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Commentary Article

Decolonising Medical Education in Low- and Middle-Income Countries: From Institutional Autonomy to Institutional Responsibility

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Introduction

In our first commentary, we argued that commercialisation and neo-colonial influences have progressively shifted medical education in low- and middle-income countries (LMICs) away from its public purpose, replacing societal needs with market-driven measures of institutional success. We proposed reclaiming social accountability as a guiding principle through which medical schools could realign education with the health priorities of the populations they serve [1]. In our second commentary, we argued that this aspiration cannot be realised unless medical schools possess sufficient institutional autonomy to define educational priorities according to local health needs rather than predominantly responding to externally rewarded indicators of excellence [2]. Together, these arguments explain why reform is necessary and who should determine educational priorities. They leave, however, one important question unanswered: once medical schools possess that autonomy, how should it be exercised?

This commentary argues that the next stage in this progression is institutional responsibility. Institutional autonomy determines who has the authority to define educational priorities; institutional responsibility determines how that authority should be exercised. If medical schools seek greater freedom to determine their educational missions, they must also accept a broader role in strengthening the health systems and societies they serve.

By institutional responsibility, we do not suggest that medical schools replace governments or become solely responsible for healthcare delivery. Governments remain responsible for financing, regulating, and delivering healthcare. Medical schools, however, are not passive educational organisations operating outside health systems. Through their admissions policies, curricula, teaching hospitals, faculty practice, research agendas, partnerships with health services, and graduate outcomes, they exert substantial influence over the capacity, priorities, and future direction of national health systems. The question is therefore not whether medical schools influence healthcare, but whether they consciously accept responsibility for the influence they already possess.

We therefore propose institutional responsibility as the logical progression of the arguments advanced in our previous commentaries. Social accountability establishes the public purpose of medical education, while recent scholarship has increasingly recognised that educational institutions must contribute directly to health system strengthening rather than functioning solely as centres of professional training [3-6].

From Institutional Autonomy to Institutional Responsibility

Institutional autonomy is frequently interpreted as independence from external influence or freedom from regulatory constraints. We use the term differently. Institutional autonomy refers to the capacity of medical schools to determine educational priorities that reflect the health needs of their own societies while continuing to meet internationally recognised standards of educational quality. It is therefore neither isolation from international collaboration nor rejection of accreditation or external evaluation. Rather, it is the ability to exercise independent educational judgement within a globally connected academic community.

Autonomy, however, is not a sufficient objective in itself. Institutions that seek greater authority to determine educational priorities must also demonstrate that this authority is exercised in ways that advance the public good rather than institutional prestige alone. Autonomy without responsibility risks replacing one form of external dependence with another form of institutional self-interest. The important question is therefore no longer who determines educational priorities, but how educational authority should be exercised once it has been reclaimed.

This question is particularly important in LMICs. Over recent decades many countries have expanded medical education considerably while continuing to experience shortages of healthcare workers, inequitable distribution of services, weak primary healthcare systems, and substantial migration of health professionals. Increasing the number of medical schools or graduates has not consistently translated into stronger health systems. These challenges arise from complex political, economic, and social factors and cannot reasonably be attributed solely to medical schools. Nevertheless, educational institutions are influential participants within these systems. Decisions concerning student selection, clinical training, research priorities, postgraduate education, and partnerships with health services directly shape the future health workforce and influence the capacity of health systems to respond to national needs.

Institutional responsibility therefore broadens the traditional understanding of educational success. Medical schools have historically been evaluated through measures such as graduate competence, accreditation status, research productivity, international rankings, and academic reputation. These indicators remain important and should not be abandoned. However, they capture only part of an institution's contribution. Equally important is the extent to which medical schools strengthen health systems, contribute to workforce sustainability, generate knowledge relevant to national priorities, and improve health equity. Educational excellence and societal contribution should therefore be understood as complementary rather than competing dimensions of institutional success.

Viewing medical schools as civic institutions rather than simply educational providers represents an important conceptual shift. Universities have long been recognised as institutions that contribute to economic development, public policy, and social progress beyond their teaching functions. Medical schools should similarly be understood as anchor institutions within healthcare systems. Their responsibility extends beyond producing competent graduates to fostering partnerships with communities, supporting healthcare delivery, informing public policy, generating locally relevant evidence, and strengthening the resilience of the health systems within which they operate. This conception is consistent with calls for medical schools to function as socially accountable institutions that actively contribute to strengthening health systems [3-6].

This perspective does not diminish the legitimate aspirations of students or faculty. Medicine remains an important profession that offers opportunities for career development, international collaboration, and social mobility. Nor does institutional responsibility imply that graduates should be prevented from pursuing opportunities abroad. Rather, it asks institutions to consider whether their collective strategies—including admissions policies, educational programmes, research priorities, and relationships with health services—are contributing meaningfully to the long-term health needs of the societies that support them.

Recognising this broader institutional role requires moving beyond general principles towards practical action. Institutional responsibility should not remain an abstract aspiration. Instead, it should provide an operational framework through which medical schools can evaluate their decisions, priorities, and societal contributions. This requires institutions to evaluate success not only through educational outcomes but also through their contribution to health system improvement [3,4].

