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'Global' is not Just 'Out There' but also 'Right Here': Expectations and Experiences in Internationalised and Globalised Higher Education

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Abstract

This paper reports on a study that took a cross-disciplinary and cross-institutional approach to investigate postgraduate student expectations and experiences in internationalised and globalised higher education. The researchers drew on Giddens' theory of structuration. They explored the way samples of specialist medicine trainees in the UK and pre-service teacher education students in Australia identify and make meaning of their circumstances in an era that is increasingly characterised by greater internationalisation of the student body and more globalised curricula. In this paper, we discuss some of the tensions students reported encountering, and propose several ways in which such tensions might be counteracted.

Keywords: Giddens, globalisation, higher education, internationalisation, medical education, teacher education

Introduction

In recent years, higher education has increasingly become a strategic factor for economic development through not only attracting increased numbers of students but also through accessing new social and cultural groups (Altbach & Engberg, 2006). This situation has been augmented by the Bologna Process that has forced universities to confront substantial changes and challenges and subsequently rethink existing concepts of learning and teaching (European Centre for the
Development of Vocational Training, 2009). Further, many learning and teaching practices are fast becoming inadequate in meeting the needs of learners in post-traditional, globalised societies.

Developments in higher education, as in other spheres of social life, have led us away from the dependence on the local, the regional and the nation to fulfil our requirements and, in a sense, to define who we are. We now have, if not a reliance on the global sphere, then at least an acceptance that the forces that shape our lives are no longer those directly around us but those that are world-wide. Emanating from this is the sense that our lives are to an extent controlled by powers or mechanisms that are 'out there' or at a distance and we can feel weakened in the ownership of the direction of our lives. The rise of abstract systems has transformed our lives as we are being ‘propelled into a global order that no one fully understands, but which is making its effects felt upon all of us’ (Giddens, 1999, p. 1).

In order to meet the changing needs of our higher education populations, we are increasingly seeing a move to more globalised curricula and also developments in delivery modes and pedagogical techniques, such as online learning, problem based and action learning (Lombardi, 2007). A corollary of these changes in professional degrees, such as medicine and teaching, is that students and practising professionals are being brought into contact with each other in new and unprecedented ways. These changes provide the potential benefit of increased and richer collaboration between those preparing for and those practising the professions. However, they also make it incumbent upon – in the context of the current study – medical and teacher educators and workplace practitioner supervisors to explicitly clarify assumptions and often-implicit understandings about the nature of learning and the professional role. Also at the same time, practitioners are increasingly challenged as society becomes more questioning of what it means to be a professional (Shrewsbury & Mohanna, 2010). We see an increase in the drive for partnership in decision making (Edwards & Elwyn, 2009) and professionals are expected to become more reflexive, not a skill all existing practitioners will be comfortable with in their interaction with those in pre-service (Lombardi, 2007).

Unlike some other university degrees, medicine and teaching are both professions of practice wherein prospective doctors and teachers must be prepared, generally through university study and clinical practice, to become expert practitioners in their fields (National Council for Accreditation of Teacher Education, 2010; Royal College of General Practitioners, 2012). However, in our current higher education climate, as trainees move between their university and workplace training, ten-
sions can build up between the twin imperatives of the globalisation of curricula and localisation of practice, between the ways in which we educate professionals and the cultures within which they will work (Allen, 2009). These tensions are experienced differently by the neophyte as each seeks to make meaning of his/her role.

An additional difficulty accrues from differential rates of change in different settings. The transition to a post-traditional society occurs unevenly across societies and across cultures (Beck, 1992; Giddens, 2003) and learners risk being caught as they move from one model to another, experiencing things they could not anticipate and for which they find themselves ill-equipped. This situation is further exacerbated as we move towards greater internationalisation of the student body and more developed globalised curricula through, for example, online learning. Giddens (2003) makes the point that ‘globalisation is restructuring the ways in which we live, and in a very profound manner’ (p. 4) and this is becoming increasingly evident in higher education.

