Breaking Borders: How Barriers to Global Mobility Hinder International Partnerships in Academic Medicine

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Abstract

This article describes the authors' personal experiences of collaborating across international borders in academic research. International collaboration in academic medicine is one of the most important ways by which research and innovation develop globally. However, the intersections among colonialism, academic medicine, and global health research have created a neocolonial narrative that perpetuates inequalities in global health partnerships. The authors critically examine the visa process as an example of a racist practice to show how the challenges of blocked mobility increase inequality and thwart research endeavors. Visas are used to limit mobility across certain borders, and this limitation hinders international collaborations in academic medicine. The authors discuss the concept of social closure and how limits to global mobility for scholars from low- and middle-income countries perpetuate a cycle of dependence on scholars who have virtually barrier-free global mobility—these scholars being mainly from high-income countries. Given the current sociopolitical milieu of increasing border controls and fears of illegal immigration, the authors' experiences expose what is at stake for academic medicine when the political sphere, focused on tightening border security, and the medical realm, striving to build international research collaborations, intersect. Creating more equitable global partnerships in research requires a shift from the current paradigm that dominates most international partnerships and causes injury to African scholars.

Imagine if every time you wanted to travel outside of your country for a research conference, you had to go through a demanding visa process. The process involves the usual documentation: applications, passports and photos, travel itineraries, and flight bookings. Add to that bank statements, income tax returns, and pay slips. Do not forget an official letter from your employer that grants you travel approval and promises that you will return to your job. But it does not end there. You also need letters proving that the institution hosting the conference has allowed or invited you to attend. The letters must be meticulously crafted because one slightly off sentence or omission could mean denial of your visa application. The denial might be for that specific conference, or it could be an indefinite denial for the host country. You feel that no matter how careful you have been, there is a strong chance that your application will be denied. Still, you apply and submit your payment—which is nonrefundable—mindful that if your visa does go through, it will have cost about 1 month of your salary. It is a discouraging scenario to imagine, but for 4 of the authors, who are from Ethiopia and Egypt, it is real.

Our experiences began when we received funding through a strategic partnership between University College London in the United Kingdom and the University of Toronto in Canada. The purpose of the grant was to identify the impacts of capacity-building collaborations in health education between Newgiza University in Egypt and University College London[1] and between Addis Ababa University in Ethiopia and the University of Toronto.[2,3] The grant would provide the opportunity for us to travel to Egypt and Ethiopia to observe how teaching and learning were cofacilitated. We would also travel to the United Kingdom for a 2-day writing retreat to develop manuscripts on the ethical engagement of international work among high-, middle-, and low-resource countries.

That was the plan. Or it was until some of us were denied temporary resident visas. Both authors from Ethiopia were denied a visa for Egypt and 1 of the 2 Egyptian authors was denied a visa for the United Kingdom. We do not wish to go down the rabbit hole of describing the global evolution of travel visas. They involve a complex system that mirrors foreign relations and international alliances through postcolonial, historical, cultural, and linguistic ties.[4] With the inequities, asymmetries, and multilayered hierarchies inherent in the process, visa denials cannot simply be traced to a global north–south divide, where southern countries fall prey to the visa requirements of northern countries. However, it is important for medical researchers who wish to collaborate with African colleagues to consider how visas are used to limit mobility across borders and how this limitation hinders international collaborations in academic medicine.

Who Enjoys Freedom of Movement?

International collaboration in academic medicine is one of the most important

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ways by which research and innovation are conceptualized, developed, and disseminated on a global scale.[5] Stable partnerships and large networks between academic institutions enable the flow of critical information among them. The past 2 decades have seen an explosion of funding and efforts to increase international health research collaborations between institutions in high-, middle-, and low-income countries.[6] Partnerships between academic institutions in high-resource countries and low- or middle-resource countries have long been considered an important means of increasing the capacity of health professional programs and medical research.[7–9]

These kinds of partnerships are important for African academics. Although Africa makes up about 15.5% of the global population, its research funding accounts for only 1.3% of global expenditures.[10] This means that African scientists must transcend the confines of that continent to be globally competitive.

