

What Do Health Workers Learn on International Placements?

Abstract Chapter 3 reviews existing research and the findings from qualitative interviews with returned professional volunteers to identify core learning outcomes associated with International Placements.

Keywords Learning outcomes · Interviews · Continuing professional development (CPD)

INTRODUCTION

Drawing on the literature reviewed and our qualitative work with returned professional volunteers, Chapter 3 summarises what is known about the forms of learning that can take place on international placements. It is extremely difficult to isolate or specify key skills or competences gained from professional voluntarism. First, the phenomenon is itself incredibly broad encompassing an overwhelming diversity of experience and learning across professional cadres and career stages. Secondly, the most common response when interviewing returned volunteers about placement learning is for them to refer to the transformational or life-changing impact it has had. Mezirow (1997) argues that significant ‘life transitions’ or crises create a disequilibrium that may then trigger ‘transformational learning’. Fee and Gray use similar language to contextualise the learning that takes place on international placements describing it as following a, ‘social, non-linear process, punctuated by a series of triggers that result in evolutionary

and revolutionary change' (Fee and Gray 2013). Other authors argue that the challenging and shocking nature of international placements in low-resource settings stimulates problem-solving, decision-making and coping skills (Kiernan et al. 2014; Longstaff 2012; Marçal-Grilo 2014). In the context of nursing education, Stephens describes the difficulty of trying to change student nurses' attitudes, values and behaviours. Using a meta-ethnography approach, she concludes that international placements constitute one of the most effective learning environments enabling nurses to move from 'compliance' through 'identification' to active 'internalisation' and behaviour change (2015: 1). Her analysis indicates that this is due to the combined dynamics of 'solving real problems', managing 'cultural encounters' and being forced out of one's 'comfort zone' (p. 7).

These sentiments are certainly echoed in the reports of respondents:

You go there and you're different and you hope that you're different when you come back. You can dress it up for other stuff but it's a whole different set of tasks and skills that I wanted to develop as a human being. [Nurse]

Staff come back motivated and inspired. They are more content in their own work, they feel very privileged and honoured to work in the NHS. [Line Manager]

I know why I became a doctor which I'd actually forgotten in the NHS. I'm going to go back to the NHS, I wasn't sure if I would go back to the NHS.

It takes some persistence and probing in interviews with returned volunteers to draw out specific competences and experiences. Before attempting to respond to this challenge, it is perhaps worth emphasising the fact that all learning is by nature difficult to capture, characterise and 'measure'.¹ This is particularly true of higher and more complex forms of knowledge or knowledge combinations blending explicit (perhaps clinical or engineering) skills with more tacit learning. Whilst we, as researchers, recognise the political and economic importance of specifying learning and its relevance and translational potential, we are also acutely aware that in trying to hold it fast and 'measure' it, we may understate its transformational qualities. Before examining the learning experiences of professional volunteers in more detail, we first consider the context within which this learning needs to be evaluated, namely lifelong learning or continuing professional development systems within the NHS.

CONTINUING PROFESSIONAL DEVELOPMENT IN THE NATIONAL HEALTH SERVICE

Training and professional development within the NHS, in common with most UK organisations, is managed and evaluated within the framework of *continuing professional development* (CPD). CPD is an important strategic tool for improving the effectiveness of the NHS workforce. The current annual allocation for Multi Professional Education and Training (MPET) in the NHS amounts to a staggering £4.9 billion (Health Education England 2016A). CPD in the NHS is not limited to the enhancement of individual clinical skill sets or career prospects; it is also a key mechanism to improve organisational effectiveness and patient outcomes. Sadler-Smith et al. (2000) identified three core functions of CPD. The *maintenance role*, which implies a generally passive and ongoing engagement with new workplace practices as they develop; the *survival role*, which enables practitioners to demonstrate their continued competence to work at an appropriate level; and the *mobility role*, which is essentially tied into an individual's aims and aspirations. This includes enhanced employability and career progression – potentially beyond their current employer. The Department of Health has long recognised the importance of CPD to NHS effectiveness, and all three strands of CPD are likely to be encountered within an arena as diverse as the NHS workforce. However, there is an acknowledgement that, in contrast to many other fields of employment, the rate of technological advancement and policy change in medicine and health care can be extremely rapid. This rapidity has a direct impact on working practices and means that there is an ever-present demand for healthcare professionals to review their knowledge and skills, and constantly engage with developments in their fields (i.e. an emphasis on *survival mode*).

As early as 2001, the framework for lifelong learning for the NHS was identifying how mandatory re-registration, post-registration and inter-professional education should focus on developing workforce skill sets (Department. of Health 2001). Until recently these types of initiative tended to have a clear clinical bias, focusing on developing and maintaining explicit, practical skills. In 2016, with the release of *Health Fit for the Future – Public Health People: A review of the public health workforce* (Public Health England 2016) the remit widened, and staff at all levels are now encouraged to engage with aspects of CPD that will ‘enhance

personal effectiveness skills, negotiating, influencing and co-production approaches' (Public Health England 2016), alongside specific technical skills. The Francis Report (2013) emphasised the importance of care and compassion at all levels of the NHS workforce. This stimulated a drive toward a 'value-based' strategy (Waugh et al. 2014) which has placed the '6 Cs'; Care, Compassion, Competence, Communication, Courage and Commitment (NHS 2016) at the heart of the NHS' skills enhancement agenda. As the NHS has attempted to utilise continuing professional development as a means of promoting productivity, innovation and efficiency so too has the emphasis shifted from more readily codified and measurable explicit skills to more complex and tacit transferable skills. The problems of codifying and measuring knowledge acquisition are as much a problem within the NHS environment as they are in sub-Saharan Africa.

KNOWLEDGE MOBILISATION THROUGH PROFESSIONAL VOLUNTARISM

So, what kinds of knowledge and skills are enhanced through professional voluntarism? A recent report by the All-Party Parliamentary Group on Global Health, *Improving Health at Home and Abroad: How overseas volunteering from the NHS benefits the UK and the world* (APPG 2013), highlighted the scale and potential contribution of overseas volunteering to improving health globally and in the UK. The report is mainly concerned with the impact that NHS staff have on host settings but a degree of attention was also given to the advantages that staff themselves might derive, and the impact these will subsequently have on the organisation as a whole. The four primary areas of benefit outlined include the following:

1. Improving health in low-resource settings: volunteers are able to strengthen the capacity of health systems, institutions and professionals in these countries, where weaker training structures mean the chance to be supported by UK professionals is highly valued.
2. Leadership development: volunteers develop strong leadership skills and return with a greater understanding of how to enact change and communicate across professional cultures.
3. Sharing innovation: NHS staff are brought into direct contact with novel approaches to healthcare delivery, returning with greater confidence to challenge and change established practice in their Trust.

4. International relationships: a valuable asset to ‘soft power’ and international influence, giving Trusts a competitive advantage in recruitment and retention at home, and generating new opportunities for partnerships, research and revenue generation abroad. (APPG 2013)

Research on the experiences of healthcare professionals taking international placements suggests that a wealth of intense and valuable learning takes place. Many professionals describe developing a new perspective as a result of international placements (Jones et al. 2013; Wright et al. 2005). Others describe the development of specific skill sets such as communication, leadership and cultural awareness (Hockey et al. 2009; Lee et al. 2011; Norton and Marks-Maran 2014). A number of themes emerged from our literature review and empirical work with regard to ‘what’ learning happens and how this learning is facilitated. Before exploring these themes in more detail, it is important to emphasise that the majority of respondents cite a whole range of skills. The following response is typical:

I have come back with teaching skills, leadership skills, management, we have also done service development which the NHS want and I have been physically involved in the project and I think these are the skills that they want. I have achieved much more out here than I ever would at home. Not just a personal way, those hard skills are there. Clinically, if I was going to stay in paediatrics it has improved my neonatal examination skills. [In the UK] you can just order a test, they definitely improved and trying to think about language barriers and communication. And a realisation of how important building relationships is. [Junior Doctor]

This case illustrates the combination of explicit skills and the emphasis on core ‘back-to-basics’ clinical skills with transferable ‘soft skills’ in areas such as management and communication. This respondent also illustrates the quite common experience of using ‘time out’ on placement to help them make decisions about their future career development deciding to apply for general practitioner (community physician) positions on her return.

