An exploration of crossborder medical curriculum partnerships: Balancing curriculum equivalence and local adaptation

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Abstract

Context: Worldwide, medical schools have entered into crossborder curriculum partnerships (CCPs) to provide equivalent curricula and learning experiences to groups of geographically separated students. Paradoxically, this process also involves *adaptation* of curricula to suit local contexts. This study has focused on challenges faced by medical Crossborder curriculum programme directors and strategies they employed to overcome these.

Methods: We conducted a qualitative study on six CCPs using document analysis and semi-structured interviews with 13 programme directors from 12 medical schools. Interview transcripts were coded iteratively, followed by cross-case analysis.

Results: The challenges faced by CCP programme directors are four-fold, springing from differences in health care systems, legislation and political interference, teaching and learning environments, and partnership. Deliberate strategies, such as intensifying interactions between partners in all academic echelons, can help to overcome these. Partnerships vary in their setup and collaboration strategy.

Conclusion: Medical CCPs are challenging though seem feasible. Partnerships with more solid integration of academic operations appear robust in terms of ownership and provide, besides financial, also academic advantages to both institutions. However, more research is needed on the long-term effects on quality of graduates and impact on the host health care system.

Introduction

Several medical schools have established crossborder curriculum partnerships (CCPs) as one of their internationalisation strategies (Karle 2006; Williams et al. 2008). In crossborder curriculum partnerships, two institutions located in different countries strive for equivalence – i.e., comparability – in terms of curriculum content and learning experiences to students in both institutions (Knight 2006). Although these partnerships can take many different legal forms, such as branch campuses, delivery agreements, or franchises of complete programmes, they all share that the curriculum developed in one place, the *home institution,* is transferred across borders to the other, or *host institution* (Wilson 2002; Verbik et al. 2006; Lane 2011). CCP has been mentioned as a logical next development phase of globalisation in Higher Education following the student and teacher exchanges of the previous decades (Harden 2006). A report from the British Council (2013) indicates that this type of partnership is expanding and has high-potential growth rates.

Although rising in popularity, CCPs are often featured by opposing inside forces that create an educational tension: on one hand, partners strive for curriculum equivalence to meet the host students' expectations – also from a quality assurance perspective differences cannot be too large – whereas, on the other hand, there is a need for adaptation of the home institution's programme to the host institution's local context and organisational culture (Coleman 2003; Knight 2008; Shams & Huisman 2012). The paradox of crossborder curriculum partnerships, then, seems to be that the two institutions' curricula should be identical as well as locally adapted (Shams & Huisman 2012). This paradox is particularly challenging in the medical domain where national variations in health care

Practice points

- In a crossborder medical curriculum partnership, curriculum equivalence and adaptation to local contexts seem to be reconcilable.
- To achieve curriculum equivalence, challenges related to health care systems, politics, education environment, and partnership culture need to be overcome.
- Partnerships with more intensified collaboration appear more robust in terms of ownership and have greater advantages.
- More comparative cross-cultural research into the long-term impact of crossborder curriculum partnerships on the health care system in the host country is needed.

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systems in which clinical learning is situated, abound. Furthermore, most medical curricula incorporate a range of domain-specific methods of instruction, such as clinical skills and communication training, ethics, and professional behaviour training. Differences in learning and teaching environments can complicate the implementation of such methods in the host institution's context. The recent end of the medical curriculum partnership between Johns Hopkins University (USA) and Perdana University (Malaysia) (Sharma 2014) is an example that illustrates the complexity of these kinds of collaborations.

Previous studies on CCPs report that an *identical* curriculum is neither possible nor desirable (Smith 2009b; Vinen & Selvarajah 2008). Although they underline the importance of curriculum adaptations, no clear guidance is given as to where to depart from there. Instead, most studies are generic in scope, focusing, for instance, on effective training programmes for visiting staff (Smith 2009a) or on the influence of English as a foreign language on student performances (Briguglio 2000). Heffernan and Poole (2005) found that the volatility of partnerships and, with that, curriculum delivery was often due to cultural differences in communication; especially a lack of personal "vibe" proved to be detrimental. A recent review of the literature on crossborder curriculum partnerships revealed that few studies have been conducted in the specific context of health care education and none of these have taken crossborder curriculum partnerships as their primary focus (Waterval et al. 2015).

As the specific features of medical partnerships call for further research, we turned to the experiences of pioneering medical schools that have embarked on such partnerships. Our goal was to describe the challenges they faced and the strategies they used to ensure both curriculum equivalence and local curriculum adaptation.

