Social Science & Medicine 67 (2008) 1924–1933

Contents lists available at ScienceDirect

Social Science & Medicine

journal homepage: www.elsevier.com/locate/socscimed

# International return mobility, learning and knowledge transfer: A case study of Slovak doctors☆

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ARTICLE INFO

*Article history:*
Available online 8 October 2008

*Keywords:*
Slovakia
Doctors
Mobility
Return migration
Knowledge transfer
Learning
Medical profession

ABSTRACT

International mobility provides opportunities for learning and knowledge transfer by health care workers, with significant potential benefits for countries of destination and, in the case of returned migration, countries of origin. This is examined using a typology that recognizes four types of tacit knowledge: embrained, embodied, embedded, and encultured. There are, however, constraints to learning and knowledge transfer in the form of professional and social recognition as well as language barriers and power relationships. These theoretical ideas are explored through a case study of internationally mobile Slovak doctors after their return to Slovakia. Individual learning and knowledge sharing with colleagues, both abroad and after return, are analysed through in-depth interviews.



## Introduction

'Health worker migration is an inescapable feature of the health sector' (Bach, 2003, p. 31) but there has been relatively little research of mobility as a conduit for learning and knowledge transfer. The research deficit is particularly marked for returned migrants, an increasingly important group both because of growing mobility, and shifts to more cyclical (King, 2002) mobility – but see Brown and Connell (2004). Their experiences pose questions about the multi-directional nature of learning and knowledge transfer both while abroad and on return.

The traditional starting point for analysing knowledge is Polanyi's (1966) distinction between codified and tacit knowledge, but Blackler's (2002) typology provides a more nuanced perspective, identifying four types of tacit knowledge: embrained, embodied, encultured and embedded. These also accord with the complex mixture of knowledge – a combination of technical, managerial and cultural – required of doctors.

The paper also seeks to broaden understanding of the geographical range of cycles of health care mobility. The research literature has largely focussed on migration from less developed to advanced capitalist economies (DRCMGP, 2006). However, despite significant cultural and linguistic barriers amongst European countries (Jinks, 2000), EU enlargement and mutual recognition of qualifications have facilitated substantial flows of health care workers, especially from pre 1989 state socialist countries, to Western European countries (Bach, 2003). Slovakia provides a case study of these new forms of mobility (see Baláž, Williams, & Kollar, 2004). There is probably greater external recognition of the knowledge of doctors from Slovakia – which has relatively well-developed health services – than for doctors from less developed countries, yet their experiences do illustrate the complexities and asymmetries of medical knowledge transfer.

The transfer of medical knowledge via mobility is not an exercise in unfettered learning and knowledge transactions but – as with all workers – is mediated by multi-level

☆ Allan Williams was supported by a British Academy Readership, 2004–2006, in undertaking this research.

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doi:10.1016/j.socscimed.2008.09.003

regulations, institutions and practices (Williams & Baláž, 2008). There are well structured and asymmetrical channels for mobility (determined by wage differentials, scholarships, and discourses about the location of 'advanced' knowledge) which bring medical workers from 'less' to 'more' developed health care systems, with very little mobility in the opposite direction. This strongly mediates resulting knowledge transactions – inward movers are seen as coming to learn, rather than to co-learn let alone to transfer knowledge. It also poses questions about the extent to which medical knowledge is transferable across borders by returnees.

The paper first explores key issues relating to health care migration and the conceptualisation of knowledge transfer via mobility, and then outlines key features of the Slovak health services and our methodology. It then considers the migrants' learning and knowledge transfer experiences abroad, and their experiences of knowledge transfer on return, drawing on 24 in-depth interviews with returnees and hospital managers. The sample size means the findings should be considered as a case study that illustrates some of the complexities, as well as the unfulfilled potential, of migration and medical knowledge transfer.

## Health care migration and knowledge transfer

International migration of health care workers is well established, and in the 1970s an estimated 6% of doctors worked abroad (Meija, Pizurki, & Royston, 1979). However, health care labour markets have become increasingly internationalised (see Buchan & Dovlo, 2004, p. 271 on the UK) for several reasons, including enhanced electronic communication and job applications, targeted recruitment drives, and the need for international mobility to meet short-term recruitment shortages, given time lags in expanding medical training (Stilwell et al., 2004). We know far less about returned migration by health care workers, not least because the distinction between temporary and permanent migration is often blurred (Chanda, 2002). However, generic migration studies have highlighted the growth of temporary migration (Dustmann & Weiss, 2007).

High levels of international mobility provide a potentially significant conduit of learning and knowledge transfer. This paper focuses on four different types of knowledge, identified by Blackler (2002), drawing especially on his earlier work and that of Zuboff (1988), Berger and Luckmann (1966), and Brown and Duguid (1991):

- *embrained* knowledge, which depends on conceptual skills and cognitive abilities, allows recognition of underlying patterns, and reflection on these. For mobile doctors, this may include classroom and library-based learning in more advanced medical institutes;
- *embodied* knowledge results from practical thinking and learning by doing, being rooted in specific contexts, physical presence, and sensory information. This may include learning from observation at, or participation in, particular health care events, such as surgical procedures or consultations;
- *encultured* knowledge emphasizes that meanings are shared understandings, arising from socialization and acculturation. This involves learning about different values and approaches to health care, whether by doctors, other health care professionals or patients;
- *embedded* knowledge is embedded in contextual factors, including shared knowledge generated in different organizational cultures and work groups. This includes learning about different health care systems, and contrasting organizational approaches to health care.

This typology is particularly appropriate in studying health care mobility because it recognizes the range of knowledge required of doctors: technical skills, academic knowledge, cultural knowledge, management know-how and administrative skills.

The question is whether migration and mobility provide a *selective* and/or *distinctive* conduit for learning and knowledge transfer. As argued elsewhere (Williams, 2007b), embrained and embodied knowledge are encapsulated in the individual, and are transferable via international migration. Of course, such knowledge can also be transferred electronically, but physical co-presence is useful, and probably necessary, for transferring some knowledge, such as 'learning by observation' or 'learning by participation' at a consultation. In contrast, encultured and embedded knowledge are place specific, being forms of socially situated knowledge and institutionally specific. They are grounded in relationships between individuals, in particular settings and in socialization processes. The lack of shared meanings, with those working outside these settings, constrains the transfer of such knowledge via human mobility. However, migrants can transfer truncated encultured and embedded knowledge, which can be discussed with others, even if they lack fully shared understanding. Moreover, knowledge of different systems and cultures increases migrants' potential for reflexivity – comparing and contrasting – in new settings. Returned migrants, depending on length of absence, already possess substantial encultured and embedded knowledge of the return setting.

The key question is whether internationally mobile doctors have potential to learn and transfer knowledge different to that available in the origin or the return setting. There are three issues here. First, mobile doctors may have opportunities to learn different techniques or approaches in some countries – because of differences in what constitutes relevant medical knowledge, or time lags in international dissemination of medical knowledge. The internet and increasing numbers of conferences mean there are other ways of acquiring knowledge, but sometimes – for example, embodied knowledge – this requires co-presence. Secondly, migrants have distinctive opportunities for what Marsick and O'Neil (1999, p. 163) term the Critical Reflection School of Action Learning: 'Critical reflection can also go beyond the individual participant's underlying assumptions and can lead specifically to the examination of organizational norms'. This has particular relevance for embedded and encultured knowledge. Thirdly, there are opportunities as potential boundary spanners, because boundaries (here understood as national borders) are 'areas