux (2019) also describes WFME as providing international standards that "improve practices of medical education overall and assist countries that do not have robust systems of medical school accreditation" (p.27). This framing of WFME standards in language of 'improvement' and 'assistance' aligns with Said's thinking about the West conceptualising its engagement with the East as civilising and charitable (Ashcroft and Ahluwalia, 2008). The word 'robust' is also of note here.

The Oxford English dictionary provides a primary definition of this word as “strong and hardy; strongly and solidly built, sturdy; healthy” (OED, 2010). In other words, the key differentiator between countries is the ‘strength’ of their accreditation systems. Said demands a more democratic representation of the world, stating that ‘no race has a monopoly on strength’ (Said, 2000). Both Said and Foucault are clear that language is not neutral but rather it shapes the world we live in. The ‘robustness’ or ‘strength’ of a country’s regulation system is not measurable using objective criteria but rather is used rhetorically to help establish a contrast between countries that require ‘assistance’ and those that can provide it.

Many of the devices used to promote ideas of development in relation to the Edinburgh declaration and WFME standards continue to be used in relation to the ECFMG ruling. The first of these is the problematisation of the status quo on the grounds of quality issues. The establishment of low quality educational practices and medical graduates advances the idea that intervention, by means of the ruling, is justified. Tackett (2019) considers the options that the ECFMG has in light of the fact that events in the decade following the ruling had not played out as expected. He describes what might happen should the ECFMG choose to abandon the policy altogether in the following way:

Aspiring medical students could still enrol in predatory schools in places where those exist, and graduates from low-quality schools may enter the local workforce and provide suboptimal care (p.947)

This framing shows that one particular line of thought around the ruling is that it is a means of development to deal with a ‘problem’ of graduates from low quality schools. Although the article does not argue in favour of this, it does list it as one of three policy options that the ECFMG has, and even by laying it out as a viable option, it becomes a legitimate idea. From a Foucauldian perspective, it is crucial to understand the circumstances that lead to an idea being possible to raise. The quotation above can be read to mean that without the ECFMG ruling, schools would continue to be low-quality. In other words, without the intervention of the U.S., these schools would not be able to improve by themselves. This idea is promoted more forcefully by Deewan and Norcini (2020), who describe the ECFMG ruling as:

An important way to reduce the number of medical school graduates who should not be physicians by both raising standards and decertifying failing medical schools (p.339)

In arguing that the ECFMG ruling will raise standards, it promotes the notion of development, but the bolder and more remarkable suggestion that it will somehow police ‘failing’ medical schools is picked up in chapters 8 and 9.

The initial announcement of the ruling states that it will “improve the quality of medical education and health care worldwide” (ECFMG, 2010) and this idea is repeated both by the ECFMG in subsequent official publications (ECFMG, 2019), as well as by the ECFMG President (Cassimatis, 2013) and by authors representing the Foundation for Advancement of International Medical Education and Research (FAIMER), a non-profit organisation established by ECFMG (Boulet and van Zanten, 2014). Although this framing of the ruling as developmental is not used by the many Eastern authors who have written about it, it is seen in an article by Gibbs and McLean (2011), where notably, Gibbs is described in the declaration of interests as “Development officer at AMEE” (p.624). Revisiting Said’s conceptualisation of the dichotomous relationship between developed and underdeveloped, this portrayal of development exclusively by Western writers can be seen as a device to legitimise the ECFMG ruling and present it in an honourable light.

As was the case with both the Edinburgh declaration and WFME standards, the ECFMG ruling is also presented as a means of ‘improvement’. This is framed by the ECFMG in the following way:

The benefits of such an accreditation system also will extend to patient populations outside of the United States, advancing ECFMG’s overall mission of promoting excellence in international medical education (ECFMG, 2010)

This language portrays ECFMG, and by extension the U.S., as a global force for development. It is echoed in the academic literature, including through a statement that describes the ruling as “likely to benefit medical education internationally” (Rizwan et al, 2018 p.112) and another that states it will “foster greater transparency and ongoing quality improvement in undergraduate medical education (Shiffer et al, 2019 p.14). Both of these sets of authors are from the U.S., and all contributing authors of the second article are employed by ECFMG.

The framing of the ECFMG ruling as developmental is established only through Western voices, and the predominant voice is of the ECFMG itself. Said sees this kind of one-sided discourse as problematic and revealing. He articulates how “someone, an authoritative, explorative, elegant, learned voice, speaks and analyzes, amasses evidence, theorizes... about everything—except itself” (Said, 1993, p.

212). Given the complex series of events that have played out since the ECFMG ruling, it is not possible to say with any certainty whether or not it indeed ‘raised standards’, ‘improved international medical education’, or ‘promoted excellence’. What is clear, though, is that language about development was an important contributor to the *modernisation* discourse.

#### **6.4 Modernisation as harmonisation**

A third and final group of ideas that help to establish and sustain the discourse of *modernisation* are about harmonisation. Of course, harmonisation does not have the same linguistic meaning as modernisation, and harmonisation is simply one device or example of modernisation. However, the two ideas have been intertwined in recent decades. In the context of the medical education literature, the words ‘harmonisation’ and ‘modernisation’ have been used synonymously and in close association, by authors from various different parts of the world (Chan, 1999; Beastall, 2008; Georgantopoulou, 2009; van der Aa et al, 2016; Chekijian et al, 2020). The terms are also closely aligned in other sectors, including in areas as diverse as contract law (Hartkamp, 2003) and public accounting (Brusca and Condor, 2002). I argue, therefore, that language about harmonisation in these texts is an important part of the *modernisation* discourse.

In establishing the problem that it seeks to solve, the Edinburgh declaration suggests a definition of the aim of medical education, going on to note that this “aim is not being realized in many places despite the enormous progress that has been made during this century” (WFME, 1988). Inherent in this phrasing is a notion of inequality. It does not say that the aim is not being realised anywhere in the world. Rather, it provides a contrast between places that are meeting it and those that aren’t. In describing those that aren’t meeting this aim as ‘many’, this suggests that this group represents the majority of the world. In other words, a few countries have made ‘progress’, which is to be celebrated, and all other countries must now harmonise with them. As discussed earlier in this chapter, this dichotomising of the modern and the un-modern is characteristically orientalist in its approach (Said, 1979). However, not only does it ‘other’ the countries that have not met this stated aim, but it implicitly suggests that they must aspire to it through a process of harmonisation.

Ideas of harmonisation persist beyond the Edinburgh declaration and are present in language about WFME standards. In their description of the establishment of a new medical school accreditation agency in Korea, Yoo et al (2020) describe the central role that WFME standards played in this process, writing in the conclusion section of their article:

The WFME-centered international standardization of medical education has been developed to ensure the minimum quality of medical practice through a common accreditation system of medical schools. Accordingly, to raise medical education to the international level, evaluation standards corresponding to the international level must be developed (p.9)

Here, the harmonisation process is framed in terms of ‘raising’ to the ‘international level’. What is this ‘level’ that medical education must raise itself to? As demonstrated in chapter 5, within the discourse of *endorsement*, WFME standards were framed as ‘comparable’ to those in the West, particularly the U.S. regulator, LCME. Implicit here, then, is a need for countries to align with Western, or perhaps even more specifically, American, standards.

Earlier in this chapter, the example of Japan was considered, where a medical school accreditation agency was established directly in response to the WFME standards and ECFMG ruling. The quotation above, and particularly the use of the word ‘must’ suggests this is also true in Korea. The WFME standards have thus been successful here in asserting authority, as they have demonstrably shaped the way that both the Japanese and Korean medical education communities have conceptualised the establishment of their new accreditation agencies. Both of these countries have ‘harmonised’ and yet there is a complete absence of any consideration of unintended consequences of these new approaches on their countries’ medical schools. Both European and North American authors have acknowledged the unintended consequences of accreditation policies and practices (Prøitz et al, 2004; Ryan, 2005; Hunt et al, 2012) and North American authors have noted the lack of empirical evidence supporting the accreditation of medical schools (van Zanten et al, 2008; Tackett et al, 2019; Blouin, 2020). Both Japan and Korea have harmonised with the West and brought in to the idea of globalisation, but it is not clear what the impacts of this will be in the medium and long term future.

Ideas of harmonisation have on some occasions been articulated using related terms, including ‘standardisation’ (Hodges and Segouin, 2008; Price et al, 2018) and ‘internationalisation’ (Karle, 2006; Brouwer, 2020). These are used in similar ways to harmonisation. For example, in a discussion about the role of WFME standards in the ‘reform’ of Chinese medical schools, Jianyi (2008) argues for the need to “guarantee a higher quality of medical education and make sure that China's medical education is on the right track towards internationalization” (p.333). Likewise in a discussion of the impact of the ECFMG ruling on the Pakistani medical education system, Sethi and Javaid (2017) suggest “it can be seen as a stimulus to harmonize accreditation standards and procedures for promoting excellence in medical education worldwide” (p.1299). In both China and Pakistan, although the impacts are not as tangible as Korea and Japan, there is nonetheless a sense of ‘buy in’ to notions of globalising the regulation of medical schools and a belief that this will lead to positive outcomes.

A final topic that contributes to the idea of harmonisation is competency based medical education (CBME), defined as “an outcomes-based approach to the design, implementation, assessment, and evaluation of medical education programs, using an organizing framework of competencies” (Frank et al. 2010, p. 641). A key rationale for this movement has been “the need to reduce unacceptable variability in graduate abilities after medical training” (Langdale et al. 2003), although there have been compelling arguments about the potential harms of CBME (Grant, 1999), the lack of empirical evidence to support it (Klaman et al, 2016), its problematic theoretical underpinnings (Talbot, 2004), and the ‘revolutionary rhetoric’ used to promote it (Hodges and Lingard, 2013). Given the scholarly debate about CBME within Western medical education, it is notable, therefore, that both European authors (Sjostrom et al, 2019), as well as those from Bangladesh (Khanam and Chowdhury, 2015) and Pakistan (Iqbal, 2019), explicitly associate WFME standards with CBME. Given its focus on reducing variability, it aligns with ideas of harmonisation but more importantly, may be another example of a Western educational construct of debatable value being unwittingly ‘exported’ through the guise of *modernisation*.

Drawing on the work of Said, Woolf (2002) points out the problems with harmonisation in the context of international education:

Notions of globalisation and harmonisation are seductive because they appear to offer untroubled gateways to mobility and, thus, enhanced understanding of other cultures. In practice, however, the greater the mobility created for the relatively wealthy nations of the developed world, the greater the gulf grows between those nations and the poorer countries (p.5)

In the context of medical school regulation, might it be the case that the imposition of un-evidenced and contentious Western approaches is proving a distraction rather than an aid? In other words, in attempting to harmonise with the West, medical educators from the East may actually be aligning to goals that are not fit for their own context and paradoxically, rather than actually getting closer to the West, may be contributing to a growing ‘gulf’.

## 6.5 Summary

The discourse of *modernisation* remained dominant throughout the period of time covered in this study and was established and sustained through ideas and language in three areas: reform; development; harmonisation. The predominant perspective of the authors that have contributed to this discourse is hyperglobalist, in that *modernisation* is framed as a positive consequence of globalisation, and one that will improve medical education around the world. As has been outlined in

this chapter, perspectives that have been critical of the potential effects of globalisation have been notable and rare exceptions. On the few occasions these have been expressed, they have not made forceful arguments against globalisation in a sceptical way, but have aligned more with a transformationalist perspective.

The *modernisation* discourse frames those enacting globalising policies as 'modernisers'. For Said (1979), an Orientalist is somebody who considers themselves 'a hero' rescuing the orient from 'obscurity, alienation, and strangeness'. The imagery of underdevelopment in the Edinburgh declaration is an example of how WFME positions itself as a 'saviour'. Likewise, writing in the Iranian Journal of Medical Education, Walton (1993), then President of WFME, writes a history of medical education in Iran, outlining the 'inexorable tide of reform' that the Edinburgh declaration is bringing to the world. That an author from the West is writing a history of medical education in an Eastern country and for an Eastern audience can be framed as highly Orientalist, but more than this, it is a clear example of how the discourse of *modernisation* positioned WFME to play a heroic role in improving the world of medical education.

What purpose is served, though, by being a moderniser? Said believed situations should be seen as contingent and not inevitable, and as the basis of historical choices that were made. The framing of globalising practices as promoting modernity, and thus those who were enacting them as modernisers, is not accidental. Both Foucault and Said were interested in those who are marginalised, and in the power relations that led to their exclusion from the mainstream. The role of moderniser is a convenient one as it not only establishes a unidirectional knowledge exchange from West to East but it additionally frames it in a progressive light. To modernise is an honourable intention and one that is not easy to challenge. As Nettleton et al (2008) highlight, ideas of 'modernisation' within healthcare services have given rise to the 'scientific bureaucratic model' of medicine wherein clinical decisions and medical practice are rooted in externally legitimised knowledge and practices. They argue that policy rhetoric of modernisation draws upon 'nostalgic and nostophobic discourses' of outmoded working practices in order to substantiate claims for necessary change. The discourse of *modernisation* outlined in this chapter uses a similar approach of questioning the quality of existing practices and offering a bureaucratic and externally legitimised knowledge system with a powerful promise of reform and development.

A further benefit of taking on the role of moderniser is the ability to set the global agenda. Having made the case for necessary change, WFME and ECFMG propose an approach that aligns with Western standards. The result of this is to compel the world to harmonise with this. The relevance of this can be seen in the medical workforce. As will be examined in detail in subsequent chapters, one of the key



impacts of these globalising policies is 'managing' the movement of doctors from East to West. International medical graduates make up 25% of the U.S. medical workforce and other Western countries, including Canada and the UK similarly rely heavily on the inward migration of doctors from the East. Thus, by imposing Western approaches on the East, the *modernisation* discourse could also be conceptualised as a means for the West to safeguard its own medical workforce by ensuring that doctors entering from elsewhere are trained in a 'Western' style, helping their integration when they arrive. Further concerns about this westward movement of doctors, sometimes described as 'poaching' or 'brain drain', are examined in the next chapter.

The discourse of *modernisation* also compels engagement by drawing on fears of being 'left out' or 'left behind', described by Foucault as 'exclusion' (Hook, 2001). In framing itself as a moderniser, WFME empowers itself by playing on these fears. Drawing on postcolonial theory including the work of Said, Mayblin et al (2016) describe how modernisation is used to suggest "some countries are lagging behind the modern West and should catch up" (p.65). They go on to clarify that "lagging behind is implicated in lacking 'civilisation'." (p.65). In other words, as well as asserting the standards and approaches that should be used, the discourse of *modernisation* is also mandating engagement, and implicitly threatening exclusion from the 'international community' for countries that do not do so.

In the globalisation of medical school regulation, the discourse of *modernisation* can be conceived of as a facilitator of holding knowledge and power in the West, and enacting this power on those in the East. The discourse also allows this activity to be presented in an honourable and heroic way. It allows the West to impose its own practices and policies on the East, playing on fears of marginalisation in the event of non-engagement.

## 7. The discourse of *resistance*

### 7.1 Introduction

The discourse of *resistance*, examined in this chapter, is present in the early time period and absent in the later period. Unlike the discourses of *endorsement* and *modernisation*, the discourse of *resistance* is a counter-discourse, in that it challenges rather than promotes the status quo. In this chapter, I will argue that although the discourse of *resistance* is inherently more critical in its perspective, it does not overall support the idea that globalisation is harmful. Rather, it alludes to both intended and unintended consequences that require consideration. It is, therefore, predominantly transformationalist in its perspective rather than sceptical.

Both Foucault and Said were concerned with ideas of resistance. As education scholar Butin (2001) emphasises, it is not possible to understand Foucault's notion of resistance without understanding his notion of power:

The point that power relations are unstable is crucial. It avoids arguing that some individuals are active and control power while others are passive and controlled by power. Relations of power are shown not to be immobile but instead are prone to change and reversal. (p.168)

He goes on to explain, that for Foucault:

Resistance may take the form of running away or standing still, of saying no or not saying anything at all. Likewise, even the acceptance of the imposition, the lack of resistance, is an act. It may neither be helpful nor life-sustaining, but it is nevertheless an action within relations of power (p.168)

Likewise, Said was uncomfortable with tendencies to read domination and resistance through a singular interpretation of oppression that eliminates multiplicity and hybridity (Zhaoguo, 2013). Empire was critical to Said's understanding of contemporary global order. He argues that while it is largely true that direct colonisation ended in the middle of the twentieth century, "the meaning of colonial rule was by no means transformed into a settled question" (Said, 1986 p.44) and spirited intellectual debates over imperialist practices and their sustaining ideologies continue unabated within the formerly colonised world (Morefield, 2018). As highlighted in chapter three, contrapuntal analysis is an important Saidian device and relies on reading across an 'activated imperial divide' (Pratt, 1992). According to Said, it was simply never the case that the imperial encounter "pitted an active Western intruder against a supine or inert non-Western native" because "there was always some form of active resistance." (Said, 1993 p.52).

This chapter describes the discourse of *resistance* and the ways in which it was used to challenge and scrutinise global approaches to medical school regulation. The discourse plays out through three key ideas (oppression, repossession, opposition), and although these are interlinked, they are each considered in turn through this chapter.

## 7.2 Resistance to oppression

The language used in the Edinburgh Declaration is striking in its soberness and severity, including about death and failure. This serious tone is particularly striking in its bold closing paragraph:

By this declaration, we pledge ourselves and call on others to join us in a sustained and organised programme to alter the character of medical education so that it truly meets the defined needs of the society in which it is situated. We also pledge ourselves to create the organisational framework required for these solemn words to be translated into sustained and effective action. The stage is set; the time for action is upon us (WFME, 1988)

The use of the word ‘pledge’ projects a ritualistic, perhaps even religious, sentiment. The document describing itself as ‘solemn words’ adds to this ritualistic imagery, heightened by the theatrical metaphor of a ‘stage’ that is ‘set’. The overall character of this document, then, is of one emphasising its own importance through language that is both forceful and ostentatious. This serves to exert authority over the global medical education community, who are expressly the target audience.