Institutional Responsibility Framework (IRF)

To translate these principles into practice, we propose a Institutional Responsibility Framework (IRF) comprising five interconnected domains through which medical schools can operationalise their broader societal role. The IRF is not intended to replace accreditation standards or regulatory requirements. Rather, it provides a conceptual framework through which medical schools can align educational excellence with meaningful contributions to health systems and society.

Educational Responsibility

Educational responsibility requires medical schools to align admissions policies, curricula, assessment, and postgraduate training with nationally identified health priorities. This extends beyond ensuring that graduates meet internationally accepted standards of competence. Educational programmes should prepare future physicians to respond effectively to the epidemiological, demographic, social, and health system challenges most relevant to the communities they will serve. Success should therefore be evaluated not only by examination performance or postgraduate placement, but also by graduate preparedness to address local healthcare needs. This aligns with international calls for health professions education that is responsive to societal needs and national health priorities [3-6].

Service Responsibility

Medical schools should recognise their contribution to healthcare delivery as an integral component of their institutional mission.

Teaching hospitals, university clinics, community outreach programmes, and rural training platforms should function not only as educational settings but also as mechanisms through which institutions contribute directly to improving access to healthcare and strengthening local health services. This reflects the growing recognition that academic institutions function as anchor organisations capable of contributing directly to health system performance [3,4]. Long-term partnerships with communities should replace episodic outreach activities, allowing educational institutions to participate meaningfully in improving population health while simultaneously enriching student learning.

Workforce Responsibility

Medical schools substantially influence the quality, distribution, and sustainability of the future health workforce. They should therefore work collaboratively with governments, professional regulators, healthcare providers, and employers to support workforce planning and development. The Commission on the Education of Health Professionals argued that medical schools should actively participate in workforce transformation rather than limiting their role to producing graduates [3]. Institutional responsibility includes promoting career pathways that encourage service in underserved areas, strengthening primary healthcare, supporting postgraduate training in priority specialties, and contributing to strategies that improve workforce retention. Graduate migration is influenced by numerous economic and political factors beyond the control of educational institutions; however, medical schools can help create educational environments and professional opportunities that strengthen national workforce sustainability.

Knowledge Responsibility

Research agendas should increasingly emerge from locally identified health priorities rather than being driven solely by international funding priorities or publication incentives. Similar arguments have been advanced within contemporary scholarship on decolonising medical education, which calls for greater recognition of locally generated knowledge and contextually relevant research agendas [7]. Academic excellence should encompass implementation research, health systems improvement, policy engagement, quality improvement, and community impact alongside conventional

bibliometric indicators. Medical schools should aspire not only to consume internationally generated evidence but also to produce knowledge that informs national policy, strengthens healthcare systems, and addresses contextually relevant health challenges.

Governance Responsibility

Institutional responsibility also requires more inclusive models of governance. Communities should move beyond being recipients of educational activities to becoming meaningful partners in institutional decision-making. Patients, community representatives, healthcare professionals, policymakers, and civil society organisations should contribute to strategic planning, curriculum development, institutional evaluation, and priority setting. Inclusive governance also reflects the principles of socially accountable institutions advocated in international guidance [4-6]. Such participation strengthens institutional legitimacy, ensures that educational priorities remain responsive to societal needs, and reinforces trust between medical schools and the communities they ultimately serve.

These five domains are mutually reinforcing. Educational reform cannot succeed without workforce planning; research cannot achieve societal impact without engagement with healthcare systems; and institutional autonomy cannot generate public trust without responsible governance. Together, they reposition medical schools as civic institutions whose responsibilities extend beyond educating future physicians to strengthening the health systems within which those physicians will practise.

Conclusion

Our first commentary argued that medical education in LMICs must reclaim its public purpose by resisting the growing influence of commercialisation and externally driven measures of success [1]. Our second commentary proposed that this objective cannot be achieved unless medical schools possess sufficient institutional autonomy to determine educational priorities according to the needs of the societies they serve [2]. This commentary completes that progression by arguing that autonomy alone is insufficient unless it is accompanied by institutional responsibility.

Institutional responsibility does not ask medical schools to replace governments or assume sole responsibility for healthcare delivery. Rather, it recognises that medical schools are influential institutions whose decisions shape future health workforces, research agendas, clinical services, and relationships with communities. Their educational mission cannot therefore be separated from their broader contribution to the health systems within which they operate.

Taken together, these three commentaries propose a progressive framework for reforming medical education in LMICs. Social accountability establishes the public purpose of medical education. Institutional autonomy enables medical schools to determine locally relevant educational priorities. Institutional responsibility provides the practical framework through which those priorities can be translated into meaningful institutional action. This perspective complements contemporary efforts to strengthen socially accountable and health-system-oriented medical education while extending them through a stronger emphasis on institutional responsibility [3-7].

Ultimately, the success of a medical school should not be judged solely by the physicians it graduates, the research it publishes, or the rankings it achieves. Equally important is the extent to which it contributes to stronger health systems, healthier communities, and more equitable societies. Ultimately, medical schools should be judged not only by the physicians they graduate, but also by the societies those physicians help to build. Institutional responsibility therefore represents not an additional obligation, but the fullest expression of the public purpose of medical education.

Declarations

Competing Interests

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Author Contribution

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

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