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TWELVE TIPS

Twelve tips for crossborder curriculum partnerships in medical education

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ABSTRACT

Crossborder curriculum partnerships are a relatively new and fast-growing form of internationalization in which the curriculum that has been developed by one institution (the home institution) crosses borders and is implemented in another institution (the host institution). These partnerships aim to provide comparable learning experiences to the students in both institutions and are driven by a variety of motives, such as strengthening international networks, increasing financial gains, and stimulating research spinoffs. Although popular, crossborder curriculum partnerships are also criticized for their potentially low educational quality, failing to address fundamental differences in teaching and learning between the home and host institutions, and not addressing the educational needs of the host country's health care system. Our aim is to provide guidance to those considering or engaged in designing, developing, managing, and reviewing a crossborder curriculum partnership or other forms of international educational partnerships in medical education. Drawing from research, personal, and institutional experiences in this area, we listed twelve tips categorized into four themes, which contribute to the establishment of sustainable partnerships that can withstand the aforementioned criticism.

Introduction

Crossborder curriculum partnerships are a growing form of internationalization in higher education (Harden 2006). By 2012, e.g. Australia had set up 394 crossborder partnership programs in higher education (British Council 2013), and by the same year, UK universities have set up 1395 crossborder partnerships in addition to 73 overseas campuses. In a crossborder curriculum partnership, a curriculum developed in one institution (the home institution) is transferred across borders and also implemented in another institution (the host institution) (Knight 2006). The partners offer their curriculum simultaneously and aim to provide comparable learning experiences to both groups of students. This definition includes partnerships that award the same degree to students in both locations, as well as host institutions that issue their own degree.

This form of internationalization enjoys popularity for the benefits it brings to both partners in terms of an expanded network, international reputation, research collaborations, and finances (Healey 2008; Kosmutzky and Putty 2016; Lim and Shah 2017). However, crossborder curriculum partnerships are not an easy internationalization strategy, especially in the medical domain, due to many differences in context that need to be bridged (Waterval et al. 2016). Most medical curricula, for instance, are highly intertwined with the local healthcare system through assignments, projects, and visits. This interconnection increases in the clinical phase as the learning environment shifts from the university to healthcare practice, and classroom teaching is replaced by learning that includes interacting with patients. This interconnection requires a careful and deliberate adaptation to balance the home program with what is feasible in the host situation, while preserving a comparable learning experience. Furthermore, there may be differences between the home and host institutions' legal and political context; for instance, a country might determine length and even content of medical programs affecting comparability. Additionally, it is challenging to address differences in teaching and learning environment and to fulfill the healthcare needs of the host country (Hodges et al. 2009; Altbach 2013).

In this article, we provide 12 tips for designing and implementing crossborder curriculum partnerships in medical education. These tips are distilled from personal experiences with crossborder curriculum partnerships and based on our experience with a larger research project on challenges and strategies of crossborder medical curriculum partnerships. All authors were part of the research team and conducted a literature review and four field studies that involved perspectives from program directors, students, teachers, and management. Because we were interested in non-case specific challenges and strategies, we included multiple partnerships in each study design. These crossborder medical curriculum partnerships have been identified at the start of the research project in 2012. The inclusion criterion was that the partnership aimed to provide comparable learning experiences to students in both settings by delivering equivalent curricula. Furthermore, we selected partnerships that existed for a period of at least three years and had at least one batch of graduates. A total of six partnerships participated in the project, with home institutions located in the US, the UK and the Netherlands, and host institutions in Egypt, Saudi-Arabia, Qatar, Singapore, Malaysia, and Cyprus.

Although the research context did not include any specific North–South or South–South partnerships, we do believe that our tips have relevance for other contexts as well. The

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tips are categorized into four interrelated themes: (1) Governance, (2) Curriculum, (3) Learning environment, and (4) Relationship management. Our aim is to provide guidance to those involved in planning, managing or reviewing crossborder curriculum partnerships, and other forms of international educational partnerships in medical education.