Although the vast majority of texts of this era and beyond do not comment on this language, there are a few notable flickers of resistance. Unsurprisingly perhaps, given that this document is written in English, this linguistic criticism comes not from the Eastern world, but from authors within the country of origin of the document, the UK. Writing in the *British Medical Journal*, McManus and Wakeford (1988) critically examine a report of the General Medical Council in the UK but also comment on the Edinburgh declaration:

Some of the details of the council's report are curiously consonant with the Edinburgh declaration from the world conference on medical education despite the Edinburgh report reading somewhat like an educational revelation from St John the Divine (p.1051)

Opting for a more direct style and picking up on the grave tone of the document, they summarise that “the Edinburgh conference was in little doubt that medical education is up a gum tree” (p.1051).

In a letter published in *The Lancet*, Roddie (1988) is equally cynical, opening with “For people with a low tolerance of platitudes, meetings to reform world medical education can be taxing” (p.908). After providing some illustrative quotations from the Edinburgh declaration document itself, he goes on to

say “In the light of this bravura, the suggested reforms were prosaic”, outlining how they seem to make “little difference to the end product” (p.908). However, it is his critical examination of the language of the document that is most revealing:

A novel feature was to wrap up the recommendations as "The Edinburgh Declaration", presumably to give them the gravitas needed to match the occasion and signal to the less well informed how really important they were (p.908)

He follows up:

It might be argued that medical education is a solemn business, but I hope that is not so. Learning should be, and for most people is, fun, and training in medicine provides unparalleled opportunities for this in an amazing variety of settings. I got no feel from the declaration for the fun, enjoyment, and the intellectual and emotional satisfaction that courses in medicine have given to so many-nor for the way medical education has motivated so many people to spend their lives doing real and valuable work in improving all aspects of health care throughout the world (p.908)

This linguistic resistance by McManus and Wakeford (1988) and Roddie (1988), published in leading medical journals closely after the Edinburgh declaration, is significant for a number of reasons. Firstly, as both Foucault and Said recognise, it acknowledges that language is intimately connected with knowledge and power. These contemporary authors, who were part of the medical education community at the time of the declaration, picked up on this use of language to exert authority generally, as well as a specific worldview, and ‘called it out’. Secondly, despite the fact that these two texts that contain arguments of resistance are published in leading medical journals, they both use casual and sardonic language, providing further contrast to the language of the declaration itself. Thirdly, and perhaps most importantly, it highlights that within the country in which this declaration took place, it was ‘possible’ to resist. In other words, despite the use of the title ‘Edinburgh declaration’, the physical location of the WFME conference in Edinburgh, and all the devices of *endorsement* and *modernisation* outlined in the previous two chapters, the (lack of) domestic authority of this document meant it was acceptable for members of the medical education community to mock it through such formal channels. This is accentuated by the absence of authors from any other country in the world following suit. This resistance came from ‘close to home’ and not from further afield, suggesting that such criticism is only possible from those with privileged, Western positions. As outlined at the beginning of this chapter, both Foucault and Said shared a belief that resistance does not have to be active and one may infer that the resistance offered by these authors may well have

been shared by others when reading the document, despite the fact that they did not have the time, wherewithal, or conviction to articulate it so publically in medical journals.

Linguistic resistance is also seen in the context of WFME standards, and again is a minority and not majority position. In an article that challenged the medical education community using ideas from postcolonial theory, Bleakley et al (2008) point out that:

A curriculum may be developed by many people: but each has vested interests, particular ideologies and value systems which he or she brings to bear when judging whether such a curriculum has global applicability. The Western medical curriculum, seen as an international text, is steeped in a particular set of cultural attitudes that are rarely questioned. How can we be sure that modern global initiatives in medical education, which are largely advocated and funded by those in the 'modern, metropolitan West' who have the resources and influence to drive them through, are not just another type of 'domination by the advanced country over the developing nation'? (p.267)

They go on to talk more specifically about WFME standards and the language they are 'expressed' in:

While proponents of global standards acknowledge the need to respect local differences and celebrate diversity, they are at the same time promoting Western values, expressed in the language of 'core competencies' and the maintenance of equity through standardisation. Effort is directed towards establishing common outcomes within competency frameworks as global standards for accreditation. At its extreme, this emphasis on standardisation risks echoing the homogenising process of Western-inspired 'McDonaldisation'. In this case, however, what is being traded in the global marketplace is knowledge rather than hamburgers (p.268)

This article is salient in that it marks a disruption to what Foucault would describe as a "regime of truth" (Foucault, 2000, p. 132) – that is, that the WFME standards are part of a system of modernisation and not oppression. Until this point, these ideas had not been publically raised in the medical education community and one might argue that it was therefore not possible for them to be raised. So what was it that allowed this resistance to take place at this time? One possible explanation comes in the opening paragraph of their article. Before dealing with medical education, and eventually WFME standards, they open by referencing challenges raised about Western medical and biomedical knowledge being 'exported' to developing countries, described as a "global capitalist market in medical research" (Bleakley et al, 2008 p.266). This would not be the first time that medical education is empowered and legitimised in a particular direction by drawing on biomedicine – indeed, the

medical education community has been characterised as being in a perennial “paradigm war” (Bligh, 2003, p.184).

Of note, though, the article by Bleakley et al (2008) that offers this resistance is not targeted specifically at WFME standards but rather offers a broader critique of “the unconsidered enterprise of globalising the medical curriculum” (p.266). The fact that the article did not focus primarily on WFME, makes it more interesting then, that it drew a direct response from the WFME president (Karle et al, 2008). The first part of this response is conciliatory:

In a critical analysis of the global spread of innovations in medical education concepts and methods, Bleakley et al. rightly warn against the emergence of a form of neo-colonialism inherent in the practice of exporting ideas and methods of Western origin to other cultures in which their relevance may be limited. We agree that there are risks in the unthinking international transfer of higher education structures and processes. Such educational neo-colonialism is a particular risk when Western solutions are exported to countries with weak regulatory systems (p.956)

This soon changes to a refutation on the grounds that Bleakley et al (2008) misinterpreted the purpose of the standards:

The authors seem wrongly to identify global standard setting with necessarily introducing an international medical ‘core curriculum’ based on common ‘core competencies’ (p.957)

They go on to say that the standards should, in fact:

...be used as a template for the development of regional, national and institutional standards. The requirement that these standards be applied as a template in the context of local cultural and socioeconomic circumstances is an integral part of the Standards, which cannot be regarded as an ‘international text’, as described by Bleakley et al. (p.957)

In essence then, the WFME rebuttal is on the basis that the Bleakley et al (2008) paper was wrong on technical grounds, because they hadn’t described the recommendation that the WFME standards should be adapted for local use. This rebuttal seems to miss the point. Bleakley et al (2008) were clearly arguing that the mere presence of global standards was enough to give a clear message of homogenisation and to provide an ideological basis for the domination of Western approaches. The fact that these were designed to be adapted is entirely true and valid, but doesn’t negate the point that Bleakley et al (2008) were making about the message that a global standards programme sends to the world, and especially the effect this has on the formerly colonised world. Moreover, it later became apparent that some countries did, in fact, adopt the WFME standards directly with no

adaptation (Ho et al, 2017), which serves to undermine the position of Karle et al (2008) in this rebuttal. Overall, the response by Karle et al (2008) can be framed as a form of ‘silencing’. Whilst politely acknowledging the argument laid out by Bleakley et al (2008), it ultimately dismisses and delegitimises it.

In the years following this noteworthy article by Bleakley et al (2008), ideas from postcolonial theory do begin to appear in medical education journals (Gosselin et al, 2016; Whitehead, 2016; Alberti and Delgaty, 2017; Naidu, 2020), also in the spirit of resistance to oppression, although the examination of the WFME standards through this lens has remained conspicuously absent from the literature. It did, though, appear in an article published firmly outside of the mainstream of medical education literature, in the *Bangladesh Journal of Obstetrics & Gynaecology* (Khanam and Chowdhury, 2015). In their wide-ranging review article entitled ‘Globalization of Medical Education Curriculum’, the first half is descriptive and methodical, whereas the second half moves into a much more critical mode, drawing on Said and other postcolonial thinkers:

Western post-Enlightenment thinking lays prodigious highlighting on the term essential or core values, assumes that things have an indispensable quality that makes them different from other things. The precise question “What kinds of core educational experiences and essentials are required for global physicians?” is based in Western essentialist thinking, thereby illuminating a neo-imperialist bias. The linguistic of the international curriculum is controversial with itself. Whereas, supporters of global standards admit the need to respect local differences and praise diversity, they are at the same time encouraging Western values (p.40)

This type of critique is extraordinary because it is not visible in the many dozens of other articles published by non-Western authors about the WFME standards. Despite the critical tone of this quotation, the authors’ position does soften from here, with a later admission that there is, in fact, an “urgent need for the development of international essential requirements and standards in education” (Khanam and Chowdhury, 2015 p.41). It also charitably describes the potential for Western educators to continue the process of colonisation “despite their best intentions” (p.41). This tempering is the reason that this discourse fit more with the transformationalist rather than sceptical outlook on globalisation, as described in the opening to this chapter.

A further question arises about the fact that Khanam and Chowdhury (2015) published this article in a journal within their own country of practice, Bangladesh, and in their own clinical specialty, gynaecology. Although one might argue that they deliberately favoured their “own” audience as an act of defiance and local empowerment, this does not hold up when you consider the fact that much

of their arguments seem to be directly to a 'Western educator' audience, who would not read this journal. Another possibility is that their article was not accepted for publication in 'influential', Western-dominated medical education journals. This is highly plausible given that the scholarly field of medical education represents what social network analysts term 'a small world network' (Hautz et al, 2016) and diversity of international contributions remains low (Buffone et al, 2020).

In a study exploring medical school accreditation in Taiwan, South Korea, and Japan, Ho et al (2017) focussed particularly on the adaptation of global standards for local practice, a process they frame as "glocalisation" (p.1715), a portmanteau of globalisation and localisation. Despite being broadly supportive of accreditation conceptually, they do highlight the possibility of WFME standards being oppressive:

The cost of developing and implementing accreditation could lead the risk-averse with limited resources to over-rely on the example sets of standards produced by the WFME. Further guidance is needed on how to revise global standards in a manner that both responds to local contexts and meets international benchmarks. (p.1716)

They go on to provide detailed descriptions of how "each country followed its own rationale in adopting or adapting external standards" (p.1719) and urge medical educators to "reflect on the diverse sociocultural contexts in which global standards are applied" (p.1720). Although they don't explicitly use the term, their process of adaptation aligns with a form of 'hybridisation' or 'hybridity' that seeks to take 'the best of both worlds'.

While the notion of hybridity can simply be seen as any form of cultural mixing, postcolonial theorist Bhabha (1994) views hybridity as "how newness enters the world" (p.227). He suggests that the imposition of knowledge and power at the site of colonisation induces the colonised to mimic the coloniser as a form of resistance to hegemonic power relations (Bhabha, 1994). Hybridity is not a simple construction by one culture over another. Rather, it is constructed through a process of symbolic interactions between competing identities that both prevents them from being characterised into primordial polarities and entertains difference without an assumed hierarchy (Bhabha, 1994). Viewed in this way, hybridity produces distortions that often sabotage the original interests of the colonisers. Thus, the concept of hybridity is central to the articulation of postcolonial resistance to the exercise of colonial hegemony (Bhabha, 1994).

A further idea that appears in relation to oppression relates to the imposition of a Western world paradigm on the East. Writing about the Edinburgh declaration a year after its publication, New York



based UNICEF special advisor and Harvard visiting professor Ramalingaswami (1989), for example, refers to the “perpetual tendency to imitate the ‘best’ in the West” (p.330).

The paradigmatic dominance, though, is more obvious in texts about the WFME standards. In fact, it arises even before the first set of standards were published but when they were the topic of conversation in medical education conferences and led to the following reflection:

If standards are ultimately intended to upgrade the quality of schools and graduates worldwide, it would seem logical that they be set by those schools, experts or countries that already have high standards of their own in place. Here a problem arises. It would not work to simply impose standards from developed countries on to others, and perhaps it should not be attempted. (ten Cate, 2002 p.603)

Once the WFME standards were published, these ideas persisted. Reflecting on a pilot that trialled WFME standards during a visit to Fiji School of Medicine, Hays and Baravilala (2004) share the following observation:

The school also found that the Guidelines fostered a predominantly developed world paradigm of basic medical education, with little room for emphasising what was unique, special or innovative about a medical school curriculum in a less well resourced setting. (p.583)

Drawing on globalisation theory from disciplines outside of medical education, Hodges et al (2009) ask a pertinent question in relation to the WFME standards programme:

Is it possible to consider global accreditation without reverting to colonialism and all of the problematic baggage associated with homogenization and cultural dominance? (p.915)

It is worth emphasising here that although the three quotations above are taken from articles that relate in some way to international standards in medical education, none of the three articles deal primarily with WFME standards, they are instead mentioned in broader contexts. It is also important to acknowledge that whilst they all contribute to the discourse of *resistance* in that they raise concerns about the unintended consequences of globalisation, none of them outright reject the idea, and are therefore more transformationalist than they are sceptical.

These three articles, which challenged WFME for imposing a developed world paradigm, were published between 2002 and 2009 and the authors were from the Netherlands, Australia, and Canada, and not from the ‘developing world’ that they were defending. This is important because in the years that followed, resistance to WFME standards on the grounds of sociocultural oppression came from

authors from a wider range of countries, suggested that Western voices need to ‘open the door’ in order for more marginalised voices to be able to be heard. An example of this is seen in a later article co-authored by an academic from Jamaica that argues:

The often neglected but crucial question, therefore, is whether the path to the globalization of medical education lies simply in the import and export of instructional techniques and designs, in other words a technology transfer, or whether it also includes the adoption and acceptance of western models of social organization as applied to medical education (Stevens and Goulborne, 2012 p.685)

Likewise, a similar position is adopted by authors from Taiwan:

We argue that it is important to question the way medical education researchers talk about globalization and culture. Is Western culture being imposed through well-intentioned efforts to improve global medical education? By resisting participation in Western-led global processes, are non-Western researchers missing out on opportunities for mutually beneficial collaboration? Are Western-influenced non-Western researchers able to genuinely represent their respective local cultures in international fora? (Gosselin et al, 2016 p.696)

The resistance to oppression highlighted here is by no means the dominant discourse in the texts of this time. Rather, it represents the minority content in a minority of articles. As Said states, though, a contrapuntal reading of these texts requires that one to have “a simultaneous awareness both of the metropolitan history that is narrated and of those other histories against which (and together with which) the dominating discourse acts” (Said, 1993, p. 59). Viewed through this contrapuntal lens, then, these examples of resisting dominant discourses are crucial to understanding the power dynamics at play. Although the resistance is infrequent and not forceful, its mere existence in these texts is crucial to understanding the breadth of experiences.

### **7.3 Resistance as repossession**

A second facet of the discourse of *resistance* relates to repossession. Unlike the previous section, which dealt with oppression and included both Western and non-Western voices, the voices of repossession are, unsurprisingly, from non-Western voices.

Drawing on the work of Said, Journey and Mishra (2000) highlight that the “chief occupation of post-colonial writers” is to help the society “repossess its own history” (p.165). In another Said-inspired analysis, Bernard (2005) describes how the “repossession of a cultural space” can take place through the act of writing (p.66). Repossession has also been framed as “reterritorialization”, a process that

replaces the 'twofold citizenship' of colonial culture (Gandhi, 1999 p.111). Repossession, then, is a recognised form of resistance in postcolonialism.

Cameroonian author Monekosso (1993) portrayed the establishment of the University Centre for Health Sciences (UCHS) in his home country. He describes how the strategies it had adopted since 1969 “were later found to be in close concordance with the tenets of the World Conference on Medical Education held in Edinburgh in 1988, the Edinburgh Declaration” (p.304). He goes on to clarify that “some of the terminology may not have been worked out at the time” (p.304), but the ideas were nonetheless the same. The message is very clearly that UCHS were ‘doing this first’ and this is emphasised in the following passage:

Social conscience or social awareness, the need to adapt oneself to the varying physical, cultural and environmental needs of populations, and appreciation of the health needs of the human race as a whole and the whole person rather than the pursuit of medical science as a subject, are all new approaches stressed in 1969 by UCHS and by the Edinburgh Declaration in 1988 (p.317)

The continued emphasis on the years is worthy of attention. Put in simple terms, the article is saying that what was new to Cameroon in 1969 became new to Edinburgh in 1988, suggesting (although not explicitly stating) that it was actually the UK that was 19 years ‘behind’ Cameroon in this regard. The article is appreciably long, 16 pages in total, and provides a detailed description of each academic year of the UCHS programme, its assessment approach, its admissions processes, and so forth. This is significant firstly because it is written in a UK-based medical education journal, suggesting that the author was hinting that the ‘locals’ in the UK may benefit from this practical advice, and secondly, because except for the short but striking quotations I have provided above, the remainder of the article is understated in tone and does not come across as supercilious in any way. This aligns with Said’s “strategy of resistance” which entails an “enter[ing] into the discourse of Europe and the West, to mix with it, transform it, to make it acknowledge marginalized or suppressed or forgotten histories” (Ashcroft and Ahluwalia, 2001 p.109). Furthermore, Said asserts that writing back to the literature may lead to more humanistic communities where “cultural hybridity and multiple identities” prevail (Ashcroft and Ahluwalia, 2001 p.109).

An article from a Brazilian-based author, meanwhile, provides a different form of repossession (Almeida, 2001). Reflecting on the Edinburgh declaration over a decade after it was published, it emphasises the involvement of South America in the process of its development:

South American countries were fully represented at the 1988 WFME World Conference on Medical Education in Edinburgh. Implementation of the Edinburgh Declaration actively involved the South American countries and the Pan-American Federation of Associations of Medical Schools (p.796)

This continues later in the article:

The full significance of the vigorous participation by Latin American educators and leaders now became apparent. Both WFME World Conferences on Medical Education were dependent on the support of South American regional leaders for the definition of the Conference themes, for the preparation of the preliminary documents, for contributions during the global discussions themselves, and for the framing of the approved recommendations emerging from the global conferences. (p.797)

This framing is at odds with the findings of this study in chapter 5, where it was highlighted that although the discourse of *endorsement* emphasised that participants from many different countries were involved, there was a notable omission of any rationale for, or justification of, the mechanisms for meaningful representation into the Edinburgh declaration development process. The purpose of this framing by Almeida seems to be to assert the authority of the South American region, framing it as an important contributor to the international community – as a ‘giver’ and not a ‘taker’ of knowledge. This is summed up in a line from the article’s conclusion section: “Latin American medical education has also been influential in contributing to the world scene in medical education (Almeida, 2001 p.798).

