Ethics for International Medicine

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CHAPTER 2
Goals and Values

Different Goals
The goal of a medical intervention is basically the desired outcome. Patients may have general goals for medical interventions such as cure of disease, extension of life, improvement in quality of life, or the ability to return to normal activities. Alternatively, they can have very specific goals, such as regaining the ability to speak after a stroke. Patients in developed countries often have goals that reflect Western values, such as seeing a child graduate from college or being able to attend a professional sporting event. Similarly, patients in developing countries may have specific goals reflective of their cultures. Goals provide the motivation for patients to undergo medical interventions and for medical personnel to provide them.

Stakeholders often have different goals for medical care. For example, a patient who develops pneumonia may have the goal of returning to work quickly, while the physician has the goal of curing the patient. In this case, the same action, giving antibiotics, will likely be effective in achieving the goals of each stakeholder. Even though the patient and physician have different goals, there is not an ethical problem, because they can agree on a treatment plan. However, ethical issues can arise when stakeholders have different goals that directly conflict with each other. Using the same example, if the physician believes that the best way to cure the patient’s pneumonia is to admit the patient to the hospital to administer intravenous antibiotics, but the patient wants to go back to work immediately, the goals can no longer be achieved with the same action. The patient and physician must now choose between two mutually exclusive actions. In this scenario, the stakeholders have to come to agreement regarding their goals before being able to decide upon the treatment plan.
In international medicine, patients and medical aid workers can have vastly different expectations for medical interventions. Medical aid workers come from medical systems in which patients rarely die from infectious disease, dehydration, or malnutrition. They formulate their goals based on experiences in the developed world, which may not be realistic given their circumstances in developing countries. Conversely, patients and local medical personnel in developing countries formulate their goals based on their experiences with medical care. They may not even realize that there is a cure for tuberculosis or effective treatments for dehydration. Their goals reflect the state of medical care in their communities, which is often significantly less than what medical aid workers can offer. The following case illustrates an ethical issue that arises when medical aid workers and the local medical doctor have different goals in an emergency situation.

**Case 2.1: Aggressive Neonatal Resuscitation**

Two medical aid workers serving at a clinic in Haiti respond to calls for help from a local medical doctor when a pregnant woman arrives in active labor. The woman has been in labor for several hours and is now tiring. It appears that she tried to deliver the baby at home with a midwife but was unsuccessful. The medical aid workers quickly assess the woman and decide that they need to do an episiotomy in order to aid with the delivery. In addition, they ask the local medical doctor to have equipment on standby in case they need to resuscitate the infant, who may have been deprived of oxygen during the prolonged labor.1

The local medical doctor has supplies that will allow the medical aid workers to suction, intubate, and manually ventilate the infant. However, the clinic does not have mechanical ventilators, oxygen tanks, or incubators, all of which will probably be needed to keep the infant alive if resuscitation is successful. Given the limitations in equipment, the local doctor does not want to attempt to resuscitate the infant, because they will be unable to meet the infant’s ongoing needs following resuscitation. He thinks that they should focus on preserving the life of the mother. The medical aid workers do not want to give up on the infant. They think that they should at least attempt resuscitation and then determine if the clinic can handle the infant’s ongoing needs.
CASE ANALYSIS

The medical aid workers and local doctor have a tough decision to make in this case. They can attempt resuscitation, which will likely be successful, and then attempt to meet the ongoing needs of the infant, which will likely be unsuccessful, or they can refrain from attempting resuscitation, which will probably result in the infant’s death shortly following birth.

Stakeholders

The primary stakeholders in this case are the medical aid workers, the local doctor, the pregnant woman, and the infant. This case focuses on differences between the goals of the medical aid workers and of a local medical doctor. Other important stakeholders in this case are the patient’s family members.

