GLOBAL NAVIGATORS

CMSS
COUNCIL OF MEDICAL SPECIALTY SOCIETIES

Navigating the Rocky Shores of Global Expansion

Business Intelligence on International Physician Engagement With US Medical Societies

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This study was envisioned, designed, and executed by Global Navigators in partnership with the Council of Medical Specialty Societies (CMSS).

Global Navigators is a management consulting firm supporting organizations with a range of management services, with a primary focus on research, strategy, and growth.

Jakub Konysz provided overall strategic vision, management, and leadership, guiding study execution and ensuring findings were documented clearly and consistently. Monica Dignam led the study design and analysis, translating study objectives into a structured instrument and synthesizing results into actionable insights. Erin Dean supported study administration, coordinating logistics and documentation to ensure smooth implementation and timely delivery.

As a coalition of more than 50 organizations representing nearly 1 million physicians, CMSS elevates the unique role of medical specialty societies. We advance the expertise and collective voice of specialty societies and the patients they serve to drive meaningful change in the future of healthcare. Julia Peterson oversaw this partnership with Global Navigators and engagement with member specialty societies to ensure our collective objectives were met. Brian Stevenson supported study administration, coordinating logistics with member societies. Dr. Helen Burstin provided strategic guidance and valuable clinician perspectives to the study. Finally, our participating CMSS member societies (p. 3) saw the value in a collective study, brought forward meaningful questions to guide the direction of the survey, and facilitated communication and dissemination with their constituents.

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GLOBAL NAVIGATORS

Introduction

US medical societies play a central role in advancing clinical practice, professional education, guideline development, and scientific exchange. Increasingly, their influence, and the communities they serve, extends beyond US borders.

International physicians engage with US medical societies as members, conference participants, customers of educational offerings, research collaborators, and advocates for evidence-based care in their home countries. Yet, some US medical societies lack the market intelligence needed to understand who these physicians are, what they value, and what conditions enable engagement that is both mission-aligned and financially sustainable.

Global Navigators and CMSS partnered to address this gap through a global study of internationally based physicians who engage with US medical societies. The goal is to move from anecdote to evidence, equipping society leaders with practical insights to guide outreach, programming, and long-term international strategy in a rapidly shifting global environment.

This intelligence is particularly timely. US medical societies are operating in a climate of heightened scrutiny and evolving perceptions worldwide, where trust, transparency, and local context shape how US institutions are received. At the same time, shifts in funding models and administrative priorities may influence the traditional leadership position of US societies in medical and scientific research. Together, these forces create uncertainty about what will endure from past international approaches. They also create opportunities to build a more resilient model that's responsive to regional realities and international physician needs.

Physicians are at the center of this inquiry because they are clinical leaders, conveners, and educators within their healthcare systems. Many seek international visibility, access to cutting-edge science, and trusted professional networks, which are motivations that can align with what US societies offer. Understanding physicians' motivations, constraints, and perceptions clarifies what drives meaningful engagement over time and what barriers (financial, professional, logistical, or political) limit sustained participation.

This report provides a shared foundation for benchmarking across societies and supports more coordinated global engagement and collective thought leadership on how US societies can best contribute to medicine worldwide.

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PARTICIPATING SOCIETIES

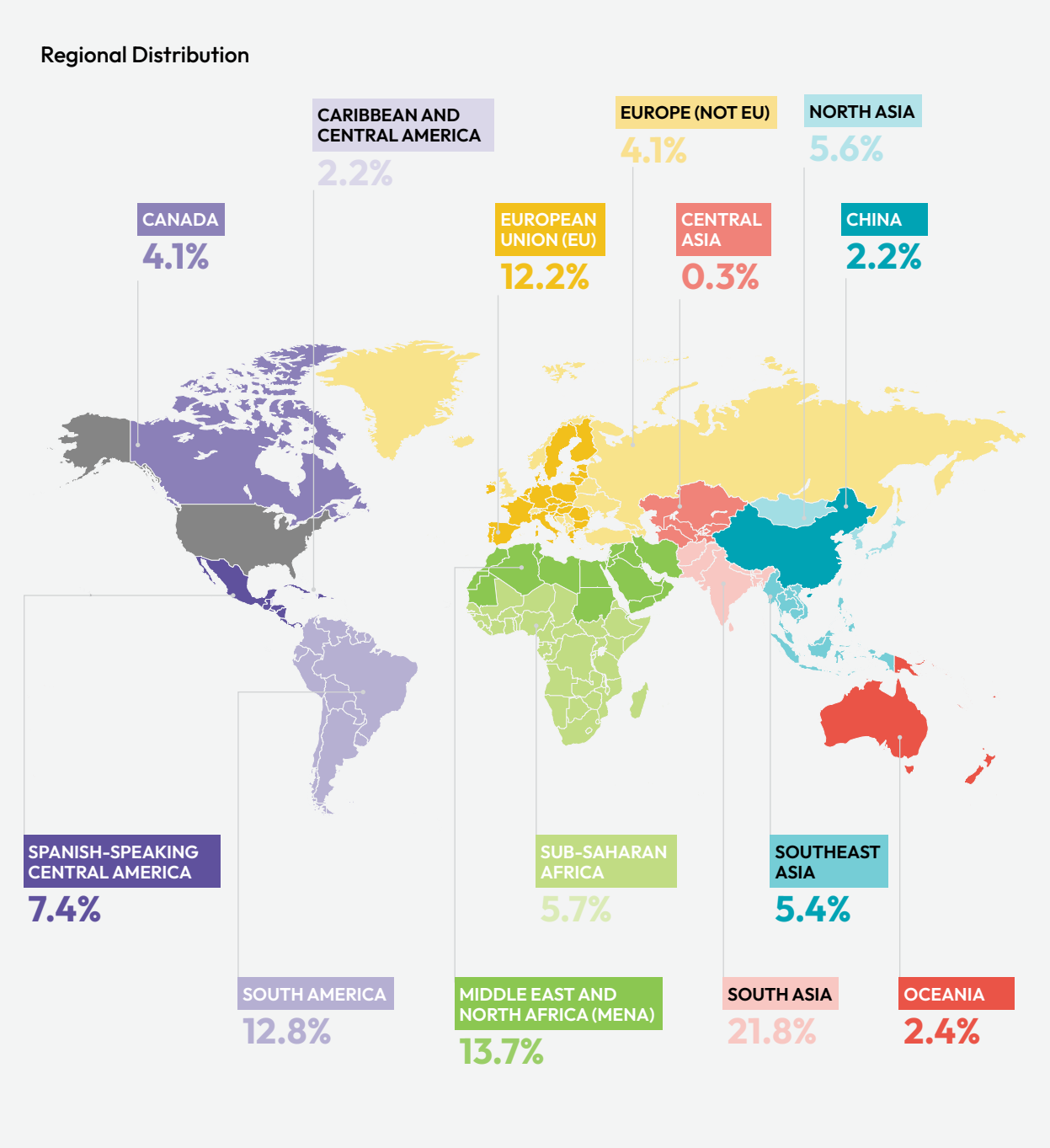
- American Academy of Neurology
- American College of Emergency Physicians
- American College of Obstetricians and Gynecologists
- American College of Physicians
- American Society for Reproductive Medicine
- American Society of Anesthesiologists
- American Society of Clinical Oncology
- College of American Pathologists
- Society for Vascular Surgery

