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Medical educators working abroad: Who are they?

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Abstract

Background: Medical education is an international activity. As students and educators travel across the globe to study and teach, both medical student populations and academic staff profiles are becoming increasingly multinational. Little is, however, known about medical educators who chose to work and live abroad.
Methods: Following a pilot study in the Middle East, an online survey was adapted for an international audience. In addition to demographic data, information was collected about international medical educators' countries of birth, where they had studied, their work history as well as their roles and responsibilities as medical educators.
Results: The survey, completed by 89 participants (58% men), revealed a highly qualified, largely medical, multicultural workforce with a rich history of international study and work. Their 'home' country was often one adopted later in life, rather being where they were born. This may explain why many defined themselves as Westerners and global citizens rather than nationals of a single country. Europe and North America lost the most educators, with Australia and New Zealand gaining. Although many were in academia, their roles and responsibilities were diverse, revealing the multiple layers of their professional careers. Based on historical academic positions, there appears to be a trend of being a local teacher to being an international teacher of local or international students.
Conclusions: Medical educators are globally mobile, working across the world in academia and as consultants. Their studies and their work in different parts of the world make many of them global citizens for whom 'home' is a country different from where they were born.

Practice points

- With new medical schools being established to meet the demand to study medicine, medical educators, are increasingly choosing to working abroad
- As a result of their international work experience, medical educators may settle in a new country and so may experience some difficulty defining 'home'
- Some regions (e.g. Europe and North America) lost medical educators while Australia and New Zealand (Oceania) had clear gains
- While undergraduate training is invariably completed in educators' birth countries, post-graduate studies are completed abroad, largely in the UK.

Keywords: International/transnational medical education, mobility, and teachers general.

Article

Introduction

In a seminal article on the globalisation of medical education, Harden (2006) described the numerous factors that drive internationalisation and used a three-dimensional model to highlight different teaching contexts (local *vs.* international) as they relate to the origin of students, their teachers and the nature of the curriculum. Harden predicted that with the "flattening" of the world in the 21st century, the trend in medical education would be towards a transnational one, in which internationalisation would be reflected within the curriculum and which would involve the collaboration of several medical schools in different countries. Since writing that article, much has happened in medical education. Some of what Harden (2006) described has come to pass, for example, the sharing of resources, including providing faculty development opportunities. This has, however, largely been collaboration between two medical schools, usually one in a developed country and another in an emerging economy or low resource country, with the view to levelling the playing fields (i.e. social responsibility) (Gibbs & McLean 2011), such as the Swansea-Gambia Link partnership between Swansea University and Abertawe Bro Morgannwyg Health Board and the Medical School of The Gambia and the Royal Victoria Hospital, Banjul (McKimm, *pers. comm.*)

A primary driving force that has 'internationalised' medical education has been the shortage of available places to study medicine. This has led to the establishment of new public and private medical schools, many of which have been set up offshore (McLean et al., 2013). Not only are large numbers of medical students now studying overseas, but medical educators too are on the move. For some, working internationally has been driven by a desire to experience a new culture or because of a sense of social responsibility, while others have been attracted to the prospect of an improved lifestyle, financial incentives and/or research opportunities (da Silva, McLean, McKimm & Major 2013; McLean, Major & McKimm 2013; McLean 2013; McLean, McKimm & Major 2014).

While the experiences of international students have received attention (e.g. Chur-Hansen, Vernon-Roberts & Clark 1997; Treolar et al. 2000), little has been documented about the international teacher apart from our recent publications (da Silva, McLean, McKimm & Major 2013; McLean, Major & McKimm 2013; McLean 2013; McLean, McKimm & Major 2014). In our pilot study conducted in the Middle East, we described motives to travel, challenges faced and the lessons learnt by medical educators who had moved to the Middle East to work (McLean, McKimm & Major 2014). The survey used in the pilot project was then adapted for an international audience. This submission provides the results of the international survey in response to a broad research question - Who are international medical educators?

