

Medical Relief Trips...What's Missing? Exploring Ethical Issues and the Physician-Patient Relationship

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"The welcome ceremony alone will leave you breathless as you become inspired by their overwhelming joy at your arrival. Here you will participate with the community and provide much needed medical care. The team will also provide care for the Talibe boys in Theis who go without medical care and are left to face disease on their own" (Senegal, 2009).

This vivid description from a nonprofit organization's website presents some of the ideas that draw physician volunteers to participate in short-term international medical relief trips. A community with a desperate need for medical attention, an opportunity to provide relief when perhaps no one else will—in many cases, these motivations are what drew physicians to the field of medicine in the first place. American physicians' growing interest in global health is evident from the thousands of physicians who travel to developing countries for periods of several days to several months every year (Wolfberg, 2006). In fact, participating in three medical relief trips to Tegucigalpa, Honduras, as an undergraduate is what led me to pursue a career in medicine. However, even my limited experience working with volunteer medical teams has revealed the unexpected ethical issues that physicians must confront when they go abroad to provide medical relief.

Despite their good intentions, volunteer physicians often face an ethical dilemma as they must choose between providing substandard, or at times potentially harmful, care or no care at all (Green et al., 2009). Analyzing recent critiques of short-term medical trips indicates that these problems arise from the lack of a good physician-patient relationship. Realistically, how can a physician-patient relationship based on trust and mutual respect, the ideal we hold in the U.S., form in the span of a few months, let alone a single week? A critical reconsideration of how to improve the physician-patient relationship during short-term medical relief trips is urgently needed as the number of globally oriented physicians rises.

Current medical standards in the U.S. emphasize the role of the physician to "help the patient understand the medical situation and available courses of action, and the patient conveys his or her concerns and wishes" (Emanuel and Emanuel, 1992). Unfortunately, in the setting of some short-term medical relief trips, more

emphasis is placed on the *number* of patients treated rather than the *quality* of patient care, as evident from newspaper headlines such as "Singapore's Medical Relief Team Treats 500 Patients in Myanmar" (Perry, 2008). This may lead to situations where patient education and understanding of available treatment options are abbreviated due to time constraints. For instance, reports of physicians giving patients injections without telling them what they are for (Bishop and Litch, 2000) exemplify the level to which the physician-patient relationship can be degraded. Additionally, during my own experience in Honduras, I saw short courses of antibiotics being distributed to numerous patients without mention of the risks of allergy or developing resistance. For a patient who walked four hours to one of these makeshift clinics, in an area where the nearest health post is a two-hour truck ride away, the potential of a serious adverse reaction such as anaphylactic shock cannot be ignored.

Much commendable work has been undertaken to improve guidelines for doing clinical research on vulnerable populations in developing countries (Bhutta, 2002). One of the basic principles of the Declaration of Helsinki is that participants in clinical trials should be "adequately informed of the aims, methods, sources of funding, any possible conflicts of interest, institutional affiliations of the researcher, the anticipated benefits and potential risks of the study and the discomfort it may entail" (World Medical Association, 2008). Interestingly, similar guidelines to ensure patients' informed consent to medical treatment by humanitarian organizations do not exist.

It is also disconcerting that the principle of "first, do no harm," considered by many to be the fundamental tenet of the physician-patient relationship, does not always guide physicians when treating patients in developing countries as it does when they practice at home. Physicians during short-term trips are often encouraged to provide "something rather than nothing at all" even if that "something" may be ineffective or even harmful to the patient (Bishop and Litch, 2000). As one example, medical groups often bring expired medications that have been donated from clinics or nonprofit agencies. In addition to the lack of research on the safety of expired drugs, these medications may be improperly stored, as with preparations that require refrigeration or are unstable at high temperatures,

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leading to reduced efficacy. In one study, an assay of several commonly used antibiotics in Nigeria and Thailand showed that 36.5% of the samples were substandard (Ette, 2004). While these medications may still have some therapeutic value, there is clearly a difference in standard of care for these patients as compared to their counterparts in the U.S. In a more extreme situation, two children, who shouldn't have been operated on due to malnourishment, died in an Asian hospital after undergoing cleft palate surgery by a volunteer surgical team (Dupuis, 2004). Situations such as these arise from the erroneous assumption that anything a U.S. medical team has to offer an underserved community will be beneficial, when, in fact, it may be detrimental.