Repossession also features as a form of resistance in relation to the WFME standards. Even prior to the first set of standards being published, Nepalese medical educator Jayawickramarajah (2001) highlighted the need for countries to ‘repossess’ their own autonomy and make decisions that fit their own context, using an example from medical practice to draw a parallel to education standards:

In remote villages in developing countries the use of ‘respiratory rate’ to diagnose ARI [acute respiratory infection] in children is considered a more realistic standard than a chest X-ray. Local contexts should be taken into consideration in defining standards for quality improvements in education. (p.515)

Even despite this resistance, though, there is a later recognition in the article that “providing essential guidelines on common concepts and principles are pragmatic steps towards a borderless enterprise” (p.515). As I’ve highlighted throughout this chapter, the concerns raised in these texts are moderated, and thus the counter-discourse of *resistance* is ultimately marginalised and prevented from becoming

dominant. Likewise in an article examining accreditation standards for medical schools in Japan, Korea, and Taiwan covered earlier in this chapter (Ho et al, 2017), concerns are raised but moderated. Despite urging “caution against oversimplifying the difference between the global and local contexts” (p.1720) in the context of developing standards, they do entirely accept the “the call for a global system of medical school accreditation” (p.1720) without fundamentally challenging it. These positions can all, therefore, be framed as transformationalist rather than sceptical.

Resistance through repossession can also be found in an article by Iranian authors soon after the first WFME standards were published (Einollahi et al, 2004). In their description of a pilot project that used WFME standards, they reflect that as well as using international standards, they consider it important that educators in Iran “think about nationally, regionally and locally specific needs and requirements in medical education” (p.63). Their concluding paragraph is particularly revealing:

The benefits of such activity in improving the quality of medical education are so great for all medical schools that the Iranian medical education authorities believe that even if this process does not lead to international accreditation, it will surely result in fundamental and essential changes and improvement in undergraduate medical education, in order to provide better services in different areas, especially public health. (p.64)

Although the bulk of the article is clearly positive about international standards, this final sentence repositions the entire endeavour as one that is being done primarily for the good of Iran and its public. Although ‘international accreditation’ is the clear framing for the entire article, finishing with this clear statement that it is not the goal is a subtle but powerful form of resistance. In so far as they do not challenge the idea that ‘international accreditation’ is desirable, the discourse of *resistance* cannot be interpreted as dominant here.

A comparative study of medical education systems in Korea, Japan, and China, similarly offers tempered resistance (Lim et al, 2007), suggesting the “three countries need a plan to standardize medical education compatible with international standards but one that differs from western medical education by incorporating traditional medicine” (p.271). Here again, repossession is seen in the resolve to ‘hold on’ to traditional medicine, although more radical resistance against international standards or globalising practices is not evident. Likewise in an article charting the last two decades of medical school accreditation in South Korea, Yoo et al (2020) do offer some resistance on grounds of repossession by actively resisting a minority of WFME standards that would not be compatible with the local context. However, the entire article is framed around the importance of engagement with WFME, both through the standards and recognition programme. Both of these examples, whilst

contributing to the counter-discourse of *resistance*, therefore represent transformationalist and not sceptical perspectives.

A final example of repossession comes in the form of resisting the westward migration of doctors. Commenting on WFME standards, Raj (2009) notes:

The provision of high-quality education in their own country will reduce the need for health care workers to travel overseas in search of internationally recognised higher-education courses, and will contribute to providing a skilled and sustainable workforce. (p.2)

Given that the international movement of doctors westward is a key policy factor driving these standards, as highlighted in previous chapters, this portrayal of standards doing the opposite is noteworthy. Much like the resistance from Iranian authors that their engagement with international standards was for Iran and not for any other country (Einollahi et al, 2004), we see here a similar notion of repossession by the representation of this work as being a service for the United Arab Emirates itself and not the rest of the world (Raj, 2009). Australian author Hays (2014), commenting on a revision of the WFME standards, furthers this idea that the local healthcare workforce should be a priority when considering the implementation of WFME standards:

However, care must be taken not to orient medical education in the developing world too strongly to European or developed world contexts, as this may reduce the relevance of medical education to local contexts where needs may be greater. It may be just as important to improve health systems and career structures as it is to improve medical education standards, if sustainable health workforce changes are to take place in the developing world. (p. 461)

These notions of repossession shift the emphasis from standards that are implemented in what Said would call the 'Western gaze', to implementation that is grounded in the priorities and interests of the local medical education communities. It is important to say, though, that the examples I have provided are an exception, as these ideas do not appear elsewhere. Given that the notion of 'brain drain', or professional expertise moving from areas of lower to higher development, has been widely argued both within medicine and medical education, its relative absence in texts about the globalisation of medical school regulation is important. It provides further evidence that the discourse of *resistance* is in fact a counter-discourse, that is not legitimised or widely expressed, and ultimately does not become dominant in this era.

## 7.4 Resistance as opposition

A final set of ideas that shape the discourse of *resistance* relate to opposition. By opposition, I mean resistance against dominant discourses of the era on the basis of challenging the assumptions and approaches that they rely on. It differs from oppression and repossession, covered already in this chapter, which relate to direct or perceived impacts of globalising policies and practices. Opposition, meanwhile, represents a more diverse set of challenges.

Commenting on the Edinburgh declaration, Roddie (1988) was uninspired by the recommendations it makes and felt that they would make 'little difference'. His critique was not on the basis of whether its recommendations were 'right' or 'wrong' but rather that he felt they would not be impactful. Goic (1993) also challenged on similar grounds, suggestion that the declaration "lacks internal consistency and falls short in new ideas to improve medical education" (p.78). A Lancet editorial (1988) contrasting the Edinburgh declaration with a GMC report in the same year was more direct in its criticism of the declaration:

This utopian happening was linked with the expectation of Health for All by the Year 2000, and reform was solemnly pledged. The Education committee of the GMC steer a less grandiose course in their report, avoiding complacency and fads as well as despair. (p.1346)

Each of these examples take issue with the declaration not because it is oppressive or colonialist, but rather because it is not considered to be inspiring or effective. Indeed, they raise no objections to its potentially authoritarian style or interpretation, which raises a question about whether or not they might have been more supportive about a better written, but otherwise similar, declaration. In other words, are they happy with the concept of the declaration and simply unimpressed by its execution? This is not clear from the statements but is certainly plausible.

Some criticisms of WFME standards have also been made. Jayawickramarajah (2001), for example, suggests that naming them 'standards' was inappropriate as the word has very different meanings within healthcare delivery. Hays and Garavalia (2004), meanwhile, found in a single case pilot of the standards that there was "duplication and overlap in some of the subsections", which "created confusion" (p.583). In a larger pilot of the standards, Grant et al (2005) found some "disadvantages", including time commitment, cost and data collection problems (p.246). These three articles were all published around the launch of the first set of WFME standards, all raise their opposition on technical grounds, and as they all draw conclusions that the standards are ultimately helpful, do not represent fundamental or insurmountable challenges. They are firmly transformationalist and not sceptical in their perspective.

Some opposition to the standards, though, is more ideological in nature. Writing about 'globalisation' and 'standardisation' in healthcare including WFME standards, Segouin et al (2005) pose the following set of questions:

To what extent can one be sure that international standards can be created that will fit the cultural, social, and economical contexts of very different countries? It is often assumed that, simply demonstrating compliance with quality processes, will lead to a result (of the education or of the treatment) that will be the same, whatever the country or the professionals involved. But to what extent can we be sure that applying, for example, North American (or European, or for that matter African or Asian) procedures and quality rules in other countries will lead to adequate quality? (p.278)

Their opposition partly relates to assumptions about the unintended consequences of imposing standards across different cultures, but also partly about the validity of this approach more generally. They are not simply saying that the standards may not be suitable for use everywhere but rather that even if they were used everywhere, it may not have the desired effect. Likewise, Pulido et al (2006) also pick up on this assumption in their description of accreditation standards in South America, including the influence of WFME standards, by noting that "little is known about the real and measurable contribution to or impact of institutional accreditation on the improvement of medical education" (p.25). An international scoping review of medical school accreditation published more than a decade later concluded that "limited evidence exists to support current accreditation practices" (Tackett et al, 2019 p.2000), suggesting these questions continue to remain unanswered.

In an article co-authored by medical educators from several Asian and African countries, assumptions about existing accreditation practices in the developing world were challenged:

Accreditation systems in several developing countries are similar to those in the developed world (Cueto et al, 2006 p.208)

This seems to directly oppose the discourse of *modernisation*, covered in the previous chapter, by suggesting that the East is not in need of 'development', 'modernising', or any other 'civilising' input from the developed world. The authors do, however, go on to frame these systems as having 'spread' from "countries such as the USA" (p.219).

In a critical discourse analysis of global medical competency, meanwhile, Martimianakis and Hafferty (2013) situate the WFME standards within a discourse of 'the universal global physician', which they describe in the following way:



The majority of western contemporary medical educational activity we encountered in our archive operationalized the assumption that medical practice transcends geographical and cultural borders. Much of this activity was centered on developing curricula that standardize physician training. This was a dominant thrust in our archive, which we labeled: discourse of the universal global physician. (p.34).

The opposition in this paper is on the grounds of the ideological assumptions that are inherent in any educational practice or construct that claims to be 'international'. Gosselin et al (2016) argue along similar lines, noting that "global dynamics have fostered assumptions about the universality of medical culture and the possibility of developing global standards for medical education" (p.691). These challenges provide a resistance that is more fundamental and existential than others within this discourse. Rather than alluding to potential unintended consequences or perceived weaknesses within the standards themselves, they question their very premise. Ultimately, these arguments are not developed further in either of these articles. That these observations have been made, though, is significant. Firstly, it accentuates the fact that in the vast majority of other articles on this topic, this existential challenge about international standards was absent. Secondly, and perhaps more importantly, it demonstrates that when viewed through the lens of Said's contrapuntal analysis, despite the infrequency and modesty of the arguments, these opinions do exist and questions are being raised. Given the power dynamics of academia and the relative 'power' that authors from different backgrounds have to share their ideas, one might deduce that the 'true' resistance on these grounds is significantly greater than what is captured in these few quotations.

## 7.5 Summary

The dominant discourses of *endorsement* and *modernisation*, outlined in the previous two chapters, were opposed by the counter-discourse of *resistance*, outlined in this chapter. This counter-discourse is not immediately obvious but is discernible through contrapuntal reading of the texts in this period. It was formed by a response to the perceived oppression of globalising forces, through a process of repossession by non-Western communities, and by opposition to globalising policies and practices on technical and ideological grounds.

As highlighted in this chapter, the discourse of *resistance* appeared only infrequently, never as the main subject of an article. Even when it did appear, it was regularly moderated by opposing, and sometimes contradictory, statements. This gives the impression that the authors had to restrain themselves in order to be 'allowed' to raise their concerns and challenges. The result of this moderation is that the perspectives presented are more transformationalist than sceptical, although

this is nonetheless in contrast to the clearly hyperglobalist perspectives that dominated the two discourses covered in previous chapters.

Perhaps the most important factor in considering this discourse is that ultimately, it did not prevail. What I mean by this is that despite the resistance outlined in this chapter, the policy directives of globalising medical school regulation continued to roll out. There is no indication that these challenges caused policymakers, including those at WFME and ECFMG, to change their positions or decisions. Indeed, as covered in this chapter, there was instead a firm rebuttal from WFME (Karle et al, 2008), which interestingly came in response to perhaps the most forceful and compelling article of resistance, authored by Bleakley et al (2008). The fact that WFME chose this article to respond to is worthy of attention. Of all the texts that contain the discourse of *resistance*, this article was the closest to being sceptical in its perspective and perhaps this is why it drew a direct response from WFME. The others, which were more clearly transformationalist, may have been perceived as less threatening in their resistance.

Another pattern that emerges in this discourse is temporal. Overall, the discourse of *resistance* was established by Western authors much sooner than it was by those further East. Why should this be the case? Foucault was interested in the social conditions that allowed certain language to be used, and actions to be taken, in different eras. In other words, he encourages consideration as to why it was possible for certain ideas to be expressed at a particular time. I argue that the resistance raised by Western authors legitimised the practice of challenging international 'authorities' within medical education, thus empowering others in more marginalised positions to follow suit.

It is important to acknowledge that the discourse of *resistance* does not rest exclusively on a single issue or cause. Some resistance is on the basis of language, some on the basis of effectiveness, some on underlying assumptions, and some on technical grounds. The biggest contributor, though, is on the grounds of cultural domination and the imposition of western paradigms on the rest of the world. This type of postcolonial resistance is encouraged by Said (1993):

Between classical nineteenth-century imperialism and what it gave rise to in resistant native cultures, there is thus both a stubborn confrontation and a crossing over in discussion, borrowing back and forth, debate. Many of the most interesting post-colonial writers bear their past within them—as scars of humiliating wounds, as instigation for different practices, as potentially revised visions of the past tending towards a new future, as urgently reinterpretable and redeployable experiences, in which the formerly silent native speaks and acts on territory taken back from the empire (p.34)

It is certainly not the case that the resistance described in this chapter can be portrayed as the kind of 'stubborn confrontation' that Said celebrates. Perhaps, though, it is the beginning of a journey towards this vision, in that it certainly seeks to reinterpret experiences and 'take back' agency about how globalising practices should be applied in local contexts.

Said also says, though, that "...in the overwhelming majority of cases, the resistance finally won out" (1993, p.52). This cannot be said of the resistance outlined in this chapter. As already outlined, this resistance did not change the policy direction. That the postcolonial resistance outlined in this chapter has been patchy, watered-down, and not directly primarily at WFME, may explain why this is the case. Had the medical education community in Eastern countries collectively adopted the style of Said's 'stubborn confrontation' more aggressively, would this have changed the course of policy events in this area?

A final point on the discourse of *resistance* is that it does not extend throughout the time period of this study. Rather, it is most noticeable in the early time period and then fades away. Whilst this is true of the publication date of articles, it is more apparent when considering the target of the resistance. All the articles that promote the discourse of resistance covered in this chapter target the Edinburgh declaration and the WFME standards, which as outlined in chapter three, form the first two nodes of this study. The third node, the ECFMG ruling, is completely missing from this discourse. That is to say, there is no explicit resistance offered against the ECFMG ruling in the same way. This is significant because it is the ECFMG ruling that has the most significant policy impact on the world and also because it is the most recent event in time. One might expect, therefore, that resistance to this would be greatest, on the grounds that it was potentially the most directly impactful, as well as because one might expect resistant voices to become more empowered over time. I will revisit this in chapter 10.

Whilst the Edinburgh declaration and WFME standards are from an international agency that is seemingly 'global' in its mandate, the ECFMG ruling is the policy of a single country, the U.S., albeit that it links back to the 'global' authority and processes of WFME for its implementation. The resistance to a 'global' imposition may be perceived as being more relevant than one from a single other country, even if that country is the U.S., a nation that Said (1993) strongly associates with 'cultural imperialism'.

I argue that there is a discursive shift away from *resistance* and toward *protection* and *control*, which become dominant in the period of time following the ECFMG ruling, and are examined in detail in the next two chapters.

## 8. The discourse of *protection*

### 8.1 Introduction

The final two discourses which I present about global approaches to medical school regulation are of *protection* and *control*. These are present in the later period of the study, and are examined in the following two chapters. I argue that a discursive shift takes place, as *resistance* makes way for *protection* and *control*.

This discursive shift coincides with an important change in events. Whilst the Edinburgh declaration and WFME standards are expressly global in their scope, the ECFMG ruling relates to a single country. A further difference is that both of the earlier events, the Edinburgh declaration and the WFME standards, can be seen as 'optional', whereas the latter event, the ECFMG ruling, is more 'compulsory' in its tone. What I mean by this is that the Edinburgh declaration simply sets out areas for improvement within medical education, and likewise, the use of WFME standards is voluntary. The ECFMG ruling, however, gives an ultimatum. It demands engagement, in the form of accreditation agencies cooperating with the WFME recognition programme before a specified date, with real consequences if this is not met. The consequences of not doing this is that graduates from schools accredited by these agencies will not be eligible for ECFMG certification, meaning the possibility of pursuing postgraduate medical training in the U.S. would end. This proviso, therefore, is fundamentally different in nature than both the Edinburgh declaration and WFME standards.

The fact that many doctors around the world have an ambition to train and practice in the U.S. is central to understanding the discourse of *protection* and indeed, the discursive shift away from *resistance* during this period of time. Whilst the Edinburgh declaration and WFME standards may have been construed as ideologically oppressive, they could ultimately be ignored by policymakers, educators, and individual medical trainees and doctors. The ECFMG ruling, though, is more difficult to ignore given that it has very real implications on people's lives and careers, and also because of its apparently firm deadline.

The discourse of *protection* serves to justify globalising forces in medical school regulation on the basis that they are preventing harm. Protectionism is an idea that has its roots in economic policy, and refers to regulations that restrict imports from other countries. Most economists agree it has a negative effect on economic growth. Drawing on the work of Said and other postcolonial thinkers, Pennycook (2002) frames protectionism as "a crucial strategy of definition, segregation, and separation" (p.21) and goes on to argue that:

Protectionism becomes part of the process of the construction of the Other, even being part of a movement to define exactly who is in and who is out (p.22)

In the context of global policies, such as those examined in this thesis, the discourse of *protection* can therefore be conceptualised as orientalist, as will be examined further throughout this chapter.

This chapter describes the discourse of *protection* and the ways in which it was used to promote global approaches to medical school regulation. The discourse plays out through three key ideas (protecting the public, protecting students, and protecting against foreign medical schools), and although these are interlinked, they are each considered in turn through this chapter.

## **8.2 Protection of the public**

A common notion in the discourse of *protection* is that of protecting the public. Language about the WFME standards, and even more frequently in relation to the ECFMG ruling, suggests that they each have a role in promoting public safety. Whilst in the earlier time period, the protection of the public is inferred, in the later period it becomes more explicit, as I will outline below.

