

From EMI to FMGE: Structural Mismatches in Cross-border Medical Education between China and India

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ABSTRACT

With the large-scale implementation of English-Medium Instruction (EMI) in medical education at Chinese universities, a growing number of Indian students have pursued MBBS degrees in China. However, the expansion of EMI courses has not improved their low pass rates in India's Foreign Medical Graduates Examination (FMGE), revealing structural mismatches between the teaching and accreditation systems of the two countries. By comparing policy documents, this study examines how language barriers, inadequate clinical training, and challenges in cultural adaptation affect students' academic performance and the construction of their professional identities. The findings indicate that EMI curricula lack adequate language support and community medicine training, placing students at a systemic disadvantage in the FMGE. Moreover, under the logic of the global education market, students are instrumentalised as "international enrolment targets," with their actual needs and identity recognition marginalised. This paper calls for the establishment of mutual recognition mechanisms between Chinese and Indian medical education standards and the strengthening of language and local adaptation support systems to foster a fairer and more inclusive environment for international medical education.

KEYWORDS

Indian MBBS; FMGE; EMI; Structural mismatch; International student mobility

1 Introduction

In recent years, China has rapidly become a major study destination for students from the Global South—particularly Indian MBBS students—due to the systematic promotion of English-Medium Instruction (EMI) in medical education. As one of the few non-English-speaking countries to implement EMI medical programmes on a large scale, China institutionalised its EMI policy in 2020, integrating it into its regular development agenda with the support of the Ministry of Education and the National Health Commission. However, the expansion of EMI teaching has not substantially alleviated the professional certification challenges faced by international graduates. Upon completion of their studies, many Indian MBBS graduates are still required to pass the FMGE administered by the National Medical Commission (NMC) of India—a long-standing compulsory threshold for medical registration.

Statistics show that between 2015 and 2021, the FMGE pass rate for Indian graduates of Chinese EMI medical programmes was only 16%^[1], far below the global average. The persistently low success rate raises a critical question: Why do students, despite completing a medical curriculum designed to meet international standards, still struggle to pass the accreditation threshold? The consistently high failure rate in the FMGE points to a structural mismatch between "curriculum" and "certification."

Against this backdrop, this study addresses two central research questions: (1) Do EMI medical programmes in China—designed in line with international benchmarks such as those of the World Federation for Medical Education (WFME)—exhibit structural misalignments with the Indian FMGE in terms of curriculum content, language requirements, and clinical competency training? (2) How does this mismatch mechanism influence Indian students' academic performance and professional confidence?

Existing research has highlighted common issues in EMI programmes, such as insufficient language support^[2], lack of cultural adaptation measures, and inadequate clinical exposure, which can lead to a state of "learned helplessness" among students^[3]. As the final accreditation mechanism, the FMGE further intensifies both psychological and academic pressures.

To address these questions, this paper adopts a policy text comparison approach, juxtaposing the official Chinese Ministry of Education EMI medical curriculum guidelines (e.g., Undergraduate Medical Education (English-Medium) for International Students syllabus) with the FMGE syllabus issued by India's NMC. From the perspectives of language, clinical training, and curriculum structure, this study identifies the structural mismatches between the two systems, revealing the systemic disjunctures in the "teaching-accreditation" chain of cross-border medical education, and offering policy insights for non-English-speaking countries in developing sustainable international medical education strategies.

2 Literature review

With the large-scale adoption of EMI in Chinese higher education, EMI has become an important pathway for

internationalisation. In the field of medical education, research has shown that EMI programmes often entail significant linguistic and cultural challenges. Alanazi and Curle (2024) found that international students in non-native English environments commonly face limited classroom interaction^[4], unclear instructional semantics, and inadequate cultural support^[5]. Such issues not only reduce classroom engagement but also constrain students' ability to internalise professional knowledge and express it critically.

Moreover, the phenomenon of "policy–practice gaps" in EMI implementation has been widely documented. On the one hand, instructors' English proficiency varies considerably, and support for clinical training is insufficient. On the other, curriculum design often lacks systematic language support mechanisms, resulting in decreased learning motivation^[6]. This disjunction between policy and practice increases the academic burden on students and directly impacts both their performance and psychological well-being. In medical education in particular, inadequate mastery of multilingual medical discourse and clinical communication skills creates persistent obstacles in knowledge acquisition and clinical practice.

