Medical education needs a new model for global leadership

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Abstract

Like other fields in medicine and healthcare, medical education relies on collaboration and co-operation between countries and regions of the world, although no single institution or position unifies the global medical education community in the way that the World Health Organisation does in public health, for example. Recent research in medical education has drawn attention to the many injustices that exist in the field, where power and influence is held in relatively few Global North countries, although most practice happens in Global South countries. In this article, we examine three positions that hold global prominence in medical education, including the presidents of the World Federation for Medical Education and the Association for Medical Education in Europe, and winners of the Karolinska Institutet Prize for Research in Medical Education. We highlight that these positions have problematic histories and have perpetuated the current power disparities in the field. We argue that an alternative model for global leadership is required that should be determined democratically by those involved in medical education all around the world. Such a model should prioritise diversity and inclusivity, empowering leaders from countries who have previously been peripheral to the decision-making platforms in the field. Given the shortcomings of existing leadership positions and organisations, we argue that a new institution is required to realise this new vision, and that the principles that govern it should be determined through debate and democracy, with a focus on inviting those voices that have not previously been heard in global medical education circles.

The 2017 election to replace Dr Margaret Chan as World Health Organisation (WHO) Director General was hailed as ‘unprecedented’ for transparency and accountability thanks to voting by member states rather than the executive board, the publication and scrutiny of candidates’ manifestos, and public debates (1). The appointment of Ethiopian Dr Tedros Adhanom Ghebreyesus, the first African to head the global agency, was also applauded as ‘a big victory for Africa and the developing world’ (2). Although this appointment does not right decades of wrongs in global health, it does offer symbolic progress towards a more equitable future in governance and leadership.

The field of medical education, like other areas of medicine and healthcare, is intertwined with political and societal forces, exemplified by the growing challenges of healthcare workforce shortages caused by migration, or ‘brain drain’ (3). Despite the interconnected modern world existing in this globalised paradigm, medical education is grounded in local challenges and is shaped by local communities, priorities, and contexts. This can cause a tension for those in medical education, who are often compelled to prioritise local perspectives rather than global ones. For instance, contemporary topics in medical education like widening participation and differential attainment have generally been approached through parochial lenses, although they are often grounded in global issues at their origin.

In recent years though, rising efforts have sparked debates about injustices in medical education scholarship and influence on the global stage (4). The medical education community is recognising, for example, that global south countries and peoples have long been marginalised and devalued (5). Global health scholars have surpassed their medical education counterparts in bringing intersectional lenses to questions about leadership, including asking why it is that despite the ‘default health worker’ being a woman, the ‘default health leader’ is a man (6). Medical education could benefit from asking similar probing questions regarding global representation and influence, including questioning the diversity of the current global leadership class. Visible global leadership from outside the global north has the potential to send a powerful message about levelling the ‘northern tilt’ in medical education (5).

Besides role modelling through identities and behaviours, effective leaders are cognisant of biases and inequities, working to advocate for marginalised communities. Given that the global playing field has been shaped by centuries of colonialism and sociocultural and

economic oppression of entire nations and peoples, the need for inclusive and influential global leadership in medical education is clear. This requires individuals with positional authority across political boundaries.

In this article, we argue that medical education requires an entirely new model for global leadership, that recognises historical oppression and ongoing injustices. Such a model would enable fairness, democracy, and representation to be prioritised from the outset and create a system that proportionately gives voice to all parts of the global community. In order to provide context for why this is required, and to help guide the conceptualisation of this new system, we critically analyse the existing landscape, focussing particularly on three existing leadership structures.

The first is the President of the World Federation for Medical Education (WFME). The presence of 'World' in the organisational name suggests the suitability of this role, supported by the presence of six regional leaders on its organisational executive council and its stated aim to 'enhance the quality of medical education worldwide' (7). Despite these figurative signals though, WFME is not widely known in the field despite having a more than 50-year history. Its focus is also surprisingly narrow, linked to developing standards and recognising accreditation agencies, which are unlikely to be directly relevant to those on the 'frontline' of medical education globally.

The second is the beneficiary of the Karolinska Institutet Prize for Research in Medical Education (KIPRIME). Awarded biannually for outstanding research in medical education, this is the major international accolade in the field, often referred to as the 'Nobel prize for medical education' (8). Although it is a research prize, in an applied field such as medical education this invariably means winners have major influence on policy and practice. A glance at the prize winners confirms that KIPRIME winners are well-recognised and respected although they do not have a sustained platform on the basis of this award alone.

The third is the President of the Association for Medical Education in Europe (AMEE). AMEE self-defines as a global organisation in that it offers support 'around the world' and seeks to promote 'excellence in health professions education internationally' (9). It has recently introduced an education advisory board with representation from all six regions of the world, although strategic decision-making is from its governing committee, which as of early 2024,

had eight out of ten members from Global North countries (9). Despite its wide portfolio and high regard in medical education, it's historical legacy as a European agency, reinforced by its administrative base in Europe, challenges its position as a global agency.