International Physician Profile

Nearly 4,600 international physicians participated in the study, with a total of 3,157 valid responses received. The following analysis is based only on the valid responses.

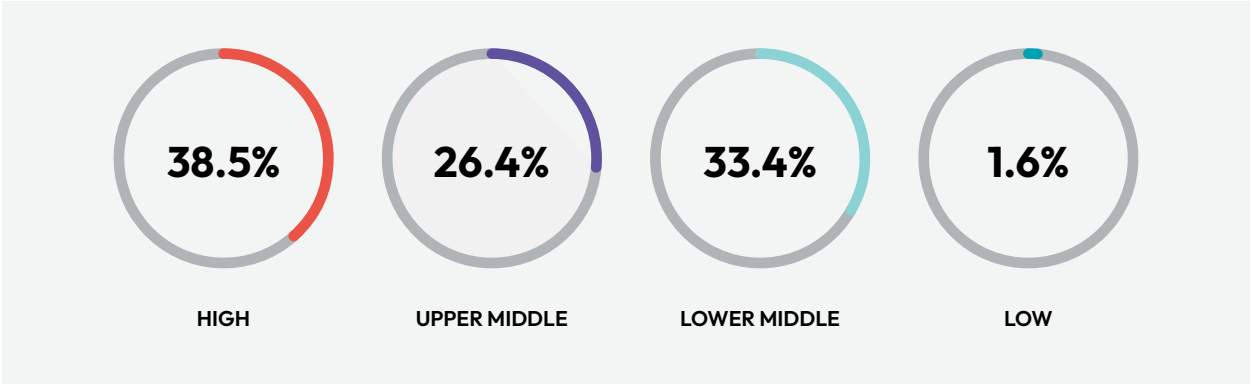
Regions

Most responses came from South Asia (22%), Middle East and North Africa (14%), South America (13%), and the European Union (12%).



World Bank Income Level

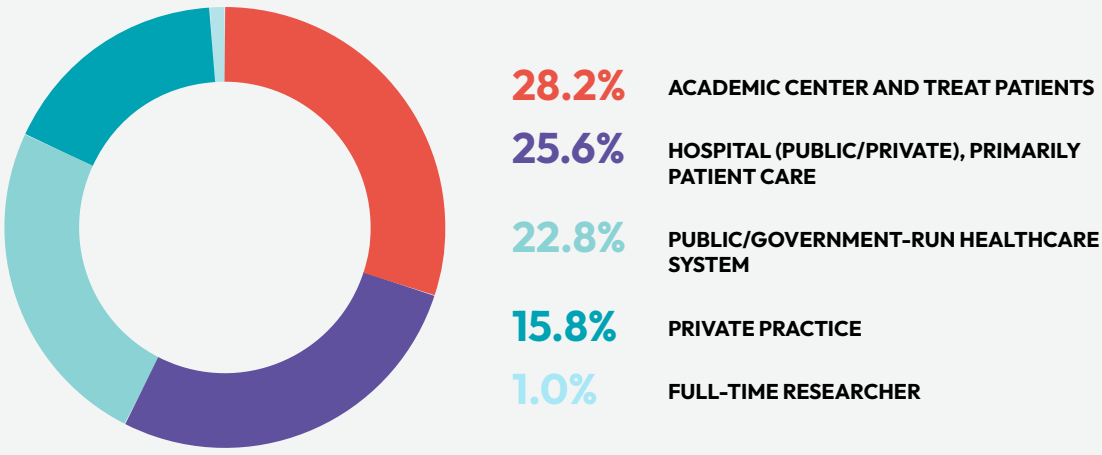
Respondents represented all four World Bank income levels, with the largest share from high-income economies (39%).



World Bank income groupings are useful for comparison but have limits (e.g., they might not accurately account for purchasing power parity or income inequality). Countries in the same income bracket may have very different individual purchasing power and ability to pay for US-based products and services.

