Ethical Challenges in Clinical Global Health



Jessica Evert MD, Executive Director, CFHI
Assistant Clinical Professor, UCSF Department of Family and Community Medicine
Affiliate Faculty, UCSF Global Health Sciences

Child Family Health International

Today, 11:29 AM

at

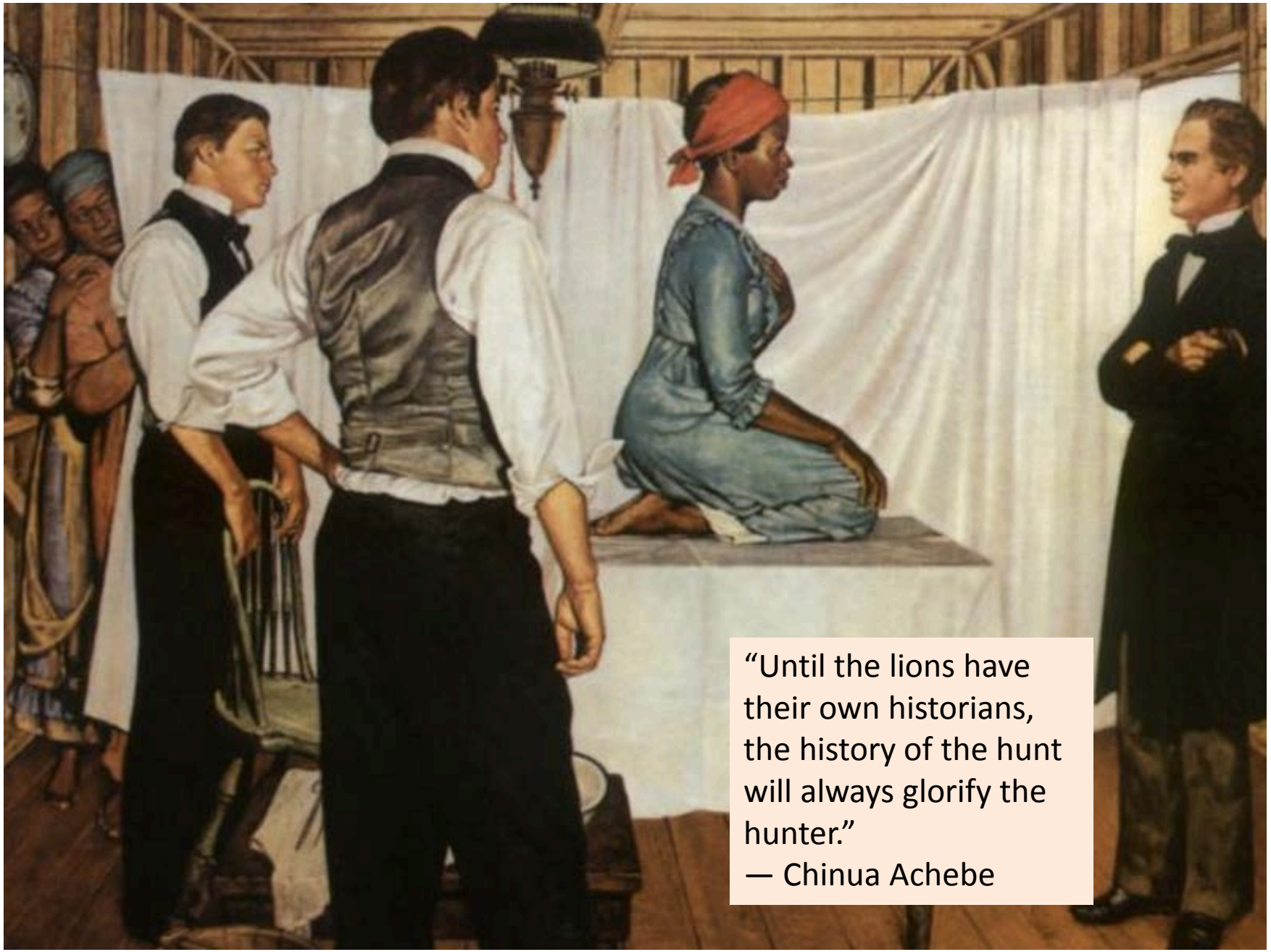
21 mins · Instagram ·

Suturing up a head laceration on one of the Vietnamese locals.
#volunteersurgeon #idkwhatimdoing

Like Comment Share

one of my friends from high school....

