

# AMSA Global Health Clinical Ethics Pre-Departure Workshop Student Resource Guide

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Introduction, Cases, and Discussions adapted from Elansary M, Graber LK, Provenzano AM, Barry M, Khoshnood K, & Rastegar A. Ethical dilemmas in global clinical electives. *The Journal of Global Health*. 2011;1(1): 24-27

## Objective

This resource guide includes cases with accompanying discussion for future reference. An annotated reference list is provided for optional further reading.

### 1. *Clinical Limits*

Maya is a student rotating on an infectious disease ward in Indonesia. In the first few days, she realizes that she is frequently left alone to care for patients, as there are few physicians available to supervise her. Maya is anxious, as she feels she is providing care beyond her capabilities, and brings these concerns to the Chief of Services, who explains, “This is the best training you could be getting in global health! We depend upon our foreign colleagues to help with short staffing.”

#### Sample discussion:

With a strong desire to help and learn, medical students may understandably be put in a position to care for patients beyond their level of training in resource-constrained settings. As articulated by Shah and Wu, “This desire to help, combined with relative inexperience, can pose ethical conflicts and leave both patients and students vulnerable to negative outcomes.”<sup>1</sup> This is a concern particularly with students early in their training, when they have limited clinical exposure. In this scenario, Maya does not feel prepared to provide care for patients on her own. However, many students do not accurately recognize their limitations. As Crump and Sugarman wrote, “In resource-constrained health care settings, trainees from resource replete environments may have inflated ideas about the value of their skills and yet may be unfamiliar with syndromic approaches to patient treatment that are common in settings with limited laboratory capacity.”<sup>2</sup>

To prevent the ethical burden placed on students, medical schools must inform host institutions of students’ skills and abilities. A study in the Solomon Islands revealed that 80% of local health workers did not understand the level of responsibility the international medical students were to assume and allowed them to work unsupervised.<sup>3</sup> In resource-poor settings, patients are particularly vulnerable to “dissymmetries of power” in medicine.<sup>4</sup> This situation illustrates

the common misconception that “people who live in poverty will benefit from any medical services, irrespective of the experience or lack thereof, of the provider.”<sup>1</sup> This perspective assumes incorrectly that low resource settings do not share the same ethical and professional standards for the care of patients. As a part of medical education, it is important to model that all patients in all settings deserve the highest quality of care. If Maya lacks adequate training to independently care for patients, she cannot responsibly provide patient care without supervision.

## *2. Burdens on the Host*

While in Honduras for a clinical rotation in a busy public hospital, Narae relies on the residents to explain patients to her because she is unfamiliar with conditions there. Although she had taken a course in Spanish in preparation for her rotation, Narae also requires frequent assistance from the staff with interpretation.

One day Narae becomes frustrated when caring for a patient who has been waiting one week for the surgical team to debride her leg wound. Narae approaches the surgical resident to discuss the situation, and the conversation elevates to an argument. Narae asks the resident what the plan is if the patient cannot get a consultation. The resident becomes angry: "That's what's wrong with you people!" "You people?" Narae interrupts angrily. "What do you mean, 'you people'?" "I mean you visiting students! You come in here without knowing how things work, what the procedures are, and expect everyone to oblige you and translate for you. I have sixty patients to take care of and I'm already spending too much time talking about this one!"

### Sample discussion:

This case introduces the issue of the effects of visiting students on host institutions. While many benefits of global electives for American medical trainees are documented, research has not been conducted to assess whether these partnerships benefit host countries.<sup>5</sup> In this scenario, the resident was diverted from patient responsibilities in order to help support and educate Narae. Physicians in low-resource settings are often in high-demand, and any diversion of their clinical time may be detrimental to patient care. Further, more local staff may expend significant amounts of time and energy to orient medical trainees, arrange for housing and transportation, locate translation services, and provide general logistical support. There may be additional financial burdens, “such as unaccounted-for-costs associated with hosting trainees that may include paying

for visas, food, and incidental costs.”<sup>2</sup> To further complicate such challenges, host institutions with fewer resources may be hesitant to address such concerns with wealthier, “sending institutions” to avoid jeopardizing relationships.