When people's attempts to move beyond their geographical space are denied, they experience social closure, a process whereby 1 group monopolizes access to opportunities by closing them off to groups deemed inferior or ineligible.[11] The visa process is one such mechanism for social closure. An analysis of visa policies in more than 150 countries found that people in high-resource countries have gained global mobility, whereas the global mobility of people from African countries has stagnated or decreased.[12] When countries attempt to maintain exclusionary boundaries through the visa process, they not only monopolize opportunities for advancement but also forgo opportunities to develop equitable partnerships with scientists in low- and middle-resource countries.

While most people from high-resource countries have achieved nearly barrier-free global mobility, people in Africa are subject to a visa process that can impose restrictions on selected nationalities.[13] Visas are a tool for controlling and monopolizing the legitimate means of movement.[14] They reflect power relations by determining who is allowed to enter, who has to wait in long lines, and who is exposed to more stringent checks. The uncertainty that African scholars face when they try to obtain a visa forces a relationship of dependence. Theories of dependence have been widely used to explain global inequities. As one scholar described, "the relation of interdependence between 2 or more economies … assumes the form of dependence when some countries (the dominant ones) can expand and can be self-sustaining, while other countries (the dependent ones) can do this only as a reflection of that expansion."[15] Because medical leaders and researchers from low- and middle-income countries cannot rely on attending professional events outside their countries, they must depend on the near barrier-free mobility of their high-resource–country collaborators to reflect that expansion of knowledge.

The Visa As an Example of Institutional Racism

"Institutional racism" refers to organizational policies, practices, and procedures that intentionally or unintentionally discriminate on the basis of racialized group membership.[16] To understand the visa process as an example of institutional racism, we need to think about borders. The rise of border security measures and migration control through legislation, policy, and enforcement is a global phenomenon.[17] A noncritical approach to understanding borders would frame them as a nation's right to define its "collective identity" by restricting membership through migration controls.[18] It is socially acceptable for nations to protect borders. However, this perspective is problematic because these collective identities often rely on racialized, neocolonial, and class-based signifiers to define belonging.[19] Similarly, the visa process can become a socially acceptable means of enacting institutional racism. That is, if social closure on the basis of border protection is socially allowed, then it enables mainly high-resource countries to enact their biases and close their borders to academics from low- and middle-resource countries by citing reasons that include "overstaying," "potential asylum seekers," and "potential threats to public life as criminals or terrorists." Exclusion is rationalized by the socially acceptable reason—border protection as a nation's right to define its collective identity. This feedback loop perpetuates the exclusionary practices of the visa process.

Emotional Tax of Racism

Our experiences of the barriers to international mobility come with a personal cost. We are exhausted by the emotional tax we pay to leave our country to collaborate with our academic colleagues. By emotional tax, we mean the fear of being stereotyped, being treated unfairly, being made to feel like the "other"—setting us apart from other colleagues on the basis of some aspect of identity such as race or ethnicity.[20] African scientists and leaders experience a lifetime of marginalization and othering, which erode health and well-being.[21,22] We have come to expect bias, exclusion, and discrimination when we travel outside our countries to pursue international collaborations. We expect this treatment to continue because the visa process is embedded in the belief that certain racial groups are superior to others, which perpetuates racial inequities. These inequities cause injury to us, and when this happens, it is racist in outcome, if not in intent.

These inequities are profoundly disorienting when in your country you are considered an academic leader who champions capacity building among health professionals, and you have collaborated internationally to develop training programs in an attempt to staunch the brain drain of local talent to more developed countries. But in higher-resource countries—if we use the visa process as a proxy—you are considered dishonest at best and a potential criminal at worst. The fear that we would overstay in a foreign country is unfounded and based on racial stereotyping that hampers the development of equitable global relationships.