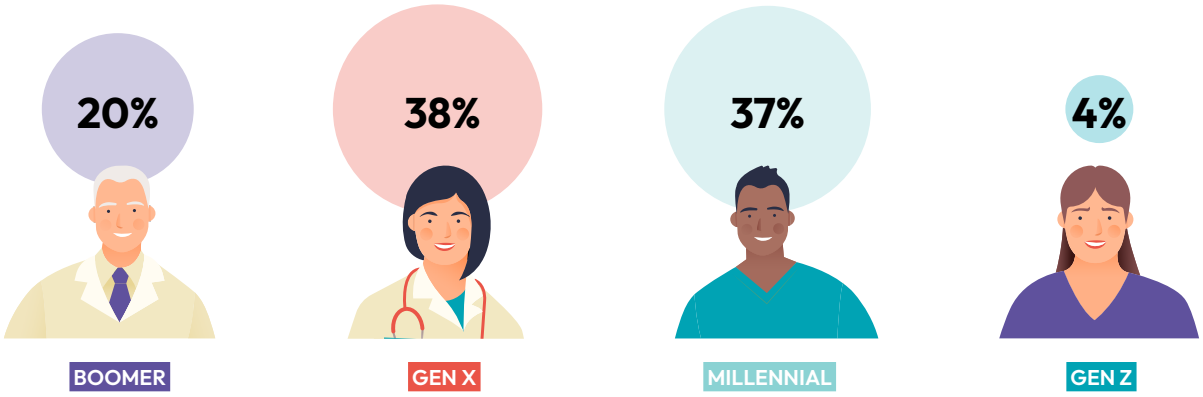
Employment Setting

Most respondents work in patient-care settings: academic centers (28%), hospitals focused on patient care (26%), or public/government-run systems (23%).



Age Distribution

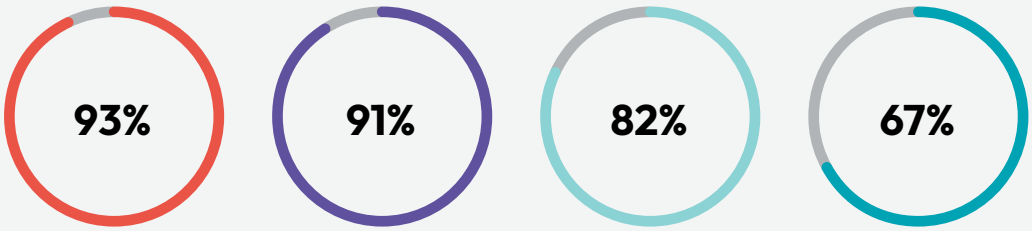
Respondents skew by mid-career generation.



Key Findings

Local in-country professional infrastructure for international physicians is strong.

Infrastructure Snapshot



SPECIALTIES OF PARTICIPATING SOCIETIES ARE REPRESENTED LOCALLY

NATIONAL CERTIFICATIONS EXIST IN MOST COUNTRIES AND REGIONS

MOST REPORT THAT CERTIFICATION IS REQUIRED BY A NATIONAL BOARD/ ENTITY

A MAJORITY ALSO REPORT REQUIRED ANNUAL CME

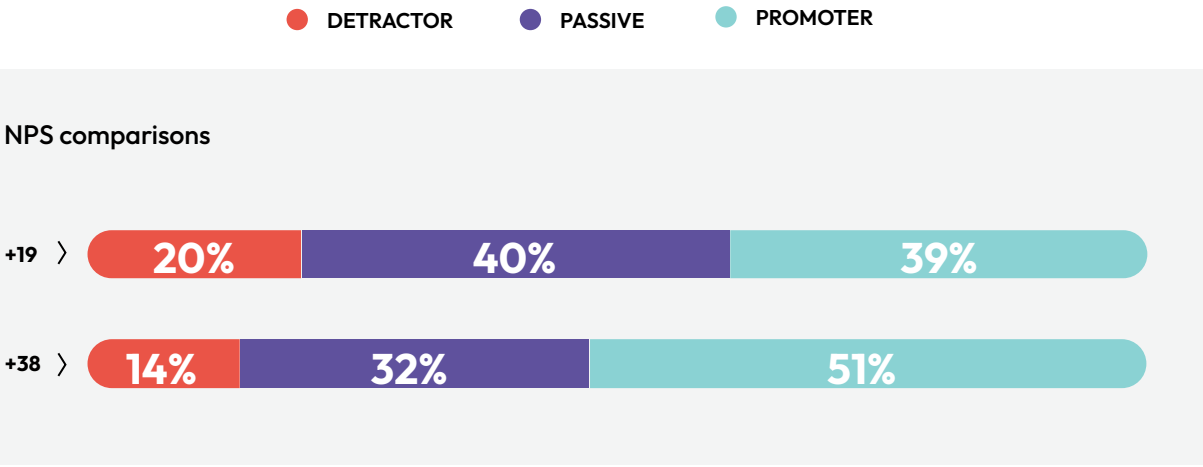
Implication: With strong local societies and certification structures, US societies may face a high bar to position membership as the primary value proposition. Education and digital offerings may be stronger entry points than membership alone, especially where local organizations already provide professional identity and credentialing.

Perceived Influence and Trust: Mixed Signals

- Roughly 40% report that US clinical practice guidelines are important in their country.
- Yet, the Net Promoter Score (NPS) is low at +19.

Perceptions are stronger when framed as recommending the society as a professional resource:

- 52% would recommend a US society for information/guidance related to specialty or clinical practice.
- NPS for this aspect is more than double at +38.