"#idkwhatimdoing"


“Until the lions have their own historians, the history of the hunt will always glorify the hunter.”
— Chinua Achebe

Dan [redacted] and Christopher [redacted] spent much of the summer caring for people in remote villages of Tanzania, where medical professionals seldom are seen. With little supervision from physicians, they traveled village to village caring for patients suffering from malaria, HIV, chronic pain and other illnesses.

"Just being thrust into a situation like that made all of the classes we took that first year very real," said Hess. "You learn quickly that way, because you don't have a choice."

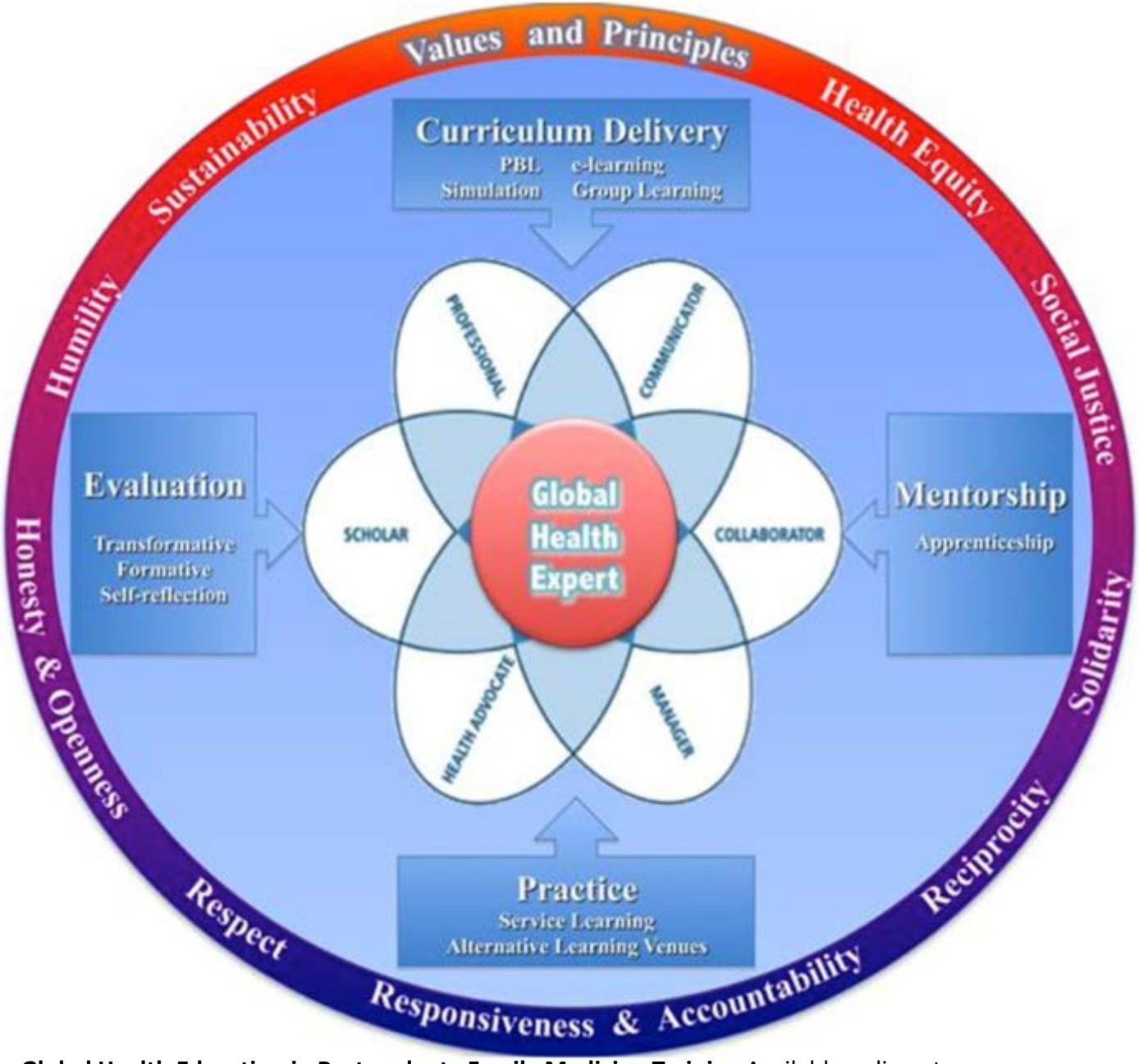
"I don't think I could have done anything that would have recharged my batteries more," Hess said. "It was incredibly rejuvenating and reinforced my choice to go into medicine, to see the impact you can have on people. You're helping them, and they're incredibly grateful for that."

