International Rotation Site Development: Does one size fit all?

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Expert Presentation Agenda

• Background

• Case Scenarios

• Questions and Answers

• Summary
Session Objectives

• Describe steps on clinical rotation site development with a focus on cross-national partnerships

• Compare and contrast medical education models globally, and its relevance with PA site development

• Describe ethical considerations for international medical education

• Present case scenarios to illustrate international site development for PA students

• Summarize best practices for equitable global partnerships
**International Clinical Rotations for PA Students**

**Key Definitions**

A Rare Commodity?
- 33% (n=36) PA Programs in US

Increasing interest for global health

**International Clinical Rotation (ICR)**
Elective practice placements to integrate theoretical knowledge with practice skills.

Clinical Educators
Professionals (MD or PA) who oversee the clinical and educational experience for PA students.

*2009 PAEA Survey of International Rotations (N:107; RR: 75%)*
International Clinical Rotations (ICR) for PA Students

Key Players

International Clinical Rotation

Elective practice placements to integrate theoretical knowledge with practice skills.

PA Program (Guest)

PA Student

International Site (Host)
To describe strategies to develop international sites

Acknowledge what is similar and what is different in rotation development, and the importance of appropriate time allocation.
Rotation Development Timeline

– 9-12 months before
– 6-9 months before
– 3-6 months before
– 1-2 months before
– On your marks, ready, Go!
Moving Beyond Obvious Differences

It is not only about differences in cultures, and languages, settings, and SES

Address differences in medical education models and ethical considerations
Medical Education Models Globally

Secondary Education (HS)

Medical School

College

PA School

Medical School

First tertiary degree

PA School

Non Physician Providers

e.g: clinical officers

YEARS of TRAINING FOR TERMINAL DEGREE

Varying clinical education formats

Varying levels of KSA towards non Physician provider roles

e.g. US, Canada

Rest of the world

e.g. England, Scotland, Netherlands

e.g. Tanzania, Uganda, Malawi
Goal: Sufficient Quality and Quantity IR

PA Programs Seeking Rotations “GUEST”

International Sites Educating PA students “HOST”

Challenges in Clinical Education Internationally

- Staffing
- Budget
- Complexity in Medicine and Education
- Students Numbers

Sounds familiar?

Interna’ional Educa’on Ethical Considera’ons

Success

Guest

Host

Altruism

Provision of supplies

Self Serving

Medical volunteerism

Practice in settings different than own’s

Practicing beyond student’s competency

Benefit to students and health care system of visitor’s country

Success

Unknown

Case Scenarios

Next, we aim to describe different scenarios that will place the international rotation site development in the context of:

A) different countries

B) different medical education models and roles

C) different types of Host organizations
Case 1

• ‘Developed’ countries where the PA model is already in place:
  – Canada
  – England and Scotland
  – The Netherlands

• Or early stages of development:
  – Australia, New Zealand

• Or under consideration:
  – Ireland
Case 1

• Must be facilitated through a counterpart institution to assure appropriate access through visa process.

• No longer can we work “under the radar”.
  – “Poaching” takes on a greater risk for all concerned.
  – Too much at stake for all parties

• Must have awareness and sensitivity to the local political climate.

• Awareness of the educational differences.

• PA students are not the same as medical students.
Case 1: Different approaches

• Abdominal exam in the American model
  – Inspect, Auscultate, Palpate, Percuss

• Abdominal exam in the British system
  – Inspect, Palpate, Percuss, **Auscultate**

• Who is right, ... and who is wrong?

• Context is everything!
Case 2

• Countries with no PA programs, but have non-physician clinician role/educational model

  – Africa
    • Tanzania
    • Uganda
    • Zambia
Case 2

• Medical education
  – Physician
    • Primary/Secondary/High School before Medical School
    • Medical school: 5 years, then 1 year internship
    • May receive specialized training (3 years)
  – Neither training nor scope is standardized across sub-Saharan Africa

– Non Physician Clinician (NPC)
  • Assistant medical officer
    – Experienced nurses w 12 mos didactic and 6 mos of internship training
  • Clinical officer
    – Secondary school graduates, who are typically trained for 3 years (post secondary) with additional year of internship experience
Case 2: NPC’s/Education/Roles