Methods

Case selection

We conducted a qualitative, multiple case study of six crossborder medical curriculum partnerships using semi-structured interviews. We used an explorative approach because this form of internationalisation is relatively new and we did not want to miss any essential features. Potentially eligible partnerships were identified using a snowballing technique: 12 international medical education experts were approached in person or by email, which yielded 22 potential partnerships. By means of an Internet research and e-mail inquiry, this selection was further condensed to include only those partnerships that met the following criteria:

- The partnership has for its aim to equalise the learning experience of students in both settings by delivering equivalent curricula.
- The partnership has existed for a period of at least three years and preferably has at least one batch of graduates.

The six partnerships that matched these criteria were all willing to participate and are listed in Table 1, being randomly coded as partnership A–F. Partnerships varied between them with respect to type of medical curriculum, type of degree, and main method of instruction. Yet, they were all geared to achieving curriculum equivalence. Ethical approval was sought and obtained from the Netherlands Association for Medical Education Ethical Review Board (NVMO file number 304).

Data collection and analysis

First, we conducted an analysis of online publications, curriculum descriptions, and public partnership reports pertaining to the six partnerships. With the background information that was retrieved this way, each interview guide was geared to characteristics of the particular partnership.

Subsequently, semi-structured interviews were conducted with 13 CCP medical programme directors, six of which represented a host and seven a home institution's perspective. Participants were purposively selected for their primary responsibility to oversee the academic quality of the curriculum being delivered and their involvement since the start of the partnership. Invitations were sent by e-mail and, prior to the interview, informed consent was obtained. The interviews lasted about one hour and were conducted online or, when feasible, face-to-face by the first (D. W.) and third author (A. O.) in the period between December 2013 and August 2014. All interviews were digitally recorded and transcribed verbatim. Participants were randomly labelled with a number that did not correspond to the partnership codes reported in Table 1.

Analysis of the interview transcripts was four-staged. In the first stage, all transcripts were read to familiarise the authors with the data. During the second stage, the transcripts were open-coded by two independent researchers (D. W. and A. O.). That is, for each partnership, sections that were relevant to the study's objective were identified, resulting in an initial coding scheme. The third stage concerned application of this coding scheme to all transcripts using Atlas.Ti. The scheme was then further refined and extended alongside ongoing data collection and analysis. Throughout this process, a research journal was kept to record analytical decisions, code definitions, and researchers' notes. Although after eight interviews the coding scheme appeared complete, we continued the final five interviews to verify our scheme. In the fourth stage, three researchers (D. W., A. O., and J. F.) performed a cross-case analysis to identify relationships and patterns across partnerships. The transparency of the analysis, the involvement of two independent researchers who read and compared ideas about transcripts, the discussion on variations of the coding scheme and the search for disconfirming evidence all bolstered the study's trustworthiness. A copy of the analysis' preliminary results was sent to all participants to elicit their comments on the representation of the data. This operation, however, did not result in any content modifications.

Results

It was found that in order for a CCP to be successful, partners needed to overcome various challenges which can be grouped into four categories. Three of these spring from differences in home and host settings, that is, differences in health care

Table 1. Overview of included partnerships and their characteristics.

Partnership	Country (private or public institution)	Type of programme	Degree	First batch	Faculty	Main methods of instruction
A						
Home	UK (public)	5 Years under-graduate curriculum	Separate degree	2006	Mainly local	Lectures and PBL
Host	Egypt (private)	5 + 1 Under-graduate curriculum				
B						
Home	Netherlands (public)	6 Years under-graduate curriculum	Separate degree	2010	Local	PBL
Host	Saudi Arabia (private)	5 + 1 Under-graduate curriculum			Regional	
C						
Home	USA (private)	4 Years graduate entry curriculum	Joint degree	2007	Local	Lectures
Host	Singapore (public)				Local and seconded higher management	Lectures and team-based learning
D						
Home	USA (private)	4 Years graduate entry curriculum	Degree with indication of location	2002	Mainly local	Lectures and PBL
Host	Qatar (public)	2 Years pre-medical +4 years graduate entry curriculum			International	
E						
Home	UK (public)	5 Years under-graduate curriculum	Similar degree	2009	Local	Lectures and case-based learning
Host	Malaysia (public)				Local and percentage higher management from home	
F						
Home	UK (public)	4 Years graduate entry curriculum	Similar degree	2011	Local	Lectures and PBL
Host	Cyprus (private)				Local and seconded project management	

systems, legal and political interference, and teaching and learning environments. The fourth category relates to intra-partnership interactions. The above categorization should not be interpreted as a strict separation – as they influence one another – but rather as a clustered overview.

