



**Supporting the Transition of International Students into Caribbean Offshore
Medical Schools:
A Phased, Theory-Informed Model Grounded in Collective Faculty Experience**

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Abstract

Phenomenon: Caribbean offshore medical schools (OCMS) enroll substantial numbers of international students, predominantly from North America, who experience a physically, academically, socially, and culturally complex transition at entry. Existing medical education literature on student transition focuses largely on domestic students in their home countries. In contrast, evidence concerning transition into OCMS remains extremely limited, and institutional practice across the region appear inconsistent and unevenly developed. Attrition rates at some OCMS range from 40 to 70 per cent, a pattern that should be interpreted not solely because of student selection processes, but also as indicative of shortcomings in institutional support structures. Although most students adapt successfully, a subset encounters preventable difficulties that may be mitigated through more intentionally designed and comprehensive support systems.

Argument: Drawing on established transition models (Bridges; Bean and Eaton; Menzies and Baron), social cognitive theory (Bandura), recent systematic evidence on peer mentoring (Gehreke et al., 2024), and the collective experience of the authoring group, we argue that OCMS should implement a structured and longitudinal transition support model extending from pre-arrival through the first two years of medical training. The authoring group comprises physicians and academics from India, Nepal and the Philippines, who trained and practiced in their own countries as well as China, Africa and the United States, now working in the Caribbean as medical educators, thereby contributing insights grounded in both international student experience and institutional practice. We propose a four-phase model of transition support consisting of pre-arrival preparation, induction, early embedding, and ongoing developmental support. Within each phase, the specific transition competencies should address general and social self-efficacy, self-directed learning, and reflective practice.

Implications: The proposed model is intended as a practical framework any OCMS can modify according to the local resources, rather than as a research-validated intervention. Its most useful function may be diagnostic; it prompts an institution to ask which phases it currently supports well, and which it does not. We describe the gaps we see within our own institutions' existing provisions, outline measures that have been implemented in response, and consider what a meaningful research agenda for OCMS transition might look like.

Keywords: student transition; Caribbean medical education; offshore medical schools; international medical students; self-efficacy; academic advising; reflective practice; peer mentoring; induction.

Introduction

The transition into medical school is widely recognized as academically and personally demanding. The transition into a Caribbean offshore medical school (OCMS), for international students, mostly from North America, is often intensified by the additional demands of relocation and cultural adjustment. Students arrive fatigued from long-distance travel, carrying more luggage than they can reasonably manage, on an island they have seen only in brochures, in a climate most have not experienced, in a curriculum many will find unfamiliar, and often without a single person they already know. Some will not return home for several months or even years. Although the majority will do reasonably well, a significant minority will struggle in ways that a better-designed transition support structure might mitigate.

Collectively, we have worked in this educational context for over a decade. Between the authors, we teach across the basic medical sciences, serve as faculty academic advisors, and include authorship of the Student Academic Support Programme handbook currently used at one of the OCMS (Shetty, 2019). Before coming to the Caribbean, we trained and practiced in clinical and academic settings across different countries, in disciplines ranging from anatomy, pharmacology, microbiology, pathology, emergency medicine and oncology. We arrived in faculty roles much as our students arrive on the island: as individuals being asked to do a job in an environment we did not yet understand, in a country whose culture, climate, and rhythms of daily life were new to us. That experience of international relocation, of being an outsider who needed to figure out how a place functions before being able to function within it, has shaped our perceptions about student transition. As such, our perspective on transition is informed not only by observation and institutional practice, but also by lived experience.

This paper presents a phased, theory-informed model for supporting student transition into OCMS. It is not intended as a research report, but as a scholarly commentary, grounded in the existing transition literature and extensive practical experience, on what works, what does not, and what the region needs next. We propose this framework in response to three interrelated concerns: the relative scarcity of scholarly literature addressing transition within OCMS; the persistently high attrition rates reported at some institutions; and the need for educators working within these environments to contribute systematically to the documentation, analysis, and improvement of student transition practices.