Theme 1: Tips on governance

Tip 1

Develop a master plan to govern the collaboration

Curriculum partnerships share many commonalities with large-scale projects and can therefore be managed accordingly, that is, by performing regular SWOT analyses, describing new work processes, responsibilities and duties, and by comprehensive time planning. This can be daunting for educational organizations as they may not be used to such a business-like approach (McBurnie and Pollock 2000; Olcott Jr 2009).

Successful partnerships are those that explicate major decisions upfront in legal contracts (Davies 2001; Heffernan and Poole 2004). Decisions need to made on the following topics:

- responsibilities for hiring faculty and recruiting students;
- growth strategy for recruiting students;
- methods of transferring and updating educational materials;
- third-party licenses of educational instruments used within the home curriculum;
- collaboration with respect to assessment policies and instruments;
- intellectual property rights on materials during and after the partnership;
- legal status of the degree awarded to host students.

By reaching agreements on the aforementioned and other topics, partners can prevent future disappointments that arise from tacit expectations (Davies 2001; Heffernan and Poole 2004; Wilkins and Huisman 2012). However, any curriculum partnership per definition spans multiple years, and many aspects cannot be foreseen at the start of the project. Therefore, it is desirable that the partners avoid placing each other inside a straitjacket, as a determining factor for success in such long-term partnerships is the ability to be flexible and to seize and adjust to unforeseen opportunities that might occur along the way.

Tip 2

Adopt a robust internal system for quality control

The UK is leading in the crossborder delivery of programs, as many UK universities are offering overseas programs and degrees (British Council 2013). In recent years, these programs have been monitored – perhaps even more than national programs – by British accreditation agencies. In contrast to these recent efforts in the UK, there are many home and host countries whose accreditation systems are not yet sufficiently robust and/or well-developed to address this form of internationalization (Wilkins 2017).

In any case, we urge partnerships to establish a robust *internal* quality assurance mechanism aiming to monitor the educational quality of the delivery of the program. This internal system should scrutinize the process through which the philosophy of the home program can be preserved given the inevitable differences in context that need to be bridged. As Boteju and Burnapp (2011) stated, there is a possibility that all those concerned (including staff, students, and quality assurance managers) may setup programs and learning activities, which really only mimic the intended features of a specific culture of education but do not actually replicate that system in its essential features. Evaluation outcomes should be discussed among partners and used to sustain a continuous cycle of quality improvement. Furthermore, such an internal quality assurance system should link with the required external (national) system and at the same time offer sufficient flexibility to tackle issues within the context of the host institution. Apart from an adequate internal quality system, we would encourage partners to regularly plan external reviews of the crossborder program (Lim 2010).

An illustration might originate from one partnership where the home institution initiates and executes bi-yearly "mock" accreditation visits to the host, which served as an opportunity for host staff to practice for their host country national accreditation process. At the same time, the "mock" accreditations provided valuable information about the quality of the implementation process to the home institution.

Tip 3

Prepare the home faculty as well

Managers of crossborder programs tend to direct their activities at setting up the host organization and therefore may neglect to foster and cultivate appropriate conditions within the home institution. Most academics in the home institution will be unfamiliar with curriculum partnerships. Studies report that they might be skeptical about such international projects and reluctant to adjust their behavior, whereas these partnerships require additional actions and changing work responsibilities (Coleman 2003; Shanahan and McParlane 2005). To enhance the commitment of home faculty, it is therefore crucial that the home institution communicates frequently and as early as possible about the partnership's rationale, potential benefits, and long-term strategy.

In addition, the home institution needs to organize the interactions and responsibilities at the project management level and to think about how to organize the project office and its place within the organization (Waterval et al. 2017). Finally, a crossborder curriculum partnership requires the integration of new working processes into the existing ones. Various tasks and responsibilities must become institutionalized, ranging from organizing online meetings to creating joint exam papers in cooperation with a geographically distant faculty.

Theme 2: Tips on curriculum

Tip 4

Adapt the content of the home curriculum to the host's local context

The original home curriculum of most medical partnerships was not designed to be exported overseas. The program is

usually interconnected with the home healthcare system in terms of intended competencies/learning outcomes as well as workplace learning activities. Furthermore, the learning materials are often developed from the perspective of the home context and of the home students (Waterval et al. 2016). These features make a medical curriculum unsuitable for exact replication across borders. Therefore, we suggest that partners adapt the learning materials at three levels.