From a social constructionist perspective, some scholars have examined the positionality of international students in EMI environments. Marginson (2014) theorised that international students' academic and social identities are continually negotiated within structural power relations^[7]. Language anxiety, cultural distance, and implicit institutional exclusion together form "silencing" mechanisms^[8] that limit students' agency and participation. In EMI classrooms, these mechanisms manifest as "tactical silence" and "marginalised participation," reflecting students' disadvantaged position within heterogeneous educational structures.

While prior research has shed light on such micro-level challenges in EMI, the literature remains largely focused on classroom language interaction and cultural adaptation, with insufficient attention to the structural alignment between transnational education systems. In medical education, students must not only complete coursework but also pass their home country's professional licensing examinations. To date, no systematic study has examined how structural mismatches between host-country EMI curricula and home-country accreditation systems shape students' career trajectories, legitimacy construction, and risks of marginalisation.

This paper addresses this gap by comparing China's EMI medical curriculum with India's FMGE accreditation regime, revealing institutional disjunctures in the "teaching – accreditation chain" and exploring their implications for the professional legitimacy and identity formation of Indian MBBS students.

3 Comparative policy analysis

3.1 Structural barriers in EMI curricula: linguistic load and cultural misalignment

Language-related gaps operate on two interconnected levels. First, instructors' limited proficiency in medical English—particularly in the contextualised use of terminology and pronunciation accuracy^[9]—means that students must simultaneously decode the language and construct a professional medical conceptual framework^[10], creating a dual "language–knowledge" decoding burden. This significantly increases cognitive load and hinders the mastery of core concepts. Second, during clinical rotations, students face a paradoxical linguistic barrier: while instruction is in English, real patient interactions require strong medical Chinese skills. Current curricula generally lack systematic training in medical Chinese^[2]. Terms such as *xinjin* (palpitations) or *huangdan* (jaundice) often pose challenges for Indian students, who may find themselves relegated to "observer" roles during clinical practice, with reduced levels of participation.

Cultural exclusion forms another layer of structural barriers, manifesting through mismatches in teaching interaction styles. Chinese instructors often adopt a "lecture–receive" model that emphasises order and authority, whereas Indian students are accustomed to deepening understanding through sustained questioning and dialogic engagement. The latter is sometimes misinterpreted in EMI classrooms as a challenge to authority, leading to tensions. To avoid conflict, Indian students often develop "tactical silence," maintaining superficial participation without genuine interaction.

Thus, the linguistic and cultural challenges in Chinese EMI medical programmes are not isolated problems but systemic design flaws. Language barriers limit effective knowledge acquisition, while cultural differences diminish the quality of classroom interaction. Together, they reinforce students' marginalised identities and pose systemic challenges to educational equity. If such issues constitute internal barriers during the learning phase, the FMGE—as the terminal accreditation mechanism—further amplifies these systemic tensions, exposing the structural rupture between educational "input" and accreditation "output" in cross-border medical education.

3.2 Institutional exclusion in the FMGE

Although Chinese EMI medical curricula align with international standards such as the WFME at the macro-policy level, their "teaching output" model is structurally mismatched with the FMGE's "accreditation input" mechanism. These mismatches occur in language, curriculum structure, and clinical training, ultimately functioning as a systemic filter for "non-domestic medical graduates."

Linguistically, the FMGE implicitly demands proficiency in India-specific medical English, including localised

terminology, clinical documentation styles, and dialect-based translation skills—forming a set of sociolinguistic codes. Chinese EMI courses, however, focus on general medical English, neglecting the linguistic variations and discursive logic of the Indian context. For instance, “palpitations” in the Indian clinical setting are often associated with “anxiety neurosis,” but Chinese EMI curricula rarely address Indian English variants (such as localised abbreviations), leading to frequent pragmatic and diagnostic errors in the FMGE.

In terms of clinical training, the FMGE emphasises community-oriented generalist skills, particularly in public health, health systems knowledge, and local disease management. According to the FMGE official syllabus^[11], the Community Medicine section constitutes about 15% of the clinical component, covering public health interventions, health administration, and primary care competencies. By contrast, Chinese EMI medical curricula prioritise basic sciences and hospital-based clinical training, with students primarily exposed to “standardised cases” rather than real-world community settings. Consequently, graduates struggle to meet the FMGE’s applied competency criteria. December 2024 FMGE results showed that around 71% of international examinees failed the clinical component, with media attributing this to “lack of clinical exposure” and “substandard medical education in foreign colleges”^[12-13].

