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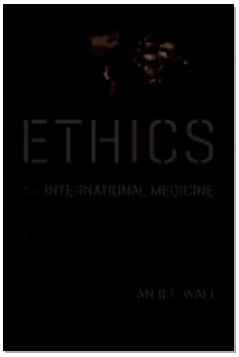
3 | Norms



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CHAPTER 3

Norms

Norms are standards of behaviors derived from ethical, professional, and legal guidelines. As illustrated in the previous cases, multiple norms are important in the analysis of every ethical issue. Norms can also serve as the source of, or contribute to, ethical issues when they conflict with each other in such a way that they support different, mutually exclusive options. For example, a patient who presents to the hospital with abdominal pain and fever is found to have perforated appendicitis. The surgeon tells the patient that she needs surgery, but the patient refuses consent for an appendectomy. The norm of beneficence, or maximizing benefits and minimizing harm to patients, is most consistent with doing the surgery. However, the norm of respect for autonomy supports not doing the surgery. The stakeholders in this case must determine if these two norms can be reconciled, or which norm should take precedence in order to make a decision about what to do.

The nature of international medicine increases the likelihood of conflicts among norms, because medical aid workers serve in areas with different legal and professional guidelines. In addition, patients and local medical personnel are often not familiar with Western norms of bioethics and may have their own bioethical norms or their own interpretations of Western bioethical norms. When faced with ethical issues in international medicine, it is essential that medical aid workers not only identify their own norms, but also identify norms important to patients and local medical personnel so as to take these into account in the decision-making process.

Disagreements about Bioethical Norms

The bioethical norms familiar to medical aid workers from developed countries are commonly described in terms of the principles of respect

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for autonomy; beneficence; nonmaleficence; and justice (Beauchamp and Childress 2001). Respect for autonomy requires that physicians inform patients about their medical conditions and options for intervention so that patients can make informed decisions about their care. Beneficence is the duty of physicians to maximize benefits and minimize harm to patients. In practice, beneficence requires physicians to determine the risks and potential benefits of interventions so that they and their patients can decide whether or not there is an appropriate balance between the two. Nonmaleficence requires that physicians do not perform procedures or prescribe treatments that exclusively cause harm to patients. Justice dictates that the benefits and burdens of medical care and research are fairly distributed at a societal level. In addition to these norms, relationality, which states that relationships are important and should be respected, is an important bioethical norm, especially in the setting of international medicine (DuBois 2008).

While most people can agree upon the general idea of these principles, they often disagree about how these principles should be interpreted and applied in specific cases. For example, most people would agree that donated organs should be distributed fairly among those who need them. However, there would certainly be disagreements about what constitutes fair distribution of organs. Some may believe that organs should go to the sickest patients, while others might believe they should go to those most likely to benefit or to those who have been waiting for the longest time.

In international medicine, patients and local medical personnel are often unfamiliar with Western bioethical norms. Even when they are familiar with these norms, they may flatly disagree with them, or interpret them very differently than do medical aid workers. The following case illustrates a situation in which the stakeholders disagree about the bioethical norm that should take precedence.

Case 3.1: Veracity and the Dying Patient

A medical aid worker from the United States is working in an oncology unit at a Russian hospital. The unit has two full-time Russian doctors and three nurses for forty patients. One of the patients on the ward is an eighty-year-old woman who was diagnosed with stage IV bladder cancer several months ago. The nurse who has been attending to the patient tells the medical aid worker that they have admitted the woman to the

hospital for pain and symptom control several times, but have not told her about her diagnosis or prognosis. The medical aid worker asks why they have not told the woman this information, and the nurse replies that they do not disclose cancer diagnoses to patients because it can be emotionally damaging. They have informed the woman's daughter of the diagnosis, and she is in charge of making medical decisions.[1]

The medical aid worker goes in to see the patient. She is weak, but manages to engage in a conversation with him through an interpreter. They discuss her level of pain, which she says is manageable, and talk about the side effects that she has been experiencing from the medications—nausea and vomiting. She says that the side effects are tolerable, especially because she knows that she will be finished with the medications soon and can return home with her daughter. The medical aid worker believes that the woman will probably die in the hospital in the next couple of weeks rather than getting better and returning home.

It is clear from their conversation that the woman is unaware of her diagnosis and prognosis. In the United States, patients are usually told about their diagnoses and prognoses, unless they specifically request not to know. The medical aid worker thinks that informing patients with cancer about their condition is the right thing to do, and he wonders whether or not he should disclose the diagnosis and prognosis to this patient while she is under his care.

CASE ANALYSIS

In this case, the medical aid worker wants to inform the patient about her diagnosis and prognosis in order to allow her to make decisions about her care. The local medical personnel do not want him to do this, because they do not routinely inform cancer patients about their diagnoses and prognoses. The medical aid worker must decide whether he should inform the patient based on the Western norm of respect for autonomy or continue to keep the prognosis and diagnosis from the patient based on the Russian conception of beneficence.

Stakeholders

The four central stakeholders in this case are the medical aid worker, the patient, the nurse, and the patient's daughter. Additional stakeholders include the Russian doctors and the other nurses in the clinic.

Medical Facts

The medical aid worker, the nurse, and the patient's daughter are aware of the patient's medical condition. She has terminal bladder cancer and will die soon. She has failed attempted treatments and now is being treated for comfort rather than cure. The medical staff recognizes the patient's daughter as the medical decision maker in this case. The daughter is likely in agreement with the nurse in fearing that the woman will become emotionally distraught if she is informed of her diagnosis and prognosis, and that the stress of this information will hasten the patient's death. The patient does not know what her medical condition is or why she is being treated. It is unclear whether she wants to know more about her prognosis and diagnosis.

Goals and Values

The goal of the medical aid worker, the nurse, and the daughter is to do what is best for the patient as she is dying. The patient's goal is to return home with her daughter, which the other stakeholders know is unlikely, given her condition. The medical aid worker values informing patients about their medical conditions so that they can make decisions about the course of their care and prepare for death. This is a reflection of the culture of Western biomedicine, which values patient knowledge and decision making. The nurse and daughter both focus on the value of preventing emotional distress to the patient. This reflects the culture of Russian medicine, which values the protection of fragile, dying patients. The patient's values are not clear from the case presentation but would be important for the other stakeholders to elicit in their analysis.

Norms

The bioethical norms of respect for autonomy, nonmaleficence, beneficence, and relationality are all important in this case. Respect for autonomy requires that physicians disclose diagnoses and prognoses to competent patients unless patients express a desire not to know. The default position in Western biomedicine is to inform patients about their medical conditions. Nonmaleficence requires that physicians do not intervene in ways that are exclusively harmful to patients. Beneficence requires that physicians maximize benefits and minimize harm

to patients. Because stakeholders disagree about the potential harms of informing versus not informing the patient, it is especially challenging to determine which option is most consistent with the norms of beneficence and nonmaleficence in this case. The norm of relationality is also important in this case. The relationship of the daughter to the patient as her child as well as her medical decision maker should be respected.

The professional norm important in this case is that of therapeutic privilege. Therapeutic privilege allows medical personnel to withhold medical information from a patient if they believe it will negatively impact the patient's medical condition. Therapeutic privilege is a norm in the Russian hospital, where they do not disclose cancer diagnoses to patients. It is no longer an accepted norm in Western medical practice. Currently, the norm of Western biomedical practice is disclosure of diagnoses and prognoses to all patients, even those with cancer or other terminal conditions, unless the physician is specifically asked not to do so by the patient. In addition to professional guidance, legal guidance from the United Nations states that therapeutic privilege should no longer be supported as a norm of professional behavior (IBC 2008).