The effects of Narae’s presence on the hospital ward took on a different dimension when her conversation with the surgical resident elevated to an argument. Some discussants may believe that Narae was justified in initiating a discussion with the resident about this patient who needed a debridement and had waited an entire week for the consultation, although perhaps she could have done so in a less confrontational way. Other discussants may believe that Narae, as a visiting student, ought to have mostly the role of observer unless she is called upon to assist in a particular case. As an additional consideration, the resident in this case expresses frustration about not only Narae but other visiting students who may lack an understanding of how things work in the host institution but nonetheless attempt to influence care. This can be seen as an indication that Narae's behavior may be seen by the resident within the context of the behaviors of prior visiting students. In the same vein, it may be important to consider that the effects of Narae’s behaviors could reach well beyond that clinical encounter and even influence the status of a collaboration between two clinical programs or the attitudes of local house staff towards visiting students in general.

Perhaps if Narae had a clear understanding of her role on the wards, she could have avoided this scenario. As a rule, reasonable expectations for sponsoring and hosting institutions should be made explicit at the outset of collaboration. For instance, comprehensive pre-departure training for students is one way to decrease the demands on hosting institutions. Mentors in developing countries should be able to expect visiting students to be well-prepared for the experience with knowledge of the regional culture, local disease epidemiology, and local language when possible. Electives implemented within a structured partnership can alleviate the demands on the host country by providing an infrastructure for student preparation at home. In recognition of the time and effort expended by local staff, appropriate compensation should be offered to clinical tutors, interpreters, and administrators. Tangible benefits to host institutions can include educational resources, research support, and project development in addition to financial compensation as is appropriate in a given setting. It may be important for students to consider the nature of the collaboration between sponsor and host institutions for any given clinical rotation prior to deciding whether they wish to participate in that rotation.

### *3. Clinical Limits Continued*

For a change of pace, Maya decides to spend a week rotating in the Indonesian hospital’s Emergency Department. One afternoon, she finds

herself left alone just as a patient is being transported in with multiple injuries resulting from a road traffic accident. The nurses turn to Maya to help them with bandaging and suturing of wounds. Maya has observed wounds being sutured at her home institution, but has never had the opportunity to try it on her own. She is deeply conflicted about the situation, but reflexively offers a hand in assisting the nurses. Unfortunately, Maya is stuck by a needle while attempting to suture a wound. As she reviews the events of the afternoon in her mind, she debates anxiously about whether or not to report the needle stick injury, knowing that she was not trained to be as involved as she was in the care of this patient.

#### Sample discussion:

Although Maya has misgivings about her preparedness to properly assist with this case, the emergent nature of it poses a difficult dilemma, as she may be able to offer some assistance but lacks an adequate understanding of what might be required of her and what the potential risks might be. The types of safety precautions taken during the procedure may not be at the same level that she is accustomed to. Nonetheless, Maya's assistance may contribute to saving a life. One possibility would be for Maya to state her training level from the beginning and acknowledge a lack of experience in suturing, thus allowing the nursing staff to have more realistic expectations about her ability to assist. In essence, she would be acting more as a "good citizen" than a "qualified doctor" on the condition that a person's life is emergently at stake.<sup>6</sup> Another possibility would be for Maya to attempt to find a physician who may be able to assist.

Given that a needle stick injury has occurred in this case, Maya is at risk for infection with HIV, hepatitis B, and hepatitis C. One can review the World Health Organization's guidelines for health care worker safety and universal precautions.<sup>7</sup> In this case, following a needle stick injury, Maya should allow the wound to bleed freely, without squeeze or rubbing it, then wash the site immediately using soap or a mild cleansing solution. The ideal window for starting post-exposure prophylaxis for HIV is within 2 hours. The decision to take this depends on the HIV status of the source individual, but in case of uncertainty, one should use prophylaxis. HIV post-exposure prophylaxis medications should be readily available on-site and their appropriate use should be discussed with students prior to leaving for a clinical elective abroad. In addition Maya should already have had a series of hepatitis B vaccinations, followed by antibody titer, before leaving her home institution.

#### *4. Navigating Local Culture*

While working in Thailand in a clinic serving Burmese refugees, Elisa diagnoses a patient with a pleural effusion. The medical team agrees that

this patient will require a thoracentesis. Narae sits down with the interpreter and patient to explain the risks and benefits of the procedure. The patient is upset about the needle going so close to her lung and adamantly refuses the procedure. Afterward, the local attending physician reproaches Narae and says that she should not have attempted to explain potential complications to the patient: "In our culture, when you say that something may happen, we believe you are predicting that this will happen!" The patient continues to refuse the procedure.