Health care system

Differences in health care systems which posed a challenge to the achievement of curriculum equivalence were two-fold: they related to dissimilarities in organisational structure and to diverging health care needs. An example of organisational differences is the system of referral by primary care physicians, such as general practitioners, which was common in all the home countries, but did not exist to the same extent in the host countries. As host participant 5 explains:

> So, we had a programme in the home country which is much tailored to the structure of the National Health Service, which did not translate. But the outcomes should be the same, so what we did was to work out novel ways in which those outcomes could be met.

The availability of teaching hospitals is another example. The home institutions' curricula required frequent and close interaction between students and patients, especially during the clinical phase. Whereas home institutions could rely on a large network of clinical placements, in the host institutions' setting such networks were often still in their infancy. Home participant 7 voices this concern:

> One of the issues we face is the availability of clinical placements for our students. This is such a hassle as the private University has to rely on governmental hospitals for the clerkships.

To overcome these differences, partnerships focused on the envisaged learning outcomes, and consequently adapted the curriculum content and didactic methods to the local possibilities. In the words of host participant 5:

> Some of those methods were more economic, more efficient and produce better outcomes in terms of student understanding, learning, skills, and performance at the host than at home.

At the same time, however, participants indicated that these differences remained a continuous point of attention and were sometimes insurmountable. In such cases, they had no choice but to compromise and make concessions to the delivery of home institution's curriculum.

The second challenge within the category of Health care system relates to diverging health care needs that complicated

the achievement of curriculum equivalence. These could be traced to deviating graduate outcomes in terms of epidemiological knowledge and generic competences. Remarkably, no uniform method appeared to be in place to map and analyse such differences, which, presuming that a fitting of contexts is key to the viability of CCPs, was quite odd. One of the partnerships, however, formed an exception, as they did a thorough two-year feasibility analysis of potential differences in epidemiological knowledge and generic competences. They found that:

> . . . there was not that much of a difference in the disease profile, . . . it was very similar to the home one. Much more so than you would have ever imagined. So there are some epidemiological gaps, but you know, that didn't particularly worry us. So we [home] found a small number of cases, clinical conditions, where we might have to tweak the curriculum or alter it slightly. (Home participant 6)

The following quote from home participant 3, about the construction of a theoretical PBL case for first-year students, clearly reflects such alterations:

> So I think a good example is sickle cell anaemia which is common in local population in the home country, while thalassemia is very common in population in the host country. So we had a hemoglobinopathy case and we rewrote the objectives up so that students studied both, in fact, sickle cell and thalassemia. So that was an example of changes that we made.

The effected changes also included more fundamental ones, as the following example from home participant 1, where the host country needed graduates with advanced research skills, demonstrates:

> So in response, we put introduction to research methods in the first year. We added statistic courses and other types of things to the home curriculum that supported our research education mission, so that's different than home institution for instance.

In general, programme directors felt the host countries' needs could be catered for by adding learning materials, assignments or longitudinal courses to the home institution's curriculum. They felt confident that these modifications would adequately prepare host students for practice in the host country's setting.

Legal and political interference

The achievement of full curriculum equivalence in both settings often also became undermined by differences in legislation. Some host country governments, for instance, dictated the length and types of clerkships and sometimes also parts of the curriculum contents, as the following quote from host participant 4 makes clear:

> The host law system obliged us to include parasitology and microbiology with public health.

Such legal and political interference could be stringent and, if in conflict with the objective of curriculum equivalence, have potentially disruptive consequences. This is evidenced, for instance, by a statement from home participant 1, who uttered his concerns over considerations by the host government, instigated by an explosion of medical schools, to implement national knowledge exams, as this would assure quality across all emerging schools:

> So the local folks have created this test. And the test looks a lot like the recitation of the facts that reflect the way that host country would teach. So the test doesn't look like the type of thing we would actually want to create . . . So, it influences the very nature of clinical education . . .. If the host government truly persists and says all students in clinical training should be treated and trained the same way, the home institution . . . would become unsatisfied with the partnership.

Finally, participants indicated that the tenure of legal and political demands was such that modifications to the home institution's curriculum could not be avoided. Hence, to minimize and circumvent this kind of interference, they advised a more diplomatic stance by appointing someone who would act in the host environment and simultaneously safeguard the home institution's interests, opening doors that the home institution's higher management had not been able to open. This is illustrated by the words of home participant 2:

> You need a bridge, somebody from that host environment who is aware of the differences. . . . So this key person who has leg in and leg out is of value in any curriculum partnership.

