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REGULATION PROCESSES

Altruism or nationalism? Exploring global discourses of medical school regulation

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Abstract

Background: Although medical school regulation is ubiquitous, the extent to which it should be based on global principles is unclear. In 2010, the Educational Commission for Foreign Medical Graduates (ECFMG) announced that from 2023, overseas doctors would only be eligible for certification to practise in the United States if they had graduated from a medical school that was accredited by a 'recognised' agency. This policy empowered the World Federation for Medical Education (WFME) to create a recognition programme for regulatory agencies around the world, despite a lack of empirical evidence to support medical school regulation.

Methods: This study employs critical discourse analysis, drawing on the theoretical perspectives of Michel Foucault and Edward Said, to identify discourses that enabled this 'globalising' policy decision to take place. The dataset includes a series of 250 documents gathered around three key events: the Edinburgh declaration by WFME in 1988, the first set of global standards for medical schools by WFME in 2003 and the ECFMG ruling about medical school accreditation in 2010.

Findings: Two discourses, *endorsement* and *modernisation*, were dominant throughout this entire period and framed the move to globalise medical school regulation in terms of altruism and improving medical education worldwide. A discourse of *resistance* was present in the earlier period of this study but faded away as WFME aligned itself with ECFMG after 2010. Two further discourses, *protection* and *control*, emerged in the later period of this study and framed the ECFMG ruling in terms of nationalism and protecting American interests.

Discussion: This study proposes a new conceptualisation of the relationship between ECFMG and WFME in light of the apparently contradictory policy motivations of altruism and nationalism. It goes on to consider the implications of this association for the legitimacy of WFME as an organisation that represents all of the world's medical schools.

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1 | INTRODUCTION

How should medical schools be regulated? This question has long occupied medical educators and policymakers.[1] Despite the widespread practice of regulation, there remains little empirical research to guide how medical schools should be regulated.[2] One particular area of dissonance relates to the extent to which a global approach can be applied. Those arguing for such an approach draw on notions of competence and standardisation,[3] as well as the requirement for qualifications to be transferrable to facilitate medical migration.[4] Those raising concerns about global approaches, meanwhile, draw on sociocultural differences around the world[5] as well as concerns about imperialism and homogenisation.[6]

The Educational Commission for Foreign Medical Graduates (ECFMG) is a private, non-profit, non-governmental organisation that certifies international medical graduates (IMGs) entering the US physician workforce.[7] It was established in 1956 to ensure IMGs were properly 'vetted'[8] by verifying applicants' medical schools. In 2010, ECFMG announced that 'effective in 2023, physicians applying for ECFMG Certification will be required to graduate from a medical school that has been appropriately accredited'.[9] Thus, only graduates from schools accredited by an authority using approaches comparable with those used in North America by the Liaison Committee on Medical Education (LCME), or by the World Federation for Medical Education (WFME), would be eligible for ECFMG certification. In 2020, this was amended to 2024 to account for COVID-19 disruption.[10]

WFME is a not-for-profit, non-governmental organisation established in 1972 that promotes accreditation, publishes expert consensus standards and maintains the World Directory of Medical Schools.[11] In response to the ECFMG statement in 2010, WFME launched a recognition programme in 2012. As no equivalent LCME process emerged, this became the default arrangement to fulfil the ECFMG ruling. Prior to this recognition programme, WFME had already published a set of 'global standards' for undergraduate medical education in 2003, which were updated in 2012, 2015 and 2020.

The establishment of the WFME recognition programme was significant because it was the first time that global influence on the regulation of medical schools was systematically and institutionally enabled.[12] Although it is inextricably linked to the ECFMG ruling, it has clear consequences beyond the United States. The opportunity for accreditation agencies to gain credentials is a realistic motivation for WFME recognition. Indeed, a 'global mark of recognition' is listed as the first 'benefit' of the recognition programme by WFME.[13]

It is notable that a decision taken by an agency in one country, the United States, quite directly led to a fundamental policy change worldwide. In light of aforementioned concerns about homogenisation and imperialism, a policy directive driven by a Western country that predominantly affects countries in other parts of the world, and significantly Eastern countries given that this is where most of the world's medical schools are,[14] is potentially problematic. Moreover, if an agency decides not to apply for WFME recognition, it closes off opportunities to pursue postgraduate medical training in the United States, which is globally considered as prestigious and attractive.[15]

