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Pre-Departure Global Health Ethics Training for Medical Volunteers: One Strategy

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Abstract
Short-term global health volunteerism is on the rise, as students and health care professionals seek short-duration volunteer experiences in low income settings. Given the potential for ethical transgressions in such situations, pre-departure ethics training is essential. We have developed a very short ethics training regimen with four dimensions: (1) an overview of the history and major challenges with respect to global health and ethics; (2) a simplified global health ethics framework for the non-specialist; (3) examples of ethical crises experienced in the field; (4) a proposed simple strategy for addressing new crises as they arise. We feel our training model can be modified and replicated for other groups in need of basic and brief pre-departure ethics training.

Keywords: Global health, volunteerism, ethics, education.

Introduction

In recent years, the phenomenon of short-term global health volunteerism has accelerated, presumably due to such factors as an increased ease of rapid travel and the rise of 24-hour news channels showing us disasters and suffering from across the globe[1]. In addition to

seasoned health care professionals, we now have medical students, residents, other allied health professions students --and often undergraduates, too—seeking global health experiences in low income and resource-limited countries[2]. While motivations for seeking such experiences are overwhelmingly altruistic, an unfamiliarity with the history of global health approaches, the legacy of neocolonialism, and the fragilities and nuances of intercultural care combine to present preponderant ethical challenges for care-givers going abroad. Good intentions are often not enough to ensure a positive experience and impact on the health of the target community.

The scope of work in which medical volunteers engage varies widely from direct medical care to public health education and capacity building. Many medical schools and residency programs offer opportunities for students to engage in global health work via short-term foreign placements, and have slowly begun to incorporate mandatory ethics training as part of students' pre-departure training. In absence of such ethics training, the threat of doing damage to community and individual health, and to institutional relationships, is real. This paper describes the ethics training developed for on-going medical missions into the interior of Guyana, based upon a model that has subsequently been tweaked for presentation to medical students at the University of Ottawa as part of their regular pre-departure training.

Context

The Toronto-based NGO Vea'havta has been sending medical volunteers into the interior of Guyana for14 years . Each mission lasts two weeks and is made up of 5-20 physicians, nurses, pharmacists, physiotherapists, other allied health professionals and support staff. The numbers vary with the aim of each specific mission. But each team visits under-serviced and impoverished AmerIndian communities in the deep forest, and provides direct clinical care, as well as public health education and limited capacity building through the education of, and resource support for, local caregivers. Most of the volunteers have never been to Guyana before, and many have never before visited an underdeveloped country or engaged in any kind of global health work.

Pre-departure training is unfortunately limited to a single day and is dominated by the necessary briefing on logistics and mission details, while the ethics component is only, at most, a couple of hours in duration. Ethics training has been implemented for two years now, and consists of: (1) an overview of the history and major challenges with respect to global health and ethics; (2) a simplified global health ethics framework for the non-specialist; (3) examples of ethical crises experienced in the field; (4) a proposed simple strategy for addressing new crises as they arise.

The Humanitarian Model vs. the Political Model

In our training model, the pertinent aspects of the history of ethics in global health have mostly to do with the legacy of colonialism. Participants are encouraged to recognize that power and wealth disparities between Northern and Southern countries often have at least partial origins in a history of conquest and economic predation. The relevance of this lesson is that it encourages humility in that emphasis is placed conceptualizing volunteers' motivation through a political model rather than the humanitarian model, based upon the definitions of Lowry, Schuklenk and Hall et al[3].

The humanitarian model holds that one seeks to do global health work through altruism. Such fervor can quickly devolve into arrogance, as one must necessarily adopt an attitude reflective of superior education, skill and knowledge relative to that of the population one seeks to serve. The political model, on the other hand, holds that individuals and organizations from the Global North must do global health work as a kind of reparation for the damages done by Northern societies in the age of colonialism and via other imbalanced economic, political and military relationships and encounters.

Our training model holds that while individuals tend to seek volunteer experiences for reasons more concordant with the principles of the humanitarian model, the realities of the field are best served by appreciating the political model. This is especially true for work in the interior of Guyana, where many of the health issues that volunteers will encounter are directly related to the industrial activities of Canadian, American and European mining adventures[4], which can be considered to be manifestations of neocolonialism[5]. An introduction to the perspectives of the political model is often a revelatory experience for volunteers unfamiliar with the history of global health and development.

Ethical Paralysis vs. Righteous Seizure

Based upon the terminology and definitions of Anderson and Mashari[6], our ethics training asks volunteers to recognize the tension between the extremes within the ethical behavioural continuum, with "ethical paralysis" at one end, and "righteous seizure" at the other.
Righteous seizure is presented as the initial mindset embraced by most novice volunteers, many of whom see suffering and injustice in the world and who are impatient to "solve" those problems. Righteous seizure is best exemplified in a quote from Sir Bob Geldof referring to the African famine: "Something must be done; anything must be done, whether it works or not"[7]. The sense is that one seeking to do "something, anything" may overlook the ethical consequences of doing the wrong thing, or of misdirecting scarce resources on an activity that had a known low probability of success.

Ethical paralysis, on the other hand, describes the state of someone who has considered that every intervention necessarily carries the threat of negative consequences, thus rendering a volunteer unable to pursue an interventionist strategy that is purely and absolutely ethical. The training seeks to encourage volunteers to identify their place on the continuum between these two extremes, and to recognize that either extreme is counter-productive.

