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Decolonising medical education regulation: a global view

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INTRODUCTION

The General Medical Council (GMC) is the medical regulator in the UK and has been subject to recent scrutiny and criticism. With the support of *The BMJ*, the British medical profession are rightly demanding better from their regulator.[1 2] Specifically, this followed a 2022 review that found that the GMC needed 'cultural competence, compassion, and a commitment to change'[3] leading to calls for fundamental reform to improve accountability. This is not, though, a parochial concern. Rather, it is one that is relevant wherever regulation occurs, whether nationally or internationally. It forces us to 'zoom out' and ask: who regulates the regulator?

Regulation has, perhaps uncritically and without evidence of effect or comparative best practice,[4] become an almost automatic response to issues of quality and accountability. In the UK alone, for example, there are at least 90 regulatory bodies, at a cost of more than £4 billion. But more concerning, perhaps, is that regulation, by its nature, is also used to achieve policy objectives.[5] Because of this, regulation requires analysis of its actual purposes and mechanisms, as well as accountability to beneficiaries, funders and those being regulated.

Similar arguments have been addressed in relevant areas of activity: international relations, international law and international journalism especially 'parachute journalism' whereby a team, much as regulatory teams, will visit a locality for a few days, write their report and leave.[6–8] In each case, the authors conclude that decolonising these areas of work is required. The idea of decolonising international regulation and accreditation has not yet been addressed.

Instead, in keeping with neoliberal ideologies including modernisation and standardisation, medicine and medical education have followed other sectors by further promoting and centralising regulation,[9] which has in turn enabled a global industry of regulation. International regulation in other domains tends to be characterised by cooperation between regulators.[10] However, in medical education, it is characterised by external judgement of performance, creating an apparent hierarchy of power and authority. For these reasons too, international regulation requires the same scrutiny that *The BMJ* has applied to the GMC, not least because of the unexamined assumption underpinning it, and the serious nature of both the intended and unintended consequences of international regulation.

SUMMARY BOX

⇒ Medical education has followed other fields by enabling a global industry of regulation despite a lack of statutory authority for international regulators and a lack of empirical evidence to support any particular models of regulation.
⇒ In recent years, global regulation of medical schools has been linked to migratory opportunities, especially from the global south to the global north. However, the power imbalances, and particularly geopolitical and postcolonial dynamics inherent in medical education regulation, have so far not been examined.
⇒ Mindful that the inherent power imbalances between regulators and those they regulate are extended and deepened in the global arena, this article critically examines international regulatory policies in medical education and highlights the lack of evaluation to scrutinise their effects.
⇒ Just as there are increasing calls for cultures in the global south to re-imagine imported views of medical education to suit their own context, we argue for the need to decolonise and re-imagine ways of supporting medical education in any context to enhance what it does to serve the local community, profession and development of healthcare.
⇒ Those ways are likely to be local rather than global, and require a fundamental restructuring of global regulatory systems. We argue for a fresh approach to supporting medical education across different contexts that focusses on local rather than global priorities, to decolonise international regulatory activities.

STATUTORY AUTHORITY FOR INTERNATIONAL REGULATORS?

In this paper, we refer to those organisations that work internationally to offer a stamp of approval to institutions or programmes as 'regulators'. We recognise that they might not refer to themselves in those terms: they might judge, recognise or accredit[11] actual regulators or programmes, but are not regulators themselves, not least because none has statutory authority. Nonetheless, they behave as regulators and model themselves on the activities and processes of actual regulators. They set standards, demand self-reviews, site visits and inspections, issue a similar range of approvals and conditions, and ask those who have paid to be inspected to be accountable to them. They can be actual or implied gatekeepers, exerting power over others' agency and careers. They are, therefore, treated as regulators by those who use them, despite not having statutory authority.

International regulation may involve a regulatory body from one country inspecting a medical school in another country. Examples of this would be the services offered by the Association for Evaluation and Accreditation of Medical Education Programmes in Türkiye,[12] the US ACGME-I,[13] and the Independent Agency for Accreditation and Rating in Kazakhstan.[14] Other agencies offer the same cross-border international accreditation services.[15]

International regulation may also involve the regulation of these actual accreditation agencies by an organisation that is not affiliated to a particular country. International recognition at this level is conducted, for example, by the World Federation for Medical Education (WFME) and the European Quality Assurance Register for Higher Education (EQAR).[16]

There is therefore an apparent hierarchy of regulation ranging from national regulation of medical schools by their own country agency, to cross-border regulation of medical schools where there is no national regulator, or the national regulator is not deemed adequate, to the regulation of national and cross-border agencies by an overarching regional or global body with the implication that those national and cross-border agencies might not be adequate in their performance and that a judgement about that can be made by an entirely external body. This raises the question of power, authority and accountability.