Learning and teaching environment

One imminent challenge faced by programme directors was the transplantation of a *student-centred* home curriculum to the host setting. For host students, this meant that they first had to familiarise themselves with the new learning method. Participants concurred that this process was challenging and sometimes required remediation measures such as extra counselling or study skills trainings. Nevertheless, they all had the impression that the influence on the delivery of the programme was a hurdle that could be taken. Their advice was to start off with only a limited number of students, as it would allow staff and students more time to become familiar with the home curriculum. Similarly, more time would become available for the creation of appropriate learning resources and experiments with programme elements.

The following quote from host participant 5 reverberates the aforesaid:

> I think in the first year, our external examiners said the [host] students are somewhat quieter, but by the time they get to year four, they're indistinguishable [from home students].

What also rendered the achievement of curriculum equivalence more difficult in the eyes of the participants was the divergence in teaching styles. As host institution staff was often trained in more conventional methods and had not been exposed to the home curriculum's student-centred philosophy, their teaching styles differed considerably from those of the home teachers. It appeared not so easy to achieve convergence, especially so in the clinical phase where students were supervised and trained by local physicians who acted as clinical teachers. Most of these clinical teachers were not, or only part-time, employed by the medical school and upheld a philosophy which differed from the one emanated by the curriculum. The following from home participant 1 quote does not leave any doubt:

> They [host institution clinical teachers] believe that having a vast amount of facts is important. So, they will quiz the students, just fire off question after question . . . to see how much the students know. We are not trying to teach the students to memorize the rhythm, we actually try to teach them how to think. And how to know and where to get the information and then know what to do with it.

All partnerships acted on this divergence by introducing continuous staff development programmes especially in the first three years. Despite these efforts, participants recognised that they were not able to change the hearts and minds of all teachers; aligning clinical teaching methods, therefore, remained a continuous point of attention for partnerships.

Finally, scepticism towards the new curriculum and the professional skills of its graduates, especially among people who were sideways involved in its implementation, constituted a major challenge. Such suspicious attitudes of stakeholders affected curriculum delivery more subtly and indirectly, as home participant 1 points out:

> I think local scepticism put the partnership at risk. It is one of the areas that make it most challenging and time will tell whether the local boots on the ground become convinced. . . . But if, over time, we can demonstrate that our students do fine when they graduate, then, slowly but surely, the acceptance at the ground levels will rise.

To counteract this scepticism, all partners pointed to the importance of unwavering support from the upper management for the partnership and long-term commitment, in addition to raising and promoting host students' learning performances.

Partnerships

The fourth category of challenges affecting the achievement of curriculum equivalence was related to the nature of and interaction within the partnership. Transferring education and assessment materials, and the knowledge to use these adequately, lies at the heart of each CCP. Curiously, it was found that coordinated forward planning was largely absent in all partnerships, as a result of which multiple ad hoc solutions and behaviours sprouted. The following quote by home participant 3 illustrates this best:

> I was running around the medical school with a USB stick, getting people's lectures off them to send them over, you know, I didn't even have administrative support for the partnership then.

As a result, partners found themselves confronted by various unforeseen problems which had its repercussions on the extent to which curriculum equivalence worked out. To name an example:

> The radiologists didn't share any of their films, because they were worried that it might be patient-identifiable, you know. None of the patient data was on the films, but they still had concerns about access because of our Information Governance Policy so we didn't end up sharing films. (Home participant 3)

Programme directors largely acknowledged that such issues could harm the relationship between partners and should, therefore, be anticipated. As home participant 2 stresses:

> Clear outline of what the agreement entailed and very clearly communicated to both parties. And what the expectations are of working together. Yeah, that's really important.

When asked what programme directors would have done differently if they could start anew, they gave answers similar to the following one:

> 80 percent of our issues are due to planning weaknesses. If we have to do it one more time then I think we should spend at least a year in thoroughly planning this project. This includes the planning of curriculum, its delivery, the human resource, the other planning aspects of management support, mechanisms, the infrastructure etcetera etcetera. (Host participant 6)

A second challenge in this context originated from the differences in roles partners naturally assumed: that of architect (home institution) versus receiver (host institution) of the curriculum. This created a tension, sometimes blurring the boundaries of ownership and autonomy. Although all six host institutions – or their governments – had initiated and financed the partnerships, they were curbed in their

authority to amend the programme, as they had to act in line with the original intent of the curriculum partnership. Hosts were not so much disturbed by this reduced autonomy provided decisions were initiated by their own staff and they were treated respectfully. As host participant 3 states:

> The responsibility is shared. . . . Like the adaptations that they [host] needed to make, they can contact their home colleagues and explain what is happening, so that we understand and didn't feel like they were just being arbitrary. Although they are finally approved by home, it is principally a decision made by the host.

