

Ethical Dilemmas in Global Clinical Electives

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Introduction

A recent Association of American Medical Colleges survey found that 30% of graduates of U.S. medical schools reported participating in global health experiences (Association of American Medical Colleges, 2010). Previous research has shown that international rotations foster cultural awareness, elicit a deeper understanding of poverty, and influence students to pursue careers caring for underserved populations (McKinley, Williams, Norcini, & Anderson, 2008; Ramsey, Haq, Gjerde, & Rothenberg, 2004; Shaywitz & Ausiello, 2002). Despite considerable interest in global health education from students and its reported benefits, however, most schools have not integrated formal global health programs into their curricula (Izadnegahdar et al., 2008; Panosian & Coates, 2006). Only recently have formal ethical guidelines for global health experiences been introduced (Crump, Sugarman, & Working Group on Ethics Guidelines for Global Health Training, 2010; Provenzano et al., 2010). The lack of an institutionalized framework for global health education has had important ethical and educational implications for medical students who pursue electives in resource-poor settings.

International research programs are governed by well-developed clinical guidelines, but global clinical electives carry with them many ethical challenges that have received relatively little attention (Shah & Wu, 2008). While international research programs contribute to the larger academic discourse and are subject to institutional review board approval and other ethical standards, clinical programs that involve students also impact the local community and thus require similar attention. In particular, the perspectives and needs of institutions that host and support foreign students at the international clinical sites in low-resource settings ("host institutions") have been neglected. Electives have been described as a "one-way opportunity" that favor students who visit from wealthier institutions (Mutchnick, Moyer, & Stern, 2003). Paradoxically, the disproportionate focus on the benefits for visiting students rather than for the host institution reinforces the same disparities in wealth and opportunity that global health programs seek to address.

The case studies presented here, based on the experiences of the student authors, show the need for a more cohesive, informed approach to global health electives. Through building formal, long-term, global North-South partnerships, medical schools and host institutions may prevent many of the ethical dilemmas that arise as a result of global clinical experiences (Horton,

2000). We recommend specific guidelines to ensure that clinical electives in low-resource settings are ethical and mutually beneficial for both visiting students and host institutions.

Burdens on the Host

While in Honduras for a clinical rotation, Narae relies on the physician running the clinic to explain patients to her because she is unfamiliar with conditions there. She also requires constant guidance from the staff for help with interpretation and simple tasks around the clinic.

While the benefits of global electives for American medical trainees are well-documented, research has not been conducted to assess whether these partnerships benefit host countries (Gupta, Wells, Horwitz, Bia, & Barry, 1999). In this scenario, the physician was diverted from his 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" (Crump & Sugarman, 2008). 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.

Reasonable expectations for both 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 for partners in the host country can include educational resources, research support, and project development in addition to financial compensation as is appropriate in a given setting. As an example, institutions from the global North could sponsor training programs for health care workers at host institutions.

Clinical Limits

Ramy has arrived in Zambia for an elective at a busy public hospital. He is frequently left alone to care for patients as there are few physicians available to supervise him. Ramy is anxious, and feels he is providing care beyond his capabilities. He 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."

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" (Shah & Wu, 2008). This is a concern particularly with students early in their training, when they have limited clinical exposure. In this scenario, Ramy recognizes that he is not qualified to work independently. Many students, however, do not have this same insight. 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" (Crump & Sugarman, 2008).

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 (Radstone, 2005). In resource-poor settings, patients are particularly vulnerable to "dissymmetries of power" in medicine (Farmer & Campos, 2004). 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" (Shah & Wu, 2008). 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.

U.S. institutions currently charge significant tuitions for foreign students taking an elective. At Yale, for example, students from international schools pay a tuition fee of \$2,500 USD for a four-week elective (Yale School of Medicine, 2009). In turn, U.S. medical schools should provide host institutions with the support and resources needed for student learning. Providing host physicians with stipends in recognition of their teaching can foster appropriate supervision for students visiting low-resource settings. Ideally, institutional partnerships should provide equitable educational opportunities for medical students from both the global North and global South.

Informed Consent

While working in a clinic serving Burmese refugees, Elisa diagnoses a patient with cardiac tamponade. The team believes pericardiocentesis is necessary. Elisa sits down with the interpreter and patient to explain the risks and benefits of the procedure. The patient is upset to hear about the needle going close to her heart and adamantly refuses the procedure. The attending physician tells Elisa that she should not

have discussed potential complications with the patient. "In our culture, when you say something could happen, we believe that you are predicting that this will happen!" The patient continues to refuse the procedure.

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 (Barry, 1988). Some 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 (Blackhall, Murphy, Frank, Michel, & Azen, 1995; Carrese & Rhodes, 1995). For example, since informed consent for the paracardiocentesis procedure requires an individual patient to make the decision, the consent process inherently does not 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?" (Gostin, 1995) 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 (Hyun, 2002). 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, Elisa should have received education prior to her departure about Burmese attitudes towards informed consent, culture, and hierarchy. With this insight, Elisa could have sat down with her mentor and discussed her thoughts and questions about informed consent. Elisa and her mentor could have then approached the patient together, as a visiting student should not seek informed consent from patients without supervision.

