A Closer Look at the Global Health PRN

Overview of the PRN

The Global Health Practice and Research Network (PRN), one of the newest ACCP PRNs, was established in July 2014. This PRN was created out of a need to provide clinical pharmacists, trainees, and researchers with a single network to address global health concerns, reduce disparities in the delivery of pharmacy services on an international level, and learn from the successes and mistakes of other nations through education, research, and idea sharing. Currently, the Global Health PRN has 173 members, including 81 students, 11 residents, and 3 fellows. Global health transcends all disease states and patient populations; accordingly, the Global Health PRN membership is diverse in clinical, educational, and research interests and experiences that span non-communicable diseases, infectious diseases, HIV, women's health and beyond.

In the fall of 2015, the Global Health PRN distributed a survey to evaluate the type and reach of the global health services provided by its members. Among the 43 respondents, 60% provide global health services, and 11% did so formerly; both professional and personal experiences were well represented. These members provide services that are far-reaching, spanning six continents and 42 countries. The most common types of global health services provided are clinical/patient care or education (88% each), followed by training (56%), research (44%), and other various public health, drug information, and nongovernmental organization–partnered services (9%).

The Global Health PRN has four active committees: Member Engagement, Scholarship, Programming, and Nominations. Some key activities for the current year include launching the Global Health PRN newsletter, developing and hosting a stimulating and relevant focus session for the upcoming 2016 ACCP Annual Meeting, and recognizing member achievements in scholarship and research. This year, the Global Health PRN is also forming a special task force to develop a statement paper that defines "global health pharmacy" and identifies roles and opportunities for pharmacists in this field. Members of the Global Health PRN are also encouraged to use the PRN e-mail list for networking and collaborative opportunities relevant to global health.

Opportunities

The Global Health PRN continuously explores new ideas for engaging its members and broadening its reach to new members. Given its infancy, this is an opportune time for fellows, residents, and students to become involved and help shape the direction of this new PRN.

The Global Health PRN welcomes and encourages fellows, residents, and students to serve on its committees. Additional opportunities include participating in poster "walk-rounds" at the 2016 ACCP Annual Meeting (October 23–26, 2016, in Hollywood, Florida), during which time trainee members can engage with other Global Health PRN members who are presenting their work during the poster sessions. During the Annual Meeting, trainee members are encouraged to attend the Global Health PRN business and networking meeting and the Global Health PRN–hosted focus session. Both are excellent opportunities to meet members with a wide range of experience and expertise in global health across the clinical, educational, and research spectrums.

Are you looking for new opportunities in global health? Are you traveling to a different country for the first time and looking for advice? Do you want to share a new idea for collaborative research within or across different countries? Fellow, resident, and student members of the Global Health PRN

are encouraged to actively use the e-mail list to solicit or identify new opportunities in global health as well as to share tips or advice for providing global health services.

In the future, the Global Health PRN plans to further develop its new ACCP website (glblprn.accp.com), highlighting upcoming opportunities and more, as well as to expand its presence on social media to fit the growing needs and interests of its members.

Current Clinical Issue: Short-term Medical Mission Trips—The Good, the Bad, and the Ugly

The Issue

Short-term experiences in global health, or STEGHs, are medical trips abroad that vary in length and scope. In general, licensed professionals lead and organize STEGHs, and trainees may participate, but demand has driven a burgeoning of these types of trips. STEGHs may provide services ranging from clinical to research, from education to public health, and in any combination. This article serves to describe the actual and potential benefits and risks of these types of experiences.

In the interest of full transparency, my start in global health was through a STEGH in Guatemala during pharmacy school. And recently, I led groups of pharmacy and medical students on a STEGH to the same country. During these experiences, and more so recently, I have reflected quite a bit on this topic in particular. My commitment to this service ended unceremoniously because of a job change and cross-country move. I can't say whether I would still be providing this service if I were still in my former position, but I can say that I would struggle with the ethical implications. It has been especially helpful to have a network of experts in global health with whom to discuss this topic. In this article, I have made an earnest effort to provide anecdotal, empirical, and clinical evidence on both sides of an issue bereft of these.

