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Introduction

This chapter offers an introduction to the complex ethical issues that arise when training physicians from Western, industrialized countries work overseas in communities with very different cultures, resources, and clinical practices. The first section offers an overview of the historic role of ethics in the medical profession and global health. Following is a discussion of the root of ethical tension and role of conflicting commitments. The third section develops approaches for program assessment, examining the extent to which global health placements meet the training requirements of program directors, the expectations of host supervisors, and satisfy ethical criteria for effective global partnerships. The chapter concludes with case studies and related discussions of practical ethical dilemmas.

An Historical Perspective of Medical Ethics

Primum non nocere ~ First, Do No Harm

For physicians, this hallowed expression of hope and humility, offers recognition that human acts with good intentions may have unwanted consequences. First articulated by Hippocrates and repeated in subsequent medical oaths, it remains the mantra that guides medical decision-making from an ethical point of view. While medical ethicists and journals such as the Hastings Center Report¹ have been considering the ethical implications of modern science and medicine for decades, comparatively little has been written about the ethical implications of medical trainees working abroad. Diverse activities, such as volunteering as a clinician at a hospital in Tanzania, performing obstetrical deliveries in an underserved community in rural Nicaragua, providing HIV care within a PEPFAR-funded center in South Africa, weighing infants in a feeding center in Southeast Asia, or simply attending a community meeting organized by urban community health workers, will require consideration of a resident's effect on individuals, communities and health systems.

Several historical documents central to the ethos of medicine provide important guiding principles. Globally active physicians and trainees should review these documents to gain a deeper, more personal understanding of how ethical concepts are relevant to international practice. The following citations create the necessary framework for promoting change in the global community:

The Physician's Oath (Geneva, September 1948)

The Universal Declaration of Human Rights (Geneva, December 1948)

The European Convention on Human Rights, (Rome, November, 1950)

The Declaration of Alma-Ata; Report of the International Conference on Primary Health

Care (Alma-Ata, September, 1978)

Perhaps the document most relevant to global health is the *Declaration of Alma-Ata*, which established a conceptual basis for the improving the health of the world's nations. The Declaration:

*strongly reaffirms that health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease and infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector.*²

Citing the inequity of the current state of health care among the World's nations, the meeting of the World Health Organization at Alma-Ata mapped improvements for global health. It emphasized the primacy of collaboration between allied health professionals and the community, accessibility of primary and preventative health care services, use of evidence-based practice, contributions of government and infrastructural development toward health promotion, and the necessity for international collaboration in the effort toward improving wellness of all individuals. These are fundamental concepts necessary for the foundation of global health education among training physicians.



Jonathan Mendelsohn of the Medical School for International Health shows a video to children at an orphanage in a village outside Pune, Maharashtra, India. (Photo credit: Ryan Davis)

Global Health Ethics for Resident Physicians in Overseas Placements

Residents seek overseas placements for a variety of reasons: to gain clinical experience that is not available at home, to serve patients whose access to health care may otherwise be limited or non-existent, to expand their cultural competency, to contribute positively to under-resourced environments, to conduct research, and to satisfy training requirements at home institutions.

Residents may encounter a broad range of ethical issues in these placements due to conflicts within and between four competing ethical commitments: professionalism, service, support, and sustainability. Each of these commitments is critical to the success of residents' overseas experience, and encompasses a number of potential challenges.

Global Health Programs and Partnerships: Four Ethical Commitments

Ethics refers to the moral principles, theories, and conceptual frameworks we use to guide our actions and choices. The variety of ethical approaches commonly used in western medicine may, with some variation in practice, be effectively brought to bear on health care in under-resourced settings. These approaches include the principle of respect for persons, beneficence, non-maleficence, and justice; consequentialist (ends-based) and deontological (duty-based) theories, virtue ethics, religious ethics, feminist and narrative ethics, and pragmatism. What is new for residents in overseas placements is the diversity of ethical issues that can arise due to unfamiliar environments, cultural norms, environmental stresses and disease demographics, limited resources and infrastructure, and differences in professional expectations.

Recognition of Ethical Tensions

The primary challenges for rotating residents are to be alert when ethical issues arise and to be willing to pursue the root of ethical tension. Until a conflict is recognized, it cannot be dealt with. As placements are usually in unfamiliar communities and cultures, residents should not expect to be able to recognize or appropriately interpret ethical conflicts until they have spent some time in the host environment. Once residents have begun to understand nuances of local culture, they may find ethical problems everywhere they turn, stemming from differences in assumptions of what constitutes sound clinical practice, professionalism, or even basic judgment.

In grappling with what can often feel frustrating, residents may find it helpful to examine their own expectations and consider why their expectations are not shared in the host community.

This kind of awareness calls for keen observation, appreciation of one's own cultural and personal values, and enough knowledge of the host culture and health care environment to have a general idea of where and why differences in values may arise.

Substantial knowledge of the history, culture, environmental, socioeconomic, and political dynamics in the host country and local health systems are extremely helpful in recognizing and effectively negotiating ethical conflicts. It is equally as important to have clear expectations of what is to be accomplished during the rotation—the learning objectives required by the training program at the home institution, the resident's personal goals, and the expectations of the host institution or program. When these are well understood by both the resident and the host country personnel, certain types of ethical conflicts may be minimized.

