

Recalibrating our efforts: from globalisation to glocalisation of medical education

Halah Ibrahim ^{1,2}, Sawsan Abdel-Razig^{3,4}

Increased economic integration and technological advancements in communication and transportation over the past several decades have spurred growth in cross-national investment, migration and cultural exchange. Nations, economies and people are increasingly interconnected and interdependent; increasingly 'globalised'. The concept of globalisation entered the mainstream vocabulary in the 1990s, but its history has been fraught with controversy.¹ Primarily an economic process involving domestic deregulation, trade liberalisation and privatisation, globalisation can have profound social and cultural ramifications. Proponents highlight the economic benefits and improved standards of living for many communities, while opponents of globalisation focus on the disproportionate channelling of wealth to larger Western nations and the further disempowerment of populations who lack the skills to meaningfully participate in this flow of information and resources.¹

Similarly, the globalisation of healthcare has also inspired competing interpretations and perspectives. Historically, the globalisation of health has referred to the cross-border flow of healthcare professionals for employment, patients for medical services and public health and research measures across nations. These broad categories reflect the challenges in defining this critical concept that informs social policy, drives change and impacts population health outcomes. More recently, the globalisation of medical education has been used to describe the transnational transfer of curricula, practices and accreditation standards, the global movements of faculty and medical trainees, and the establishment

of international branches of medical schools and academic institutions.^{2,3} The importation of Western-based competencies and educational modalities has sparked discourse around the potential for 'homogenisation and cultural dominance' in medical education.^{2,4} Global accreditation requirements purport to establish standard outcomes and ensure minimum levels of competence, using standardised curricula and accreditation protocols.³ However, globalised medical education may not consistently align with local priorities and needs and has been criticised for imposing Western paradigms on non-dominant nations.² For example, in India, Western influences predominate medical education, whereby curricula often focus on diseases not relevant to the community.⁵ In Southeast Asia, student-centred teaching approaches, including problem-based learning, were adopted even though they conflicted with longstanding cultural traditions and norms between students and teachers.⁶ As such, researchers and educators have expressed concerns that international medical education is overlooking important cultural nuances and is, instead, promoting standards that are Western, rather than truly global.²

As medical educators in the Middle East, we have witnessed the effects of globalised medical education. Many students are sponsored by the government to train in medical schools and residency programmes in North America, Australia and Europe, with little consideration of the alignment between the type and content of training received abroad and the needs of the home country to which they return. More recently, several Gulf countries have mandated the wide-scale implementation of US-based accreditation frameworks as part of graduate medical education reform efforts.^{3,7,8} This often translates to medical trainees that are taught by multinational faculty, using Western-based curricula and assessment methods, in fundamentally different sociocultural, economic and regulatory contexts. The question remains: how do educational systems maintain best practice and

outcome standards while remaining responsive to the local needs? Over the past decade, educational researchers worldwide have proposed glocalisation as a potential answer.

Glocalisation, a neologism combining the terms globalisation and localisation, describes the adaptation of international standards to local needs and cultures.⁴ By glocalising curricula, accreditation standards and educational practices, trainees learn to provide global standards of care that address local health priorities. The ultimate goal of the glocalisation of medical education is the advancement of population health outcomes and system responsiveness to local health needs. Glocalisation efforts in the medical education literature highlight three main themes: (1) local adaptation of accreditation standards, (2) exploration of educational methodologies towards glocalisation and (3) identification of challenges facing glocalisation efforts. We will review each of these areas in an attempt to further describe this construct.

Much of the globalisation in medical education literature deals with the adoption of accreditation standards. Many countries in Europe, Asia and the Middle East have adopted the competency-based framework of the Royal College of Canada.⁹ When the US-based Accreditation Council for Graduate Medical Education offered international accreditation services in 2010, several countries rapidly adopted its model and standards.³ Not surprisingly, glocalisation efforts have focused on ensuring local relevance of related standards and processes. Research has shown that these efforts are diverse and often require input from multiple stakeholders. For example, Ho *et al* describe four categories of deviation between global accreditation standards and medical schools attempting to glocalise their local accreditation systems in Taiwan, Japan and South Korea.⁴ These include structural differences of medical education in the national context (such as programme length, entry requirements and school governance), differences requiring adaptation of standards to conform to local regulatory environments, developmental trajectory differences representing the influence of contextual events on medical education and aspirational differences reflecting local priorities and focuses.⁴

Other attempts to glocalise have focused on educational competencies, rather than accreditation standards. Several authors have questioned the applicability of Western definitions of

¹Department of Medicine, Sheikh Khalifa Medical City, Abu Dhabi, UAE

²Department of Medicine, Johns Hopkins University School of Medicine, Baltimore, Maryland, USA