In this paper, we report on UK and Australian studies that investigated how cohorts of postgraduate learners in medicine and teaching identify and make meaning of their circumstances in this internationalised and globalised era of higher education. Drawing on Giddens' theory of structuration, we discuss some of the tensions students have reported encountering at a time when higher education is becoming increasingly learner-centred and pedagogical techniques are more likely to include self-directed and problem-based learning and less likely to rely on expert instruction. Our intention in focusing on reported tensions is not to present a deficit view but, rather, to point to issues around learners engaging in social conduct that medical and teaching educators might need to consider when working in the types of programs under consideration. As such, we seek to make a contribution to the international literature on professional culture and identity, workplace-based learning and the changing nature of higher education in globalised societies.

**Context**

As indicated above, the studies reported on in this paper were contextualised in medicine and teaching and were located in diverse geographical areas, namely the West Midlands of England, and Tasmania, the southern island state of Australia. Our motivation in conducting an investigation into two seemingly quite disparate programs was twofold. First, although there is a significant body of extant research into workplace-based learning in professional degrees (see, e.g., Allen & Peach, 2007; Coll & Eames, 2004), limited work has been done to date across the disciplines. We seek to contribute to filling this gap.
Second, we are interested in investigating within the international arena the evolution of professional cultures and identities as trainees transition into the workforce.

In the UK study we investigated the felt experiences of specialty trainees preparing for a career in general practice (family medicine) and for the Clinical Skills Assessment (CSA) part of the end point licensing exam, the Membership of the Royal College of General Practitioners (MRCGP). Basic medical education is generally a five-year undergraduate program in the UK that is followed by a two-year Foundation Program and then a variable length (three to seven-year) graduate training program as doctors choose their specialised discipline. International medical graduates who attain their first degrees and medical training outside of the UK may compete to enter the Foundation Program or specialty training, subject to various gate-keeping assessments (Modernising Medical Careers Applicants Guide, 2013).

Postgraduate training is workplace based with one-to-one supervision following an apprenticeship model and augmented with authentic ‘off the job’ training in small groups. The latter is characterised by a mixture of learner-led activities, which might include an audit of practice, simulated skills training, analysis of cases, and collaborative work, such as role-play. Training is continuously assessed in the workplace and also ends with an exit point assessment to complete the MRCGP. In the West Midlands, international medical graduates (IMG) make up around 48% of the postgraduate general practice training program (Royal College of General Practitioners, 2012). This is in the context of a region where 13% of usual residents were born outside the UK (Office for National Statistics, 2012). The CSA, a simulated surgery with trained role players taking the part of patients, has a high failure rate for IMGs. For those taking the CSA for the first time in 2011/12, the pass rate for UK graduates was 90.3% and only 34.7% for non-UK graduates (Royal College of General Practitioners, 2012).

The Australian program, the Master of Teaching (MTeach), is a newly developed and accredited postgraduate degree, which was implemented for the first time in 2010. The MTeach is designed to build upon tertiary qualifications and experience, enabling students to complete a teaching qualification in two years. Program delivery occurs through on-campus, mixed mode and fully online modes. The coursework and integrated field experience through practicum are intended to provide theoretical and practical opportunities that enable aspiring teachers to practise what they have learnt in supported environments. Students spend a total of 70 days in four practicum placements, which involve a university coordinator who maintains contact, generally via
email or phone, with the pre-service teacher and his/her supervising teacher in the school. School visits only occur during the third and fourth placements, unless the student is deemed at risk of failing.