In texts that focus primarily on WFME standards, the discourse of *protection* appears in the context of the migration of doctors. Whilst a few papers go on to make the link between doctor migration and public safety, others signal at this implicitly without firmly hypothesising a mechanism for it. In describing a global curriculum for musculoskeletal conditions in medical schools, which references WFME standards, Woolf et al (2004) propose it will ensure “adequate educational grounding for migrating doctors” (p.519) without explaining exactly why this is necessary or desirable. Segouin et al (2005) make similar statements about the migration of doctors with no explicit statement about how it will lead to a ‘threat’ to public safety. Referencing WFME standards, Gukas (2007) also hints that migration may open up a threat without articulating this fully:

In today’s globalized world, ease of travel, increasing physician migration and internationalization of hitherto localized diseases, the achievement of the Global Standards for medical training should be the minimum expectation from training institutions anywhere in the world. As suggested by Schwarz, internationalization of health education is now a priority rather than an option (p.887)

Sudanese author Sukkar (2008) uses similar linguistic devices to signal a link between migration of doctors and a sense of threat to the public. Once again, though, this is implicit rather than explicit:

There is also increased mobility of doctors across boundaries for employment or for post-graduate studies. At the same time the information revolution has increased the awareness

of the public for the need for quality assurance and in particular their right to receive proper medical attention. (p.131)

Gordon and Karle (2012) and van Zanten et al (2012) both follow a similar pattern of problematising the migration of doctors without firmly linking this to public safety. Hays and Baravilala (2004), meanwhile, raise the migration of doctors in the context of questions of competency, which links in a slightly clearer way to public protection:

There are 2 possible approaches to setting global standards. One, and perhaps the strongest, is to measure directly the competence of graduates from as many medical schools as are interested; many national jurisdictions already do this for immigrating graduates of foreign schools. (p.582)

Likewise, in a paper from the United Arab Emirates, Ibrahim et al (2015) note that whilst doctors are becoming more mobile, “the competencies of graduating physicians can vary considerably from one country to another” (p.121), again hinting at (in)competence as the basis for the need to consider protection.

WFME President Karle (2006), meanwhile, juxtaposes a sentence about migration with one about poor quality medical schools:

Globalization of medicine is increasing, as manifested by the growing number of migrating doctors and cross-border education providers. In addition, new medical schools of dubious quality are proliferating. (p.S43)

In a later paper by the same author, an almost identical passage appears, this time raising migration of doctors and poor quality medical schools in the very same sentence (Karle, 2008). The effect of this positioning is to give the sense to a reader that all doctors that migrate are from low quality medical schools. On both occasions, framings of ‘proliferating’ and ‘increasing frequency’ add to the effect, almost suggesting that these low quality schools are deliberately ‘sending’ doctors abroad, invariably to the West. Australian author Hays (2014) follows the path set by Karle, writing about physician migration and low quality schools in the same opening paragraph. In a pattern described in previous chapters, the approach initially adopted by the WFME president is later repeated by authors from the East, with Bangladeshi authors Halder and Khan (2015) similarly juxtaposing sentences about migration and low quality.

Examining the different uses of licensing exams around the world, Price et al (2018) note a link between doctor migration and public protection, stating “the principle of free movement includes doctors, but at the same time nation states increasingly are interested in protecting their own publics”

(p.788). In their analysis of accreditation in Libya, Atia and Elfard (2020) similarly raise the association between migration of doctors and 'concerns' about quality. Again here, the message to the reader is that all doctors who migrate come from low quality medical schools.

As well as doctors, ideas of protection are also raised with regard to medical students. In their article about WFME standards, Armenian authors Markosyan and Kyalyan (2008) consider medical student mobility after graduation, with a particular emphasis on "the competencies that students should exhibit on graduation in relation to their subsequent training and future roles in the health system" (p.71). American authors Rizwan et al (2018), meanwhile, highlight that "the increase in new medical schools and medical students, and migration of medical students has drawn greater attention to assessing the quality of individual graduates and undergraduate medical education programs" (Rizwan et al, 2018 p.4).

In all of the examples provided above, medical migration is problematised in the context of 'low quality' medical schools and doctors. Invariably in these examples, this migration is from East to West. The net effect of this is to 'other' migrant doctors from the East. Said (1979) argues that imagined geographies "dramatize the distance and difference between what is close to it and what is far away" (p.55). The imagined geography here casts migrant doctors as problematic, of questionable competence, from low quality medical schools, and ultimately, a 'threat' to the public. Said clarifies that imagined geographies "can be entirely arbitrary" (p.54) as many of these arguments seem to be. Said also notes that the West creates a view of the East that is static and universal, framing all of the East as the same, a place that is placid and does not develop. This can be seen in the problematisation of medical migration, which seems to place all international medical graduates in the same box, as potential threats to the public simply on account of the location of their training. It fails to recognise, for example, the exceptionally high quality of medical training in many countries outside of the Western world.

Whilst the link between migration of doctors and public protection in the context of WFME standards is mostly indirect, this link is articulated much more forcefully in relation to the ECFMG ruling. Although the ruling was formally made in 2010, the first ideas for it can be traced back to a decade earlier, in an article published in the *New England Journal of Medicine* (Kassebaum and Cohen, 2000). In it, they raise concerns about medical schools in the Caribbean particularly, as well as the lack of accreditation of medical schools outside of the U.S. in general:

Although a few other countries are currently developing an American-style system of accreditation, most countries largely sidestep assessment of the educational process and

merely accept graduation from a medical school and passage of required examinations as sufficient evidence of preparedness for practice. (p.1602)

One might read this sentence as saying that any country that does not follow an 'American style' is either inadequate, or else immoral because they want to 'sidestep' assessment. This argument may have carried more weight if the evidence base for 'American' accreditation was strong, but as Tackett et al (2019) show, this remains weak even two decades after this statement. As part of their proposals for 'more stringent' approval processes, Kassebaum and Cohen (2000) suggest the following:

In the interest of providing greater assurance to the U.S. public that its physicians are appropriately qualified to practice, states and their boards of licensure should require that medical schools that conduct a substantial part of their educational programs in the United States be chartered in the appropriate states. (p. 1604)

Although their recommendation does not relate to medical school regulation directly, what is noteworthy is that they are framing foreign medical schools in the context of public protection. This is, in essence, the same fundamental principle as the ECFMG ruling and therefore can be seen as an antecedent to it that sets off the discourse of *protection* a decade prior to the announcement of the ruling. In 2006, Hallock and Kostis, ECFMG President and board member respectively, celebrated the 50<sup>th</sup> anniversary of the ECFMG in an article in *Academic Medicine*, a leading North American journal in medical education. In it, they highlight the core mission of the organisation to be to provide "assurance to the American public" (p.8). Thus, ideas of protection were apparent even before the ruling in 2010.

In their announcement on 21<sup>st</sup> September 2010, ECFMG state the following:

The ECFMG Board of Trustees has determined that it can enhance its protection of the public by incorporating medical school accreditation using globally accepted criteria into ECFMG's requirements for certification of international medical graduates (ECFMG, 2010)

The first sentence of the 'conclusions' paragraph further emphasises the point:

ECFMG's decision to require medical school accreditation as a requirement for ECFMG Certification is a significant step in its continuing efforts to enhance protection of the public (ECFMG, 2010)

It is clear, then, that *protection* is the dominant discourse in the ECFMG's presentation of its own ruling. This is widely echoed by others writing on the topic. Representations of the policy decision have included that will allow 'safe passage' of doctors from one country to another (Gibbs and McLean, 2011), that it was 'essential to ensure high quality' (Eckhert and van Zanten, 2015), and that



it fits with ECFMG's 'historic role as a protector of the U.S. public' (Dauphinee, 2019). Each of these examples frames this movement of doctors from East to West. Authors in the last two of these examples declare links to ECFMG in their articles, reinforcing that this conceptualisation of public protection is very much an 'establishment' position.

Indeed, in an article about the ruling co-written by four ECFMG employees, ECFMG is again set up as dealing with international medical graduates and serving a primary purpose of providing assurance to "the public that these physicians have had their credentials properly reviewed and have met standards for basic medical knowledge" (Shiffer et al, 2019 p.8). ECFMG President, Pinsky (2020), meanwhile, argues along the lines of 'quality', stating "With physicians and other health care workers increasingly crossing borders to provide health care, a meaningful system of accreditation of medical education establishes a baseline of quality, regardless of where physicians are educated" (p.7). Providing assurance to 'the public' remained a stated goal of this ruling present on the ECFMG website as it announced in 2020, in light of the COVID19 pandemic, that it would be moving the implementation date back to 2024 (ECFMG, 2020). Whilst this projection of ECFMG as a public protector very much originates from itself, it is, in turn repeated as it becomes a 'truth'. In a paper authored by U.S. and Middle Eastern authors, for example, the ECFMG ruling is framed in the terms of the organisation's role as a "gatekeeper to protect the American public" (Elkhammas et al, 2019 p.135).

What is the purpose, then, of this protectionist language? Said posited "an ontological distinction between the east and the west by producing the former as inferior and the latter as superior" (Chandrashekar, 2017 p.368). Drawing on this theoretical framework, Chandrashekar suggests we can "understand security discourses as rationalizations that are deployed to produce certain groups as threats against which the nation proper should be protected" (p.369). Also drawing on Said's work, Kundnani and Kumar (2015) agree that security is the primary mechanism for reproducing and enforcing racial differences. In other words, seen through the lens of Said's work, one can frame the discourse of *protection* as orientalist in both its composition and effect.

A further lens through which ideas of public protection can be viewed is that of the 'patient safety' movement, which has emerged in recent decades as a powerful idea in medicine and a major international health policy priority that questions the efficacy of existing regulatory practices (West, 2006). Harrison (2002) asserts that this movement has resulted in medical practice becoming increasingly bureaucratic in nature as the medical profession seeks to legitimise its role within the context of enhanced perceptions of risk and declining public trust. Drawing on Foucauldian theory, Waring (2007) suggests that the effect of this bureaucratisation has been to 'turn the tables' on medicine by providing managers with an expertise or 'gaze' to engage in the regulation of medical

work. Indeed, an important feature of Foucault's work was to understand the relationship between disciplinary discourses and their articulation as forms of social control. In other words, another explanation for the focus on public protection by the ECFMG may be to position itself with a dominant idea in this era, and one that has fundamentally challenged the medical profession as a whole.

### **8.3 Protection of students**

An idea that wasn't present in the initial ECFMG ruling announcement but that became prominent much later is that as well as protecting the U.S. public, it also serves to protect medical students.

In a paper about the ruling co-authored by ECFMG employees in 2019, the abstract mentions one of the goals is to "provide greater assurance to medical students" (Shiffer et al, 2019 p.8). It goes on to outline its 'implementation plan' for 2018 until 2023 in the run up to the ruling taking effect. The first of four phases of this plan is to launch "a new ECFMG web resource to help students make better decisions on medical school selection" (p.14). In the conclusion of the article, they reaffirm this by suggesting that "students will be motivated to check accreditation status when researching medical schools" (p.15). This focus on students is absent in the original text on the ruling and yet appears much later as the deadline for the ruling gets closer.

Other articles around this time follow suit. Dewan and Norcini (2020), discussing the ruling, suggest that medical education must be focused on protecting "both our patients and our students" (p.339). Writing to defend the ruling, ECFMG President Pinsky (2020), meanwhile, suggests it will provide "a valuable service to medical students" (p.7). On the ECFMG website around this time, the framing also shifts to include medical students, suggesting that the ruling will "provide greater assurance to both medical students and the public that they will be appropriately trained" (ECFMG, 2019). This final quotation is particularly striking as in contrast to the original announcement, students are actually mentioned before the public, whereas they were not mentioned at all in the original announcement.

What, then, might explain this shift towards protecting students? I propose two possible explanations. The first is that the students referred to here may not be those that one might expect. Given that the focus of this ruling is on medical schools outside the U.S., one might expect this protection of students to be those in Asia or Africa or South America. However, a number of the articles that mention the ruling refer to the significant number of U.S. citizens that go abroad for medical school and return after graduation. Indeed, the early articles that argued for this ruling had a strong focus on low quality Caribbean medical schools for exactly this reason. In other words, I argue that this protection of U.S. citizen medical students is an extension of the orientalist discourse, as this protection is in fact analogous to the protection of the U.S. public.

The second possible explanation I offer relates to 'student power'. Foucault (1979) argued that "power is not an institution, and not a structure; neither is it a certain strength we are endowed with; it is the name that one attributes to a complex strategical situation" (p.93). His concept of power has often been characterised as 'capillary power', not a force that is wielded, but an inevitable consequence of any system of relations (Bleakley and Bligh, 2009). In this sense, one cannot simply frame a teacher as 'powerful' and a student as 'powerless'. In the context of this study, students actually have enormous influence. As Tackett (2020) outlines, a number of countries that 'send' large numbers of doctors to the U.S. have not yet complied with the ruling, leaving concerns about what impact this may have on the U.S. medical workforce. One way of encouraging countries to engage more rapidly, is in a 'bottom up' approach. Put simply, the focus on protecting and empowering students may serve to encourage these students to use their 'power' to lobby their schools and national accreditation agencies to comply with the ruling before the deadline. Indeed, as students bring considerable income in tuition fees, they have been framed as powerful agents in the context of university admissions (Klemenčič, 2014).

#### **8.4 Protection against foreign medical schools**

A final strand in the discourse of *protection* is not offering protection to a particular group, but a protection against one. Here, foreign medical schools are framed as the threat. These ideas emerge originally in relation to WFME standards, but become more prominent in relation to the ECFMG ruling. The threat from these schools is expressed in two main ways, namely through proliferation and commercialisation of schools. Before the first WFME standards were published, a WFME 'position paper' set out the rationale for their development, noting:

With the explosion in the number of medical schools occurring in the last half of the 20<sup>th</sup> century, in total now exceeding 1400 worldwide, the differences in institutional structure, curriculum content, and teaching methods have increased greatly (WFME, 1988 p.552)

This is elaborated on further in the same paragraph:

Many of the new schools have been established too 'thinly', without adequate academic, institutional and financial resources, the foundation often being driven by political influence and personal ambitions. A new trend has been the rise of commercialized medical education in the form of 'for profit' medical schools, the main goal of which is the easy and convenient production of graduates. These schools particularly attract students who are academically unqualified to enter well-established schools, but who are affluent. (p.552)

The picture painted here is one of outright corruption. The suggestion seems to be either governments ('political') or individuals ('personal ambitions') are deliberately profiteering from medical schools, by offering substandard training to 'unqualified' but 'affluent' students. This is an extremely disturbing and serious suggestion and yet no references are provided and no evidence is presented to substantiate the claim. Moreover, as the examples of good practice offered in the paragraphs immediately preceding these were from 'Harvard medical school' and the 'European community', it seems to be giving these warnings of what happens elsewhere in the world – i.e. in the East. As Said (1979) notes, Western authors often position Europe as central and as the 'main observer', as they seem to be here. Said also notes that 'Orientals' are often portrayed as 'problems' that need to be solved, which again is a representation that can be seen through this problematisation of corrupt medical education practices.

Once the WFME standards are eventually published, the problematisation of medical school commercialisation becomes widespread. In the context of rationalising WFME standards, some texts allude only to increasing medical school numbers (Hays and Baravilala, 2004; Sukkar, 2008; Tackett et al, 2019), some refer only to the 'commercialisation' of medical schools (Segouin et al, 2005; Hays, 2014; Khanam and Chowdhury, 2015; Iqbal, 2019) and some refer to both together (Karle, 2006; Karle, 2008; Halder and Khan, 2015; Atia and Elfard, 2020).

As Whitehead (2011) highlights in a critical discourse analysis of a century of medical education literature, concerns about commercial schools and rising numbers of medical schools are not new and go back to the time of Flexner's landmark report on North American medical education in 1910:

Flexner's discourse of production becomes quickly linked to concerns about overproduction. Flexner argues that there are, overall, too many physicians, albeit most badly trained. As described by Ludmerer, one objective of Flexner's report (or at least one consequence of it) was to limit access to medical school and make it more the exclusive domain of socially and financially advantaged students, primarily white males. Having set up a discourse of production, which considers commercial schools to be shoddy factories turning out dubious products, Flexner then discusses the "overcrowding" of the profession with "low-grade material" as an unfortunate outcome of such production. This over-production reduces the status of the profession and limits the potential for "well-trained men" to secure a reasonable livelihood within the profession (p.62)

The discourse of *protection* is, therefore, not a new one in medical education, nor is it new to North America. Just as Flexner used this idea discursively over a century ago to justify widespread reform,

the notion of 'overproduction' and threats from 'commercial' schools is once again apparent in this study, albeit this time with a global, rather than domestic, outlook.

In relation to the ECFMG ruling, protection from foreign medical schools is emphasised with urgency. As with the WFME standards, this is first raised even before the ruling was announced, in an editorial in the *Journal of Medical Licensure and Discipline*:

It should also be noted that the estimated number of medical schools worldwide continues to increase, particularly in the Caribbean region where many schools draw heavily upon U.S. citizens for much of their enrollment. Depending upon how one chooses to define the Caribbean geographically, the number of medical schools in that region runs between 45 and 60. According to the Medical Board of California, 29 new schools have been established in the region within the last six to seven years. Many of these medical schools are for-profit endeavors utilizing non-traditional educational practices, e.g., no formal examinations for admission, awarding credit for prior experience in related health care professions, granting credit hours based upon limited on-site education (Johnson, 2008 p.8)

Whilst the WFME standards problematised medical school proliferation and commercialisation in a more generalised way, the argument in relation to the ECFMG ruling is, as one might expect, more directly focussed on the direct importance of this for the U.S. medical workforce pool. van Zanten and Boulet (2009) also use the Caribbean as an exemplar, expressing concerns about the growing number of medical schools in the region, including 'for profit' schools. A study by the same authors two years later repeats these concerns, again with a focus on the Caribbean (van Zanten and Boulet, 2011). Eckhert (2010) similarly worries both about growth of schools and the rise of 'for profit' schools, including with a focus on the Caribbean.