The Good

Ask anyone who has participated in a STEGH: it has changed their lives in at least a minor way. For many, it is their first time out of their home country. For some, it is their first time in a country dominated by poverty and inhabited by people with chunks missing from their hierarchy of basic needs. You find yourself asking: is it even possible to stay healthy if … you can't eat enough calories? The water isn't clean? You can't stay warm? You don't own shoes? It is eye-opening to be immersed in these civilizations, truly becoming SYM-pathetic to some of the conditions in which our patients live day in and day out. All are exposed to another culture, which can improve the communication and quality of care back home. In addition, lasting personal and professional networks are developed. For those on a return trip, it serves as a reminder: gratitude, pace, technology, and the importance of language (or the lack thereof). On a purely self-serving note, it allows trainees an opportunity to develop a mentor-mentee relationship and hopefully to obtain a glowing letter of recommendation for residency and fellow applications.

Clinically, trainees and experienced providers alike in STEGHs can learn to appreciate the importance of patient interviews and physical examinations in the science of diagnosis when modern laboratory testing capabilities are unavailable. Moreover, exposure to patients with new and familiar conditions can teach us about aspects of pathophysiology that we have only heard or read about and remind us that we are all susceptible to non-communicable diseases. In the STEGH model, we learn how to manage disease when modifiable risk factors can't be modified. We learn how patients receive and respond to medical information differently. We learn how to prescribe and dose medications differently in a population that is generally naive to regular exposure to Western medicine and has different genetic patterns. We also work side-by-side with physicians, pharmacists, and nurses from the host country,

learning from them how their decisions are informed and how they maintain relationships with their patients. And we hope that these patients and clinicians learn from us as well.

Limited data collected on patient outcomes after the STEGH interventions indicate that patients exposed to this model benefit from reduced morbidity and mortality (however, published results are largely limited to observational, descriptive reports). In addition, providers can be taught what we know, and we can help them improve the health of their community in the long run. "Teach a man to fish …" is a philosophy that appears to work well as long as it is approached in a sensitive way and the provider is willing to accept the partnership.

The Bad

Let's start by circling back to "The Good" section: almost everything of benefit in STEGHs is focused on the learner, not the prospective or actual patients, their families, and their community. The whole point of participating in these experiences is to improve the health of underserved patients, but there is a failure on our part to demonstrate that this has happened. At best, we are making an entire community dependent on our services for days or weeks and then abandoning it for 11 months while patients' clinical conditions continue to deteriorate. At worst, we are doing harm to patients. This produces a dissonance between the principles and the realized impact of the STEGH.

Furthermore, the volunteers attending these trips typically do not have to demonstrate a baseline level of cultural competency. Although it varies widely, some participants may simply have to indicate their interest and submit the required fees. Most volunteers who sign up are involved for valuable reasons and with good intention, but some are driven by the opportunity to travel with friends (leading to terms such as *voluntouring* and *donor-paid vacation*), avoid a more challenging educational experience, or practice outside the constraints of the regulatory pressures in their home country.

Even more harmful is that, regardless of the intent of STEGHs, we may be giving patients only a short supply of medication that does not modify their disease trajectory but does cause an adverse event. This hits a particular nerve for me, being a palliative care provider. Patients with a serious illness often experience overprescribing and polypharmacy because of their disease burden. When we review their medications, it is common to see that we are giving them extra medications that are not improving their quality or quantity of life, and we are often making it worse by causing noticeable symptoms. At the STEGH clinic, it can be tempting to focus on the handful of patients that present with a life-threatening emergency, and we are able to promptly diagnose and treat or transport them. But saving the life or limb of a handful of patients at the risk of hundreds to thousands of others … that number needed to treat would never be acceptable in a clinical trial.

Another problem with STEGHs: we may be giving patients a false sense of security that their disease is controlled, or that what they were treated for in the temporary clinic was the only issue. This may in turn prevent patients from pursuing further medical advice and getting appropriate referral to a specialist. STEGH providers cannot provide follow-up disease state education and disease and safety monitoring. This can only be done by sustainable clinics and medical practices. And it is best done at a location that is convenient to patients who lack easy access to transportation.