Examples from the Field

Any ethics training for global health volunteers must include scenarios, both hypothetical and historic, for demonstrating the application of theory. Examples were sought which demonstrated cultural differences, communication barriers, challenges to individual moral precepts, and power imbalances. Attendees were asked how they would respond in each scenario, then asked to rate their response on the continuum between righteous seizure and ethical paralysis.

One such example was the story of a health education team visiting a remote Guyanese community with fundamentalist Christian beliefs. The community suffers from a high rate of unwanted teen pregnancy and is at risk for experiencing spikes in STI and HIV/AIDS infections. The community's leaders have permitted the team to talk about sex and contraception, but not to give out condoms. If the team does give out condoms, they will be asked to leave the community and may not ever be invited back. Surreptitiously, some of the community's teens ask team members to give them condoms. Team members must now decide whether to give the condoms or to adhere to their promise to the community leaders, or to fashion a third option.

Attendees are then asked to explore the scenario and to: work through the possible behaviours and choices of the health education team; identify the power disparities at play and the cultural and communication barriers that may confound proper understanding of the situation; predict the possible and likely outcomes of any actions taken, both short- and long-term; and to develop a strategy for identifying the action of least harm.

The lesson is that some in-field ethical crises can be anticipated, but many more cannot. However, some of the characteristics of most crises can be expected, such as communication

gaps, power imbalances and competing world views. Any resulting standard strategy cannot be a simple recipe for conflict or crisis management that would be too specific or inflexible for the unpredictable scenarios, but rather a general approach for team management and consolidation.

Suggested Strategy

The in-field ethical crisis-management strategy we have developed is a simple two stage process: (1) establish an objective and (2) agree to debate every ethical crisis.

Each team is advised to agree upon a single mission objective during the pre-departure training session. The team leader facilitates the elucidation of such an objection. In the absence of a clearly defined leader, the team is instructed to nominate one. The defined objective will then serve as the stop against which any proposed activity will be evaluated. If the activity is not simpatico with the stated objective, then the activity is deemed inappropriate and likely unethical. Activities can include the regular conduct of the team's medical mission or the proposed solution to an ethical crisis that may arise in-field.

The agreed-upon objective in this case is unlike objectives defined for research or evaluation purposes; it is typically immeasurable. It must be distinct from mission outputs (for example, the number of patients treated) and from expected mission outcomes (for example, a decreased prevalence in a specific disorder). Instead an ethics objective is relationship based and takes into account the grander goals of the program, not just of the mission. A standard objective to consider is, "To sustain good will [such that future missions will be able to contribute to incremental positive change]."

The requirement to debate every ethical crisis appears commonsensical on its face, but in the heat of a crisis, the tendency towards righteous seizure often precludes challenge to one's personal moral framework. By introducing the requirement for debate in the pre-departure setting, it is hoped that participants will be prepared to err on the side of restraint in the moment of crisis. Debate, then, serves to calm participants, delay the taking of unconsidered action, allow all team members some input, and increase the chances of at least one team member remembering to apply their agreed-upon objective to whatever action is eventually decided upon.

Discussion

Our ethics training model was developed from some of the existing literature on volunteers' and students' typical responses to global health experiences. Other published frameworks were considered, such as that of Crump et al[8]. Through the Working Group on Ethics Guidelines for Global Health Training (WEIGHT) at Duke University, they developed a template for appropriate global health pre-departure ethics training. The WEIGHT process is more comprehensive than our approach in that it considers the roles of sponsors, governments, competing institutions and licensing bodies. However, the aspects of their system that are most pertinent to the specific activities and behaviours of short-term volunteers are in concordance with our pervasive philosophy, which is that any mission's burden on the host nation and community must be both minimized and measured relative to the potential contribution of the mission.

The WEIGHT system also focuses on the clarification of goals, much like our in-field crisis resolution strategy, but goes further by recommending that goals be institutionalized and formalized through explicit written statements, as well as being defined differently for various stakeholders (for instance, sponsors, trainees, mentors, etc.).

Pre-departure ethics training is unavoidably subjective to an extent. It tends to be based on previous personal experiences of the trainers, and more limitedly on published training

frameworks and norms. One of the reasons for this, as pointed out in the paper describing the WEIGHT guidelines[8], is the dearth of published data both on various in-field ethical crises in global health and on tried strategies for addressing and assuaging such crises. Clearly, as global health volunteerism increases in popularity, the need for ethics training will also increase. It is incumbent upon the scholarly community to share more of our experiences and training regimens, in hopes that a somewhat universal educational standard may emerge.
Such a standard will necessarily depend upon regional legal frameworks, prevailing moralities and, more subtly, on the cultural ethical framework being considered. The underlying assumption to all reviewed training processes is that the Western liberal ethics framework is at play. This is a rational assumption, given the role of that framework in helping to define critical Western medical constructs, such as informed consent and patient decision-making autonomy.

As more nations with varied cultural philosophies enter the global health milieu, it will become increasingly important to revisit the assumptions of the Western liberal framework. A commenter on the WEIGHT guidelines pointed out that the role of South-South trainee exchanges is not considered in the existing ethics training regimens[9], alluding to the implicit imperialistic notions of the prevalent North-South exchanges, and lending credence to our concern for the unquestioned supremacy of the Western liberal framework.

However, the need of medical schools and NGOs dependent on short-term volunteerism is for concise, potent and practical ethics training whose focus is on crisis resolution skills and techniques, and not so much the larger scholastic discussion of relevant frameworks and philosophies. To that end, we feel that our training system can be modified and replicated for use by medical schools and NGOs in need of such basic and rapid ethics training.

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