CLINICAL SKILLS

Perhaps the most obvious (and potentially measurable) area of skills enhancement concerns explicit clinical skills (Kiernan et al. 2014). When asked about their motivations for applying for placements professional

volunteers, especially doctors, refer immediately to the potential for clinical skills enhancement. And, post placement, professional volunteers report gains in clinical skills achieved through the sheer volume of cases they encounter; their exposure to diseases that are unusual in the UK; conditions that are rarely seen due to early or preventive intervention (the outcomes of delays) or, quite commonly, scenarios that they would have limited direct (hands-on) access to due to their status (in terms of seniority or cadre).

One of the most tangible and obvious benefits of spending time in a low-resource setting concerns the large volume of cases and the access that clinicians are likely to have, even at a relatively junior stage in their careers, to these. The idea that learning is gained through repetition (case volume) is captured by theories of learning focused on ‘deliberative practice’ which suggest that individuals acquire or hone skills through practice (Ericsson et al. 1993). Skills enhancement here relies on an assumption that the learner has been taught the skill in the first place, and it is use of that skill that perfects the skill and builds confidence in its utilisation; similarly, lack of practice may result in skills wastage or more likely in waning confidence. This form of learning, through repeated use of pre-existing skills, could arguably happen in the absence of supervision but may be significantly enhanced when the learner has access to a ‘more knowledgeable person’ (Kolb 1983; Nonaka and Takeuchi 1995).

An experienced midwife volunteer described the gains she feels she made in terms of clinical skills:

Some of my clinical examination skills are ten times better than before we came out. In the UK we lose our basic skills and midwifery skills of how to palpate a uterus and to say which position the baby is lying in because if there’s any doubt we just send for a scan. I had a woman who came and I felt her abdomen and she saw it on my face – she said, ‘you think I’ve got two babies don’t you?’ I said, ‘I really do think you’ve got two babies in there’. She laughed, she said she had a scan the week before and it said single baby but there were too many poles and too many limbs for it to be one baby. I said I’m not happy with that scan result I want you to go to [hospital] and have another scan and ring me. In the evening I got a telephone call. She said ‘I have twins!’ How fabulous that?

We have cited her at length here as the language she uses indicates not only the actual learning but also her sense of achievement and the confidence this has given her. A core clinical skill frequently mentioned by many volunteers from various cadres’ concerns neonatal resuscitation:

I have resuscitated more babies in a few weeks here than in my whole career at home. There are times (in the UK) when the paediatrician is stuck in theatre or you're at a home birth and actually what do you do? Well you keep going (Midwife).

The midwife in this case points out the potential value of this on her return to the NHS either when staff are committed elsewhere or when she is at a home delivery. The effect of skills shortages combined with patient volume generates important opportunities to gain exposure in areas tangential to clinician's roles in the UK. We have noted a similar experience in relation to undergraduate electives (Ahmed, Ackers-Johnson and Ackers 2016) where students refer to opportunities for 'exposures' or 'spoking-out' from their main area of specialism. The following case involves a junior obstetrician:

I had not done any neonatal resuscitation until I came out here – obstetricians don't do neonatal resuscitation in the UK.

The opportunities for learning through repetition not only improve clinical skills but also enhance confidence in using those skills:

From a professional point of view, I've always had a gap...well not a gap... I'm not very confident and I should be more confident with neonatal resuscitation and care of the new-born.

Do you feel that you'll go back with confidence in neonatal resus?

Yeah, definitely, yeah.

This case illustrates the close relationships between actual skills and confidence in using those skills. In practice, it is hard to disentangle the two. The following anaesthetist makes a similar point about her exposure to working with children:

I have done a lot more paediatrics than I've ever done [in the UK] without supervision, so that is a clinical skill. I was anaesthetising neonates.

The following doctor realised the benefits of this confidence when she returned to work in the NHS:

I have noticed that when I am on call at night – I know when I go to theatre there is pretty much nothing that can faze me; if I open for c/section I am pretty sure that whatever is there is not as bad as what I've done [in LMIC]. From a practical point of view that makes a big difference to your confidence.

One anaesthetic volunteer describes the patients he has encountered in a low-resource setting as ‘sicker’ than those he meets in the UK:

The patients are generally sicker so it’s a combination of factors. In certain clinical areas, you will de-skill, yes, but in other clinical areas it’s a form of crash course, six months and then all your acute care skills as a physician you’re just practicing them more commonly. You’re less reliant on the high-tech stuff and you become more reliant on your clinical acumen.

These cases also illustrate the importance of volunteer learning in situations of emergency. The sheer volume of emergencies in these settings certainly provides critical learning across all specialities and a preparedness to think out of the box and react. One key informant referred specifically to this experience and the confidence it spawns:

Their knowledge and skills are enhanced by what they’ve seen and they’re more confident in responding to emergencies.

The volume of patients by definition implies a diversity of conditions and, sadly, in a low-resource setting characterised by extensive delays and poor patient management, exposure to conditions that are rarely witnessed in the UK. Kiernan et al. contend that the breadth and depth of conditions seen in low-resource settings provide exposure to a variety of illness allowing health workers to tap into a wider range of diagnoses. In the following case, a midwife refers to her experience with breech deliveries but also tropical diseases complicating normal pregnancies:

From a purely medical point of view there is the opportunity to see a lot of conditions. I can do breech deliveries to get more skilled up in that – diseases in maternity so HIV, hepatitis in pregnancy, malaria, TB and that kind of stuff. . . . These things will be useful when I return in the UK.

A very experienced volunteer midwife who had spent time in a number of African countries returning to the UK in between argues that these skills could be very useful in the UK where the medicalisation of childbirth has (in her view) reduced patient choice:

Can I just talk about clinical skills because I think that is really important – having been back and forth to Africa for a few years now, I have certainly

found that clinical skills say with breech and twins in the UK are really going downhill because everything goes to section. In the UK I see very often the obstetric distress where the person on call actually has not dealt with a breech or hasn't had much experience with twin deliveries. And they're the one who is getting really upset and stressed because the woman wants a vaginal delivery and that causes problems. To come here is actually an opportunity to witness and deliver twins where there is not that feeling that this woman must go for section or because you have a breech you must go to section. It is very much regarded as normal here.

Linking into the 'global health' discourse, the following volunteer notes that, although many of the conditions volunteers encounter are not common in the UK, they are increasingly relevant given high levels of immigration:

I have increased my knowledge of tropical diseases and malaria. I know it is not common in the UK but they do come up sometimes with people coming from other countries so it is nice to have that.

Obstetricians almost always report their experiences of serious complications that are either rarely seen in the UK (and they have only come across in textbooks) or that they would have limited direct access to in the UK due to their seniority:

I have had the opportunity to do complex cases here which are far different from the UK... there were plenty of uterine ruptures this week, multiple pregnancies and I had never done an ectopic pregnancy but I have now done that as well.