Why OCMS Transitions Are Distinct

OCMS emerged as a viable pathway for students, mainly from the United States and Canada, who were unable to secure admission to medical programme in their home countries (Boulet et al. 2007). With average acceptance rates at US medical schools below 6 per cent, and Canadian programme similarly competitive, the demand for offshore alternatives appears structurally entrenched (WES, 2024). Consequently, the student body at OCMS is international, heterogeneous, and often carries the emotional weight of being a “second chance” cohort. The institutional setting is typically an island in the Caribbean, novel for most students and structurally different from a North American university town in ways that are not obvious until arrival. Housing, transport, food, climate, healthcare access, the social environment are all unfamiliar. OCMS also advertise aggressively to an anxious applicant pool, which causes students’ pre-arrival expectations to sometimes be shaped more by marketing information than by realistic preparation for the demands of transition (Hodges et al., 2017).

Three features distinguish OCMS transitions from those described in the broader higher-education literature. First, the physical transition is a genuine international relocation, not a move within the same country. Second, the academic environment is a medical curriculum, typically competency-based and active-learning oriented, that is unfamiliar to students whose pre-medical experience might have been primarily lecture- and examination-dominated. Recent research confirms that first-year medical students frequently struggle to shift from passive to self-directed learning, with one meta-analysis reporting that 63 per cent experiencing significant adaptation difficulties in the initial year of study (Manuaba et al., 2022). Third, the emotional context is distinctive: many students have experienced at least one cycle of rejection from a home-country program and carry that emotional burden alongside the financial debt of offshore tuition.

There is a fourth feature we feel remains insufficiently acknowledged within the literature. As faculty who have us relocated internationally to work in this setting, we recognize the challenges that students face during transition are not entirely different in kind from those facing a new educator arriving from another country and culture. The scale and stakes are different, but the experience of landing in an unfamiliar environment and having to build competence, social connection, and a sense of belonging from scratch is genuinely shared. We raise this concern, not to draw false equivalence but because it informs how we advise: we know something about what it takes to settle into a place that is not yet yours. Our perspective is therefore informed not only by educational theory and institutional practice, but also by lived experience of adaptation within the Caribbean context.

Attrition rates across the OCMS sector remain concerningly high. Figures of 40 to 70 per cent have been reported at larger institutions; smaller schools report rates closer to 10 to 15 per cent (TSOM, 2024). The causes are multiple, academic, financial, personal, but a proportion of early attrition is attributable to inadequate transition support rather than to student ability. Some students who might otherwise have succeeded, leave medical school because they are insufficiently supported during the critical early stages of adjustment. This represents not only a significant educational concern but is both an ethical failure and a substantial financial harm to individuals who incur substantial debt to pursue their dream of becoming a doctor.

The published scholarly literature on what happens to students during OCMS entry remains notably limited. Existing research on OCMS has focused heavily on graduate outcomes, USMLE performance, residency match rates, subsequent practice patterns (van Zanten and Boulet, 2013), with comparatively little attention to the experience of entering and adapting to the OCMS environment. Searches across major medical education databases for studies on OCMS transition, induction, or first-year student experience reveal very few studies examining transition, induction, or first-year student experiences within offshore medical schools. This represents a substantial literature gap that educators working within the region are best placed to address.

What the Transition Literature Contributes

Several models from the broader higher-education literature help frame what happens during an OCMS entry, even though none was developed with the offshore medical education context specifically in mind.

Bridges' (2011) three-phase transition model (ending, neutral zone, new beginning) describes the psychological structure of almost any significant life transition and maps onto the student journey well. The U-curve model of cultural adjustment (Risquez et al., 2008) adds an important insight: the emotional trajectory of a transition is not monotonic. Students often feel worse in weeks four to eight than on arrival, especially once the novelty has faded and the academic load has risen. We observe this regularly in advising conversations, and it is worth naming to students explicitly, so they are not surprised by it. Menzies and Baron's (2014) five-phase extension, developed specifically for international students, captures this fluctuating mood more accurately.