86° All-indigo rainbow

the ONION
America's Finest News Source

New 'Doctors Without Licenses' Program Provides Incompetent Medical Care To Refugees

NEWS IN BRIEF · Doctors · Healthcare · News · ISSUE 50·08 · Feb 25, 2014



Framework for Global Health Education in Postgraduate Family Medicine Training Available online at: http://globalhealth.ennovativesolution.com webcite©The Ontario Global Health Family Medicine Curriculum Working Group, (2010) [17):

Redwood-Campbell *et al. BMC Medical Education* 2011 **11**:46 doi:10.1186/1472-6920-11-46

Qualitative Data

Themes: Biggest Challenges & Ethical Issues

- Constraints/limitations of visitor
- Over-confidence locally in visitor
- Superiority
- Perception of limitations in local abilities
- Sustainability
- Cross-cultural difficulties
- Cognitive Dissonance
- Perception of lack of options
- Non-maleficence
- Beneficence
- Humility

Constraints/Insufficiencies of Visitor

"Difficulties around having insufficient knowledge of the resources and disease prevalence of the setting in question."

"Trying to navigate what is appropriate care for the patient in front of me when I do not fully understand the cultural or socioeconomic context that the patient is coming from."

"Performing surgeries that require long-term follow-up which we rely on local physician to handle."

Trainees generally have a poor understanding of the ethical standards within a particular country. They also have very limited understanding of the country as a whole. For example, what cultural elements may impact the health of the population? Many trainees do not know enough of the culture to address this question but are quick to judge what shouldn't happen in other countries.

Local over-confidence in visitor

“Local understanding of limited scope--the sense that just because I'm a doctor doesn't mean that I can fix everything or see every kind of patient.

“Often there is less concern in the general population of these areas for clear consent and patient self-advocacy, so pre-med students are often presented as higher ranking or more knowledgeable than they actually are. “

Superiority

“working with the limited resources and seeing patients die knowing that if they were in the US they could have been helped.”

“Ongoing pervasive belief that "helping" must be occurring if someone visits from high income country.”

“Training someone the best way to treat a condition but knowing full well it is not even a possibility in their country.”

Perception of limitations local abilities

“Clinicians are poorly trained or not trained at all but are expected to carry out procedures without supervision. An example: nurses in rural areas are not trained to deliver babies, however, if a women comes to the clinic in labor the nurse is not trained to deal with this. In many settings there are no supervisors on hand to assist.”

Sustainability

“One of the biggest challenges is sustainability of programming and long term relationships due to funding and time constraints.”

“Practicing in a manner that can sustainably affect development.”

Cross-Cultural Difficulties

“Unlike the US, the patients I treated did not want to hear the risks, benefits, and alternatives and make their own informed decision, but rather wanted me as the doctor to decide what they should do. While I know what the standard of care would be in the US, this often was not applicable in an impoverished, cash pay setting.”

