

Virtual Mentor

American Medical Association Journal of Ethics
December 2006, Volume 8, Number 12: 808-813.

Clinical case

Limits on student participation in patient care in foreign medical brigades

Commentaries by Naheed Rehman Abbasi, MD, MPH, and Michael Godkin, PhD

Phil Denton is a third-year medical student at a northeastern university. During the summer between his second and third year, he was selected to go to El Salvador with a team of surgeons who staff a rural clinic for two weeks twice a year.

Phil thought that his main activity would be shadowing the surgeons. The clinic, however, was extremely busy with the doctors seeing hundreds of patients a day. On Phil's first day, one of the surgeons gave him a white coat and told him to introduce himself as "Dr. Denton." He saw patients by himself and, with his fairly fluent Spanish or through translators, gained their consent for surgical procedures. In the operating room, after a brief introduction to suturing and sterile technique, Phil was given the responsibility of prepping the patients before surgery and suturing the incisions afterward. The surgeons were usually out of the room while he performed these functions.

At first, Phil was thrilled to be getting such experience at so early a stage in his training. In the United States, that kind of responsibility was usually reserved for second- and third-year surgery residents. But after a patient he had prepped for surgery returned with a wound infection, Phil looked at the situation differently.

He asked one of the surgeons at the clinic if it was appropriate for him to be performing functions on patients in El Salvador that he would not be allowed to perform on patients in the United States. The surgeon replied, "Relax, the rules here are different than at home. No one tells us what to do here. Besides, if you didn't help us out, we wouldn't be able to see as many patients and some people wouldn't get the help they need. Is it better for the patient to get less expert care or no care at all?"

Commentary 1

by Naheed Rehman Abbasi, MD, MPH

Few would contest the claim that the rise in popularity of medical volunteerism is commendable and represents a heightened awareness of health care inequities, both domestic and international, on the part of medical professionals. Cases such as this one illustrate common challenges facing physicians-in-training who are working in

international settings, and they should stimulate careful consideration of ethical, legal and practical aspects of care provision in international contexts.

Physicians and medical trainees volunteering in international developing communities commonly encounter environments starkly different from those of their native countries. Challenges facing these caregivers are myriad: linguistic, cultural and gender barriers in patient-physician communication; a paucity of health care resources and basic supplies; diverse and unfamiliar conceptions of disease and health; low levels of literacy; and confrontation, usually for the first time, with abject poverty that limits the ability of patients to prioritize and dedicate resources to health problems. Coming face-to-face with these significant barriers is a necessary but often uncomfortable part of the volunteer physician's experience. Added to these challenges are the struggles of trainees who must confront the limits of their abilities or confidence while serving patients who are naive about their caregivers' uncertainty and often possess blind faith in doctors and medical personnel.

Phil Denton's experience is one to which many physicians and medical students can relate, yet the specific circumstances are made more challenging by their international context. Students commonly report discomfort with being identified as "doctor," a term which elevates them to the level of more experienced colleagues and may unfairly raise patient expectations regarding their abilities and knowledge base. Nearly every medical trainee can recount instances of performing procedures for the first time on a trusting patient in contexts of minimal supervision. Asking for supervision in such instances can be awkward or even impossible, since heavy clinical volume and power hierarchies may make more senior physicians inaccessible. In settings with ample resources, challenges like these are remediable through actions as simple as yelling for help. The assumption that help will be available in an instant, and the very construct of calling a "code," can be viewed as luxuries of medicine in developed countries.

It is a cruel irony that medical trainees working in developing communities may find themselves elevated to levels of heightened responsibility precisely at the times when their potential errors may be the least remediable. The arguments Phil Denton confronts that "rules here are different than at home" and "if you didn't help us [no one would]" are uncomfortable to the trainee and cannot be justified on ethical grounds. In practice, however, arguments such as these are used on a daily basis to justify delivery of medical services in developing countries by students, trainees or volunteers. Countries in which voluntary services are commonly provided generally lack specific laws regarding scope of practice or supervision for international medical volunteers, and no international code of medical ethics exists to guide the specific practices (in challenging circumstances) delineated in the current case.