Limitations

One limitation in this case is time, because the patient is probably going to die in the next couple of weeks. The medical aid worker is also limited by the peripheral role that he is playing at the hospital as a temporary volunteer rather than a permanent physician. If he is only serving for a week or two, it is unlikely that he will develop a strong relationship with this patient that is similar to those she has with the Russian doctors and nurses. He is also limited in his understanding of the culture of Russian medicine.

ANALYSIS AND JUSTIFICATION OF OPTIONS

There are a few options for the medical aid worker in addressing his concern about the woman not being aware of her diagnosis and prognosis. At the extremes, he could either inform her or continue to keep her diagnosis and prognosis a secret. An intermediate option would be to speak with the nurse and the daughter to learn more about why they do not want to inform the patient and to determine if they will allow him

to speak with the patient about whether or not she wants to know more about her condition. The justification of these three options is explored in this analysis.

The first step in justification is to determine whether the option will be effective in achieving the goal. In this case, the general goal could be defined as doing what is best for the patient. The problem with this goal is that there is disagreement among stakeholders about how best to achieve it. If the medical aid worker decides not to inform the woman, his action would be effective from the perspectives of the nurse and the daughter. If he does inform her, his action would be effective from his perspective. If he decides to continue the discussion, the stakeholders may be able to come to an agreement about the most effective way to achieve their goal.

The next step in justification is to determine if the benefits of the option outweigh its infringement on the identified norms and values. According to the nurse, the option of not informing the patient has the potential benefit of avoiding emotional distress. It infringes upon respect for autonomy as interpreted by the medical aid worker, because the patient is not being given the information needed for her to participate in decisions regarding her care. It may infringe on beneficence if the potential harms of withholding information outweigh the potential benefits. In addition, it infringes on the professional norm of the medical aid worker, which requires physicians to tell patients about their condition unless patients request not to be given this information.

The option of informing the patient has the potential benefit of giving the patient knowledge about her condition and letting her make decisions about her medical care, if there are any to be made, as well as to make other decisions in preparation for death. If she does not want to know about her diagnosis or prognosis, then telling the patient about her condition would infringe on respect for her autonomy. This option also infringes on relationality because the medical aid worker would be informing the patient against the wishes of her daughter, who is also her medical decision maker. Making the unilateral decision to inform the patient would fail to respect the relationship between the mother and daughter. This option may also infringe on the norms of beneficence and nonmaleficence if giving the woman information about her condition does in fact cause emotional distress with little or no benefit.

The third option of talking to the nurse and daughter about why they do not want to inform the patient and determining if they will allow the medical aid worker to speak with the patient about what she may want to know about her condition has the potential benefit of achieving consensus among the stakeholders. It may also be a step in the direction of changing the professional norms at the hospital to encourage greater disclosure of medical information to patients. This option respects relationality by involving the daughter in the discussion. It also allows the medical aid worker to explain to the other stakeholders why informing the patient may be important and for the nurse and daughter to explain why not informing the patient may be important. Moreover, it respects the autonomy of the patient by allowing her to be involved in the conversation about whether or not to be informed about her condition. Finally, it allows the stakeholders to discuss the benefits and burdens of disclosure and determine what action is most consistent with the norm of beneficence.

The next steps in justification are to determine whether infringement is necessary and, if so, whether or not it can be minimized. The option of not informing the patient necessarily infringes on respect for autonomy. This could be minimized if the medical aid worker elicits the patient's values and goals for treatment and encourages the daughter to make medical decisions consistent with them. It infringes on beneficence only if the risk-benefit profile is less acceptable than that of the other options. The option of informing the patient necessarily infringes on relationality because it fails to respect the relationship between the patient and her daughter. It also necessarily infringes on the Russian professional norm of therapeutic privilege. These infringements cannot be minimized if this option is chosen. The final option of engaging the stakeholders in a conversation about informing the patient has the potential to avoid infringing on any of the identified norms and values. If this option does require infringement on an identified norm or value, part of the discussion among the stakeholders should involve determining how best to minimize that infringement.

The final step in the justification process is determining whether the stakeholders would be comfortable sharing their decision-making process with others. If the medical aid worker chooses the first or second option, he has made a decision not to involve the other important stake-

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holders in the process. This may not be something that he is comfortable sharing with others, especially if he makes the decision to inform the patient, thereby infringing on the ethical and professional norms identified by the other stakeholders. The third option, of the medical aid worker discussing his concerns about informing the patient with the nurse and daughter and attempting to speak with the patient about her desires regarding disclosure, is a process that he should be comfortable sharing with others. It encourages communication and negotiation, and it has the potential to avoid infringing on the identified norms and values.

CASE COMMENTARY

In this case, the medical aid worker encounters a practice that is not in accordance with his values or the norms of Western biomedicine. While it may be tempting for the medical aid worker to make the unilateral decision to inform the patient of her condition because this is consistent with the ethical, professional, and legal norms that he identifies, there are a couple of reasons why this may not be appropriate, beyond the fact that it infringes on the values and norms of the other stakeholders. First, the medical aid worker does not have a long-standing relationship with this patient and is therefore unaware of her personal values. She may actually not want to know about her condition and be comfortable leaving her daughter in change of making medical decisions. In addition, the patient may not be receptive to hearing her diagnosis and prognosis from a physician she does not know. Without a prior relationship with the patient, it may not be the place of the medical aid worker to disclose this sensitive information to her.

In addition to affecting the care of the individual patient, the medical aid worker may undermine the more general goal of changing the professional norms about informing patients of their conditions in this hospital by informing the patient without first consulting with the local medical personnel. A unilateral decision may anger the local medical personnel, making them less willing to inform dying patients of their diagnoses and prognoses in the future. It may also discourage local medical personnel from allowing the medical aid worker to interact with dying patients. When medical aid workers encounter practices that conflict with their values or norms, it is important that they engage the local stakeholders so as to learn more about the sources of conflict and negotiate about

which action to take. If, after careful consideration, medical aid workers feel that local norms should be changed, communication and negotiation with local medical providers are the best ways to address not only the immediate situation but also to encourage permanent changes in policy. Because medical aid workers only serve temporarily, they should recognize that the local medical personnel have to be involved in decision making in order for permanent changes to occur.

The Challenge of Justice

Justice takes on an entirely different character in international medicine. In developed countries, decisions about the distribution of medical goods and services are generally made on a governmental or organizational level. Physicians in clinical practice are rarely confronted with having to make a decision about how to distribute needed medications or procedures to their patients. The relative abundance of medical goods and services in the developed world allows physicians to make decisions about what care patients require without worrying about whether or not resources to provide that care are available. However, in developing countries, scarcity and lack of access to medical care are a norm. Because clinics and hospitals in developing countries are limited in what they can offer patients, medical aid workers must often make decisions about how best to distribute these limited resources. The following case illustrates a situation in which what is medically indicated may not be consistent with the norm of justice.

