ALTERNATIVES HUMANITAIRES
HUMANITARIAN ALTERNATIVES

*17th Issue – July 2021*
*p.94-107*

# An analysis of ethical dilemmas in medical internships in countries with limited resources

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What are the cross-effects (advantages and disadvantages) of humanitarian missions in fragile contexts? New light is shone on this long-standing issue through the lens of medical internships in countries with limited resources, a common practice in Quebec. Thanks to a study conducted by the authors, we learn a little more about the ethical dilemmas that participants on such courses may experience. Lessons that could really be useful for traditional humanitarian missions.

Every year, international medical missions involve many participants from high-income countries who go – for days or even months at a time – to a country with limited resources. These missions may take the form of an emergency relief operation, a humanitarian aid programme or a medical mission, be they long- or short-term.

In this study, we looked at short-term medical missions of which medical internships in countries with limited resources are the most well-known form in Quebec. The motivation to take part in these courses varies considerably from individual to individual, but more often than not it is based on the desire to improve the health and well-being of disadvantaged populations. The advantages of these courses are well known: an improvement in clinical knowledge and skills, a better understanding of cultural sensitivity, and the adoption of a global health perspective[1]. These experiences also facilitate the sharing of teaching methods and medical practices with the host structures.

The impact and effectiveness of these medical internships in countries with limited resources, however, are increasingly being called into question. Criticism has been levelled at the ethical challenges they pose, criticism which could well be extended to traditional "humanitarian missions". Examples of this criticism include the asymmetry of power in partnerships, benefits that are not shared, lack of preparedness and leadership, the risk of unintended harm, and the lack of a regulatory framework of professional ethics[2]. To improve effectiveness and minimise these risks, an increasing number of institutions are introducing preparatory training programmes which address issues relating to culture, safety, ethics, travel medicine, language, mentoring, professionalism, emotional well-being and culture shock.

Despite these programmes, trainees face ethical dilemmas relating to cultural differences, professional issues, limited resources and personal moral development[3]. Such situations can lead to frustration, anxiety or emotional trauma among the participants who are torn between the willingness to do good and the potential negative consequences of their actions[4]. There is still not enough data, however, to understand how beneficiaries perceive these courses.

[1] Matthew J. Thompson *et al.*, "Educational effects of international health electives on US and Canadian medical students and residents: a literature review", *Academic Medicine*, 78(3), 1st March 2003, p.342-347.
[2] *Ibid.*; Nikki Bozinoff *et al.*, "Toward reciprocity: host supervisor perspectives on international medical electives", *Medical education*, 48(4), 2014, p.397-40.
[3] James D. Harrison *et al.*, "What are the ethical issues facing global-health trainees working overseas? A multi-professional qualitative study", *Healthcare*, 4(3):43, 13 July 2016, p.1-9.
[4] Laurie Elit *et al.*, "Ethical issues encountered by medical students during international health electives", *Medical Education*, 45, 2011, p.704-711; James Aluri *et al.*, "The ethical experiences of trainees on short-term international trips: a systematic qualitative synthesis", *BMC Medical Education*, 18, 324, 2018, p.1-15.

The aim of our study was therefore to analyse the ethical dilemmas of the students, supervisors and beneficiaries who, over the previous five years, had taken part in a medical internship in a country with limited resources organised by the Université du Québec en Abitibi-Témiscamingue (UQAT). This will provide us with a better understanding of the nature of these dilemmas and allow us to deepen our knowledge of the ethical issues associated with this type of partnership.

## Methodology

This was qualitative research with an exploratory focus. The data come from semi-structured individual interviews. To compare and contrast the various points of view we selected participants who had played different roles during internships organised by UQAT over the past five years, i.e. trainees, supervisors and hosts. When selecting the participants, we took care to choose a variety of profiles; our final sample therefore included six trainees, four supervisors and five hosts. The data were analysed according to a thematic approach[5]. Each of the interviews was first analysed vertically and then compared with all the other interviews. QDA Miner software was used to codify the entire corpus according to the research issues and themes that emerged during the analysis.

## Lessons learnt

Presented here in the order in which they emerged in the interviews, the lessons learnt tell us a great deal about the ethical concerns of those who took part in these courses.