I will go home having done breach deliveries and lots of uterine rupture repairs. That will be two things on my obstetric CV that you won't have unless you do something like this.

One respondent expressed some concerns about the value of her new-found skills on return to the NHS where such complications were highly unusual:

I am not sure how these skills are transferable to my UK practice because I have been dealing with uterine rupture and some more obscure things and I'm not likely to see them for a long time in my practice in the UK if I ever do. I have been exposed to all sorts of clinical scenarios.

A leading representative of the Royal College of Obstetricians responded to these concerns in an SVP workshop re-assuring volunteers that these skills are relevant and, furthermore, often lacking among NHS consultants:

The skills you are learning are fantastic and actually the majority of UK consultants could not do any of these things you have just mentioned because they have never seen them and that is a huge risk to the mothers in the UK. We are seeing maternal deaths occurring because the people just don't have that experience which the previous consultants may never have seen before. That demonstrates something in you – that your experience allows you to confidently say, 'well somebody has to do it' while in the UK people don't seem to have that and they are frightened of doing that. So if you are given that confidence to actually deal with the situation which you are presented with this is hugely valuable. You may not use it in ten years but that 1 in 10 years – that is very important.

The opportunities for clinical learning will vary by cadre and placements may not provide opportunities for all people or in all skills. And, from that point of view, it may be difficult for them to map neatly and comprehensively onto a comprehensive CPD framework. Anaesthetists, for example, often report fewer opportunities for the kinds of clinical skills enhancement that is immediately relevant to their practice in the UK. This reflects the fact that the equipment and gases used are so different:

Clinically it won't be cutting edge things that I've learned but I've learned how to use drugs that I haven't used before, like ketamine which I've never used in the UK.

Other anaesthetic volunteers immediately identify skills applications in the UK:

The clinical skills I've learnt? I don't normally use ketamine back in the UK; I've never used the anaesthetic agent ether or halothane before and so you're using all these drugs but some of them are available in the UK. Some are not but the ones that are you'll be so much more skilled in using them. I'll even go as far as saying I know people that are so much more senior than me at consultant level that have never used drugs that I've used that I could make useful in settings back in the UK. They've gone on to become established consultants and they may have only seen one or zero cases. Some of the cases you see out here as a registrar level anaesthetist sure

you won't see those commonly again in the UK, and if you do, something has seriously gone wrong but the skills you learn are very transferable, very transferable to other conditions and you're incredibly more confident.

In the following example, a junior doctor distinguishes learning in surgical skills from internal medicine:

I think the people who learn the most from this experience will be internal medicine which is not surgery, just because of the array of things they see over there, people usually present very advanced malaria and how to treat it, I mean I don't know how you would apply that [in the UK] but it increases infectious disease knowledge. They would see more advanced TB that could be applied over here now. They can see very advanced things. From the anaesthetic and surgery point of view, we see things like very advanced cancer, someone with a huge tumour, something that could have been solved earlier. Things are more scary and exciting, you don't have as much modern equipment, you have to make do and adapt to your patient. You learn so much.

In such cases, skills enhancement may be constrained by the lack of access to essential equipment, consumables or cultures of practice. Indeed, in many situations, clinical intervention may simply be impossible due to these environmental factors. The prevalence of these kinds of situation led to the development of the THET-funded bio medical engineering project designed specifically to reduce the occasions on which interventions are limited by lack of usable equipment.² As well as improving local health systems this project has enhanced opportunities for volunteer learning by keeping theatres, neonatal units and high dependency units operational. Equipment is not always the main factor. One mid-career obstetrician suggested that, from a narrow clinical perspective, his skills were not being enhanced because 'here there is nothing between a normal delivery and a c-section – they don't do assisted deliveries and that is where a lot of the skill lies'.

This in part (and at face value) reflected a lack of equipment but in fact reflects a much deeper seated cultural³ opposition to the use of forceps or vacuum for assisted delivery. In another case an ophthalmologist suggested that in his specialism, experiencing new diseases was a less significant component of overall learning:

In ophthalmology, I don't think the primary benefit for medical staff is that you will see unusual things because most blindness in [LMICs] is cataracts and squints and we've plenty of those ourselves. So I don't think seeing new

diseases – that’s not a big issue. You might see a more advanced case of something you already know but that in itself is neither here nor there.

Certainly, as managers of professional volunteers, we were aware that placing some cadres presented greater immediate challenges that would affect clinical learning. Where a specialism is underdeveloped or even non-existent, it is more difficult to relate clinical skills learning directly to CPD frameworks at home. Mental health is a case in point. One mental health nurse suggested that her learning was less focused on improving clinical skills and much more focused on ‘soft’ skills.⁴

We have referred (above) to ‘exposures’ outside health workers’ disciplinary specialisms. In many cases these exposures have played quite an influential role in helping volunteers to make decisions about their future careers – or adding to their CVs to make those decisions possible. The following junior doctor used the opportunity to gain experience in midwifery as the basis for a planned specialism in obstetrics:

I’m almost certainly going to go into obstetrics training when I get back so for now I’m still quite a general doctor. It’s good experience for me, practically it’s a lot of hands on stuff, I’m doing a lot of midwifery work – it’s useful to have that basic background isn’t it? When I say basic that’s a bit rude really, I just mean it will be useful to know how things should work normally compared to when things go wrong so that’s really useful. Already I’m much better at delivering babies than I was two months ago so that’s brilliant, that’s really fun and satisfying.

The SVP social science volunteer, involved in evaluation, later decided to train as a nurse in the UK. In another case, a more experienced midwife used the opportunity to gain access to management experience which she felt would help her to make the next step in her career:

It depends what stage in your career you are as well, I don’t need to go and learn clinically really. I’m looking to stop working totally clinically (to work) in management.

Sadly, the exposure to acute situations also results in very immediate experiences of mortality:

I have looked after ladies with more still births in the six months I have been here than I have ever in my whole career. In the UK, people are absolutely

mortified even if they have a late miscarriage. It's so upsetting. If they have a stillborn it's devastating. You know huge counselling and just horrendous.

The immediate and repeated experience of mortality constitutes a key component of risk in volunteer management and must be managed accordingly. However, it does also present opportunities for skills development in terms of counselling skills and resilience; these are often also linked to elements of cultural awareness (see below).

Whilst the opportunities generated through patient volume or disease complexity will doubtless generate novel exposures for UK health professionals, the quality of the training environment may reduce the potential for knowledge gains. A key factor here is supervision. Where junior or non-specialist staff are exposed to situations without access to adequate mentoring or supervision skills enhancement will not be optimised. Indeed, the level of absenteeism of staff and especially doctors in low-resource settings (Ackers et al. 2016) can significantly reduce the clinical exposure of professional volunteers as theatres remain closed for extensive periods. The following junior doctor refers to the need for clinical supervision in low-resource settings and the importance of having a UK mentor to compensate for the lack of immediate supervision:

It becomes a challenge when you have a baby that you don't know what to do and you don't, at the health centre, have someone to discuss that baby with and I've emailed my mentor about a couple of babies and have had to rely on a senior doctor from the UK rather than having a senior doctor here. So in terms of co-presence I mentioned that I am not always working with a doctor but I am always working in co-presence with the nurse in charge of that unit. I do think for junior doctors, you do need a doctor that you can talk to about cases.

Literature on learning theories describes the importance of a 'more knowledgeable other' to some forms of learning (Vygotsky 1988) which enables the learner to move from the 'zone of current development' to the 'zone of proximal development' (Harland 2003). According to this theory, the 'more knowledgeable other' could be someone from other professional cadre; what is significant is that they have a higher skill set on that specific aspect of knowledge.