Although WFME does not anywhere suggest that its standards or recognition programme are designed to standardise medical schools,[11,13] the existence of a single set of statements that can be applied globally inherently implies this. The cost of applying for WFME recognition includes a $60 000 fee and costs of the team completing the site visit,[16] which represents a significant sum for many lower income countries. There are also many hidden costs. Preparation for regulatory inspections takes considerable time and may divert attention away from other healthcare or educational activities.[17,18]

Given that global approaches to medical school regulation are questionable from an ideological basis, in the extent to which they impose values from dominant countries, and from a resource perspective, one might expect a firm body of empirical evidence to support regulation itself. That is not, however, the case. Although research has shown the impact of accreditation on student performance[19] and medical school processes,[20] studies demonstrating sustained positive outcomes as a result of regulatory interventions do not exist, and cost-effectiveness analyses demonstrating that investment in regulation is worthwhile are also lacking. As a scoping review notes, 'limited evidence exists' to support current regulatory practices due to a paucity of studies on the topic.[2]

Recognising both potential benefits and harms of applying a global approach to medical school regulation, the aim of this research was to examine the way in which discourses made these ECFMG and WFME positions possible in order to better understand how their decisions had been justified and how the global approach in medical school regulation has gained apparent policy dominance. The overall research question guiding this study was: What were the dominant discourses that made it possible to 'globalise' medical school regulation?

2 | METHODS

This study used critical discourse analysis (CDA) to examine documents that describe the movement towards global approaches to medical school regulation. The term 'discourse' relates to language, texts and the contexts in which language and texts are used.[21] It is important for the creation and reproduction of knowledge as it enables certain statements to be prioritised over others. Discourses shape our experience of what is 'real'.[22] CDA examines the way that discourse makes certain statements appear inevitable and closes off challenge or debate.[23] CDA focuses on changes in language and practices.[24] As such, it is a powerful tool to examine how dominant ideas about medical school regulation evolved.

This study drew on the work of two scholars who were interested in language, power and knowledge. Although their perspectives and approaches do not align wholly, Michel Foucault and Edward Said were both fundamentally attracted to how power is enacted through discursive practices.[25] They also proposed theoretical approaches to critically analyse historical events.

As Bleakley and Bligh have noted, 'engaging Foucault critically is not straightforward—his work is full of paradoxes and open to multiple readings'.[26] The concept of discourse was described by Foucault as 'the system or rules by which certain statements appear and not others'.[27] Foucault aimed to study that which appears obvious or self-evident. In his examinations of madness, prisons and hospitals, he demonstrated that these arise as a result of the existence of particular discourses that make them possible and that their nature and functions change as discourses change, assume dominance and disappear.[28] Given that this study is about medical school regulation, it is notable that Foucault specifically examined medicine and medical education,[29] conceptualising the 'medical gaze' to describe the modern scheme of biomedicine moving from description to ascription.

Said described a process by which colonisers determined how the colonised were described and understood. In *Orientalism*,[30] Said demonstrated how European culture was able to 'produce' the Orient. Portrayals of the Orient were invariably as backward nations and peoples, in stark contrast to the 'superior' Occident. In *Culture and Imperialism*,[31] he took this further by describing how a 'contrapuntal' reading of texts can challenge underlying assumptions. A contrapuntal analysis involves reading a text in the context of its relations to empire, as well as in the 'counterpoint' to the position that colonised or marginalised people themselves produced. As Bleakley et al have highlighted, postcolonial theory has much to offer medical education research and practice.[6]

CDA seeks to problematise 'truths' that have been widely accepted; it is not intended to be a methodology wielded from a vantage point of unbiased objectivity.[32] The choice to use CDA in this study is deliberate, as a means to identify and interrogate dominant ideas about medical school regulation. However, this does not mean that the goal is either to promote or reject any particular policy decision. Rather, in keeping with other medical education scholars who have used CDA,[21] the hope is to advance the field in constructive ways.