Case 3.2: A Young Boy with AIDS

A medical aid worker is spending six months serving in rural Zambia. He is helping run a new home-based care program for children with HIV/AIDS. This program is designed to identify children with HIV/AIDS through screening and diagnostic work-up and then treat them with antiretroviral therapy and antibiotic prophylaxis. The reason for the home-based care is that members of the community have no sustainable, reliable way to get to clinics or hospitals that treat patients with HIV/AIDS.[2]

During her first week in Zambia, the medical aid worker is called to the home of a family in the community because their ten-year-old son is getting progressively sicker. He has not yet been screened by the home-based care program, but after examining him, the medical aid worker

is certain that he has AIDS and is suffering from pneumonia. Without prompt antibiotic and antiretroviral treatment, this boy will certainly die. Because the boy is so sick, the medical aid worker believes that he should be hospitalized immediately. She knows that she can find someone in the village who has a vehicle to bring the boy to the hospital and that she can pay for his hospitalization. However, she wonders if she should send the boy to the hospital, because she might be undermining the home-based HIV/AIDS treatment program and setting an unsustainable precedent for care.

CASE ANALYSIS

This case illustrates a common ethical issue that medical aid workers encounter when serving in developing countries. Medical aid workers have the resources to work around the health care system, getting patients access to a higher level of care than they would otherwise be able to receive. However, going around the health care system is not a sustainable way to ensure that patients have access to the health care they need in the future. Moreover, it can set expectations that medical aid workers will consistently do this with all patients in need. In these situations, medical aid workers have to decide whether or not it is fair for them to work around the health care system, knowing that they cannot do this for all patients.

Stakeholders

The central stakeholders in this case are the medical aid worker, the boy, and his family. Additional stakeholders include other children in the community with HIV/AIDS, the people who are running the home-based HIV/AIDS treatment program, and community leaders.

Medical Facts

While the medical aid worker has not run any diagnostic tests, she is sure that the boy has AIDS and pneumonia. The boy has lost weight and is experiencing fevers, chills, and a cough. The underlying cause of his medical problem is likely the human immunodeficiency virus, which has weakened his immune system and made him susceptible to infection. In order to get better, he needs treatment with antibiotics and antiretrovirals. He probably also needs supplemental nutrition and IV fluids.

His prognosis is poor without treatment and hospitalization. With treatment, he will most likely be cured of the pneumonia. He will require lifelong antiretroviral therapy to control his AIDS. The case does not discuss the effect that the illness has had on the boy and his family, what they believe is wrong with him, or whether they have done anything to treat him. However, the family is obviously concerned enough about the boy's condition that they have called on the medical aid worker for help. They likely fear that the boy will die without intervention, because deaths from AIDS and AIDS-related illnesses are common in Zambia.

Goals and Values

The medical aid worker has two goals in this case. The first is to cure the child's pneumonia and stabilize his HIV infection. The second is to create a sustainable, effective home-based HIV/AIDS treatment program. The goal of the family is for the child to get better. The medical aid worker values both the life of this child and the life of all the children in the community with HIV/AIDS. The family values the well-being of this child above that of other children in the community because of the relationship that they have with him.

Norms

The two bioethical norms important in this case are justice and beneficence. Justice requires that the benefits and burdens of medical care are fairly distributed at a societal level. In this case, the home-based HIV/AIDS program is designed to respond to the community's limited access to health care by bringing antiretroviral drugs to patients rather than bringing patients to hospitals and clinics. By giving this child access to the hospital, the medical aid worker will be working outside the home-based program. The medical aid worker cannot hospitalize every child in the community who has AIDS and pneumonia, so she must determine whether or not it is fair for her to hospitalize this child. Beneficence is a competing norm to justice in this case. Beneficence is the duty of physicians to maximize benefits and minimize harm to their patients. Obviously, hospitalizing the boy to treat him with antiretrovirals, antibiotics, fluids, and nutrition is more consistent with the principle of beneficence than not hospitalizing him.

One professional norm important in this case is the duty of physicians

to be advocates for their patients. Physicians in the United States are generally expected to make decisions that are in the best interests of their patients without considering the impact that these decisions have on other patients. Due to the constraints on resources in developing countries, however, decisions about how to treat one patient may have a real and immediate effect on the care of another patient. In this case, sending the child to the hospital will not take resources away from another child in need, but it might set a precedent that the medical aid worker cannot continue during her six months in Zambia.

The legal norm important in this case is the duty of physicians to treat patients. The medical aid worker has an obligation to treat this patient with the standard of care or to transfer him to a place where he can receive the standard of care if she cannot provide it. The standard of care in the community is home-based treatment or no treatment. However, the standard of care in the developed world would be hospitalization. The medical aid worker must determine if she has a duty to transfer the child to the hospital or if trying to treat him at home is acceptable.

Limitations

The medical aid worker has just started a six-month medical aid mission in Zambia, so she is not limited by time in the treatment of this patient. She is, however, limited by resources. She believes that the boy needs a higher standard of care than she can provide in the community. The community, as a whole, has limited access to medical care. The medical aid worker could get around this limitation for this patient, but would not be able to permanently secure reliable access to hospitals and clinics for all community members.

ANALYSIS AND JUSTIFICATION OF OPTIONS

The medical aid worker has a really tough decision to make in this case. She can either send the boy to the hospital or try to treat him at home. In the developed world, she would send the boy to a hospital without question, because that level of care is both available and standard. Moreover, it would be rare to see a child with advanced AIDS in the developed world, because children with HIV/AIDS are treated with antiretroviral drugs and monitored for infections so as to keep their medical condition under control. The facts that the patient in this case is a child

and that the medical aid worker is new in the community compound the complexity of the decision. This analysis focuses on the medical aid worker as the central decision maker but recognizes that there are additional important stakeholders, including local medical personnel, the patient and his family, and community members who are involved in the home-based HIV/AIDS treatment program. The two general options for the medical aid worker are to send the child to the hospital or treat the child at home.

The first step in justification is to determine whether the option has the potential to be effective in achieving the goals of the stakeholders. The two goals of the medical aid worker are recovery of the child and sustainability of the home-based HIV/AIDS treatment program. The goal of the family is recovery of the child. The option of sending the child to the hospital has the greatest potential to achieve the goal of patient recovery. However, it might undermine the home-based program by going around it to get this child health care. The option of attempting to treat the child at home is likely going to be less effective with respect to his recovery. However, because this option adheres to the home-based HIV/AIDS treatment program, it might encourage the program's long-term sustainability, especially if the child recovers.

The second step in justification is to determine if the benefits of the option outweigh its infringement on the identified norms and values. The primary benefit of sending the child to the hospital is that he will have the best chance for recovery there. However, this option infringes on the norm of justice, because not every child in this condition from this community would have the opportunity to be transported to a hospital for treatment. The community has recognized this deficiency and set up the home-based treatment program so that children can get the care that they need without going to a hospital. The main benefit of treating the child at home is that this option stays within the parameters of the home-based treatment program. If he is treated effectively at home, this will show that the program has the potential to work even with seriously ill children. However, this option has the potential to infringe on the bioethical norm of beneficence, because it has greater risks and less potential for benefits than hospitalization. It may also infringe on the duty of the physician to advocate for patients. In the absence of the home-based treatment program, the medical aid worker would undoubtedly make all

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possible attempts to get this child to a hospital for treatment, because that is the most medically appropriate option. This option may also infringe on the legal duty of the physician to provide her patient with the standard of care or transfer if that standard is not available. The medical aid worker would have to determine if the standard of care in the community, namely home-based treatment, is acceptable, given that she could transfer the child to the hospital for a higher level of care.