Cognitive Dissonance

“I would have to balance out whether additional testing or procedures would change management, but even if it did, I would still have trouble deciding whether to do it or not, as sometimes the finding of a test (such as a brain tumor on a CT scan) meant the patient needed additional care there either was not available or was too cost prohibitive.”

Perception lack of options

"First do no harm" but if there are pathology that physicians with better training may be able to help the patient AND it is possible to make that happen, the patient should be referred to the better qualified physicians. However, there will be cases and patients where even though it is "beyond the scope of training" but there are [physicians] that will have the necessary skills and know-how to treat the patient AND the patient will not have any treatment otherwise."

"Trying new procedures on patients who have less resources, because they have less choice."

I think the biggest ethical challenge is being put in a position where you are asked to perform beyond the scope of your training, but the alternative is to not have anyone who is adequately trained in this position.

Non-Maleficence & Beneficence

“Providing a meaningful experience for the students that will encourage them to speak positively about the program (to ensure continuation of the program) without subjecting the populations in the LMIC setting to undue harm.”

“The biggest challenge is the fact that sometimes what you do in those settings may not be optimal but for the situation given, may be the best option. For example, for a condition which requires a total thyroidectomy, you may have to do a subtotal thyroidectomy because the patients may not have access to Synthroid and therefore if you do a total thyroidectomy, you may create a big problem.”

“For trainees it is where to draw the line with what constitutes adequate supervision when allowing the resident to operate and for professionals in general is when to say "no" to an operation that may be outside of a surgeon's comfort level or one that is made riskier by the constraints of the environment.”

“Whether I'm actually doing harm by trying to help”

Humility (or lack thereof)

“Ignorance of HIC professionals and trainees about history, local context, language, and cultural/social issues that affect health outcomes. In other words, the unacknowledged arrogance of "first world" people.”

When is it ok to go outside Scope of Practice?

Qualitative Data

When is it ok to go outside SOP?

"When there are not alternative providers and the situation clinically requires it, it may be the only option available to a patient."

"There are potentially examples of particular procedures or methods within one's scope of practice but not frequently completed in the HIC that could be appropriately taught in the appropriately supervised situation within local standards for training and competency certification. (I.e. It wouldn't necessarily be inappropriate for a trauma surgeon who'd never done a DPL in a HIC in a clinical situation to do one supervised with a colleague in a LIC --within the scope of practice of a trauma surgeon) also in some circumstances generalist practice is appropriate for a specialist though they dont practice that at home (when appropriately trained and credentialed in the LIC)."

"It is unethical except in emergency situations when you would do the same thing in your home country."

When is it ok to go outside SOP?

“It depends on the context. If there is provider in the vicinity (whatever this means--for our patients I think 4 hours was counted as in the vicinity) that the patient could go see and afford who was more qualified than me to perform the procedure, then by all means, it would be wrong for me to do the procedure. If I was the only person who could offer them the service with minimal chance of harm (or if the natural course of disease already doomed the patient), then it would be reasonable to try. If there was reasonable chance of harm by me doing something, then certainly doing nothing was better than doing something.”

“No one should perform any care that they are not credentialed to do at home.”

When is it ok to go outside SOP?

“Often improvisation and logic can be used to look at situations and be helpful even if it is not typical to your work at home. I think it is also difficult to strictly limit "scope of care." For example, I'm a pediatrician but I delivered babies with minimal supervision in medical school. It is not something I would choose or seek out, but if there is a woman in front of me in distress (either here or in the US) I'd of course help.”

When is it ok to go outside SOP?

“Practicing beyond their scope of training with adequate support in person or remotely can build necessary skills to work in LMIC settings and provide care to those that might not otherwise get care.”

When is it ok to go outside SOP?

“This isn't ethical/ you wouldn't do it at home so why do it abroad? However, if someone is in grave need and you've learned about something or think you could try it, I support the intervention over death.”