We attempted to answer this question by asking:

1. From where do they originate?
2. What are their professional qualifications?
3. In which countries have they studied, worked and are currently work?
4. In what kind of health and medical education activities are they engaged?
5. Where is "home"?
6. How do they describe themselves in terms of their upbringing and world view?

For the purpose of this study, we have defined an international medical educator as an individual who has worked in medical education outside his/her country of origin or birth. In this paper, we report primarily on the quantitative data collected. A subsequent paper will report on the qualitative data and describe participants' reasons for working internationally and personal and professional issues they may have faced in making the transition, which is often to a different culture.

Method

Survey instrument

The questionnaire was adapted from an approved pilot study conducted in the Middle East (McLean *et al*., 2014). Modifications involved removing two items, rephrasing three (e.g. removing reference to the Middle East) and adding six new questions to gather information about respondents' current position (e.g. starting dates, country) to allow them to provide accounts of their international experiences during their careers. Using both selected response items and open-ended questions, the survey instrument anonymously collected biographical information as well as details of participants' past and current positions and roles as international medical educators. The questionnaire comprised 42 items: Respondents' demographics (6 items), current and prior academic positions and/or roles (7 items, including identifying positions within Harden's (2006) 2 x 2 matrix), experiences and views on being an international educator (17 items). The final version of the questionnaire was checked by all researchers to ensure ease of access, usability and safe data collection and storage.

Participant recruitment

The online survey was hosted by Swansea University (Wales) for three months during 2012. A web-link to the survey was sent electronically by each researcher to her respective collaborative networks. The networks included the Foundation for the Advancement of International Medical Education and Research (FAIMER), the Social Accountability Network, the Royal College of General Practitioners' International and various medical schools. Permission was also granted to post the survey on the MedEdWorld platform for two months in late 2012. Included in the invitation to participate was information relating to the purpose of the survey and assurance of the anonymous nature of data collection and storage.

Data collection and analysis

Data exported from the institutional survey system were verified for possible exporting errors and uploaded into Excel. SPSS (Ver. 20) was used to analyse the quantitative data.

Results

After removing overtly incomplete submissions, data were collected from 89 participants. The current submission reflects their gender, age, origins, qualifications, as well as their various roles and responsibilities as international medical educators.

Who are international medical educators: Age, gender and languages spoken?

Respondents' mean age was 51.4 ± 12.1 (median: 51.5 years; range: 28-82). Fifty-eight % of respondents were men. No significant gender differences were recorded in terms of the parameters analysed.

Sixty-five participants (≈76%) spoke more than one language, with about 16% speaking four or more languages. About one-quarter (24.4%; n = 21) spoke only one language (i.e. their home language), which, in this case, was English.

Where were they born?
Participants originated from 29 countries in 7 regions, with the majority being born in Europe (± 58%), followed by Asia (± 17%) and North America (± 13%)(Table 1). The most frequent countries of birth were the UK (includes, Britain, Wales, Scotland and Northern Ireland) *(n* = 31), the US *(n* = 8), Pakistan (*n* = 7), the Netherlands *(n* = 6) and Canada and the Republic of Ireland *(n* = 4 each).

See TABLE 1

What were their professional qualifications and where did they study?
Sixty-four % (*n* = 57) were medically qualified. The only other professions identified were nursing (± 8%; *n* = 7) and education/psychology (± 8%; *n* = 7). Approximately 16% (*n* = 14) did not indicate their academic qualifications, merely stating 'professor'.

Eighty-six % had completed their primary degree in their birth country. Primary degrees had been completed in 27 countries (Table 1), mostly in the UK (± 39%; *n* = 35), followed by the US (± 9%; *n* = 8), Pakistan (± 8%; *n* = 7) and the Netherlands (± 7%; *n* = 6). Eighty-five % had completed their primary degree in English, including some who had studied in Pakistan, India, Egypt and the Netherlands.