The next steps in justification are to determine if infringement on norms and values is necessary and whether this infringement has been minimized. The option of sending the child to the hospital necessarily infringes on the norm of justice because there is no reliable, sustainable way to send children with HIV/AIDS to surrounding hospitals when they get sick. If the medical aid worker could set up a reliable, sustainable ambulance service and contract with the nearest hospital to accept patients from the community for treatment, then this option would not infringe on justice, because all patients in a similar condition would receive the same care. If this cannot be done, offering the option of hospitalization to other similarly ill children while relying on the home-based treatment program for care of most of the children with HIV/AIDS could minimize infringement on justice. However, the home-based treatment program was developed to respond to the community's inability to access hospital care, so there may not be a way to set up a hospital transportation system.

The option of treating the child at home would only necessarily infringe on beneficence if the risk-benefit profile were significantly worse than that of hospitalization. If the risk-benefit profiles are comparable, then not only does this option not infringe on beneficence, but it is also in line with the standard of care and the duty of the physician to be a patient advocate. However, the medical aid worker does not believe that the two options have comparable risk-benefit profiles, so this option would most likely infringe on these norms. This infringement could be minimized if the physician attempts to treat the boy at home while reserving the option for hospitalization if he gets significantly worse.

The final step in justification is to determine whether stakeholders would be comfortable sharing their decision-making process with others. In this case, not only should the family be involved, but the medical aid worker should also consult with local medical personnel and leaders in-

volved in the home-based care program if there is time to do so. It is important that the medical aid worker does not make the decision unilaterally, if possible. If she does, she could either unintentionally undermine the home-based program by hospitalizing the child or her own credibility as a caregiver by treating the child at home.

CASE COMMENTARY

The norm of justice, or fairly distributing the benefits and burdens of medical care, takes on a different character in international medicine. First, medical aid workers are often the people who have to decide which patients will receive the limited medical goods and services that they can provide. This often means turning away sick patients. Second, medical aid workers have the resources to work outside the infrastructure of the health care system. There are many reports of medical aid workers bringing patients from developing countries back to the developed world to have medical procedures that they could not get at home, or, as in this case, medical aid workers pulling together resources to get a patient to a nearby hospital or clinic. The central ethical issue in these types of cases is determining whether or not providing short-term unsustainable interventions or onetime ways around the medical infrastructure is acceptable, given that these actions infringe on the bioethical norm of justice.

Competing Professional Norms

Professional norms are the standards of practice and behavior agreed upon by members of the medical profession. These norms are often tricky to identify and, even more frequently, tough to agree upon. There are, however, several sources for professional norms that are well respected. These include guidelines from professional societies such as the American Medical Association (AMA) and specialty societies such as the American College of Surgeons (ACS). It should be noted that not every member of the AMA or ACS agrees with all of the professional norms developed by these organizations and that there are frequent debates regarding these norms, often resulting in changes being made to them. However, these types of norms are generally respected and followed by medical professionals. If nothing else, they provide a starting point for identifying professional standards of practice.

In international medicine, local professional norms can differ greatly

from the professional norms of developed countries. Reasons for this include a practice setting with limited resources, different medical traditions based more on cultural practices than on scientific evidence, and a lack of basic facilities for the provision of care. When medical aid workers either disagree with the standards of practice in the areas where they are serving or insist on adhering to their own standards of practice, ethical issues can arise. The following case illustrates how professional norms can compete with each other in international medicine.

Case 3.3: Medical Student Involvement

A group of six fourth-year medical students and an attending family medicine physician visit a clinic in Haiti for a three-week medical aid mission. The main focus of the group is providing primary medical and obstetric care. All of the medical students have clinical experience in both internal medicine and obstetrics. The clinic where they are volunteering has a small staff of two local nurses and a local doctor. The clinic provides the only medical care for patients in the vast surrounding area, serving an average of one hundred patients per day. The local medical personnel welcome the extra help provided by the medical students and their attending physician. It allows them to make house calls while the aid workers staff the clinic.[3]

After spending the first day learning about the common diseases in the area as well as the appropriate and available medications for treating these diseases, the medical students are prepared to begin working in the clinic. They start seeing patients, making diagnoses and developing treatment plans. The attending physician signs off on the diagnoses and treatment plans made by the medical students without independently examining the patients. Because the medical problems that the patients have are routine, the attending physician is comfortable giving this level of responsibility to the medical students.

When a woman arrives at the clinic in labor, the attending physician is seeing another patient and tells two of the medical students to get her into a room and examine her to see if she is ready to deliver. After wrapping up with his patient, the attending physician checks in with the students, who think that the patient is ready to deliver. The attending physician examines the woman and agrees. It looks like the delivery is going to be routine. Since the medical students have some experience in ob-

stetrics, the attending physician asks them if they want to take charge of the delivery while he continues to see the other patients. While this is an exciting prospect for the students, they are not confident that they are adequately trained to do the delivery and are unsure whether or not they should handle this patient without direct oversight.

CASE ANALYSIS

Medical students doing aid work are often given significantly more autonomy in caring for patients than they have in their training programs at home because of the large volume of patients, less strict regulations for clinical oversight, and the limited number of trained medical personnel to provide oversight. Less oversight can be positive in the sense that medical students are given the opportunity to gain practical experience. However, it can also put patients at greater risk of harm because inexperienced providers are treating them. The medical students are unsure about whether or not they should attempt to deliver the baby without oversight, given their limited experience doing this type of procedure.

Stakeholders

There are several important stakeholders in this case, including the medical students, the patient, the attending physician, and local medical aid workers from the clinic. This analysis focuses on the medical students but considers the other stakeholders when appropriate. In addition to the central stakeholders, the entire community is a stakeholder, as are the institution where the medical students are being trained and the organization for which the group is working.

Medical Facts

The medical facts in this case are straightforward. The woman is in labor and seems to be progressing appropriately. The attending physician believes that the delivery will be uncomplicated. He thinks that the medical students will be able to perform the delivery without his assistance or oversight. The medical students have some experience with obstetrics but have never delivered a baby without oversight. They are unsure about whether or not they are adequately prepared to attempt the delivery by themselves.

Goals and Values

The primary goal for the intervention is to successfully deliver the infant. The stakeholders value both the health and well-being of the infant and the mother. In addition, the attending physician and the students value the educational opportunity that this case presents for the students to gain hands-on experience, which they have not gotten at their home institution.

Norms

The three bioethical norms important in this case are beneficence, respect for autonomy, and justice. In addressing the norm of beneficence, the potential benefits of the procedure can be defined narrowly or broadly. In a narrow sense, the benefits to the mother and infant would be maximized if the attending physician, who has the most experience in labor and delivery, performs the procedure. More broadly, the medical students' education should also be considered a benefit. The more involved they are in the procedure, the greater potential they will have for educational benefit. The risks of the procedure will naturally be greater the more that the medical students are involved because they are less experienced in labor and delivery than the attending physician. Respect for autonomy, or allowing patients to make decisions regarding their care, is also important in this case. The woman is an important stakeholder who should be consulted about medical student participation in the procedure. In the United States, patients are asked if they will allow trainees to be involved in their care and can request that trainees not be involved. Justice, or fair distribution of the benefits and burdens of medical care, is another important bioethical norm in this case. The reason that patients allow medical trainees to be involved in their care, from the perspective of justice, is that they are willing to bear the burden of lower-quality care for the benefit of continuing the medical enterprise into the future. Patients ultimately benefit from trainee involvement in their care because they ensure that high-quality medical care continues in the next generation of physicians. In international medicine, the patients who bear the burden of medical trainee involvement do not necessarily benefit from the trainee's medical education because the trainees are more likely to base their professional practice in their home country rather than in the developing world.