Moving Beyond Borders for Equitable Academic Partnerships

As medical scholars, we need to understand how racism operates in the global arena. Racism affects everyone. A big barrier to transformative change is failing to consider how inequities as unfair consequences give unearned privilege to others.[23,24] In other words, racism affords social advantages to some people to be complicit in maintaining uncritical views of our socioeconomic and political systems that perpetuate unearned privilege.[25] For those of us in Canada and the United Kingdom, working toward more equitable relationships with our Ethiopian and Egyptian colleagues requires a paradigm shift in which we reframe

our perspectives and consider our own oppression and privilege to understand the oppression and privilege of others.

Too often, academics and researchers from high-resource countries overlook the structures and systems that created and sustain inequality. We tend to underestimate how centuries of oppression, legal discrimination, and sanctioned inequality continue to hinder international collaborations for medical research and education. In his call to action around racism and health, *Lancet* editor-in-chief Richard Horton urges us to develop "equity-oriented interventions" to counter institutionalized racism.[26] We cannot ignore how the intersections among colonialism, academic medicine, and global health research have created a narrative that systematically perpetuates inequalities in global health partnerships. To create more equitable global partnerships in research, we must critically examine the visa process and how the challenges of blocked mobility increase inequality and thwart research endeavors.

We are contemplating our future collaborative opportunities amid the COVID-19 pandemic. This pandemic uprooted, upended, and disrupted health systems around the world. In response, the scope of the digital revolution ushered in by COVID-19 could transform the educational ecosystem.[27] Now that almost all national and international conferences have been moved to a virtual space, with very limited international travel for everyone, it is tempting to imagine how the pandemic might equalize access to partnerships and opportunities. However, in times of rapid change and scarce resources, egalitarian principles that promote addressing inequities are less popular than more utilitarian approaches to academic medicine.[28] Unless we challenge entrenched colonialist patterns that continue to shape the language and response to the pandemic, we risk deepening inequities in global partnerships.[29] To date, the West has largely ignored the responses and strategies that public health officials in African countries have used to successfully manage emergencies and pandemics.[30] Will the same dominant narrative be used to add yet more restrictions to the visa process when international travel resumes? Although the visa process is less of a central focus for international academic exchanges because of limited travel now, if we do not critically question the process, it has the potential to become even more restrictive when the world opens up to travel. Problematizing the effects of the visa process is an important step toward ending complacency with a system that generates and perpetuates exclusionary policies and practices within international research partnerships. But mere acknowledgment of inequities is not enough to shift from the current paradigm that dominates most international partnerships and causes injury to African scholars; rather, change requires transformative learning approaches and critical reflections that challenge deeply held beliefs and promote new attitudes and practices.[31]

We know that this essay, written by 8 authors from 3 continents, is not likely to change the visa process. However, ongoing critical reflection of processes and practices that reinforce inequities and that we take for granted is one essential step toward the decolonization of global partnerships.