The focus of the Australian research was on students who study through the fully online mode. The university that provided the context for this study is one of many Australian higher institutions that offer pre-service teacher education fully or partially online. Indeed, online learning in Australian universities is fast becoming one of the preferred delivery modes for many domestic students, with 19% of higher education students studying fully or partially online in 2010 (Australian Bureau of Statistics, 2012). However, some learners have raised concerns about how effectively the online mode prepares them for work (Howland & Moore, 2002; Smith, 2012). Identified as particular areas of concern by learners have been: the need for total self-reliance in relation to many aspects of the learning experience; feelings of isolation from peers and university teaching staff; a sense of abandonment and lack of affirmation by the lecturer or instructor; and the difficulty in building and sustaining self-confidence about their acquisition of knowledge and skills (Smith, 2012).

Theoretical Framework

The practice of both medicine and teaching are areas of social life that might best be understood through a combination of ‘big picture’ analyses of social structures and organisations, alongside seeking to understand how individuals make meaning and identity through their circumstances and endeavours locally. Giddens (1984) developed a theory of ‘structuration’ to combine both perspectives and this can be useful to frame how we understand, and thus educate for, the role of doctors and teachers in society. One of the basic premises of Giddens’ theory is that social life, on the one hand, is more than random individual acts or a mass of micro-level activity but, on the other, is not simply determined by social forces acting upon the individual agent and thus cannot be examined by only searching for macro-level explanations.

In the case of this research, we might consider there to be an implicit societal agreement of what a good doctor or teacher is and this will be both formed from and perpetuated by how doctors and teachers understand their professional role and also inform and perpetuate that understanding. It is possible, or even likely, that this societal compact will differ from one setting to another and the understanding of it from one person to another. In order to be successful in their professional roles, practitioners need to develop social identities that enable them to understand and be able to model what is required in the work setting. In
Giddens' (1984) view, social identities 'are associated with normative rights, obligations and sanctions' (p. 282) that are formed and reproduced in institutionalised practices. One of the complexities faced by those constructing new social and professional identities, such as the participants in our research, is that much of the professional conduct embedded in accepted social practice is inferential and unexpressed. Although professionals are generally able to articulate why they conduct themselves in certain ways in certain social circumstances, the need for them to rationalise their habitual behaviour in this way generally only arises when they are asked by others why they acted as they did (Giddens, 1984). In the absence of this questioning and associated discourse, a range of conventions and observances can remain unexplored by those aspiring to enter the profession. Giddens makes the case that changes within social structures wrought by globalisation can further compound the issues associated with this absence of discursive interchange.

Following Giddens' (2003) argument, it is the contention of this paper that 'globalisation isn’t only about what is 'out there', remote and far away from the individual. It is an ‘in here’ phenomenon too, influencing intimate and personal aspects of our lives’ (p. 12). Accordingly, if practitioners move locations or settings, for example, from higher education to the workplace, from training to practice, or from one country to another they are required to readjust, to make sense of new rules of engagement and, for some, to go as far as adopting a new professional identity. The readjustment and re/formation of identities and accompanying social conduct is, according to Giddens, governed by four key drivers: procedural rules, moral rules, material resources and resources of authority. These four drivers impact each other and are constantly altered through the production and reproduction of social conduct, as illustrated in Figure 1 (see appendix).

Procedural rules relate to how practices are performed within given roles. They encompass language and symbolic rules, how encounters are carried out, and working with others. Moral rules involve appropriate forms of social action and interaction through, for example, the enactment of activities and routines, and laws and regulations concerning what is acceptable and what is not. Material resources govern social conduct through the ways in which resources are allocated among activities and members of societies and social groups. The fourth driver, resources of authority, helps determine how space and time are organised and how key features of social conduct are produced and reproduced (Giddens, 1984).

In order to delimit our research for the purposes this paper, we focus
on the procedural and moral rules of professional conduct. The other two drivers (material resources and resources of authority) will be used to frame another future study. In the case of teaching, procedural rules can be exemplified in the enactment of pedagogies, classroom and behaviour management and in the ways teachers and students express themselves in language and gesture. In medicine, these might include accepted forms of history taking, examination, exploration of management options and shared decision-making. Moral rules for teachers relate to, for example, their ethical conduct with students and staff when executing the tasks that fall within the scope of their role. For doctors, these include doctor-patient confidentiality and the exhortation to 'first do no harm' (General Medical Council, 2013).

