International Medical Student Rotations: Ethical and Emotional Dilemmas

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Abstract
An increasing number of medical students are choosing to do an elective abroad. While there is much in the peer-reviewed literature about curriculum development, there is very little, if anything, about preparing medical students for the ethical conflicts and emotional turmoil that working in an underprivileged setting can cause. This paper examines some common threads of conflict found in multiple countries including the role and treatment of women, the lack of pain management, economically driven medical decisions, dealing with unnecessary death, reproductive health and social taboos, bribery of physicians, informed consent and reintegrating into Western medicine. Vignettes gleaned from the experiences of the authors common to multiple disadvantaged settings are presented. These can help serve to prepare the student for situations he or she may encounter. Several suggestions are offered to mitigate the emotional conflict including setting realistic goals before going abroad, peer and family support, journaling, etc. Finally, a cognitive framework is offered to help the student make sense of what he or she may be experiencing.
DISCUSSION

Introduction
An increasing number of students in health care fields are choosing to do an international elective as part of their education. Fully 31% of 2010 medical school graduates in the United States report having a global health experience [1]. Many students function in the role of a semi-autonomous provider or observer. Other students will work with indigenous populations on projects such as water safety, etc. While much has been written about the curriculum and goals of international electives, little, if anything, has been written about preparing students emotionally and cognitively for these electives [2-6]. It is likely that the ethical and cultural climate in the host country will differ significantly from that in the United States. While the principles of patient autonomy, beneficence, non-maleficence and justice form an integral part of our (Western) education, they may not be a significant part of the value system in other countries. Furthermore, the understanding and application of these principles may vary depending on the country. Additionally, economic factors, both familial and societal, enter into the medical decision making process in a different way than in the US and other Western countries [7, 8]. The purpose of this paper is to examine some of the ethical and emotional challenges facing the medical student and other health professionals working in another culture. We will also propose a framework for helping students cope with these dilemmas. Demonstrative examples from the authors’ experiences will be used as examples of ethical and cultural conflicts that can arise. We have chosen these examples because of their ubiquity; all (except for wife burning) have been encountered in multiple countries. Reviewing these vignettes as a basis for discussion may help the student develop a better understanding of what he or she will encounter. Because we are still actively engaged in some of these countries, we have chosen not to identify specific locations or dates.

Emblematic Cases

Case 1: The Role and Treatment of Women
There is often a major disparity between the way women are (ideally) treated in Western countries and other countries. This can result in significant health implications [9-11]. One of the most poignant, yet simple, examples occurred when a sick child was being attended to by a mother in the Emergency Department. The mother was sitting at the bedside comforting the child. The husband walked in, and, in a way that seemed very arbitrary, ordered the mother to stand up. He did not want the chair nor did anyone else take the chair. He simply, for whatever reason, did not want her to sit. While there was no immediate harm in this case, this example is reflective of a cultural paradigm that undervalues women and can have major health implications. One of the most egregious violations of women’s (and human) rights is the practice of “wife burning”, officially termed “dowry deaths”, which occurs primarily in Northern India but is now becoming more prevalent in cities among the middle class [12]. In this case, the wife is burned to death, ostensibly by an “exploding stove”. Generally this is an economic crime in which the husband demands more dowry from the wife’s family. If this is not forthcoming, the wife is murdered, usually by burning. This leaves the man free to remarry and obtain another dowry. This occurs despite the fact that dowry transactions are illegal in India [13, 14]. The current law in India mandates that these instances be investigated only during the first 7 years of marriage [13]. Over 60% of cases are dismissed by the courts [15].
**Case 2: The Treatment of Pain**

A 4 year old male fell into a vat of hot, scalding milk and sustained second degree burns to approximately 40% of his body. No appropriate, “non-cling” dressing was available and no pain medication beyond acetaminophen and NSAIDS were available. The parents were visibly upset at the child’s discomfort but there was no recourse beyond over-the-counter analgesics. Pain control is often less-than-adequate in many countries (including our own). However, it can be particularly problematic in other countries. Often, fractures are set without pain medication and patients with burns may not be treated with adequate analgesia. The reasons for the lack of pain management are protean. Sometimes it is economic: in some areas, lidocaine is neither affordable nor available for use in the repair of wounds. Other reasons include physician training and lack of access to opiates as a policy matter. Clinicians working abroad may find themselves in situations where they are asked to perform painful procedures, such as laceration repairs or fracture reductions in a setting where no analgesia is available.