One of the more obvious dilemmas that arise during short-term medical trips is the issue of continuity of care. Recent reviews of medical literature emphasize that continuity of care is associated with better health outcomes and improved preventive care (Saultz and Lochner, 2005). However, short-term medical trips generally only last several days to several months, leaving little opportunity for follow-up care or treatment of chronic health problems, let alone time for a trusting physician-patient relationship to develop. One example where continuity of care is vital is in obstetric vesico-vaginal fistula repair. A vesico-vaginal fistula is an injury that generally occurs due to prolonged, obstructed labor and results in an abnormal opening between a woman's bladder and vagina, leading to urinary incontinence. While rare in industrialized countries, this condition continues to afflict millions of women in developing areas (Wall, 2006). If the woman survives, an unrepaired fistula turns the woman into a social outcast, divorced by her husband and rejected by her community, due to the odor from continuous leakage of urine onto her clothes and legs (Waalwijk and Armiya'u, 1993). Because of increased awareness of this devastating condition, there has been a recent increase in the number of surgeons traveling to Africa and Asia as part of short-term surgical teams to perform fistula repair operations (Wall, 2006). While these teams have performed thousands of valuable surgeries, it is important to realize that these women are not completely "healed" once the surgery is performed. In addition to her need for long-term postoperative care, surgery is just the first step in the process of her psychosocial recovery from what may have been years of social isolation. These patients may also continue to have problems with infertility, vaginal stenosis, and incontinence requiring care and support from physicians long after their surgical wounds have healed (Waalwijk and Armiya'u, 1993); furthermore, some of these issues may not become apparent until well after surgical teams have left.

The importance of cultural sensitivity in the physician-patient relationship is apparent considering the extensive effort U.S. medical schools have undertaken to teach cultural competency as part of the medical

education curriculum (Crosson et al, 2004). It is all the more relevant for physicians working in foreign countries to understand the cultural factors that influence how illness and medicine are perceived. For instance, in Hispanic cultures, *caída de mollera* (sunken fontanelle), presumed to be caused by the sudden release of the nipple from the baby's mouth during feeding, is traditionally treated by holding the baby upside-down and dipping its head in a pan of water or tapping the feet several times (Hansen, 1997). These treatments, which are gently performed, have been misunderstood to be a form of child abuse by physicians unfamiliar with the practice. Similarly, distributing condoms to prevent HIV transmission will be ineffective in a culture where condom use is equivalent to admitting infidelity (Maharaj and Cleland, 2004). Patients' conceptualizations of illness and healing are often deeply embedded in their culture. Understanding these influences requires significant time and a high level of community involvement; unfortunately, this is difficult to achieve during the short time physicians spend in the community.

Physicians must also take into account what resources patients have available in order to choose the most appropriate medical treatment. Understanding a community's living conditions often requires extensive preparation and groundwork before physicians even arrive in the country. In one study in the Guatemalan highlands, a medical team visiting the area implemented a de-worming campaign in an area without access to clean water (Green et al., 2009). A quick survey of the community's water supply would have quickly shown them that any attempts to use antiparasitic medications would provide only short-term relief without addressing the underlying problem. In another example, giving a patient with moderate hypertension a two-month supply of Atenolol will probably be much less effective than counseling him on his diet and physical activity if medical teams come to his village only once a year. Unfortunately, from observations of medical teams in Honduras, it seems that pills are much more likely to be handed out than advice on lifestyle changes.

Short-term international medical volunteer work is experiencing a surge in interest among physicians and medical students. This trend is only expected to increase given that 25% of 2007 U.S. medical graduates participated in an international health experience (Association of American Medical Colleges (AAMC, 2007) as compared to 6% in 1984 (AAMC, 1984). While volunteer physicians elect to participate in these trips intending to improve the health of people in great need, much too frequently, they end up providing care that is substandard or even harmful. The issues described above of inadequate patient education, potentially harmful treatments, culturally inappropriate care, and lack of continuity of care all point to the need for a better physician-patient relationship in these situations. In most cases, volunteer physicians already know what

needs to be done since they follow these same ideals when they treat their patients at home: educating patients to ensure they understand treatment options, putting health care decisions in patients' hands, respecting cultural differences, and forming relationships based on mutual trust and respect.

Critiques of short-term medical trips suggest numerous opportunities for improvement. For instance, emphasizing *quality over quantity* of care will help ensure that physicians have adequate time to explain treatment options and allow patients to make informed decisions. Medical teams often measure their impact in the number of patients seen, amount of medications prescribed, and number of teams per year (Sociedad Amigos de los Niños, 2005). Perhaps additionally measuring qualitative aspects such as patient outcomes and perceived improvements in health would help enhance continuity of care; these assessments could be performed by physicians or even nonmedical volunteers. Also, creation of guidelines for humanitarian medical groups will help new physicians volunteering abroad avoid the pitfalls of their predecessors.

Despite criticism of these trips, there have been promising steps towards creating culturally appropriate and sustainable improvements in health care in developing countries. These improvements are all grounded in good physician-patient relationships. For example, pediatric residents from the University of Washington working in El Salvador created nutrition handouts containing information on local foods rich in iron to help prevent anemia (Suchdev et al., 2007). In Guatemala, medical students from the University of Colorado surveyed local community health experts on their perceptions of short-term medical relief efforts in order to help develop more appropriate health interventions (Green et al., 2009). In 1999, the World Health Organization (WHO) created a set of drug donation guidelines to ensure humanitarian organizations only provide high-quality, unexpired, and appropriate medicines to places in need (WHO, 1999).

International medical experiences can be life-changing and highly influential in providing physicians with a deeper awareness of global health disparities and motivation to continue working with underserved populations. However, patients treated by volunteer medical groups deserve the same standard of care that physicians provide their patients at home—including a considerate and respectful physician-patient relationship.

NOTE

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