<table>
<thead>
<tr>
<th>Country</th>
<th>Occupation</th>
<th>Education Level</th>
<th>Experience</th>
<th>Qualification</th>
<th>Specialization</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rwanda</td>
<td>Nurse clinician</td>
<td>RN with experience</td>
<td>1</td>
<td>None</td>
<td>Medicine, obstetrics (but no caesarean section)</td>
<td>Mostly rural</td>
</tr>
<tr>
<td>Senegal</td>
<td>Health officer</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>Medicine only but can take additional courses to train in minor surgery, obstetrics or others</td>
<td>Urban and rural</td>
</tr>
<tr>
<td>Seychelles</td>
<td>Nurse clinician</td>
<td>RN</td>
<td>1</td>
<td>None</td>
<td>Medicine</td>
<td>Urban and rural</td>
</tr>
<tr>
<td>Sierra Leone</td>
<td>Community health officer</td>
<td>Secondary school</td>
<td>2</td>
<td>0.5</td>
<td>Medicine, obstetrics (but no caesarean section)</td>
<td>Mostly rural</td>
</tr>
<tr>
<td>South Africa</td>
<td>Physician assistant</td>
<td>Secondary school</td>
<td>3</td>
<td>NA</td>
<td>Medicine</td>
<td>Rural</td>
</tr>
<tr>
<td>Sudan</td>
<td>Clinical officer</td>
<td>Secondary school</td>
<td>3</td>
<td>None</td>
<td>Medicine only but can take additional courses to train in minor surgery, obstetrics or others</td>
<td>Rural</td>
</tr>
<tr>
<td>Tanzania</td>
<td>Assistant medical officer</td>
<td>3 years experience</td>
<td>2</td>
<td>None</td>
<td>Medicine, minor surgery, obstetrics including caesarean section, orthopaedics, dermatology, anaesthesia.</td>
<td>Urban and rural</td>
</tr>
<tr>
<td></td>
<td>Clinical officer</td>
<td>Secondary school</td>
<td>3</td>
<td>None</td>
<td>Medicine, obstetrics (but no caesarean section)</td>
<td>Urban and rural</td>
</tr>
<tr>
<td>Togo</td>
<td>Medical assistant</td>
<td>RN†</td>
<td>2</td>
<td>NA</td>
<td>Medicine, minor surgery obstetrics (but no caesarean section), ophthalmology</td>
<td>Urban and rural</td>
</tr>
<tr>
<td>Uganda</td>
<td>Clinical officer</td>
<td>Secondary school</td>
<td>3</td>
<td>2</td>
<td>Medicine, hospice care</td>
<td>Urban and rural</td>
</tr>
<tr>
<td>Zambia</td>
<td>Clinical officer</td>
<td>Secondary school</td>
<td>3</td>
<td>1-1.5</td>
<td>Medicine, obstetrics (but no caesarean section) anaesthesia, orthopaedics</td>
<td>Mainly rural</td>
</tr>
</tbody>
</table>
Case 2

• Alignment of interests
  – Physicians/NPC are interested in training with our PA students

• Incentives
  – For all
    • Physicians work with our students-keeping up to date
    • NPC’s work with our students
    • Our students work with them-diverse exposures to both common and unique disease states/different socioeconomic backgrounds

• Harmonization of practices and procedures
  – Very difficult due to variation of practice of NPC’s in different countries
Case 3

• Countries with no PAs, or non physician clinical providers.

• Best known clinical educational model is based on training of physicians at academic sites (e.g. All countries in Latin America, the Caribbean, Spain, etc).

• Multiple non government health organizations (NGO) also exist as potential sites for clinical training, specially in remote areas.
Case 3

- Multiple sites in the same country
  Satisfy demand
  Diversify learning experience
  Have a plan B in case of emerging crisis

- Upper middle income country
  Huge health disparities between regions

- Relatively easy access from US and safe
  Politically stable
  On the good list of US State Department

- Peruvian Medical Education System
  7 years post secondary for MD
  Last year mandatory “internado” in remote areas

- Reliance on University Worldwide Reputation
Case 3: What Reputation?

Translation: -”Yale: Return the artifacts from Machu Pichu! Long live Peru”

The National Confederation of Taxi Drivers
Case 3: Meet Mutual Needs

Challenge: Find Common Ground  
Pros: Good governance.

<table>
<thead>
<tr>
<th>Academic Setting</th>
<th>Non Profit Organization</th>
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<tbody>
<tr>
<td>Host: - What is a PA? Is it like a “técnólogo de medicina”?</td>
<td>Host: We need as many volunteers as you want to send!</td>
</tr>
<tr>
<td>Guest Faculty: - Not sure! Tell me more...</td>
<td>Guest Faculty: thanks, but not thanks!</td>
</tr>
<tr>
<td>• Speaking the same “language”?</td>
<td>Realigned interests: learning versus service</td>
</tr>
<tr>
<td>• Compared courses of study in Peruvian medical student and American PA student</td>
<td>Local Supervising MD evaluates (empowering) students versus US MD or PA volunteers</td>
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<tr>
<td>• Agreed on 6 days/week rotation; final exam</td>
<td>Define expectations for all stakeholders</td>
</tr>
<tr>
<td>• Language proficiency a must</td>
<td>Interpreter service as needed: no “getting by”</td>
</tr>
</tbody>
</table>

Flexibility, mutual trust, and adaptive communication skills a must!
Case #3: Reported Incentives from Host Partners

As reported by clinical educators and administrators:

- Derive great satisfaction from teaching
- Value formal recognition as preceptors
- Value feedback on educational experience from student
- Appreciate guidance and support for clinical educators
- Provide exposure to other learning styles for local trainees
- Compare-contrast models of clinical education (feel validated)

As reported by students (example):

“My rotation in Peru was outstanding. Although I had less clinical responsibility than during rotations in the US (which was expected), I learned just as much, if not more, while in Peru. The supervision was fantastic – I have never received so much attention from a preceptor before. In addition to seeing patients, I prepared 2 power point presentations a week and read approximately 300 pages of an infectious disease book. There are many formal educational opportunities at this site- including daily lectures at noon and weekly ground ground rounds; I really enjoyed being able to work at both the public hospital and public clinics.” (PA S-II)
Questions?

International Rotation  Site Development

Does one size fit all?
Summary: Best Practices Around the World

1. Alignment of interests
2. Representation of all stakeholders
3. Good governance
4. Harmonization of practices/procedures
5. Adequate finance
6. Incentives for partners
Take Home Message

BE FLEXIBLE

KNOW BEST PRACTICES

ONE SIZE DOES NOT FIT ALL
References


9. Buse et al. Seven habits of highly effective global public–private health partnerships: Practice and potential. Social Science and Medicine. 2007; 64(2); 259–271