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References

1 Rashid A, Gill D, Ragab L. The best of both worlds: Experiences of co-developing innovative undergraduate health care programmes in Egypt. J Med Educ Curric Dev. 2019;6:2382120519885122.
2 Alem A, Pain C, Araya M, Hodges BD. Co-creating a psychiatric resident program with Ethiopians, for Ethiopians, in Ethiopia: The Toronto Addis Ababa Psychiatry Project (TAAPP). Acad Psychiatry. 2010;34:424–432.
3 Whitehead C, Wondimagegn D, Baheretibeb Y, Hodges B. The international partner as invited guest: Beyond colonial and import-export models of medical education. Acad Med. 2018;93:1760–1763.
4 Czaika M, de Haas H, Villares-Varela M. The global evolution of travel visa regimes. Popul Dev Rev. 2018;44:589–622.
5 Godoy-Ruiz P, Cole DC, Lenters L, McKenzie K. Developing collaborative approaches to international research: Perspectives of new global health researchers. Glob Public Health. 2016;11:253–275.
6 Institute for Health Metrics and Evaluation. Financing Global Health 2013: Transition in an Age of Austerity. Seattle, WA: Institute for Health Metrics and Evaluation; 2014.
7 Tache S, Kaaya E, Omer S, et al. University partnership to address the shortage of healthcare professionals in Africa. Glob Public Health. 2008;3:137–148.
8 Whitworth JAG, Kokwaro G, Kinyanjui S, et al. Strengthening capacity for health research in Africa. Lancet. 2008;372:1590–1593.
9 Frenk J, Chen L, Bhutta ZA, et al. Health professionals for a new century: Transforming education to strengthen health systems in an interdependent world. Lancet. 2010;376:1923–1958.
10 United Nations Educational, Scientific and Cultural Organization. UNESCO Science Report: Towards 2030. http://uis.unesco.org/sites/default/files/documents/unesco-science-report-towards-2030-part1.pdf. Published 2015. Accessed March 23, 2020.
11 Murphy R. Social Closure: The Theory of Monopolization and Exclusion. Oxford, UK: Clarendon Press; 1988.
12 Mau S, Gülzau F, Laube L, Zaun N. The global mobility divide: How visa policies have evolved over time. J Ethn Migr Stud. 2015;41:1192–1213.
13 Czaika M, de Haas H. The effect of visas on migration processes. Int Migr Rev. 2017;51:893–926.
14 Torpey J. Coming and going: On the state monopolization of the legitimate means of movement. Sociol Theory. 1998;16:239–259.
15 Dos Santos T. The structure of dependence. Am Econ Rev. 1970;60:231–236.
16 Bailey ZD, Krieger N, Agénor M, Graves J, Linos N, Bassett MT. Structural racism and health inequities in the USA: Evidence and interventions. Lancet. 2017;389:1453–1463.
17 Vollmer B. Policy Discourses on Irregular Migration in Germany and the United Kingdom. Basingstoke, UK: Palgrave Macmillan; 2014.

18 Walzer M. Spheres of Justice: A Defense of Pluralism and Equality. New York, NY: Basic Books; 1983.
19 Bauder H. The possibilities of open and no borders. Soc Justice. 2014;39:76–96.
20 Travis, DJ, Thorpe-Moscon J. Day-to-Day Experiences of Emotional Tax Among Women and Men of Color in the Workplace. https://www.catalyst.org/wp-content/uploads/2019/02/emotionaltax.pdf. Published 2019. Accessed March 23, 2020.
21 Hamblin J. Why succeeding against the odds can make you sick. The New York Times. https://www.nytimes.com/2017/01/27/opinion/sunday/why-succeeding-against-the-odds-can-make-you-sick.html. Published January 27, 2017. Accessed March 23, 2020.
22 CBC News. African visitors least likely to obtain Canadian visas. CBC News. https://www.cbc.ca/news/canada/ottawa/canada-s-temporary-visa-approval-rate-lowest-for-african-travellers-1.5369830. Published November 26, 2019. Accessed July 5, 2021.
23 Nixon SA. The coin model of privilege and critical allyship: Implications for health. BMC Public Health. 2019;19:1637.
24 Corneau S, Stergiopoulos V. More than being against it: Anti-racism and anti-oppression in mental health services. Transcult Psychiatry. 2012;49:261–282.
25 Hardeman RR, Medina EM, Kozhimannil KB. Structural racism and supporting black lives—The role of health professionals. N Engl J Med. 2016;375:2113–2115.
26 Horton, R. Offline: Racism—The pathology we choose to ignore. Lancet. 2017;390:14.
27 Keesara S, Jonas A, Schulman K. Covid-19 and health care's digital revolution. N Engl J Med. 2020;382:e82.
28 Thakur A, Soklaridis S, Crawford A, Mulsant B, Sockalingam S. Using rapid design thinking to overcome COVID-19 challenges in medical education. Acad Med. 2021;96:56–61.
29 Büyüm AM, Kenney C, Koris A, et al. Decolonising global health: If not now, when? BMJ Glob Health. 2020;5:e003394.
30 Estifanos AS, Alemu G, Negussie S, et al. 'I exist because of we': Shielding as a communal ethic of maintaining social bonds during the COVID-19 response in Ethiopia. BMJ Glob Health. 2020;5:e003204.
31 Eichbaum QG, Adams LV, Evert J, Ho MJ, Semali IA, van Schalkwyk SC. Decolonizing global health education: Rethinking institutional partnerships and approaches. Acad Med. 2021;96:329–335.