Approximately 89% (*n* = 79) of respondents had one or more post-graduate qualifications. For ≈ 13% (*n* = 12), this was their clinical speciality training, while ± 48% (*n* = 43) had both a clinical speciality and a certificate or diploma, a Masters degree or a PhD (Table 2). Post-graduate studies or speciality training had taken place in 22 countries (Table 1). Most (± 72%; *n* = 64) had completed their post-graduate training in Europe (± 49% UK, ± 10% Netherlands, ± 4% Republic of Ireland), followed by ± 12% in North America, ± 9% in Asia and ± 9% in Australia or New Zealand. Approximately 27% (*n* = 21) had undertaken their post-graduate studies in more than one country, including individuals who identified themselves as being involved in a regional programme.

Table 2. Details of medical educators' post-graduate qualifications (*n* = 89).

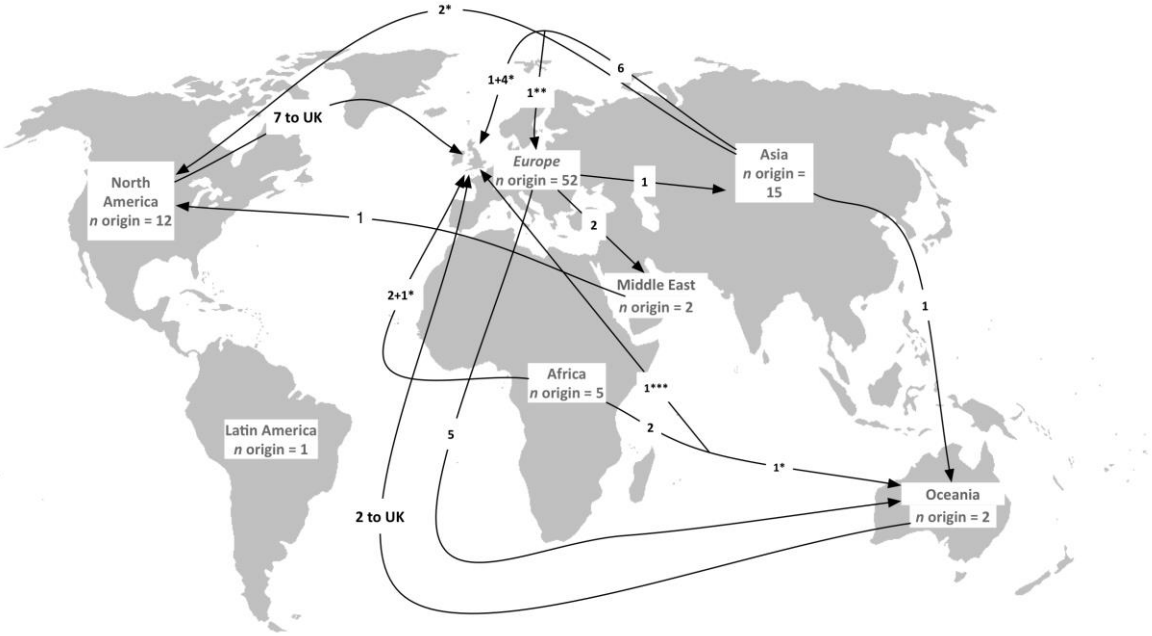
Qualifications	**% of educators (*n*)**
No post-graduate education	11.2 (10)
Clinical or professional specialty only	13.5 (12)
Academic post-graduate degree (Masters, PhD) only	27 (24)
Clinical plus academic post-graduate degree	48.3 (43)

A pattern emerged in terms of respondents' first degrees mostly being completed in their countries of birth (± 86%; *n* = 76), but their post-graduate training being completed elsewhere (± 58%; *n* = 45). Table 3 and Figure 1 depict the regional movements of educators relating to their undergraduate and post-graduate studies. Europe emerged as the preferred study region for this sample of educators, retaining 85% (*n* = 44) of those born in Europe and attracting another 15.

Table 3. Regional movements of international medical educators (*n*) for study purposes.