Ethical issues may arise for residents in their relations with patients, their colleagues, and their host communities. Typically, those involving patients are in the context of clinical care -- the service component of resident placements. Relations with colleagues generally have to do with residents' needs as learners, their responsibilities supporting clinical staff, and potential opportunities for collaboration with their hosts. Ethical issues with the host institution or community as a whole typically have to do with the relationship between the resident's home institution and the overseas host partner and the extent to which this relationship strengthens or burdens the host community over time. Underlying all these relationships are the basic expectations of medical professionals, the details of which vary from place to place with differences in environment, culture, resources, and infrastructure.

The diverse relationships between residents and their patients, colleagues, and host communities, combined with cultural differences and economic disparities between industrialized and developing countries, suggest four ethical commitments in global health placements: *professionalism, service, support, and sustainability*. Ethical issues may arise within each of these commitments, when two or more of these commitments are in conflict, or because a situation that appears to promote some of these values in the short term may over time detract from the same values.

When faced with what appears to be an ethically troubling situation, the first step is always to clarify what is going on. Conflicts of values are usually at the root of most ethical tension; identifying and articulating what those values are often provides a degree of control over the situation. Resolving the conflict then requires determining which values take priority in the situation at hand and what can be done to uphold them. These questions call for judgment, which in turn relies on insight into how the situation is perceived by the involved parties, awareness of one's own values, motivations, and emotional responses, and knowledge of possible alternatives given the particular cultural and institutional contexts.

The following sections explore each of the four commitments: professionalism, service, support, and sustainability, identifying a range of circumstances in each arena that are known to lead to moral distress or ethical conflicts for residents.

Professionalism

The Physician Charter on Professionalism identifies three principles considered fundamental to medical professionalism worldwide: the primacy of patient welfare, respect for patient autonomy, and a commitment to social justice.³ Each of these is challenged in global health: the first, by the inevitable confusion that arises when physicians' commitments to patient care are impeded by a lack of resources and infrastructure; the second, by the differences in cultural norms, education, and social standing between patients and physicians, and the third by the difficulty of knowing how to engage meaningfully with the elusive goal of social justice. The Charter also identifies a number of expectations fundamental to medical professionalism:

- clinical competence and life-long learning
- honesty with patients
- ensuring informed consent and error management
- confidentiality
- maintaining appropriate relations with patients

- improving access to care
- “wise and effective management” of health care resources
- duties to uphold and promote advances in medical knowledge
- managing conflicts of interest appropriately
- effective collaboration with other professionals in the interests of patient care
- establishing and monitoring standards for professional training
- remediating, disciplining, and censoring those who fail to meet those standards

Of these, the expectations that only involve the resident, such as clinical competence and maintaining appropriate relations with patients, are straightforward. But in non-Western, less-developed countries, most of these professional expectations will be upheld in ways that differ, sometimes considerably, from what residents are used to. Residents will want to remind themselves daily that their professional expectations may differ from those of their host colleagues. This awareness will facilitate effective management of ethical conflicts and is probably the resident’s best defense against frustration.

Tourism and recreation: Most residents drawn to overseas rotations love the adventure of travel, new environments, and new experiences. But among the many medical professionals who work overseas, there are those who have use their placements primarily as a “medical safari,” or base camp for recreational tourism. Residents will be watched by their hosts, and if repeatedly absent, may be perceived as using their overseas placements to take a vacation. While some recreational exploration is understandable, as representatives of their countries, profession, and home institutions, residents are responsible not only for themselves but for the future of their program or partnership, and should conduct themselves with that in mind.

Licensing, service, and accountability: Again, as visitors, residents will often need to obtain a medical license in order to take primary responsibility for patient care. If a license is not obtained, they may still contribute to patient care but their clinical activities will be overseen by a supervising physician. That said, for a variety of reasons, it is not uncommon for host country supervisors to be absent at times, leaving the resident in charge of patient care. This can place residents in an ethical bind: whether to do their best to meet patient needs without adequate licensing or oversight, or to withhold necessary care that may be urgent and that they think they are capable of providing. This is a common ethical conflict in which professionalism—the duty not to practice without a license or to exceed the bounds of one’s training—runs up against the commitment to service, where the resident may well be able to provide competent care, absent which patients will suffer. In such circumstances, residents will rely on their best judgment to find the solution that fits the circumstances, drawing on their perceptions of patient need, their clinical abilities, potential consequences for themselves, their patients, their supervisors, their programs, and available alternatives. What is never conscionable is for residents to use such opportunities to “practice” their clinical skills. Unfortunately, this form of opportunism does happen, invariably tarnishing relations between visitors and their hosts.



A qualitative project interviewing women in northern Ghana about their use of contraceptives. Sponsored by the Bixby Center for Population, Health, and Sustainability at UC Berkeley. (Photo credit: Sirina Keesara.)