At the level of national regulators, such as the GMC, there are typically higher statutory and legal authorities which allow the regulator to operate. The GMC, for example, is accountable to the British public through Parliament and the monarch's Privy Council. But even then, as *The BMJ* has illuminated, their conduct has been deemed far from acceptable. How much might that problem be magnified where there is no statutory or legal framework, such as is the case in the realm of international regulation? Here, regulatory decisions are taken despite lack of statutory or legal powers or external scrutiny, by implication of improved quality, even though evidence to support this driver is absent, or by implicit threat of penalty.[17]

LINKING GLOBAL REGULATION TO MIGRATORY OPPORTUNITIES

Regulation at a global level will enable activity at that same level. An example of this is evident in the WFME Recognition Programme. This was established in 2012 to support a US policy decree from the Educational Commission for Foreign Medical Graduates, who announced in 2010 that overseas doctors would only be eligible to sit the US Medical Licensing Examination (USMLE) for certification to train and practise in the USA, if they had graduated from a medical school that was accredited by a 'recognised' agency. This policy decision, then, had the potential to block medical graduates' access to training in one country, the USA, of the global north.[18] This penalty did not and does not apply to training for international medical graduates in any other country. In exchange for a substantial fee plus inspectors' expenses, WFME 'recognises' an agency for a period of 10 years, thus allowing graduates from all schools accredited by this agency to sit USMLE and migrate to the USA to pursue higher medical training. In order to be eligible, agencies should either be government entities, or entities that are recognised by either their government or the appropriate professional association.

As has been noted in relation to European Union regulations designed to facilitate freedom of movement between member states:

> Turning education and training into a market product like this is already in full swing in postsecondary education …. As with other consumer goods, education and training also need to be marketed and provided with informative labelling, and companies must comply with quality standards and norms, which can be declared.[19]

Unsurprisingly, enabling medical migration to the USA has been a seemingly central driver for agencies seeking the 'informative labelling' of WFME recognition. In regions where offering such migration to graduates is an important commercial driver of medical schools, accreditation agencies have been quick to position themselves.

The Caribbean, for example, now has three WFME recognised accreditation agencies, one operating entirely from another country. Elsewhere, other recognised agencies operate prolifically outside their own original jurisdiction, sometimes in countries where there are also national WFME recognised agencies.[15] Such trends suggest there has developed the possibly unintended consequence of an accreditation-based business model, rather than one focused on quality. This model of regulatory competition has been criticised in other professional domains, not least for being associated with a 'race to the bottom'.[20]

Countries in the global south, who typically have considerable medical workforce shortages, could theoretically use this policy backdrop to deprioritise gaining WFME regulation and thereby limit or discourage their graduates from seeking migration opportunities to the USA. In reality, this seems a challenging position to adopt for three reasons. First, the opportunity to complete postgraduate medical training in North America is widely

accepted as being prestigious and important to enhance skills and reputation.[21] Second, such a position would create a challenging dynamic for institutions to manage with medical students and junior doctors, who may feel aggrieved by this limitation for both professional and personal reasons. Finally, there are many other pressures to comply, including pressure from medical professionals both inside countries and in diasporas, as well as a fear of 'falling behind' and 'missing out' compared with other countries on the global stage.