### *The decision to begin treatment and the legitimacy of treatments*

It is well known that in resource-limited countries, socio-economic factors influence a patient's decision to begin treatment. So when a lack of money or poor decision-making power leads a woman to refuse to begin the treatment recommended for herself or her children, ethical dilemmas arise among the participants: "A mother brought us a child who was suffering from severe malnutrition. [We] realised that [we had to] keep him in, but the mother didn't want to stay because she didn't have her husband's permission and she had no money, so she returned to her village and we never saw her again" (Trainee 1).

Another crucial issue is whether to begin a treatment when it is far from certain that it will be completed. Most of the trainees and supervisors responded in the negative, a position summarised by one participant as follows: "… to begin a treatment we know people will not have the means to continue, it's pointless as far as I'm concerned" (Supervisor 3). However, one trainee said: "I still think there is something to be gained by starting the treatment […]. If we're talking about a child who is in the early stages of an infection and we know that antibiotics are needed, perhaps for quite a while… perhaps giving him (the antibiotics) at some point will allow us to achieve the intended effect and avoid death" (Trainee 6).

To ensure that treatment is adequate and that the socio-cultural factors of the intervention context are respected, several interviewees stressed the need to work with local staff: "We must think in terms of sustainability. This assumes that the treatment begun complies with the conditions, […] rules [and] medical procedures of the country" (Supervisor 2).

Over and above the very appropriateness and potential benefits of the treatments, the participants generally felt that the treatments administered were legitimate and that they corresponded, insofar as possible, to the needs of the populations. According to one trainee, even though the working methods differed, the legitimacy of the treatment was not questioned: "I am convinced of that. We have slightly different methods – with regard to pain management, for example, we would probably go further, but we'll use non-medical methods, exercises, food…" (Trainee 4). One host, however, thought that because

[5] Pierre Paillé et Alex Mucchielli, « L'analyse thématique », *in* Pierre Paillé et Alex Mucchielli (dir.), *L'analyse qualitative en sciences humaines et sociales*, Éditions Armand Colin, p. 231-314.

of their limited knowledge of the context, some trainees suggested treatments that were not in keeping with local reality: "Some of them suggest further examinations. Most patients can't do that. They don't have the means to have these examinations, or we may not even do them here" (Host 3).

The difficulties patients have accessing care because of financial barriers and the fact that certain treatments are not available in outlying healthcare facilities were the basis of the ethical dilemmas experienced by the trainees. This was especially true where not beginning a treatment, or offering an alternative treatment that was not recommended, risked compromising patient safety: "There was one woman who had placental retention and should have been transferred to a hospital, but she couldn't afford it. … that woman was going to die. It plays with our values" (Trainee 3).

To address these ethical dilemmas, most participants tried to assess the likely consequences of their actions in terms of the benefits for their patients. For example, one of them justified their decision not to carry out an epidemiological review of a homosexual patient by invoking the possible consequences of this action for the individual: "If I treat this patient and discover that he has an STBBI [for "sexually-transmitted and blood-borne infection", Editor's note] [and] if he tells me that his partners are men, I will try to talk to him about it, but I won't go any further than that. I won't do an epidemiological review by going to look for his partners because all that will have consequences" (Trainee 1).

***Compliance with the laws and powers in place***

All the participants in the study generally agreed on the principle of respecting the laws, customs and mores of the host country in accordance with the agreement signed between the University and the local institutions. One supervisor summed up this mindset perfectly: "On this point I am absolutely clear. I cannot understand or accept that students violate the rules established by the country" (Supervisor 2). We can assume that his opinion was conditioned by the fact that he was a supervisor. Others, however, found it more difficult to accept certain rules, especially when these rules were inconsistent with their own values or professional standards. One trainee, for example, recounted her experience in the delivery room with a midwife who seemed to be acting inappropriately with the mother: "It really got to me because it didn't reflect my personal or professional values. I had a flash. First and foremost, I couldn't behave like that, even though that's how the midwife was behaving; me, I was next to the pregnant woman, I was holding her hand, I was telling her she was doing well, trying to encourage her" (Trainee 3).

In some cases, the "clash" between the various approaches could make it difficult for the trainees to adapt: "In hindsight, I think there was one detail that struck me, and that is that some students had difficulty adapting to the cultural context" (Supervisor 2). When some trainees decided to discuss this with local staff, the fact that differences between the two cultures were identified was not regarded by the hosts as a challenge to their professional competence, but rather as an opportunity to explain the reality of the situation to them: "We just explained to them that… sometimes it's because of a lack of means [and not] because of a lack of will" (Host 2).