Methods

This paper reports on a comparative study drawing on data from two previously-conducted studies in a UK and an Australian university. Within our theoretical frame, the relatively large scope of each of the earlier research projects was delimited in this study to identify ways in which learners encountered tensions in negotiating their transition between the university and workplace environments. The study was thus framed by the central research question: In relation to their professional and social development and conduct, what types of tensions did participating postgraduate students encounter during their higher education programs?

In each of the original studies, purposive sampling (Cohen, Manion & Morrison, 2011) was used to select both medicine and teaching postgraduate students undertaking training for the Membership of the Royal College of General Practitioners and the MTeach respectively. Samples and numbers of participants differed between the two studies, as described below. Table 1 (see appendix) provides an overview of methods and data sources in both studies.

The UK sample was drawn from IMGs who were preparing for the CSA end-point licensing exam in their final year of training. The study was carried out between 2009 and 2011, with data collected in three phases. First, the researcher used the findings from non-participatory observations of practice of six trainees over a three-year period to inform her research questions. Observation was a weekly event for each trainee lasting for about two hours and was part of the regular training program. Second, two focus groups of eight participants were held with members of small group teaching programs running in parallel with workplace training. All those invited had agreed to participate. Third, individual semi-structured interviews were conducted with 17 IMGs, drawn from one examination diet in the West Midlands, who had been
invited to participate because they had failed the CSA (55% response rate). It is likely that these high response rates reflect the interest in the CSA arising from the differential success rates and also the desire of failing candidates to express their concerns. Data collected by focus groups and interviews were thematically analysed, with the assistance of NVivo 8 software (QSR International, 2008). Thematic analysis is an adaptation of grounded theory methodology and is a method for identifying, analysing and reporting patterns (themes) within data (Braun & Clarke, 2006).

The teacher education study was carried out in 2010 and drew on a sample of first-year domestic students studying the MTeach through online delivery, representing a sample of 122 potential participants. The researcher adopted a sequential mixed-methods approach, using an online survey instrument and follow-up interviews. The five-point Likert scale survey constituted 30 closed questions and a set of six open questions. The 26 valid responses represented a 21% response rate. Preliminary analysis of survey data was used as a basis for the design of the interview schedules, which provided the researcher with the means of further probing the key issues that had emerged (Cohen et al., 2011). Semi-structured interviews were conducted by phone with the 11 participants who had elected to be interviewed in a question inviting participation at the end of the survey. Data analysis methods included Rasch analysis of Likert scale items to generate descriptive statistics and categorical analysis of the qualitative data using Coffey and Atkinson's (1996) coding and categorical analysis techniques.

Given that findings from the survey data in the teacher education study were used to generate the themes in the subsequent interview schedule, we focus on the qualitative data only in the presentation and discussion of our findings.

**Summary of Findings**

Three major themes emerged across both data sets in relation to the professional and social development and conduct of the two cohorts of participants. These themes included: challenges in postgraduate learning; disconnect between university and workplace based learning; and workplace assimilation hurdles. Table 2 (see appendix) provides an overview of the themes and the categories of each. The tensions that we identify here emerged as the most disempowering for the cohorts of postgraduate learners under review; however, we acknowledge that some of them are not confined to the lived experience of international and online learners and can also apply to higher education students in other contexts.
All of these issues are complex and none are easy to attend to. Nevertheless, they are indicative of the types of tensions that students do, and will continue to, encounter as the forces of globalisation and internationalisation alter the structural and social environments in which they learn and work.

Having discerned these descriptive themes through analysis of the empirical data, we now interpret them through the theoretical framework of our study.

Although procedural and moral rules govern different facets of social conduct, most human endeavours, actions and interactions comprise elements of each (Giddens, 1984). This is why we discuss them as one.