**Case 3: Economically Driven Health Decisions**

A 2 year old female presented to the emergency department with dehydration and likely sepsis. Although a charitable institution, the hospital requires that the patient’s family pay for needed medications ahead of time (a very common situation in many countries both at charitable institutions and public hospitals). This is necessary; physician time can be volunteered but medications cost money and providing free care can quickly bankrupt even the most well-meaning institution. After a meeting of the extended family, it was decided that, although the child could readily be treated, it would be too great a financial burden on the family and the child was taken home to almost certain demise. Often, decisions are not made based on prognosis but on economics [8, 9]. To make the emotional conflict worse, as visiting professionals we had the means to pay the several dollars to treat the patient. On the other hand, this is only one of 15 similar cases that had come through the door that week and we did not have the resources to cover the treatment of all of the patients.

**Case 4: Involuntary Detention**

Inpatients may be held in the hospital against their will until the family is able to garner the resources to pay the inpatient bill. This inpatient detention only adds involuntary costs to the ledger and is a clear violation of autonomy as we interpret it in the West. Again, however, it is a matter of whether or not the hospital will have the resources to be able to provide care to other patients.

**Case 5: Reproductive Health and Social Taboo**

A 19 year old unmarried female presented to the emergency department complaining of abdominal pain. The vital signs were 90/50 with a pulse of 140. A pregnancy test was positive and a presumptive diagnosis of ruptured ectopic pregnancy was made. The patient’s hemoglobin was 2.8g/l. In this particular setting, if a patient needs blood, the family is asked to donate. Because she was unmarried and had violated taboos on premarital sex, she was considered to be unmarriageable and a long-term economic drain on the family. For these reasons, no family members were willing to donate blood. The surgeons were unwilling to operate without blood available despite the likely outcome of death without an operation. Luckily, one distant uncle agreed to donate blood and the patient survived.
DISCUSSION

Case 6: Bribes and Kickbacks
A 45 year old woman presented to the emergency department after sustaining an ankle injury. She was immediately brought back to a room despite the fact that others in the waiting room were of a higher triage level. At the end of the encounter, the physician discretely showed the extra money she had given him. Bribing physicians for faster, more personalized care is something we have seen in most countries that we have worked in. The physician was amazed that US physicians are not allowed to take bribes from patients.

Bribes are not limited to patients; kickbacks for referrals to another physician or for ordering a test are often the norm. This creates an ethical conflict, violating both beneficence and non-maleficence. A second ethical concern occurs when sicker, but poorer, patient are being relegated to the waiting room in favor of those who may offer a bribe.

Case 7: Unnecessary Death
A 55 year old male presented to the emergency department with an anterior myocardial infarction. The patient was given aspirin and nitroglycerin with minimal relief of pain and no resolution of the ECG changes. The internal medicine staff chose not to use a thrombolytic (streptokinase) because of a minor risk of hypotension (which can be corrected by slowing the infusion, adding a pressor, or fluids). The patient languished in the ED before finally dying.

The clinician on a rotation abroad will often see what we would consider preventable deaths. This can be secondary to a lack of resources, or more disturbingly, to a lack of training or knowledge on the part of the local practitioner. It places the US clinician in an uncomfortable position when she has the knowledge to save a patient but is restrained from doing so. Trying to change the local medical practice or even intervening in one patient’s care can be difficult or impossible, especially if you are a student.

Case 8: Informed Consent
While informed consent is a center of patient rights in the West, who gives consent is different in different societies and in some instances informed consent is not even considered. Often, the patient is not involved in decision making with the family, and in some instances even the patient’s supervisor at work, making medical decisions for the patient [16]. Patients are often not told the prognosis, nor given enough information to make their own decisions.

Discussion
These cases, and many others like them, present major ethical or emotional dilemmas, which can put the clinician in an uncomfortable position. On the one hand, our training and sensibilities see what we would consider unethical practices. On the other hand, there is a need to be culturally sensitive if we are to affect any change at all. The feeling of helplessness can lead to guilt, outrage, resentment and alienation.

Solutions
It is clear that exposure to stressful/difficult situations in the medical setting can lead to work related stress and even post-traumatic stress disorder [17, 18]. Unfortunately, too frequently these traumatic incidences are not discussed [19]. Formal debriefing has a mixed record with some literature suggesting it may actually be detrimental [20-23].
However, there is often more than one foreign student or other clinician doing a rotation at an overseas facility and when available, peer support can be beneficial [24, 25]. Contact with one’s family, friends and colleagues via email (if available) is another option. Internet blogging as a means of venting should be avoided since access to blogs is generally not restricted and a blog may be read by someone at the host institution. This obviously has the potential to cause problems between the clinician and the host institution. A potentially useful strategy for coping is journaling. Journaling has been found to aid in stressful situations and can be a helpful coping technique [26, 27]. Not all journaling is created equally, however. Journaling that includes both emotional and cognitive reflections seem to be the most effective. In fact, journaling that is only emotive may make the situation worse [28].