COLONIALITY OF POWER

Kwame Nkrumah understood that despite formal independence, the influence of the former coloniser on the former colonies remained, by having their systems and policies directed from the outside.[22] In relation to both medical education, and to the regulation of biomedicine and professional practice, it has been argued that the regulatory systems established in the colonial era themselves, by referencing the educational, scientific and professional practices of the colonial power '… remain a major obstacle to improving the availability, retention and quality of health workers in many LMICs (low and middle income countries)'.[23] The systems of regulation now applied at international level were modelled on the processes of the colonial powers in relation to their own contexts and conditions. It is argued that these do not necessarily suit the contexts and conditions of others who have a different trajectory of development and provision. The methods and processes of regulation that we see applied at international level were not developed in the contexts to which they are now applied. LMICs, therefore, might best serve their own contexts by 'being ready and willing to evolve new regulatory institutions that meet our current moment'.[23]

Given this, we cannot think meaningfully about international regulation without considering power relations. The inherent power imbalances between regulators and those they regulate are extended and deepened in the global arena. International regulation tends to judge whether processes are in place, and graduates are produced, to match the practices and requirements of the global north, thus enabling migration and perhaps inhibiting the development of professions and services and the education and research to support them, that are actually required in the regulated context. Institutions and individuals from lower income, global south countries that may have formerly been colonised, are not empowered to 'speak up' or 'speak out' about those from higher income, global north countries, especially when the global north asserts a position of authority. This authority does, of course, enable institutions and individuals in the global south to use policies and so gain power[24] borrowed from sources in the global north to establish their own positions in their own hierarchies. At every level, the assumed authority and associated power relations are a fractal of those seen at higher levels, and in other places. This authority is derived not only through the regulatory process but in fact by their broader economic and political dominance. Just as this 'coloniality of power'[25] perpetuates ideas about how medical education research should be conducted, it also perpetuates ideas, and discourages critique, about how medical education regulation should be undertaken, and by whom.

THE HARMS OF INTERNATIONAL REGULATION

Since the 1980s, there has been a movement towards global standards for medical education, and sometimes a response to demonstrate that those global standards are adhered to. The problems associated with this have been thoroughly examined in terms of, for example, its neocolonial implications, the difficulties faced by LMICs in complying,[26] the lack of automatic cultural appropriateness, the lack of evidence of positive effect and the inhibition of local variation.[27] The globalisation of standards is problematical.

Globalisation of regulation is also a problem. Despite a lack of scientific evidence to suggest that any particular regulatory approaches are more effective or cost-effective than others, or indeed, have any constructive effect at all,[28] it is clear that current regulatory methods take up significant time and resources, which could potentially be diverting attention away from higher value healthcare or education work.[29 30] While in high income settings like the UK, unevidenced and burdensome regimes could be leading to an unnecessary and irritating inefficiency, it can be vastly more destructive in lower income countries where healthcare and education organisations are often dangerously overstretched and are facing a variety of other forms of oppression concurrently.

So what are the medical profession to make of international regulatory processes that are unsupported by scientific evidence, are costly in time and money, and may be expressly designed to facilitate migration to the USA, despite global medical workforce shortages and the perennial and devastating effects of medical 'brain drain'[31]?

Despite the costs, and the gate-keeping functions of international regulation of medical education, and its serious intended and unintended consequences,[30] there is no obvious external accountability process for international regulators. WFME, to its credit, did commission an internal report in 2020, that eventually made 'over 50 recommendations where actions taken should pave the way for longer-term prosperity',[32] but this has not been publicly shared, and it remains unclear whether any of these recommendations will lead to changes in its international regulatory 'recognition' programme. It might seem anomalous that while cross-border regulators of medical schools are themselves subject to national or international regulation (by their own national processes or by WFME or EQAR, for example), similar external

scrutiny does not yet extend to these powerful overarching bodies.

NEED FOR INDEPENDENT SCRUTINY

So, whether international regulation of medical education is actually about quality, or facilitating medical migration (one of three reasons given for the WFME Recognition Programme[33]) or about the business of medical education, the quality of such high-stakes regulation itself should be accountable and open to independent scrutiny, as such scrutiny has been called for in relation to the performance of the GMC. Importantly, regulation is not a neutral act, and has the potential for unintended consequences, including harms.[34] In the absence of any evaluation, one can only speculate about the potential harms that may have taken place around the world, including to some of the most oppressed and marginalised communities in the world, in response to the international regulation processes that have sprung up in the last decade.

Such harmful and unintended consequences of regulation have been examined in industries as disparate as accounting, cruise tourism, public utilities, executive pay and even healthcare,[35] but not in the international regulation of medical education. So far, international regulation of medical education has not made itself externally accountable, open to external scrutiny, or open to the analysis of unintended or harmful consequences.