***The legitimacy of donations***

The supervisors and trainees were almost unanimous about not donating medicines. The reasons cited were the difficulty of ensuring the storage, use and resupply of medicines. Most hosts, however, regarded the donation of medicines in a positive light as this made it possible to provide access to treatments that patients would not have been able to obtain.

Whilst opinions on donating medicines differed between the supervisors and trainees on the one hand and the hosts on the other, opinions regarding the donation of items of equipment were more unanimous and better perceived as it was not regarded as a contentious issue: unlike medicines, equipment can last and improve the quality of care.

***Partnerships***

The majority of the participants in our study felt that collaboration between the different actors involved was a good thing. For the trainees, these training courses abroad enabled them to discover a whole new world, different practices and, often, realities they did not even know existed: "I loved it! I've never had any regrets about it. It was a fantastic experience of an expanded role" (Trainee 2). For the hosts, these encounters were an opportunity to share knowledge and chat with the trainees: "Sharing what we were experiencing, talking. We love medicine, in fact we love healing people, we love talking, we love sharing what we do with others" (Host 3). Other benefits also emerged in the interviews, such as the development of friendships, community members' positive perception of the arrival of foreigners, and the trainees' contribution to healthcare.

Some hosts, however, had the impression that these training courses were more beneficial to the trainees than to the host country: "We chatted whilst treating our patients. But other than that, no – I didn't see (any other benefits)" (Host 4). Some hosts expressed the idea that they might also be offered the opportunity to go on a training course in Canada: "It would certainly be beneficial for me to have the experience. Just as it's important for trainees to come and learn here, we too need to go and learn something new and be able to practise it" (Host 2).

**Action plans**

The results of this research show that one of the most important difficulties trainees have when they sign up for a short-term medical mission is deciding whether or not to begin a treatment. This concerns both a patient's refusal, for whatever the reason, or the very decision taken by practitioners when they identify a problem with the follow-up of the treatment. To address the ethical dilemma, practitioners are more willing to think in terms of the likely consequences of their decisions rather than in terms of these decisions' intrinsic moral value; the principle of utility plays a key role here. A prime example of the application of this principle relates specifically to the decisions about treatments that are abandoned because they are deemed impossible to continue until the very end, even if – in absolute terms – they are the most appropriate. There are, however, many references to duty and compliance with the rules, regardless of the consequences, and therefore to the morality of duty. This is reflected in the call for professionalism and, above all, respect for human rights, particularly with regard to children and women.

Another important issue is the balance of the partnership. Even though the majority of our participants appreciate the medical internships in countries with limited resources, many of the hosts are asking for changes so that the benefits can be shared more widely. Such considerations are now shared by many global health experts as they see this as the basis for more equitable and authentic reciprocity and partnership. For this to happen, however, better sharing of responsibilities between institutions in the North and those in the South in terms of planning and conducting medical internships in countries with limited resources will inevitably be required[6].

The importance of inter-cultural communication and dialogue must also be emphasised. This requires mutual respect. It must be accepted, with humility, that we cannot understand a society in the space of a few days, and that it takes time and effort to discern why things are organised as they are. This does not mean to say that there is no injustice or that this injustice is not blatant, but merely that this reality – as is the case everywhere else – is part of a set of sociological, anthropological, historical and religious relationships that we cannot understand and appreciate as our presence in the country is but a fleeting one.

We must be careful about making quick assessments of existing social structures, even if at first glance they seem archaic, unjust or revolting. When faced with a practice or belief that seems wrong or absurd to us, it is better to offer a "second opinion" rather than try to impose practices inspired by the progress of Western science. This means that trainees must make a huge effort to change their way of thinking.

[6] Nikki Bozinoff *et al.*, "Toward reciprocity…", art. cit.

Some of our reflexes are deeply rooted and require a great deal of effort to overcome. In any event, it is essential to demonstrate a certain "cultural humility" and especially – for healthcare workers – to adopt practices that respect each other's culture.

***Translated from the French by Derek Scoins***

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Marc Imbeault, *Émilie Gélinas and Oumar Mallé Samb,* "An analysis of ethical dilemmas in medical internships in countries with limited resources", *Humanitarian Alternatives*, n°17, July 2021, p.94-107,
https://alternatives-humanitaires.org/en/2021/07/20/an-analysis-of-ethical-dilemmas-in-medical-internships-in-countries-with-limited-resources/
*ISBN of the article (PDF): 978-2-37704-840-3*