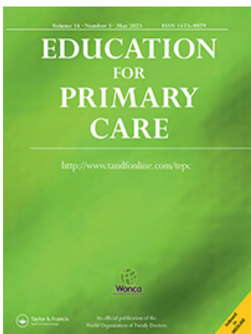

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LEADING ARTICLE

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Respect and reflexivity: international education partnerships in primary care

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ABSTRACT

The UK general practice model has been described as the 'jewel in the crown' of the National Health Service and is widely respected and emulated around the world. In recent years, there has been a particular interest in the UK approach to primary care medical education, including at undergraduate and postgraduate levels, leading to a number of international education partnerships designed to draw on the best of UK experience and expertise in this area. Drawing on the limited academic literature in this area, and the authors' personal experiences of working across many international partnership projects with countries around the world, this article reflects on the central importance of respect and reflexivity when engaging in such work. A respectful approach relies on a genuine and deep curiosity for the local context, and a desire to empower partners to build their own solutions that are contextually authentic. A reflexive approach, meanwhile, relies on those engaging in partnerships to understand themselves as 'invited guests' and to remain mindful of current and historical power differentials and inequities when framing their engagement, looking both inwardly and outwardly as they conduct themselves. As primary care education around the world develops and expands, there may be a greater role for international partnerships and it is critically important that those engaging in such partnerships bring a thoughtful and scholarly lens to this work.

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Introduction

It is an obvious truth to many 21st century healthcare workers in high-income countries that primary healthcare (PHC) is the central ingredient to achieve universal healthcare coverage. It is, therefore, sobering to think that although this has been widely accepted in public health since at least the Alma-Ata declaration in 1978 [1], many countries are still struggling to develop or embed PHC into their healthcare systems [2]. Given that the challenges facing healthcare systems around the world following the COVID-19 pandemic continue to include multimorbidity, medical complexity, and clinical uncertainty in decision-making, the need for holistic, comprehensive, and proactive patient-centred care remains as pressing as ever. Fortunately, politicians and policymakers have in recent years renewed their focus and efforts on strengthening PHC [3,4]. Those with existing PHC systems are seeking to bolster and embed them, and many other countries are designing or growing PHC structures from scratch.

Developing primary care through education

Because of the shortcomings that those of us working in UK general practice see on a daily basis, it is easy to forget that it is widely seen as the 'jewel in the crown' of our National Health Service and is respected, valued and emulated worldwide [5]. For those countries and regions who are developing their own systems and seeking to draw on this model then, how should they go about it? Given that healthcare is shaped fundamentally by people and not by buildings or equipment, PHC education and training is undoubtedly a key part of this [6]. This includes UK models of PHC undergraduate placements and the postgraduate speciality training system that has its origins in vocational training schemes. Countries seeking to draw on the successful clinical model of PHC in the UK typically do so by looking to draw inspiration from the education and training systems that underpin it.

International education collaborations

Senior healthcare policymakers seeking to develop PHC models understandably look to globally reputable institutions that typically exist in Western high-income countries, including the UK, US, and Canada. Given the particularly illustrious status of UK general practice as a cornerstone of its National Health Service, the UK is

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a popular country to approach for such collaboration. In recent decades many individual GPs and GP educators from the UK, and many medical schools, universities, national organisations and charities have engaged in a raft of advisory support projects that have sought to draw on the UK model to help develop systems around the world.

As GPs and medical educators, we have had the great privilege of being involved in a number of projects that have had such a focus, including with partners in countries right around the world. As such, we seek to outline in this paper some of our experiences and reflections about the opportunities and challenges that such engagement presents. In particular, we highlight the potential for unintended harm that can arise from uncritical engagement. Although the academic literature in this space is sparse, we draw on it where available, and combine it with many years of experience of working across a range of international activities in both personal and professional capacities for various institutions.

An overarching ethos of respect and reflexivity

The dominant model of international partnerships in academic medicine for many decades was one of dominance by Western, high-income country partners. The flow of knowledge in the last century has been almost exclusively unidirectional, with Europe and North America as 'exporters' of knowledge and the rest of the world as 'importers' [7]. Perhaps more worryingly still, the dominant discourses in this space have been economic in nature, leading medical education scholars to worry that their field was not in fact getting 'flatter' as globalisation evangelists had envisaged, but rather becoming uneven and 'spiky' [8]. As Bleakley et al have noted, many medical education practices can be problematised through a postcolonial lens [9], and as Naidu demonstrates, this coloniality is not new to medical education and practice [10].

In light of these very stark dangers of imposing dominant Western ideas and values in a 'copy and paste' way, how can one operate in an international partnership meaningfully and sensitively? There is another way. A model of partnership that prioritises the local context and acknowledges inevitable power differentials. This type of model emphasises the relational aspects and strives to build connections between individuals. Existing literature about this type of partnership has focussed on reflexivity and understanding one's own context before advising on the extent to which it can be adopted by a partner [11], and on capacity building and co-development through a respectful 'invited guest' mindset [7].

Understanding power relations

Edmund Burke famously said: 'The greater the power, the more dangerous the abuse' [12]. Medical education does not occur in a vacuum and is shaped by the cultural, socioeconomic and political landscapes in which it operates. As such, power matters. Whilst this is true in all of education, whether in a classroom or clinic or exam centre, it is especially true when one extends out of the relationship between individual trainer and trainee. Partnerships are a prime example, and international partnerships even more so, given that the historic and structural factors that invariably make one partner dominant from the outset.