This is a point we pick up in [Chapter 4](#) and reflect the potential tensions between optimising the skills of volunteers and minimising the damage to

health systems caused by unintended consequences (Ackers and Ackers-Johnson 2016). In the absence of effective safeguards, professional volunteers may also be exposed to unacceptable levels of risk through lone working in such circumstance, a point we return to later.

LEADERSHIP

Leadership is notoriously difficult to pin down both as a discrete skill and as an element in self-reported assessment. The lack of clarity around the concept was pointed out over 40 years ago (Sales 1966), and many attempts have been made to disaggregate its components (see, for example, Tourangeau and McGilton 2004; Rohs and Langone 1997). In terms of professional placements and international volunteering, the hypothetical construct of leadership is often referred to as if it were a homogeneous concept. Even the Chartered Institute of Personnel Development brackets elements as diverse as time management and creativity under the rubric of ‘leadership skills’ (CIPD 2014). At policy level, there is also ambiguity. The 2010 framework for NHS involvement in international development (NHS and DoH 2010), for example, singles out the development of ‘leadership’ as a key strategic priority. The 2013 All-Parliamentary Group on Global Health similarly refers to volunteers developing ‘strong leadership skills’, and returning from their overseas encounters with ‘a greater understanding of how to enact change and communicate across professional cultures’ (APGGH 2013). So, in this case, there is a conflation of leadership skills with cultural competency.

Many NHS policy documents outline the requirement of NHS staff to demonstrate leadership skills. The NHS ‘5 Year Forward View’ document has a focus on leadership (NHS England 2014). Additionally, the ‘2022 GP’ has a focus on co-ordinating complex care and the role that general practitioners play in coordinating multidisciplinary skills. The Health and Care Professionals Council (HCPC) standards of proficiency suggests physiotherapists, psychologists and radiologists should understand the concept of leadership and be able to apply it to practice. Furthermore, leadership is named as one of eight principles of nursing practice by the Royal College of Nursing (2015).

Clearly leadership is recognised as a core skill across the NHS and an ability to demonstrate leadership is necessary and desirable in staff of all professions and all career stages. If it were well-evidenced that

international placements develop these skills, then it could provide a way to increase human resource capital, at a time when maximising staff skills is increasingly important.

Furthermore, the NHS Leadership academy has created numerous frameworks to help assess leadership in healthcare professionals. The medical leadership competency framework (MLCF) was devised in 2008 and aims to identify competencies that need to be developed and can be used by any NHS professional (Hockey et al. 2009). The model includes five domains: personal qualities, setting direction, working with others, improving services and managing services. It has been argued that this framework, along with others, can be applied to work in low-resource settings to develop leadership. In a specific project involving UK professionals working in Cambodia with a purpose of leadership development, authors argue that having complete ownership of a healthcare improvement project enables professionals to engage in processes of planning, management, critical evaluation, systematic enquiry and encouraging innovation (Hockey et al. 2009).

Available literature suggests that professional volunteers based in low-resource settings are presented with opportunities to lead that they would otherwise not have in the NHS (Baguley et al. 2006; Banatvala and Macklow-Smith 1997; Jones et al. 2013; Kiernan et al. 2014). Many of our respondents describe being in a low-resource environment as a catalyst for them to acquire leadership skills, out of necessity. As noted above, the kinds of skills or experiences they identify are quite diverse ranging from elements of project management, health systems thinking, quality improvement, audit and cross-cultural, inter-professional communication within teams frequently involving conflict management. Some volunteers, often at a more advanced stage in their careers, identify this as a specific objective of their placement to gain management experience to support career development on their return. Others become involved in high-level project management initiatives. The first case presented below involves a registrar who was in part motivated to volunteer in order to gain management skills. She identifies the difficulty she has had in the UK in gaining this kind of experience, even though, according to her, this forms an explicit component of her training:

It is difficult as a registrar in the UK to really get involved in management...there is management stuff in my training; there are specific things that I have to do. You don't really get a lot of say in how things

are running and should happen. . . . and I mean that is the way forward to try and get the team we were working with to think about new ideas. I think that would be good to try and do that before I become a consultant rather than after.

In this case, the doctor developed a large triage area in the national referral hospital. Whilst this may sound relatively straightforward from a UK perspective, triage is one of the most difficult concepts to introduce in LMIC settings (see Ackers et al. 2016, for a case study of this process). The next respondent refers specifically to the emphasis on managing ‘dysfunctional teams’ in her training and the experience she has gained:

Lots of management, I’m sure it will make me better at managing a team where all is not going as it should do. That’s one thing that’s on my advanced training modules ‘how to manage a dysfunctional team’.

As noted above, many quite junior volunteers engaged directly in managing complex interventions. Arguably this type of experience is likely to be more prevalent in volunteering positions that are focused on capacity-building rather than service delivery per se as these often encourage volunteers to develop or work within multi-professional teams. In such cases and especially where projects are funded, placements will have an emphasis on evaluation and audit. The SVP evaluation identified many situations in which early career health workers became actively involved in management and leadership for the first time in their careers. The respondent in the next case immediately linked her own experience of project management as an early career obstetrician to evidence of personal qualities such as initiative and responsibility:

It shows initiative. How you can cope in such situations. I got a level of responsibility that I would never have got in the UK working in project management and leadership. It shows that I have more skills.

In the two following cases, quite junior doctors (pre-specialisation) achieved a high level of engagement with staff and very senior managers setting them apart from their peers at home:

From the professional point of view it’s benefitted me. Obviously something I’ve never done before and it’s really more on the coordination and

management of people. I feel like I am actually benefitting a great deal from coordinating different people. We are meeting people even up to directorship level who are inputting lots of quite useful ideas and I'm meeting guys who are meeting at a technical level within a low-resource setting which is something that I was never used to, so this is also quite beneficial to me professionally. I think I'll be stronger from here, professionally.

I am much more experienced than my grading as a doctor. I spent time on wards to train a great many staff and I am much more comfortable in different settings and difficult situations. Now, I have seen it before and have done it before in different circumstances. I got different skills in leadership and in people management. [But] communication was the main place where I learned lots of extra skills.

Volunteers were acutely aware that these are the kinds of skills that are highly prized in the NHS or at least in NHS rhetoric and believed that their ability to concretely evidence them is likely to accelerate their career progression. In the following case the doctor refers to the systems thinking components of this experience and the link to organisational innovation:

Things like managing people, leadership, quality improvement projects especially as you get more senior. That's what consultants want to see when you are applying for a job, they don't need to know that you can hold an airway because that's competency, they want to see that you can see a health system and innovate, how you can improve something, and I think that's something that I would say to my Deanery when they ask what I learned from this.

She also uses the language of 'quality Improvement' as a component of management. Quality improvement emerged in other volunteer accounts. In the next case the respondent links this closely to inter-personal and inter-cultural skills. She also makes direct reference to the value of learning from failure:

I've done a few quality improvement projects which have been a real obstacle and I've come to learn how you have to strategize, deal with different personalities, when to move forward, when to stop and observe so a lot of inter personal and inter cultural skills that I've had to learn. I've also learned about myself, to understand myself more, ask myself why I am frustrated.

Some volunteers talk of leadership in a more routine way in terms of managing difficult trainees and the use of diplomacy to instil behaviour change:

Its leadership, service development and communication where I've learned a lot. I think my people handling skills; I've got an intern who is particularly difficult to manage. I'm trying to get the best out of him, those kinds of skills have come on a lot.

Interpersonal skills that you're drawing on every minute of the day; trying to get things done in a diplomatic fashion.

