

## PERSONAL NARRATIVE

### Voluntourism

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#### Abstract

A rise in international medical volunteering (IMV) poses complex issues for organizations, clinicians, and trainees to navigate. This article explores ethical implications of IMV, such as scope of practice, continuity of care, and erosion of local health systems, and offers a personal perspective from a related field.

#### Imperialism and Medicine

British imperial writer Rudyard Kipling published a poem in *McClure's Magazine* in 1899 that Theodore Roosevelt described in a letter to Senator Henry Cabot Lodge as “rather poor poetry, but good sense from the expansion point of view.”<sup>1</sup> Taken out of context, parts of Kipling’s poem, “The White Man’s Burden: The United States and the Philippine Islands,” describe a thankless pursuit of humanitarianism: the white man is tasked with seeking profit and gain on behalf of others—feeding, healing, and pacifying them—even if they are resentful of his protection and aid. Taken in its entirety, however, the poem was meant to provide support for America’s waging the Philippine–American War by serving, as Foster and McChesney note, as one of the “ideological veils for a barbaric reality” at the time.<sup>2</sup> At an Anti-Imperialist League protest in Chicago in 1899, Jane Addams criticized pro-imperialists’ thinly veiled guise of beneficence: “to ‘protect the weak’ has always been the excuse of the ruler and tax-gatherer, the chief, the king, the baron; and now, at last, of ‘the white man.’”<sup>3</sup> The obvious assumption underlying this commentary is that, for imperialists, there is a lot more to be gained through imperialism than the “hate” and “blame” Kipling notes in his poem.

Today, Kipling’s defense of [imperialism](#) retains some support. Quoting Kipling in his book, *The Savage Wars of Peace: Small Wars and the Rise of American Power*, Max Boot encourages modern armies to take up a similar responsibility in the developing world.<sup>2</sup> And Niall Ferguson says of imperialism that “[n]o one would dare use such politically incorrect language today,” but “[t]he reality is nevertheless that the United States has ... taken up some kind of global burden” and “unfailingly acts in the name of liberty, even when its own self-interest is manifestly uppermost.”<sup>4</sup> In a more general sense, the poem and ensuing commentary represent the idea that the work one does to help others can serve the primary purpose of self-gain.

Although health care professionals provide expertise and services that are invaluable to society, they may nevertheless have something in common with imperialists: for both, significant ethical issues may arise as a result of expansion into new territories. According to David Welling et al, medical humanitarianism does “not always successfully accomplish our goals of providing safe, modern, successful, appropriate care.”<sup>5</sup> With this caveat in mind, this article will discuss international medical volunteering (IMV), ethical concerns that can arise in IMV and immersion experiences, and possible improvements in such cultural exchanges in the medical sphere based on a personal perspective from a related field.

### **Good Intentions**

Recognition that IMV is not necessarily beneficial to all stakeholders has become increasingly common in the media and in health professions research. For example, compare the satirical article, “6-Day Visit to Rural African Village Completely Changes Woman’s Facebook Profile Picture”<sup>6</sup> (describing a 22-year-old woman’s “completely transformative” 6-day trip to a Malawian village that she “just knew” would change her Facebook profile photo “forever”) with the following statements from Omnia Elnaway et al’s qualitative study.<sup>7</sup> The statements were given by 3 different British general practitioners following a 2-week program in which they acted as trainers for Nepalese health care professionals.

Overall, I think it had a very positive impact ... for me personally. I was able to just switch off my life back home and also to put things in perspective when I came back.

It was a real life change actually. It was ... really so provoking and [a] stimulating and scary experience.... I think in a way it made me confident and made me make decisions without back-up much more quickly. I think it made me rely on clinical decisions and actually made me bolder...

I did a course in expedition medicine earlier in 2009. That looked like something very interesting, to give me the opportunity to travel, giving me the opportunity to do some good for a charity.... How I would describe [my experience] ... very fulfilling and I would recommend it ... pretty much to any GP...

These quotations demonstrate that physicians participating in IMV experiences can focus more on [benefits to themselves](#) than to the people they are putatively helping. Although Welling et al suggest that health care professionals “who go on humanitarian missions are definitely engaged in a noble cause,”<sup>5</sup> they also identify “seven sins of humanitarian medicine” that tend to occur when visiting physicians try to help others. These include, among others, “failing to match technology to local needs,” “failing to have a follow-up plan,” “allowing politics, training, or other distracting goals to trump service” (even though the mission is represented as service oriented), failures in organizational cooperation, and “doing the right thing for the wrong reason.”<sup>5</sup>