**Codes of conduct**

Novices often struggle to comprehend and enact codes of professional conduct and the ‘tacitly enacted practices’ (Giddens, 1984, p. 131) inherent in them. An example in medicine that presented itself in this study was doctor-patient confidentiality, considered paramount in (as elsewhere) the UK. Unless immediate and significant harm is presented to a known third party or to the public health in the case of infectious disease, a doctor may not breach this duty of confidentiality. It is possible that societies where individualism is enacted by a person’s role in relation to the extended family that this same understanding of confidentiality may not apply. Involvement of family members in consultations and reliance on family members to break bad news to patients, for example, is nowadays unusual in the UK but may be familiar to some IMGs.

In UK medicine, a highly involved partnership model of decision-making is privileged, which some IMGs described as different from how medicine was practised ‘back home’. This seems to accord with the very limited evidence available in the literature about medical consultations outside the West. For example, a South-East Asian study reported on 393 observed consultations and concluded that, although doctors and patients stated that they valued a partnership style of communication, observation of patient contacts looking for ‘informed and shared decision making’ showed that a ‘paternalistic style’ prevailed (Claramita, Utarini, Soebono, Van Dalen & Van der Vleuten, 2011, p. 76). The style of communication privileged by the MRCGP as ‘good consulting’ has largely been derived in western settings, and doctors in the UK study, not trained in the West, found this a difficult model to adapt to:

It’s different here, the two countries are very different, the ways doctors are seen is very different. If I do the same consultation back home in
India honestly no patients would come back to me after if I ask them... ‘what do you think is wrong, what do you think might help?’ They’ll think ‘this doctor she doesn’t know anything, I won’t come back’.

Claramita, Mubarika, Nugraheni, Van Dalen and Van der Vleuten (2013) point out that adopting the partnership-style doctor patient approach generally advocated in western medicine ‘is no easy task in a culture in which communication is determined by accepted social differences and indirect communication patterns aimed at avoiding conflict and maintaining a pleasant atmosphere’ (p. 27).

An example of how pre-service teachers in this study struggled with codes of conduct was in knowing and enacting the systemic requirements of the schools in which they did their practicum. Although they reported having been taught many of the legal requirements, many still felt ill-prepared for the daily decision making around student behavioural and management issues. This type of comment is indicative:

I got to know [a student] quite well by the end of the prac. She told me one lunchtime that she’d been bullied on Facebook by some of the other girls... She begged me not to say anything but I ended up telling [the supervising teacher]. I think he was really [expletive] with me because apparently there’s mandatory reporting of, what is it, cyberbullying in that school... I was worried he’d fail me.

In several cases, trainee teachers reported ‘giving in’ because they felt incapable of grasping and enacting all that they felt was expected of them:

I’m not sure I can do this [teaching] work. I’ve tried doing some of the stuff we learned at uni but it hasn’t really worked. I really don’t think I have a handle on it at all.

Clearly, this type of apparent shortcoming, insofar as the participants reported feeling unprepared, is not confined to online programming arrangements. However, it does speak to the need for those responsible for content creation and delivery to remain vigilant of the relevancy of their programs to contemporary teaching environments, as emphasised by Darling-Hammond (2006):

Tweaking traditional programs that are organized around the fragmented and front-loaded designs adopted in the 1950s is unlikely to result in the political capital or educational momentum to allow them to become powerful exemplars of what is possible in preparing teachers for the challenges they now face. (p. 286)

One of the inherent complexities of both medicine and teaching is
that both professions involve interaction between people in unequal positions, albeit in different ways. In the case of the relationship between a patient and their doctor, the interaction is 'between people in unequal positions, often non-voluntary, often addressing vitally important issues, emotionally laden, and requiring close co-operation' (Edwards & Elwyn, 2009, p. 4). The following data excerpt epitomises the struggle IMGs reported encountering:

The problem is [back home] they see doctors as gods. If we would try to treat them like we have been taught here, they rather just want us to tell them.