Service

The goals for residents in overseas placements typically include gaining experience with unfamiliar disease patterns in environments with scarce resources, strengthening the local health care system through patient care and teaching, and perhaps undertaking research projects. A few common ethical concerns that may arise in the course of clinical service include the following:

Residents as learners: Residents are attracted to overseas placements for the rich learning opportunities they provide. For their first few weeks, residents will learn how to work with limited resources, treating conditions they have never seen before, in an unknown environment, sometimes where they do not speak the local language. As learners, they can burden their hosts until they become acquainted with their new environment, practice patterns, and support staff.

For this reason, the first responsibility of the resident is to come as prepared as possible and to commit to rapidly becoming a productive member of the medical staff. Inevitably, residents will be exposed to circumstances and practices that take getting used to. Common frustrations include a lack of functioning medical equipment, scarcity of basic supplies and pharmaceuticals, and fluctuating water and power supplies. How residents manage the adjustment may occasionally merit psychological attention or ethical concern, but simply being aware that adjustment can be challenging may alleviate stress.

Clinical Practice: In settings with limited resources, clinical practice differs in numerous ways from that of industrialized countries. Physicians and patients may have very different notions of what constitutes health or disease, what is expected to happen when seen by a doctor, and how they understand disease causation and medical treatment. In less-developed countries, diagnoses will usually rely more on clinical skills than laboratory test results, and treatments may involve non-specific use of fluctuating supplies of limited medications. For physicians used to accurate diagnoses and targeted interventions, some clinical approaches may at first seem strange, inefficient, inappropriate, or incorrect. As at home, residents will want to keep in mind that their host physicians have knowledge and experience that they lack, and question practices judiciously with the expectation that much of what they question can reasonably be explained. Once past the novelty, learning how to diagnose and treat patients with limited resources is one of the most important skill sets that residents can bring home.

Record-keeping: In industrialized health systems, medical records serve a variety of purposes: as a document of patient care, legal evidence, research data, and billing record. But where paper and pencils are in short supply, record keeping may be very limited. Adapting to clinical settings where detailed record keeping is not the norm is one more challenge residents should be prepared to encounter. Such challenges are not without recourse, and in the case of medical records, for example, residents may be able to share knowledge and practice from their home institution in order to begin collaborative discussion, possibly helping to analyze and improve clinical practice in the host community. It is critical to approach all such discussions with a spirit of equality, as both the host and visitor have valuable knowledge and experience to contribute

Long-range planning: In health systems in industrialized countries, monitoring resources, keeping plentiful supplies, maintaining equipment, and overseeing usage patterns are routine. Where resources are abundant, it is common to anticipate the future, to plan ahead, and to take action to minimize risk. But in many developing countries this kind of planning ahead is often not possible. As a result, the focus defaults to the present. In clinics and hospitals, the focus on the present may result in failure to maintain equipment, disruptions in basic supplies, long waits to see a physician or to get supplies, and little regard for notions of conservation or triage. For patients, the inability to plan ahead or control uncertainty are often met with a sense of inevitability and fatalism; the family is where one turns for material support, and the efficacy of healing is often attributed to God or Providence. These differing attitudes toward uncertainty, time, resource use, and human agency will vary with individuals, cultures, and circumstances, but they are worth noticing in any setting as they will govern much of day to day operations.

Paternalism, Autonomy and Informed Consent: Whereas in highly-resourced, westernized medical culture the doctor-patient relationship is characterized by patient autonomy, other countries the physician-patient relationship is characterized more by paternalism. There are a number of reasons for this, some having to do with differences in education, gender, and social class. Whatever the reason, many patients will not expect to be involved in medical decisions or to have their preferences solicited and respected; instead, they will expect physicians to be the experts and will do as they are instructed by their medical provider. For these patients, being asked to participate in decisions may even be unsettling. But as in all cultures, physician-patient dynamics will vary with individuals. Some host-country physicians do make an effort to involve

patients in decisions, and some patients ask many questions.

Truth-telling: Just as expectations regarding informed consent can vary with individual physicians and patients, what patients and families are told about diagnoses and prognoses, especially when conditions are serious or terminal, may also vary between individuals and cultures. In some cultures, depending on the diagnosis, patients will not expect or want to be informed—being told the truth may be considered a violation of their rights or as destroying the possibility for hope. Other may want to know. Residents will want to watch their host colleagues carefully when caring for patients with terminal illnesses and become familiar with local practice patterns in end-of-life care.

Importantly, in some settings, patients may be accompanied by family members who are responsible for providing food, washing clothes and bedding, and dispensing medications. This “carer” or family member may be the person with whom the physician interacts the most. Being aware of who is providing supportive care for patients can therefore be important, sometimes raising ethical issues, especially if the carer is a young child or otherwise of questionable ability to understand what is needed. (Note: where having a carer is essential, someone must usually leave school or the workplace which can create other kinds of hardships for a family, sometimes lapses in care, and incentives for the patient to return home as quickly as possible.)

Confidentiality: In open wards, privacy and confidentiality may be difficult to sustain, even when physicians speak very softly. Despite lack of privacy, confidentiality is of critical importance, especially with conditions that may carry stigma such as cancer or HIV. As a widely-prevalent case example, HIV raises complex ethical problems. In some parts of the world, men may resist testing as a positive diagnosis suggests weakness. Women may seek testing more often than men, but in countries where women have few rights, being diagnosed with HIV may result in abuse or being forced out of the home. As with any sexually transmitted disease, residents should be aware that partner notification may not be expected or may need to be handled very carefully. Confidentiality is an area where assumptions are best avoided and local norms learned quickly.