#### Sample Discussion:

Obtaining informed consent is a complex undertaking even at one's home institution. The informed consent process, however, takes on further complexity when one participates in the care of patients of an entirely different culture, and provides an example of why cultural competency training is necessary for successful global rotations. While the concept of "informed consent" is largely heralded by international human rights groups, its value and role may have a different meaning in different cultures.<sup>8</sup> Researchers have asserted that some communities find informed consent to be empowering, while others find it to minimize the patient's hope and undermine his or her family-centered culture.<sup>9,10</sup> For example, this student's understanding of informed consent seems to require an individual patient to make the decision for him or herself. This view of the consent process, therefore, may not adequately incorporate the beliefs and values of family members and cultural leaders into patient care. Such complexities highlight the relevance of Lawrence Gostin's question: "Is the kind of rugged individualism inherent in informed consent truly respectful of all people in all cultures?"<sup>11</sup> As an alternative to the individualistic nature of informed consent, Hyun posits that the incorporation of family-centered culture into consent, given that it represents the values held by the patient, does not compromise patient autonomy.<sup>12</sup> Thus, modifying the model of consent to match cultural expectations is a necessary step when obtaining informed consent in a specific community.

A discussion of informed consent in the context of culture is helpful for students preparing for an elective abroad. Students can learn more about medical decision-making in a community by actively seeking advice from individuals intimately involved in patient care. In this example, a student would have benefited from education prior to departure about local attitudes towards informed consent, culture, and hierarchy. This knowledge could then serve as a basis for discussions with a local mentor about informed consent involving patients in the host institution. Although it is inadvisable for students to independently seek informed consent from patients on an international rotation, such groundwork might at least prepare students to approach patients in the presence of their mentor. The importance of a local mentor, who can advise students on local cultural norms and health beliefs, cannot be overestimated.

The informed consent process is one example of a situation in which students would benefit from cultural competency education as a component of pre-departure training, which would help to supplement careful reflection upon their experiences on the ground. Indeed, many scholars of global health education argue for more cultural competency training for medical students.<sup>13</sup> According to Betancourt and colleagues, cultural competence involves “understanding the importance of social and cultural influences on patients’ health beliefs and behaviors; considering how these factors interact at multiple levels of the health care delivery system ...and, finally, devising interventions that take these issues into account.”<sup>14</sup> Cultural competency education can provide students with the opportunity to study local culture(s) and concepts intimately intertwined with the practice of medicine, such as autonomy and personhood. If such training is not available or provided by your institution, consider preparing yourself by reading as much as possible about the local culture and the local health delivery system.

### *5. Resource allocation*

John arrives on a tuberculosis ward in Uganda outfitted with his N95 mask. He notices none of his colleagues are wearing a mask. When he inquires about this, they reply, “Our supply of masks has run out, but we have ventilated the room better since the outbreak.” John continues to wear his mask, feeling awkward, but when one of his patients is diagnosed with cavitary XDRTB, he is relieved he has done so. Now he does not know whether to share his few N95 masks with the staff, all of whom are worried about another outbreak.

#### Sample Discussion:

The concept of distributive justice, requiring that both harms and benefits be equitably distributed and thus not add further burden to already vulnerable groups, has been defined by the World Health Organization in a research context,<sup>15</sup> but can be similarly applied to clinical scenarios, including equitable access to protective gear and post-exposure prophylaxis for all health care workers. In this scenario, John is placed in the tenuous position of having access to N95 masks while others did not have this protection. While a student’s instinct to share is well intentioned, a student should not compromise his or her own safety. This problem could have been resolved at an institutional level with a thoughtful policy regarding the provision of resources for the safety of students and staff at the host institution. This is critical as institutions are responsible for the safety of their students, but must not perpetuate inequities between students and their colleagues at host institutions. While practical and financial limitations may make it difficult to provide for the safety of all health professionals, the principle of distributive justice should be considered and upheld when possible. Students should feel empowered to inquire with their sending organization about the safety measures provided for students and local colleagues at the host institution.

Practically speaking, students should be alert to possible safety risks that they may encounter during short-term experiences abroad. Consider how you will be minimize personal safety risks, such as coming prepared with N-95 masks or a supply of disposable gloves. If you find yourself in a difficult position with regards to lack of resources for healthcare worker safety where you are training, discuss your situation with your advisor at the site as well your advisor at your home institution.

### **Annotated Reference List for Further Reading**

1. Elansary et al. Ethical dilemmas in global health electives. The Journal of Global Health 2011 Spring. <http://www.ghjournal.org/spring-2011-issue/>

This pre-departure global health ethics training is based upon this article. It contains cases similar to those discussed in the training session, accompanied by discussions that summarize current thought on the subject matter.