Similarly, pre-service teachers reported struggling to establish the correct tenor and demeanour in their interactions with students during the practicum:

I tried to be friendly yet firm . . . but some of [the students] just wouldn't pay attention, especially some of the kids up the back. They sometimes just ignored me.

This type of reflection demonstrates the difficulty that participants faced in establishing an appropriate and respectful balance in the teacher-student relationship. Compounding the issue was the lack of 'real life' role modelling provided through online learning, leaving pre-service teachers with their supervising teacher/s as their only guide:

[The supervising teacher] just expected me to toe the line and copy what she did. But we have totally different personalities and I just couldn't copy her like some robot.

According to Giddens (1984), all social interaction is expressed within a given range of contexts and, in globalised societies, these contexts are becoming embedded increasingly in broader spectrums of space and time. Evidenced in the above indicative data extracts is the somewhat thwarted attempts of trainees to engage effectively with the institutionalised practices of the workplace. They seemed to have difficulty in 'applying an understanding of 'what is called for' in [the] given set of circumstances' (Giddens, 1984, p. 345) in which they found themselves in order to meaningfully shape their conduct to suit those circumstances.

**Social environments**

A related hurdle encountered by IMGs and pre-service teachers was in adapting to the procedural and moral rules of social conduct as they are manifested in the different settings of the university and the work-
place. For example, many of the medical trainees struggled to demonstrate that they could perform effectively in their new role when they were required to do so in a simulated university setting:

If you’re not a natural, excuse my pardon really, bullshitter or the gift of the gab sort of thing, you are going to find it hard this exam... but I just think it’s not real. I need acting skills for this. It’s not real.

As we have seen, since much of the societal compact between doctors and patients is implicit, perhaps based on tacit cultural knowledge, it might be difficult for trainers to reify that knowledge into a form that can be made visible, discussed and learned. Some IMGs certainly felt their trainers were not helping:

I am doing [medicine] in second language, with pressure of three fails on my head and all my trainer can say is ‘work on your accent’.

Training for general practice in the UK aims to cultivate a sense of curiosity in trainees about the patients’ lived experiences. This is an example of a procedural rule that may not apply equally in all societies. In the CSA, examiners will expect to see evidence that the doctor has considered the meaning of particular symptoms of the patient. However, cues to this experience in the language of the patient can go unnoted or unremarked on by some IMG trainees even when demonstrating good knowledge of the science of medicine:

*Patient*: My wife thinks I am a hypochondriac... I’ve got aches and pains all

Over... I just can’t do what people want me to do.

*IMG trainee*: Which joints are affected?... A blood test might help.

*Patient*: I am scared about Friday... They found my BP was high at the pre-op clinic for my mastectomy... They said to come and get some tablets.

*IMG trainee*: Have you got any family history of BP?... Do you get any chest pain?

It may be that some international medical graduates struggle with the CSA because it is not flexible enough to recognise different ways in which the doctor-patient relationship is performed around the world; that different cultural settings have different procedural and moral rules. In addition, the literature describes a *linguistic penalty* derived by Roberts (2010) from notions of *ethnic penalty* and *linguistic capital*
This is more than a language deficit; many IMGs know the formal language of English and may have learned medicine in English. It is about the performed, socially-bounded use of language, including familiarity with the colloquial use of English that characterises non-jargon laden conversations between equals. This linguistic penalty has been said to apply to minority applicants in oral assessment of behaviours such as interviews, oral exams and, here, a licensing practical exam. If a linguistic penalty applies for these doctors it might be said to exert a gatekeeping role (Roberts, 2010). It is possible that examiners might not even recognise the hidden drivers at play when they interpret as medical incompetence the incongruities of language and consulting style. This is derived from a lack of socialised understanding of the meaning of the doctor-patient relationship, and from a lack of informal language with which to frame explanations to patients.