### **Ethical Concerns**

*Scope of practice.* According to Irmgard Bauer, "It is difficult to define a medical volunteer other than as a person with a qualification in a health profession who decides to offer these skills on a voluntary basis to residents of resource-poor regions."<sup>8</sup> However, private volunteer organizations have also marketed "neglected health facilities as sites where foreigners can 'make a difference', regardless of their skill set."<sup>9</sup> Thus, ethical issues that arise in medical volunteering exist along a spectrum in terms of gravity and vary according to volunteers' qualifications. The idea of a "renowned hand surgeon" or "junior plastic surgery resident" performing a Furlow operation<sup>10</sup> could be, to some, less disturbing than an undergraduate performing unsupervised deliveries and unnecessary episiotomies.<sup>11</sup>

*Limited collaboration.* Although IMV programs tend to be cast as opportunities for collaboration between visiting health care professionals and their hosts, they can actually provide appropriate clinical opportunities for residents or trainees to the exclusion of local health care workers (who might be equally or more qualified).<sup>10</sup> The one-sided benefit of partnerships exists in other sectors as well; as a consultant at KPMG in Nairobi once said to me, "Why should an American be hired when there is a qualified Kenyan to do the job?" Bauer similarly remarks that "unsolicited 'help'" can hinder progress, particularly in "an existing local health system where locals' skills were improving and confidence in the system growing."<sup>10</sup> Furthermore, she notes that the "impact of western volunteers" can actually undermine local health strategies instead of supporting them.<sup>8</sup>

*Lack of continuing care.* Short-term programs incorporated into health professions education and offered during vacation may also be disruptive. Bauer states that such programs "focus on under- or post-graduate students' learning opportunities" and are popular among students with a "keen interest in surgical residencies."<sup>8</sup> These programs can result in harm to patients because participants do not have much skin in the game with respect to care quality and outcomes, as the nature of their work may shield them from any true responsibility. As Bauer explains, "unless a condition can be treated completely in one visit, volunteers are unable to provide continuity of care, await lab results that may take longer than at home, deal with any complications on location and, overall, cannot be held accountable for their actions."<sup>8</sup>

*Failure to foster independence and erosion of local services.* Bauer also identifies numerous ways in which IMV fails to create self-sufficiency in developing communities, "such as leaving locals with the product of pointless or questionable 'work', being a burden to the community, taking away local jobs, creating a dependency on foreign help, paralyzing local initiative or ensuring that locals remain firmly at an assumed level of helplessness to secure more volunteer placements."<sup>8</sup> Where a volunteer system supplants a local health system instead of supporting it, it may cause the local system to erode because volunteer health care can become so prevalent in a community that even people who can

afford to pay for services prefer to wait until free care arrives from overseas. Staff of local health care services notice “how patient numbers drop off when volunteers leave, modern treatment stops and drugs are running out.”<sup>8</sup> As a result, local patients do not form trusting relationships with local physicians and clinics, causing the system to erode and leading to underpayment and even unemployment of local professionals.<sup>8</sup>

### **Guidance**

There is no bright-line way to solve these issues, but professional medical organizations have made progress in the right direction. For example, in partnership with the Rwandan Ministry of Health, multiple US medical schools have joined the [Rwanda Human Resources for Health \(HRH\) Program](#), which began in 2012.<sup>12, 13</sup> The program seeks to address the shortage of health care professionals in Rwanda by increasing the number of faculty at the University of Rwanda’s medical, nursing, and midwifery schools.<sup>13</sup> Between 2012 and 2017, visiting faculty from US institutions such as Dartmouth and Harvard have spent anywhere from 2 to 12 months in the program annually, with approximately 55% of faculty staying for more than 6 months and approximately 52% returning at least once.<sup>13</sup> As Cancedda et al note, visiting and existing faculty and students collaborate on a “variety of training, research, and health service delivery activities” and “continuing professional development programs.” At the same time, “Rwandan faculty and students have traveled to the United States to give lectures, participate in clinical clerkships, and pursue further training, while others have presented their work at ... conferences.”<sup>13</sup>

According to the then-Rwandan Minister of Health, Agnes Binagwaho, “the Rwanda HRH Program represents a new model for health education and for the delivery of foreign aid”<sup>12</sup> that will create a framework for cooperation between international academic institutions. Significantly, the program is designed to be completely Rwandan run, and visiting faculty will phase out as they are replaced with top Rwandan program graduates. The program emphasizes ownership and sustainability such that the Rwandan government, in Binagwaho’s words, “will be positioned to sustain the improved health workforce on its own without foreign aid.”<sup>12</sup>