Gender raises a host of ethical issues that vary across cultures. In many cultures, while women may have important social roles that carry considerable respect, their legal rights are limited.

While women provide support for their partners, raise children, and contribute to family income, and they may lack rights to property, control over money they have earned, and a voice in their own health care decisions. For a geographically isolated woman, the cost of transportation to a clinic or regional hospital may be more than she or her spouse can afford to spend. When seen by a physician, her partner may expect to be present and may wish to speak for her—indeed, this may be what she expects as well. Visiting residents will want to learn about local gender norms and expectations and find ways of adapting that will permit necessary information exchange.

Especially troubling are domestic violence and abuse where women have few legal rights, limited social standing, and there are few safe alternatives.

Traditional medicine: In many developing countries, patients and their families may have health beliefs that invoke religious or supernatural beliefs, and/or confidence that traditional healers may be necessary and effective. Traditional approaches to health care and healing can be fascinating, revealing much about how individuals understand disease causality, the “sick role,”

and their moral responsibilities. Traditional healers may make effective use of local plant-based remedies; they may also cause real harm. If a patient has confidence in a particular healer and wishes to make use of traditional medicine, there may be some benefit in making the effort to do so. But when and how to integrate traditional practices into allopathic medicine will probably need to be determined on a case by case basis. Residents would again be advised to watch their host colleagues handle such requests. The default position should be to go with the best clinical practices possible under the circumstances. Treatment aside, learning as much as possible about traditional medicine and health beliefs can strengthen residents' cultural knowledge and relationships with patients and colleagues, and in some cases, may be valuable clinical information.

Support

Residents are invited to developing countries in part for the opportunities they offer to their host colleagues and local health systems. All residents potentially provide knowledge, skills, resources, and collaboration opportunities, but if and how these are realized will be up to individuals. Residents will want to think about how to most effectively engage with the needs of their host colleagues and host institution. Some opportunities and potential hazards are described below.

Medical errors: Self-regulation is a central element of medical professionalism that requires physicians to monitor errors and near misses with the expectation of correction and ongoing pursuit of excellence. But if and how personal criticism is given and taken varies enormously across cultures. Ideally, residents should talk with their hosts in advance about what to do when they make medical mistakes and what to tell patients and colleagues. Similarly, how residents should respond if they witness a host colleague mishandle a patient or make a major mistake will likely vary from what is done at home. Self-regulation is always sensitive; it is all the more so when visiting physicians are involved.

Teaching: Residents bring a great deal of knowledge with them and may be asked to teach their host colleagues or medical students. This is one way residents can positively support their colleagues and medical community and strengthen the institutional partnership. But before launching into any teaching, it is usually helpful to ask enough questions to get a sense of what the audience already knows, and as best as is possible, to tailor one's teaching to what is possible in the host medical community.

Research: Another important need to which residents can contribute is research and publication. The 90/10 global health disparity -- that 90% of the world's disease burden, primarily responsible for illness in under-resourced nations and communities, is supported by only 10% of the world's research funding -- reflects the need for increased research and publication on health care in developing countries. Some of this research is already happening, but is usually designed and conducted by westerners. One of the greatest needs in global health is for indigenous researchers in developing countries to learn to design, conduct, and publish their work in journals that are publicly available. Building research capacity in these countries is a huge task, requiring funding, trained personnel, research oversight, regional or national journals devoted to global

health and access to published literature. Ethical issues involved in human subject research are complex and variable, well exceeding the scope of this chapter, encompassing vulnerable populations, informed consent, benefit sharing, diverse forms of exploitation, use of placebo controls, and more. Nonetheless, even without engaging in major clinical studies, residents on short-term placements may support local research initiatives. Because research training tends to be limited in developing countries, residents may contribute by teaching their colleagues how to conduct a needs assessment, a literature search, develop a research question, find funding, and write grants. If they anticipate returning, they may invite host colleagues to collaborate on a research project of their own. Each of those activities provides tangible support for individuals, and indirectly, strengthens host country health systems and institutions.

Publication: Writing for publication may also be challenging for medical professionals in developing countries. In the absence of ready access to journals or the internet, strong language and writing skills, and knowledge of the publication process, many fine researchers in developing countries have difficulty getting their work published and disseminated. Residents with experience in research or writing can provide valuable support by offering grant-writing or editing assistance and helping host-country colleagues find appropriate journals and on-line publishing opportunities for their work. These activities can in turn advance individual careers, contribute to global health care knowledge, and ultimately strengthen health care capacities worldwide.

