Implementing Recommendations For Short-Term Medical Missions

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Although U.S. health systems and individuals have invested millions of dollars and countless volunteer hours on short-term medical missions, there are no overall standards for evaluating impact, patient safety and quality control. There also is no common system for selecting members of U.S. medical mission teams and preparing them for work in the host country's setting and cultural context.

The Catholic Health Association has prepared 20 recommendations to guide U.S. organizations while they are considering, planning and evaluating short-term medical missions in low- to middle-income countries (See story page 29). The recommendations advise organizations to clearly define requirements for people who want to volunteer and to provide training that helps members of the medical mission not only understand what to expect in the host country, but to build cultural competency skills that will enable them to help the host community build its own capacity.[1]

ATTITUDES AND ADJUSTMENTS

In a robust selection process for short-term medical missions abroad, there are strong roles for the country of origin and for the country of service. Unfortunately, the host country usually is left out, though virtually every country of service has regulatory and compliance requirements that apply to short-term medical missions. It should be standard practice for short-term medical mission teams to properly submit credentials and to declare incoming medicines and supplies, regardless of the host country's ability or inclination to enforce such requirements.

Effective medical missions have strong, accountable systems and a well-articulated statement of purpose, with clear goals that look after the self-identified needs of the host community. The effective medical mission team embraces the notion of being invited to the host country rather than being *sent* there — an important distinction. Organizations that recognize this and make clear that they are part of a larger effort to address health equity and build capacity demonstrate the best efforts toward achieving sustainable world health goals, as outlined by the World Health Organization.[2]

In the U.S., the process for screening and selecting volunteers for an overseas medical mission might include gauging credentials and professional integrity, a peer review and a health screening, including mental/emotional health and resiliency. The latter is important — working in under-resourced communities can be very chaotic for participants who never have been to the developing world. A team member's unexpectedly emotional reaction to poverty, disorder

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and security concerns can distress all the participants and even jeopardize a mission's safety and success.

TEAM ORIENTATION

Often what is called orientation really amounts to telling the team about getting ready for the trip and logistics — weather, apparel, travel arrangements and preventive health. These matters are important, but they are not sufficient. Some essential elements of team orientation include:

Time: Allow enough time for the sessions. For a one-week trip that implies 50-72 hours of participants' work in a new setting, one to two days of orientation should be factored in.

Ethical engagement: Orientation sessions must include case scenarios around respect for local laws, informed consent, codes of conduct, resource allocation and proper authority for decisions.

Clinical standards and operations: Caregivers should make proper clinical preparations before they arrive at the service site. This requires pre-trip assessments to check equipment, supplies and the facility. In addition, profile summaries of the community and patient population should be presented to the group before they arrive in the host country, and operational standards should be clear.

Cultural awareness: Cultural errors abound. Exploring individual perceptions and letting go of stereotypes are vital components of cultural awareness. It is important for the team members to be aware of themselves as guests in the country and for them to respect others in their home.

Attention to right relationship: Good orientation planning includes discussion of the caretaker-patient relationship and explanation of the informed consent process, as well as the peer-to-peer relationship. Local empowerment of staff and treating peers as competent counterparts are important to building right relationships that last beyond one mission trip.

Personal safety: Establishing group norms and awareness around safe conduct is an essential component of orientation.

Post-trip debriefing session: Participants should agree to this prior to departure. In addition to having observations that can improve the medical mission process, many caretakers return home feeling a sense of loss or emptiness. They need a space to reflect, discuss and formally evaluate their experiences.

PUSHBACK

Requiring the volunteers to participate in team orientation may not be well received. Seasoned clinicians may view mandatory orientation as a challenge to their expertise — they already know that their skills are vital and effective.

Framing the discussion around the following three points may help health care professionals gain insight into the differences between practicing their skills in the context of their home system versus in under-resourced communities.

Informed consent: A settled matter in the United States, every medical facility has a process by which clinicians and patients share decision-making, collect release forms, etc., according to uniform standards.

There are no uniform standards in the medical mission setting by which risks, benefits and alternatives specific to the patient's environment of care are understood and practiced. A recent survey of participants in medical missions abroad that explored practices around informed consent revealed the following:[3]

- Only 55 percent of participants surveyed believe that adequate informed consent is currently achieved in their experience, but 76 percent believe that it is possible to achieve informed consent. This demonstrates a performance gap in an accepted standard.
- 75 percent surveyed believe that achieving informed consent is a responsibility shared by the medical team, the sponsoring organization and the host community, thus emphasizing the need for overt agreement and attention to achieving it.
- Nearly 25 percent of those surveyed believe

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that providers "may function in whatever capacity they feel themselves capable and competent" during non-emergency missions. That means there is no strong agreement that providers should be confined to their usual scope of practice while abroad. Yet the implications for informed consent are far-reaching, in that patients in host communities generally believe they are receiving the highest standard of care, which is inconsistent with providers extending beyond their scope of practice.