A simple explanation for the focus on the Caribbean is its proximity to the U.S. geographically and the fact that a large number of graduates from this region enter the U.S. medical workforce (Eckhert, 2010). Based on the work of Caribbean Studies scholars, though, I suggest that there may be more to it than this. Sheller (2003), for example, asks "while Orientalism has been examined by Edward Said as a discourse within Europe about the East, how did it shift from this geographical referent to take on a wider significance as a generic 'regime of difference' in the Caribbean, understood as another 'Indies'?" (p.125). The problematisation of the Caribbean in the U.S. may, therefore, be conceptualised as analogous to European problematisation of the Orient, as described by Said (1979), and carry with it the same issues of power, domination, and complex hegemonic systems of control.

Rizwan et al (2018) also raise concerns about increasing number of medical schools as well as “for-profit and predatory schools that capitalize on a student’s desire to become a physician and on their ability to pay tuition” (p.111), and similar issues are raised by Elkhammas et al (2019), again in relation to the ECFMG ruling. ECFMG authors Shiffer et al (2019) also raise rising numbers of medical schools as well as “a small number of medical schools engage in questionable business and educational practices, misrepresenting their status and misleading prospective students” (p.8). Again, no citation or elaboration is provided here.

## 8.5 Summary

Whilst the discourses of *modernisation* and *engagement* were present through the entire period of this study, the discourse of *protection* emerges in the later part of this time period, and becomes dominant at the time of, and following, the ECFMG ruling in 2010. It is constructed based on arguments of protecting the public, specifically the U.S. public, protecting current and future medical students, and protecting against foreign medical schools. Whilst one might imagine that a discourse of *protection* would frame globalisation as ‘sceptical’ in light of its threats, the reality is that this threat is always moderated by the need for doctors and the solutions offered are consistently to ‘manage’ rather than ‘stop’ medical migration. It is, therefore, transformationalist in its perspective.

The effect of the discourse of *protection* is to create a justification for globalising approaches to medical school regulation. What is especially interesting, though, is how the discourse evolves over time. As outlined in this chapter, around the time of the first announcement of this policy, the primary context was about protecting the public, whilst several years on, it became about protecting students, despite this not being mentioned at all at the start. As I argue in this chapter, this shift of focus to students may relate to the high number of affected students that are in fact U.S. citizens who have moved abroad for medical school, and also to the realisation that students are an important lobby group for engagement with the policy around the world.

I propose that some elements of protection are longstanding in medical education, as it has sought to ‘safeguard’ standards and propriety of the medical profession since at least the time of Flexner’s landmark report over a century ago. However, the idea can also be conceptualised as a product of its time. In the decade since the ECFMG ruling was announced in 2010, much has changed in world politics, particularly in the Western world. Neoliberal globalisation, the dominant economic and political policy of the decades before, had been replaced by populism and nationalism, especially in the U.S. and Western Europe, as demonstrated through countless political events and leaders. As Peters (2018) notes, such populism has strong links with elements of the far-right, not only in terms of ethnocentrism and xenophobia, but also with traditional and social conservative values including

the subordination of cultural minorities, as well as foreign policies based on ‘protectionism’ and ‘isolationism’.

Another key consideration, as argued in this chapter, is the extent to which ideas of public protection in this discourse capitalise on the patient safety movement. As Dixon-Woods et al (2011) show, in recent decades, the longstanding collegial model of self-regulation of the medical profession has eroded, and shifting social and political conditions led to an “ascendancy of pro-interventionist, managerialist and political agendas from the early 1990s onwards” (p.1452). As social theorists such as Beck have argued, this period has also been dominated by fears about risk and security, particularly as a result of globalisation (Jarvis, 2007). In light of these dominant ideas about risk and safety, especially in the context of the medical profession and globalisation, one might argue that in this era – the globalisation of the medical profession – was bound to be dominated by the discourse of *protection*.

The discourse of *protection* is complimentary to the other dominant discourses outlined in this thesis. Whilst the discourses of *endorsement* and *modernisation* serve to provide a moral argument for global approaches to medical school regulation, the discourse of *protection* provides a more direct and practical argument. One can also see how the discourses of *endorsement* and *modernisation* are ‘outward’ arguments, in that they deal with how this policy appears externally, whereas the discourse of *protection* is an ‘inward’ argument, in that it provides a justification for an internal, Western audience, and specifically an American one. This, in turn, ensures the right ‘buy in’ of this policy from domestic stakeholders.

What is striking, though, is that there is no clear argument presented about why the public needs protecting from foreign doctors. In fact, there is consistent evidence to show that there is “no mortality difference when comparing all international medical graduates with all U.S. medical school graduates” (Norcini et al, 2010) and even that “patients treated by international graduates had lower mortality than patients cared for by US graduates” (Tsugawa et al, 2017). They also comprise a “significant proportion of the primary care providers in high-need rural and urban areas” (Zaidi et al, 2020). Language about *protection* is discursively used as a means to problematise foreign doctors and medical schools, and to justify approaches that could be conceptualised as authoritarian and orientalist, although without any empirical ‘proof’ that it is indeed problematic.

Like the discourse of *protection*, a further discourse emerges in the same time period – the discourse of *control*, which is examined in the next chapter.

## 9. The discourse of *control*

### 9.1 Introduction

Like the discourse of *protection*, the discourse of *control* is not present across the time period of this study, but rather emerges in the latter part of it. It shares much in common with the discourse of *protection*, as it too first emerges at the time of the first set of WFME standards and is reinforced at the time of, and in the reaction to, the ECFMG ruling. The discourse of *control* is the final discourse presented in this study and is examined in detail in this chapter.

Foucault argues that systems work at the level of knowledge to form an architecture of power that is famously termed ‘panopticism’, and is described by Foucault as ‘a state of conscious and permanent visibility’ (Foucault, 1979). He bases this idea on a ‘panopticon’, a prison-like architecture that enables unlimited ‘surveillance’ over inmates, which was originally developed by English philosopher Jeremy Bentham. There has been widespread sociological interest in the panopticon, as many have sought to extend its model of power into a broader account of what might be called ‘surveillance society’. Indeed, Foucault suggests that ‘our society is one not of spectacle, but of surveillance’ (1979). Developing Foucault’s ideas into a framework of a ‘control society’, Gane (2012) suggests the following:

Control is not tied to a heavy architectural structure, but is a form of power that can be modulated: its pitch and range can easily be varied. Unlike discipline, control is not moulded to remain in a fixed form but can be open or closed to varying degrees to enable access for some while immobilizing others. (p.620)

Said, meanwhile, repeatedly insisted that knowledge produced about the ‘other’ was then used to control colonised peoples in both a physical way through exploitation of bodies and lands, as well in a long-term psychological way through what French sociologist Bourdieu (1991) would later describe as “symbolic violence which is not aware of what it is” (p.51). In other words, a Saidian representation of control is a social reality of the ‘other’ that involves a complex nexus of symbolic and material realities. As postcolonial sociologists Guhin and Wyrzten (2013) outline, Said argued that the extension and operation of imperial power requires the production or acquisition of knowledge about populations that need to be controlled or managed. Put simply, Said argued that the West dominated and ‘controlled’ the East by gaining knowledge about it.

I will argue in this chapter that the discourse of *control* is used to promote global approaches to medical school regulation. Three key ideas make up this discourse (control through collaboration,



control as managing variation, and control by monitoring) and whilst these are interlinked, they are considered in turn in this chapter.

## 9.2 Control through collaboration

The first set of ideas that make up the discourse of *control* relate to collaboration. By depicting themselves as collaborative, strategic, and purposeful, the organisations involved in promoting global approaches to medical school regulation, particularly WFME and ECFMG, portray a sense of control. Focussing on collaboration portrays this as a ‘joined up’ endeavour that is co-ordinated and rational.

At the heart of this idea of collaboration is the relationship between the two organisations that are the primary focus of this study – WFME and ECFMG. As argued earlier in this thesis, these two agencies are fundamentally different in that WFME ostensibly represents all countries (‘world’ is in its title), whereas the ECFMG is an agency representing one country, the U.S. (although the presence of ‘foreign’ in its title suggests that it has something of an international perspective). Given their fundamental difference on these grounds, this relationship may be perceived as problematic. WFME has relationships with other organisations that are ‘global’ in their reach, such as WHO, but not with any other agency than the ECFMG that represents a single country.

Even prior to the ECFMG ruling announcement in 2010, the idea of collaboration had been raised. Writing to suggest the establishment of an “information and data clearinghouse on international medical schools” (p.7), American author Johnson (2008) suggests “potential allies and partners abound, all of whom bring extensive expertise to international medical education”, including both ECFMG and WFME. At the time of the announcement in September 2010, ECFMG were clear that they had already started engagement with WFME:

WFME has established standards that could be used for this purpose and, through its upcoming pilot, is establishing the necessary procedures and a working model for accrediting bodies and medical schools that wish to attain a new standard of quality medical education and meet the accreditation requirement for ECFMG Certification (ECFMG, 2010)

The reader gets a sense that WFME and ECFMG are almost one seamless organisation, as WFME seems to immediately mobilise and do what is ‘necessary’ to help ECFMG achieve its policy. Given that WFME is a global organisation that apparently represents all countries in the world, its unhesitating engagement with the agency of one country might be perceived as surprising. ECFMG president Cassimatis (2013) later provides more detail:

The plan, arrived at after much discussion and collaboration with the World Federation, is that WFME will review and recognize regional or national accrediting agencies for compliance with

its standards. The expectation is that regional and national agencies that have been recognized by WFME will accredit individual schools. For ECFMG purposes, accreditation of an international medical school by an agency recognized by the WFME will meet our new requirement for certification. (p.4)

Rather than one seamless entity, the relationship here is portrayed as one of mutual interest. The collaboration between these two powerful organisations allows each of them to forward their agendas of increasing the ‘globalising’ of medical school regulation. The close relationship between WFME and ECFMG beyond the announcement of the ruling is widely reflected in published articles of this time (Javaid, 2017; Hays, 2018; Latif and Wajid, 2018; Elkhammas et al, 2019). Noteworthy descriptions of the relationship include that ECFMG have ‘entrusted’ WFME (Sethi and Javaid, 2017), that the two organisations have ‘partnered’ (Dauphinee, 2019), that WFME have ‘accelerated’ their programme in response to the timeline of the ECFMG ruling (Tackett, 2019), and they are even linked at one point by just a hyphen, as the ECFMG ruling is referred to as the “ECFMG-WFME initiative” (Ho et al, 2017 p.1719).

As described in the previous chapter, a region of the world that was consistently portrayed as a ‘threat’ that required ‘protecting against’ was the Caribbean. It was an interesting decision, therefore, that the accrediting agency of this region, The Caribbean Accreditation Authority for Education in Medicine and Other Health Professions (CAAM-HP), was chosen to complete a ‘pilot’ of the WFME recognition programme. In an article describing this pilot, the authors write that “the WFME partnership provides support, enhances credibility, and gives international exposure for developing organizations such as CAAM-HP” (van Zanten et al, 2011 p.775). It is not entirely clear why a medical school regulator would want ‘international exposure’, but the portrayal of this ‘partnership’ with WFME in such a positive way is an example of the importance of language of collaboration at this time.

Another organisation that frequently appears in descriptions of collaboration is the Foundation for Advancement of International Medical Education and Research (FAIMER). According to its website, this organisation was ‘incorporated as a non-profit foundation of ECFMG in September 2000’ and the board of trustees continues to be chaired by the ECFMG president (FAIMER, 2020), indicating the intimate association between the two organisations. In an announcement on March 13<sup>th</sup> 2013, ECFMG announced the following ‘milestone’:

To stimulate efforts to develop such international accreditation, WFME and the Foundation for Advancement of International Medical Education and Research (FAIMER®) worked in collaboration throughout 2011 to develop a process for evaluating and recognizing accrediting agencies. The WFME-FAIMER team developed proposals for an application, recognition

criteria, and policies and procedures to support the recognition of accrediting agencies (ECFMG, 2013)

FAIMER, an organisation closely aligned with ECFMG, played a central role in developing the WFME recognition programme, which claims to be a global programme of activity with a global mandate, and which has already had a profound impact on many countries. The collaboration between FAIMER and WFME is reaffirmed in an announcement two years later by ECFMG (2015). Sjostrom et al (2019) also describe the 'co-operation' between FAIMER and WFME to 'develop policy'. Sudanese author Karrar (2019) also picks up on the relationship, noting the following:

In dialogue with FAIMER it was decided that WFME could take a lead in formulating and implementing policies and procedures for recognition of agencies accrediting medical schools. (p.1520)

What, then, is the effect of this association? To start, it raises questions about the legitimacy of the WFME recognition programme as a truly global programme, or whether it can, in fact, be considered an instrument of U.S. policy. Although FAIMER has an international reputation and employs some recognised experts in the field of medical education, its association with ECFMG means it primarily represents U.S. interests, which further complicates an already complex association with WFME.

The close collaboration between the trio of ECFMG, WFME, and FAIMER in this way, developing policy that will potentially impact medical schools around the entire world, can be framed in terms of Said's work. He notes, for example, how orientalism is a form of 'intellectual power' that is projected as 'civilising' and how orientalist tend to cite one another (Said, 1979). He also notes the importance of the U.S. in world politics following World War Two, reflecting on:

...a major change in the international configuration of forces. France and Britain no longer occupy center stage in world politics; the American imperium has displaced them. A vast web of interests now links all parts of the former colonial world to the United States (Said, 1979 p.286)

Put simply, the decision by WFME to collaborate so closely with ECFMG (and FAIMER) can be conceptualised as a means of aligning itself with the dominant nation of the time, drawing on U.S. authority to promote the WFME cause that had been present for many decades prior. It was, after all, 22 years between the Edinburgh declaration in 1988 and the ECFMG ruling in 2010. One might argue that WFME pivoted at this moment, recognising the opportunity that the ECFMG ruling represented to advance its cause, and capitalised on it by collaborating closely.

Having had the privilege of working with medical education leaders in many different countries of the world, and seen the strength of ambition to work in the U.S. amongst many doctors from the East, it is clear to me that the ECFMG ruling is what brought WFME to the attention of many medical educators and policymakers. Although it existed for over four decades prior to this moment, there was little awareness of it as an organisation. In that sense, the decision by WFME to associate itself with ECFMG so closely could be conceived of as successful in that it helped it to become more prominent and move forward its agenda of bringing a more global approach to medical school regulation. In Foucauldian terms, decades after WFME came into existence, its power relations with the global community of medical education changed dramatically due to this collaboration.

### **9.3 Control as managing variation**

A second set of ideas that shape the discourse of *control* relate to managing variation. These involve firstly establishing that variation exists between countries in medical education and is problematic, then using this as a justification to propel global approaches to medical school regulation by suggesting that this variation needs to be ‘managed’.

These ideas are present both in relation to WFME standards and the ECFMG ruling. In fact, it first emerges even prior to the first WFME standards, in the opening paragraph of an editorial by Hamilton (2000):

Do we, in medical education, not owe it to the world that all doctors be trained to the same standard? The quality of care from doctors is not universally the best. (p.547)

WFME president Karle (2004) later highlights that “a number of dissimilarities between regions and countries can be enumerated regarding the basic conditions for medical education” (p.205), which is also repeated elsewhere in the context of WFME standards (van Zanten et al, 2012; Abdalla, 2014; Hays, 2014; Ibrahim et al, 2015; Rizwan et al, 2018; Prideaux, 2019).

As described earlier in this thesis, a key driving factor for the ECFMG ruling was concern about the Caribbean region. Language about ‘variability’ also appears in this early period about this region, initially by authors with ECFMG and FAIMER affiliations (Norcini et al, 2008, van Zanten and Boulet, 2009, van Zanten and Boulet, 2011) and later by a professor from a medical school within the region itself (Shankar, 2019).

One proposed solution to manage this variation is presented through alignment with the competency based medical education (CBME) movement, first covered in chapter five. Alignment with this movement is suggested as a method of dealing with variation, as it focusses on outcomes and the

finished 'product' of medical education – i.e. a 'competent' doctor. In an editorial in 2004, Prideaux first makes the connection between WFME standards and this movement:

While the WFME methodology places an emphasis on medical schools engaging in the processes necessary to achieve the standards, the setting of international standards with an expectation that they will be achieved is a clear example of a focus on outcomes. (p.580)

Likewise, Armstrong et al (2004) list WFME as one of a number of organisations “that have identified and recommended to medical schools core objectives and competencies to meet minimal essential standards of practice” (p.725). This association between 'competency' and 'outcomes' has consistently been reasserted since, including from authors in both Western and Eastern countries (Abdalla, 2012; Khanam and Chowdhury, 2015; Sjostrom et al, 2019; Iqbal, 2019). As described in chapter five, CBME has been widely challenged in the medical education community in the West on various grounds. In the context of WFME standards, though, it is presented as universally positive, and as a means of managing variation. One significant area of concern about this movement has been its association with neoliberalism and 'managerialism':

Competencies are closely related to the managerialism that has come to dominate so much of higher education. In an age of the so-called massification of higher education where universities are being expected to “turn out” larger numbers of new graduates with the same resources and numbers of faculty and staff as we have in the past, then this poses a serious problem. This may be why managerialism and the competency-based approach are so popular. They provide a false promise of generating new professionals at a low cost. (Loftus, 2016 p.502)

In the international context of this study, and in light of the significant contributions that foreign-trained doctors make to the medical workforce in countries like the U.S. and UK, I propose that this can be extended to describe a form of 'international managerialism' that seeks to produce doctors that are 'competent' for Western practice irrespective of where they have trained. This chimes with Said's argument that the West seeks to 'transport' the Orient into 'modernity', or at least its own version of modernity (1979). As Said outlined, this is both for material as well as symbolic purposes – in the context of medical schools, the material purpose is the 'poaching' of doctors created in the 'Western mould' and in the symbolic, it is the imposition of the Western idea of CBME on the pedagogical philosophies of the rest of the world.

Another idea that emerges as a solution to variation is that of 'standardisation'. It is important to note that this differs in a subtle but important way from the idea of 'harmonisation' that was presented in

chapter six in relation to the *modernisation* discourse. Whereas harmonisation was fundamentally expressed as a means of improvement, standardisation is expressed as a means of managing variability and assuring quality. Standardisation is proposed as a benefit of both WFME standards and the ECFMG ruling.