In offering general guidance for “humanitarian missions in the third world,” Christian C. Dupuis states that “[o]ne should never perform operations abroad that one would not do on one’s own private patients at home, and our residents should not be left alone to perform ... operation[s] if they are not allowed to do them unsupervised at home.”<sup>10</sup> Providing residents and students with opportunities to use the methods they have learned at their home institutions but have not been permitted to perform there may be counterintuitive to promoting better health for patients and to the broader goal of fostering [health care sustainability](#) in international communities through professional development. In addition, Bauer calls for “responsible guidelines for clinical student placements”<sup>8</sup> in increasingly globalized health settings, continuous and collaborative

development that builds on existing capabilities, and meaningful, long-term partnerships. Accordingly, international student or resident training programs should focus on students and residents learning alongside local clinicians and classmates who can offer unique perspectives or insights on medical practice in their area. Central to collaboration is true exchange—both cultural and academic.

### **A *Mzungu* in Kenya**

I am not a health care professional, but I can speak personally to the value of collaborative partnerships. After graduating from Indiana University and before returning to Chicago to study health care law, I was lucky to meet a generous family and a Kenyan researcher with whom they were associated. Having taken interest in their projects to construct a maternal health center and facilitate maternity services in Dandora, a community on the eastern border of Nairobi, I was offered an opportunity to assist with the administration of the newly minted program. When I arrived, I was welcomed by 5 Catholic sisters who graciously allowed me to stay in their convent for a few months. Although I never felt unwelcome, at the beginning, I felt somewhat out of place.

My feeling of being out of place is illustrated by an experience I had one morning while jogging. An elementary student I regularly saw on his way to school approached me with a puzzled look on his face and asked, “are you a *Kalenjin*?”—referring to the Kenyan ethnic group that produces most of the country’s elite distance runners.<sup>14</sup> Laughing, I told him I was just a *mzungu*—the Swahili word for white person or Westerners generally. Helmut Spitzer explains that the term has “manifold linguistic connotations and derives from the Swahili verb *kuzungua* which means ‘to go around’, thus ironically denoting the high level of mobility associated with light-skinned foreigners.”<sup>15</sup>

At the health center, my job was to draft standard operating procedures (SOPs) based on reports of the daily activities of health care workers and their departments, clinical and laboratory forms, and other administrative documents. At first, I was not very successful. Admittedly, the blank form and list of instructions asking each employee to disclose the details of his or her day may have been somewhat off-putting. After a few weeks, I grew concerned about my ability to develop the SOPs because I had not yet gained my coworkers’ trust in me or in my project more generally. Around the same time, I started to retain some Swahili and a kind friend purchased a dress from a local tailor for me. When I wore the dress to work, a coworker and I laughed together at the coworker’s ironic remark that he “barely recognized me!” Soon, people were visiting my office to make friendly conversation; small talk beginning with *habari yacko?* (Swahili for “Your news?” or “What’s up?”) often ended with more fruitful discussions regarding the SOPs. Others began to approach me with ideas for projects that I could assist in, such as service brochures for their departments. In making myself less of a stranger, I was happy to realize that my presence at the health center actually had utility.

However, this transition was not seamless. Like others, I am not entirely innocent when it comes to the “seven sins of humanitarian medicine.”<sup>5</sup> A particular example—while I was taking inventory and discussing SOPs with the laboratory technician—comes to mind and may be considered within Welling et al’s framework<sup>5</sup> as a failure to collaborate or to match technology with local needs. To prepare for a meeting with the lab technician, I began developing a few SOPs for certain sampling methods with which I was familiar from biology and neuroscience labs I had taken as a college student. I imagined that doing so would ease the process of altering them according to his personal preference, if need be. Excited to see the center’s equipment, I arrived a few minutes early and realized that a certain device that I had included in my SOPs was not there. Embarrassingly, my first thought was “Oh no, where can we get one? I’ll have to change the SOP...” and not “Oh, we don’t need one, what should I include in the new SOP?” Remembering the purpose of our meeting, we ultimately discussed the proper method to be included. However, I imagine that thoughts such as my initial one, when acted upon, can be disruptive or at least inefficient. In that moment, I learned a lesson about the importance of collaboration if I wanted to contribute anything of value to the health center in my time there.

### **Conclusion**

Although humanitarian aid is a noble cause, IMV can disrupt local life when volunteers or their organizational and institutional sponsors put their own needs before the needs of those whom they try to serve. Greater efforts at humility on the part of health professions training programs—specifically, recognizing local capacity and collaborating with local professionals—can create more just, respectful, and mutually beneficial exchanges. Participants in such programs should consider ways in which learning international practice methods can enrich their own knowledge instead of practicing outside of their scope. Clearer [ethical guidelines](#) on this topic might shore up nonaltruistic impulses to serve others while enabling health care practitioners to understand global conceptions of health.

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