Bi-directional International Resident Scholar Exchange
Is It Valuable?

Ana M. Crawford, M.D., M.Sc., Program Lead
ASA-GHO Rwanda Overseas Training Program

Berend Mets, M.B., Ph.D., FRCA, Chair
Committee on Global Humanitarian Outreach

The ASA-Committee on Global Humanitarian Outreach has developed and supported a Residency Training Program in Rwanda, setting up the virtuous cycle of graduating consultant anesthesiologists who in turn educate residents in the program. In so doing, we are building the capacity for specialty anesthesia programs in countries where anesthesia education is most needed.

To attract doctors and advance the standing of the specialty of anesthesiology in Rwanda, the GHO Committee has established exchange programs in the departments of anesthesiology at Stanford, Cornell and Penn State Universities, where Rwandan residents are hosted by the home institutions. These exchange residents are supported through the generosity of these departments' funds. The considerable expense of this endeavor (around $5,000 per person) has provoked questions:

"What is the value in having foreign residents rotate in our department?" a colleague recently asked.

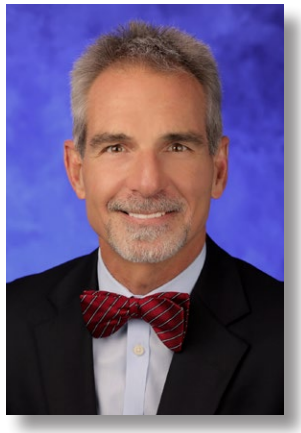
For some, the answers are obvious: global health experiences for those otherwise unable to travel, the sharing of ideas and expansion of professional networks, and global patient advocacy. To others, this program is a hard sell, especially when they hold the purse strings funding the effort.

Primum non nocere.

While many in the U.S. clamor for a global health experience, potentially inveigling themselves into a foreign anesthesiology department, we cannot be colonialists and must reciprocate by providing similar opportunities for learning within our U.S. departments. As a core concept in global health curricula, departments are obligated to ensure that we balance personal global health enrichment with altruism.

Gurney used for patient transport in a Rwandan public hospital.

Ana M. Crawford, M.D., M.Sc., is Clinical Assistant Professor and Global Health Division Advisor, Stanford University Department of Anesthesiology, Peri-Operative and Pain Medicine, Stanford, California.



Berend Mets, M.B., Ph.D., FRCA, is Chair, ASA Committee on Global Humanitarian Outreach; Director of Partnerships and Board Member, World Federation of Societiesof Anaesthesiologists; and Professor and Chair, Pennsylvania State UniversityDepartment of Anesthesiology and Perioperative Medicine, Hershey, Pennsylvania.

There is a lot to learn that cannot be taught.

Disease management for one population may not apply to another. Witness the FEAST trial (2011) demonstrating that Western sepsis fluid management strategies had disastrous consequences for the children of sub-Saharan Africa.[1] Increasingly, viewing the practice in less-resourced environments reveals to us how we may improve our own medical care. The goal is creating more simple solutions at home and abroad that address complex problems when divergent perspectives inform the differences in patient populations.

Doing more with less.

At a time when the cost-effectiveness and efficiency of the U.S. health care system is under scrutiny (opioid crisis, drug costs, drug shortages), there is much to be gained in learning from other approaches to similar health care problems. In low-resourced settings, it is not uncommon for patients to pay for and bring many of the disposable supplies used for their perioperative course. The effect on providers is the judicious use of equipment and supplies – a glove can be used as a tourniquet, fresh gases are not left flowing at the end of cases, less expensive medications are used as a rule. Thus, cost-effectiveness can be learned.

Globalization of health care.

There is a health care provider shortage. Arguably, bi-directional exchanges benefit home institutions. As foreign medical graduates train, they become our colleagues. On an individual level, as world travel becomes more accessible, travelers would hope health care access and quality abroad improve as well. A Rwandan resident rotating in the U.S. stated that the greatest learning gained included the culture of patient safety, the level of professionalism and time-management. This suggests that a portion of health care disparity is attributable more to cultural and attitudinal shifts than simply financial support or tangible resources. This argument is bidirectional.

So, is the Resident Scholar Exchange valuable? Perhaps we cannot put this in monetary terms – nevertheless, some things are priceless.

Reference:

1. Maitland K, Kiguli S, Opoka R, et al; for FEAST Trial Group. Mortality after fluid bolus in African children with severe infection. *N Engl J Med.* 2011;364(26):2483-2495.