Writing in the context of WFME standards, language of standardisation appears in a number of articles. Khanam and Chowdhury (2015), for example, suggest that “knowledge and competencies could be predicted and solved by standardization of teaching and evaluating system of education curriculum worldwide” (p.38). Price et al (2018) use similar language, arguing that “the drive towards standardization in medical regulation can be understood as a response to the internationalization of medical training” (p.788). Yoo et al (2020) link this much more explicitly to WFME, describing a “WFME-centered international standardization of medical education” (p.9). The notion of standardisation also appears in the context of the ECFMG ruling (Kuwabara et al, 2015; Javaid, 2017, Sethi and Javaid, 2017).

Standardisation, then, is conceptualised here positively, as a means of creating a ‘level playing field’ around the world. What does not appear, though, is any explicit examination of what this level is, or who is setting it. These authors, from both West and East, have accepted the ‘truth’ that variability is problematic and taken the next step to try and manage this. Seen through a Foucauldian lens, I argue that the system of thought at this time did not permit a more fundamental challenge of the assumptions underpinning the problematisation of variation and argument for standardisation as a solution.

A final strand that forms the discourse of *control* by managing variation is the notion of the ‘global doctor’. This vision, that seemingly captures a single, monolithic description of all medical professionals in the world, is a final discursive device that emerges as a means to counter the problem of variability. Outgoing and incoming WFME presidents, Gordon and Lindgren (2010) shared an entire editorial on this topic, proposing that the medical community needs to “propose a policy and philosophy for the future global role of the doctor” (p.19). Indeed, in their analysis of an archive of medical education texts over forty years, Martimianakis and Rafferty (2013) note that the vision of a ‘universal global physician’ is the ‘most established’. Brouwer et al (2020) found similar in their case studies of international medical programmes, identifying the profiles of ‘global physician’ and ‘universal professional’. As highlighted earlier in this thesis, Western authors have dominated the published medical education literature, and one might therefore argue that this concept of the ‘global doctor’ is made in the image of the West, and can be viewed as a means for the West to project its

own values and priorities on the rest of the world. In other words, visions of a global doctor have a similar effect as language of standardisation, albeit that the former is more figurative and abstracted.

#### **9.4 Control by monitoring**

A final group of ideas that has formed the discourse of *control* relate to monitoring. These ideas suggest that global approaches to medical school regulation are desirable because they allow for improved methods of monitoring medical education around the world. The notion of monitoring particularly relates to the ECFMG ruling, and the idea that more information is needed about the world's medical schools. This first emerges prior to the announcement of the ruling, as mentioned in an overview of the world's medical schools authored by ECFMG and FAIMER authors:

Given the physician's role in the healthcare team, the challenges presented by migration of healthcare workers, and questions concerning the adequacy of existing institutions to meet healthcare needs, developing and maintaining accurate and detailed information on the world's medical schools and their graduates is paramount. (Boulet et al, 2007 p.20)

This is mirrored by Eckhert (2010), who argues that "the public and the profession will be best served by knowing more about medical education outside of the United States" (p.622), as well as in the context of U.S. citizens who travel overseas to 'offshore medical schools' (Eckhert and van Zanten, 2015).

Tackett (2019) explains why this additional information would be useful:

At the time of the announcement in 2010, the ECFMG required applicants to have graduated from a school listed in its official database, which included schools that were approved by an appropriate local authority, such as an accrediting agency or government ministry. The ECFMG decided to change this policy because the structures and functions of these local authorities varied considerably. Such variation led to the potential for its database to include schools that were not comparable to one another in quality, limiting the usefulness of the data for prospective students, residency program directors, and others who rely on the database as a source listing reputable medical schools. Standardizing the process by which schools became approved by local authorities could therefore strengthen a link in the ECFMG chain of quality assurance. (p.943)

This quotation is helpful in understanding how the problematisation of variability and desire for standardisation discussed in the previous section of this chapter, ultimately relates to knowledge. As Foucault and Said both identify, knowledge is inextricably linked with power. To control knowledge

about the world's medical schools and accreditation agencies is to possess 'power' over them, which in terms of the ECFMG ruling, is power that will ultimately be wielded in the selective entry of doctors.

As Zhao (2017) states, Foucault believed that "at least for the study of human beings, the goals of power and the goals of knowledge cannot be separated; in knowing we control" (p.377). Zhao goes on to highlight that this Foucauldian insight informs Said's Orientalism, which points out the extent to which 'knowledge' about 'the Orient' as it was produced and circulated in Europe:

...so far as the West was concerned during the nineteenth and twentieth centuries, an assumption had been made that the Orient and everything in it was, if not patently inferior to, then in need of corrective study by the West. The Orient was viewed as if framed by the classroom, the criminal court, the prison, the illustrated manual. Orientalism, then, is knowledge of the Orient that places things Oriental in class, court, prison, or manual for scrutiny, judgment, discipline, or governing. (Said, 1979 p.40)

Other language used about monitoring relate to 'supply'. Even prior to the ECFMG ruling announcement, Cooper (2005) outlined "the draw that the United States has made on other countries to accommodate for deficiencies in its own supply" before going on to analyse "projections of the adequacy of physician supply" (p.10). Boulet et al (2007) also express how difficult it is to "accurately gauge physician supply" (p.25), and Pinsky (2017) identifies the importance of an 'adequate supply' of practitioners for the U.S. medical workforce. In the context of international medical graduates from India, Tackett (2019) explains how "this supply source is in jeopardy" (p.946). Other articles from this period use similar 'market' language when referring to overseas doctors.

As Hodges et al (2009) note, the medical education community seem to be oblivious to this increased use of economic language:

The current trend of conceptualizing economic and social development in global terms is permeating the language of medical education with increasing frequency. Consider for instance that many countries with a shortage of physicians speak of 'importing' medical trainees (p.911)

The effect of this economic language is to dehumanise. The portrayal of medical school regulation in terms of a 'supply problem' is to ignore the humanity and professionalism of the doctors that are affected. The deprofessionalisation of medicine has been extensively theorised and debated. It's description by Freidson (1985) as "the reduction of physicians to mere secular specialists, dependent on rational, well-informed consumers who approach their services with the same questioning attitude they bring to other commodities in the marketplace" (p.11) demonstrates that it has been closely



linked with economic language and neoliberal ideas. There is, though, a further implication here. In that all of the discussion about 'supply' relates to the ECFMG ruling, the argument is essentially one that frames the U.S. medical workforce as the ultimate priority. The effects of this policy on overseas medical schools, the moral arguments of 'brain drain', and the health workforce of other countries, are not part of this narrative. Furthermore, this ruling is not about U.S. trained doctors, who are therefore excluded from this deprofessionalisation. It is, rather, a selective deprofessionalisation of foreign doctors.

A final notion within the idea of monitoring relates to compliance. Japanese authors Maeshiro et al (2014), for example, express their hope that the "Japanese medical education system will seek to meet ECFMG compliance" (p.194), and this is echoed by Onishi (2018). Elkhammas et al (2019) write that medical schools will need to "comply with the WFME and ECFMG guidelines" (p.135) and similar language is used by Mochizuki et al (2019) and Heist and Torok (2020). Although the ECFMG did not use this language at the initial announcement of the ruling, it was used in an announcement five years later:

ECFMG encourages all agencies that accredit medical schools to visit the WFME website, review the available information, and take action to allow medical schools and their graduates to be in compliance by the deadline (ECFMG, 2015)

The effect of the language of compliance is to reinforce the discourse of *control*, in that it emphasises that the ECFMG ruling is an ultimatum with a deadline, and that there will be tangible consequences for those that do not 'comply'. A Saidian contrapuntal reading of the quotation above from the ECFMG may perceive it as threatening. The presence of a temporal deadline to the ruling means that a metaphorical clock is ticking for the rest of the world, and the language of compliance serves to reinforce this. Compliance can also be seen through Foucault's model of 'Panopticism' presented at the start of this chapter. It paints a picture of surveillance, with close tracking of who has and has not 'brought in' by taking action in response to the ruling.

## **9.5 Summary**

The discourse of *control*, like the discourse of *protection*, was not present throughout the entire time period of this study and rather emerged in the latter part of it. It was not, for example, dominant around the time of the Edinburgh declaration in 1988. However, it became dominant over time, and particularly so following the ECFMG ruling in 2010. It is comprised of notions of collaboration, managing variation, and monitoring. Like the discourse of *protection* presented in the previous

chapter, the discourse of *control* is transformationalist, in that it presents globalisation neither as fundamentally positive nor negative.

The overall effect of the discourse of *control* is to promote and justify global approaches to medical school regulation. As I argue in this chapter, it presents WFME, ECFMG, and FAIMER, the key organisations operating in this space, as working in a collaborative and synchronised way, and thus in control of the future of medical school regulation practices.

The deliberate choice from WFME to be involved in the ECFMG ruling is striking. Although this relationship is not problematised at all in the published literature, one might think it strange that an apparently global organisation would involve itself so intimately in the policy of a single country. Might one imagine the WHO associating itself so closely with the health priorities of a single country, for example? Or can one envisage WFME having such a collaborative relationship with a country other than the US? A European country, perhaps might be plausible, but is it possible to imagine WFME working with China, India, or Nigeria in the way it has done with the U.S.? An important extension to these questions is a consideration of the perspective of countries who may perceive the US as oppressive or authoritative for cultural or geopolitical reasons. When viewed through the Saidian contrapuntal lens, it is possible to see how this association may actually serve to alienate many countries or regions in the world away from WFME.

The problematisation of variation is an important part of the discourse of *control*. As I have outlined in this chapter, this includes variation amongst doctors, medical schools, and accreditation agencies around the world. What remains absent from these texts, though, is any critical debate about this problematisation. Put simply, nobody has challenged why this variation is problematic. As outlined in chapter seven, the discourse of *resistance* is present in the early time period of this study and fades away in the period related to the ECFMG ruling. It becomes a 'truth' that variation in medical education is a problem. The necessary differences between countries and regions of the world does not appear as a counter argument. Whilst the increased movement of medical professionals is an undeniable reality, the entire discourse of *control* serves to optimise this movement rather than to challenge it as exploitative and part of the 'brain drain' phenomenon that has been grappled with both inside and outside of medicine.

Viewed in the terms of Said's Orientalism (1979), the focus on variability of medical education outside the U.S. can be seen as a means to position the West as rational and scientific, in contrast to a barbaric and irrational East. This positioning also provides grounds for the proposed solution of 'standardisation', which serves to 'civilise' and bring the world in line with Western practices. This

notion is furthered by the vision of a global doctor, which as I argue in this chapter, may be interpreted as an idealised Western doctor.

Through the concepts of monitoring and surveillance, the discourse of *control* exerts authority through gaining knowledge and by extension, power. Emphasising the importance of knowledge, Said (1979) gives the example of Napoleon's invasion of Egypt in 1798, which was as much an 'intellectual' operation as it was a military one. The surveys of Egypt that his army completed were not for the people of Egypt, but for Europeans. One possible explanation of monitoring, then, is as a means of gaining knowledge from around the world, which in turn is a method of gaining power over it. The discourse of *control*, therefore, can be understood as an orientalist discourse.

## **10. Altruism or nationalism?**

### **10.1 Introduction**

In the previous five chapters I have outlined discourses about the movement toward global approaches in medical school regulation that I have identified in this research. These discourses are linked to economic, political, educational, sociological, and healthcare factors of the time period in which they emerged.

It is not unusual to find multiple discourses present simultaneously in the way I have identified in this study. Foucault recognises that discourses do not “escape from history and float in the air like disembodied and solitary entities” (Foucault, 1999 p.285). Rather, they develop through the “emergence of a whole group of highly complex, interwoven objects” (p.65). Hence, the links between the discourses I have identified in this study, and other discourses relevant to medical education during this period, are complex and non-linear. Hodges (2009) outlines that even when shifts take place in these discourses, they are not straightforward:

The historical beginnings and ends of discourses are not finite and their chronological limits cannot be fixed precisely. Neither can they be said to be linear in their appearance and disappearance. Further, when a particular discourse rises to prominence and another can be seen to fade, there is no certainty that they do so in lock step. Thus, several discourses can exist simultaneously (Hodges, 2009, p. 45).

In this chapter, I explore the relationships between these discourses and examine what they mean for regulatory policies in medical education.

### **10.2 Altruism or nationalism: who is this for?**

Having examined each of the discourses I identified in this research in turn, I return now to my initial area of focus, which was the ECFMG ruling that prompted the establishment of the WFME recognition programme. Looking across the discourses outlined in this study, two overall discursive strands emerge. One is of *altruism* and ultimately sets up this policy as a means to modernise and improve medical education around the world. The second is of *nationalism* and ultimately sets it up as a means to improve medical care in the U.S. and protect the U.S. public. I argue that these strands have operated in parallel and the discourses outlined in this thesis have fit into one of these two overarching positions. Importantly, both of these discourses are dominant and there is no ultimate clarity about which is the ‘real’ reason for the policy. In other words, the ECFMG ruling is framed both as a means to improve medical education in the world, and to protect the U.S. public. Both of these strands are dominant and one is not foregrounded or emphasised over the other.

The notion of *altruism* is perhaps best demonstrated by the concluding sentence of a letter written by the ECFMG president in which he states that “the ultimate beneficiaries are, of course, the world’s patients, who will receive better health care as this initiative moves forward” (Pinsky, 2020 p.7). The suggestion of improving the health care of patients throughout the world is a particularly bold example, and most of the claims are instead about improving quality of ‘medical education’ or ‘medical schools’. In chapter 5, I outlined how the discourse of *endorsement* was made up by notions of representation and implementation, suggesting that the world was engaged in, and supportive of, this policy decision. Likewise, in chapter 6, I described how ideas of reform and development portrayed this policy decision as being a means of bringing positive change and improvement. These ideas all ultimately contribute to a projection of this policy in altruistic terms. Put simply, this discursive strand sets up the ECFMG ruling as one that is outward looking and designed to primarily be a force of good in the world.

The second discursive strand is *nationalism* and is demonstrated in the following extract written in the context of the ECFMG ruling in the *New England Journal of Medicine* by Eckhert and van Zanten (2015):

We believe it will be necessary to examine the accreditation processes and the level of authority that accrediting organizations have over schools. If offshore medical schools are to continue to supply a substantial number of U.S. physicians, particularly in primary care, greater accountability is warranted to assure the American public that their physicians are well trained” (p.1687)

Here, the policy is set up entirely as a means of providing information and assurance to U.S. policymakers and citizens. In chapter 8, I outlined how the discourse of *protection* included protection of the public, protection of (primarily U.S.) students, and protection from predatory, overseas medical schools. In chapter 9, I described how the discourse of *control* relates to monitoring the world’s medical schools and managing existing variation. Each of these ideas contribute to this discursive strand, and project the ECFMG ruling as an ultimately nationalist policy. Simply stated, this strand sets up the ECFMG ruling as a policy that is inward looking and designed to primarily help the U.S. itself.

The parallel nature in which both of these discursive strands emerge is noteworthy. Whilst they are not contradictory, they clearly offer very different perspectives about the rationale for the ECFMG ruling. Seen through a Foucauldian lens, one might argue that each of these positions represent powerful and persuasive ideas to different audiences. For an ‘internal’ audience within the U.S., one can see that nationalist discourses are likely to be powerful, and for an ‘external’ audience outside the U.S., the projection of altruistic discourses are likely to be powerful. In other words, the combination

of these two projections maximises the appeal, and therefore the authority, of this ruling to multiple different audiences and stakeholders.

Drawing on the theoretical approach of Said, both of these discursive strands can be conceptualised as orientalist. Whilst *altruism* can be viewed as a means of the west ‘civilising’ the east by modernising and improving it, *nationalism* can be viewed as the west portraying a ‘barbaric’ east that cannot be trusted. One might argue, therefore, that these discursive positions are actually less different than it might first appear, in that each of them serves to ‘other’ the East and to contrast it with the West overall.

As I laid out in chapter 2, the globalisation literature in medical education has shifted over time from hyperglobalist and sceptical to a more transformationalist approach, recognising the complexity of globalisation and its potential to do both harm and good. Throughout this thesis, I have categorised each discourse according to this framework. What is clear from these categorisations is that the divergence between *altruism* and *nationalism* fundamentally changes how the ECFMG ruling can be seen. If one takes the set of *altruism* discourses, a clearly hyperglobalist picture emerges, that seeks to project this policy as one that ‘flattens the world’ and leads to greater global harmony and equity. If one takes the set of *nationalism* discourses though, a very different picture emerges that is protectionist and cautious about globalisation, fitting more clearly into the sceptical and transformationalist perspectives. This reinforces the fact that these two parallel projections serve very different functions in terms of how they frame the ECFMG ruling. It is not possible to force them both into a single perspective, suggesting they are fundamentally different.

It is possible that the ECFMG ruling was motivated by both *altruism* and *nationalism* in equal measure, and that this policy was simultaneously both for the world’s medical schools and for the U.S. public. It is also possible that one of these two motivations was primary and the other was a secondary benefit that was promoted because it became valuable to do so for particular audiences. The purpose of this study was not to find an absolute ‘truth’ about what the ‘real’ motivation for this policy was. Rather, in uncovering assumptions and justifications in the discourses surrounding it, it has drawn attention to how language has been used to shift power relations, justify decisions, and ultimately legitimise the policy to globalise medical school regulation.

### **10.3 The position of WFME**

As I outlined in chapter 1 of this thesis, whilst the ECFMG ruling was the primary focus of this study, this was inextricably tied to WFME, and as I have reiterated throughout this study, the two

organisations have been closely associated during the time period I have studied. In this next section, I consider how and why this association came about, and its implications.

I chose as a starting point for this study the Edinburgh declaration in 1988 as it struck me as an important landmark in the ideological history of applying global approaches to medical school regulation. Not only was it the first major event in WFME's history that caused a noticeable reaction in the scholarly literature on medical education but it also represented the first published attempt at agreeing on principles of quality that could apply to all medical schools in the world. Two discourses, *endorsement* and *modernisation*, were dominant from this early stage, and as I argued in the previous section of this chapter, this altruistic discursive strand continued all the way until the ECFMG ruling announcement 22 years later and beyond. The other discourse present in this early period was a discourse of *resistance*. As I argued in chapter 7, this was a counter discourse and argued from sceptical and transformationalist perspectives against the hyperglobalist discourses of *endorsement* and *modernisation*. In other words, one can argue that this early period was characterised by a 'healthy' debate about policies to globalise medical school regulation.