Implication: International physicians appear more willing to recommend US societies as trusted resources than to endorse the importance of US guidelines, suggesting "information authority" travels better than "guideline authority," depending on country context.

The top reported challenges and barriers standing in the way of international physicians engaging with US medical societies are more likely to be financial.

Key Barriers

61% NO EMPLOYER FUNDS FOR MEMBERSHIP

41% EMPLOYER/OTHERS WON'T FUND PARTICIPATION BEYOND DUES

30% VISA/TRAVEL RESTRICTIONS

16% TIME ZONES

15% CME NOT RELEVANT IN THEIR COUNTRY

Who Pays for Activities Outside Home Country (if they participate)

DUES, US MEMBERSHIPS	CE, OUTSIDE COUNTRY	TRAVEL, OUTSIDE COUNTRY	CONFERENCE FEES, OUTSIDE COUNTRY
			
58% SELF ALONE	50% SELF ALONE	41% SELF ALONE	40% SELF ALONE
4% EMPLOYER	6% EMPLOYER	7% EMPLOYER	7% EMPLOYER
2% GRANTS	3% GRANTS	5% GRANTS	5% GRANTS
1% GOVERNMENT	1% GOVERNMENT	1% GOVERNMENT	1% GOVERNMENT

Implication: Financial barriers are the primary constraint, strongly supported by the finding that the vast majority of respondents report that, if they participate at all, they themselves pay for most or all of the fees involved in activities offered by US societies. Travel/visa barriers are a meaningful secondary constraint. Commonly assumed friction points (technology, English proficiency, time zones, political sensitivity) are present but not dominant in these findings. It is clear that internationally, the customer of society membership and products is the individual physician, not their employer. This is useful information for marketing and communications efforts.

Engagement Patterns (Past Two Years)

Membership is the baseline. Nearly nine in ten respondents belong to at least one society that serves their specialty: 38% both local and US, 37% local-only, 10% US-only; 15% report no membership.

In-country societies lead in-person and visibility activities.

Virtual participation is more mixed, but "neither" remains the dominant response. Virtual meeting attendance is distributed across local-only (29%), both (25%), and US-only (11%), but 36% report neither.

Education Shows Reach... and Room for Growth

Scholarly contribution represents a small niche. Most respondents report "neither" for submitting manuscripts (51%) and serving as a reviewer (62%). 11% report submitting manuscripts only for US societies, while 7% report serving as a reviewer. "Both" sees higher participation: 16% have submitted a manuscript and 11% have served as a reviewer.

Digital engagement is the strongest "both" behavior. Accessing information on the web is highest among stakeholders who engage in US and local societies (34% both), with 38% reporting neither (local-only 15%, US-only 14%).

Engagement Channel Comparison

ATTENDED AN IN-PERSON MEETING

- 40% LOCAL SOCIETY
- 7% US SOCIETY
- 23% BOTH
- 30% NEITHER

ATTENDED A VIRTUAL MEETING

- 29% LOCAL SOCIETY
- 11% US SOCIETY
- 25% BOTH
- 36% NEITHER

PARTICIPATED IN FREE EDUCATION

- 27% LOCAL SOCIETY
- 11% US SOCIETY
- 24% BOTH
- 39% NEITHER

PURCHASED AN ONLINE COURSE

- 18% LOCAL SOCIETY
- 12% US SOCIETY
- 8% BOTH
- 62% NEITHER

SUBMITTED A MANUSCRIPT

- 22% LOCAL SOCIETY
- 11% US SOCIETY
- 16% BOTH
- 51% NEITHER

BEEN A REVIEWER

- 21% LOCAL SOCIETY
- 7% US SOCIETY
- 11% BOTH
- 62% NEITHER

SPOKE AT A MEETING

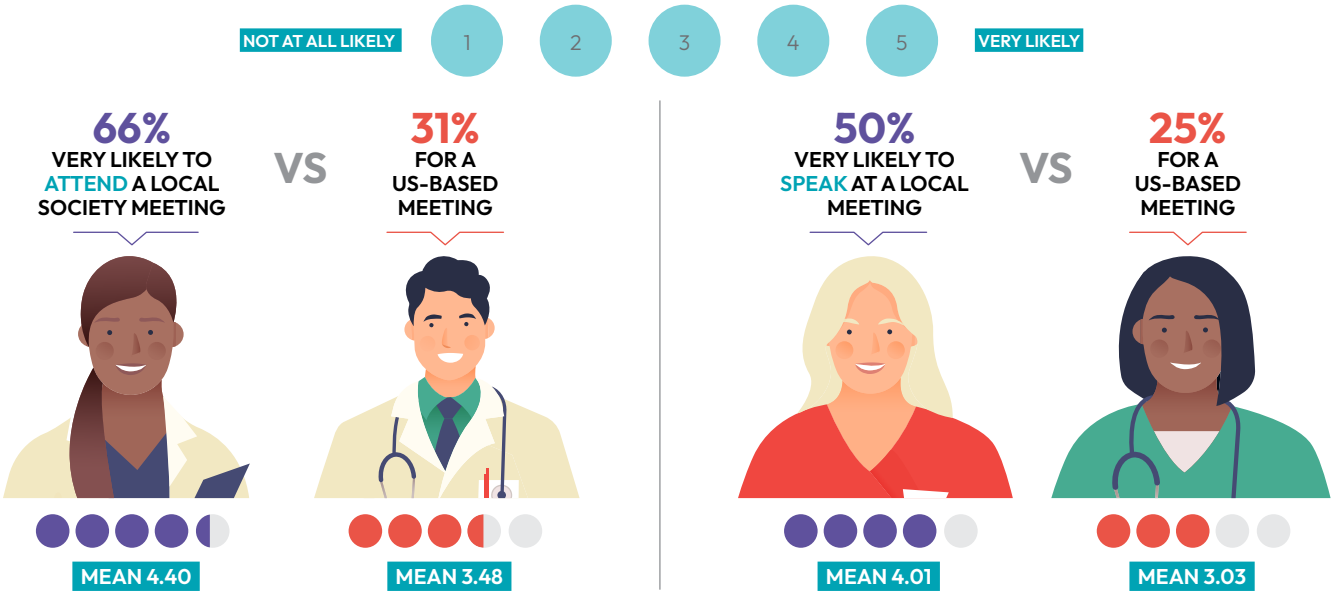
- 39% LOCAL SOCIETY
- 2% US SOCIETY
- 7% BOTH
- 52% NEITHER