In addition, the treatments offered to patients in the STEGH models usually provide little to no oversight or regulation of trainees, medication dispensing, and treatments. Each clinic group may have its own "stash" of medications to prescribe and dispense, obviating the role of the pharmacist. No doubt, this is a time-saver, but it may lead to overlooking serious issues such as allergies, appropriate

dosing based on weight or age, drug interactions, and the availability of more effective medications. Moreover, the surgical and invasive procedures provided in STEGHs such as intra-articular injections and tooth extraction may be performed in nonsterile environments and without follow-up to determine whether the treatment was effective and whether any signs of infection have developed.

The Ugly

Medical mission trips typically partner with the host country to facilitate the arrival, transportation, and safety of its visitors. Yet I have personally seen this type of partnership subject the objectives of the STEGH to political influence (i.e., providing a portion of supplies and medications to the government or medical employees who are not impoverished, or even ill). This has been disheartening to witness and has soured some otherwise pleasant memories and lessons from these experiences.

Moreover, although STEGHs are typically funded by a combination of donations and individual contributions to travel, the capital invested could easily be used to fund local efforts to create sustainable medical resources instead. Yet participants in STEGHs are unlikely to donate the amount spent on a trip. Melby and colleagues suggest incorporating capacity-building efforts into the successful STEGH model, such as collecting a nominal fee for a clinic visit.[1] This not only creates a tangible exchange between the patient and the visitor, but can also generate funds to help communities meet needs beyond those provided by a STEGH.

Most STEGHs solve downstream problems: uncontrolled chronic conditions and acute problems apt to recur without public health efforts. But the downstream approach can lead to a delay in the time to crucial morbidity and mortality outcomes, as opposed to a reduction in their overall number. This is likely the result of a line of thinking about what is capable in a short period. It is much simpler to see patients, prescribe them a medication, and send them out the door than to sit at the table with the host country, ask what problems it is seeing, and then match the skill set of the volunteer group to the needs. But this is exactly what needs to occur if STEGHs are going to have any chance at success. And that's only the first step. Quality assurance implementation is crucial to determine the efficacy of the program. If we are visiting these countries and not making an impact—or worse, causing harm—it begs the question: What is the point?

The Bottom Line

In this brief article, I have tried to highlight both sides of the issue of STEGHs. However, the informal consensus of experts in the field is that the lasting impact of STEGHs in their current rendition is harmful. Thus, we need to be directing our efforts toward providing self-sustaining clinical services and educational initiatives to the countries we visit. We can only do this by prioritizing the needs of the host country over our own, letting altruism guide the path and shape of each program. To learn more about how you can start or get involved in global health in a safe, effective, and helpful manner, please engage with our officers and members on- or offline and review the suggested resources.

References

1. Melby MK, Loh LC, Evert J, et al. Beyond Medical "Missions" to Impact-Driven Short-term Experiences in Global Health (STEGHs): Ethical Principles to Optimize Community Benefit and Learner Experience. Academic Medicine. Available at https://www.cfhi.org/sites/files/files/pages/beyond_medical_missions_to_impact_driven.98631.pdf.

Recommended Resources

Impact of STEGHs:

Sykes KJ. Short-term medical service trips: a systematic review of the evidence. Am J Public Health 2014;104:e38-e48.

Melby MK, Loh LC, Evert J, et al. Beyond Medical "Missions" to Impact-Driven Short-term Experiences in Global Health (STEGHs): Ethical Principles to Optimize Community Benefit and Learner Experience. Academic Medicine. Available at https://www.cfhi.org/sites/files/files/pages/beyond_medical_missions_to_impact_driven.98631.pdf.

Loh L, Cherniak W, Dreifuss BA, et al. Short-term global health experiences and local partnership models: a framework. Global Health 2015;11:50.

Research:

NIH Fogarty International Center. Nongovernmental Organizations (NGOs) Working in Global Health Research. Available at www.fic.nih.gov/Global/Pages/NGOs.aspx. Accessed April 1, 2016.

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