Teaching and Learning Moments
In a Box

As I took my hair out of the elastic band, I noticed a flicker of something bright. I investigated further and my suspicions were confirmed: It was my first gray hair. Declaring this a significant finding may seem vain, but the discovery made me pause—this single strand of hair represented my last year of clinical training.

I was an anesthesiology critical care fellow in the midst of Boston's COVID-19 surge. Ultimately, I worked a lot of extra shifts and bore witness to the devastation that the virus had on individuals and their families. Despite this, I rarely cried.

After Boston's surge, I transitioned into the role of attending without a second thought. Recently, I watched a video diary of 2 intensivists sharing their experiences in New York City at the peak of the pandemic. Within moments of hearing their account of the physical and emotional toll their experiences had on them, I felt uncomfortable. I felt dyspneic as a whirlwind of emotions descended.

At the beginning of the surge, I was scared. I was not sure if my personal protective equipment was adequate, so I entered a minefield each day, feeling completely naked. The invisible enemy taunted me with every breathing tube I placed. Then I was heartbroken. Most of my patients were immigrants trying to live the American dream, only to become infected from workplace exposures. With every call I made to their family members, I could not help but think that my patients could have easily been my mom or dad—who never took a day off from work in their determination to make a better life for me. Darkness quickly followed. Even when I could see and feel the sun on my skin, I felt betrayed by the crowds and ongoing gatherings of people who were oblivious to the catastrophe hidden within the confines of our hospital. And finally, guilt. I felt guilty taking in a breath of fresh air when so many others could not. I felt guilty for not being able to help all my patients. I felt guilty for being alive.

Around the time of watching the video diary, one of my co-fellows reached out through our group chat to ask if any of us felt like we had posttraumatic stress disorder (PTSD) from our COVID-19 surge experiences. I read the question and dismissed it. But as I watched the video diary and felt convulsions of emotion pouring out from my soul, I realized I never processed what I witnessed, experienced, and lived through. I put it all in a box so I could keep going to work. I sealed the box so that nothing could escape and distract me from the mission at hand: caring for critically ill patients.

With time, I noticed certain triggers would poke holes into my box. Watching the video diary and reliving moments of fear, anxiety, and despair caused by caring for someone's mother, sister, or daughter ripped open that box. Now when I am triggered, I let these feelings wash over me. I have started my healing process by reflecting upon the intimate moments I witnessed. With time, I have acknowledged my survivor's guilt, instituted a gratitude practice, and allowed for self-compassion. Healing my battle wounds has required solitude and time away from the hospital—a luxury I now have as an attending that rarely exists for trainees.

Trainees who were thrust into the heat of battle during the surge are now tending to their emotional battle wounds. Each of us is processing the trauma differently. As casualties of COVID-19 continue to rise, I implore our educational and hospital leadership to allow for the unpacking of these metaphorical boxes in a safe way. Some trainees may experience PTSD, and others—like myself—may have boxed everything up and never had a chance to unpack it through reflection in a safe, supported space. Merely encouraging the use of employee assistance programs is not enough; offering staff nonclinical time to reflect and debrief individually, with peers, and with program leadership allows those who need it to tend to battle wounds and allows them to face the next battle with a new set of tools to protect vulnerable learners.

I am healing now, but each time I see the glimmer of light in my dark waves of hair, I am reminded of the need to unpack.

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