Bean and Eaton's (2002) psychological model of retention links academic and social integration to persistence, which matters considerably in an OCMS setting where early departure is expensive for everyone involved. At one OCMS, for example, peer support and early acclimatization are facilitated through pre-assigned small groups known as PODs (Plan, Observe, Debrief).

Each POD consists of approximately five to six students and meets weekly with an assigned faculty mentor. Although participation is mandatory, sessions are intentionally conducted within an informal and supportive environment designed to promote open discussion, reflection, and interpersonal connection. The POD structure enables students to establish rapport with peers at an early stage of training, develop supportive social networks, share experiences and transitional challenges, and engage in collaborative learning through peer exchange and guided faculty mentorship. Such initiatives may play an important role in fostering social integration, reducing isolation, and supporting adjustment during the initial stages of entry into the OCMS environment.

Running through all these models is a concept worth paying close attention to self-efficacy. Bandura (1977) defines self-efficacy as a person's belief in their capacity to perform a given task. Within the transition process, it is not one thing. There is general self-efficacy (can I cope with this at all?), social self-efficacy (can I make friends and navigate relationships here?), and academic self-efficacy (can I succeed in this curriculum?). Each matter at a different phase. Each can be supported or undermined by what an institution chooses to do.

Peer mentoring has accumulated a solid evidence base in the transition support literature. A 2024 systematic review by Gehreke et al. found it to be effective across outcomes including social and academic integration, dropout intention, and sense of belonging, with face-to-face delivery producing stronger gains in self-efficacy and psychological support than digital alternatives. This finding matters particularly for OCMS, where geographic isolation makes structured peer connection from the very first week, a genuine requirement for students rather than something that is nice-to-have. A 2025 review by Pereira et al. goes further, identifying program elements that most reliably reduce dropout, giving institutions a practical checklist rather than a vague recommendation.

The literature on self-directed learning (SDL) in medical education points towards similar conclusions. An early transition into an integrated, active-learning curriculum, which is now standard at most OCMS, requires study strategies that most incoming students have simply not had to develop yet. Boyd et al. (2022), evaluating an SRL intervention at Harvard Medical School, found that explicit early coaching in self-regulated learning strategies produced significant improvements in students' intended use of those strategies. SDL skills can be taught at induction, and given the evidence, there is no good reason not to teach them.

A Phased Support Model

The model proposed here comprises four interconnected phases of transition support. The first three phases are informed by established transition and student adjustment literature, while the fourth reflects the practical reality that adaptation to medical school extends well beyond the initial orientation period. Transition into an OCMS is not a discrete event completed during induction week, but an extended developmental process that unfolds over time as students negotiate academic, social, cultural, and personal adjustment. Accordingly, institutional support should not terminate abruptly following orientation, but instead diminish gradually as students develop increasing confidence, competence, and independence within the new environment.

Phase	When	What most students need	Who delivers it
1. Pre-arrival	6 to 8 weeks before arrival	Realistic expectations about the island, accommodation, climate, food, immigration, and day-to-day logistics. First human contact with a real person, not just a form email. Short videos from current students narrating their own first weeks.	Student affairs staff; current-student video series; one optional live webinar with staff and two or three current students.
2. Induction	Week 1 to end of month 1	Orientation to the physical environment; structured early socialisation; introduction to active-learning methods; assignment of peer mentor and faculty advisor; explicit orientation to academic culture and the assessment calendar; clear signposting of where to go if things go wrong.	Welcome committee (near-peers, faculty, local guide); student affairs; introductory curriculum session; academic advising office.
3. Early embedding	Months 2 to 6	Coaching in self-directed and self-regulated learning; reflective practice introduced and scaffolded; support through the first summative assessment cycle; continued mentorship; routine advisor check-ins.	Academic advising; reflective portfolio embedded in curriculum; near-peer mentors in a structured (not optional) role; counselling on referral.
4. Ongoing	Terms 2 to 4	Scaled-back but sustained advisor contact; attention to cohort-level issues surfacing through feedback surveys; proactive outreach to academically at-risk students.	Academic advising office; curriculum committee; student support services.