ACCESSED INFO ON WEB

- 15% LOCAL SOCIETY
- 14% US SOCIETY
- 34% BOTH
- 38% NEITHER

Future Engagement Intention (Next Two Years)

Local intent stays highest for in-person participation and speaking. In contrast to the fact of past behaviors, future intent is based on many factors. They are a good barometer of engaging interest—intent is not the same as actual behavior.



International physicians largely self-fund engagement with both local and US societies. Employer support is limited and appears most common for travel and conference attendance (reported as <10%), with preference toward local meetings. Intended participation in US-based activities appears most likely where barriers are lowest.

US-BASED VIRTUAL MEETINGS:

44% VERY LIKELY (MEAN 3.90), EXCEEDING RECENT US-CHANNEL VIRTUAL PARTICIPATION (35% PAST).

FREE US-BASED EDUCATION:

54% VERY LIKELY (MEAN 4.13), WELL ABOVE PAST US-CHANNEL PARTICIPATION (34%).

There is a strong "access gap" for in-country chapters of US medical societies. While past attendance at local/regional meetings hosted by US medical societies was limited (8.9%), 37.2% say they are very likely to attend US-society local/regional chapter meetings in-country (mean 3.63) in the future, if they are available.

Scholarly Contribution Intent Is Higher Than Past Performance

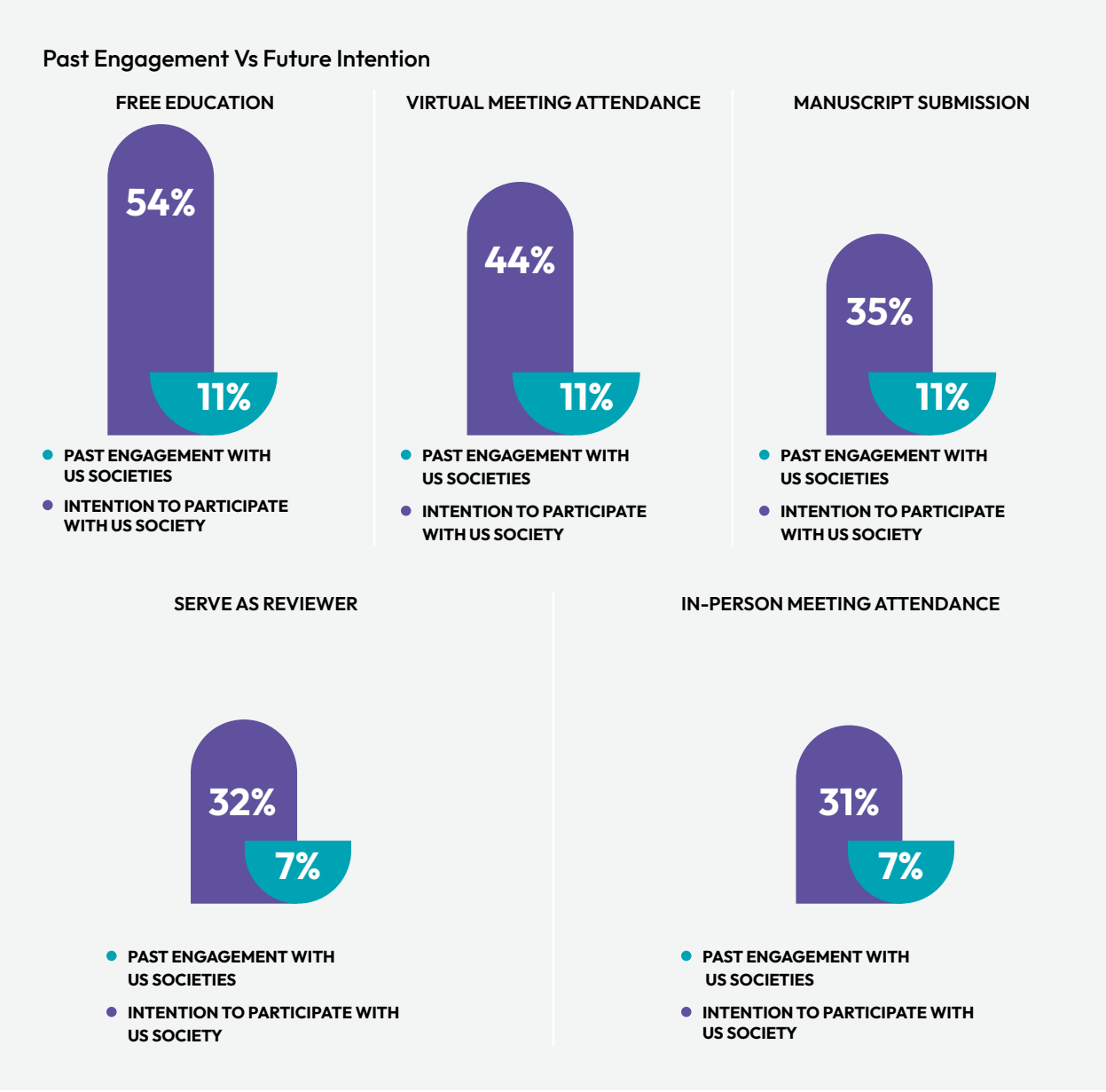
WILLINGNESS TO SUBMIT A MANUSCRIPT VIA US CHANNELS:

34.8% VERY LIKELY (MEAN 3.61) VS 26.6% WHO REPORT HAVING SUBMITTED A MS IN THE PAST.

SERVING AS A REVIEWER VIA US CHANNELS:

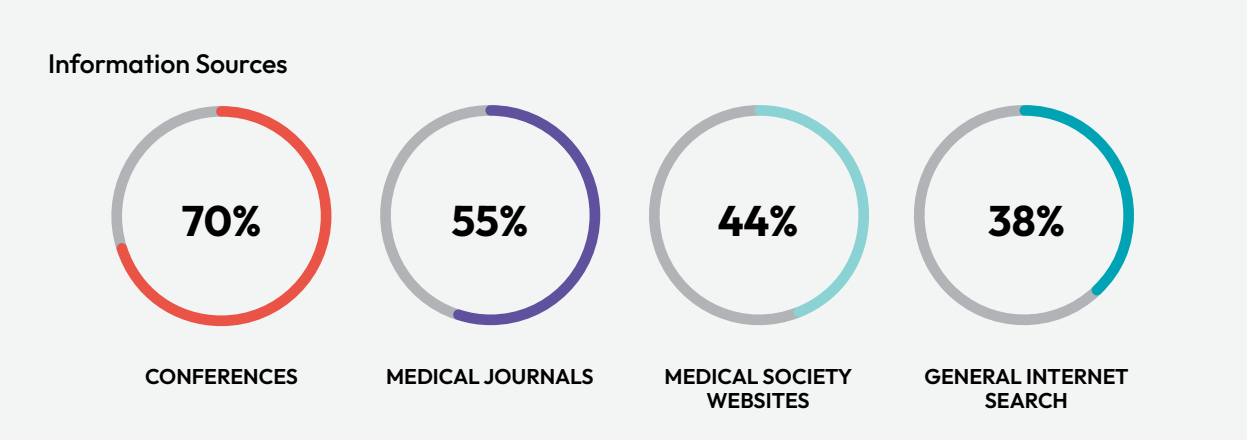
31.8% VERY LIKELY (MEAN 3.35) VS 17.7% PAST.

Bottom line: Local societies remain the center of in-person engagement, while US societies are best positioned to grow through virtual formats, free education as a gateway, local chapter access points, and contribution pathways (reviewing and manuscript submission).



Information Sources

Respondents most often get medical information from:



Topics of Importance

Language (English Proficiency)

The survey was distributed in English, so results likely skew toward physicians comfortable responding in English. Some open-ended responses were submitted in other languages, suggesting use of translation tools and/or AI support.

Overall, respondents report strong English proficiency, especially for receptive skills.

Implication: English is unlikely to be a primary barrier for consuming content, but speaking confidence is lower for a meaningful minority (Average/Poor 25.5%), which may influence live participation (Q&A, networking, presenting, etc).

Implications for US Medical Society Engagement

Membership Is Not the Only Pathway to Engagement

More than half of respondents are current members of at least one participating US medical society, but a substantial minority, **nearly 44%, do not currently belong to any society that participated in the study**. Importantly, these nonmembers were contributed by participating societies, and are likely to be engaged as meeting attendees, consumers of products and services, and/or authors and reviewers. This pattern suggests that membership is not the only mechanism by which internationally based physicians connect with US medical societies. In other words, **engagement and value exchange can persist even when formal membership does not**, creating a meaningful audience segment that societies can serve and learn from without assuming membership is the default endpoint.

The presence of a large, active nonmember cohort also has strategic implications. It points to a conversion opportunity (where membership is appropriate and mission-aligned) and a product/engagement opportunity (where nonmember pathways are the better fit, given local professional structures and funding constraints).

Many of the respondents report that they have never been asked to join a US medical society. Upon further analysis of regions with most respondents across participating societies, 54% in the EU, 43% in MENA, 38% in South Asia, and 35% in South America were never asked to join. Across high-, upper-middle-, and lower-middle-income respondents, rates of not being asked to join appear broadly similar, suggesting the invitation gap is not limited to one economic tier.

Nonmembers may face practical barriers to joining, such as limited employer support for dues, competing local society identities, or uncertainty about the relevance of US-based benefits. Yet, they still perceive value in high-trust information, convenient virtual access, and selective participation. Understanding what keeps nonmembers engaged, what would most meaningfully improve their experience, what would prompt a move toward membership (or sustained nonmember participation) can help societies design more resilient international strategies that do not rely solely on dues-based participation.

Local Professional Infrastructure Is Strong

Across all regions, most respondents indicate their specialty is represented locally, signaling that **local societies are likely the primary professional connection**. Even the lowest region (MENA at 87%) still reflects broad local representation. This has two potential strategic implications:

1. Partnership is the win-win path: US societies may achieve greater reach and trust through collaboration with local societies rather than trying to compete with them.
2. Local value propositions are harder to establish: Where local societies already confer identity, community, and access, US societies may need to lead with their other strengths (science-based research, global visibility, training pathways, publication opportunities).