The middle period of this study was marked by the publication of the first set of WFME standards. This period saw a discursive shift, as the discourse of *resistance* gradually faded and the discourses of *protection* and *control* began to emerge. Both of these two emerging discourses became considerably more prominent following the announcement of the ECFMG ruling as WFME became associated not only with the standards but additionally with the recognition programme, which was clearly and explicitly a development that resulted from the ECFMG ruling. In other words, the discursive shift occurred around the time that WFME began its association with ECFMG. A concrete example of this association is the inclusion of ECFMG onto the WFME executive council in 2007 (WFME, 2012). This is particularly important because even in 2021, the ECFMG remains one of eleven voting members of the WFME executive council. Of the other 10 members, six are regional associations for medical education across the different parts of the world and four are made up of international organisations, such as WHO. ECFMG, though, is an agency representing a single country, the U.S., and it is therefore not entirely clear why it has voting rights on this international council.

Throughout this thesis, I have emphasised that a fundamental difference between WFME and ECFMG is that whilst the former is global in scope, the latter is national. Their union is therefore an unusual one and requires consideration. As I have argued in this thesis, both organisations have benefited from this association by gaining credibility, authority, legitimacy, and ultimately, power. As I outlined in the previous section of this chapter, the ECFMG ruling has been projected in terms of both *altruism* and *nationalism*. The association with WFME fits with both of these discursive patterns. It supports

*altruism* by projecting an outreach focus, and supports *nationalism* by presenting a dependable external authority who can be relied on to serve U.S. needs.

The benefits of this association for the WFME, meanwhile, can be most clearly seen by drawing on Foucauldian ideas. Four years prior to the ECFMG ruling announcement, WFME had already raised the idea of a programme that would ‘accredit the accreditors’ (Karle, 2006). This was raised again subsequently (Karle, 2008). In other words, the idea for the recognition programme was already there as an ambition for WFME following the launch of the global standards. It did not, though, come to fruition until the ECFMG ruling. One explanation for this is that there were no reasons for regulatory agencies of the world to engage with a WFME recognition programme. As I’ve explained in this thesis, there are considerable costs associated with gaining recognition, so agencies must have a clear motivation to do so. What the ECFMG ruling provided was exactly this opportunity to compel engagement. Indeed, the WFME recognition programme was quickly developed after the announcement and has continued to grow since. Analysing these events through Foucauldian theory, one can see how the discursive shift outlined earlier in this section, away from *resistance* and towards *protection* and *control*, was in fact a shift in power relations to enable this new policy position. In other words, the shift from discourses of *altruism* towards discourses of *nationalism* could be conceptualised as a means for WFME to empower and validate the development of its recognition programme.

What is clear from this research is that since the time of the ECFMG ruling, the link between ECFMG and WFME has been strong. The implications of this for WFME as an organisation depend on which framing of the ECFMG ruling you look at. Viewed in terms of a policy motivated by *altruism*, WFME emerges as an organisation of reform, improvement, and modernisation that is working with ECFMG to improve medical education around the globe. Viewed in terms of a policy motivated by *nationalism* though, WFME emerges in a less glowing light that is difficult to reconcile given its stated organisational mission. Although the ECFMG ruling allowed WFME to develop the recognition programme that it had wanted, it is unclear what cost it paid for this in terms of its own credibility as an organisation.

As I have outlined in this chapter, both *altruism* and *nationalism* can each be conceptualised as orientalist discursive positions according to Said’s theoretical position, given that they both contribute to ‘othering’, albeit in different ways. Although both potentially represent orientalist positions, this does not mean that both are comparable. Given that WFME is an organisation with an ambition of global representation, one can consider how countries in various different parts of the world may be observing its decision to associate so closely with U.S. policy. Consider, for example, how medical



education policymakers in Asia, Africa, or South America may view this decision. Put simply, a position of *altruism*, although it may be based on orientalist assumptions, is still likely to be more palatable for the majority of the world than a position of *nationalism*. I suggest, therefore, that the fact that these two positions have both been promoted as motivating factors for the ECFMG ruling, is problematic for WFME in terms of its global mandate.

Said (1996) emphasised the importance of challenging orthodoxy and dogma, and encouraged the raising of 'embarrassing questions' for the 'power elite'. He considered it particularly important to fight for people and causes that are perennially forgotten. As Kuper et al (2013) propose, medical education scholars can draw on critical discourse analysis to 'make strange' and problematise normalised positions and approaches. In this thesis, I have questioned the assumptions that WFME, a global organisation, should have a 'special relationship' with ECFMG, and I have attempted to explain why this position may have arisen in a particular historic moment through the discourses that preceded and enabled it. Perhaps the most striking way to do this is to imagine what a global organisation for medical education, like WFME, could hypothetically look like. It could, for example, proactively associate itself with the most marginalised, vulnerable, and repressed countries and medical schools of the world. It could distance itself from any policies or practices that could remotely be considered orientalist or in any other way oppressive. It could actively seek to celebrate differences, foregrounding and showcasing examples from around the world where countries have bucked trends and been bold and ambitious in creating curricula, teaching and assessment methods, and indeed regulatory systems, that are purposively different from other countries and international norms in order to work in its own sociocultural, educational, and healthcare context. This hypothetical vision of such an organisation provides a means to examine current global organisations through a lens of 'possibility'.

## 11. Reflections

It was, as I explained in the first chapter of this thesis, conversations with senior medical educators and leaders around the world that first got me interested in this research area. I was struck by the high regard that they held for WFME and the great authority it seemed to have in some, but not all, countries. In the UK, where I am based, it is a relatively obscure organisation that is not widely known or respected, and yet in countries in Africa and Asia, it is considered extremely influential. As I became more immersed in reading about WFME, it became clear to me that it was the ECFMG ruling in 2010 that had a significant impact on it becoming so relevant and widely known in these parts of the world. It was for this reason that it became a focal point of this research. I have found this journey to be intellectually challenging and stimulating, and have been genuinely surprised by some of my findings.

### 11.1 Strengths of this research

In applying an analytical framework to medical education research on globalisation, I have been able to position the ECFMG ruling as an atypical policy event in the field, and one that was supported by both hyperglobalist and transformationalist discourses. By tracing these discourses over recent decades, I have cast light on assumptions and devices that have been used to promote certain ideas and positions, and marginalise others. These discourses have profound implications for the authority that WFME holds. As I outlined in the previous chapter, the parallel discursive strands of *altruism* and *nationalism* have dominated the ECFMG ruling. The strand of *nationalism*, in particular, is a challenging one for WFME to reconcile given that it positions itself as an organisation with global representation for the medical education community.

In employing critical discourse analysis in this study, I have been able to explore connections between language, knowledge, and social interactions. All of the discursive positions that I have outlined in this study have privileged certain ways of thinking and have marginalised others. Drawing on the work of both Foucault and Said, I have been able to point out some of the ways that global approaches to medical school regulation have been framed, and how these conceptions have limited other positions. For example, the discourse of *modernisation* projects harmonisation as a necessary and absolute goal, limiting attention to the ongoing marginalisation of contextual factors and detracting from a focus on local healthcare priorities and cultural approaches. All discourses shape thinking and practice, often in ways that are not anticipated, and by highlighting the unanticipated effects of globalising discourses, I offer policymakers and educators a perspective on potential harms from apparently benevolent and reformative practices.

One significant finding that I have highlighted in this thesis is the discursive shift that took place in the middle of the time period of this study, which involved a fading away of the discourse of *resistance*

and an emergence of the discourses of *protection* and *control*. This, to me, is a worrying shift as it closes off healthy debate and argument. The discourse of *resistance* challenged the dominant discourses of the time, providing opposition on technical grounds and pointing out oppressive ideas and language. One might argue, based on Foucault's notion of the power relations of discourses, that whilst challenges were 'sayable' in the period of the Edinburgh declaration and whilst the WFME was still a new organisation establishing itself, they became 'unsayable' in the later period of this study, when WFME had become better established and more influential because of its association with ECFMG. I propose that challenge and opposition is, in fact, crucial for an organisation like WFME, who should be continuously re-calibrating and 'checking the pulse' of medical education all around the world. In order for the medical education community to have the best possible version of WFME, this challenge is needed and its absence is troubling.

I hope that this research will draw attention to the value of Said's work when considering global questions in medical education research. Having spent some time searching for and reading studies in medical education that have dealt with globalisation and global issues, I did not come across a single study that had used his work in a theoretical way to examine policies or practices in the field. In particular, the notion of contrapuntal analysis, or reading 'against the grain' of dominant texts is, I believe, a valuable tool for medical education scholars to be able to understand the assumptions and unintended consequences in many widely practised and accepted areas in the field. Perhaps the identification and analysis of the discourse of *resistance* in this research will help to look for new ways of understanding the positions and perspectives of marginalised groups in medical education. One example might be the WFME presidency. The last four presidents of the organisation have been white, male, and European. Given its apparent global mandate as an organisation, the work of Said and other postcolonial theorists may help to analyse this and many other facets of the 'global' medical education community. My drawing on the work of Foucault and Said in tandem in this study is also a first in the field of medical education and has demonstrated the compatibility and synergy of their theoretical perspectives.

### **11.2 Limitations of this research**

There are several important limitations to this research. Firstly, despite exhaustive database searching and snowballing methods, it is possible that documents were missed. Crucially, the limitation to English language documents significantly limits this research, as many opinions may not be 'possible' to express in English and could therefore have been published in other languages. In particular, this constricts the contrapuntal method, although it was nonetheless still effective in this English language dataset. A further limitation is the exclusive use of document analysis. Whilst it is recognised that oral

histories rely heavily on memory, which can be flawed and prone to exaggeration (Hobsbawn, 1997), there may nonetheless have been some additional insights from interviewing those engaged in ECFMG and WFME in recent decades. Finally, given my inevitably complex relationship with this topic area due to my professional, institutional, and personal background, as highlighted in chapter 1, the research could have been improved by drawing on a broader research team from different disciplinary, personal, cultural, and geographical backgrounds, in order to provide a more nuanced and multifaceted analysis.

### **11.3 Personal reflections**

Soon after I began to commence this research in 2019, I attended a WFME conference in Seoul. Having visited a number of medical education conferences in the past, there was something very different about this one. The attendance was dominated by delegates from Asia and Africa and it was clear that WFME has a particular influence in some of the poorest parts of the world and some of the most unstable countries from a geopolitical perspective. What struck me most of all, though, was the final address. It is usual practice for a closing address to be given by the leader of the organisation hosting the meeting. One might expect then that the final address was reserved for the WFME President. This was not the case. The final address was instead given by the ECFMG President. Although this did not seem strange to other delegates, it struck me as incongruous and looking back, I can now see why. The association between WFME and ECFMG is, I argue, really exemplifies the incongruities associated with global approaches to medical school regulation.

The journey that I took to complete this research was by no means linear and I spent much time reading and exploring areas that did not feature in this thesis. What is clear to me, though, is that the journey fundamentally changed my understanding of medical education. In a sense, this research has forced me to 'zoom out' and see the bigger picture in the field of medical education, and by applying specific critical lenses, I have been able to see what I may have previously accepted as 'true' without much thought. Already, I have seen the way that this is shaping my thinking as a medical education practitioner and scholar and I am hopeful that this will continue to develop as I take on new challenges and studies in the next parts of my professional career.

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**Figure 1 Three events that frame the data archive**



Figure 2 Temporal relationship of discourses

	Edinburgh Declaration (1988)	WFME standards (2003)	ECFMG Ruling (2010)
<i>Endorsement</i>			
<i>Modernisation</i>			
<i>Resistance</i>			
<i>Protection</i>			
<i>Control</i>			

**Dominant discourse**
**Counter discourse**

**Appendix 1 Worked example of coding to Walton, 2001 text**

# Global Demands ON Medical Education The Case of Iran\*

The sole authorship of this article is striking - the 'voice' of this piece is exclusively from a Western, WFME-affiliated author and despite the article being expressly about Iran, there is no co-authorship from anyone linked to Iran.

That the (former) WFME President is 'allowed' to 'speak' about Iran but no Iranian is able to 'speak' on equal terms or on the same platform is striking, and an example of creating the West as 'Other' in a way that is classically Orientalist in Saidian terms. The absence of an Iranian co-author can also be conceptualised using Foucauldian approaches, as a means to consolidate and control by using the techniques of silencing and exclusion. This fits within his descriptions of 'disciplinary' power.

Henry Walton\*\*

## Abstract

World action in medical education, notably the global programs of the World Federation for Medical Education, the Edinburgh Declaration of 1988 and the 1993 World Summit, has led to major curricular change in medical schools. For educational reform to result in improved health services of nations, an essential requirement is integration between the medical education system and the health care delivery systems of countries.

Particular countries have been viewed as models of such integration: Cuba, Thailand and latterly Iran. The Iranian system of integration between the health care services and the health education sector, regarded as a model for other countries, is of the greatest interest internationally. The progress of the Iran initiative is watched with keen attention by medical educators and health care managers worldwide. This interest requires that Iranian medical education projects and experiments be reported in the world literature, and for facilitation of visits through the fostering of international cooperation. Iran is expected to contribute significantly by example to the global movement now taking place.

## 1. The Position of Iran in International Medical Education

In the 1960's Cuba captured global attention as a world leader in provision of coverage of health care to the entire population of that country. By a decade later, Thailand had become the country attracting international interest for its system of delivery of medical services extending from cities into the provinces, and reaching into villages and rural areas: this nationwide health care system was led by governmental administration and implementation of medical education principles<sup>1</sup>.

Most recently, world interest has focused on Iran. Distinguished Iranian medical educators, including Fanaee, Ghassemabadi, Haeri, and Mahmoodi had participated in 1995 at the WFME Eastern Mediterranean Regional Conference at Al Ain<sup>2</sup>. To implement the recommendations of this Regional Conference, a Ministerial Consultation was held at Cairo<sup>3</sup>, where the Minister of Health and Medical Education of Iran reported the unique integration of the health care and medical education systems (one Ministry responsible for both clinical services and also medical education), with health care coverage for the entire population. Integration achieved between the health delivery system and medical education brought about in his country. Marandi's subsequent report on in the international medical literature<sup>4</sup> gave rise to the widest interest in "the Iran Experience"; the paper by Azizi<sup>5</sup> further extended general awareness of medical education reform in Iran.

It can be said that during the 1980's the main emphasis was on medical education as a system. In the 1990's attention paid the *medical education in isolation* was no longer considered adequate. The question became pressing: medical education for *what*? As the massive changes took place in the delivery of health care (due to the managerial revolution, the increase of patient autonomy, and the profit motive), the emphasis shifted to emphasis on medical education for *better health care delivery*. Under present circumstances, the Iranian system is being

studied by other countries as a case demonstration of medical education fully integrated with the health services, and intended to provide health care coverage for the entire population.

## 2. The World Federation for Medical Education

WFME, when embarking global reform of medical education, learnt from an unsuccessful but nevertheless valuable attempt<sup>6</sup> in the U.S. which demonstrated that the essential requirement for reform was a public, agreed and specific *statement*, which had to be arrived at, and formally adopted, by those undertaking the change process. The *Edinburgh Declaration* was the mandate for reform of medical education, which was derived from intensive enquiry starting at national level, then endorsed regionally, and finally adopted internationally. The *Declaration* was agreed by medical educators at the 1988 World Conference<sup>7</sup>, and this global consensus was then formally approved by the world health parliament (World Health Assembly Resolution 42.38, 19 May 1989). All national governments were called upon to reorient the curricula of their medical schools in keeping with the 12 principles of the *Declaration*. Five years later, following the WFME World Summit on Medical Education<sup>8</sup>, the World Health Assembly adopted a second similar resolution, WHA Resolution 48.8, repeating the charge to member states to reform their medical education systems. The *Edinburgh Declaration*, translated into all major languages, has been very widely adopted as a mandate for reform of medical education. There is now a greater surge of reform worldwide than at any time since the start of the century<sup>9</sup>.

## 3. The Impact of the Declaration

Entire regions of the world have in recent years aimed to change their medical education systems in keeping with the 12 principles of the Declaration. For example, the Pan-American Federation of Associations of Medical Schools credits the Declaration accordingly, as do the National Associations for Medical Education of many South American countries. The Declaration was reformulated<sup>10</sup> to meet South American regional priorities and administrative structures at the 1995 international conference at Bogota, Colombia.

Individual countries perhaps illustrate most explicitly the direct impact of the *Declaration*. An example is Portugal, where UNESCO and WFME with the Portuguese government and national medical education authorities carried out a joint national project for reorienting the curricula of the medical schools, using the *Declaration* as "a reform protocol of medical education in Portugal, at the request of the Ministers of Education and Health of that country"<sup>11</sup>. The recent monograph which specifies in detail the extensively revised medical curriculum to be implemented in all the Faculties of Medicine in that country cites as its first reference the *Edinburgh Declaration*<sup>12</sup>.

This demonstration of the primary importance of the *Declaration* as the very basis of reform and reorientation of curricula medical worldwide can be replicated by manifold instances where explicit acknowledgement is expressed. Equally frequent are the extensive national or institutional reforms which manifestly implement the principles of the *Declaration* without overt acknowledgement, but with close accord. The validity of the *Edinburgh Declaration* remains uncontested as a global mandate for reform of medical education.

The late James Grant<sup>13</sup>, Executive Director of UNICEF, spoke of "the historic *Edinburgh Declaration*", commenting it had been a vision in 1988 but by the 1993 *Summit* the proposed reforms had become "practical, realistic and do-able".

Table 1. The Edinburgh Declaration (1988)

- |   |
|---|
| Actions within the medical school                     |
| 1. Widen educational settings                         |
| 2. National health needs as the context for curricula |

This description of the Edinburgh Declaration contributes to the discourse of 'Endorsement'. As well explicitly describing the Declaration as being endorsed, two ideas are particularly projected - one about consensus (and thus 'mandate') and one about adoption, which are each strands of this discourse.