Table 1. A four-phase support model for international student transition into an OCMS.

Table 2 sets out the core transition competencies the model should develop, why they matter in this context, and what the literature and direct experience suggest for developing them.

Transition competency	Why it matters in this context	How to develop it
General self-efficacy	Students arrive at a moment of maximum self-doubt: in a place most have never seen, often far from anyone they know, sometimes carrying the memory of prior rejection. Belief in one's capacity to cope is the single most consistent predictor of early persistence.	Pre-arrival videos featuring current students narrating their first weeks; early, achievable academic wins; explicit acknowledgement of what students have already overcome to reach this point.
Social self-efficacy	Isolation is the most common theme in informal student feedback during Term 1. Students with stronger early social connections report less anxiety, less depression, better attendance, and better marks. The association between social isolation and psychological distress is well documented (Wei et al. 2005).	Structured social events in the first two weeks; near-peer mentoring with clear, assigned contact rather than passive availability; small-group learning from week one; student clubs actively promoted.
Self-directed learning	The curriculum is active, integrated, and demanding. Students who arrive expecting lecture-based rote learning often struggle in the first module. Studies show 63 per cent of first-year medical students have significant difficulty adapting to self-directed curricula (Manuaba et al. 2022), and early structured SDL coaching produces measurable improvements in learning strategy use (Boyd et al. 2022).	An explicit workshop on how to study in this curriculum, delivered at the start of induction; coaching in retrieval practice, interleaving, and time management; an honest conversation about the difference between pre-med study habits and what medical school requires.
Reflective practice	Students who adapt fastest are those who can step back and describe, even briefly, what is happening to them. This meta-cognitive skill is predictive of resilience, and it can be taught.	A structured reflective journal embedded in the curriculum rather than bolted onto it; scheduled reflective conversations with academic advisors; faculty modelling of reflection in supervision settings.

Table 2. Core transition competencies and approaches to developing them

Phase 1: Pre-Arrival

The transition process begins well before the student boards the plane. Pre-arrival support has two functions: reducing avoidable uncertainty and making the institution's first human contact a warm one rather than an administrative one. Short videos from current students, describing what they wish they had known, what turned out to be fine, what was genuinely hard, do more for incoming student confidence than any official brochure. Bean and Eaton (2002) place general self-efficacy at the heart of pre-transition preparation, and Bandura's (1977) work on vicarious learning tells us why: hearing another student say, "I was scared, and I coped" is simply more effective than hearing a staff member say, "don't worry, you'll be fine."

A single optional live webinar six weeks before arrival, run by student affairs staff and two or three current students, answers more real questions than any written FAQ. It also tells incoming students that there is a human being on the other end, which matters more than its brevity suggests. One thing the webinar should not do is sanitize the experience. Research on OCMS website messaging finds that these schools already oversell and under-prepare (Hodges et al. 2017), so pre-arrival support is the first real opportunity to close that gap rather than widen it. We would also suggest that faculty involvement in these pre-arrival contacts, even briefly, signals to incoming students that the educators who will teach them are genuinely interested in their arrival, not only their tuition fees.

Phase 2: Induction

Whatever is done in the pre-arrival phase, the first two weeks on the island will still be a shock. In our own experiences relocating from other countries to assume faculty roles within OCMS, the process of adjustment involved navigating unfamiliar climates, food systems, social norms, and institutional cultures while simultaneously attempting to perform competently in demanding professional roles. We refer to these experiences not to center faculty perspective but because they informed a shared conviction: a good induction does not spare people from disorientation. It gives them the tools and the company to move through it.

Physical orientation is usually done well enough: campus tours, housing allocation, a supermarket visit, help opening a bank account. Social connection is harder and is more often done poorly. Structured, low-stakes social events in the first two weeks matter more than their casual appearance suggests. Pederson (1991) and Moores and Popadiuk (2011) both identify early friendship formation as the strongest protective factor against the mental health consequences of international student transition, and students who have not started forming a peer network by the end of week two are at measurably higher risk.