There are two competing professional norms in this case. The first is that physicians and medical trainees are expected to only do procedures that are within the scope of their medical training. In the United States, medical students are often involved in deliveries and sometimes do the procedures themselves. However, they do so under the strict oversight of attending physicians and residents. The woman in this case, by virtue of being poor and living in a developing country, might be subject to a different standard of care than a woman in the United States. Importantly, a different standard of care is not necessary in this case, because there is an attending physician who could perform the delivery, or at least oversee the medical students. However, because there is a large volume of patients, and regulation is less strict, the attending physician is willing to let the medical students do the delivery without oversight. The second professional norm is that physicians have a duty to educate the next generation of physicians in order to continue to be able to provide patients with high-quality medical care. The attending physician sees this delivery as a good hands-on learning opportunity for the medical students.

With respect to legal norms, laws governing the participation of medical trainees in the provision of medical care to patients often are less strict in developing countries. However, this does not change the ethical and professional obligations that medical providers have to their patients or to their trainees.

Limitations

One significant limitation in this case is the students' relative lack of training in obstetrics as compared with their attending physician. Another limitation is that local medical personnel are not staffing the clinic, so they cannot help the students or provide oversight.

ANALYSIS AND JUSTIFICATION OF OPTIONS

There is a spectrum of options for this case, ranging from allowing the medical students to take full control of the delivery to having the attending physician take charge and not involve the students at all. The justification focuses on how to come to a compromise between these two extremes.

The first step in justification of the options is to determine whether or not the option will be effective in achieving the goal. The goal in this

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case is successful delivery of the baby. An ancillary goal is to further the practical training of the medical students. The more that the attending physician is involved in the delivery, the more likely it is that the goal of successful delivery will be achieved, but the less likely it is that students will gain practical experience. The more that the medical students are involved in the delivery, the less likely it is that the goal of successful delivery will be achieved, but the more likely it is that the students will gain practical experience. Because they expect that the delivery will be uncomplicated, there may still be a high likelihood of successful delivery with significant medical student involvement.

The next step in justification is to determine if the benefits of the option outweigh its infringement on the identified norms and values. Allowing the medical students to deliver the baby without oversight infringes on beneficence because the students lack experience, which increases the risks of the delivery. If the attending physician leaves to go see other patients, then there is no backup if something goes wrong during the delivery. This option may infringe on respect for autonomy if the patient is either not informed of the medical students' involvement or does not want the medical students to be involved. In addition, the option may infringe on the professional norm of performing medical interventions within the scope of medical training because the medical students would not do this procedure unsupervised at their home institution. This option may also infringe on justice because the woman will take on increased risk by allowing the medical students to do the delivery in order for future patients, most likely in the United States, to benefit from their medical training. The option of having the attending physician doing the delivery has the benefit of maximizing the potential for a successful outcome. It infringes on the professional norm of educating medical students through practical experiences if they are not involved in the delivery at all.

The next step in justification is to ask whether or not it is necessary to infringe on the identified norms and values. Whenever medical students or residents perform procedures, their lack of experience increases the likelihood of harm. If the medical students perform the procedure, it would be necessary to infringe on the principle of beneficence, because the risks would be greater than they would be if the attending physician were to perform the procedure. It would also necessarily infringe on

justice as well as the norm of performing procedures within the scope of training. If the attending physician decides to perform the procedure himself, he would necessarily infringe on the professional norm of educating medical students through practical experience.

The next step in the justification process is to determine how infringement can be minimized. Neither of the extreme options discussed in this section minimizes infringement on the identified norms and values. In order to minimize infringement on the identified norms and values, a balance should be reached that involves medical students in the procedure at a level consistent with their training. Rather than leaving the medical students in charge of the delivery, which could result in harm to the patient, the attending physician should take an active role in the procedure, allowing the students to be involved while at the same time supervising them.

The final step in the justification procedure is to determine whether the stakeholders would be comfortable sharing the decision-making process with others. If the stakeholders are able to agree on an option that involves the medical students in the procedure while having them supervised by the attending physician, they should be comfortable sharing this decision because it balances their obligations to both the patient and to medical education.

CASE COMMENTARY

The involvement of medical trainees in patient care requires balancing the obligations of attending physicians to patients and the obligations of attending physicians to their trainees, regardless of whether this training occurs in developed or developing countries. In developing countries, additional factors may encourage an increased level of medical trainee involvement during clinical experiences. These factors include laws that are less strict, numerous patients, an overwhelming amount of medical need, and a lack of medical providers in the areas where medical students and residents are serving. Even though legal norms are different in developing countries, professional and ethical norms should remain the same. Attending physicians have an obligation to ensure that patients receive competent care from their trainees. They also have an obligation to ensure that medical trainees are involved in care at an appropriate level. In general, medical professionals should strive to maintain the same

standards of practice with respect to trainee involvement in developing countries as they would do in the developed world.

Different Professional Norms

Not only do medical aid workers encounter situations involving competing professional norms, but they also face situations in which they hold themselves to different professional standards while in developing countries. This is often necessitated by limited resources and facilities. However, sometimes the mentality of medical aid work creates these different professional norms. For example, medical aid workers often leave the place where they are serving before all medical needs have been addressed and without ensuring the transfer of care to another medical provider or medical aid group. If this were done in their home countries, medical aid workers would likely be accused of patient abandonment. However, the temporary nature of international medicine has created a culture in which medical aid workers are not responsible for addressing patient complications, ensuring follow-up, or transferring patients to new providers. The following case illustrates a situation in which a medical aid worker questions a professional norm common in international medicine.

Case 3.4: Rural Outreach Clinics

A group of medical aid workers goes to Guatemala for a two-week rural medicine mission. They coordinate their visit with a local church that runs a clinic in the area. The medical aid team plans to do twelve rural medical outreach clinics while in Guatemala. The team members bring boxes of medications with them from the United States so that they will be able to treat patients. About half of the ten medical aid workers are fluent in Spanish, but none speak the Mayan language of many rural Guatemalans, so they have to bring translators with them for the outreach clinics. As the aid workers are driving up to the first clinic site, they see a line of at least two hundred people standing outside the door waiting to be seen.[4]

They start seeing patients, making diagnoses and giving out prescriptions. By lunch time they have seen about 120 patients and have run out of antibiotics for treating amebic dysentery, which is by far the most common diagnosis among these patients. They decide to continue see-

ing patients and offering those with infections prescriptions that they can fill at the clinic, which is ten miles away. At the end of the day, they have seen a total of three hundred patients and have run out of almost all of the medications they brought with them.

That evening, several of the group members are talking about how much of an impact they were able to make in just one day by seeing so many patients. One medical aid worker says that he is not so sure that they are intervening in a meaningful way, because they have no way to follow up with patients to determine if their interventions were successful or to intervene in the future if these patients get sick again.

CASE ANALYSIS

The medical aid worker who questions the meaningfulness of the work in this case brings up a couple of important points. The workers cannot follow up with the patients they have seen, so they will not know whether or not their interventions have been successful. In addition, they will not be able to treat patients who have adverse effects from the medications that they were given. Using the framework of the case analysis method, modified to address the structure of medical aid interventions, the following discussion focuses on the ethical issues associated with this model for medical aid work.

Stakeholders

There are many stakeholders in this case. The medical aid workers and their patients are the central stakeholders. The organizational stakeholders are the local church and the aid organization or medical institution that the medical aid workers represent.

