Research Open

Journal of Clinical Research and Medicine
Volume 9 Issue 1

Commentary Article

Decolonising Medical Education in Low- and Middle-Income Countries: Beyond Social Accountability—Reclaiming Institutional Autonomy

Abeera Fawad Khan*

School of Health Professionals' Education, Research & Entrepreneurship, Health Services Academy, Islamabad, Pakistan

***Corresponding author:** Abeera Fawad Khan, School of Health Professionals' Education, Research & Entrepreneurship, Health Services Academy, Islamabad, Pakistan

Received: July 22, 2026; **Accepted:** July 27, 2026; **Published:** July 28, 2026

Introduction

In our previous commentary, we argued that reclaiming social accountability was essential if medical education in low- and middle-income countries (LMICs) was to resist the growing influence of commercial metrics and remain responsive to the societies it serves [1]. Social accountability, as defined by the World Health Organization and more recent AMEE guidance, calls upon medical schools to align their education, research, and service activities with the priority health concerns of the populations they are mandated to serve [2,3]. This principle provides an important moral direction for medical education. However, it leaves a more fundamental question unresolved: who determines what counts as educational excellence?

This question has become increasingly important as medical schools in LMICs seek to balance national health priorities with growing expectations for international recognition. Accreditation systems, publication metrics, university rankings, research productivity, and graduate mobility have become influential indicators of institutional success. These measures undoubtedly strengthen quality assurance and encourage academic excellence. Yet they also shape institutional priorities, often in ways that reflect global rather than local expectations.

The purpose of this commentary is not to argue against international collaboration or internationally recognised standards. Medicine has always advanced through the international exchange of knowledge, shared scientific evidence, and collaborative innovation. Rather, we argue that decolonisation requires a distinction between shared standards of educational quality and externally determined educational priorities. Social accountability defines the purpose of medical education, but institutional autonomy determines whether medical schools possess sufficient authority to pursue that purpose when local priorities differ from internationally rewarded measures of success.

When Success Is Defined Elsewhere

Contemporary discussions of decolonising medical education have focused largely on curricula, knowledge systems, representation, and global partnerships [4-6]. These debates have been essential in exposing how historical and contemporary power relationships continue to influence medical education. Less attention, however, has been paid to the institutional mechanisms through which educational priorities are established.

Most medical schools do not make decisions in isolation. Institutional strategies are shaped by accreditation requirements, regulatory expectations, funding opportunities, faculty promotion criteria, research assessment exercises, and graduate outcomes. Increasingly, these are also influenced by international indicators such as WFME recognition, university rankings, citation metrics, and international postgraduate opportunities. Each serves a legitimate purpose. Collectively, however, they create powerful incentives that influence how institutions define success.

The consequences are not necessarily deliberate, but they are significant. Activities that improve international visibility, high-impact publications, international collaborations, and globally recognised accreditation, are often rewarded more readily than initiatives whose primary impact is local, such as implementation research, rural clinical education, community partnerships, or health systems strengthening. These are not competing forms of excellence; nevertheless, institutional reward systems frequently privilege one over the other.

The challenge, therefore, is not whether international standards are beneficial. Rather, it is whether medical schools possess sufficient freedom to determine how those standards should be balanced against the needs of the health systems they ultimately serve.

Reclaiming Institutional Autonomy

Institutional autonomy should not be understood as independence from regulation, rejection of international standards, or withdrawal from global collaboration. Rather, it refers to the ability of medical schools to determine their own educational priorities within internationally accepted standards. In other words, quality should be shared internationally, but purpose should be determined locally.

This distinction is particularly important in LMICs, where health systems often face challenges that differ substantially from those of high-income countries. Institutions may need to prioritise primary

healthcare, rural workforce shortages, implementation research, community-based education, or locally prevalent diseases. These priorities are legitimate expressions of educational excellence, even if they contribute less to conventional measures of international prestige.

Institutional autonomy therefore changes the questions that medical schools ask. Instead of asking only, "How can we improve our international standing?" institutions should also ask, "How can we better prepare graduates for the health needs of the populations we serve?" These questions are complementary rather than contradictory, but they do not always produce the same institutional decisions.