The following respondent suggests that her experience of managing change will be of direct value to the NHS and impress her managers far more than gains in clinical skills that may arise from placements in high-resource settings:

What they will be very interested in, what they will see in me is an individual who is very motivated to try to change things in spite of a very difficult environment, and if she is able to do that, if she comes to our Trust and we give her a project/protocol to start to improve things, she would be the one. I think they will appreciate that more than say if I went to America and learned a new fancy skill.

This area of learning, especially for those cadres with little previous exposure to leadership, could be interpreted as an example of 'experiential learning' which Ng et al. (2009) characterise as a 'holistic process of adapting to the world'. Patrick describes experiential learning as, 'learning through reflection on doing' (Patrick 2011). Arguably, this kind of learning can continue to happen effectively in the absence of co-present supervision (Kolb 1983), although this learning process will vary according to the environment and qualities of the learner.

Whilst many respondents talk about leadership and management in terms of people management skills, others referred to the experience they had gained in resource management more generally. Low-resource settings are characterised by major problems in terms of consumables and medicine management. This by no means only concerns the lack of resources per se but very poor systems resulting in regular stock-outs further compounded by endemic and highly innovative corruption. It is by no means unusual to see theatre lists closed due to a lack of surgical

gloves, theatre linen or basic equipment or triage halted due to the lack of blood pressure machines. Inevitably professional volunteers become involved in these processes on a daily basis:

I've gained skills and expertise related to logistics, resources and stores, stocks and supplies and all those kind of things that really could be useful.

As Crisp (2010) notes, managing resources is as much a problem for high income settings and the NHS as it is for low-income settings such as Bangladesh, and there are great opportunities for knowledge transfer and frugal innovation. The NHS' '5 year Forward View' suggests innovative ideas for cost saving are important and that these should be implemented more quickly in the future (National Health Service England 2014). Evidence suggests that placements in low-resource settings improve awareness of the relative costs of interventions and the damaging effects of resource misuse (Kiernan et al. 2014; Leather et al. 2010). The phrase 'problem-solving' is used throughout the reviewed literature to describe a skill set that develops as a result of international placements (Baguley et al. 2006; Horton 2009; Longstaff 2012). The interviews link this financial awareness to 'back to basics' clinical skills and problem solving:

I Had to Use My Eyes, My Ears and My Stethoscope like I've Never Done Before.

We're so used to ordering investigations, we've forgotten some of those basic skills.

The development of soft skills can be seen as a key facilitator in the various stages of clinical skill development. For example, planning, concentration, repetition and revision (a tendency to practice), study style and reflection (a tendency to self-regulate learning). The next two cases show how a resource constrained environment improves the ability to plan and solve problems:

I've become more resourceful because of the lack of resources and equipment that works. I've learned to anticipate what's ahead and what might go wrong and get myself ready for it, whereas back home I have an assistant so I don't have to worry. So it makes me prepare and not rely on anyone else.
[Anaesthetic volunteer]

I learned to be more resourceful, clinically, because if something bad happens, there's no one else. It taught me to how to monitor patients even with the most minimal equipment especially with kids and I think that's quite a useful skill. [F2 doctor]

The next case is very typical and refers to the awareness that volunteers gain from their core skills. We have used the word awareness here as in many cases this is not about developing new skills but remembering and revitalising skills. In this example the bio medical engineer volunteer is talking about the fundamental science that lies at the heart of his profession but lies dormant in the UK:

It's made me think about things completely differently. About the way I work in the NHS particularly in times of resource constraints and trying to think laterally about the way you do things. It makes you go back and think about things in their fundamentals... of course physics and that kind of thing. UK degrees are fantastic but they are so theoretical.

The MOVE project did not set out to capture the views of line managers as such. However, some returned volunteers had themselves become line managers as in the following case:

Low-resource settings give people the ability to think on their feet and be quicker and I think they become people who can solve things; people who are used to working in high resource setting, I don't think they are very flexible – especially when you have worked somewhere like Australia or New Zealand where health care is very prescriptive and very defined (Midwifery Lead)

One of the line managers interviewed was involved with the recruitment of Army reservists and their deployment to low-resource settings usually in crisis situations. He was very clear about the skills they were offering potential recruits and the NHS:

The organisational skills are gonna be first and foremost. These people will have to stretch themselves clinically with the things they are dealing with and bring this clinical practice back to the UK. So we've seen catastrophic traumatic situations that are influencing how we deliver care back in the NHS. We'll offer you leadership, we'll give you confidence in presenting and all that sort of stuff cos you've got to be quite credible, so all of these things will give you an edge. When we're dealing with the NHS we find that senior

managers straight away see the benefits of reserve service. You send us someone with clinical ability and we'll enhance that ability in a wider field than you do. We'll give you back somebody who's very comfortable with sorting order from chaos, being in a stressful situation and able to manage people and lead teams. That's quite an ambitious statement to make, but that's what we deliver.

This statement echoes the literature on highly skilled mobility generally and scientific mobility, in particular. In this context mobility is often seen as a way of recruiting the 'brightest and the best' or those individuals more willing to take risk and innovate. Nevertheless, we must allow for the fact that those individuals who put themselves forward for professional placements in low-resource settings (all else being equal) may be a self-selecting group. And, added to that, recruitment and deployment processes may identify individuals with a high degree of resilience and ethical commitment. The following volunteer hints at such:

I don't know if you have to be a tough person already to some degree?

Another volunteer talks of how she is no longer afraid of 'risky situations' – the question is whether organisations recruit people who are less risk averse or whether the process itself develops this quality. Certainly, the recruitment processes that volunteer deployment organisations are involved in will actively valorise resilience.

Leadership and management are necessarily linked to team working. The NHS and its training arm (Health Education England) have recently placed significant emphasis on the development of multidisciplinary teams and the dissolution of counter-productive professional boundaries (HEE 2016C). Kiernan et al. (2014) suggest that international placements provide unique opportunities to work with people from other professions. This finding is echoed by professional volunteers who describe the skills they gain through team working with other cadres. This arises in a number of ways. First, deploying organisations may actively mobilise multi-professional teams in complex interventions. This is the case both in systems-focused capacity-building environments and humanitarian crisis situations. Secondly, volunteers witness the stark absence of team-working in hosting organisations which heightens their awareness of its value. And, thirdly, the act of simply living in proximity to other volunteers from diverse

backgrounds undermines professional boundaries as the following case illustrates:

It's great that teams go out there that are multi-disciplinary because you see your colleagues in a different way and appreciate their roles more. You are all in it together when you're out in a difficult situation. I mean it's so resource poor that it is actually a hard thing to go and live in an environment where it's not a guarantee that water will come out of a tap or you plug something in and it will work. That's quite difficult really, so I think you see people rather than colleagues.

We have made the point on several occasions that active learning in low-resource settings often comes about as a direct result of observing or experiencing failure. This is also the case with regard to team-working where the challenge of solving immediate problems precipitates a team dynamic:

When they go and realise the absence of team work [there] it makes them aware that they do do team working (in the UK) and they realise how important team working is. [Line Manager]

Team working was also specifically emphasised in the interviews with army reservists:

Certainly one thing about the military is team work, because everybody just works as a team and just does it. There is no preadonnas. And that team work, if you could bring that team work back that is what you would want to bring back. [to the NHS]

Volunteers often report positive experiences while working in local teams. Key among these was a heightened appreciation of the damaging effects of professional hierarchies and boundaries. This was not because such boundaries are any less evident in low-resource settings which are often more hierarchical (Briscoe 2013). It was more closely related to dimensions of positionality⁵ and the uniquely privileged status that volunteers acquire – as supernumerary foreigners – which positions even quite junior health workers in critical leadership roles.