- The use of medical interpreters or translators is largely left to the discretion of providers and may not be considered mission-essential. Consequences need to be spelled out.

Vulnerability and trust: How do misunderstandings around informed consent and other standards lead to harm? Part of the answer resides in the host community's profound vulnerability and excessive trust in medical providers from abroad. First, there is a tendency for caretakers serving in poorly resourced communities to assume an inordinate responsibility for "saving" patients who may be best served by other means. This tendency stems from a belief that no other options exist for the patient, and it leads to shortcuts and poor standards adherence. Orientation processes that clearly define mission scope and community alignment can help prevent this error.

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Second, there is a strong tendency for patients to accept the visiting professional's recommendation because the patient in an under-resourced host nation equates the visiting medical team with the system and standards from which it came. Unfortunately, that assumption often is not valid. This kind of identification-based trust[4] is not a bad thing, when properly applied, but it is not appropriate for the short-term mission setting. Add in cultural norms that demand high respect for medical professionals as authority figures, and the result can be unquestioning acceptance.

Even with a highly competent team full of good intentions, the patient's inherent vulnerability may lead to misunderstandings and harm. The power differential and trust balance can be improved through the team's adhering to recognized overall standards for short-term medical missions and similarly standardized methods of obtaining informed consent from patients.

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Capacity building: For medical missions abroad, developing patient and community capacity begins with recognizing the power differential inherent between the mission team and the host community, as well as the paucity of generally accepted standards governing all overseas medical missions. Then comes the important stage of creating processes that build host community capacity around informed consent and quality standards.

Of course, merely informing patients abroad of their rights to self-determination and medical standards is not sufficient to build capacity. The comprehensive goals of global health require self-determination. From the perspective of informed consent, health care teams must anticipate questions and create space for empowering knowledge-based trust. For example, provider credentials and experience should be offered as important information rather than assumed; over time, communities will recognize that credentialing and experience are reasonable matters for discussion. This kind of capacity building requires team orientation.

Capacity building also requires local leadership. Matching visiting medical teams with local counterparts is one method of building capacity in developing systems. Often, visiting teams have no interaction with local health care professionals, and sometimes the visiting teams actually diminish capacity by taking cases away from local coun-

terparts. Peer-to-peer exchange can be enriching to both parties, and it improves continuity of care. Optimally, a consistent partnership can develop between a cohesive medical team of visiting and local practitioners over time to enhance mission effectiveness and good will among nations.

CONCLUSION

Short-term medical missions have the potential to contribute to the broader, sustainable goals of health equity by intentionally building capacity in the host country. Since professionals who engage in overseas medical mission work are making a generous investment, it is simply good stewardship to help that investment develop beyond clinical encounters to lasting contributions through thoughtful, standardized processes of orientation, collaboration, communication and care.

Selecting competent and credentialed professionals meets a minimum standard in a very narrow part of the mission, however. No matter how dedicated and talented the individuals, they must understand that host communities usually do not have structures in place to assure quality and empowerment. Ignoring that fact leads teams to commit a contextual error that historically disempowers communities and leads to harm. Therefore, creating awareness through team orientation is an important step to cultivating insight and caution.

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NOTES

1. The Catholic Health Association of the United States, *Short-Term Medical Mission Trips: Recommendations for Practice 2015* (St. Louis: Catholic Health Association, 2015). www.chausa.org/docs/default-source/international-outreach/short_term_medical_mission_recommendations_for_practice.pdf?sfvrsn=0&id=3173.
2. World Health Organization, *World Health Statistics 2016: Monitoring Health for the SDGs Sustainable Development Goals,* (Geneva, Switzerland: World Health Organization, 2016). www.who.int/gho/publications/world_health_statistics/2016/en/.
3. The survey was created and conducted by the authors.
4. Noam Ebner, "ODR and Interpersonal Trust," in *Online Dispute Resolution: Theory and Practice*, eds. Mohammed S. Abdel Wahab, Ethan Katsh and Daniel Rainey (The Hague, Netherlands: Eleven International Publishing, 2012).

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