For example, faculty promotion systems based almost exclusively on publication metrics may unintentionally discourage research that influences local policy or strengthens health services but attracts fewer citations. Similarly, educational innovation aimed at improving rural workforce retention or strengthening district health systems may have profound societal impact without substantially improving university rankings. Institutional autonomy enables medical schools to recognise these contributions as markers of excellence rather than treating them as secondary to internationally rewarded achievements.

Importantly, autonomy should not diminish accountability. On the contrary, it strengthens it. Rather than being judged solely by external indicators of institutional performance, autonomous medical schools remain accountable for demonstrating that their educational priorities respond meaningfully to national health needs. Accountability therefore shifts from institutional conformity to institutional relevance.

Looking Forward

Reclaiming institutional autonomy requires changes at multiple levels. Regulatory authorities and accreditation bodies should continue to safeguard educational quality while allowing sufficient flexibility for institutions to respond to local health priorities. Likewise, universities should broaden promotion and evaluation systems to recognise implementation research, health policy contributions, community-engaged scholarship, and health system innovation alongside conventional academic metrics.

International partners also have an important role. Collaboration should increasingly be characterised by reciprocity rather than diffusion, recognising that educational innovation can emerge from every region of the world. Partnerships should strengthen locally identified priorities rather than assuming that successful models developed elsewhere can simply be transferred into different social and healthcare contexts [4-6].

Finally, institutional autonomy should not be interpreted as limiting the legitimate aspirations of students. For many learners, medicine represents not only a profession but also an important avenue of social mobility. International postgraduate training and career opportunities have benefited individuals, families, and health systems worldwide. The objective is therefore not to discourage international engagement but to ensure that institutional priorities are not driven predominantly by external labour markets at the expense of national health needs.

Conclusion

Our previous commentary argued that reclaiming social accountability was essential if medical education was to move beyond commercial measures of success [1]. This commentary extends that argument by suggesting that social accountability alone is insufficient if institutions lack the authority to determine their own educational priorities.

Institutional autonomy is not a rejection of international collaboration, accreditation, or quality assurance. Rather, it is the capacity of medical schools to interpret educational excellence through the realities of the societies they serve while remaining internationally connected and academically rigorous. Decolonisation therefore requires more than changing what is taught; it also requires reconsidering who determines why it is taught and how success is ultimately judged.

Medical schools in LMICs should aspire to meet international standards while retaining the confidence to define excellence according to their own healthcare priorities. Only then can decolonisation move beyond curricular reform towards genuine institutional transformation. Institutional autonomy is therefore best understood not as the endpoint of decolonisation, but as the foundation upon which the next stage of reform—institutional responsibility—can be built.

Declarations

Competing Interests

The author declares that there are no competing interests.

Funding Information

No external funding was received for this work.

Author Contribution

AFK conceptualised the commentary, conducted the literature review, drafted the manuscript, and approved the final version for submission.

Acknowledgements

The author would like to acknowledge the contributions of researchers whose work informed the development of this commentary.

Keywords: *Medical education, Social accountability, Decolonisation, Institutional autonomy, Low- and middle-income countries*

References

1. Khan AF (2026) Decolonising Medical Education in Low- and Middle-Income Countries: Reclaiming Social Accountability Beyond Commercial Metrics. *Journal of Clinical Research and Medicine* 9: 1-3.
2. Abdalla ME, Taha MH, Onchonga D, Preston R, Barber C, et al. (2025) Instilling social accountability into the health professions education curriculum with international case studies: AMEE Guide No. 175. Medical Teacher.
3. Taha MH, Abdalla ME, Cameron E, Dharamasi S, Strasser R, et al. (2026) Leadership as a catalyst for advancing social accountability in health professions education: AMEE Guide No. 187. Medical Teacher.
4. Rashid MA, Ali SM, Dharanipragada K (2023) Decolonising medical education regulation: A global view. *BMJ Global Health* 8: e011622.

5. Eichbaum QG, Adams LV, Evert J, Ho MJ, Semali IA, et al. (2021) Decolonizing global health education. *Academic Medicine* 96: 329-335.

6. Naidu T (2023) Southern theory and decoloniality in health professions education. *Medical Education* 57: 692-700.

Citation:

Khan AF (2026) Decolonising Medical Education in Low- and Middle-Income Countries: Beyond Social Accountability—Reclaiming Institutional Autonomy. *J Clin Res Med* Volume 9(1): 1-3.