Region	Origin	Stayed in region	Moved out of region	Moved into region
Europe	52	44	8	15
Asia	15	5	10*	1
North America	12	5	7	3
Africa	4	0	4	2
Middle East	2	0	2	2
Oceania	3	0	3	8
Latin America	1	1	0	0
Total	**89**	**83**	**20**	**29**

*Six individuals were part of joint programmes: (1) Bangladesh-US, (1) Pakistan-Canada, (1) UK-India, (1) Pakistan-Netherlands, (2) Pakistan-UK.



Legend:
*Programme in more than one region, including region of origin
**Several countries in a region different from the birth country
***Programmes in several regions different from region of origin
Map source: http://commons.wikimedia.org/wiki/Maps_of_the_world

Figure 1. Medical educators' movement from their region of origin for study purposes.

In which countries had they worked or were currently working? (Table 4)
On average, excluding their country of birth, respondents had worked in 3 or 4 countries (mean: 3.67 ± 6.5). The most frequent pattern was for medical educators to have worked in one (n = 28) or two (n = 14) other countries in addition to their home country, with the remainder ranging from those who had not worked for an extended period outside their 'home' country (n = 14) ('home' defined by respondents, so it may refer to their birth country or the one which they now consider 'home') to one individual who had worked in >40 countries. Those who indicated that they had not

worked outside their home country had completed the survey because of their international experiences, e.g. as an external examiner, as a member of an international committee or as a supervisor. The 87 respondents (excludes the individual who identified only "> 40 countries" and a missing value) had worked in 88 countries: 31 in Europe, 17 in Asia, 15 in Africa, 12 in the Americas, 10 in the Middle East and 3 in Australia and New Zealand (Table 4).

Table 4. Countries (*n* = 87) and regions in which international medical educators have worked.

Europe (*n* = 30)	Asia (*n* = 17)	Africa (*n* = 15)	The Americas (*n* = 12)	Middle East (*n* = 10)	Oceania (*n* = 3)
Albania Austria Belgium Bosnia Bulgaria Croatia Cyprus Denmark Finland France Germany Greece Hungary Ireland Italy Kosovo Latvia Lithuania Malta Netherlands Norway Poland Portugal Romania Russia Sweden Switzerland Turkey Ukraine UK	Armenia Bangladesh Brunei China Hong Kong India Iran Japan Korea Malaysia Nepal Pakistan Philippines Singapore Sri Lanka Thailand India	**Sub-Saharan Africa** Botswana Gambia Ghana Kenya Malawi Mauritius Mozambique Nigeria Somalia South Africa Tanzania Uganda Zambia Zimbabwe **North Africa** Egypt	**Northern America** Bermuda Canada United States **Caribbean** Dominica Jamaica Saint Lucia (West Indies) Turks & Caicos Islands **Latin and Central America** Argentina Brazil Chile Colombia Mexico	Bahrain Iran Israel Kuwait Lebanon Oman Qatar Saudi Arabia United Arab Emirates Yemen	Australia Fiji New Zealand

In what professional positions and roles have they worked as international medical educators?
At the time of the survey, about 82% (*n* = 64) of the educators, of whom 58% were medically qualified, were in an academic position. Forty-six % were working outside their home country. Most had been in their current academic position for 2-6 years. Some identified short-term positions as visiting faculty. From the list of possible roles, most were or had largely been involved in teaching medical students (including post-graduates) and curriculum development. Just under half had also been involved in quality assurance and about 38% had undertaken or were undertaking consultancy work and/or aid or development work. Only one-quarter reported being involved in research-related activities.

Where are medical educators positioned in Harden's 2 x 2 matrix?

Figures 2a and 2b depict where respondents positioned themselves in Harden's (2006) 2 x 2 matrix in terms of their three most recent academic positions. While the number of medical educators were or had been academic positions as 'international' teachers is similar to that of the local teacher of local students, the trend is, however, towards an international status, teaching either international or local students.