First, change original names, places, and circumstances to descriptions that are more recognizable to host students. Although this seems trivial and might be perceived as window dressing, it does contribute to contextual learning and it increases motivation and feelings of ownership among staff and students of the host institute. We have come across cases where the context of the home learning materials had been placed in a Western context involving, e.g. drugs, alcohol, sex, or combination. Such learning materials might not only be difficult to relate for host students, they could also be perceived as culturally offensive for host country teachers, students, or parents. Here, we do not mean the intended learning objectives, but the context in which learning materials are offered to students.

Second, delete elements that are not relevant to the learning outcomes of the host students, e.g. curriculum elements that are too home specific. Examples might be the prevalence of certain diseases in the home country or a detailed elaboration of a characteristic element of the home country healthcare system.

Third, adapt and add learning activities as necessary or legally required in the context of the host institution, such as additional courses on child delivery or tropical diseases. These adaptations are aimed at developing competencies relevant for the host country's healthcare system.

Adapting the curriculum to the context of the host institution raises the issue of who is responsible or who should take the lead for these adaptations. We encountered different approaches; however, the participation of host country stakeholders, e.g. students, teachers, representatives of the healthcare system, seems indispensable, as they are the ones most capable of determining their needs and the required competencies and of designing materials that fit the host context. We often encountered that a lack of clarity on this responsibility prevented actions within the partnerships.

Tip 5

Address technical and logistical barriers

An often neglected issue within curriculum partnerships is the actual transfer of all curriculum materials (Lane 2011). Although it can be considered the core of the partnership, an interview study among medical crossborder program directors revealed that there often was no clear working plan for the transfer of curriculum materials (Waterval et al. 2016). As a consequence, many challenges with respect to transfer, synchronization, and updates of the curriculum were faced along the way. This led, for instance, to program directors running around with USB-sticks to collect home institutions' lectures.

These technical and logistical barriers can be overcome but require deliberate on-time planning and coordination between both sides. We advise institutions to map all curriculum elements, including whether or not third-party licensed software is used, and to devise transfer strategies accordingly. In cases where this had not been done upfront accurately, promises and unspoken expectations were made between partners to exchange materials, while the materials legally were not owned by the home institution.

Tip 6

Capitalize on the unique global learning community at host institutions

A unique learning environment exists within many host institutions that offers opportunities for a global perspective on the curriculum's content and objectives. In comparison to their home counterparts, host students often have a more heterogeneous background (Pyvis 2005), and they study a foreign, albeit adapted medical curriculum delivered by teachers from different countries. In host institutions, one can easily find students who were born in Malaysia and study a medical program in Saudi Arabia that was developed by Dutch teachers and adapted to the Saudi healthcare context. They study together with colleagues from India, Jordan, Egypt and are taught by American, Saudi, Pakistani, and Egyptian teachers. In our view, the adaptation of the home curriculum to the host institution's context (see Tip 4) should be directed in optimizing an international approach that does justice to the international learning environment in these institutions. This might, for instance, include designing learning activities in which students are exposed to different healthcare systems around the world and to different ways of approaching patients or dealing with colleagues in order to familiarize them with a global mind-set regarding healthcare issues.

Theme 3: Tips on learning environment

Tip 7

Manage the culture shock for host students

The host students often experience a "culture shock" with respect to the new academic learning environment and the required study behavior, especially in the first months. Some authors argue that the student-centered didactic model that is characteristic of many home curricula needs to be molded or adapted to fit with the host student's learning style (Chapman and Pyvis 2006; Heffernan et al. 2010), as the majority of host students have been exposed to a more teacher-oriented didactic approach (Pyvis 2005; Pimpa 2009).

