On gunboats and grand pianos: medical education exports and the long shadow of colonialism

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I recently had the honour of signing a memorandum of understanding with Chinese colleagues. As a result, my family medicine department in Toronto is now working with educators in Shanghai as they expand their family medicine education programmes. Many countries worldwide are currently enhancing primary care structures and training, giving family medicine educators increasing opportunities to develop international partnerships. These partnerships are now found in many areas of medical education—such as school curricula, teaching and assessment tools, competency frameworks, and accreditation standards—and with them comes the responsibility to consider the principles and values that we bring to this work.

As citizens of the twenty-first century, we frequently speak about the internationalised state of our economies, markets, and social structures as if it were a new phenomenon. While instantaneous cyberspace-enabled global connectivity is indeed a sign of our times, widespread cross-cultural trade and exchange can be traced back centuries along the Silk Road and across many of the world's mountains, deserts and seas. Medical education is among those things that have a longer history of cross-cultural interactions than we necessarily recall as we engage in international work today. When Abraham Flexner traversed North America in the early 1900s, passing judgment on each and every medical school in the USA and Canada, his standards were drawn from British and German educational models. Flexner's use of a European-inspired standard entrenched twentieth century North American medical education in a university-based model and led to the abrupt closure of many small medical schools (Flexner 1910; Ludmerer 2010). William Osler and William

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Stewart Halsted, similarly, turned to Europe for inspiration when developing the first US residency programs (Ludmerer 2014).

In addition to medical educators seeking inspiration from afar to adapt for their home settings, we also find abundant historical examples of efforts to export local medical education ideas. I need only to look at my own family, where I can trace back four generations of missionaries who travelled from Europe and North America to take Western medicine and Western education practices to the Gold Coast (now Ghana), India and China. Last year before signing the Memorandum, I took a boat trip up the Yangtze River. While admiring the dramatic vistas along the river gorges, I pondered this family history. One great grandfather made exactly the same journey up the Yangtze in the 1890s as a Canadian missionary to Sichuan Province. He was part of a Western influx following victory over China in the second Opium War, as a result of which China was required to cede rights to Europeans to travel to the Chinese interior and accept Western trafficking of opium (Lovell 2012). British gunboats escorted him on his voyage.

A generation later, that great grandfather's son returned to China, again travelling up the Yangtze, which was still patrolled by British gunboats. He and his wife did not travel lightly: their luggage included a grand piano, a British silver tea service, and many other accoutrements of Western life. Eager to 'modernize' educational practices in Sichuan, they also brought with them the newest English language teaching methods. On my twenty-first century voyage up the Yangtze, I took along current medical education theories and practices. Discomfited by my family history, I also packed several books of post-colonial theory to read on deck.

I used the cruise as a time to think about my assumptions and actions. How confident should I be that my convictions about what constitutes good medical education apply elsewhere? We know that many currently popular educational practices are based on tradition and assumption rather than on evidence (Asch and Weinstein 2014); we also know that recent international medical education standards draw primarily on Western educational practices (Hays 2014). When working with international colleagues, to what extent am I promoting Western values and priorities?

The notions of 'validity' and 'generalizability' are highly prized in medical education, and the more an educational tool or process is deemed to be separable from a specific social, political, historic or cultural context, the more it is accorded value. But how can we be objective judges of the social context in which our international work is embedded, especially when, as, Martimianakis and Hafferty (2013) describe, the medical education community's desire to produce universally competent doctors using particular techniques aligns quite well with the selling of those educational products in an international marketplace? The flow of these validated tools and best practices, moreover, has been largely unidirectional, primarily developed in Europe or North America and then disseminated to the rest of the world. If what is currently being positioned as universal medical education is in essence Western medical education, we might want to consider the implications of such a construction.

Postcolonial theory provides an important lens with which to examine international medical education exports (Bleakley et al. 2008). European colonialism was infused with the belief that colonizers took civilization and enlightenment with them. The superiority of European ideas and models was taken for granted, whether they were in the form of religion, medicine, dentistry, or legal and bureaucratic practices (Loomba 1998). This hierarchical and dualistic construction of the world created a dichotomy between the West and the non-West. Described by Edward Said (1979) in *Orientalism*, it was a way of thinking that positioned the West as rational and scientific, in contrast to a barbaric and

irrational East. Western ‘scientific’ medicine was a key component of this colonial endeavour (Bala 2014).

When we export educational approaches that have been created and developed in Western contexts today, it behoves us to consider to what extent we are still making assumptions about their superiority. This issue is particularly pertinent in an era where universities are expected to seek revenue-generating opportunities and we are encouraged to market our educational “products.” Accrediting bodies are also entering the business of commercially exporting their standards (ACGME International LLC 2015; Royal College of Physicians and Surgeons of Canada 2014). If we are selling our expertise and our wares, to what extent can we also remain critical about their uses and their context-specificity? How does the commercialization and commodification of these academic products influence the ways that they are put into practice? Even though I do not hesitate to share my concerns about recent developments in medical education, the things I take abroad with me are undoubtedly laden with a particular culture and set of values. In the end, how different is my work from that of my grandfathers or great-grandfathers?

It is an honour and a privilege to develop international partnerships. Cross-cultural exchanges between respectful partners have great potential to benefit all involved, and it is exciting and rewarding to engage in such work. Those of us who are cast in the long shadow of our colonial past must, however, take heed that we do not carry too much of that baggage—even inadvertently—on our journeys. Nowadays we go where we are invited, and gunboats are nowhere in sight. We are, nevertheless, still often transporting and transposing educational products that were developed and refined for use in specific Western contexts. Even when travelling as invited guests, it would be wise for medical educators to consider very carefully what it is we are taking with us and why we are doing so. We must understand to what extent our work is a commercial transaction. Even when engaging in what are primarily collaborative academic partnerships, we should pay attention to how educational products are shaped by cultural values. Although a grand piano can be used to play music from many cultures, it is still an instrument with a particular history and was made for a particular musical scale; a performance on it raises images of that history, along with its concomitant cultural values. The same is true of educational tools and instruments. By paying attention to these issues, there is potential for international medical education to be shaped in a way that is not colonizing, but rather, a true cultural exchange.

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Compliance with ethical standards

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