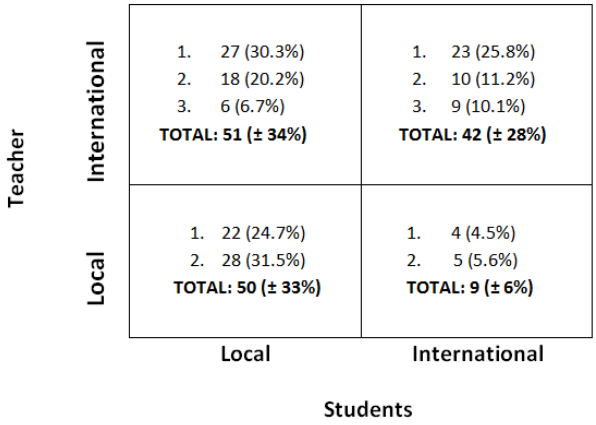


Figure 2a. Number of (*n*) and percentage of international medical educators' positions in Harden's (2006) 2 x2 matrix for their last three academic positions. Position 1 is their most recent or current academic position.

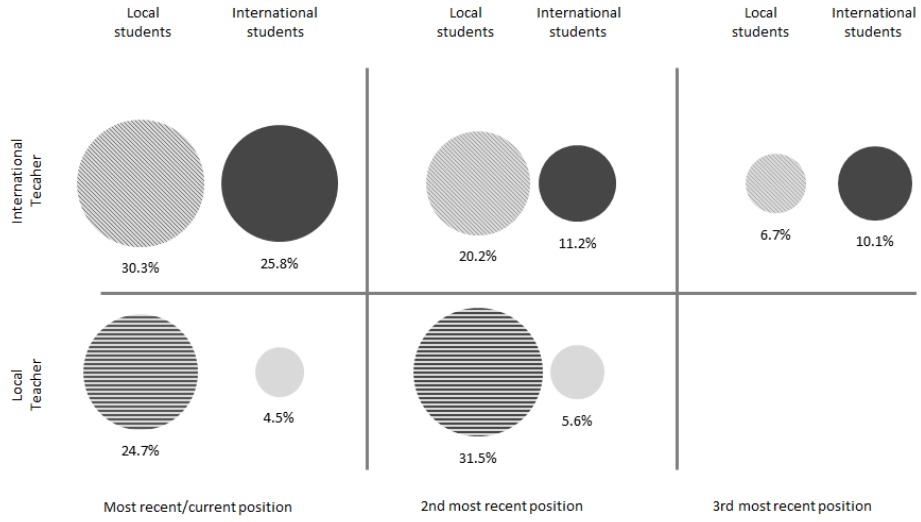


Figure 2b. Percentage of educator positions in Harden's (2006) matrix, based on their last three academic positions.

Where is home?

When asked what country they considered 'home', several respondents found this question challenging. Although 29 countries were identified as birth countries, only 23 countries were listed as 'home' (Table 1). While home remained the birthplace for 55% respondents, for the remaining 45%, 'home' was where they had studied or worked or were currently working. The greatest movement from a region was reported for Europe (± 27% decline). In particular, for the six medical educators born in the Netherlands, none now considered it home. As a region, Oceania,

gained the most educators who now considered it 'home': Australia (from 2 to 8) and New Zealand (from 0 to 2).

How do medical educators they define themselves?
When asked to define themselves in light of their cultural upbringing and world views, the majority described themselves as Westerners (≈ 55%)(Table 5). About 17% and 12% of medical educators identified themselves as nationals of a particular country or region, respectively. Sixteen % described themselves as either multicultural/multinational or global citizens or globalists (≈ 3 %).

Table 5. Respondents' classification of themselves in the light of their cultural upbringing and worldviews (*n* = 87).