2. Shah S, Wu T. The medical student global health experience: professionalism and ethical implications. Journal of medical ethics 2008;34:375-8

Given the rapid increase in the number of medical students having global health experiences, this article discusses some ethical considerations and recommends that students undergo ethical and professional education before having these experiences.

3. Banatvala N, Doyal L. Knowing when to say "no" on the student elective - Students going on electives abroad need clinical guidelines. British Medical Journal 1998;316:1404-5.

This is a brief but substantial discussion of deciding the limits of involvement in patient care, a common challenge encountered by medical students in global health experiences. An emphasis is placed on the importance of students recognizing their limitations so they can make good decisions when asked to participate in patient care.

4. Gupta AR, Wells CK, Horwitz RI, Bia FJ, Barry M. The International Health Program: the fifteen-year experience with Yale University's Internal Medicine Residency Program. The American Journal of Tropical Medicine and Hygiene 1999;61:1019-23.

As evidence for promoting international health electives, this retrospective survey found that such electives for residents in internal medicine appear to influence residents' attitudes and career decisions in several ways.

5. Carrese JA, Rhodes LA. Western bioethics on the Navajo reservation. Benefit or harm? *JAMA : the journal of the American Medical Association* 1995;274:826-9.

This study illustrates concerns regarding informed consent and advance care planning for non-Westerners. Navajo participants believed that theoretical discussions about negative health outcomes would be potentially harmful to Navajo patients.

6. Drain PK, Holmes KK, Skeff KM, Hall TL, Gardner P. Global health training and international clinical rotations during residency: current status, needs, and opportunities. *Academic medicine : journal of the Association of American Medical Colleges* 2009;84:320-5.

This article discusses the benefits of training in global health during residency, some of the barriers to the provision of such experiences and to medical trainees participating in them, and some suggestions for expanding opportunities for global health training.

## References

1. Shah S, Wu T. The medical student global health experience: professionalism and ethical implications. *Journal of medical ethics* 2008;34:375-8.
2. Crump JA, Sugarman J. Ethical considerations for short-term experiences by trainees in global health. *JAMA : the journal of the American Medical Association* 2008;300:1456-8.
3. Radstone SJ. Practising on the poor? Healthcare workers' beliefs about the role of medical students during their elective. *Journal of medical ethics* 2005;31:109-10.
4. Farmer P, Campos NG. Rethinking medical ethics: a view from below. *Developing world bioethics* 2004;4:17-41.
5. Gupta AR, Wells CK, Horwitz RI, Bia FJ, Barry M. The International Health Program: the fifteen-year experience with Yale University's Internal Medicine Residency Program. *The American Journal of Tropical Medicine and Hygiene* 1999;61:1019-23.
6. Banatvala N, Doyal L. Knowing when to say "no" on the student elective - Students going on electives abroad need clinical guidelines. *British Medical Journal* 1998;316:1404-5.
7. Health Care Worker Safety. Geneva, Switzerland: World Health Organization; 2003.
8. Barry M. Ethical considerations of human investigation in developing countries: the AIDS dilemma. *The New England journal of medicine* 1988;319:1083-6.
9. Blackhall LJ, Murphy ST, Frank G, Michel V, Azen S. Ethnicity and attitudes toward patient autonomy. *JAMA : the journal of the American Medical Association* 1995;274:820-5.
10. Carrese JA, Rhodes LA. Western bioethics on the Navajo reservation. Benefit or harm? *JAMA : the journal of the American Medical Association* 1995;274:826-9.
11. Gostin LO. Informed consent, cultural sensitivity, and respect for persons. *JAMA : the journal of the American Medical Association* 1995;274:844-5.
12. Hyun I. Waiver of informed consent, cultural sensitivity, and the problem of unjust families and traditions. *The Hastings Center report* 2002;32:14-22.
13. Drain PK, Holmes KK, Skeff KM, Hall TL, Gardner P. Global health training and international clinical rotations during residency: current status, needs, and opportunities. *Academic medicine : journal of the Association of American Medical Colleges* 2009;84:320-5.
14. Betancourt JR, Green AR, Carrillo JE, Ananeh-Firempong O, 2nd. Defining cultural competence: a practical framework for addressing racial/ethnic disparities in health and health care. *Public health reports (Washington, DC: 1974)* 2003;118:293-302.

15. Council for International Organisations of Medical Sciences and the World Health O. International Ethical Guidelines for Biomedical Research Involving Human Subjects. Geneva: CIOMS, WHO; 2002.