Given the approach of using CDA to look historically at discourses that enabled the ECFMG ruling in 2010 to occur, this start point was in fact an 'end point' chronologically. Drawing on Foucault's approach of genealogy, the delimiting of the dataset therefore proceeded backwards from this point, identifying important preceding landmarks. Given the central role of WFME in 'enacting' globalising policy, its history as an organisation was the basis for this. As WFME standards were first published in 2003, 7 years prior to the ruling in 2010, their inauguration seemed an important antecedent event. Although WFME was established in 1972, the first major event in its history was the publication of the Edinburgh Declaration at the World Conference on Medical Education in 1988, presented as a consensus statement about quality of the world's medical schools. This represents the first seemingly 'global' statement about medical school quality and was therefore as a suitable 'start' point of the analysis.

Data sources included research articles, editorial and commentary articles, other scholarly writings from educators and policymakers and current and historical policy documents. Electronic database searches using keywords from each of the three events described above were combined with manual searches of webpages and key journals. Key documents and articles relating to each event were then tracked using a 'snowballing' process,[33] pursuing references of references and using citation-tracking software. This iterative process continued until it was clear that major documents had been located.

Analysis was carried out using document analysis.[23] Once the dataset had been defined and delimited, the texts were read and analysed to identify discourses and discursive shifts following the CDA stages outlined by Fairclough.[23] Statements, keywords and metaphors were sought with particular attention to recurring arguments and shifts in these arguments. In keeping with Foucauldian CDA principles, the absence, as well as the presence, of statements and uses of language were noted. These discourses were also analysed with attention to practices, institutions and social relations, read through the lenses of the approaches of Foucault and Said described above. A total of 250 documents comprised the dataset and were managed using Microsoft Excel. The overall aim was to identify the ways in which discourses about the importance of the globalisation of medical school regulation became dominant and how these in turn enabled policy decisions to establish global approaches to medical school regulation.

3 | RESULTS

Overall, five discourses were identified in this study: *endorsement*, *modernisation*, *resistance*, *protection* and *control*. The discourses of *endorsement* and *modernisation*, which both promote the globalisation of medical school regulation, were present throughout the entire time period of this study. The discourse of *resistance*, though, was present in the early period, specifically around the Edinburgh declaration (1988) and the first publication of WFME standards (2003), and absent in the later period of the study, at which time the two remaining discourses, *protection* and *control*, appeared. These two discourses became dominant around the time of the ECFMG ruling announcement (2010) and the period following this, although had been absent in the earlier time period.

3.1 | Endorsement

The discourse of *endorsement* projects the policies that move medical school regulation in a more global direction as having widespread support. It draws on the authority of respected institutions and ideas of the time to hint at the inevitability of globalisation. It plays out through four key ideas: consensus, alignment, implementation and representation.

The Edinburgh declaration is just 664 words long and has no named author(s), instead giving the title and dates of the World Conference on Medical Education at the end, hinting that it represents a consensus of all participants.[34] The text itself also gives an indication of consensus:

> This concern … reflects the convictions of a growing number of medical teachers and medical students, medical doctors and other health professionals and the general public around the globe[34]

WFME was also clear about the importance of developing consensus when it set out to develop its global standards 5 years prior to their first publication.[35] Once published, the importance of consensus was consistently reiterated, with descriptions including 'consensus-based' standards,[36] standards that are 'agreed by most educators'[37] and having 'obtained international endorsement'.[38]

This discourse also projected alignment of WFME and ECFMG with prominent and esteemed agencies and policies. The most frequently cited alignment was with the World Health Organisation (WHO). The sponsorship of the Edinburgh declaration by WHO was emphasised by the WFME President[39] and others,[40] as well as WHO and other organisations that were aligned to include UNICEF, UNESCO, UNDP, WMA and IAMRA.[3,41–43] In parallel to the alignment with reputable global organisations, there was also alignment with topical policies, including universal health coverage[44] and the Bologna declaration,[45,46] as well as with powerful national regulators, notably from Europe and North America.[47,48]

Assertions about implementation included that the Edinburgh declaration led to changes in medical schools, that WFME standards have been widely used globally and that countries are responding to the ECFMG ruling by seeking WFME recognition. The final approach within this discourse emphasises the representation of those involved in the development of both the Edinburgh declaration and WFME standards. The argument here, although not explicitly stated, is that the diversity of those who developed these documents implies their validity. Contemporary accounts of the Edinburgh declaration, for example, went to great lengths to describe the diversity of participants:

> The 137 participants came from 67 different countries well distributed among the six regions of the world-Africa, the Americas, the Eastern Mediterranean, Europe, South-East Asia, and the Western Pacific[49]

The absence of any description of the manner and extent of representation related to either the Edinburgh declaration or WFME standards is, however, striking. Rather than authenticating the representation by framing it as meaningful participation, it is instead used discursively as a means of depicting *endorsement*.

