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MEDICAL EDUCATION

What Does a Mutually Beneficial Global Health Partnership in Family Medicine Residency Look Like?

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Abstract

Motivated by interest in enhancing their clinical experience and contributing to communities in need, US medical resident physicians are increasingly keen to train abroad. Guidelines are needed to help ensure that trainee, institutional, and faculty engagement in global health is ethically appropriate and mutually beneficial for all involved. Supported by the nonprofit organization Seed Global Health, the WWAMI-University of Malawi/College of Medicine partnership leverages long-term US faculty to structure rotations for Malawian and American trainees and endorses strong onboarding, monitoring, and evaluation practices and a mutually beneficial bidirectional international partnership and exchange model.

Global Health Experiences

Global health has been defined by Koplan et al as an "area of study, research, and practice that places a priority on improving health and achieving equity in health for all people worldwide,"[1] and it is increasingly recognized as an important component of medical education in the United States. Many medical schools and residencies that have global health programs have established ways to incorporate global health immersion experiences.[2] Today, about 36% of medical students have volunteered abroad.[3]

Academic global health programs are motivated not only by increased student and trainee demand but also by a range of pragmatic, consequentialist considerations.

- Globalization of diseases directly impacts our local communities; knowledge about and experience with diseases that used to exist only outside of our borders is increasingly relevant to taking care of patients within our national borders.[4]
- US-based medical students and trainees can gain a deeper understanding of a new culture with a firsthand experience abroad and, as a result, are potentially primed to better value the diversity of their colleagues and patients in the United States.[5,6]

- US-based trainees can gain a better perspective on sensible resource utilization that can inform their future practice and empower them to practice medicine with less reliance on costly technology and tests.[7]
- US-based trainees who have the opportunity to practice in a resource-limited setting may be more likely to work in a resource-limited setting domestically after graduation.[8]

Despite students' and trainees' growing interest in global health, there remains little standardized guidance for how to build these experiences ethically. In 2010, Crump and Sugarman facilitated the Working Group on Ethics Guidelines for Global Health Training (WEIGHT).[9] WEIGHT suggested a set of guidelines intended to encourage good practices for those who develop global health immersion programs. The mutual partnership model we describe below incorporates and expands upon those guidelines.

Mutual Partnership

In 2009, Malawi's Ministry of Health (MOH) recognized the need for and value of training family physicians to meet the medical needs of Malawi's population. The MOH outlined a primary care-based system comprising family physicians working at district-level hospitals around the country. The goal to train a cadre of family physicians for the workforce was ambitious but exceeded available resources within Malawi.[10] Malawi's MOH and the University of Malawi College of Medicine (COM) therefore partnered with Seed Global Health (Seed), a US-based nonprofit whose mission is to strengthen human resources for health in countries facing severe shortages; Seed's model includes placing experienced clinical faculty at local training institutions for longer-term capacity building and support of local medical and nursing educational needs.[11] In 2014, with buy-in from the Malawi COM and MOH, Seed partnered with the Swedish Family Medicine Residency Program, which is part of the University of Washington (UW) Family Medicine Network, to pilot placement of select US senior family medicine residents (USRs) in Malawi as an extension of its local clinical educational support efforts.[12] The first author (E.H.), then a Swedish Family Medicine Residency Program faculty member who served as a Seed educator, catalyzed the partnership, seeing it as an opportunity for a novel collaboration to build capacity for both Malawi and US medical education. The goals of this partnership are to improve the training environment for Malawian health care students and residents; support the regional (Mangochi) health system's efforts to deliver comprehensive, integrated care; and provide US residents an ethically sound opportunity to develop new knowledge and skills and to advocate for individual and community health in resource-poor settings.

Below we highlight several key components of this partnership from August 2014 to date.

Structured program. USRs (from UW-affiliated programs) travel to Mangochi District Hospital (MDH), a principal family medicine training site in Malawi, between August and the following June. Arriving in pairs for 4-week rotations, USRs work alongside Malawi-based Seed faculty to support the academic learning environment. Specifically, USRs participate in clinical care alongside Malawian residents and students, exchange knowledge through bedside and didactic teaching, support quality improvement projects, reinforce concepts integral to family medicine training (ie, multidisciplinary interactions, biopsychosocial approach, and community-oriented primary care) and build deep friendships with Malawian residents, faculty, and hospital staff.

Routine evaluation and monitoring. Following each USR rotation, members of the MDH staff, Malawian medical students, and COM faculty anonymously fill out surveys evaluating the impact of the visiting USRs. COM, in-country Seed staff and faculty, and UW faculty annually meet in person, review the surveys, and discuss the perceived benefits and burdens of the partnership. Jointly, they assess how well the partnership is meeting its goals and whether it should continue for another year. If at any time the COM or MOH feel that the arrangement is too burdensome, it would be stopped without negative impact to the ongoing Seed-supplied faculty support to the family medicine program in Malawi.