The incongruities encountered by pre-service teachers were associated with the constraints of studying in an online environment in preparation for a profession defined by group and in situ social activity. In addition to the lack of 'real life' peer and expert modelling (mentioned above), participants reported a gap between the types of knowledge and skills engaged with online and the practices required for the classroom:

The only way I can study is online because I've got kids. I've done really well on all my assignments but almost failed my second prac. The [supervising] teacher wanted me to plan [lessons] her way and I'd just learned a totally different way at uni.

Many online learners expressed concern that all they did was read prescribed readings and write in online discussion boards. It seems that the reality shock of entering the classroom as a trainee teacher, long identified as a hurdle in the novitiate teaching experience (see, e.g., Kelchtermans & Ballet, 2002), may be exacerbated through online learning:

As a distance learner, I feel, well, distant! . . . I guess I'd expected magic or something . . . I certainly don't feel as prepared as I'd like.

Additionally, these indicative comments point to a gap between theory and practice, which, though prevalent since the professionalisation of teaching in the 1960s (Yayli, 2008), seems to have widened for these online learners. Giddens' theory can again be considered elucidatory here. Giddens emphasises the material conditions and the social and material environment that, in any given situation, both enable and constrain social action. In particular, he emphasises the importance of
space – how proximity or distance are mediated by technology and social structures – and time – continuity and discontinuity and the organisation of activities – in the production and reproduction of social conduct. The continued or enduring practices of social action and interaction become ‘institutions or routines, [thus] reproducing familiar forms of social life’ (Giddens, 1984, p. 131). Following Giddens’ argument, it may be that online learners have more limited opportunities than their on-campus peers to express themselves as actors and to engage in the creation and recreation of the types of recursive social activities typifying the traditional ‘face-to-face’ classroom environment.

**Conclusion**

Framed within Giddens’ (1984) theory of structuration, the study reported in this paper investigated ways in which cohorts of postgraduate medicine and teaching students identified and made meaning of their circumstances and associated social conduct in the internationalised and globalised era of higher education. Findings from the study showed that some students find it difficult to adapt to the procedural and moral rules of both the training and workplace social systems in which they studied and worked. This difficulty derives, arguably in large part, from the invisibility of a number of those rules.

The UK study revealed that overseas graduates, who have had a much shorter time than UK graduates to be socialised into western medicine, risk falling into a gap between two models of consulting (the UK model and that of their home country), which are bound by different procedural and moral rules. This might help to explain the differential success observed in postgraduate assessments. One implication for some of these trainees is in the way in which they prepare for the CSA, especially after having failed it once. Trainees typically express their understanding of what is needed to pass in terms of their previously successful study techniques. They feel the need to ‘work harder’, attend courses and read books. Our analysis here suggests that seeing a number of patients, plus interacting socially with other people in both formal and informal settings, might be more useful.

The Australian study showed that online teacher trainees identify a schism between their ways of engaging with professional learning and the ways in which they then engage in the workplace. Online learning activities and assessments are predominantly text-based and require individual application to the task while, conversely, pre-service and in-service teaching requires high levels of verbal and inter-personal skills enacted in group environments. The separation between time and space in online learning and workplace-based practice seems to limit trainees’ opportunities to develop and practise these skills. It can be
argued that, for these particular postgraduate students, the long-identified ‘theory-practice’ gap associated with pre-service teacher education has widened as they find themselves encountering numerous hurdles in enacting the procedural and moral rules of appropriate professional and social conduct in the teaching profession. There can be little doubt that the move to online learning in higher education will continue to escalate and that the onus is on educators to find ways to ensure students experience optimum authentic learning experiences in this environment. Already there are innovative practices emerging, such as online scenario role-playing. Our findings in this study suggest that more is needed.