The American Medical Association's *Code of Medical Ethics* articulates several opinions that relate to the current case. Opinion 8.087 regarding medical student involvement in patient care states that "students and their supervisors should refrain from using terms that may be confusing when describing the training status of

students” [1]. By this standard, Phil Denton’s supervising physicians misrepresented him in a manner that was both untruthful to patients and uncomfortable to Phil. Opinion 8.088 regarding resident physicians’ involvement in patient care states that “training must be structured to provide [trainees] with appropriate faculty supervision... with graduated responsibility relative to level of training and expertise” [2]. Clearly, such supervision was not available to Phil Denton, yet the extreme circumstances of the case make transgression from ethical guidelines difficult to critique.

Inasmuch as the overarching purpose of both legal and medical ethical guidelines is and should be the protection of patient and physician safety and well-being, it is unclear how lines of responsibility should have been delineated for and by Phil in the current case. That Phil should have refused to participate in tasks which he believed he was unqualified to perform independently, such as skin closure after surgery, is a valid perspective, but it is also valid to argue that Phil’s supervising physicians were entrusted with (and failed) the charge of supervising him more closely and helping to delineate tasks which a student at his level could reasonably and safely perform. In the United States, Phil’s responsibilities and supervision in the operating room setting would have been quite different.

The very existence of the AMA’s *Code of Medical Ethics* as a living and evolving corpus to guide the ethical practice of medicine is an invaluable asset to the global community of medicine. Whether one agrees or disagrees with specific aspects of the *Code* is not as important as the concept that the medical community can and must preserve its own professionalism. Codes of medical ethics can and should be debated and revised over time in response to new demands of a complex world.

The challenge of adherence to ideal ethical guidelines in emergent or extreme situations such as those illustrated by this case is real, however, and deserves greater scrutiny. Debates generated by such attention may result in the formulation of specific legal and ethical guidelines to direct and facilitate the practices of international medical volunteers.

Greater awareness of the challenges and rewards facing medical volunteers must also be stimulated by physicians, nongovernmental organizations and the lay press to prepare future generations of health care volunteers for the complexities of their chosen roles. Physicians today are both health care professionals and participants in a global civil society, and a careful analysis of both the demands and limitations facing medical volunteers is critically necessary.

References

1. American Medical Association. Opinion 8.087 Medical student involvement in patient care. *Code of Medical Ethics*. Available at: <http://www.ama->

assn.org/apps/pf_new/pf_online?f_n=browse&doc=policyfiles/HnE/E-8.087.HTM&&s_t=&st_p=&nth=1&prev_pol=policyfiles/HnE/E-7.05.HTM&nxt_pol=policyfiles/HnE/E-8.01.HTM&. Accessed November 3, 2006.

2. American Medical Association. Opinion 8.088 Resident physicians' involvement in patient care. *Code of Medical Ethics*. Available at: http://www.ama-assn.org/apps/pf_new/pf_online?f_n=browse&n_p=T&s_t=&st_p=&nth=1&prev_pol=policyfiles/HnE/E-8.085.HTM&nxt_pol=policyfiles/HnE/E-8.088.HTM&. Accessed November 3, 2006.

Naheed Rehman Abbasi, MD, MPH, is a resident in dermatology at New York University Medical Center in New York City. She was the AMA student representative on the Council of Ethical and Judicial Affairs from 2001-2003 and has worked as a public health volunteer in Bangladesh, Mexico and Pakistan.

Commentary 2

by Michael Godkin, PhD

When foreign students and doctors provide medical care in a host country they encounter a spectrum of ethical dilemmas intensified by the addition of foreign medical personnel. Not only do the host institution's standards and the personal and professional standards of local clinicians influence patient care, but the standards of the foreign brigades do also. Added to this is the likely burden of a cultural divide that can lead to false assumptions and misunderstandings between caregivers and between caregivers and patients.

On one hand, the ethical boundaries of this scenario are quite clear compared to many of those that cause real-life quandries for medical students. The ultimate responsibility for the appropriate care of patients in this case would appear to lie with the brigade physician because he has assumed primary responsibility for the patients. As an aside, one might question how this assumption of authority originated; most likely not from a deliberative and collaborative process between the hosts and the foreign volunteers as a partnership of equals.