Gehreke et al.'s (2024) systematic review confirms that the effect is strongest when peer mentoring is structured and assigned: passive opt-in programme produces weaker gains than ones where students are simply matched and expected to meet.

The academic component of induction is where most OCMS programme are weakest, in our collective experience across advising, teaching, and curriculum roles. A half-day workshop on how the curriculum works would spare many first-term students a great deal of distress. What will active learning sessions feel like? What does independent study have to look like in medical school? When are the summative assessments and how do they build on each other? Briggs et al. (2012) and Christie et al. (2013) both identify the transition to self-directed learning as one of the hardest parts of higher-education entry; the medical school version is particularly unforgiving because the content load is heavy, and the first module arrives fast. Boyd et al. (2022) showed that even a brief SRL-focused session at the start of the year raised students' intended use of effective study strategies by a statistically significant margin. There is no compelling reason OCMS programme should not do the same.

Phase 3: Early Embedding

Induction ends, teaching begins in earnest, and the first round of summative assessments approaches. This is the point at which the cultural-adjustment U-curve bottoms out (Risque et al. 2008). Students who seemed settled in week two can be struggling by week six. The institutional response at this phase needs to be low-key but consistent: routine advisor check-ins, a peer mentor who is reachable without the student having to initiate, scheduled reflective conversations, and a visible route to counselling for those who need it.

A structured reflective journal, embedded in the curriculum rather than added on top of it, is the single most useful intervention we have found at this phase across our combined advising experience. Schön's (1987) concepts of reflection-in-action and reflection-on-action give students a language for what they are experiencing, and Moon's (1999) framework provides a usable structure. Students who write about what is happening to them adapt faster than students who do not. The journal also creates a paper trail that allows an advisor to see patterns the student may not have recognized themselves. Koh and Townsend (2024), using the Master Adaptive Learner model with first-year medical students, found that structured reflective writing improved self-monitoring and goal-setting relative to controls, which is consistent with what we observe in advising conversations at our institution.

The question of proactive outreach is worth addressing plainly here. Research consistently shows that students most at risk of leaving are least likely to self-identify as struggling or to ask for help (Glogowska et al., 2007). An advising system that waits for students to come to it will miss exactly the students it most needs to reach. Routine check-ins, brief and informal and not contingent on the student taking the first step, are not optional extras. They are the system working as it should.

Phase 4: Ongoing

Transition into medical school is not over at the end of Term 1. Students pass through further transitions as they move into Term 2 modules, face the first major summative assessment cycle, navigate the gradual intensification of pre-clinical workload, and eventually make the move to clinical rotations in North America. Laing et al. (2005) and Leese (2010) both argue that induction should be conceived as an ongoing process rather than a one-off event, and that argument applies particularly in OCMS where cohort diversity is high and starting points vary so widely.

The practical form of ongoing support is scaled-back but sustained advising contact, regular feedback through cohort-level surveys, and a visible institutional culture in which asking for help is normal rather than stigmatized. The last of those is harder to engineer than the first two. It requires faculty who are seen to seek advice and support themselves, institutional messaging that frames early difficulty as expectable rather than exceptional, and an advising architecture designed around reaching students rather than waiting for them to appear.

Where the Gaps Are

We recognize that proposing a transition support model is considerably easier than implementing one, and we want to acknowledge the limitations and gaps we continue to observe within our own institution's approach to student transition. Three stand out.

First, pre-arrival support is limited. Administrative information is generally delivered efficiently, but there is no structured mechanism for providing incoming students early meaningful contact with current students prior to arrival. A live webinar run as a pilot was well-attended and well-received. Despite this, the initiative has not yet been embedded as a routine component of institutional practice. In our view, this represents a missed opportunity to strengthen early reassurance, reduce uncertainty, and foster initial social connection before relocation occur.

Second, the academic component of induction remains insufficiently developed. Students are oriented to the physical environment comprehensively but receive comparatively limited preparation for the realities of the academic environment. Students encounter active learning environments without a clear understanding of what active learning will feel like, and across our collective experience in academic advising, this accounts for more first-term anxiety than any other single factor we encounter. Given what the evidence now shows about SDL coaching at induction (Boyd et al., 2022; Manuaba et al., 2022; Greenberg et al., 2023), continuing without it is increasingly hard to justify.