Past engagement with US-based societies is highest in South Asia (13%), followed by MENA (12%) and South America (10%), but in all regions, engagement with local societies is greater. This reinforces a consistent theme: **US societies play a meaningful role internationally, but local societies remain the center of activity** for participation—especially for in-person engagement and volunteering.

Income Patterns Suggest Different Drivers of US-Society Membership

Lower-middle-income respondents report the highest rate of US-society membership (12%), followed by upper-middle (10%) and high income (9%). One interpretation is that **US society membership may be more attractive where local society infrastructure or offerings are comparatively less robust,** or where US society affiliation provides a stronger signal of prestige, access, or professional differentiation. This relationship is not definitive without further research but it suggests that income does not necessarily correlate with "ability to pay" and may instead reflect differences in local professional ecosystems.

Meetings and Events: Age, Income, and Membership Shape Participation

As expected, **older physicians are more likely to attend US-based in-person meetings (around 9%), while Millennials are the largest group attending local meetings,** raising the strategic question of whether Millennials should be the primary target for growing participation through local and hybrid pathways. Income also shapes meeting attendance: lower-income groups attend more local events, while higher-income groups attend more US-based events. Membership status further differentiates behavior—members are slightly more likely to attend US-based meetings, while nonmembers are far more likely to attend local meetings. Similar patterns appear among past members, suggesting membership creates some incremental "buy-in," but local participation remains dominant.

Younger Generations Show Promise

Boomer and Gen X generations are much more likely to be asked to join US medical societies. Where 74% and 59% respectively report being invited to join a US medical society, 50% of Millennials and 51% of Gen Z respondents indicated they were never asked to join any medical society. **This is a missed opportunity for US medical societies to recruit future generations of members.**

Millennials have the highest rates of promotion of US medical guidelines at 41%, albeit still low overall.

Millennials are also more likely than others (54%) to recommend a colleague consult a US-based medical society for information or guidance related to their medical specialty or clinical practice; Gen Z respondents report even higher levels (55%). Yet, these two groups are the least likely to be contacted by the US medical societies. Boomers have the highest rates of Detractors (54%), followed by Gen Z (54%).

More people volunteer in their local society than with a US medical society, but **Gen Z report the highest rate of voluntarism,** with 34% reporting they volunteer with their local society vs only 2.5% with a US medical society. 22% of Millennials volunteer with local societies vs only 2% with US medical societies. The numbers further decrease with the older generations. **Younger professionals could be the untapped source of future volunteers.**

Travel and Access Constraints Vary Sharply by Region

Visa and travel restrictions are a meaningful barrier, but they are not evenly distributed by region. **Respondents in Sub-Saharan Africa report the highest travel-related constraints (54%), followed by South Asia (46%), and MENA (45%).** By contrast, respondents in Canada, the EU, and North Asia report the lowest levels of travel restrictions (12%, 13%, and 13%, respectively), with South America (16%) and Spanish-speaking Americas (20%) also reporting comparatively lower restrictions. Taken together, these findings suggest that **travel barriers may require region-specific engagement strategies,** with greater emphasis on virtual and in-country opportunities in markets where cross-border travel is most constrained.

Financial Barriers Are Dominant

Across regions and income levels, **inadequate sources of funding or revenue consistently emerge as a top challenge.** The burden appears highest in South America (65%) and South Asia (65%) but remains substantial in other regions including Canada (52%), MENA (49%), and the EU (44%). Employer support is also limited: lack of employer funding for membership dues is a major barrier across most regions-South Asia (70%), South America (70%), MENA (64%), and the EU (56%)—with Canada as the notable exception (26%). These patterns reinforce that cost sensitivity is the primary limiting factor for sustained engagement and **underscores the importance of pricing, sponsorship, and lower-cost entry points** (e.g., free education) for international audiences.

Continuing Education Requirements Signal Where CME May Have Strongest Pull

Requirements for continuing education vary by region. Canada stands out with 100% of respondents indicating annual continuing education is required, followed by MENA (72%), South Asia (70%), and the EU (65%). By contrast, only 25% of respondents in South America reported an annual continuing education requirement. This variation suggests that **the perceived "must-have" value of CME (and the potential demand for CME-aligned offerings) is likely strongest in Canada and several high-engagement regions,** while other markets may respond better to clinical updates, practical tools, or non-credit-bearing education.

Language and Time Zones Are Not Significant Barriers in This Sample

Commonly assumed friction points—language and time zones—appear less dominant than financial and travel constraints among survey respondents. Only 22% of respondents in South America and 7% in the EU indicated English as a barrier. Similarly, time zone issues were cited by a minority: MENA (18%), EU (17%), and South Asia (16%). These findings suggest that, for this English-language sample, **most respondents can access and consume content effectively.** However, live engagement formats may still need thoughtful scheduling and facilitation for certain regions.

Political Sensitivities Are a Distinct Regional Concern

Political sensitivity is generally not a leading barrier across all regions, **but it is highly pronounced in Canada**, where 66% of respondents identified it as a barrier, followed by the EU (16%). This signals that "political climate" is not uniform globally and may shape how US-based organizations are perceived and how openly physicians can affiliate, participate, or advocate in certain contexts.

Virtual Engagement Remains Low—and Not Driven by Income

Virtual participation with US societies appears modest, around 10%, and region-by-region comparisons may not be reliable. But, **virtual attendance does not vary significantly by income, suggesting affordability alone may not be the limiting factor.** Generational effects are also limited for US-society virtual events (slight Boomer tilt), while Millennials are more active in local virtual participation and Gen Z is the lowest. Members of US societies are more likely to attend US virtual meetings, while nonmembers are far more likely to attend virtual meetings hosted by local societies—again reinforcing that local societies are the primary default channel.