Description	% educators
Westerner	55.2 (*n* = 48)
Country national	17.2 (*n* = 15)
Multicultural or mixed descriptions*	12.6 (*n* = 11)
Regional identity (European/Asian/African/Arab)	11.5 (*n* = 10)
Global citizen, globalist	3.4 (*n* = 3)

* Mixed descriptions include comments such as "moderate liberal with a balanced view for all and everything", "mixed Westerner/African", "Westernised African"

Discussion
The current study set out to start developing a profile of international medical educators in terms of their origins, their qualifications, where they have worked and how they perceive themselves. Through our various contacts, many of whom are involved in organisations with a global focus mainly in the UK, Europe and North America, we were able to gather information from 89 participants who were born in 29 countries, studied in 27 countries, worked in more than 88 countries and identified 23 countries as 'home'. Respondents were largely medically qualified and, at the time of the study, were mostly in academic positions, with more than half (53%) working outside their 'home' country.

A key issue that emerged from our analysis was respondents' difficulty defining 'home', largely because of their convoluted journeys in terms of where they had studied, worked and now live. While most had completed their primary degree in their country of birth, many had done their post-graduate studies in another part of the world, had worked in several countries and/or were now working and/or living in another country or region. Based on this sample of educators, a clear pattern emerges both in terms of their movements across continents and regions for study purposes and where they consider 'home'. Europe, the UK in particular, appeared to attract individuals for post-graduate studies and while most regions lost educators, the primary shift (number of individuals) was from European countries and Canada and the United States to Australia.

Their international status is evidenced by their global mobility, descriptions of themselves as multicultural, multinational or global citizens, as well as the fact that most spoke at least two languages. Further evidence of their journeys across countries, regions and continents is borne out by the changing status of their teaching contexts based on Harden's (2006) matrix – a trend from local teachers to international teachers of local or international students.

Although Harden's (2006) model viewed international medical educators predominantly as visiting scholars, aid helpers and expert consultants whose careers were punctuated by multiple episodes of internationalisation clearly defined in time, our data suggest a different picture. This study reveals a profile of educators with longer academic appointments outside their country of origin who have undertaken a range of academic activities as well consultancy, aid and/or development work.

This study explicitly set out to capture information from individuals who had worked as medical educators outside their country of origin. As this is, to the best of our knowledge, the first survey to attempt to profile 'international' medical educators, it is difficult to estimate globally how many individuals can be described as such. Although this study represents only a sample of the many medical educators who now work and live across the world, it has provided us with valuable insight into profiling international medical educators and to begin to unravel the multiple layers of their individual professional journeys. It has shed some light on their very different career paths, with many now working and living in countries far removed from where they were born.

The demand for clinicians and teachers to meet the growing number of medical students around the world will continue to entice individuals to move from their birth countries. Although this has, in part, contributed to a global brain drain, particularly from under-resourced regions (Bundred & Gibbs 2007; Gibbs & McLean 2011), Merryfield (2002) has highlighted the benefits of having global educators in schools. To this end, these individuals tend to confront stereotypes, resist simplification of other cultures and global issues, foster the habit of examining multiple perspectives and provide cross-cultural experiential learning. As medical education becomes even more global, ensuring support and development for educators intending to work or working internationally will become essential. This descriptive study, which is primarily a descriptive quantitative analysis of international medical educators' origins and movements, will be followed up with a qualitative account of their decisions to work abroad and the personal and professional consequences.

Limitations

While we believe that we canvassed broadly, with representation from all regions, the 89 respondents represent only a snapshot of individuals from a growing community of international medical educators. Despite there being an apparent skew towards the European educators, this should not detract from the value of this study, which we believe is the first to attempt to profile medical educators who chose to work abroad. We acknowledge that because the survey was conducted in English, this may have prevented some medical educators from participating.

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Table 1. Countries of origin, countries in which they studied and 'home' countries of 89 international medical educators, including the gain or loss from birth country to 'home' country.