Such an analysis may well suggest alternatives to the regulatory imposition of policy defined elsewhere and out of context. If quality improvement really is the main purpose, self-regulation and coregulation,[36] for example, may well be more appropriate to a professional environment of trust and respect. Such concerns about the conduct and effects of regulation, and how to regulate regulators, whether national or international, have been developing in other professional fields for some time, with policies and proposals for how this might be done.[37 38] Perhaps it is time to extend this to the international regulation of medical education.

REGULATING INTERNATIONAL REGULATORS

A never-ending spiral of regulators regulating regulators is not sensible and, as has been argued in relation the GMC, and to existing regulators, is no guarantee of robust and lasting good practice. Regulatory models in their current incarnation, especially at international level, gather only snapshots of performance that lack evidence of current or future effect. Instead, a different approach to the regulation of international regulators is needed that offers ongoing and continual transparency and openness to scrutiny at any time, by any interested party. This would require systematic provision of a baseline of open information about all processes and activities, as is already required of many national regulatory organisations. The GMC website, for example, provides details of processes, policies, guidance, inspection reports (with the names of the inspectors whose qualifications can be verified), its own governance framework, its council agendas, minutes and papers, individual salaries and expenses claims, education inspection teams and their reports. As a baseline for scrutiny, this seems an essential minimum, against which any international regulator should be judged, but currently cannot be.

The very powerful position attributed to international regulators of medical education, by virtue of either the implication of quality or the threat of penalty, has a further responsibility to be open to scrutiny, to mitigate the imbalanced power relationship between the regulator and the voluntarily regulated who have purchased the service.

NEO-COLONIALISM OF INTERNATIONAL REGULATION

Outside of medical education, there has been a fierce analysis of neo-colonialism mediated by education and regulation, and supported by lack of examination of underlying assumptions. Powerful and longstanding critiques of neo-colonialism in medicine and medical education and its effects have been published and are gaining traction.[22 39–41] Part of the accountability of a regulator should be defence of the derivation, applicability, and effect of the regulatory process it sets, and open defence of the quality of the judgements it makes. Current debates in this field call into question the extent opaque model of international regulation of medical education whereby a small group gathers and reviews information at one point in time against broad requirements, using the same general ideas for every applicant regardless of how different the contexts of those agencies might be, and another committee takes their descriptive report to decide on whether the applicant has met the standards required, with no public reporting of any of these stages and deliberations. National regulators, who are judged in this process, often do provide such public audit trails, and so seem steps ahead of international regulation practices.

Neo-colonialism in education is seen as the process of enforcing global north approaches to education as a means of perpetuating global north influence and positional power, while continuing to take advantage of the former colonies[41] by, for example in our instance, taking their medical graduates rather than their raw materials.

Just as there are increasing calls for cultures in the global south to re-imagine imported views of education to suit their own context, we might envisage and re-imagine ways of actually supporting medical education in any context to enhance what it does to serve the local community, profession and development of healthcare. Those ways might be local rather than global, contextual rather than general, cooperative rather than hierarchical,[36] supportive rather than judgemental, flexible[42] rather than rigid, developmental rather than a single snapshot in unstable time.

CONCLUSION

Many challenges cross national and continental boundaries and are shared by the medical profession throughout the world. And yet few would argue that we live in a 'flat' world in a way that early globalisation scholars in the 1980s dreamt of and predicted. There are many inequities and injustices, and the migration of doctors from the global south to the global north is widening disparities yet further. Indeed, medical regulatory systems and agencies in the global south are sometimes weak,[43] possibly related to the legacy of colonialism, prompting arguments that international regulatory approaches may, in fact, facilitate improvements. While we do not know whether such benefits occur, there can be no doubt that improving contextually appropriate regulatory systems in the global south (and in the equally heterogeneous global north) should be an enduring priority. How best to do that is not yet clear.

The paucity of scientific evidence guiding regulation of medical education leaves a vacuum that has been filled with unexamined practice and unchallenged rhetoric. These, in turn, invariably serve particular interests and agendas. Notwithstanding the important campaigning to improve the regulatory landscape in the UK, we must avoid the temptation to cast our gaze exclusively inwardly. We should, instead, consider how we use our privileged positions to argue for, and contribute to reshaping and challenging global regulatory policies. We must also ensure that contextual sensitivity and appropriateness, and equity and inclusivity are key principles of all future policies and that voices from the global south are heard and prioritised in a decolonising exercise. We must demand better.

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