Medical Facts

There are some important general medical facts in this case. First, as evidenced by the line of people, there is great medical need among people living in rural Guatemala. The medical aid team has minimal resources with which to address that need. They have medications but no diagnostic equipment. Even if they were to take blood or urine samples back to the clinic, there would be no mechanism for following up with patients. In addition, they have no medical records that would give them insight into patients' medical histories. Basically, the rural outreach

clinic model is one of interviewing, examining, diagnosing, and treating patients in one visit without any scheduled follow-up.

Goals and Values

From the discussion among the medical aid workers, it seems that the primary goal of this group is to see as many patients as possible in the rural outreach clinics. They are focused on what has been termed the body-count mentality (Dupuis 2004). Because there is no reliable mechanism for following up with patients and tracking outcomes, medical aid groups have adopted this mentality as a proxy for quantifying the impact of their work. However, the goal, more broadly defined, is to help as many patients as possible.

Norms

The important bioethical norms in this case are beneficence and justice. Beneficence is the duty of physicians to maximize the benefits and minimize the harm to their patients. In the case of medical aid work, beneficence is sometimes viewed in a collective manner. Medical aid workers aim to maximize the benefits and minimize the harm to the group of patients they are serving. In addition, because outcomes are so hard to track, the number of patients treated is often used as a proxy for the amount of benefit provided by medical aid teams. Justice is the fair distribution of the benefits and burdens of medical care and research at a societal level. In this model of medical aid intervention, patients are seen on a first-come, first-served basis. The medical aid workers are unable to triage patients due to the shear volume. Therefore, while distributing medical care on the basis of a line might be one way to ensure fairness, some may argue that a more appropriate approach would be to triage by acuity of illness or the potential for cure.

The professional norms important in this case are the body-count mentality of international medicine and the outcomes-based mentality of medical care in the developed world. As discussed above, the body-count mentality is the practice of quantifying the benefit or impact of medical aid work using the number of patients treated. It is a numbers game, with the basic idea being that the more patients seen, evaluated, and treated, the more the impact on the overall health of the area where a medical aid group is serving. The body-count mentality does not mea-

sure outcomes or complications. On the other hand, medical practice in the developed world is very focused on outcomes and quality improvement. Morbidity and mortality are closely monitored. For example, many surgery departments in the United States participate in the National Surgical Quality Improvement Program (NSQIP), which quantifies risk-adjusted morbidity and mortality rates in participating institutions (Itani 2009). Through quality improvement initiatives such as NSQIP, medical providers in developed countries are continuously changing their practices to improve the quality of patient care and patient outcomes.

An important legal consideration in this case is the level of responsibility that medical aid workers have for the outcomes of the patients they treat in rural outreach clinics. In this model of international medicine, medical aid workers see patients once and treat them without any plans to follow up. If a patient has an adverse reaction to a medication or takes a medication inappropriately, the medical aid workers have no way of knowing this or of intervening to resolve the issue. Because of the temporary nature of medical aid work and its location in developing countries, which are less litigious toward physicians, medical aid workers may not be considered legally responsible for their patients' complications.

Limitations

There are several limitations to consider in this case. The first limitation is time. The medical aid workers are spending only a couple of weeks in Guatemala, so they will not be able to provide long-term care for the patients they see. Second, the patients the medical aid workers encounter have limited access to health care. This may be their only opportunity to see a doctor for several years. Another important limitation is the ability of the medical aid workers to communicate with patients. Because many of the patients speak Mayan, the medical aid workers need translators for Mayan to Spanish and then from Spanish to English, which makes taking a history very challenging. Information can be lost or changed in translation, especially when translators are not trained in medical terminology and when multiple translations are needed.

ANALYSIS AND JUSTIFICATION OF OPTIONS

The medical aid workers in this case have two basic options: either to continue their current model of medical intervention or to redesign

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the model. The group already has its itinerary and is in the country for only two weeks, so redesigning the model at this point in the mission might not be appropriate. However, the medical aid workers could work toward changing the model for future medical aid groups. This analysis compares the body-count mentality model to an alternative model that focuses on infrastructure, record keeping, community involvement, and outcomes monitoring. An alternative model could be designed so that medical aid workers help in an established clinic, keep paper records or set up a computerized record system, train local people to be health liaisons to the community, and implement a system for monitoring outcomes.[5]

The first step in justification is to determine whether or not the option will be effective in achieving the goals of the intervention. In this case, the goal of the medical aid workers is to help as many patients as possible. The body-count model is effective in achieving this goal in the sense that it maximizes the number of patients that the medical aid workers see and treat. The basic logic behind this model is that the more patients seen by medical aid workers, the more patients who are helped. The alternative model will decrease the number of patients that the medical aid workers are able to see, because those workers will have to spend more time documenting medical records, training community members to be health liaisons, and developing a system for monitoring outcomes. On the other hand, because it increases the amount of time spent with each patient, it has the potential to improve the quality of care on a per-patient basis. This option might be effective in achieving the goal of the medical aid workers in a different way than the body-count model. Over the long term, this model has the potential to create a sustainable infrastructure for the delivery of health care, so patients will continue to be seen and helped even after the medical aid workers leave. In addition, it will allow clinics to monitor the quality of interventions and develop ways to improve the quality of patient care.

The second step in justification is to determine whether or not the benefits of the intervention outweigh its infringement on the identified norms and values. The primary benefit of the body-count model is that medical aid workers can maximize the number of patients they see and treat. This gives them a concrete indicator of how many people they are potentially benefiting. This option may, however, infringe on the bioethi-

cal norms of beneficence and justice. Beneficence requires maximizing the potential benefits and minimizing the risks of interventions. In the body-count model, the focus of patient care is on quantity rather than quality. Rushing to see hundreds of patients per day increases the risk that more patients will be misdiagnosed and incorrectly treated. This model may infringe on justice, which is the fair distribution of medical care, because it makes the choice of whom to treat based on a patient's place in line. It is likely that many of the patients seen by medical aid workers have minor problems that could be addressed by local medical personnel or health liaisons in the community (if they exist). A more just approach may be for medical aid workers to see patients with complex medical problems that are difficult for local medical personnel to address while deferring the straightforward cases to the existing medical system. The body-count model also infringes on the professional norm of outcomes-based monitoring. In the developed world, physicians and medical systems focus on patient outcomes to drive continuous quality improvement and evidence-based medicine. The body-count model does not monitor outcomes, so it is unable to improve interventions or patient care in this way. In addition, without measuring outcomes, this model cannot truly quantify how many patients benefit from interventions and to what extent they benefit. Finally, the body-count model may infringe on the legal responsibility of physicians to treat complications that arise from their medical interventions. Medical aid workers who see patients one time, without any plan for follow-up monitoring, currently have no responsibility for addressing the complications that arise from adverse events (such as an allergic reaction to a medication). This practice would not be acceptable in the developed world.

One benefit of the alternative model for medical aid work is that it will likely result in higher-quality care for each patient seen by medical aid workers. In addition, if the medical aid workers focus on building infrastructure and training local health liaisons, their model will be sustainable after they leave, so more patients can be helped over the long term. This option could infringe on the medical aid workers' value of helping those in need, because spending more time with each patient, documenting encounters, and training local health liaisons means that the medical aid workers will have to turn patients away. This model also infringes on the body-count mentality of international medicine. If the

medical aid workers see and treat fewer patients, then they may be perceived by their organization or by donors as doing less good than groups who see more patients. By deviating from this professional norm, the value of their work could be questioned.