Selection of trainees. Recognizing the significant challenges to creating a genuine value-added opportunity with visiting USRs who come to Malawi for only one month, the UW faculty coordinator establishes clear sets of expectations for interested participants and rigorous selection criteria for admission to the program. USRs fill out an application that includes essay responses to questions that address their motivation and level of insight about anticipated challenges. The USR's program director then provides a recommendation as to whether the USR is qualified to participate. The UW faculty coordinator additionally interviews the applicant to confirm interest and probe his or her fitness for the program. Humility, flexibility, and resilience are essential qualities.

Orientation and preparation. At the beginning of the academic year, all USRs attend an orientation that clearly defines the roles and responsibilities of the rotation as well as cultural and professional expectations. Through guided conversations, trainees grapple with ethical considerations of working overseas and the reality that most short-term visitors are considered by their local hosts as more burdensome than helpful. Prior to travel, each USR meets with a UW faculty member to review orientation materials, ensure readiness, and ask questions. Since the pilot program began in 2014, future participating USRs have attended monthly global health case presentations by residents who have returned from MDH. They are expected to be familiar with the Malawi Standard Treatment Guidelines[13] and other local MOH resources that are relevant to care given in Malawi as well as the current longer-term capacity-building projects supported by Seed at MDH. These ongoing and interlinked experiences help build a sense of

continuity over time. After returning home, USRs have extensive debriefing meetings with the UW coordinating faculty member to address any issues and to ensure timely responses to any USR or local host concerns. UW faculty and USRs work together to keep the orientation materials up-to-date. These documents provide a living repository of group wisdom, so that time spent on in-country orientation is kept to a minimum.

Comprehensive accounting of costs. Many costs in implementing a global health rotation have a clear price tag (eg, travel costs, housing), but there are others that do not. All quantifiable expenses are paid for by the USR with support provided through domestic fundraising efforts. Malpractice insurance is covered by the USR's home teaching institution. In-country administrative tasks are managed by a Malawian coordinator, employed by the COM, who receives salary support from US partners. USRs and faculty raise funds and gather donated supplies in order to offset the costs of their consumption of local supplies in Malawi during the course of their rotation.

On-site mentorship and supervision. Seed faculty provide the principle supervision of USRs to minimize the additional burden on host-country faculty. Direct supervision and mentoring by long-term Seed faculty[11] with established relationships to local staff and familiarity with both local approaches to patient care and local language and culture help USRs integrate into the setting and utilize their skills. Direct supervision and mentoring can also prevent trainees from being placed in ethically problematic clinical service assignments[14]; visiting trainees from resource-replete environments could have an inflated sense of the value of their skills while underestimating the strain they add to an already overwhelmed local system.[14]

Bidirectional exchange. Bidirectional exchange is a critical contribution to equity in global health partnerships. During their third year of training, Malawian residents are sponsored to come to the United States for a 4- to 6-week rotation at a UW-affiliated program. The opportunity increases their exposure to health care practice in a relatively resource-replete setting, informs their sense of what should be possible in Malawi, and helps supplement specific training and learning gaps. Malawian residents also participate in a global health leadership course and learn about community health in the US context.

Focus on education and empowering Malawian education leadership. Expansion of the health care workforce is a strategic goal for the MOH, but there is a paucity of clinical education programs to support this need.[10] The partnership intentionally chose this focus rather than research. Research collaborations are often led by Global North academics and supported by government, philanthropic, or industry funding; while these resources can benefit institutions or individuals in resource-poor settings, they also risk driving these same institutions to become the "repository of raw materials for expatriate-driven research."[15] The goal of the Seed Global Health-MOH/COM partnership is to fill a mutual

educational gap built on mutual respect, common priorities, and a shared commitment to excellence in education and patient care.

The model of partnership we have described attempts to prioritize fundamental ethical principles in the pursuit of global health aims. Global North actors such as US-based academic institutions and nonprofits typically enjoy a power advantage over their Global South counterparts because the former comes to the negotiating table with significant resources (financial, material, human) that the latter might benefit from accessing. Such a power dynamic can insidiously cut against the goal of mutual respect, for example, through mission or agenda setting on the part of the Global North participants. Defining what is genuinely beneficial to all stakeholders—and doing so transparently—is, we argue, an essential first step toward any ethical collaboration in global health practice. Simultaneously, the Seed Global Health-MOH/COM partnership model attempts to encourage a deeper mindfulness on the part of individual actors (USRs, US faculty) about the unseen costs of their presence as health care practitioners in settings of severe poverty. Despite the best of intentions, it would be easy to cause more harm than good if Global North partners were not vigilant in listening to their local partners and willing to routinely revisit the terms of their engagement and its continued utility for all involved.

Conclusion

In 1969, an editorial in the *Journal of the American Medical Association* stated, "If, as a routine, young American doctors were encouraged to spend some months working in a developing country before they became tied to the responsibilities of practice, the result could only be better medicine at home and abroad."[16] The sentiment is elegant and simple enough, but its ethical implementation remains fraught a half-century later. It is clear that practicing global health—caring for and about the well-being and health outcomes of all people, regardless of the luck of birth circumstances or citizenship—is a worthy and ambitious moral goal. We argue that achieving this goal—effectively, respectfully, and equitably—requires great humility on the part of those positioned to provide assistance.

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