

Virtual Mentor

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Global Health Ethics and Professionalism Education at Medical Schools

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Shah S, Wu T. The medical student global health experience: professionalism and ethical implications. *J Med Ethics*. 2008;34(5):375-378.

Global health has enjoyed a great deal of attention in the past several years, due to the growing sense of interconnectedness across continents and cultures, as well as to the health challenges we collectively face, such as the H1N1 influenza pandemic and the effects of climate change. These challenges compound the existing problems of health worker migration, disparities in access to affordable care, armed conflict, and population growth that already confront health care systems around the world.

Interest in global health within the medical and public health community might be crudely assessed by the number of peer-reviewed articles discussing the topic. If a hypothetical researcher searched MEDLINE for “global health” or “international health” in 1925, one article would appear. By 1990, there would be 528 articles, but by 2010, 9,243 articles would be related to those terms.

Medical students and medical schools are not insulated from these trends. Among medical students in the United States graduating in 2009, 29.9 percent will have participated in a global health experience [1]. Depending on where they went to school and their own motivation, these students may or may not have engaged in discussions of the ethical or professional implications of their work. Their formal education related to global health could have ranged from virtually nothing to multiyear programs with close faculty supervision. In the view of U. S. medical students who graduated in 2009, medical schools’ ability or willingness to provide global health education does not match the demand; 41.3 percent of them felt that inadequate time was spent on global health [1].

The Obligations of Medical Schools

As students within this system, Shah and Wu provide an insightful discussion of ethical and professional implications of medical student participation in global health experiences (GHEs) [2]. Though they note that “research, teaching, and related activities are also GHEs,” they limit their discussion to clinical scenarios. This is an understandable distinction to make, as the challenges, relevant ethical and professional principles, and potential solutions are different for each of those domains. Physicians and students should keep in mind, however, that in actual practice, the work that medical students do in resource-limited and international settings rarely fits neatly within those boundaries.

Shah and Wu emphasize the institutional obligations of medical schools in addition to the responsibilities of medical students or physicians—which numerous other articles discuss. They note that

medical schools bear the responsibility of fostering principled and professional frameworks for students to approach medicine, and it seems natural that this preparation ought to extend to patients served in any context, including those populations in resource-limited settings [3].

That is, the authors focus on the educational structures that produce the medical students and physicians who later find themselves in ethical and professional dilemmas in resource-limited or international settings.

This emphasis is increasingly relevant, since, in my experience, many of these institutions now directly sponsor global health experiences through groups based within the school and provide indirect support for students and faculty working with organizations unaffiliated with the school. The institutions have an obligation to ensure that the global health experiences comply with the highest ethical standards. They should, for example, require that a physician licensed in the jurisdiction where the GHE is taking place supervises provision of medical care and that all donated pharmaceuticals and medical supplies comply with WHO standards. The institutions must also ensure that students are aware of their ethical and professional obligations while working in resource-limited settings.

Shah and Wu specify that medical schools should develop a “formalized global health professional curriculum” to “better prepare their students for the unique challenges of practicing medicine in resource-limited settings” [3]. They refer to the Association of American Medical Colleges’ (AAMC’s) four key attributes of professionalism as a starting point for standardized ethical guidelines for global health experiences. These attributes are: (1) adhering to high ethical and moral standards, (2) responding to societal needs that reflect a social contract with the communities served, (3) subordinating self-interest to the interest of others, and (4) evincing core humanistic values. They also mention that the courses should “incorporate preparation for the health and personal safety challenges of working in these environments” [4].

Professional and ethical behavior and attitudes are greatly influenced by students’ and other professionals’ understanding of the environmental, social, political, economic, and cultural structures and forces at work in host communities. Thus, any effort to teach global health ethics and professionalism must be grounded in a broader education on the history, ideas, organizations, and challenges that affect global health in general and the particular communities where the students plan to work.

Education about global health should not be limited to those students who happen to participate in global health experiences during their time as medical students. As the

world becomes more interdependent and interconnected, a basic understanding of global health topics will be necessary for all physicians [5], but there is no consensus on what those topics should be. The Global Health Education Consortium and the Association of Faculties of Medicine of Canada Resource Group on Global Health have begun the process of developing consensus by forming a committee to develop global health curriculum guidelines that will be relevant to all medical students [6].

The Obligations of Individuals

Shah and Wu make important recommendations for institutions, but they do not neglect the responsibilities of individuals. The authors make an astute observation about the dilemma experienced by medical students who seek to serve in resource-limited and international settings:

The *opportunity to serve* an underserved population is an important factor motivating GHE participation for many of our peers. This *ability to serve*, however, is often tempered by the limitations in our clinical knowledge, given our status as physicians-in-training. This desire to help, combined with relative inexperience, can pose ethical conflicts and leave both patients and students vulnerable to negative outcomes... [emphasis added] [7].

They also discuss the all-too-pervasive view that many volunteers (not just medical students) have about the communities they serve: “people who live in poverty will benefit from *any* medical services, irrespective of the experience, or lack thereof, of the provider” [8]. I sometimes hear this from students and physicians stated as “Well, it’s better than nothing.”

Physicians and physicians-in-training are bound by the ethical principle of nonmaleficence, often succinctly stated as *primum non nocere*. Working abroad or with people who have no other options for care does not eliminate this ethical requirement. Physicians and medical students must evaluate the potential harm of their actions and inform patients of this harm. Often, however, physicians and students working in new settings, with unfamiliar diseases and disease presentations and without sufficient knowledge about options for follow-up care, are not fully aware of the possible harms of their actions and inaction [9, 10]. Moreover, cultures vary in how they balance risks and benefits and how they assess uncertainty. This underscores the need for physicians and students to learn as much as they can about their destination prior to leaving, and the need for them to work in conjunction with local health care providers. As Shah and Wu state, physicians and students “bear the responsibility of saying ‘no’ and recognizing their own limitations” [4].

Conclusions

It is exciting and encouraging that an increasing number of physicians and medical students are interested in promoting global health equity. Although a large percentage of medical students think medical schools have not kept pace with this interest, these institutions play a crucial role within the health care system domestically and internationally. They can strengthen efforts to address the needs of the underserved by incorporating global health topics into the core medical

curriculum, teaching more continuing medical education classes on relevant topics, and supporting efforts to develop guidelines for ethical and professional behavior for physicians and students participating in global health experiences.

Health care professionals who seek to serve the underserved devote their already-stretched time and energy and should be commended for their efforts. Their patients should expect that they will receive high quality care and that their caregivers will adhere to the highest ethical and professional standards. In their role as patient-advocates, physicians and medical students should demand this of themselves, their colleagues, and the organizations with which they work.

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