The next steps in justification are to determine whether it is necessary for the option to infringe on the identified values and norms, and if so, how to minimize that infringement. As discussed above, the body count model necessarily infringes on beneficence and justice. If it is logistically impossible to change the intervention model in the midst of the trip, then the medical aid workers have no choice but to continue with the rural outreach clinics. This option necessarily infringes on the outcomes-based professional norm of medical practice in the developed world because it does not even try to monitor or improve patient outcomes. In addition, it infringes on the legal responsibility of medical practitioners to address adverse events in patients resulting from treatments and interventions. Infringement on the outcomes-based mentality could be minimized if medical aid workers are able to implement an outcomes monitoring system in each community where they hold a clinic. This would be very challenging, given the lack of medical infrastructure in these areas. Infringement on professional responsibility could be minimized by having the medical aid workers return to the villages and follow up with patients either during their mission or on subsequent missions. Alternatively, they could coordinate follow-up with the next medical aid group that visits the area.

The alternative option necessarily infringes on the professional norm of the body-count mentality in international medicine. The medical aid workers will have to see fewer patients and spend more time on building infrastructure and training community members to be health liaisons. Infringing on the body-count mentality in order to create a sustainable, higher-quality health care system is a reasonable trade-off, so the medical aid workers should not try to minimize this infringement. It is important for them to keep in mind that they have the ability to improve the health of more people by creating a sustainable system that is available to patients after they leave than if they work outside of the health care system, providing onetime interventions without follow-up or outcomes monitoring.

The final step in justification of the options is to determine whether

the stakeholders would be comfortable sharing their decision-making process with others. In particular, the medical aid workers would have to justify their decision to their organization and ultimately to the people who fund their work. The option of continuing with the body-count model would be easy to justify in the sense that it is one of the most common models of medical aid work. It is very easy to quantify the number of patients seen each day and report this back to the organization and donors, so as to show that the medical aid workers are helping a lot of patients. The alternative option may actually be harder to justify to both the organization and donors because the quantification of impact is not as straightforward or as immediate. If the medical aid workers decide to change their model, they will have to develop a long-term plan that includes building infrastructure, tracking outcomes, and training community members as health liaisons. They will have to justify seeing and treating fewer patients during their mission with the prospect of a sustainable health care system that will benefit more patients over the long term. If an alternative option is designed well and communicated effectively, the medical aid workers should be comfortable sharing this decision with others and defending their deviation from the body-count model.

CASE COMMENTARY

Many international medical missions strive for the body count. They have the explicit goal of treating as many patients as possible (Dupuis 2004). The body count provides a tangible outcome measure for medical aid workers and the organizations they serve. Medical aid workers in developing countries serve in areas of immense need, and they are generally not able to help all of the patients who need their services. The body count allows them to conceptualize the impact that they have made during their missions. The body count does not, however, measure patient outcomes. It is based on the number of patients seen in clinic, the number of patients given medications, or the number of operative interventions performed. It says nothing about the number of patients who were successfully treated. It is not, therefore, a measure of benefit, but rather a proxy estimate of benefit. The body-count mentality may reflect a belief that the more patients that medical aid workers encounter, the more that they will benefit, even if some treatments fail.

Beyond the limited use of the body count as a tool for measuring benefits, an emphasis on the body count may contribute to negative patient outcomes. The body-count mentality encourages speed and efficiency rather than efficacy in patient care. Medical aid workers encounter patients who have different cultural beliefs, speak different languages, and often have limited education, all of which make communication difficult. The emphasis that the body-count mentality puts on efficiency encourages medical aid workers to limit the time spent with each patient, thereby further frustrating communication. This may increase the number of misdiagnoses, misunderstandings, or ineffective treatment plans.

In surgical missions, the body-count mentality can also have significant adverse effects on patients. It can encourage surgeons to work exceptionally long hours, leading to fatigue and reduced concentration (Cappello, Gainer, and Adkisson 1995; Patterson 2007; Souers 2007). Moreover, in order to reach their body-count goals, surgeons may choose to operate on patients who are not good candidates for surgery, thereby increasing the likelihood of morbidity and mortality (Dupuis 2004).

Because of the potential adverse effects that the body-count mentality has on patient outcomes, several medical aid workers have suggested a change in focus. For surgical aid missions, Dupuis (2004) suggests concentrating on performing a few operations well and using the opportunity to train local medical providers who can continue the work after the medical aid team leaves. This model encourages sustainable local care that will eventually achieve more interventions than a short-term medical mission. Yeow and colleagues (2002) suggest modifying the goal of surgical teams from benefiting the maximum number of patients to achieving the maximum benefit for each patient. Rather than having the explicit goal of treating as many patients as possible, medical aid workers should adjust their focus to comprehensive patient care, health personnel education, and medical infrastructure development so as to maximize the benefits to the patients they encounter and create sustainable, lasting change in the areas where they serve.

Different Legal Norms

In addition to different bioethical and professional norms, medical aid workers encounter different legal norms. Differences in legal norms do not necessarily create ethical issues. However, when local legal guide-

lines conflict with either legal guidelines from the medical aid worker's home country or international legal guidelines, ethical issues can arise.

In some cases, these legal norms are based on religious law. In the United States, physicians are generally obligated to respect medical decisions based on the religious beliefs of patients, even when those beliefs conflict with the ability of physicians to care for patients (Jonsen, Siegler, and Winslade 2010, 76–80). For example, competent adult Jehovah's Witnesses have the right to refuse blood transfusions, even in cases of imminent death from blood loss (Beauchamp and Childress 2001, 187). Physicians are not, however, required to perform surgeries on Jehovah's Witnesses if those physicians are uncomfortable with not being able to give a blood transfusion if necessary. The following case describes a situation in which a patient requests a procedure that is in accordance with religious law but is not medically indicated.

Case 3.5: Amputation for Sharia Law

Two police officers bring a man to a hospital in Afghanistan where an American surgical aid team is stationed. They explain to one of the attending surgeons that the man has been convicted of robbery and that under Sharia law his punishment is amputation of the right hand. They tell the surgeon that the man has requested that the amputation be done at a hospital and ask if she will perform the procedure. If she does not agree to do the procedure, they are going to bring him back to the police station and do it themselves that day. The surgeon is troubled by this request, because she is being asked to perform a medically unnecessary procedure that will cause significant and irreversible physical damage. However, if she does not perform the procedure it will still be done, in a less sterile environment without anesthesia by an untrained individual, and have a higher risk of morbidity and mortality.[6]

CASE ANALYSIS

Stakeholders

The surgeon, the man, and the police are the primary stakeholders in this case. The man has come to the physician, albeit involuntarily, in an attempt to decrease the risks of serious adverse effects or death from the amputation that will be done regardless of the surgeon's participation. While there is international legal guidance on this type of situation, it

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still poses a challenging ethical issue for the surgeon. This analysis focuses on the surgeon's moral dilemma in spite of clear international law.

Medical Facts

In this case, the man does not have a medical problem, but rather is seeking a medical intervention to minimize the risks of harm from an amputation that is required for religious and legal reasons. The amputation would have fewer risks if performed by the surgeon rather than at the police station. The risks of amputation include hemorrhage, infection, permanent disability, and death. However, there is no medical indication for the surgeon to perform the amputation.

Goals and Values

The goal of each stakeholder in this case is somewhat different. The surgeon does not want the man to have an amputation because it is not medically indicated. The man wants to minimize pain and complications from the amputation. The police simply want the amputation to occur and are not particularly concerned about minimizing the risks.