3.2 | Modernisation

The discourse of *modernisation* is similarly used to promote and justify globalising ideas and practices. It plays out through three key ideas: reform, development and harmonisation.

The Edinburgh declaration sought to define universal aspects of quality in medical education and directly used language of 'reform' in doing so.[34] Others writing at the time mirror this,[49,50] as did those commemorating the 30th anniversary of the declaration in a special issue of *Medical Education* in 2018.[51–53] Reform is also a clear and stated goal of WFME standards from even before work on them had begun:

> The first objective is to stimulate all medical schools to identify and formulate their own needs for change and quality improvement, by assessing their own strengths, weaknesses, potentials, capabilities and needs for change and reform[35]

Similar language was used after these WFME standards were eventually published[54,55] and is also used about the ECFMG ruling in 2010.[56,57]

Another feature of the discourse of *modernisation* is development. The Edinburgh declaration, for example, contains much imagery of underdevelopment, contrasting areas of the world, seemingly West and East, in terms of their civilisation and 'progress'.[34] Many devices used to promote ideas of development in relation to the Edinburgh declaration continued to be used in relation to the WFME standards and ECFMG ruling, including a problematisation of the status quo on the grounds of poor quality and a projection of the ruling as a means of 'improvement'.[58–61]

A final group of ideas are about harmonisation. The Edinburgh declaration dichotomises the modern and unmodern in a characteristically orientalist way.[30,34] Not only does this 'other' countries who are not following 'modern' trends, but it implicitly suggests that they must 'harmonise' by catching up. Ideas of harmonisation have also been articulated using related terms, including 'standardisation'[62,63] and 'internationalisation'.[3,64]

3.3 | Resistance

The discourse of *resistance* was present only in the early time period of this study. Unlike *endorsement* and *modernisation*, it is a counter-discourse, in that it challenges, rather than promotes, global regulatory policies. It plays out through three key ideas: oppression, repossession and opposition.

Resistance to oppression is notable in contemporary responses to the Edinburgh declaration that ridiculed its solemn and grandiose language:

> A novel feature was to wrap up the recommendations as 'The Edinburgh Declaration', presumably to give them the gravitas needed to match the occasion and signal to the less well informed how really important they were.[65]

> Some of the details of the council's report are curiously consonant with the Edinburgh declaration from the world conference on medical education despite the Edinburgh report reading somewhat like an educational revelation from St John the Divine.[66]

Similar resistance emerged in response to WFME standards, noting that they 'promote Western values'.[6] Language about repossession also features around the time of the Edinburgh declaration, with contemporary non-Western authors noting they had were ahead of the curve and asserting their own contributions to the global exchange.[67,68] Repossession related to the WFME standards, meanwhile, focuses on 'holding on' to local and traditional values and priorities and ensuring that standards primarily serve local, and not global, agendas.[69–71] Language about opposition represents a more direct form of resistance, for example, by deeming the Edinburgh declaration uninspiring and ineffective[65] or the WFME standards as confusing and difficult to use.[36]

Crucially, the discourse of *resistance* appeared only infrequently and regularly moderated by opposing, and sometimes contradictory, statements. This suggests that authors restrained themselves in order to be 'allowed' to raise concerns and challenges. This is important as the key focus of resistance is about cultural domination and the imposition of Western paradigms. Additionally, the discourse of *resistance* fades over time and is completely absent in relation to the ECFMG ruling.

3.4 | Protection

The final two discourses are *protection* and *control*, present in the later period of the study. This represents a discursive shift, as *resistance* fades away at the time they appear, coinciding with an important change in events. Whereas the Edinburgh declaration and WFME standards were expressly global in scope, the ECFMG ruling links to a single country.

The discourse of *protection* serves to justify globalising approaches as necessary to prevent harm, playing out through three key ideas: protecting the public, protecting students and protecting against foreign medical schools. Language about WFME standards, and even more frequently in relation to the ECFMG ruling, projected their roles in promoting public safety, directly and indirectly making a link to the migration of medical students and physicians from 'low-quality' medical schools.[3,4,72] Invariably in these examples, this migration is from East to West, thereby 'othering' migrant Eastern doctors. Noticeably, though, there is no clear argument or evidence presented about why the public needs protecting from foreign doctors—for example, evidence showing that IMGs perform worse than US medical graduates.