Many volunteers become involved in aspects of audit, protocol development and related training (Ackers et al. 2016). This broad area of skills

could be categorised as a component of teaching or research (see below) but also forms a key component of leadership in the NHS. The ‘Trainee Doctor’ underlines the importance of accurate and clear clinical records and understanding the principles and practice of infection control (General Medical Council 2009). Working in low-resource settings exposes professionals to the stark reality and consequences of lack of compliance with clinical guidelines and protocols, especially in areas such as patient management and infection prevention control. Standage and Randall (2014) argue that working overseas provides nurses with a greater understanding of why it is necessary to do things that are required in the NHS such as gaining a child’s consent by experiencing an environment in which such systems are not in place. Nurses on international placements become critical observers of the difference in the implementation of safety procedures such as infection control (Button et al. 2005). Some returned individuals reported that experiencing a world without NHS standards, allowed them to appreciate their importance (Greatrex-White 2008). Certainly the ethnographic work with SVP volunteers shows that almost every volunteer when confronted with the chaos that is present in most public health facilities immediately jumps to advocate interventions focused on patient management, record-keeping, audit, infection prevention control and surgical safety (Ackers et al. 2016). The stimulus for this comes from the immediate and stark reality of outcomes associated with its absence. Patient safety is an ongoing theme in most interventions and the spectre of Ebola/Marburg pushes this home:

It just made me think in terms of patient safety in this environment.

LEARNING FROM FAILURE

At a pragmatic level, it is argued that learning experiences embedded in the context of a developing country provide invaluable opportunities for staff to see the consequences of poor healthcare system management. The senior manager of a charity providing volunteer placements in Africa told us:

I was talking recently to some returned mental health nurses who were learning about the side effects of the drugs that are given to schizophrenics. But when they went to Africa they actually saw the side effects of these drugs that they never see here – patients foaming at the mouth

and whatever. And they saw the end stage of things that would've been dealt with much earlier here. And that's very dramatic, but on a different level, I think that a lot of people in the NHS get sick to the back teeth of paper pushing. Then as soon as they get to a developing country, and see really chaotic health care and the first thing they want to do is paper push because they understand the real value of audit and basic patient management, of basic triage. They get to see how badly things go wrong if those systems aren't in place, that I guess on a routine day to day over here might seem a bit boring – maybe even unnecessary. But they see the lack of audit and the consequences of basic patient observations and patient notes. They see the value of interventions that they take for granted here, and they see the consequences of stuff that doesn't work.

The absence of the highly ordered societal and organisational structures that we are so used to in the West was mentioned by many people who had worked in low-resource settings. A fundamental lack of basic administration systems in many settings could be difficult to come to terms with. This appeared to be especially frustrating for nursing staff who tend to be known for their reliance on securely structured protocols, and were used to working in the 'protocol heavy' environment of the HNS. A placement provider told us how she had noticed that while there was a general culture of negativity towards the opaque layers of bureaucracy which tend to characterise the NHS, when staff returned from locations that did not have even the basics of such systems they often found a renewed appreciation for them and: *'...the first thing they want to do is an audit.'*

Barbara was a senior clinical manager and part of a team who regularly travelled to Central Africa to provide training courses in emergency obstetric care. She told us how the complete lack of structure in many of the health centres she had encountered still shocked her, even after many trips. This lack of structure could extend well beyond the clinical environments that she and her team needed to engage with:

They don't register births, deaths, marriages. It just happens. Which is such an alien thing to us in a country where I think we have an image of who's here – we know how many are here – you know with all the information that we gather when we do a census we've got a good grasp on what we think our population is, whereas in Africa that doesn't exist. Patient records are hit and miss. They may have a record, they may not. So it's very difficult because

when somebody dies there's a process that we have to go through of reporting it and making sure the right forms are filled in. It just doesn't happen there. It's just give them back to the relative and off they go. Without it [medical bureaucracy], although it feels like a lot of red tape and it feels like a barrier to giving the care that we want to give, but it actually gives us so much more than that, just on that level of a process, although it is sort of a name and a number, it gives that person some value. And I think it's different when you go to Africa, it makes you feel a bit vulnerable because you could just disappear. Nobody would look, and nobody would even know that you existed.

The absence of good teamwork in some settings was also reported, but even this could be seen as an important learning opportunity:

It's learning through the observation of failure. I don't think they're going there and seeing wonderfully good practice or team working or patient safety. When people learn over here [in the UK] and when people prepare learning materials, they show them best practice, and all the examples are best practice. That's not what they see in developing countries. They see dreadful practice, but it shocks them into very simple back to basics thinking. Things like 'no one took that patient's temperature' or 'no one made a note of that'. And I think 98 per cent of what they're doing is learning from and reacting to bad practice. [Placement charity worker]

Many volunteers comment on the level of bureaucracy in the NHS and its impact on clinical time; but at the same time most engage in some form of protocol development and audit. In the following case the respondent is planning to use her new skills as soon as she returns home to a new role:

I've just got a new job doing audit which will be really interesting. I'm hopefully going to use some of that here as well.

Witnessing the outcomes of bad practice and lack of clinical guidelines also makes volunteers aware of the role that these processes play in promoting justice for patients:

I try to look at things from another positive perspective, it makes me much more tolerant of a lot of bureaucracy because I think well at least we do have that level of protection somebody will pay attention if reported something in

the UK and that I think is right – somebody will listen and there is some system that to try and get some justice in some way

Having said that there is often a sense among volunteers that returning to the NHS will undermine their new found autonomy and weigh them down with what they view as excessive administration:

How are you feeling about returning to the NHS?

To be honest it fills me with a bit of dread, as much as things are tough here and frustrating, sometimes when you save lives here it really hits home and its more rewarding but I do miss the efficiency, but I don't want to go back to administrative paper work and that's what the NHS is heading towards. And over here I have more freedom with my ideas and back home it's a lot more structured and there's so many levels of authority and administration for someone to ok you.

The empirical data generated as part of the MOVE project supports existing literature to suggest significant and accelerated (intense) exposure to managerial and leadership skills on placement in low-resource settings. Unfortunately, the paucity of research that exists suggests that these competencies may fail to support effective knowledge mobilisation in the NHS on their return due to a lack of leadership options or systems closure. The engagement of often very early career professionals (and even students) in leadership roles often reflects the fact that volunteers find themselves to be the most senior person in the facility, or are perceived by local staff to be in such a position. This carries both opportunities and risks and raises questions about supervision and responsibility (Dowell and Merrylees 2009).

COMMUNICATION

The ability to communicate is a key skill in any and every workplace especially when dealing with customers and patients. Guidance from the Nursing and Midwifery Council (2012) identifies 'poor communication skills' as a common area of concern with regard to fitness to practice and the General Medical Council (2009) emphasises the need for 'Tomorrows Doctors' to communicate appropriately in different circumstances. These concerns are echoed in the Health Professions Council assertion that physiotherapists and psychologists should be able to communicate

effectively using both verbal and non-verbal methods and understanding the impact of culture on these. Communication is also one of the ‘6C’s’ (NHS England 2014). This document focuses on the centrality of communication in care, specifically that decisions should not be made about the patient without their consent; it also has a focus on the importance of listening.