Brain drain: Research conducted in developing countries may provide a number of short-term benefits that are attractive to host institutions: jobs, infrastructure, drugs, supplies, computers and other technology, training, publication opportunities, and more. But in the process, researchers often draw on local health care staff to facilitate their research, generally people who are fluent in the local language who can effectively communicate with research participants. When external salaries or other opportunities are compelling, indigenous staff will be easily drawn away from their usual clinical duties. This siphoning off of skilled health workers from the institutions and patients that rely on them has the effect of an internal brain drain. In parts of the world where research or development projects are abundant, this brain drain can be considerable. Similarly, by bringing in quantities of free medical supplies and drugs, researchers can disrupt local pharmacies and businesses. In these and other ways, short-term global health projects can impose hidden costs on local communities. International partnerships, even those undertaken with the goal of strengthening local community health care capacities, must therefore be carefully designed in anticipation of their foreseeable and unforeseeable consequences.



Dr. Robert Fuller, attending physician in emergency medicine from the University of Connecticut, reviews a patient's CT scan with David Aragundi, an Ecuadorian medical student, at Hospital Luis Vernaza in Guayaquil, Ecuador. (Photographer: Benjamin Silverberg.)

Sustainability

The Physician's Charter identifies the commitment to social justice as one of the guiding principles of medical professionalism. What constitutes "social justice" is not specified. In the context of global health, Western physicians often use this term to promote international aid programs, whether of humanitarian disaster relief or development. But while our discomfort with the vast economic disparities between nations prompts calls for social justice, what can or should be done to rectify disparities remains politically and practically elusive. Critiques of global aid efforts have been mounting in recent years, pointing out that despite a trillion dollars worth of monetary aid to the African continent since the 1960s, most African countries are experiencing greater poverty, health care need, and political tension than they were forty years ago.⁴ There are numerous reasons given for this, most notably political interests behind the aid industry which have long permitted corrupt governments to prosper. Other factors include the population explosion across the continent since 1960 which creates serious social, economic, medical, and environmental stressors, "learned helplessness" fostered by habituated reliance on external aid to solve local problems, and top-down, theory-driven aid efforts that have not included host country perspectives or personnel in leadership positions and are rarely assessed or held accountable for outcomes.

So what should be done? What *can* be done? Regardless of the difficulties of providing aid effectively, it is now clear that international security calls for effective and lasting public health and health care systems in every corner of the globe. The increasing incidence of infectious disease which can travel the world in a few days calls for rigorous monitoring of disease outbreaks everywhere. This kind of surveillance requires vigilance in local clinics by trained health care personnel, record-keeping capabilities, communication systems, containment capacities, and more. A question of some urgency today is how industrialized nations, which have long benefitted from the best and the brightest medical graduates from developing countries, can now contribute to the development of strong, indigenous, sustainable, health care systems everywhere in the world.

This question needs to be at the forefront of international partnerships and residency placements. While the ultimate goal--effective health systems worldwide--calls for investment and leadership well beyond the reach of any individual or program, visiting physicians, residents, researchers, and others involved in global health partnerships can nonetheless consider that their overseas placements may offer leadership examples and other meaningful opportunities to their host colleagues. Medical residents are in effect ambassadors of their native countries, cultures, and profession. Demonstrating quality patient care, collegiality, initiative, accountability, eagerness to learn and a willingness to share what they know, can communicate volumes and sometimes inspire new ways of thinking. A risk for residents and other visitors is that because of their skills and motivation, they may be encouraged to take on major responsibilities and leadership roles. But they must hold back, aware that the growth and sustainability of effective health systems relies on developing indigenous leadership.

The goals of sustainable health systems can only be achieved through carefully designed and coordinated training programs, mentoring, and infrastructure development. Each of these is clearly beyond the reach of visiting medical residents. What they can do is to become familiar with the cultures, needs, and people on the ground. By working closely with professionals and lay people, medical residents will have knowledge that development planners often lack. Sharing this knowledge when they return home is an unquestionably vital role that residents can play in contributing to goals of social justice.

This section has been a short introduction to the broad range of social and ethical issues western medical residents can expect to encounter when working in developing countries. This is just a beginning—it is impossible to comprehensively capture the variety and complexity of ethical conflicts that can arise between people and communities with vastly different cultures, languages, and resources. Our hope is that being aware of where conflicts of ethical and professional values can arise will help to make transitions easier, conflicts manageable, and global health experiences more rewarding for residents and their hosts. But while they go abroad to learn, residents return with additional responsibilities. In the effort to strengthen health systems around the world, they are important resources and we need to hear from them. Their final ethical responsibility is to come home and to share what they have learned.

Assessing the Ethics of Global Health Training Experiences

Before carrying out an ethical assessment of a global health training program, the evaluator has several choices to make: (1) what aspects of the program should be evaluated? (2) according to what norms will the evaluation be conducted? (3) what indicators will be relied upon to

demonstrate whether and to what extent the norms are being met? Crump and Sugarman, for example, have suggested four ethically significant stakeholders whose interests could be the focus of a comprehensive assessment: (1) patients and other intended beneficiaries, (2) trainees, (3) local staff and host institutions, and (4) sending institutions.⁵ As an overarching governing norm they propose “mutual and reciprocal benefit” for all stakeholders, the optimistic corollary to the precept *primum non nocere* with which this chapter began. In common with most commentators, however, Crump and Sugarman omit any discussion of specific indicators that could help a program director determine the extent to which his or her program is approximating its chosen norm with respect to any of its stakeholders.