Although none of these potential positions emerge to obviously occupy the role of global leader, they do demonstrate that the current leadership landscape in medical education lacks diversity and does not present an inclusive environment for all global players. This lack of diversity pervades all of these positions and institutions and demonstrates that the current system is not equitable to the global community of medical education practitioners, scholars, and policymakers.

The WFME, for example, has existed for over five decades but has held offices only in Europe and America and each of its six presidents have been white and male (10). Moreover, in its policy work, it has been observed to be a force for standardising and 'westernising' the field of medical education. A postcolonial analysis of its recent flagship recognition programme has highlighted that is has positioned itself as a 'modernising' force, aligning itself directly with policies that enable migration to the global north (11).

Likewise, with KIPRIME, it is noteworthy that all 11 of the winners of this prestigious prize have originated from the Europe and North America, emphasising that research underpinning current policies and practices is significantly North-skewed. This has been confirmed by bibliometric research that has demonstrated a startling dominance of a few Northern countries in medical education research output (12), and a similar picture in editorial leadership positions of prominent journals in the field (13).

Finally, AMEE is a globally focussed organisation that is perhaps best known for hosting the largest major international conference in the field of medical education. Although AMEE presidents have been from more diverse personal backgrounds than those from WFME, for instance, including notable recent female presidents, they have nonetheless all been from Europe and North America to date. Furthermore, although its popular conference has actively encouraged participation from the Global South particularly in 2023 when this was a theme of the meeting, it nonetheless has always been held in Europe and has been dominated by speakers and attendees from Northern countries, who are more likely to have resources and visa permissions to attend (14).

Those new to the field of medical education might understandably be struck, therefore, by the lack of diversity and inclusion that is being modelled in current visible leadership positions. The organisations considered above have structures and histories that are inescapably linked to the colonial past, reinforcing inequities and sustaining Western dominance. The fact that certain high-profile male actors have personally held multiple leadership roles described above, while entire countries and continents have never done so, exemplifies the narrow grip of power in the field.

We are not suggesting that organisations and leadership teams are acting in consciously sinister ways. Indeed, efforts are underway to improve current systems across each of the organisations. Furthermore, there are growing numbers of medical education societies, journals, and conferences emerging in Global South countries, reflecting a greater independence and confidence about national and regional priorities. To date, though, these Global South platforms have failed to establish the degree of popularity and success that Global North institutions do, and therefore seem a long way from being able to claim influence on the global stage. Indeed, his challenging intersection between 'local' and 'global' is a key source of tension and inequity. Notwithstanding current endeavours to redress the balance of global power the hegemonic influence of the Global North in medical education does not look likely to change in the short- or medium-term future.

Returning to the WHO Director General, it is clear that no comparable role exists in medical education, although there is no reason it could not. Beyond the ceremonial benefits of a global figurehead democratically and equitably selected from across the world, there may be opportunities to align priorities and be a credible unified voice for the community, as successive WHO DGs have demonstrated (15). We argue, therefore, that such a position should be designed and implemented in medical education to bring much-needed equitable and inclusive leadership to its global community.

In light of the historical tensions that existing medical education organisations face, we suggest that an entirely new institution is required to realise this goal. One striking reality that cements the injustices that we have outlined in this article, is that most of the world's medical schools are located in Global South countries (16). In other words, most of the practice of medical education happens in the South, although most of the power resides in the North, where the research, policymaking, and leadership is located. It is this tension that a new

agency could ameliorate, by prioritising global diversity and bringing a more equitable and egalitarian paradigm to medical education. The composition, structure, governance, and leadership of such an institution would need to be established democratically, and it would be insincere for one individual or group to claim to hold the solutions. Decisions about what the agency should prioritise, and how it should operate, would depend on the priorities of those it represented in a proportionate way. In order to achieve that, representation needs to focus on prioritising all voices, especially those that have historically been peripheral and marginalised. Most crucially, the leadership of a new institution should be determined in a democratic and equitable way, prioritising global diversity and seeking actively to avoid perpetuating the current Northern dominance that we see.

Two factors identified as important components of future global governance in science (17) are notably relevant priorities in medical education. The first is individual empowerment and the second is international power shifts. Rapid changes in technology and media have meant individuals have much more ‘information power’ than in previous times in history, which creates great opportunities for engagement and transparency. In medical education, this means creating greater platforms for individual medical professionals, teachers, and students to contribute to global debates and thinking. Power shifts in international relations are apparent in all fields and exemplified by the growing influence of states such as China and India on the global stage. Multilateralism is therefore a crucial contextual factor that must be prioritised in medical education, recognising that structures that align with historic periods of unipolar global power dynamics are likely to be ineffectual.

We have argued in this article that medical education lacks global leadership and that the current landscape is fragmented and problematic, with little attention to diversity or inclusivity. The result is that those in the majority-world of medical education exist outside current power bases and are not adequately represented or prioritised. As medical education seeks to be a more open and inviting global community, collective debate about what is needed from global leadership is imperative. Inclusive ways of selecting future global leaders are urgently needed to help to liberate the field from the colonial legacies shaping current institutions.

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