Much of the literature describes how communication skills are enhanced during international placements (Kiernan et al. 2014). This argument centres around the development of skills to communicate with people from a different culture/country, such as overcoming language barriers, developing non-verbal communication and communicating in a culturally sensitive manner. Furthermore, the development of a generic ‘communication’ skills set is stated throughout many of the articles found in the systematic review (Jones et al. 2013; Kiernan et al. 2014; Lee et al. 2011; Norton and Marks-Maran 2014). Whilst most literature talks in general terms, some break this down into more specific learning. Norton and Marks-Maran (2014), for example, refer to the development of ‘interpersonal skills to live and work together with people of all nationalities and cultures’ and Duffy et al. suggest that simply being in a foreign culture is the most important facilitator of learning in an international environment. Clampin (2008) argues that being in another environment and outside your comfort zone forces individuals to reconsider their existing methods of communication and this results in novel approaches.

The majority of professional volunteers interviewed identified ‘communication’ amongst the key areas of learning. This embraced a range of skills including verbal and non-verbal skills and involving patients and/or colleagues. Many of the respondents had worked in countries where English is the language used at work (amongst professionals). In these cases, their learning often reflected a heightened awareness of how, even when using English, communication presents a challenge. This may reflect the type of English used or its combination with other forms of non-verbal communication. Volunteers become acutely aware of how problematic communication can be even when they share a common language:

You are developing different communication skills – different people, different cultural norms. They speak very good English but you have got to communicate in a different way to make yourself clearly understood so communication is a big thing. The knowledge and skills framework is about communication, equality and diversity – all those kind of things.

Although much of the literature emphasises communication from a health worker-patient interface, volunteers speak more about communication with other health workers in multidisciplinary and often international environments. The following volunteer uses the language of diplomacy to characterise these skills:

The non-technical skills are the most prominent thing; the interpersonal skills that you're drawing on every minute of the day trying to get things done in a diplomatic fashion.

In other cases respondents spoke of the challenges of communicating with patients through the use of translators; an experience that will be of great value on their return to the UK. In other contexts communication skills were closely aligned with leadership and negotiation skills and networking with key stakeholders outside of their disciplinary specialisms:

I've learnt about the networking thing really; approaching people in different ways, like someone who is political, you also meet him as a politician. To break that ice.

The cases above suggest an emphasis not so much on communication with patients but more on the role that professional volunteers play as knowledge intermediaries or brokers (Ackers et al. 2016) spanning the boundaries between different cadres of staff or levels of seniority or the interface between health workers and health planners and stakeholders. Peate (2008) similarly identifies the importance of communication skills for negotiation whilst Banatvala and Macklow-Smith (1997) refer to communication as affecting the ability to liaise between diverse groups. The following example illustrates these boundary spanning skills and their value to a hierarchical NHS:

I often didn't ask the name of the scrub nurse because I never thought it would be relevant to me, I never thought I'd want to know the name of the guy who's pushing the trolley in and out of corridors. But you come here and realise actually just by getting to know the cleaner which you may not do back in the UK so just building those personal, professional relationships with people can make a big difference to your outcome. I'm starting a job in a new hospital now [in the NHS] and I'm going to make a lot more effort to get to know the people I'm working with.

The relative lack of reference to their communication skills with patients may reflect the overwhelming emphasis on inter-professional relationships in many international placements rather than the fact that volunteers do not experience or learn about communicating with patients. Our ethnographic experience of working with professional volunteers suggests that the stark absence of attention to communication with patients in low-resource settings is in itself a huge learning process. In the Ugandan public health context (which needs to be differentiated from the private sector), for example, it is very usual to see no verbal communication taking place between health workers and patients or to witness verbal abuse. In that respect, volunteers are learning through the observation of bad practice and often find this aspect of learning quite stressful.

CULTURAL AWARENESS

In an increasingly diverse British society, much of the literature stresses the increasing importance of adapting to the needs of individuals from other cultures. Between 1993 and 2014 the number of foreign-born individuals living in the UK almost doubled from 7% to 13%, suggesting there is an increasing need for NHS staff to be able to best serve the needs of migrant populations. The General Medical Council's 'Tomorrows Doctors' suggests that doctors should understand the sociological factors that contribute to illness, course of disease and treatment success, including the effect of poverty (GMC 2009). The Royal College of Surgeons' 'Good Surgical Practice' suggests that encounters with patients and colleagues should be culturally sensitive and non-discriminatory. Similar commitments are expressed by the Nursing and Midwifery Council (NMC 2015). International placements provide an excellent opportunity for staff to experience other cultures and develop cultural awareness (Leather et al. 2010).

Respondents also emphasised this area of learning and its relationship with personal qualities such as patience and tolerance:

The value of working with the team, managing other people, looking at your own expectations and how you view patients and other members of staff. Taking into account other cultures, other perspectives. It broadens you as a person and it makes you more tolerant.

The reference here to patience and tolerance is very common. In the next case the volunteer nurse suggests that being out of her ‘immediate comfort zone’ will improve her empathy on return:

You come back and you are a bit more generous with your time, a bit more understanding, a bit more empathetic with people from different backgrounds. We see everybody in all walks of life in the NHS and sometimes despite all our training in equality and diversity let’s face it y’know we can have some inbuilt kind of prejudice against whatever it is and I think that it helps break those down. It makes you broader minded.

It is clear from the above that cultural knowledge, skills and attitudes are extremely important to team working and service delivery in the National Health Service. It is interesting to reflect at this juncture on the issue of cosmopolitanism and heterogeneity. The UK is in many respects far more cosmopolitan and diverse than many of the locations professional volunteers will find themselves in especially if they have experience of working in the larger multi-ethnic urban areas. Our experience as researchers on the ground would suggest that it is not so much the exposure to new cultures that precipitates the acute learning that takes place but the profound sense and experience of being an outsider themselves and reflecting on their own identity and people’s perceptions of them:

The soft skills you learn are huge and valuable because you are doing it in a different culture as the outsider, and constantly working at five different ways of asking something silly. I think those kinds of skills you don’t find [in your own culture] I can’t imagine getting them at that level in such a short period of time.

Norton and Marks-Maran (2014) describe ‘cultural awareness’ as the exploration of one’s own cultural and professional background, including recognising one’s biases, prejudices and assumptions about individuals who are different. Briscoe (2013) similarly argues that cultural sensitivity develops out of self-awareness and an ability to critically reflect; immersion in an international context may encourage a growth in self-awareness and critical thinking that underpins genuine cultural awareness. This point is illustrated in the next two cases both of which refer to communication with peers rather than patients as such. In the first case the respondent

explains how her training and experience in the UK failed to prepare her for her own experience of being an ‘outsider’:

The first half of the placement was an eye opener. Certainly in the UK you’re kind of aware of all the cultural differences and you ‘do’ equal opportunities but until you’re actually in a place where you’re the outsider, you don’t realise how much it impacts, so I’ve gained non clinical skills such as communication and cultural awareness.

In the next example the volunteer is herself a third country national employed in the NHS. She suggests that whilst her own experience as an outsider in the NHS has increased her awareness of cultural difference, she has gained in communication skills:

I am from Thailand so for me I am used to it and can integrate but I think it’s a very useful skill for people. It’s really important, in any job communication is so important and in the UK there are so many different cultures, it does help for communication.

In the next example the respondent talks about her experiences as a ‘mzungu’ (white person) in sub-Saharan Africa:

Personal skills, how to deal with the frustration. In the end it made me understand the other person more, why are they behaving like this, putting it in perspective and taking it at a pace that is more realistic and not in a ‘mzungu’ time frame instead of being upset.