The primary value of the surgeon is to use her medical skills only within the purview of legitimate medical practice. She does not believe that nontherapeutic amputation fits within this purview. The man either values adhering to Sharia law or at the least recognizes that he has no choice but to accept his punishment as determined by Sharia law. The man also values maintaining the functionality of his limb, avoiding serious adverse effects, and avoiding death. The police value observing Sharia law and carrying out punishments in accordance with it.

Norms

The three bioethical norms important in this case are respect for autonomy, nonmaleficence, and beneficence. Respect for autonomy requires that physicians respect and follow the decisions made by patients regarding their medical care. Respect for autonomy also encompasses respect for the religious beliefs and values of patients and for decisions made based on these beliefs and values. However, there are limits to respect for autonomy, one of which is that physicians are not required to perform procedures that are outside the purview of medicine. The norm of nonmaleficence requires that physicians do not perform procedures

that exclusively cause harm to patients without any medical benefit. In the absence of Sharia punishment, the physician would not even consider performing an amputation on a perfectly healthy adult because the procedure itself is harmful and without any medical benefit. The difference in this scenario is that there might be medical benefit in the sense that having the amputation performed at the police station increases the risks of morbidity and mortality. This is why the bioethical norm of beneficence, or the duty of physicians to maximize benefits and minimize harm, is important. The patient believes that he will benefit from having the amputation performed by the surgeon rather than by the police, because he will likely endure less pain, have less disability, and have a lower risk of infection and hemorrhage.

The professional norm important in this case is the obligation of physicians to perform procedures that are within the purview of legitimate medical practice. While some physicians disagree about whether or not certain procedures are within the purview of legitimate medical practice (abortion, for example), many would agree with this surgeon's belief that a nontherapeutic hand amputation is outside the accepted practice of medicine.

The different legal norms in this case contribute to the surgeon's uncertainty. Sharia law, which mandates amputation as a punishment for robbery, is the basis of legal norms in Afghanistan. However, international legal guidelines prohibit physicians from engaging in certain punishments of prisoners (OHCHR 1982). This case illustrates a situation in which the physician would not be allowed to participate in prisoner punishment according to international law.

Limitations

There are no limitations to the man's ability to adhere to the amputation. To the contrary, both the man and the police make it clear that the amputation is going to happen whether or not the surgeon performs it. The surgeon has access to the resources and facilities necessary to carry out a successful amputation.

ANALYSIS AND JUSTIFICATION OF OPTIONS

The options that the surgeon has in this case are to perform the amputation requested by the man or not to perform it. The first step in justifi-

cation of the options is to determine whether the option will be effective in reaching the identified goals. If the surgeon decides to perform the amputation, she will be able to achieve the goals of minimizing adverse effects, minimizing pain, reducing the risk of death, and amputating the hand. She will not achieve her own goal of not having the amputation performed at all. If the surgeon does not perform the procedure, then it will be left to the police. The amputation by the police will most likely result in more severe pain, more prominent disability, and more severe adverse effects. Moreover, the man has a greater likelihood of dying if the police do the amputation. By not performing the procedure, the surgeon will not achieve the goal of minimizing adverse effects, pain, or the risk of death, but will still be allowing the amputation to occur.

The second consideration in justifying the options is whether or not the benefits of the option outweigh its infringement on the identified values and norms. If the surgeon decides to perform the amputation, she will benefit the patient by providing a safer, less painful procedure that has a lower risk of adverse effects and will probably result in less significant disability. Performing the procedure is also consistent with respect for autonomy because it allows the patient his choice of having the amputation performed by a surgeon rather than by the police. This option will, however, infringe on the ethical norm of nonmaleficence, because the amputation will result in harm to the patient without any medical benefit. It will also infringe on the professional norm of only performing procedures that are within the purview of medicine. Further, this option infringes on international legal guidelines that prohibit medical professionals from being involved in prisoner punishment.

The benefit of not doing the amputation is that the surgeon will not be performing a procedure that is exclusively harmful to the patient. This option adheres to the professional norm of only performing procedures that are within the purview of medicine. In addition, it is in line with international legal guidelines. Not performing this procedure may infringe on the ethical norm of beneficence because allowing the amputation to occur in the police station will increase the risks of pain, adverse effects, and significant disability as compared with performing the amputation in the operating room. It may also infringe on the norm of respect for autonomy—in particular, respect for the religious beliefs of the patient. However, one important limit to patient autonomy, with re-

spect to this case, is the autonomy of the medical provider. Physicians are not obligated to perform procedures that contradict sound medical practices, even when these procedures are requested by competent patients (Jonsen, Siegler, and Winslade 2010, 98). In this case, the physician would be justified in infringing on the autonomy of the patient to make medical decisions based on his religious beliefs for two reasons: the requested procedure contradicts sound medical practices, and the man will still be able to have his hand amputated without the surgeon's intervention. This option does not infringe on the legal norms of Sharia law because the police will amputate the man's hand regardless of the surgeon's involvement.

The third consideration for justification is whether infringement on the identified norms and values of the stakeholders is necessary to achieve the desired goal. Whichever option the surgeon chooses will necessarily infringe on some of the identified norms and values. The only way to prevent infringement would be to convince the police and the man that the amputation should not be done, which seems unlikely in this case.

The next consideration for justification of the options is whether or not the level of infringement is minimized. If the surgeon chooses to perform the amputation, there is nothing that she can do to minimize the infringement on nonmaleficence or on the identified legal and professional norms. She will be harming the patient as well as violating professional and legal norms. If the surgeon chooses not to perform the procedure, she can minimize the infringement on the principle of beneficence by offering postamputation care to control bleeding and prevent infection.

The final consideration for justification of the options is to determine if the surgeon would be comfortable in sharing her decision-making process with others. If she chooses to perform the procedure, she would have to explain why she engaged in an activity that is outside the scope of accepted medical practice and prohibited by international law. If she determines that the benefits of participation are so great that they can justify these infringements, then she should be willing to share this reasoning. If she decides not to perform the procedure, her explanation for choosing this option would rely on adherence to international law and professional norms. Of the two options, the one that better achieves the criteria for justification in this case is that of not performing the procedure.

CASE COMMENTARY

In addition to international legal guidelines, some medical aid organizations have policies regarding medical aid worker participation in Sharia punishment. For example, the International Committee of the Red Cross (ICRC) refuses to allow any medical aid workers to participate in this practice or even to provide logistical support for it (such as operating room space or sterile instruments) (Perrin 1999). Médecins Sans Frontières (MSF) also opposes amputations for the purpose of Sharia law. MSF, like the ICRC, does not totally oppose Sharia law, but only the corporal punishment that is permitted under it, such as stoning and amputations. MSF aid workers are not allowed to participate in amputations for Sharia law in any capacity (for example, preparations, provision of instruments, or the procedure itself) (Nolan 1999).

The surgeon's decision in this case is challenging because she knows that if she does not perform the amputation, then it will still happen, and will happen in much less satisfactory conditions. In cases like this, the medical aid worker should familiarize himself or herself with both international laws and the guidelines of the medical aid organization for which he or she is working. Because both international guidance and the guidance of well-respected medical aid organizations clearly state that physicians should not be involved in Sharia amputations, even in situations when the participation of the medical aid worker will limit the complications of the amputation, it would be challenging for the physician to justify participation in this procedure. It is, however, acceptable, and even obligatory in emergent situations, for medical aid workers to treat any complications that result from Sharia amputations.