Third, the ongoing phase is under-structured and lacks proactive engagement. Existing advising system tends to work more effectively for students who seek help than for those who need it most. Students at greatest risk of leaving are often the ones least likely to request an advising meeting. The current system is not well calibrated to find them. A more proactive and systematically structured advising approach may therefore be necessary to identify at-risk students before problems become entrenched.

Importantly, these challenges do not appear unique to our institution. Informal discussions with colleagues across multiple OCMS within the region suggest that similar concerns are widespread. This points to the need for a broader regional conversation regarding what constitutes effective transition support within the offshore medical education context. Such discussions would benefit from the involvement of accrediting bodies and regional educational organizations, particularly given the implications of student transition for retention, wellbeing, educational quality, and institutional accountability.

A Research Agenda for OCMS Transition

The most striking feature of this commentary is how little published research exists to draw on. Almost every empirical claim we would like to make about OCMS transitions, on attrition correlates, on the relative contribution of different support elements, on the relationship between advising contact and retention, remain difficult to evaluate, because the data have not been collected or published.

A manageable regional research agenda would include longitudinal cohort studies tracking well-being, academic performance, and attrition through the first year; randomized or quasi-experimental evaluations of specific induction components; comparative studies of different induction formats across institutions; and qualitative interviews with students who withdrew, to understand what might have changed their outcome.

The 2026 Frontiers study on stress and adaptation at a Caribbean medical school during educational disruption offers a workable methodological template for the quantitative side. None of this requires large external funding. Most of it requires time, institutional permission, and a willingness to share data across institutions rather than treat it as proprietary.

It is also important to recognize that the authors of this paper occupy a perspective that remains underrepresented within the medical education literature: international faculty members trained in different countries who now work within OCMS environments supporting students undergoing their own processes of international transition. Faculty perspectives shaped by experiences of relocation, adaptation, and professional integration across cultures may represent an important but largely unexplored source of insight into student transition processes. We would therefore encourage colleagues occupying similar positions across the region to document and publish their observations and experiences. The current research gap concerns not only the experiences of students, but also the backgrounds, perspectives, and transitional experiences of the educators who support them. OCMS collectively contribute a significant share of the North American primary care physician workforce (van Zanten and Boulet, 2013), and the quality of the transition experience matters both for the students themselves and for the healthcare systems they will eventually serve. A coordinated, multi-institutional research effort would therefore address an important gap in medical education scholarship—one that no single institution is well positioned to address independently, and one unlikely to resolve without deliberate collaborative action.

Conclusion

The transition of international students into Caribbean offshore medical schools is complex, widespread, costly, and largely undocumented. Attrition rates at some institutions suggest that several aspects of the transition process are not adequately supported and that a better-designed support structure may help mitigate preventable student withdrawal. A phased support model, grounded in the lived realities observed by educators working within the region, represents a practical and achievable approach for institutions willing to prioritize and organize around student adjustment and retention.

In this commentary, we have proposed a framework while acknowledging the limitations and gaps that remain within our own institutional practice. Ultimately, however, the principal value of this article may lie less in the specific model proposed than in the diagnostic question it encourages institutions to ask: which phases of student transition are currently being supported effectively, and which are not? Addressing this question requires institutions to examine transition not as a brief administrative process completed during

orientation week, but as an extended developmental period with significant implications for student wellbeing, persistence, and academic success.

The students with whom we have worked over the years, many of whom have themselves gone on to become colleagues, educators, and collaborators deserve more systematic, evidence-informed, and compassionate approaches to transition support than are currently available across much of the region. We hope this paper contributes to the beginning of that conversation.

Ethics, Consent and Conflicts of Interest

This paper is a scholarly commentary informed by published literature and the authors' professional experiences within OCMS environments. No student data were collected, analyzed, or reported. The authors declare no conflicts of interest. No external funding was received for the preparation of this work.

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