On the other hand, students have a responsibility to refuse to perform procedures that they do not think they are trained or competent to perform or perhaps are just uncomfortable performing. In this scenario, the comfort level or competency of the student, Phil, is not known, nor is the content of his "introduction" to prepping and suturing—or even how many patients he had seen independently and successfully. We do not even know whether Phil was responsible for the infection or whether it was related to conditions in the surgical suite. What is important, aside from possible negative consequences for the patient, are the potentially devastating emotional consequences for the student. A colleague recently shared with me that he has regrets

to this day about a procedure he performed independently while in Guatemala as a fourth-year medical student.

Phil could have told the doctor that he was unable to see patients independently until he had received more training and supervision during the treatment of his first few patients. While this premise would apply both at home and abroad, I think students need to be especially careful not to “experiment” when they are guests in another country. Sometimes this boundary is not always clear. In response to this case, a colleague who was the patient safety officer at the University of Massachusetts, commented that students are frequently “at the edge of their comfort zone” and that learning takes place because students have new experiences and increase their ability to act independently. We both agree, however, that if a student expresses discomfort at performing a procedure, it is the responsibility of the attending to supervise the student initially.

When the senior clinician is from the host country, I think it is more complicated, in that he or she may be more likely to overestimate the skill set of the foreign student, being unfamiliar with the training the student has received. In such instances U.S. students have to take the primary responsibility to act within their current training boundaries.

While there may be greater likelihood of a case such as this one occurring abroad, I am reminded by one medical student that the exact scenario has occurred during her medical training here. Another student said, “I think a lot of medical school involves performing tasks that you are not qualified for or adequately trained to do.”

There will be some occasions when it is appropriate for a student to go beyond his or her skill set, especially if a life is on the line and there is no physician around. Just such a situation was experienced by one of our senior students in Africa. She was helping transport a patient by pick-up truck when he suddenly went into respiratory distress and was close to failure. The accompanying nurse was 19 years old and had training equivalent to that of a first-year medical student. Realizing that the nurse was looking to her to act, our student proceeded to nebulize the patient and gave him steroids and the appropriate antibiotic. Her treatment was successful. A U.S. student is unlikely to be in a similar situation here at home, so at times it is appropriate for a student to function differently abroad because of a paucity of adequate resources. Although she had not encountered such a patient before, the senior student had a critical base of knowledge, ability and problem-solving skills to go beyond her training but not beyond her competency level.

Two key tenets: competence and non-experimentation

The tenets of competence and non-experimentation are cornerstones of a standard of appropriate caregiving. Students have to feel competent in performing a procedure and judge that they are not experimenting on a patient in a way that could cause harm. Added to that standard is the need for full disclosure, whereby, whenever

possible, students abroad inform patients of their level of training and disclose whether they have performed a procedure before.

How can we as educators responsible for placing students abroad prevent them from providing care for which they are not trained? Adequate preparation by medical school faculty is paramount. This involves the careful selection of brigades in which it is appropriate to include students. Phil Denton's supervisor, the surgeon, has a pejorative attitude toward his hosts, barely masked in his statement that "the rules are different than at home. No one tells us what to do here." A student once told me that she thought the U.S. physician on her brigade was "experimenting" with unorthodox procedures.

In addition, medical schools need to prepare students adequately. We currently do not have a code of ethics at the University of Massachusetts specific to student electives abroad, but medical schools should probably adopt one that includes specific scenarios like the vignette in this article. Such a code or at least the case scenarios could then be used in faculty preparation of students for work abroad, whether it be as part of a course on global health or a more informal setting.

Acknowledgment

My thanks to Eric Alper, MD, at the University of Massachusetts Medical School for his thoughtful comments on his experiences abroad and on this case.

Michael Godkin, PhD, is professor of family medicine and community health and director of the International Medical Education Program at the University of Massachusetts Medical School in Worcester. His research interests focus on the impact of global education on medical students' cultural competence and desire to work with multicultural and underserved populations.

Related articles

[The educational value of international electives](#), December 2006

[A caution against medical student tourism](#), December 2006.

[Student clinical experiences in Africa: Who are we helping?](#) December 2006

Virtual Mentor welcomes your response to recently published articles and commentaries. Send your correspondence to the *Virtual Mentor* e-mail address: virtualmentor@ama-assn.org.

The viewpoints expressed on this site are those of the authors and do not necessarily reflect the views and policies of the AMA.

Copyright 2006 American Medical Association. All rights reserved.