It is also important to have appropriate expectations. You are not travelling abroad to have an impact on a foreign medical system; you are not going to be able to “fix” everyone. Set goals that you can accomplish, for example doing the most for people with the resources available. Realize that your experience will change you more than it will the local medical system and patients. If your mission is education keep your aims modest. Medical education is difficult even in optimized situations. It is that much harder without a shared cultural background and language.

**Other Considerations**

Reconciling the fact that we (in general) have so much material wealth while much of the rest of humanity has so little is another task faced during an overseas rotation. The day-to-day decisions a family has to make can be life altering. One common reaction (at least in the authors’ experience) is a feeling of guilt about having so much when others have so little. However, in a finite period of time we will return to our Western life style. Not many of us choose to abandon all of our belongings to become an ascetic working with the poor (even Buddha took the middle path: neither asceticism nor excess) [29]. How does one reconcile the widespread poverty seen in other countries with the relative abundance in the US? It may not be entirely reconcilable. One can, however, contribute to removing the disparity as best as one can. This could be through charitable contributions, continued work in less privileged countries or, in some cases, a life dedicated to this cause.

Anticipate that re-acclimation to the US medical system may be difficult. Patient problems in the US may seem frivolous compared to that in other countries. One may find oneself getting very frustrated with patients who “abuse” the system or are ungrateful. Keep in mind that most people haven’t seen what it is like in an impoverished nation and they may not have the same insights, perspectives and point of reference that you have.

**Practical Solutions**

If you think that you might be in a situation where you may have to work without analgesia, it may be wise to bring along some lidocaine. If you anticipate finding patients in need of care that they cannot afford, consider setting aside a certain amount of money before you leave to be used in these situations. This money should be given to someone within the institution once you arrive. This can have a direct impact on patient care without breaking societal norms. It also removes the burden of having to make a decision each time a patient presents in need.
DISCUSSION

Make sure that there is some down-time in your work schedule. Even though it may seem selfish in the face of overwhelming need, one risks burn-out if one is working incessantly. Some time away from clinical duties can help the clinician process and hopefully better understand the daily experiences.

A Cognitive Framework for Adaptation
Above, we speak of an acceptance of the situation one finds oneself in. This can be a difficult process. The cognitive framework of Kubler-Ross’s stages of grief can provide a basis for understanding the process one is undergoing when adapting to a rotation overseas [30]. This framework has been found to be applicable not only to patients with terminal illnesses but also in other stressful situations such as job loss, divorce, etc. [31-33]. The ethical and emotional dilemmas faced by the clinician abroad are analogous to the situation described by Kubler-Ross in that an individual is put into a situation to which a satisfactory resolution is unlikely. Similarly, there is a loss: in the case of Kubler-Ross it is a diagnosis of a terminal illness, in the case of the clinician it is a cognitive or emotional loss. Most clinicians go into their first international rotation with a great degree of idealism and a conviction that they can change things. Seeing the situation first hand is often a shock, which leads to a degree of moral and emotional disorientation; what the clinician believed comes up against reality.

The first stage in Kubler-Ross’s progression, denial, is likely not operative in most instances (though perhaps in some). The needs and disparity are usually pretty obvious. However, subsequent stages, anger (“Why can’t they get the oxygen working?”, “How can the physicians be so insensitive to pain?”), “Why aren’t the physician’s and nurses working faster to take care of this sick patient?”), bargaining (“Maybe if I work harder…”), depression (“Things will never change…”), and finally acceptance all may be applicable depending on the individual. As in grief, not all individuals will go through each stage but the goal is the same: to arrive at the point of acceptance, which allows one to continue working without an undo emotional burden. The important point for the clinician is to realize that acceptance is a process, which can take a great deal of time and emotional turmoil to achieve.

We also think it is a good idea that clinicians be offered a seminar prior to an international rotation where these and other potential problems can be discussed. Having the ability to address some of these issues ahead of time will allow solutions to emotional and ethical tribulations to be in place. To some degree, this obviates the need of having to deal with them ad hoc during a crisis. The goal is not to suppress ethical judgments and emotional reactions but rather to reflect on them ahead of time, and, if possible, develop a support network that can be available in person, by phone or by Internet (email or a “Skype equivalent”).

Conclusion
Providing healthcare to impoverished communities can be a rewarding experience but can be accompanied by a substantial culture shock. Often clinicians are unprepared for many of the ethical and emotional dilemmas that may arise, leaving them without the tools to cope emotionally and cognitively. We have suggested some ways to mitigate the emotional turmoil causes by unsolvable ethical dilemmas and stressful situations. These include recognition of the problem and understanding steps that may make the task of dealing with disparity and poverty easier. If we can prepare clinicians for the emotional burden that can accompany working with
severe poverty and social injustice, and teach them to find some acceptance of what they see, they may be more likely remember their experience as a positive one and continue to help more communities in the future.
References


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