Others, including program directors, teachers, and students, argue against this adaptation and indicate that after a transition period, students adapt well to the difference in required learning behavior (Waterval et al. 2017). Interestingly, the resulting didactic model will likely never be a carbon copy of the model applied in the home institution and will develop naturally in a way that fits the host context, as Frambach et al. (2012) showed that there is a continuous interaction and influence between students, culture, and learning model.

Therefore, we would argue that efforts should not be geared to a predesigned adaptation but to developing and

implementing an additional safety net and remedial program for those students who need support and coaching in developing self-directed learning competencies.

Tip 8

Address language issues

In most partnerships, English is used as instructional language, and for most students, English is their second language. Similarly, for teaching staff at the host institution, English is often the second or third language (Dobos 2011). Not surprisingly, teachers and program directors as well as students report that especially in the beginning, a proportion of students face language problems that interfere with their study results and behavior. For these students, additional remedial measures are needed. However, it is not necessary to make any structural adjustments to the program and its instruction methods, as students with help of some support structures seem to pick up their English language skills (Green 2015).

A greater challenge with respect to language is the potential mismatch that host students experience in the clinical phase between English as the language of instruction and the local language of the patient population. This can be a bottleneck for those medical partnerships where the host institution's patient population does not speak English and the student population is very heterogeneous. A possibility for institutions might be to offer two parallel clinical tracks: one offered to students who have mastered the language of the local patient population by additional efforts in their pre-clinical years and another track with predominantly English-speaking patients.

Tip 9

Invest in staff development

The host teachers play a crucial role in the quality of the actual delivery of the program. However, these teachers usually were not involved in the development of the curriculum materials. Furthermore, it is likely that most of them are educated in a teacher-oriented didactic system, and hence they will be relatively unfamiliar with the student-oriented didactical model. This means that continuous and intensive faculty development activities are required for full-time host teachers as well as for clinicians who are involved in teaching in the clinical phase (Waterval et al. 2016). These activities aim to involve staff members who are unfamiliar with the content and didactics of the curriculum and bring them in this aspect up to par with their colleagues at the home institution.

We would urge partnerships to map out a comprehensive professional development plan regarding the main educational and management roles in the curriculum. In the initial phase, the emphasis will lie on the transfer of basic knowledge and on understanding the didactics of the program. This can be achieved via short mutual training visits, online or face-to-face educational workshops and formal medical educational training for a selection of key members of the host staff. In the next phase, the focus might shift from knowledge and understanding to "showing how". This can be achieved by host staff members setting up their own training department and delivering, first in collaboration with the home institution, the didactical training. In the ultimate phase, this competency development plan would involve interacting with home staff members at an equal level within communities of practice, which is further specified in Tip 10.

Besides the teaching staff employed by the host institution, the partnership's professional development plan also needs to include the staff members of the affiliated hospitals who supervise the students during the clinical phase of their education. Reaching out to these professionals is particularly challenging because teaching is often a small part of their job and it is therefore difficult to get in contact with them for training and to familiarize them with the principles of the curriculum (Waterval et al. 2016). Increasing awareness of this risk and taking extra efforts, for instance, by inviting them from the start to all types of faculty development sessions is recommended. In our experience, this group offers most resistance, which is echoed in often voiced remarks such as: "we are doing this for so many years, are we not trained as good doctors?" It could be that these teachers feel most threatened by host students, who are educated in a different way.

Theme 4: Tips on relationship management

Tip 10

Establish communities of practice

Although most crossborder curriculum partnerships start with a unilateral flow of ideas, materials, and experts from home to host, in the longer run sustainable partnerships require that the exchange of educational expertise becomes more bi-lateral and preferably of equal strength. Program directors and medical teachers in host institutions voiced frustrations that it was often difficult to communicate their ideas for improving the curriculum – resulting from their experiences of working with home materials – to the home institution due to a lack of appropriate channels of communication (Waterval et al. 2016). To quote one program director: "They (the home institution) sometimes couldn't possibly imagine good comes out of here (the host institution)."