Table 1 Core differences between Chinese EMI medical curricula and the Indian FMGE

Dimension	Chinese EMI Medical Curriculum	Indian FMGE Accreditation System
Language of Instruction	English (with wide variation in instructor proficiency)	Medical English + India-specific linguistic context
Clinical Training	Standardised case-based training, tertiary hospitals	Community-oriented, public health, and local disease management
Teaching Materials	International standard textbooks (WFME-aligned)	Indian disease profile + localised medical knowledge
Communication Language	Chinese-dominant; limited medical Chinese training	English + dialects; strong code-switching requirements
Teaching Approach	Theory-driven, lecture-based	Practice-oriented, community-based application

Economic barriers further reinforce the filtering effect. While FMGE registration fees are modest, long-term preparation requires significant investment in language tutoring, clinical skills training, study materials, and living expenses—posing a hidden burden for students from low- and middle-income families. Such structural costs are not accounted for in exam design, producing a “structural exclusion” effect that disadvantages those with limited economic capital.

Overall, the FMGE operates not merely as a knowledge assessment tool but as a legitimacy mechanism combining linguistic localisation, practice-based contextualisation, and financial gatekeeping. This filtering mechanism does not explicitly discriminate by nationality but structurally disadvantages Indian students trained abroad, reproducing implicit biases against “non-domestic training backgrounds.” Breaking this exclusionary structure requires building mechanisms for mutual recognition of medical education standards between China and India and developing a more inclusive transnational accreditation framework.

3.3 The “south – south cooperation” paradox and the reproduction of inequality in global medical education

The dual mismatch between teaching and accreditation systems means that the marginalisation of Indian medical students is not an isolated occurrence but a structural outcome of the global education market. Situating China’s EMI medical education policy within the political economy of global higher education reveals this dynamic more clearly.

Altbach and Knight (2007) note that international education has increasingly evolved into a market-driven activity oriented toward tuition revenue and institutional rankings, with international students viewed as both “human capital” and “sources of income.”^[14] Robson and Wihlborg (2019) further argue that under neoliberal governance, universities tend to expand international enrolments rapidly to meet financial and reputational targets, often without adequately addressing governance challenges or ensuring equity in student experiences^[15].

Within this context, Chinese universities have leveraged EMI to attract large numbers of Indian students, thereby boosting internationalisation metrics. Yet, little has been done to adapt curricula, clinical training, or accreditation pathways to meet students’ professional needs. This policy arrangement shifts the risks of resource misallocation onto students, who bear the consequences of systemic gaps alone—completing their degrees but failing to practise due to misaligned certification systems.

In global education governance, these students are functionalised as “symbols of internationalisation” but seldom recognised as full rights-bearing learners. Their educational needs and social identities are frequently overlooked, reducing them to instrumental figures within higher education metrics. In practice, “South–South cooperation” has failed to achieve genuine institutional equality or resource sharing, instead deepening the marginalisation of students from

developing countries in the global education hierarchy.

4 Conclusion

This study has demonstrated the structural mismatches between China's EMI medical curricula and India's FMGE accreditation system in terms of curriculum content, language use, and clinical practice. First, despite being delivered in English, EMI courses lack systematic language support and localised adaptation mechanisms. Variations in instructor language proficiency and the absence of medical Chinese training place Indian students at a disadvantage in both academic and clinical contexts. Second, unaddressed cultural differences in teaching interaction styles lead to "tactical silence"^[16], limiting students' ability to articulate academic perspectives or receive meaningful feedback. Finally, while the FMGE emphasises community medicine, local disease management, and contextualised linguistic competencies, Chinese EMI programmes focus largely on standardised hospital-based training, leaving students underprepared for applied assessments.

This triple mismatch—across language, culture, and accreditation—forms a chain of structural disadvantage in the transition from education to professional practice. Students who complete their degrees but fail certification face exclusionary mechanisms that extend beyond pedagogy to systemic discrimination against non-domestic training backgrounds. Such misalignment wastes talent and exposes the structural paradox of "South–South cooperation": when international educational mobility fails to integrate with local licensing systems, foreign graduates lose both position and value in the global medical education industry chain.

Addressing these challenges requires action beyond classroom-level reforms. First, China and India should explore mutual recognition frameworks for medical education standards and accreditation systems to reduce institutional barriers in licensing. Second, EMI curricula should incorporate localised training modules aligned with FMGE requirements, especially in community medicine, public health, and culturally contextualised communication. Finally, international students' identity formation should be central to policy discussions, with attention to their academic legitimacy, social belonging, and psychological well-being—thereby fostering a more equitable, sustainable, and culturally responsive global medical education ecosystem.

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