Giddens (2003) argues that globalisation is a complex set of processes that ‘operate in a contradictory or oppositional fashion’. Globalisation ‘pull[s] away power from local communities and nations into the global arena’ (p. 13). Yet it also has an opposite effect. It ‘also pushes downwards, creating new pressures for local autonomy’ (Giddens, 2003, p. 13), which can lead to a renewal and reassertion of local social and cultural identities. It is our contention that, in adapting to the procedural and moral rules of their university and workplace institutions, trainees can become trapped in this pulling upwards and pushing downwards of globalisation. They can find themselves unable to deal adequately with the ways in which social relations exist across space and time within the duality of the structure within which they study and work. By failing to acknowledge and cater for this dichotomy, our training programs and assessments aimed at developing professionals in the workplace risk perpetuating a cultural hegemony that minimises or marginalises linguistic, cultural or epistemological diversity.

Note
1. Key Terms in this Research
‘Authentic learning’ typically focuses on real-world, complex problems and their solutions.
‘Globalisation’: we adopt Giddens’ (1990) definition, namely, ‘the intensification of worldwide social relations which link distant localities in such a way that local happenings are shaped by events occurring many miles away and vice versa’ (p. 64).
‘Internationalisation’: we employ Maringe, Foskett and Woodfield’s (2013) definition: ‘It is a developmental process through which institutions continuously seek the creation of more and more value in the global context’ (p. 11).
‘Practicum’ refers to the professional or field experience component of the pre-service program.
‘Workplace-based learning’ comprises the part of the curriculum where students learn through engagement with industry and community partners in ‘on the job’ activities that are planned for and assessed.
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from http://news.bbc.co.uk/hi/english/static/events/reith_99/week1/week1.htm


Appendix

Figure 1: Key drivers of social conduct, based on Gidden's' theory of structuration

Table 1 Overview of methods and data sources

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<th>UK study</th>
<th>Australian study</th>
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<td><strong>Research sample</strong></td>
<td>Final year IMGs in GP training</td>
<td>First-year online MTech students</td>
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<td><strong>Sample size</strong></td>
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<td>122</td>
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<td><strong>Data collection instruments</strong></td>
<td>• Observation of practice of 6 students</td>
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<td></td>
<td>• Focus groups: 2 x n=8; 100% response rate</td>
<td>• Semi-structured interview: n=11; 42% response rate</td>
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<td>• Semi-structured interview: n=17; 55% response rate</td>
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<tr>
<td><strong>Data analysis methods</strong></td>
<td>Thematic analysis of audio recorded data</td>
<td>• Rasch analysis of Likert scale survey items</td>
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<td>• Categorical analysis of qualitative data</td>
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<tr>
<td>Theme</td>
<td>Medical training</td>
<td>Categories</td>
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<tr>
<td>Challenges in postgraduate learning</td>
<td>Trainers don’t know enough about the exam or how to prepare candidates for success</td>
<td>Sense of isolation from university staff and peers can lead to demotivation during a 13-week semester</td>
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<td></td>
<td>‘Hidden agenda’ to the exam; testing perceived as discriminatory and aimed at keeping migrants out of the profession.</td>
<td>A sense of sameness and monotony in online delivery mode</td>
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<td>Disconnect between learning and practice</td>
<td>‘Flow’ and simulation: the exam is different to real practice and needs acting skills</td>
<td>Text-based online learning does not allow for modelling of best workplace practice</td>
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<td>Non-universality of shared decision making as a feature of patient-centred care - universally privileged by the RCGP, and expected in the CSA, but said not to be so, at least in the same way or to the same extent, for some patient groups</td>
<td>A gap between the knowledge and skills engaged with online and practices required for the classroom</td>
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<tr>
<td>Workplace assimilation hurdles</td>
<td>Different: • Medical practices in the UK; ‘It’s not like this back home’</td>
<td>Different teaching practices from those ‘rehearsed’ in university; not knowing the systemic requirements</td>
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<td>• Codes of doctor-patient behavioural conduct</td>
<td>Difficult to establish the correct tenor and demeanour with students; ‘They sometimes just ignored me’</td>
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<td>• Language and symbolic rules</td>
<td>Perception that in-service teaching staff expect pre-service teachers to ‘toe the line’</td>
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</tbody>
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