It followed that partners minded their language, both in written policies and spoken language, being careful not to use utterances that could inadvertently inflict any sense of inferiority on the host institutions. The following quote from a home programme director 2 demonstrates the delicate nature of these relationships:

> The Head of host institution Assessment unit once said: Why do we have to double mark? . . . We know how to double mark and we're doing it well on our side. Why are you [home institution programme director] still overseeing us by this quality assurance process?' And I said 'We are not overseeing you, we are making sure both cohorts are marked in the same way.' It's mutual alignment. Double marking is about quality alignment, rather than quality assurance, now. So this framing seemed to be acceptable [for our partner]. (Home participant 2)

Another strategy to strengthen intra-partnership relations was to purposively screen the first host teacher recruits for high motivation, out-of-the-box thinking, and excellent communication skills. This was valued more than reputation or academic rank. In some cases, a certain percentage of host institution key figures were appointed by the home institution, an approach that worked, as it decreased the cultural distance between institutions.

The pursuit of curriculum equivalence in two different settings demanded intensified interaction between educators and administrators. This also called for different working procedures in the home setting, which appeared quite challenging to home programme directors, as the following quote from host participant 1 indicates:

> As long as home staff members don't have to do anything differently, the relationship is okay. But if you make them do something different then it is not okay.

Despite the reluctance to adjust procedures in the home setting, various forms of collaboration resulted in accordance with the nature of the partnership. For instance, CCPs who graduated students with identical degrees integrated their academic working processes as much as possible:

> We have, in fact, mirrored the roles that exist by doing this, we almost had a pairing amongst colleagues. . . . There are countless hours, countless hours of proceedings that are happening via video conferencing. Committee meetings, fitness to practice meetings, student support meetings, question assessment meetings, meetings about exam results. . . . there is a huge amount of contact. (Home participant 3)

Interestingly, such efforts yielded several academic advantages, as the following quote suggests:

> We've seen loads of changes in our home programme, because of the feedback from host. Whereas our home staff sometimes couldn't bother giving feedback. So lots of things have improved, lots of suggestions are coming. (Home participant 2)

Intensified collaboration, however, also had other consequences that should not be overlooked as stressed by home participant 2:

> And most importantly, the administrators have had an enormous role and they need to be in contact with each other as much if not more than the academics. As the administration of this course is very complex, there has been a lot of administrative training as well and exchange of administrative people from here to there.

Discussion

From our study on crossborder medical curriculum partnerships, it results that partners are not looking to achieve an exact copy of the home curriculum, as they realise this is neither possible nor desirable. It is not possible because resources or learning opportunities available in the home setting are simply absent or differ from those available in the host setting. Neither is it desirable because partners acknowledge, in line with the existing literature on globalisation in medical education that international medical partnerships can potentially lead to a misalignment with local health care needs (Bleakley et al. 2008; Hodges et al. 2009; Burgis-Kasthala et al. 2012). In response, partners took to adapt the home curriculum to accommodate differences in health care systems, health care needs, legal interference, and educational environments.

Yet, the very nature of curriculum partnerships calls for comparability of curricula and learning experiences in both locations. Finding a balance between adaptation and equivalence creates an educational tension as the adaptations to local settings are constrained by the intentions of the partnerships. We found that when resources differed between host and home settings, partners bridged this disparity by focusing on similarity in educational outcomes rather than on using similar

methods of instruction. Other adaptations were aimed at accommodating the home curriculum to the host country's health care needs by adding (longitudinal) courses, assignments, and exposure to local health care systems. This confirms our initial statement that crossborder curricula are not just carbon copies of home curricula. Some participants expressed their confidence that such revisions adequately prepared host students for practice in both countries. It is important to investigate more closely whether this truly is the case. After all, a CCP is deemed successful when a seamless fit with local needs has been achieved, distinguishing it from "offshore" medical schools that explicitly cater for the home rather than the host market (Knight 2006).