In recent years, medical educators have increasingly recognised the value of using theoretical approaches that are mindful of power relations, including for example those that draw on academic philosophers including Foucault [13] and Bourdieu [14], and particularly in the global space, those that draw on postcolonial theorists [15,16]. It is critical, though, that this scholarship does not stay on the pages of academic journals but rather permeates to the frontline of medical education and influences practitioners who are engaged in medical education in all different contexts around the world, including through international collaborations.

When we have worked in international partnerships power differentials have been apparent from the outset and have dominated all exchanges, whether virtual or in-person, whether written or spoken, and whether articulated or unsaid. As we are based in London, often representing influential and historic institutions, we have come to understand that this power can be used both constructively and destructively. When used to help give credence to innovative and reformative ideas and support change-makers to build momentum it can be a force for good. However, if it is used to uncritically exercise a 'lift and shift' approach that promotes (or even forces) Western practices in a context where they do not fit, it can also be a force for harm.

Context is everything

It is impossible to imagine that one might simply be invited to a new organisation, city or country and automatically or suddenly understand the history, culture and values that has shaped it and continues to define it. Whilst it is reflexivity that helps one to try and manage power relations, it is a deep respect for the local context that helps to ameliorate this inevitable ignorance. Those

engaged in partnerships need to have a genuine curiosity for their partners' settings and take time to listen and understand what the local challenges are.

Listening and understanding, though, are not enough if they are not followed up by a suitable intervention. In general terms, we suggest that the default position in partnerships should always be that the solutions or interventions are designed locally. Despite our best listening skills, we can only catch a glimpse of the local challenges and those immersed in it and living it will always understand it more deeply. The role of the 'invited guest', then, is to gently and respectfully probe, clarify, and reflect on issues together, ultimately empowering local partners to follow their judgement and build solutions that are contextually authentic. After all, PHC is embedded in communities and societies, and training therefore has to be grounded in these local realities.

Evaluation and scholarship

In recent decades medical education has become a professional field with a large number of postgraduate training programmes, academic journals, research grant funds and scientific conferences. With this there has come a recognition that research is critically important to advancing the field in a healthy and positive way [17]. Especially in light of the potential for harm through dominance in international partnership working, it is vitally important that this is not ignored. Although many partnerships are unfunded or funded only to cover basic costs, which means that evaluation and scholarly activities may not be prioritised, it is crucial that they are given sufficient importance across the course of a project that they can provide appropriate scrutiny and help guide future work. Only in this way can all stakeholders involved in these partnerships be reassured that they are working effectively and, crucially, that they are not inadvertently causing unintended harms.

A case study

The break-up of the USSR led to rapid economic decline in the region, which exacerbated historical under-investment in the health sector. Central Asian countries lacked the funds to finance large scale healthcare reforms and this 'crisis' attracted '*a horde of health development specialists from the World Bank, WHO, USAID, DFID . . . to propose solutions to reform the "sclerotic" Soviet health care system*' [18]. The World Bank (WB) agreed a loan in 1993 to support a new PHC reform programme through the Project 'Health' which was composed of three components:

(1) Strengthening of PHC services through the restructuring of current primary care facilities and creation of new extended primary care services (SVPs),
(2) Training of physicians and nurses for PHC,
(3) Strengthening health financing and management in the regions.

Agreement was reached with the then UK Department for International Development, through the Know How Fund, to provide support to assist the Uzbekistan government in developing PHC training capacity through training of 'GP Trainers'. These were chosen by their medical institutions, and many had originally trained in specialities other than family medicine.

Evaluations of the project highlighted that the strengths of the programme were primarily relational and related to the opportunity to interact with experienced GP educators from the UK, who drew both on their experience and their knowledge of educational theory and evidence. These relationships with those who were actively engaged in PHC clinical educational roles were greatly valued, and their respectful engagement was appreciated by the Uzbeki participants in the training events. The key limitations of the programme, meanwhile, linked to a relatively greater focus on theoretical rather than practical training and difficulty understanding English for some participants. Despite the programme being received largely positively, the exodus of doctors from Uzbekistan continued and frustration about this 'brain drain' was felt by those left behind.

The last two decades have seen major reforms not only in the healthcare system in Uzbekistan, with a greater focus on primary care particularly in rural areas, but also in medical education systems including at postgraduate level [19]. While the impacts of a single programme cannot be isolated and these improvements are linked to a much broader set of issues, this case study demonstrates the importance of prioritising relational and human elements of partnerships, and on conducting scholarly evaluations to ensure that programmes are improved in subsequent iterations.

Conclusion

As UK primary care medical educators, we work in a system that is widely respected and valued around the world. As such, our approaches and expertise are widely coveted and valued in countries where primary care systems are being established and extended. When

invited to work with international partners, though, we must recognise that such work is not as technical as it may appear on the surface. It can be easy to convince oneself that advice is simply about curriculum, assessment or clinical supervision. Primary care and medical education are shaped by values, culture, politics and much more. As such, we must bring our most holistic selves to these engagements, perhaps even more so than we are with our patients, students and trainees. The dual approach of respect, to value our partners' contexts, and reflexivity, to understand our own positions and privileges, are in our experience two of the most important ingredients to shape our approaches to these relationships.

Disclosure statement

MAR is Vice Dean (International) at UCL Faculty of Medical Sciences and leads the UCL Centre for International Medical Education Collaborations. He was previously Medical Director for International Training for RCGP. AAK has been involved as an International Healthcare Consultant since 1998 and is currently Medical Director for International Accreditation for RCGP.

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