Ethical Concerns with Medical Missions Abroad

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The calling to serve humanity in a global medical context is not new, and it remains loaded with ethical issues related to human dignity, motivation, benefit to patient, benefit to sponsor, sustainability and disparity perpetuation. In today's global medical realm, missions serve in conditions representing post disaster emergencies, disease outbreaks, war and political unrest, refugee circumstances and stable under-resourced communities. Each of these contexts presents unique ethical challenges, and international medical mission organizations sometimes struggle to anticipate and formulate responses to operational ethical dilemmas.

In an age of rapid transportation and real-time communication the world seems smaller. Health care professionals see the needs abroad and naturally want to help. In spite of religious, cultural, political and economic disagreements and ongoing conflict, humanity truly is becoming more globally conscious. Bon Secours' Strategic Quality Plan identifies global ministries as a means to serve those who are vulnerable. In a public health context, more people are now aware that access to goods and services is not evenly distributed in local communities or across the planet. It is understandable and laudable that well-resourced communities and organizations want to help, but what that help looks like must be carefully discerned. Broadly considered, international medical missions must take into consideration right relationship with local communities, needs assessment, professional standards and capacity building.

From a Catholic perspective, sponsorship and implementation of international medical missions require balancing the desire to bring health and wholeness to the world through a healing ministry that follows the example of Jesus Christ with appropriate caution and discernment around respect for persons and empowering individual and corporate self-determination. These values coexist in tension. Standards created in this environment must promote effective health care delivery while protecting individuals and communities from harm.

Defining and achieving success in medical missions is a complex process based in right relationship, and many Catholic health care organizations benefit from local congregations' work in communities. Ideally, even before the details around needs assessments, goals, scope of work, ethical standards and operational processes are addressed, local stakeholders and mission participants work to discern values and norms

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that define relationship. For Catholic health care organizations, understanding that medical mission teams visit and work by invitation and partnership with local stakeholders is central to achieving a sustainable good. Right relationship drives mission success as much as provider skills and system resources, and it must be preserved even in circumstances that beg expediency.

Following this logic, many urgent missions that draw medical professionals to service, such as disaster relief and disease outbreaks, are best handled by larger global organizations that already have logistics expertise and mobile resources in place. Many Catholic global missions collaborate with these efforts. Although Catholic medical missions may assist in urgent missions, this is a small piece of the global effort. The majority of services provided within Catholic global missions is designed to meet ongoing community needs, such as nutrition and clean water, routine infectious disease and immunizations, general surgical interventions, maternal-child health and chronic disease.

In right relationship, mission goals meet defined local community needs. Before a mission is undertaken, an honest assessment of the visiting organization's willingness and ability to address problems that the community sees as high priority is imperative. Our genuine desire to help does not necessarily imply membership, ownership or authority to determine priorities in distant communities or take to action.   Of course, visiting medical teams may shed light on needs that the community has not considered, but local leadership drives mission priorities. Indeed, as local communities determine priorities, visiting teams must give honest assessments regarding ability to meet needs. The external and temporary nature of most medical missions requires humility in service; introducing unsustainable technology and expertise often leads to disappointment and harm.

In addition to complex matters around relationship and needs assessment, practical matters around scope of practice and standards of care that seem obvious and intuitive in some countries cannot be assumed in locations that do not have experiences with such matters. For example, providers with very narrow scope of practice in their home country may see the medical mission environment as an appropriate opportunity to practice more generally or to gain new skills. While primary benefit of medical missions abroad should be directed toward local communities, it is reasonable to expect that the visiting medical providers will benefit from mission experiences, as well. The real question is whether the visiting provider is benefitting at the expense of the local community, an unacceptable paradigm.

Significant harm can result when visiting medical teams assume that any medical care they provide is better than what the local community can provide or is better than no intervention. Frequently, local leaders and patients do not perceive the need to inquire about credentials. One approach for medical providers might be to ask themselves, "Would I do this at home?" Professional societies and global non-government organizations have developed standards in some specialties of care. Researching those standards gives visiting health care professionals a reasonable perspective on what an informed group of colleagues might expect of them. While

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standards published in some fields of medical mission work are helpful, they do not exist across all specialties. In addition, most countries hosting visiting medical teams do not have the resources to ensure compliance. In this situation, professionals and sponsoring organizations must unilaterally ensure safe medical standards, and clinical circumstances often lead to compromises.

One ethical standard that currently challenges the medical mission environment is how to achieve informed consent across language, culture and technology barriers. For medical missions whose presence in the community is likely to be fleeting, expectations around achieving informed consent vary significantly. Even in circumstances in which medical teams and patients live in the same community and are similar in language, social identities and resources, informed consent can be difficult to achieve. Since informed consent requires essential elements of substantive communication, and understanding of the nature of the medical condition and the risks, benefits and alternatives of a treatment or procedure under specific conditions, the specific conditions involved are extremely important.

The combination of factors involving the environment of care, technology and local values creates levels of complexity and uncertainty that can impact the ability to truly inform. Yet, the value placed by most societies on individual or communal autonomy makes informed consent a foundational ethical requirement. Although it is helpful if visiting health care professionals speak the language of the host country, trained interpreters or local translators can help ensure patient understanding and informed consent as their knowledge and sensitivity to nuances of respect and social structures can support the patient's ability to participate and advocate for herself. Ideally, medical interpreters and translators should be part of the medical team, but should not be providers of medical services to avoid a potential situation in which providers interpret, give medical advice and counseling at the same time. Involving local medical professionals in planning and informed consent processes can also foster understanding and collaboration for follow up and referrals.

In medical missions abroad, achieving informed consent includes significant capacity building around standards and advocacy. Communities and individuals need to understand that standards exist, and they need to be assured that Catholic health care organizations conducting missions meet them. For example, surgical candidates must understand that their surgeon is working in her field of expertise and scope of care; they need to know if a provider is participating in a training program and if their work in the mission involves research. Patients should also understand that they were selected for the surgical intervention based on criteria that assure the best possible outcome, and they need to know details around surgical follow up and what to do if there are complications. A patient's assumption that a provider is making decisions based on best practices might be implied in clinicians' countries of origin, but, in the global setting, such assumptions can lead to hazard. Communities are often unaware of the wide variation in practice among international providers.

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Finally, moving forward to expand services as guests in the global context requires significant formation. Cultural competency, language studies, environmental consciousness and team safety and dynamics require commitment of resources, time and attention. Sincere willingness and exemplary skills are necessary for this work, but they are not sufficient. Right relationship and excellent standards of care must be what distinguishes Catholic health care organizations in service abroad; proper formation is essential to both. As Catholic health care organizations look to internal resources and external partners to co-create healthy communities, careful attention to right relationship and formation will improve our ability to become instruments of health and wellness for humanity. Meeting global medical needs, as defined by community stakeholders, requires the same attention to medical standards and respect for persons as is required at home. Context and resources challenge this work, but the goal of excellent care transcends borders. Why else would we go?

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