In this section we will outline an approach to program evaluation, expressed in the form of three questions.

1. How well does the program help the residents anticipate and prepare for the ethical challenges they are likely to meet in their international placements?
2. How conscientiously do the residents attempt to fulfill their professional ethical obligations in their placements?
3. What is the impact on the host community of accommodating the educational objectives of the program?

We will accept as our overarching norm the obligation to pursue the greatest possible net balance of benefit over harm, with respect both to our trainees and to host communities. (We are mindful that in emphasizing this consequentialist formulation of our governing norm we seem to be leaving out of account some other significant elements of ethical evaluation that are independent of consequences, e.g., whether actions conform to a moral rule, respect rights, or express a moral virtue. We will have occasion to refer to these important perspectives below.)

We will then briefly suggest some indicators that might be helpful in determining the extent to which we have achieved this goal.

How well does the program help the residents anticipate and prepare for the ethical challenges they are likely to meet in their international placements?

We noted above that residents’ ability to function conscientiously and respectfully in their international setting requires them to possess substantial knowledge of local history, culture, environment, and contemporary political dynamics, as well as the socioeconomic conditions of the local population, and the nature of the local health system. To this we might add the impact of the global economic and political system on the ability of the national government to make and carry out policies for health and social welfare. Accordingly, some basic preparatory work should be required of residents prior to their departure. Some useful indicators of a program’s ability to provide this preparation would include:

- Content experts in relevant disciplines and area studies participate in residents’ didactic curriculum, including representatives from the local communities where possible.
- Residents learn research methods for gathering relevant country- and community-level information on, e.g., social determinants of health; health indicators disaggregated

according to gender, ethnicity, socioeconomic status, and geography; status of the enjoyment or violation of internationally recognized human rights; local resources for health and human rights advocacy; global macroeconomic context for national policy making.

- Residents anticipate and analyze paradigm cases of ethical conflict (similar to those in the previous section) through oral discussion and written analysis.
- Local mentors are selected and remunerated in part for their ability to provide appropriate supervision and feedback for residents' encounters with social and cultural issues, as well as for their clinical abilities.

How conscientiously do the residents attempt to fulfill their professional ethical obligations in their placements?

We observed earlier in this chapter that residents may play several roles during their placements, including, e.g., physician, teacher, learner, colleague, researcher, and guest. Within each of these there are role-specific norms, expectations, and obligations that provide a pattern and context for conscientious professional behavior. While it would greatly exceed the bounds of this section to elaborate in any detail these norms and obligations, about which ethicists can and do sometimes disagree, there is broad agreement on the considerations that ought to be taken into account in determining one's ethical responsibilities in a given situation. Thus, as suggested above, conscientious ethical deliberation should begin by *identifying the stakeholders* affected by one's actions. Then, with respect to those stakeholders, we should attempt to identify the *consequences* (in terms of benefits and harms) of our actions; *duties* that we might have toward affected persons that are independent of particular consequences (such as being truthful, protecting confidentiality, keeping a promise, or respecting a right), and commitments *inherent to the identity of a professional*, such as the priority of patient welfare over personal gain, and the responsibility to maintain and enforce professional standards.

The evaluator's question then becomes the extent to which the resident has internalized the commitment to acting according to these norms, and how well he or she has succeeded in doing so. Data for answering these questions might be collected either contemporaneously or retrospectively, depending on resources and telecommunications capabilities. For example, if residents can be in simultaneous contact during their time abroad by email, telephone, or videoconferencing, they can present current cases or issues that raise ethical concerns and demonstrate their commitment and ability to analyze them according to the terms in the preceding paragraph. Alternatively—and possibly more realistically given constraints of time and resources—residents can provide retrospective written analyses of cases or issues at the conclusion of their rotation, participate in oral debriefing, or both. Useful indicators that the resident had met the expectations for ethically responsible conduct would include:

- The resident identifies a comprehensive, if not exhaustive, range of affected stakeholders.
- The resident identifies relevant, role-specific norms and obligations.
- The resident draws appropriately on knowledge of social, cultural, political conditions in the community.

- The resident reasons logically and coherently in applying the norms, professional obligations, and local knowledge to the case at hand.
- The local mentor confirms (or disconfirms) the resident’s self-report via independent observation and feedback to the program director that reflects the local community’s value system and priorities.

These indicators are useful complements to evaluation of the resident’s “professionalism” as suggested by the ACGME, which uses categories such as: always demonstrates respect, compassion, integrity, honesty; teaches/role models responsible behavior; shows total commitment to self-assessment; willingly acknowledges errors; readily places needs of others above self-interest.⁶

What is the impact on the host community of accommodating the educational objectives of the program?

Of the various possible effects that the program might have on the local community, those that are likely to be of greatest interest are also the least likely to be determinable, namely, the effects on the health of the local population. After all, what could be a more direct measure of host-community benefit or harm than improvements or deterioration in important population health indicators that are attributable to the community’s hosting of a residency placement? As with most clinical interventions themselves, however, there are simply too many confounding factors, and the likely effect sizes too small, to permit such a causal connection even if we could agree on which health indicators to use. Nevertheless, if we are to advance beyond merely exhorting programs to produce “mutual and reciprocal benefit,” we should try to develop more specific, measurable indicators that can contribute to this assessment.