An idea not present in the initial ECFMG ruling announcement but that emerged later is that as well as protecting the US public, it also protects medical students. The primary focus is US citizens attending offshore medical schools, often in the Caribbean.[43] A final strand of this discourse offers protection against, rather than to, a particular group. Here, foreign medical schools are framed as threatening, specifically because of their proliferation and commercialisation.[3,58] Of note, these concerns often focus on the Caribbean, especially in the context of the ECFMG ruling:

> It should also be noted that the estimated number of medical schools worldwide continues to increase, particularly in the Caribbean region where many schools draw heavily upon U.S. citizens for much of their enrollment … Many of these medical schools are for-profit endeavours utilising non-traditional educational practices.[73]

3.5 | Control

The discourse of *control* also emerged in the latter part of the study period and has three strands: control through collaboration, control as managing variation and control by monitoring. By depicting themselves as collaborative, strategic and purposeful, the organisations involved in promoting global approaches to medical school regulation, particularly WFME and ECFMG, portrayed a sense of control.[74] For example, the ECFMG President describes how the two organisations co-operated:

> The plan, arrived at after much discussion and collaboration with the World Federation, is that WFME will review and recognize regional or national accrediting agencies for compliance with its standards. The expectation is that regional and national agencies that have been recognized by WFME will accredit individual schools. For ECFMG purposes, accreditation of an international medical school by an agency recognized by the WFME will meet our new requirement for certification.[7]

Focusing on collaboration portrayed this as a 'joined up' endeavour that is co-ordinated and rational.

A second set of ideas related to managing variation, establishing that differences between countries is problematic.[75,76] This was used as a justification to propel global approaches to medical school regulation by suggesting that this variation needs 'managing', through the notion of 'standardisation'[77–79] and an idealised, monolithic description of a 'global doctor'.[80]

A final group of ideas was about monitoring, suggesting that global regulatory approaches would help to scrutinise medical schools around the world. The notion of monitoring was particularly firm about the ECFMG ruling, where it was suggested that information about medical schools was necessary.[12,81] The language was often economic, including framing a 'supply' of doctors to the United States,[82] and at other times more managerial and linked to 'compliance' with the ruling,[83] implicitly suggesting consequences of non-engagement.

3.6 | Altruism and nationalism

Across these five discourses, two overall discursive strands surface. One is of *altruism* and ultimately portrays the ECFMG policy as a

means to modernise and improve medical education worldwide. The second is of *nationalism* and ultimately portrays it as a means to uphold medical standards in the United States and protect the US public. These strands have operated in parallel, and importantly, both positions are dominant, and there is no ultimate clarity about which is the 'real' motivation for the policy.

4 | DISCUSSION

This study used CDA to explore the policy dominance of global medical school regulation, specifically linked to WFME and ECFMG. Two discursive strands are dominant in the textual archive, one presenting a story of altruism and improving global medical education and the other presenting a story of nationalism and protecting US citizens. Of note, these strands run in parallel, and although they are not contradictory, each of these positions represent very different perspectives about the rationale for the ECFMG ruling.

Seen through a Foucauldian lens, one might argue that each of these positions represent powerful and persuasive ideas to different audiences. For an 'internal' domestic audience, nationalist discourses are likely to be powerful, and for an 'external' overseas audience, altruistic discourses are more likely to be effective. In other words, the combination of these two projections maximises the appeal, and therefore the authority, of this ruling to multiple stakeholders. Of note, although IMGs are framed as a threat to the American medical system discursively throughout the nationalist discursive strand, studies have shown that their clinical outcomes are as good as,[84] and perhaps even better than,[85] US medical graduates.

In Saidian terms, both discursive strands can be conceptualised as orientalist. Whereas *altruism* is a means of the West 'civilising' the East by modernising and improving it, *nationalism* is the West fearing a 'barbaric' East that cannot be trusted. In this sense, both serve to 'other' the East and contrast it with the West overall. The purpose of this study was not to find an absolute 'truth' about what the reason for this policy was. Rather, in uncovering assumptions and justifications in the discourses surrounding it, it draws attention to how language has been used to shift power relations, justify decisions and ultimately legitimise the policy to globalise medical school regulation.

