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Medical and medical educator migration: A complex issue

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Opinion piece

In response to our article, “*So you want to work overseas...*”, in this edition of *SEAJME*, we feel a social responsibility to provide another perspective on the issue of medical educators working overseas. This has a particular impact when those medical educators are also physicians, and has been highlighted as an issue from regions such as Africa, South East Asia and Eastern Europe where doctors leave their home countries where services are sorely needed to study and work (sometimes permanently) in the US, Canada and the UK.

The intention of our article was not to encourage medical educators to leave their home country and move elsewhere. Rather, it was to provide guidance for those considering taking up a position elsewhere. This guidance emerged from our own experiences as medical educators ‘on the move’ across continents as well as the experience of respondents to an online questionnaire survey posted on MedEdWorld, the Association of Medical Education in Europe’s (AMEE) global resource website and circulated to various national and regional professional organisations (McLean et al. 2015). The respondents were primarily educators and physicians in the UK and North America who had chosen to work elsewhere. The inclusion criterion was that they had worked as a medical or health professional educator in at least one country other than their country of birth. The vast majority had worked in low resource countries where they believed there was a need or where their institution had a collaborative agreement. Their motive for working in these countries was largely altruistic. A reasonable proportion of respondents were now living in a country that was not their birth country. The guidance that emerged was largely around being culturally competent and the importance of the move on their families. All of us have stories to tell of being away from family, or of partners or children not adjusting to the move.

One of the *SEAJME* reviewers felt very strongly in writing the following in their feedback to us, highlighting that there must be “*consideration of the impact of the person moving on the institution or country which trained him/her (and) the responsibility that person has to the country/college Medical education is not a passport to greener pastures*”. This prompted us to provide this counterpoint to the guidance which aimed to assist medical educators leaving their home country to work abroad – that of the widely-documented ‘brain drain’ in which physicians leave regions of extreme need to work where there is the more personal and financial security. Some of the more recent articles in this issue have been published by the Foundation for the International Advancement of Medical Education and Research (FAIMER), an organisation established to promote regional medical education by developing human capacity and expertise. Sub-Saharan Africa in particular has been hard-hit by the exodus of doctors, exacerbated by conflict and civil war as well as episodic epidemic outbreaks such as Ebola. Not unexpectedly, one of Africa’s most populous nations, Nigeria, has contributed the greatest number of sub-Saharan doctors to the International Medical Graduates (IMGs) working in patient care in the US (FAIMER 2013). IMGs now make up 25%

of the US health care workforce. Interestingly, when IMGs were compared in terms of being Nigerian, all other Sub-Saharan IMGs, other IMGs (e.g. from Indian, the Philippines, Pakistani) and those of American citizenship returning from an offshore medical education, other IMGs, Nigerian physicians and the other Sub-Saharan IMGs were more likely to work in underserved areas and in lower socio-economic communities than returning Americans. Thus, although non-American IMGs have left an area of need, they are addressing a need elsewhere. We do recognise, however, that this is no justification of the social inequity caused by medical migration.

In 2011, with Trevor Gibbs, one of us (MM) wrote about the need to level the playing fields in medical education. We advocated the need for greater global citizenship in medical education. On reviewing what we had advocated five years ago, in writing this Opinion Piece, we believe that great strides have been made in this regard, particularly that of medical education's global social accountability. With Global Health now an integral part of most medical curricula and with increasing numbers of medical students now undertaking electives in under-resourced communities, many inter-institutional or inter-governmental agreements of mutual exchange have been set up with the view to developing resources and infrastructure in areas of need. A UK example is Swansea University's long-standing partnership with the University of the Gambia under which staff and students from both institutions regularly visit one another's countries for mutual collaboration. This is fully supported by local health boards, the Universities and Welsh Government.

While individuals in most countries have the right to migrate (for various reasons), we believe that through collaborations which assist low-resource and emerging economies with their health infrastructure and undergraduate and post-graduate medical education, the push factors may help to balance the pull factors. This is, however, a highly complex picture, with many shades of grey. Perhaps the best we can do as individuals is to consider our own motives and the wider impact of our actions, and for organisations and governments to continue to work collaboratively to develop and build health care and educational capacity wherever it is needed.

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