A possible route to solve this issue is to establish "communities of practice:" at an early stage of the partnership. Communities of practice consist of teachers who are jointly responsible for the development, implementation, assessment, and evaluation of the curriculum components (Keay et al. 2014). Of course, host staff members first have to become acquainted with the curriculum, but in due time, a mutual exchange of ideas and experiences within these communities of practice can serve as a mechanism for quality improvement. Communities of practice also have other benefits; for instance, they can contribute to an increased sense of commitment among host teachers (Keevers et al. 2014) and provide a fertile soil for joint research projects.

Tip 11

Foster cultural intelligence at all levels

Many authors have specifically emphasized the importance of cultural intelligence within crossborder curriculum

partnerships (Heffernan and Poole 2005; Seah and Edwards 2006; Eldridge and Cranston 2009). In curriculum partnerships, interactions between institutions are taking place at multiple moments and at various levels. Consequently, the people involved will encounter different approaches and ways of doing things, which may potentially create "little annoyances", misunderstandings, or even frustrations (Waterval et al. 2017). Due to differences in time zones and culture between partners, these feelings, which might arise at both sides, may jeopardize the sustainability of the partnership in the long run, as they impair interpersonal relationships.

A helpful approach to this dilemma might be the framework of "cultural intelligence" developed by Early and Ang (2003). Fostering cultural intelligence implies that partners suspend their judgment about a particular experience until enough information becomes available to adequately describe and act on the situation and the people involved. Cultural intelligence, defined as "a person's capability for successful adaptation to new cultural settings" comprises three components: (meta)cognition (Do I know what is going on?), motivation (Am I motivated to act?) and behavior (Can I act appropriately and effectively?) (Early and Ang 2003). Strategies to promote the cognitive element of cultural intelligence include, for instance, striving for a better understanding of the working context of both partners, as this helps to frame experiences in a more constructive and collaborative way. To increase motivation, partners could, for instance, spend time on reflecting on the cultural aspects of experiences after visits or interactions. In terms of behavior, even teachers who generally adopt a respectful and curious attitude might, in times of small conflicts, be inclined to put energy into blaming and looking for the source or cause of a conflict. Although understandable, this is counterproductive. Instead, a strong problem-solving attitude at the project management level, which deliberately avoids blaming and shaming, is perhaps the key to a partnership's success and sustainability. Although there are no quick fixes, fostering and promoting cultural intelligence on these three aspects is vital. Heffernan et al. (2010) and Smith (2009) strongly advocated that a focus on cultural intelligence should already inspire the screening and selection of suitable project officers and key teachers.

Tip 12

Communicate, communicate, communicate

Last but certainly not the least, a tip that should be considered as a foundation for all other tips for success is to create open, easily accessible channels of communication. Communication was identified as a crucial factor in partnerships (Stella 2006; Dunworth 2008). A review distinguished three levels of communication: between teachers, between project officers, and between members of upper management, each of which has its own strategy and pitfalls (Waterval et al. 2014). These open channels of communication might not be so easy to establish due to differences in time zones and working days. The use of new technologies such as WhatsApp, Facebook groups, or online meeting platforms might provide some solutions but also has its downsides. Relying too much on a virtual environment will not do the trick, as collaborators also need to see each other to develop a personal relationship. During mutual visits, a balance between social and work-related activities is advised. A number of studies tackled this specific issue and encouraged teachers to do "the little things" (Dobos 2011); for instance, make an effort to filter out irrelevant information upfront when transferring educational materials from home to host or showing genuine interest in personal and social issues.

All communication and contact will gradually build upon a degree of "trust" between partners. This trust is vital because the long-lasting nature of crossborder curriculum partnerships means that unanticipated opportunities and threats may occur that can only be solved on the basis of trust and with good communication.

Conclusions

Although the number of crossborder curriculum partnerships in medical education is expected to grow, they are by no means easy endeavors. Such partnerships require deliberate planning and informed decision-making during the design, implementation, and operational phase in order to guarantee a comparable and high-quality learning experience for students at both locations. We provided 12 tips that address some of the critiques to this form of internationalization and contribute to establishing sustainable partnerships. A partnership where there is a bilateral flow of educational ideas.

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Disclosure statement

The authors report no conflicts of interest. The authors alone are responsible for the content and writing of the article.

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