Respondents’ comments about cultural awareness suggest a far deeper process than one simply of observing and learning about different cultures. Indeed, what many volunteers learn, particularly if they are able to spend some time in one location and build relationships effectively with their peers, is that cultural awareness is more than about observing difference; it is fundamentally about trying (as a privileged outsider) to understand behaviour and engage with the contextual underpinnings of that. Greatrex-White (2008) argues that the experience of being a ‘foreigner’ is underrated, and that this ‘disturbance’ affects cultural knowledge and perspectives. The following volunteer explains that she has learnt that cultural awareness involves ‘*making less assumptions about what someone’s behaviour says about their thoughts and feelings*’. This is where the

distinction between shallow forms of ‘voluntourism’ (observation of difference) which may reinforce cultural stereotypes and actually working alongside colleagues in a very different environment lies. The final case cited here recounts the experience of a British Muslim doctor:

I am more in tune with how cultural differences affect you professionally; you can’t go in there and start shouting and screaming, you need to build relationships. I always knew they were important but maybe didn’t appreciate how important. I will be a lot more in tune about how I’m making people feel because I’ve been in situations where all of a sudden I’m the foreigner.

The respondent goes on to identify some very specific scenarios where these skills could be actioned:

The way I do consent will change. I will understand when an 80-year-old grandmother who’s broken her hip and says, ‘I want to wait for my son to arrive before I sign’. Oh gosh there’s going to be a delay, why can’t this 80-year-old just say yes? We are here for her benefit and she’s delaying her own treatment. But now I think, ‘actually you know what, you should wait for your son because it’s important for you, whilst it’s important for me to give you the right treatment as soon as possible, I can see that your priority is to wait here for your son to arrive’. So I think it will influence a whole area of things; cultural awareness, family awareness, how important family is to patients.

TEACHING, RESEARCH AND PRESENTATIONAL SKILLS

There is some reference in existing research to the role that international placements play in terms of developing teaching, presentational and research skills (Banatvala and Macklow-Smith 1997; Lovett and Gidman 2011). Much of the literature regarding development of teaching skills refers to the experience of adapting existing skills to new environments, or having the opportunity to practice already established teaching skills (Jones et al. 2013). This is one component of learning that is very much a reflection of placement structure and volunteer roles and will be more evident in capacity-building interventions. Health Partnership projects, such as the SVP, funded by the Tropical Health Education Trust (THET) are focused on systems change through capacity-building. This has implied a heavy emphasis on knowledge transfer through CPD-style

interventions (Ackers et al. 2016). The SVP has attempted to shift this emphasis from formal classroom style teaching/training to encourage mentoring on the job through co-working as our research indicates greater impact on behaviour change. In this respect SVP volunteers have been explicitly characterised as knowledge intermediaries and co-researchers/teachers. In practice this thrusts volunteers into a wide variety of (co) teaching roles and research activities including

- The development of classroom teaching skills including teaching to large and diverse multi-professional audiences
- Active engagement in the development of continuing professional development often involving protocol/guidance adaptation to local circumstances and associated training to promote implementation and behaviour change
- On-the-job mentoring and supervision, often across diverse multi-professional teams
- Presentation of their work to other volunteers, professionals and policy-makers/stakeholders
- Applying for grants and designing/costing projects.

The following nurse volunteer talked about her teaching experiences:

I was asked to teach medical students – formal teaching on the special care unit on respiratory management etc. Your confidence just goes up because these are people who are training to be doctors and save people’s lives and they are seeking to learn from you. Now I know I have something to give; it gives me satisfaction.

In this case the volunteer engaged in a wide variety of knowledge transfer activities ranging from active mentoring of midwives and nurses on-the-job in a health facility, through organisation of intense CPD programmes in conjunction with a British paediatrician volunteer. She also organised the rotation of staff between facilities to optimise opportunities for learning and became involved in the formal class room teaching of medical students. It is clear from her narrative that she gained huge confidence from this. However, her interview in the UK suggested an immediate frustration as she was very aware that she would be unable to engage in these activities in her role in the NHS.

In the next case a UK obstetrician explains how the teaching components of her work stretched her previous teaching skills developing new areas of competency. It is important to note that in this context most of the clinical work in the hospital she was based in was undertaken by undergraduate nursing students on placement and medical interns (trainee doctors). In that sense she was working with health workers who are at a very active stage in their own learning:

I've used some of my teaching skills, but I've realized teaching out here is so different to the UK and a lot of the skills I have for teaching in the UK aren't applicable here. It's quite hard to engage students out here in that way because they are not used to being taught in the way I do in the UK. So I've had to adapt a lot of my teaching skills. Practically, I've done quite a lot of operating, mostly with the interns (trainee doctors) and it's really helped me with my practical tutoring, most of the time in the UK I've been teaching relatively simple operations whereas here none of the operations are simple so I've been letting them do it and that means that when they get stuck they might have made a difficult situation very difficult so then it's stretched my skills to get them out of that situation.

In another case involving a team of UK midwifery and nursing volunteers, the teaching roles formed a new and exciting component of their work that motivated her to explore new career directions:

Teaching – I guess that's been the biggest part of my four months. And I just feel really positive about that. One thing that I have got out of the teaching in terms of my own career development is that I think I would really like to go in to teaching. I really really enjoyed the teaching and we ended up teaching over 200 midwifery students. They just want to know absolutely everything that they can get from you and you feel like they really listen and engage. So from my own perspective, I think that might be something I would consider further down the line. I know I won't be a midwife for the rest of my life, I wanna do other stuff within midwifery and I didn't know I'd want to do teaching. I always thought it was something I'd never ever want to do.

Depending on a range of factors, professional volunteers will also have unique opportunities to develop as researchers engaged in evidence-based interventions (Jones et al. 2013). In the SVP context this has involved multi-lateral processes of; harnessing volunteers to support research-based interventions (two volunteers were deployed as programme evaluators);

supporting volunteers' suggestions for research-based interventions and finally working in terms to develop research initiatives proposed by Ugandan colleagues. Of course teaching and research go hand-in-hand and all those volunteers engaged in teaching will have researched the topics they are working on:

I have read up on things a lot. You have to read up well before you teach – you must know your topic. I was not doing formal teaching (in the UK) at all.

SUMMARY

This chapter has reviewed the available research and empirical data collected during the SVP and MOVE projects to summarise the key areas of learning gained from professional volunteering in low-resource settings. There can be little dispute that such placements provide fertile and unique environments for professional development in areas that are of key concern to organisations such as the UK's National Health Service and explicitly recognised in current NHS training objectives. An important theme running through the learning theories literature and echoed in respondents' experiences suggests that the learning that happens in such international contexts is informal by nature with a much greater emphasis on tacit knowledge. Marsick and Watkins describe the '*incidental learning which occurs in institutions, as not typically classroom-based or highly structured, and where control of learning rests primarily in the hands of the learner*'. Learning in these environments becomes integrated with daily routines, is triggered by internal or external jolts; a haphazard, and inductive process of reflection and action linked to the learning of others (Marsick and Volpe 1999). Of course this is precisely what makes it difficult to measure. The following chapter moves on to consider some of the costs and potential risks associated with placements and approaches to mitigating risks and structuring placements so as to optimise relevant learning.

NOTES

1. The second component of the MOVE project is focused on developing a psychometric tool to measure learning outcomes and will be reported separately.
2. www.knowledge4change.org.uk/our-projects
3. We are using the word culture here to refer to occupational culture.

4. This can be contrasted to the experiences of undergraduate mental health nurses who identified important areas of learning in relation to the side effects of drugs (Ahmed et al. 2016).
5. Positionality is defined by the Oxford English Dictionary as, ‘The occupation or adoption of a particular position in relation to others, usually with reference to issues of culture, ethnicity, or gender’.

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