The fundamental difference between WFME and ECFMG is that whereas the former is global in scope, the latter is national. Their union is therefore unusual. For ECFMG, the association with WFME fits with both discursive patterns. It supports *altruism* by projecting an outreach focus and supports *nationalism* by presenting a dependable external authority who can serve US needs. The benefits for WFME, meanwhile, are less clear. In the years prior to the ECFMG ruling announcement, WFME had already raised the idea of a programme that would 'accredit the accreditors',[3,58] and so, the idea for the recognition programme was already an ambition. It had not, though, come to fruition. What the ECFMG ruling provided was an opportunity to compel engagement. Indeed, the WFME recognition programme quickly developed after the ECFMG announcement and has escalated since. Analysing these events through a Foucauldian lens, one can see a shift in power relations whereby WFME positioned itself in alignment with ECFMG to realise a policy ambition.

What is clear from this research is the link between ECFMG and WFME has strengthened in recent years. The implications of this for WFME as an organisation depend on which framing of the ECFMG ruling one considers. As a policy motivated by *altruism*, WFME emerges as an organisation of reform, improvement and modernisation. As a policy motivated by *nationalism* though, WFME emerges in less glowing light, a position difficult to reconcile given its stated organisational mission. Although the ECFMG ruling allowed WFME to develop the recognition programme it wanted, it is unclear what cost it paid for this in terms of its own credibility. In the context of this relationship, the absence of discourses is particularly noteworthy. In the period prior to 2010 and its association with ECFMG, the discourse of *resistance* was strongest, and there was constructive debate and dialogue about unintended consequences of globalisation and WFME policies. Moreover, in this early period, the discourses of *protection* and *control* were not present. However, following 2010, voices of resistance were seemingly silenced, and the nationalist discursive strand emerged. These absences suggest, worryingly, that thinking may have narrowed rather than broadened over time.

4.1 | Strengths and limitations

The use of CDA has enabled an in-depth exploration of connections between language, knowledge and social interactions. Each discursive position has privileged certain ways of thinking and marginalised others. Drawing on both Foucault and Said has helped to uncover some ways that global approaches to medical school regulation have been framed and how these conceptions have limited other positions. All discourses shape thinking and practice, often in unanticipated ways, and this study highlights potential harms from apparently benevolent and reformative practices. The use of Saidian theory, and particularly the contrapuntal method, has not been used in medical education and this study confirms its utility in examining impacts of globalisation.

There are several limitations to this research. Firstly, despite exhaustive database searching and snowballing methods, it is possible that documents were missed. Crucially, the limitation to English language documents significantly limits this research, as many opinions may not be 'possible' to express in English. In particular, this constricts the contrapuntal method, although it was nonetheless still effective with this dataset. A further limitation is the exclusive use of document analysis. Although it is recognised that oral histories rely heavily on memory, which can be flawed and prone to exaggeration,[86] there may nonetheless have been some additional insights from interviewing those engaged with ECFMG and WFME in recent decades.

4.2 | Implications for medical education

This study suggests that ideas about quality and regulation in medical education science and practice are not always based on empirical evidence and emphasises the importance of careful interrogation of policies enacted by global organisations with significant power and influence. Said emphasised the importance of challenging orthodoxy and dogma and encouraged the raising of 'embarrassing questions'.[87] He considered it particularly important to fight for people and causes that are perennially forgotten. By questioning the assumptions that WFME, a global organisation, should have a 'special relationship' with ECFMG, this study attempts to explain why this position may have arisen in a particular historic moment through the discourses that preceded and enabled it. Perhaps the most striking way to do this is to imagine what a global organisation for medical education, like WFME, could hypothetically look like. It could, for example, proactively associate itself with the most marginalised, vulnerable and repressed countries and medical schools in the world. It could distance itself from any policies or practices that could be considered orientalist or in any other way oppressive. It could actively seek to celebrate differences, foregrounding and showcasing examples from around the world where countries have bucked trends and been bold and ambitious in creating curricula, teaching and assessment methods and indeed regulatory systems, which are purposively different from other countries and international 'norms', championing the social accountability and local contexts of medical schools. This hypothetical vision of such an organisation provides a means to examine current global organisations through a lens of 'possibility'.

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AUTHOR CONTRIBUTIONS

MAR completed all aspects of the study and wrote the manuscript.

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