We have seen that CCPs not only thrive on revision of the home curriculum but also on proper management. Interestingly, all partnerships in our study were initiated by senior health care decision-makers and/or policy-makers from the *host* country. Nevertheless, with knowledge and materials stemming from the home institution, and remuneration from host to home, the relationship between partners of a CCP is inherently unequal, which can complicate collaboration and communication processes. Our findings confirm studies by Heffernan and Poole (2005) and Sidhu (2009) who argue that seeming trivialities, such as timing of joint meetings and perceived impolite communication, can cause harm to the relationship and the quality of curriculum delivery. Furthermore, it remains to be seen whether contextual differences related to clinical teaching culture, students' learning behaviours, and feelings of scepticism among stakeholders can truly be overcome by deliberate management strategies over the longer run. This issue definitely merits to be investigated further as soon as the pioneering partnerships have become more mature.

The present discourse gives rise to a fundamental question, which is: how to define 'equivalence' in the first place, and who determines the extent to which equivalence should be reached in a crossborder curriculum partnership? Although different institutes such as UNESCO have set guidelines for curriculum partnerships (Castle & Kelly 2004; Karle 2006; Stella 2006; Zwanikken et al. 2013), there is currently no internationally agreed accreditation standard by which 'equivalence' can be measured. It therefore remains a grey area, often leaving it at the discretion of both partners to decide. More alarmingly, the absence of an acknowledged judge or institution makes way for other dynamics: financial considerations, for instance, might just prevail over the commitment to assure equal quality of student experiences (Coleman 2003).

This makes the experiences of home medical schools, such as one of the partnerships in the present study, who guarantee their host students that their final degree is of exact equivalence to the one from the home institution, an interesting object of scrutiny. These partnerships distinguish themselves for involving, as intensely as possible and from the start of the partnership, the host institution's staff in many academic spheres of the home institution. This more collaborative, participatory approach yields greater benefits, such as increased feedback on the home institution's educational materials and assessment papers, and a more profound evaluation of the educational programme. Furthermore, partners report that close integration offers the opportunity to try out educational innovations and new delivery modes, ultimately resulting in joint research ventures. Evidently, this integrative approach has a potentially strong positive effect on the quality of curriculum delivery. This approach might ultimately elevate the notion of CCPs to entail partnerships where teachers conjointly develop materials and establish international medical curricula, and where educational knowledge not only travels from home to host but in both directions (Harden 2006). Eventually, such partnerships could grow to become a fully integrated global university network, as envisioned by Wildavsky (2010) and Knight (2008).

One of this study's merits is that it addresses a relatively young and rather unexplored trend in the ambit of medical education. Another strength is that data were collected first hand, reflecting the perspectives of programme directors who, from the very beginning, had been overseeing the quality of curriculum delivery on both sides of the partnership. It should be mentioned, however, that the data only reflect one side of the story and it cannot be determined to what extent participants were in a position to disclose all their strategic sensitive challenges and partnership experiences. It would therefore, be interesting to expand and triangulate the data with teacher and student perspectives.

A second potential restriction of this study is that challenges programme directors encountered were predominantly based on small batches of students and only few partnerships had actually graduated students. We, therefore, support the suggestion made by Hodges et al. (2009) that a broader comparative research programme is needed to examine long-term impacts of CCPs on host country health care systems, their graduates' professional skills and cultural and collaborative aspects.

Conclusion

Establishing crossborder medical curriculum partnerships is a challenging endeavour due to the educational tension created by opposing inside forces that seek to achieve curriculum equivalence while adapting curricula to local contexts. Home and host settings differ in health care systems, legal and political interference, and teaching and learning environments requiring partners to make concessions to the equivalence objective of CCPs. The experiences of pioneering medical institutions seem to suggest that it is feasible to overcome these differences without harming curriculum equivalence.

From a management perspective, it seems that there are not only financial but also academic advantages to be had for both institutions as long as equal relationships on all institutional levels are deliberately promoted and sustained by modern communication facilities. Lessons on how to integrate academic operations, balance the interactions between staff, and on optimal ways to transfer curriculum materials can be learned from pioneering medical partnerships.

However, before embarking on a crossborder curriculum partnership, we strongly recommend institutions to critically reflect on their motives and to factor in ample time for planning. A culturally and locally sensitive partnership with an

emphasis on alignment with host country health care needs and addressing the impact on learners and teachers, requires of both partners a profound analysis and hence significant investment from the start. This, however, is worth the effort as it limits the chance of failure and maximises the chance for potential advantages of CCP in the long run.

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