Foucault argued that power can be productive and used to create a compelling vision of a social structure. The descriptions used here seek to portray this Declaration as being popular and well supported. The use of specific details (e.g. the Resolution numbers, the exact date it was passed) fits with Foucault's description of discipline in *Discipline and Punish* ('political anatomy of detail') and adds emphasis to the authority of these statements. The focus on translating to major languages is important given that WFME emphasises its own international power and influence. This language projects the Declaration as being globally influential and is an example of Foucauldian 'normalisation'

This passage about the impact of the Edinburgh Declaration contributes to the 'Endorsement' discourse through ideas of consensus (explicitly a 'global mandate') and additionally through alignment, through the affiliation to UNICEF.

That this quotation and others in the article come exclusively from individuals with clearly English names can be seen as Orientalist, as Said notes 'citing other authors' is a way to preserve Western hegemony. The alignment to UNICEF, meanwhile, is noteworthy because UNICEF is widely recognised and respected. Associating WFME with UNICEF encourages the reader to think of the two agencies as equivalent, a form of social coercion that Foucault recognises in his descriptions of disciplinary power.

\* Fifth National Congress on Medical Education, Iran, Tehran, Nov. 14 - 17, 2000 "as the invited lecture.

\*\* Past-President, World Federation for Medical Education Professor Emeritus of Psychiatry and of International Medical Education, University of Edinburgh

3. Active learning methods (tutorial, self-directed and independent) for continuity of learning throughout life
4. Require professional competence (not mere knowledge recall)
5. Train medical teachers as educators
6. Prevention of illness and health promotion
7. Integration of science and clinical practice
8. Selection of applicants, for non-intellectual as well as intellectual attributes

Requires wider involvement

9. Coordination of medical education and health care systems
10. Balance in production of categories of medical staff and other health professions
11. Multiprofessional training and teamwork
12. Provision for continuing medical education

#### 4. Real Life Settings vs. The Ivory Tower

The very first principle of the *Edinburgh Declaration* was the insistence that the university centre alone could no longer serve unaided as the educational base for future doctors (*Table 1*):

**“Enlarge the settings in which educational programs are conducted, to include all health resources of the community, not hospitals alone.”**

For such enlargement of the learning base to occur, all health service resources of the country have to be mobilized. *Principle 2* requires medical education to reflect national health priorities and the resources available in countries. Ministries of Education and Ministries of Health have to cooperate, and together create the committee structures integrating the medical education system with the health care system. Perhaps such academic and health care delivery partnership is the foremost among the necessary reforms, and spells the end of academic elitism and exclusivity in medical education. District hospital, community clinics, and family practices are settings for learning in addition to the teaching hospital, as are schools and the workplace. Skills are to be acquired in the places where medical morbidity is actually encountered.

#### 5. Active Learning

*Principle 3* requires elimination of passive methods of learning. The Flexner Report at the start of the century<sup>14</sup> already insisted that the only sort of medical student of any use is an *active* medical student. Exactly because contemporary medicine requires a scientifically sophisticated doctor, the science base of the medical curriculum must function to activate students - and not perpetuate the passive role induced by obsolete didactic methods. Flexner could never have envisaged the disastrous misreading of his Report, leading to separate basic science departments being administered as competing fiefdoms, each with their own didactic agendas, resulting in passivity-inducing curricula becoming commonplace.

#### 6. Information Overload

Two other liabilities result, one of which - *information overload* - is targeted by *Principle 4*. The curriculum is disfigured by emphasis, both in teaching methods and in examinations, on retention and recall of facts as a curricular aim. Much content now cluttering curricula in any case can be moved into postgraduate programs or, indeed, CME.

#### 7. Medical Teachers as Educators

One obdurate barrier to necessary reform, which *Principle 5* addresses, is the inertia of medical teachers - a profound obstacle within the medical school itself. Educational commitment is accorded scant regard. Many teachers, it hardly needs mention, have not ever had personal instruction about how to teach. The *ACME-TRI Report*<sup>15</sup> published by the AAMC showed that a main reason for failure of reform is the apathy of teaching staff: the general conclusion was that it seemed next to impossible to get a critical mass of medical teachers interested, concerned and involved in the education of medical students. At issue is the regularity with which medical education can still get dismissed as merely the harmless hobby of isolated academics. The medical education literature remains little cited in medical faculties, and medical education research is invariably a closed book to all but very few medical teachers. Such educational obscurantism on the part of the staff of medical faculties is now altogether untenable. The entire medical professional scenario has changed, and with this transformation medical education has come of age. Economically, medical education is big business: in England the postgraduate deans receive government funds to pay half the salaries of all junior doctors (the hospitals pay the other half); and in Scotland the postgraduate deans pay the total salaries. Medical education

is legally of great consequence. In the EC medical education is governed by international law: for instance, the European Court ruled against the legality of the UK specialist regulations, and this adverse legal ruling led to massive restructuring of the entire postgraduate training system of Britain, which previously had been in stasis under the aegis of the Royal Colleges. Managerially, also, medical education has become a force to be reckoned with: Medicare in the US pays half the costs of graduate medical education.

#### 8. The New Medicine

The preamble of the *Declaration* urged: “The aim of medical education is to produce doctors who will promote the health of all people - not merely deliver curative services to those who can afford it or for whom it is readily available.” The first principle insisted on extended settings for learning. Skills are to be acquired in the places where medical morbidity is actually encountered. *Principle 6* states that the *new medicine* calls for equal emphasis on promotion of health and prevention of illness, as well as curative medicine. The requirement follows that every department and branch of medicine must rethink the educational content provided as its contribution to the medical curriculum.

#### 9. Education in the Sciences

*Principle 5* attends to the charge that basic science education is too little, too isolated, and too simplistic. Throughout the world the medical sciences are taught separately from the clinical subjects. *Principle 7* specifies science teaching must be integrated with clinical practice. As anomalously, the sciences are taught in isolation from each other<sup>16</sup>. To package different sciences in separate departments obfuscates learning, by suggesting that the sciences present clinically in separate subject or disciplinary parcels. Division of the curriculum into halves, with the so called *basic sciences* taught first, has been disastrous. Empirical surveys repeatedly show students are bored with these *preclinical* disciplines, which they regularly perceive as hurdles to be overcome before they can proceed to clinical studies.

Science must imperatively be rehabilitated in the curriculum, vested interests and expediency countered by insistence on the biosciences as integral to proper medical studies. Of the three curriculum paradigms (traditional, systems-based, and problem-based), only the first is tenable when the curriculum is bifurcated. The third paradigm is supported by *Principle 7*.

#### 10. Three Kinds of Curriculum

Most medical curricula are *traditional*: they have a preclinical phase, they are discipline focused, and the major objective is memorization of facts, with teachers in a dominant authority role and students passive. The innovative development since the 60's was the *organ systems approach*, with basic sciences and clinical subjects integrated, and with the curriculum administered by educational committees and not controlled by individual disciplines. The third, most recent form of curriculum is *problem-based learning*, in which separate disciplines are not learned in sequence; instead, the students (working in groups) are presented with a particular “problem” (e.g. sudden, severe left chest pain), and they pursue all possible knowledge and skills to explain that phenomenon. All medical schools wish to advance from the *traditional* paradigm: the difficulty is that by and large medical teachers are not trained as educators, and do not have the skills for adopting sophisticated teaching styles, which promote self-learning on the part of their students, in recognition that the knowledge base is constantly changing.

#### 11. Two Types of Medical School

Medical schools are either *public*, when they are government funded and in most cases part of the national university system, almost always under the Ministry of Education. Otherwise, they are *private*, independently funded, and the students pay comprehensive tuition fees. This differentiation can constitute two rather distinct spheres of medical education, administered by separate organizations (e.g. Japan). Some of the very many private medical schools around the world, within countries or “offshore”, are academically substandard, inadequately funded, sometimes set up for dubious motives. On the other hand, private schools of course can be flexible and innovative: e.g. in Germany the only problem-based curriculum is in a private school, Witten-Herdecke.

#### 12. Governance

Reform of any particular subject in a medical curriculum is an overall faculty undertaking and not merely a departmental matter, and may be resisted by the medical school as a whole. The politics of medical education are only now coming to be understood. The hard lesson has not yet been learnt that a curriculum should never be changed until the

This description of curriculum portrays problem based learning as a means to improve the world, and it contributes to the 'development' strand of the 'Modernisation' discourse.

The portrayal of problem based learning (PBL) is not only as one possible curriculum method, but as a clearly superior option and one that all medical schools can 'advance' to. That PBL was developed in the West and is based on Western educational values and practices suggests that this is an imposition of Western ideas on the East in a way that Said saw as Orientalist. Moreover, the suggestion that some people in the world 'do not have the skills' for this 'sophisticated' approach, it contrasts the civilised West with the barbaric East, who cannot progress without support.

The historical tone of this passage is noteworthy when considering Foucault's ideas. The author portrays the movement across three different curricular approaches as almost evolutionary - gradually improving over time. By suggesting that these transitions were clear cut and universal (which they were not), it projects the movement 'forwards' as inevitable. This fits with the technique of 'exclusion' within disciplinary power dynamics described by Foucault. It closes off debate and dissent by retelling a historical story to fit within a certain social structure that is discursively useful to this text.

system of administration and the committee structure responsible for the curriculum has first been modified appropriately. A separate, independent curriculum committee is essential to counter the influence of departments over the organization of teaching, and thus to prevent control of the curriculum by staff who are certainly not concerned primarily with education. Information overload, which is perniciously destructive, is inevitable and progressive unless demands of departments are neutralized by taking the curriculum out of departmental control.

Bloom<sup>17</sup> has documented: "Educational values become subordinate to the requisites of the organizational structure of the medical school". Curricula are controlled by basic scientists or by teachers whose primary interest lies in research, clinical investigation and scientific publication. Medical school teachers appointed to be in charge of academic departments and teaching hospitals of course are scientists and specialists. They all stake claims for curriculum time. Inevitably the empire-building that results has a distorting influence on the curriculum. Special pleading by such department heads for "coverage" of their discipline is a doctrine now thorough discredited.

Those responsible for administering medical schools do not give priority to education. Certainly in the UK the deans are frank that they have too much else to do, and delegate educational matters to curriculum committees. However, such committees often have no budgets of their own, have limited autonomy, and indeed may be dominated by departmental heads. A *governance system* must be set up which reports directly and only to the dean, and is not answerable to the various departments of the medical school.

### 13. Institutional Leadership Needed

The solution lies in educational leadership, certainly not provided by deans at all commonly. The necessary educational administrative and committee structure is essential. Medical student involvement is necessary. The curriculum must on no account allow or require medical students to be passive. Teaching and learning must focus on clinical competence and performance, not memorization of excessive detail. Medical school staff cannot continue as educational amateurs. The curriculum is no longer to be constructed through power play among contesting departments. The literature on curriculum reform leaves no doubt about the customary sabotage maneuvers that constantly neutralize efforts at reform, and is equally explicit about methods to achieve effective change. The educational brief for institutional leadership is clear.

### 14. External Forces

The *final four principles* of the Declaration insist that forces extraneous to the medical school are formidable barriers to reform in medical education. Medical education is only partially under the control of medical faculties. As medical schools face up to the challenge of reform they are confronted by the brute reality that capacity to change is only partially within the power of the institution itself.

The final four principles, outside the scope of medical schools themselves, depend for implementation on external agencies, like the national government, or a national statutory body such as the General Medical Council in the UK, or a quasi-statutory body such as Wissenschaftsrat in Germany, or the Commission of the five universities with medical faculties in Switzerland. Full cognizance must be given to this crucial reality, that external agencies have statutory powers over the medical schools which may prevent reform. In Denmark, for instance, all medical schools by governmental decree now have to institute a bachelor degree within the curriculum, not conducive to countering the preclinical-clinical split.

Inept though the educational institutions have often proved at reforming the aspects of their curricula within their competence to change, their obsolescent, damaging teaching methods and examination practices particularly, medical schools, therefore, do not carry sole blame. Their room for maneuver can be drastically restricted, the limiting external forces often completely unidentified.

### 15 Medical Education as a Continuum

The *Declaration* concludes with *principle 12* principle targeting continuing medical education. It is accepted as an anachronism to focus on any one of the three phases of medical education in isolation. Comprehensive planning of the entire continuum of medical education has become obligatory. The number of entrants admitted to medical school should be in keeping with the provision for postgraduate training places, and these in turn should accord with the doctors needed by the nation; the competence of such doctors must be maintained throughout professional life. This actuarial planning should also seek to achieve a proper balance between specialists and primary health care doctors

(general practitioners). Medical education policy-making bodies are essential in every country, with representation from the universities, postgraduate training bodies, health services, governments, medical associations, etc.; their purpose is to ensure professional standards, warrant public confidence, and prevent the misguided production of excessive numbers of doctors with defective skills.

### 16 After the Declaration

Since its adoption, a concatenation of massive social, political, economic and managerial changes impacted worldwide in major ways on medical schools. The 1993 *World Summit on Medical Education*<sup>8</sup> again held at Edinburgh, was entitled "The Changing Medical Profession", precisely to emphasize that educational redefinition of medical doctors had to heed the sweeping changes in health care delivery.

The *World Summit* focused on new external and tangential forces affecting the entire practice of medicine. Prodigious changes have resulted from economic recession, the managerial revolution, and transformation of medicine into a business. Immense political changes also supervened; in Europe the demise of Communism led to the creation of 22 new countries; and worldwide genocidal wars of barbaric ferocity. The 1993 *Report* of the World Bank, launched to the medical community at the Summit, *documented* the *Health Transition*: in developing countries the same diseases as in the West were now occurring, and longevity was approaching that in developed countries. Medicine had helped create, and was confronted by, an ageing world. Moreover, an entirely new epidemic had arisen, AIDS confronting educators with the novel challenge of young, often intelligent adults requiring care, when numerous surveys had amply established that a main deficiency of contemporary doctors was inability to communicate appropriately with patients.

### 17 Regional Action

Implementation of the Summit *Recommendations* was carried further at six Regional Conferences<sup>18</sup> during 1994-5. Every region (Europe, Africa, the Americas, the Middle East, SE Asia and the Western Pacific) explored intensively, in the local context, the crucial requirement that effective medical education is no longer possible without a close relationship between the health care system and the medical education system. To achieve such harmonization between medical education and health care, all six WFME Regional Conferences called for the conjoint setting up in every country of authoritative and resourced health councils, to link Ministries of Education and of Health, the medical schools, and professional bodies<sup>16</sup>. Medical education reforms always need the sanction of national governments for full implementation, very often imperatively so if any practical action is to follow aspirations and plans.

For such enlargement of the learning base to occur, all health service resources of the country have to be mobilized. Ministries of Education and Ministries of Health have to cooperate, and together create the committee structures integrating the medical education system with the health care system. Perhaps such partnership is the foremost among necessary reforms, and spells the end of academic elitism and exclusivity in medical education. WHO and UNESCO have sponsored the global enquiries resulting in consensus which supports this major reorientation, and have together called the Ministerial Consultations<sup>18</sup> for mobilizing governmental commitment.

### 18 The Tide of Reform

Progress has been prodigious. An inexorable tide of reform is now flowing worldwide, greater than at any time since the start of the century when Flexner's *Report*<sup>8</sup> revolutionized medical education in North America. There is no doubt that the world scene is now set for decisive, effective action.

In formulating the extensive reorientation of all stages of the training of doctors, to accord with the health needs of countries, WFME has been allied in the reform process by the UN agencies concerned with health in the widest sense, notably WHO, UNESCO, UNICEF, UNDP and the World Bank, and by the international NGOs partnering the Federation, the great foundations, and the national governments<sup>18</sup>. The health parliament of the world, by World Health Assembly Resolutions 42.38, 1989 and 48.8, 1995, has endorsed the mandates for reform arrived at by regional and global action, and has fostered political will by calling on the governments of all member states to implement the reorientation in medical education which has been outlined in the *Edinburgh Declaration*. Without a global strategy the necessary change on an international scale will never happen.

Language of reform is present throughout this article and not only in this section, as well as language of change, reorientation, and progress. This contributes to the 'development' strand of the 'Modernisation' discourse.

The effect of this language is to contrast the West and East, especially when examples of 'good' practice throughout (e.g. sections 7, 11, 12, 14) use European and North American practices and institutions. The effect is to contrast the East as backwards and in need of Western intervention.

This passage demonstrates how WFME attempts to associate and position itself with larger, more established and well recognised organisations that are 'global' in reach, thus contributing to the 'alignment' strand of the 'Endorsement' discourse.

The listing of these organisations can be conceptualised in Foucauldian terms as a means to legitimise knowledge claims. The authority of WFME is enhanced by this alignment with organisations that hold social power in the world of medicine and global health. Foucault was concerned with how power relations are (re)produced through a network of institutions, agencies and authorities dispersed across society. Disciplinary power does not flow from one direction but rather, circulates. This example of a network of organisations that are all global, authoritative, and seen as forces of good, is used to pass authority, and hence, power.



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This reference list is dominated by Western articles and publications. More specifically, this former WFME president cites his own articles and those associated with WFME. Although this article is entitled 'The Case of Iran', only two references are actually about Iran, both of which are published in Western journals. What is absent from this reference list is any indication that the author attempted to understand Iranian medical education through a wide and deep literature search, including looking beyond the Western journals and English language literature.

As Said notes, Orientalists classically cite themselves and one another. This system of citation is a discursive practice that serves to control the kinds of statements that can be made about the East. This article claims to tell an Eastern story but the Western author does not give a sense of having read widely about this Eastern country in order to write it. Rather, the reference points, lenses, and priorities are all derived from Western ideas, norms, and practices. This, in turn, portrays the West as the saviour of the East and thus fits with the 'Development' strand of the 'Modernisation' discourse

Foucault conceptualised power as being productive as well as negative in that it can be used to produce and consolidate knowledge as well as to exclude or conceal it. The widespread referencing of WFME in this article has the effect of what Foucault described as 'normalisation', in that it constructs an idealised norm of how to think about medical education in national and international terms. This kind of social control of how to frame thinking using vocabulary and ideas from particular organisations is an example of 'disciplinary power' in that it encourages conformity. The framing of Iranian medical education in terms of WFME builds and consolidates power towards it as not only a possibly relevant organisation but one that is essential for Iran. It therefore contributes to the 'Development' strand of the 'Modernisation' discourse.

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