Purchasing Behavior and Courses: Age and Membership Suggest Where Demand Is and Where It's Being Missed

Purchasing differs by generation and channel: Millennials purchase more from local societies (23%), while Gen X purchases more from US societies (14%). Recently qualified physicians (2004-on) are more likely to purchase from local societies, while older physicians purchase from US societies (slightly). This may indicate a missed opportunity: **US societies may not be offering online courses or paid products that are sufficiently tailored to younger professionals' needs, budgets, and practice contexts.** Membership is associated with higher purchasing and online-course participation (even if absolute numbers are small), suggesting membership correlates with deeper engagement and willingness to transact.

In-Country Societies Dominate Free Education

Across all cohorts, **respondents are more likely to participate in free education from local societies.** Income differences are minimal (and low-income sample sizes are too small to interpret confidently). Millennials and Gen X are more likely to engage in free education offered by local societies, while **Boomers and Gen X engage more with US societies for free education.** Recently qualified physicians rely more on local free education, while older physicians use US society offerings more, again raising the question of whether US offerings are sufficiently relevant or discoverable for younger professionals. Members are more likely to engage with US societies for free education, while nonmembers default to local societies.

Scholarly Contribution: Manuscript Submission Varies and Not Connected to Membership

Manuscript submission to US medical societies is highest in the EU (17%), South America (13%), and MENA (12%). **By income, high and upper-middle respondents submit more to US societies** (consistent with research concentration and resources), while lower-middle respondents submit more to local societies (potentially reflecting access, capacity, or journal fit). Millennials submit more manuscripts to local societies**. Notably, manuscript submission does not appear connected to US society membership,** suggesting that publication pathways may function as a distinct engagement channel, one that can be strengthened independently of dues-based membership.

Summary

Local professional infrastructure for international physicians is strong and local in-country medical societies are the most likely source for identity and in-person engagement, while US societies are best positioned to grow through lower-barrier channels such as virtual participation, free education, local access points, and scholarly contribution pathways. Financial constraints, especially limited employer funding for dues and participation, are the leading barriers for most regions, with travel/visa restrictions a meaningful secondary constraint for some regions.

International physicians are generally more willing to recommend US medical societies as trusted professional resources than to endorse US clinical guidelines as locally important, suggesting that "information authority" travels more consistently than "guideline authority."

Overall, the results support a shift from membership-first assumptions toward a segmented, multi-pathway strategy that builds trust, affordability, and locally grounded relevance over time.

Taken together, the findings suggest that global engagement strategies will be strongest when they:

- Acknowledge strong local connection (local societies, certification systems) and work with them rather than against them.
- Reduce reliance on travel and high-cost participation, shifting toward scalable digital and in-country access points.
- Treat international stakeholders as a segmented audience, tailoring value propositions by region, income, and career stage.
- Build trust through transparency and local relevance, especially in how guidelines and evidence are positioned.
- Offer relevant continuing education topics, particularly clinical practice, patient safety and quality improvement, and professional growth.

Thank you for the opportunity to help navigate your global growth.

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www.globalnavigators.net

Methodology

This multi-society market intelligence initiative quantified and characterized how a select group of physicians practicing outside the United States engage with US medical societies. Questions covered the motivations, perceived value, and barriers to sustained participation of this constituency. The study addressed a sector-wide gap: no multispecialty, cross-society dataset currently captures international physician engagement patterns in a way that supports shared benchmarking and evidence-based global strategy.

Study Design

The study had two phases:

- **PHASE 1:** Facilitated discussions with participating societies to identify shared challenges, refine the research approach, and outline survey question areas tied to real-world strategic decisions. This phase was conducted from May to August of 2025.
- **PHASE 2:** Online survey of international physicians who are currently or were previously engaged with participating US societies. Each participating society selected and deployed the same questionnaire to the individuals they selected. The survey was distributed in September of 2025 and remained active for approximately one month.

Eligibility

Initial questions screened for respondents who were physicians (MD or equivalent), who reside and practice full time outside the US. Participating societies were instructed to deploy a link to their current or recent stakeholders (e.g., current members and past members; meeting attendees; authors; reviewers; customers, etc. who were engaged with the participating societies within the past two years).

Respondents are at least 18 years of age and have a valid email address in a participating society's database. Exclusions from the final data set included US residents and non-physicians based on response to initial screening questions as well as incomplete questionnaires.

Sampling and Recruitment

Each participating society built its sampling frame using shared eligibility rules and tracked deployment metadata (e.g., unique emails contacted, source lists used) for response rate reporting and quality checks. Recruitment occurred via society-sent email invitations (GDPR-aligned), using a standardized invitation and two reminders. No incentives were offered. Participation was voluntary.

Instrument and Domains

The survey was fielded in Qualtrics in English and pilot tested with participating society staff/leadership. Survey areas included:

1. Engagement history (membership, products, meeting attendance)
2. Motivations and barriers (Likert-style)
3. Perceptions of US medical societies (trust, relevance, brand attributes)
4. Future intentions
5. Environmental influences (political climate, funding, employer support, and English proficiency)
6. Demographics and practice characteristics

Where feasible, validated measures were included (e.g., Net Promoter Score, English language proficiency, etc.).

Privacy and Retention

Global Navigators did not collect personally identifiable information (e.g., names or contact information). Societies retained their individual contact lists; analysis datasets were de-identified.