If the residency placement is to be a genuinely collaborative partnership with the host community, which is itself the first requirement for an ethically sound program, the selection of these indicators of community impact must be a shared process between the sending program and the hosts. Because each community will have its own social and health-related characteristics, and each host institution will have its own priorities and expectations, we cannot specify any particular set of indicators as a general prescription.

We would like to suggest, however, that a promising resource for the partners to use in developing their indicators is the “normative framework for the right to health” developed by the Committee on Economic, Social, and Cultural Rights in its *General Comment 14 on The Right to the Highest Attainable Standard of Health (Article 12 of the International Covenant on Economic, Social, and Cultural Rights)*. The Committee developed its framework as a guide to States Parties to the Covenant on Economic, Social, and Cultural Rights to help them evaluating their compliance with their legal obligations under the Covenant to “respect, protect, and fulfill” the right to health for their inhabitants.

The Committee identified several *health system characteristics* that States Parties—and the treaty bodies and human rights advocates monitoring them—could use to assess treaty compliance:

- Availability (of health services and facilities)
- Physical accessibility

- Economic accessibility (affordability)
- Acceptability (cultural respect, gender and life-cycle sensitivity, respect for confidentiality)
- Quality (skilled personnel, approved and unexpired drugs and equipment, safe and potable water, sanitation)

And the Committee identified *issues and groups* of “special concern”:

- Non-discrimination
- Gender perspective
- Children and adolescents
- Older persons
- Persons with disabilities
- Indigenous peoples

These health system characteristics, and the quality of care provided to these populations, could be the basis for a meaningful assessment of what we might call the “ethics and human rights impact” of global health residency placements. The challenge would be to design quantitative measures—for example, clinic waiting times, patients seen per day, births attended by skilled personnel—that could be tracked in settings with and without, before and after, the presence of trainees and whose fluctuations could be plausibly attributed at least in part to the host community’s participation in the training program. Even granting the epistemological and methodological difficulties of designing such measures, the very act of paying attention to these aspects of the placements—as a collaborative effort of senders and hosts—is a salutary recognition of the moral dimensions of global health education.

Cases for Discussion

The following cases are focused on residency trainees in global health placements, and provide a framework for discussion using the concepts introduced in this chapter.

Case 1: David is a pediatrics intern on an elective in a large public hospital in Uganda. He is part of a group of students listening to a senior physician on bedside rounds. They are clustered around the bed of a 4-year old boy who likely has acute bacterial meningitis. The patient’s mother and sister are present, as the physician discusses the risk of death and disability. The hospital ward is undivided, and other patients, families, and staff are listening. The physician turns to David and asks him to do a lumbar puncture – something he has never done before but would love to learn how to do. David feels concerned about the way that the discussion can be heard throughout the ward, and about how he will obtain consent given that he does not speak the local language. He questions whether he is the most appropriate provider for this procedure, and whether the patient’s family will even be able to afford the necessary antibiotics if the diagnosis is confirmed.

This case illustrates a) of the need for preservation of patient privacy and confidentiality b) the challenges to informed consent, c) matching responsibility to ability and d) issues of

affordability and limited resources.

a) Patient Privacy-Confidentiality:

Even under ideal circumstances, confidentiality can be difficult to achieve. Bedside rounds allow for a discussion of the patient's case history between medical educators and students. At times, multiple patients may share a room and in some settings, patients are treated in adjacent beds in large wards. Families frequently provide nursing and supportive care to patients in under-resourced settings, and are therefore privy to discussions about other patients. Adding dividing curtains and screens does not entirely mitigate these circumstances, and may not be financially feasible. However, appropriate gowning of patients, draping and other barriers provide partial psychological "security" to patients and families. In the case of this discussion about a child with meningitis, the teaching points of physical diagnosis and the review of potential sequelae (e.g. death, disability) would ideally be conducted in a semi-private space with a culturally concordant interpreter for the family, or alternatively the discussion of prognosis reviewed with family in a separate space and at a separate time from teaching to trainees about the illness.

b) Challenges to Informed Consent:

While widely practiced in settings with western medical ethics, the notion of informed consent in other nations is highly variable, and culturally dependant. While some communities value individual autonomy, in others, consent is obtained through families or via tribal hierarchy. This complexity is compounded by language barriers, variation in levels of education, and differing conceptions of health, wellness and scientific principles. Even the notion of information is dependent on the situation, and some patients may want to avoid any discussion of the medical details of their illness. The process of informed consent may best be performed in tandem, with an interpreter or cultural broker, who can both teach the trainee about the salient linguistic and cultural norms specific to the setting, while conveying the relevant information to the patient or surrogate decision maker in an appropriate level of detail. By aligning with a local interpreter, medical trainees may also accomplish increased "buy in" from the patient or decision-maker, by demonstrating connection to the community and sensitivity to cultural issues specific to the host community. This process should be undertaken and reflected upon with perspective on the visiting trainees own ethical framework.

c) Trainee Professionalism:

Due to the under-resourced staffing in many international placements, as well as to the respect afforded to medical trainees from highly resourced, western training centers, visiting medical trainees may be offered the opportunity to perform medical tasks at a high level of responsibility and complexity. The availability of these opportunities is not a surrogate for judgment about a trainee's qualification for the task. Prior to performing all treatments or procedures, especially those that are new or unfamiliar, trainees should review their level of training, the procedural and biomedical details of the case, and the process of consent with their host supervisors. As medical documentation varies between settings, it is also critical to review with host physicians or staff how and if documentation is accomplished. In this reflection process, if a trainee feels under-qualified for the complexity or the risk of a given situation, they must communicate this to the supervising provider – and not allow opportunity to dictate responsibility.

d) Issues of Resource Scarcity:

One of the major barriers in providing healthcare in under-resourced communities is the paucity of supplies or medication. In such situations, it may be of limited benefit to perform invasive tests or procedures on a patient, especially in geographically or economically isolated settings, unless treatments are available in a timely and geographically appropriate manner. The recommendation or performance of diagnostic maneuvers may be understood by a patient or a family as implying that the treatment is readily available depending on the results. Even if a patient may be diagnosed and a treatment is available, the patient or their family may not be able to wait for an entire course of therapy due to economic or safety constraints. For these reasons, trainees should carefully consider the balance of benefit and risk to the patient, as well as to discuss with patients and families, the details of treatment availability, duration, and cost prior to performing invasive diagnostic tests or treatments.

Case 2: Ayana is a second year resident in internal medicine in the United States, interested in pursuing an infectious disease fellowship. She is fluent in Spanish, and has previously participated in volunteer humanitarian and medical trips to rural communities in Central America. She has become particularly interested in Leishmaniasis, and would like to conduct a research project on disease prevalence in rural Northeastern Guatemala. She will take skin biopsies of patients with Leishmaniasis ulcers, and send them to a laboratory for analysis. The population in the planned study community does not have widespread access to medical care, and standard treatments for Leishmaniasis are not available there. The community is very rural, 200 kilometers from the nearest city hospital, and most of the residents are subsistence farmers. The average education completed by the local residents is the fourth grade. Ayana worries that study participants will not understand that the study will likely not result in treatment for them. Although she is hopeful that other residents will continue her work in the following years, Ayana is not sure about the sustainability of the research effort in this region. Finally, she is concerned that the local physician, with whom she has worked in the past, will see her study as exploiting the local population for her gain as a physician from a more highly resourced nation.

This case illustrates a) the challenge of human subject research in communities not familiar with the practice of medical research b) issues of sustainability in resident-driven global health research c) resident-host physician relationships in global health collaboration.

a) Human subject research is a complex and time-consuming process, even in highly resourced medical settings. Many communities in global health settings may not be familiar with the concept of medical research – especially, the idea that research is not usually designed to directly benefit the participants, but instead may provide benefit for future generations. Furthermore, informed consent, a critical part of the research process, may be complicated by linguistic and cultural barriers in unfamiliar study communities. As mentioned in *Case 1*, the concept of informed consent may clash with local concepts of decision-making. Enlisting a local interpreter to serve as a cultural broker may help visiting residents to understand the nuances of the host community. Providing thorough explanation at a level of complexity appropriate for the local community, if possible at a community meeting, or via local public health workers, may help to inform local populations about the purpose of a study and the potential risks and benefits of participation. Consideration of low literacy among both research subjects and project participants may lead to pictorial or verbal demonstrations instead of written explanation. Finally, providing training and supplies as appropriate compensation – such as educating study

participants on vector control and donating bed nets in a community affected by insect-borne disease – may sustainably decrease disease burden and increase mutual collaboration for future research, even if the current project does not result in clinical cure for participants.

b) One of the greatest challenges in global health work with underserved communities is continuity of effort once the international volunteers have left the host community.

Sustainability and institutional memory can be difficult to accomplish especially with limited budgets, differences in priorities between visiting and host collaborators and geographic or technologic isolation of the host community. Prior to beginning a research or clinical project, long range planning is key, ideally carried out in consultation with senior physicians or researchers with knowledge in both the subject area and in the geographic and cultural specifics of the planned study community. Engaging local experts in the host community (physicians, nurses, public health researchers) early in the planning process, will help to refine study proposals and give insight into prior local research that may not have been widely distributed.

Conducting a needs assessment in the host community – if possible involving host community members as well as medical and local government or health ministry officials – can increase community engagement and lead to connections with local colleagues who may provide institutional memory as well as a sustainable work force if such funding exists.

c) Fostering successful host physician-volunteer relationships is an integral part of a fulfilling global health experience. In *Case 2*, the perception of an international medical volunteer as profiting from disease in the local community may be damaging to productive collegial interaction. Co-authoring research publications may help to engage local physicians and medical personnel, as well as present opportunities to share research and technological skills among colleagues. Scientific needs assessment with local allied health professionals and health ministry officials may increase host personnel interest and engagement. Finally, developing funding that supports training of previously underemployed local residents, may lead to skill-building for future employment, and combat “brain-drain” by increasing the health workforce.

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