ETHICS IN ACTION

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CASE

You are currently in a US-based residency program, completing an international emergency medicine rotation at a hospital in a low-resource country. As the only doctor in the emergency department overnight, you receive a call from a hospital two hours away. The referring physician asks you to accept, in transfer, a patient who sustained a head injury 12 hours previously. Currently the patient has a GCS of 13, and is known to have a 2cm depression fracture of the left parietal skull confirmed by x-rays, since no CT scanning technology is available at the transferring hospital. Given the lack of CT scanning technology in the country, a CT is generally considered an adjunct to clinical diagnoses, and due to a lack of neurosurgeons, medical management precedes surgical intervention. The local guidelines are to observe a patient with head injury for 6 hours, and if the patient's neurological status declines, then he is given a bolus of mannitol and observed for another six hours for improvement. An operation is only considered in cases of decline after mannitol. This patient has not received mannitol, and the transferring physician suggests that you obtain a CT scan to further clarify the patient's diagnosis. Although you do have a CT scanner, you are only permitted two emergent CT scans per 24-hour period due to cost containment protocols, and you have already allocated those two scans to patients in your emergency department. Given these circumstances, how should you proceed: Should you accept the patient in transfer? And if so, should you obtain a CT scan?

DISCUSSION

Medical trainees are often enthusiastic when given the opportunity to conduct short-term electives in underserved/resource-poor settings around the world. The motivation for such electives lies somewhere between altruism and a desire to experience the exotic. Regardless of the motivation, the opportunity to undertake international global health electives is increasingly part of medical training in the US. For example, in a 2008 survey of 96 US allopathic medical schools, McKinley, et al. reported that 59% of the schools had international rotations for residents and 11% a formal global health track for medical students.[1] According to the 2012 Association of American Medical Colleges graduate questionnaire, 30.4% of American medical students participated in a global health rotation during training. Thus, medical trainees in all types of specialties engage in global health work during their formative years. The central question of this commentary is: What ethical complexities exist surrounding an international rotation, and how do these short-term clinical experiences in resource-limited countries influence an EM physician's ethical standards "back home"?

Many trainees hold the view that it is generally ethically appropriate for physicians to undertake short-term medical relief missions and electives. This assumption is based on the principle of beneficence with the consideration that providing some health care service is better than no medical assistance. Yet this ethical challenge, related to short-term international health work, is significant, and the ethical equation may not be so simple, particularly when some medical assistance may lead to future harms both for the patient and for the local health care system.

Medical students and residents in the United States are trained to practice medicine in a resource-rich setting. Significant issues arise when a physician or student, trained with access to the most advanced equipment and testing, is suddenly expected to take on a greater stewardship role for finite medical resources, or to practice medicine using unfamiliar treatment and testing modalities. In response, some trainees may defer to the clinical practices and protocols of their host setting, while others may attempt to practice medicine according to the standards "back home." The case above highlights such a conundrum. For example, how can an international rotator decide when it is clinically, and ethically, appropriate to defer a CT scan in a patient with a depressed skull fracture when her US-based medical training suggests that patients with depressed skull fractures should receive a head CT to evaluate for an intracranial hemorrhage requiring an operation? Similarly, medical trainees abroad are

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often asked to perform unsupervised procedures that they have never previously performed, or to undertake procedures that are above their competence level.[2] One may argue that being asked to make such a decision or perform such procedures without specific training borders on experimentation on the underserved, and is unethical in light of the primary duty of nonmaleficence.

The situation can be remedied by adequate pre-rotation preparation and close supervision during the international rotation. Yet most international rotators receive little dedicated teaching on local patterns of disease and treatment protocols, they often are not trained in the bioethics of international medical relief, and once abroad they routinely lack adequate clinical supervision.[3] If adequately prepared and supervised, international rotations can provide fascinating educational experiences to the US medical trainee, improve cultural competence, enhance medical knowledge, and strengthen clinical aptitude.[4] Moreover, international work may also attune American trainees to their responsibility of ethical stewardship in the management of finite medical resources. Indeed, prudent resource stewardship is part of the American College of Emergency Physicians (ACEP) code of ethics and is a growing part of the emergency physician's role in the changing United States health care system. Finally, international rotations can help teach residents to calibrate their medical practice between the ethical poles of beneficence and nonmaleficence.

As more American medical trainees spend time in global health activities, medical schools and residency programs need to enact specific policies and pre-field training that will prepare them appropriately and ensure that, while abroad, students and residents are adequately supervised. By doing so, we help to assure that trainees learn the most from their international experiences and realize the altruistic goal of lending knowledge and skill to benefit others. ◗

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3. Shah, S. and T. Wu, The medical student global health experience: professionalism and ethical implications. J Med Ethics, 2008. 34(5): p. 375-8.
4. Ackerman, L., The Ethics of Short-Term International Health Electives in Developing Countries. Annals of Behavioral Science and Medical Education, 2010. Vol. 16(No. 2): p. 40-43.

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