Countries: Birth (*n* = 29)	*Responses: 89*	Countries: Undergraduate studies (*n* = 27)	*Responses: 89*	Countries: Post-graduate studies* (*n* = 22)	*Responses: 107**	'Home' countries (*n* = 23)	*Responses: 86*	Gain/loss: From birth to 'home'
Europe (*n* = 12)	***52***	**Europe (*n* = 11)**	***55***	**Europe (*n* = 9)**	***64***	**Europe (*n* = 6)**	***38***	***-14***
UK (Britain, Scotland, Wales, N Ireland)	31	UK	35	UK	44	UK	27	-4
Netherlands	6	Netherlands	6	Netherlands	9			-6
Republic of Ireland	4	Republic of Ireland	4	Republic of Ireland	4	Ireland	3	-1
Germany	3	Germany	3	Germany	2	Germany	2	-1
Finland	1	Finland	1					-1
France	1	France	1					-1
Italy	1			Italy	1			-1
Macedonia	1	Macedonia	1					-1
Malta	1	Malta	1	Malta	1	Malta	1	0
Poland	1	Poland	1	Poland	1	Poland	1	0
Portugal	1	Portugal	1					-1
Spain	1	Spain	1	Spain	1	Spain	4	+3
				Sweden	1			n/a
Asia (*n* = 7)	***15***	**Asia (*n* = 7)**	***14***	**Asia (*n* = 5)**	***8***	**Asia (*n* = 8)**	***13***	***-2***
Pakistan	7	Pakistan	7	Pakistan	4	Pakistan	6	-1
India	2	India	2	India	1	India	1	-1
Malaysia	2	Malaysia	1			Malaysia	1	-1
Bangladesh	1	Bangladesh	1	Bangladesh	1	Bangladesh	1	0
South Korea	1	South Korea	1			South Korea	1	0

Sri Lanka	1	Sri Lanka	1			Sri Lanka	1	0
Taiwan	1	Taiwan	1	Taiwan	1	Taiwan	1	0
				Hong Kong	1			n/a
						Thailand	1	+1
Countries: Birth (*n* = 29)	***Responses: n* = 89**	**Countries: Undergraduate studies (*n* = 27)**	***Responses: n* = 89**	**Countries: Post-graduate studies* (*n* = 22)**	***Response: n* = 107***	**'Home' countries (*n* = 23)**	***Responses: n* = 89**	***Gain/loss: Birth to 'home'***
Africa (*n* = 3)	***4***	**Africa (*n* = 3)**	***4***	**Africa (*n* = 2)**	***2***	**Africa (*n* = 2)**	***2***	***-2***
Nigeria	2	Nigeria	1	Nigeria	1	Nigeria	1	-1
South Africa	1	South Africa	1	South Africa	1			-1
Sudan	1							-1
		Egypt	2			Egypt	1	+1
Middle East (*n* = 2)	**2**	**Middle East (*n* = 2)**	**2**	**Middle East (*n* = 1)**	**1**	**Middle East (*n* = 2)**	**2**	**0**
Syria	1							-1
Yemen	1							-1
		Iraq	1					n/a
				Bahrain	1	Bahrain	1	+1
		Lebanon	1			Lebanon	1	+1
Oceania (*n* = 2)	***3***	**Oceania (*n* = 1)**	***3***	**Oceania (*n* = 2)**	***8***	**Oceania (*n* = 2)**	***11***	***+8***
Australia	2	Australia	3	Australia	6	Australia	8	+6
Papua New Guinea	1							-1
				New Zealand	2	New Zealand	3	+3
North America (*n* = 2)	***12***	**N America (*n* = 2)**	***9***	**N America (*n* = 2)**	***11***	**N America (*n* = 2)**	***6***	***-6***
US	8	US	7	US	9	US	4	-4

Canada	4	Canada	2	Canada	2	Canada	2	-2
Latin America (*n* = 1)	***1***	**L America (*n* = 1)**	**1**	**L America (*n* = 1)**	**1**	**L America (*n* = 1)**	***1***	***0***
Peru	1	Peru	1			Peru	1	0
				Chile	1			n/a
				Regional programme (no countries identified)	**2**	**Difficult to answer**	**13**	n/a

*More than one post-graduate degree undertaken in different countries