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 (Drain, Holmes, Skeff, Hall, & Gardner, 2009). 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" (Betancourt, Green, Carrillo, & Ananeh-Firempong, 2003). 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.

Distributive Justice

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 cavitory 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.

The concept of distributive justice requires that both the harms and the benefits of research be equitably distributed and thus not adding further burden to already vulnerable groups (Council for International Organisations of Medical Sciences and the World Health Organisation, 2002). This is a narrow view of the concept, as distributive justice 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 was in the tenuous position of having access to N95 masks while others did not have this protection. John's instinct to share is well intentioned, but he should not compromise his 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 hosts. 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.

Conclusion: Recommendations for Ethical and Equitable Global Electives

As the global health community faces ongoing challenges, medical student interest in global electives is encouraging and needed. Such electives can familiarize students with gross inequities in health resources between the global North and South and encourage student activism and advocacy concerning health disparities. Many factors, however, compound to make global health electives complex, including a misunderstanding of the responsibilities of a health professional student, perceptions of culture and ethnicity, and socioeconomic disparities. Student preparation can often be inadequate, leaving students ill equipped for the clinical and ethical challenges posed by global experiences. These concerns are magnified by the lack of attention given to the burdens on local staff and institutions in settings of disproportionate poverty and disease. While the focus of this paper is on the unique ethical dilemmas posed to medical students by short-term clinical electives, it is important to recognize more broadly that global health training programs and their ethical challenges encompass multiple disciplines and varying levels of trainees. In order to address these wider concerns, the Working Group on Ethics Guidelines for Global Health Training (WEIGHT) recently developed a set of broadly applicable ethical guidelines and practices for institutions, trainees, and sponsors of field-based global health training (Crump et al., 2010).

Many of the ethical dilemmas faced by medical students on short-term electives may be mitigated by building long-term partnerships between medical schools and host institutions, with the goal of mutual education, training, and capacity building.

Several recommendations are offered here for global collaboration between medical schools and host institutions (See Table 1), with the primary aim of improving the quality of patient care in low-resource settings. Several different collaborations model this goal, exemplifying both the feasibility and importance of these relationships and pre-departure trainings (AFMC Global Health Resource Group, 2008; Barry, 2011; Chase & Evert, 2011; Einterz, Kelley, Mamlin & Van Reken, 1995). Electives for students from both the global North and global South represent one component of such collaboration. Furthermore, long-term institutional partnerships with appropriate financial compensation have the potential to improve the quality of global health education, reduce the burden on host institutions, and create an equitable and ethical framework for the training of physicians.

Table 1: Recommendations for North-South Institutional Collaboration Between Medical Schools and Host Institutions

Development of mutually beneficial North-South partnerships between medical schools and cooperating international sites
Development of educational programs designed to improve education of local health professionals through shared educational opportunities for local and international students
Compensation for hosting institution faculty, clinical tutors, interpreters, housing, and logistical support
Pre-departure training that includes explicit expectations of student responsibilities, discussion of ethical scenarios, cultural competency training, local disease epidemiology, and basic language instruction

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Fighting Stigma: Lymphatic Filariasis

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Introduction

Mosquitoes are everywhere, and millions of people fall victim to mosquito bites daily. While mosquito bites are generally harmless, for those who live in underdeveloped countries, these bites carry diseases that result in severe socioeconomic and physical subordination (Wynd et al., 2007). People who contract Lymphatic Filariasis (LF), an infectious disease transmitted by mosquitoes, may experience grotesque enlargements of their affected body parts, which include the arms, the legs, and the genital areas. When such swelling occurs, the patient is said to have progressed to a stage of LF known as elephantiasis, a term designed for the elephant-like texture of the resulting skin (Evans, Gelband & Vlassot, 1993).

In 1997, the World Health Organization classified LF as a potentially rectifiable disease. Since then, the World Health Assembly has called upon its member states to initiate drug pro-

grams to eliminate LF as a health problem (Wynd, Melrose, Durrheim, Carron & Gyapong, 2009). LF has been effectively controlled in endemic areas in the Pacific, the Caribbean, and in China, but the disease still runs rampant in India, East Africa, and 80 tropical and sub-tropical countries. Approximately 120 million people are already infected with LF, and 40 million have advanced to elephantiasis (Evans et al., 1993; Sudomo, Chayabegara, Duong, Hernandez, Wu & Bergquist, 2010; Wynd et al., 2007). In these countries, medical access and hygiene measures do not adequately accommodate overpopulation (Wynd et al., 2007). Reforming the healthcare systems of these countries, contrary to popular belief, is not enough. Battling LF is an issue that requires a profound radicalization of human thought. However, before we can begin to examine what is implied by this "revolution of thought," it is important to understand how LF is contracted and spread.