³Department of Medicine, Cleveland Clinic Abu Dhabi, Abu Dhabi, UAE

⁴Department of Medicine, Case Western Reserve University, Cleveland, Ohio, USA

Correspondence to Dr Halah Ibrahim, Department of Medicine, Sheikh Khalifa Medical City, 51900 Abu Dhabi, UAE; halahibrahimmd@gmail.com

medical professionalism to their local contexts. In this regards, glocalisation efforts towards the development of culturally relevant medical professionalism curricula represent a common area of study.¹⁰ For example, in the United Arab Emirates, we implemented a novel methodology towards glocalising medical professionalism, employing several consensus-gathering techniques. The resultant definition identified additional domains to Western definitions of professionalism that incorporated culturally relevant constructs, including spirituality in professional practice and the role of family and community in patient care decisions.¹⁰ Many other educational constructs, such as leadership, communication skills and medical ethics, cannot be directly imported from one country to another but require local adaptation.

Finally, when considering the process of glocalisation, studies reveal that educational leaders must give due consideration to the complexity of challenges encountered. These include diverse or conflicting views on educational objectives and scopes, a lack of representation of the diverse perspectives of the local context, a lack of a shared mental model of competence, misalignment of educational requirements and health system factors and the influence of power relationships and decision-makers on the glocalisation process.⁴ Ensuring diverse representation in glocalisation efforts is critical to fostering consensus, mitigating the challenges identified, facilitating the

consideration of contextual factors and leveraging local networks of support.

All education is local. However, for the foreseeable future, healthcare and health education will be impacted by an increasingly interconnected world. This serves to highlight the critical importance of ensuring that medical education institutions remain accountable to the communities they serve. These seemingly discordant responsibilities are reconciled through deliberate glocalisation efforts. If the ultimate goal of medical education is the production of a competent healthcare workforce, equipped with universal practice standards that can meet local population health needs, glocalisation practices must be viewed as essential components of educational standards, and should be adopted by medical educators, accreditation and regulatory bodies and healthcare institutions in the global arena.

Contributors HI and SA-R were involved in the conception and design of the study. HI wrote the first draft of the paper. SA-R critically revised the manuscript. Both authors are accountable for the manuscript and approved the final manuscript for publication.

Funding The authors have not declared a specific grant for this research from any funding agency in the public, commercial or not-for-profit sectors.

Competing interests None declared.

Patient consent for publication Not required.

Provenance and peer review Not commissioned; externally peer reviewed.

© Author(s) (or their employer(s)) 2021. No commercial re-use. See rights and permissions. Published by BMJ.



To cite Ibrahim H, Abdel-Razig S. *Postgrad Med J* 2021;**97**:545–546.

Received 11 December 2020
Revised 13 January 2021
Accepted 15 January 2021
Published Online First 4 February 2021

Postgrad Med J 2021;**97**:545–546.
doi:10.1136/postgradmedj-2020-139579

ORCID iD

Halah Ibrahim <http://orcid.org/0000-0002-9240-7726>

REFERENCES

- 1 James P, Steger MB. A genealogy of 'globalization': the career of a concept. *Globalizations* 2014;11:417–34.
- 2 Hodges BD, Maniate JM, Martimianakis MAT, et al. Cracks and crevices: globalization discourse and medical education. *Med Teach* 2009;31:910–7.
- 3 Archuleta S, Ibrahim H, Stadler DJ, et al. Perceptions of leaders and clinician educators on the impact of international accreditation. *Acad Med* 2015;90:S83–90.
- 4 Ho M-J, Abbas J, Ahn D, et al. The "glocalization" of medical school accreditation: Case studies from Taiwan, South Korea, and Japan. *Acad Med* 2017;92:1715–22.
- 5 Supe A, Burdick WP. Challenges and issues in medical education in India. *Acad Med* 2006;81:1076–80.
- 6 Amin Z, Hoon Eng K, Gwee M, et al. Medical education in Southeast Asia: emerging issues, challenges and opportunities. *Med Educ* 2005;39:829–32.
- 7 Ibrahim H, Al Tattari H, Holmboe ES. The transition to competency-based pediatric training in the United Arab Emirates. *BMC Med Educ* 2015;15:65.
- 8 Abdel-Razig S, Alameri H. Restructuring graduate medical education to meet the health care needs of emirati citizens. *J Grad Med Educ* 2013;5:195–200.
- 9 Royal college. About CanMEDs, 2020. Available: <http://www.royalcollege.ca/rcsite/canmeds/about-canmeds-e>
- 10 Abdel-Razig S, Ibrahim H, Alameri H. A culturally relevant definition of medical professionalism for an emerging Arab country. *J Grad Med Educ* 2016;8:165–72.