Medical Facts

The local medical doctor and the medical aid workers are in agreement about the medical facts. The patient is in prolonged active labor and has been unable to deliver the baby. They believe that she will be able to deliver safely if they do an episiotomy. Without delivery the woman is at risk of serious morbidity and mortality, and the fetus will surely die. The medical aid workers and local doctor are concerned that the fetus is in distress and will need resuscitation following delivery. Because they are unsure of the duration of labor thus far, they cannot accurately predict the likelihood of fetal survival or the extent of anoxic brain injury. The local medical doctor and medical aid workers agree that they will probably be able to resuscitate the infant if needed, but they are not sure if they will be able to meet the infant’s needs following resuscitation.

Goals and Values

The goals of the medical aid workers are survival of the mother and successful resuscitation and long-term survival of the infant. The local medical doctor is more reserved. His primary goal is to preserve the life of the mother. These goals are compatible with each other in the sense that delivery of the fetus is needed to preserve the life of the mother, and resuscitation of the infant following delivery will not be detrimental to the health of the mother. The disagreement in this case is over the
goal of the medical aid workers. The local medical doctor does not think that long-term survival of the infant is likely, because the clinic does not have the supplies to treat a seriously ill newborn, so resuscitation would merely prolong the infant’s dying.

While not explicitly stated, the cultural values of the medical aid workers and the local medical doctor are apparent in this case. The medical aid workers come from a medical tradition in the developed world that values technology and the ability to save marginally viable lives. If a patient like this presented to a hospital in the United States, there would be no question about whether or not to attempt to resuscitate the infant. Physicians would automatically attempt resuscitation and, if successful, send the infant to a neonatal intensive care unit. The medical culture in Haiti is less aggressive with respect to neonatal resuscitation. Because of the lack of resources, coupled with the large burden of disease in Haiti, the local medical doctor is more accustomed to patients dying of conditions that would not be fatal in developed countries. He cannot attempt to resuscitate every marginally viable life or to sustain the lives of all seriously ill patients because he does not have the resources to do so. Therefore, his medical culture values realistic victories, such as saving the life of the mother, rather than heroic saving of marginally viable lives. In addition to exploring their own goals and values, the medical aid workers and local medical doctor should assess the goals and values of the woman and her family, if time permits, to get a sense of what they want done.

Norms

The main bioethical norms important in this case are nonmaleficence and beneficence. Nonmaleficence requires that physicians do not perform interventions that exclusively cause harm to patients. The medical aid workers would infringe on this principle if the resuscitation attempt is likely to be harmful to the infant without any hope of benefit. If the resuscitation attempt promises benefits, then the norm of beneficence is important. The stakeholders would have to balance the risks and potential benefits of resuscitation to determine whether or not they should attempt this intervention.

In addition to nonmaleficence and beneficence, the bioethical norm of respect for autonomy and its legal correlate of parental rights to make
decisions regarding their children are important in this case. Pregnant women have the right to make decisions regarding their care and the care of their fetuses. In addition, parents have the right to make decisions regarding the medical care of their children. If the woman is able to make a decision regarding the resuscitation of the infant, then this decision should be considered. Alternatively, if the woman cannot make a decision but family members are present, they should be consulted. The challenge with allowing the patient or her family to make a decision in this case is that there may not be time to consult them given the emergent nature of the situation.

The cultural differences between the medical aid workers and the local medical doctor dictate different professional norms in this case. In the developed world, resuscitation of an infant in this type of situation is the standard of care, based on the professional duty of physicians to preserve the lives of viable infants. Aggressive neonatal resuscitation is not generally considered extraordinary treatment in the developed world. Decisions about withholding or withdrawing treatments for seriously ill newborns tend to be made in neonatal intensive care units after interventions have been tried and tests have been done to determine the prognosis of these infants. This allows families to make decisions in a more controlled and less emergent manner. On the other hand, aggressive neonatal resuscitation is not a standard of care in Haiti. In the absence of the medical aid workers, the local medical doctor would not attempt to resuscitate the infant because he would not be able to support the infant with oxygenation, ventilation, or incubation following successful resuscitation.

While the medical aid workers would have to rely on the local medical doctor to determine if there are any applicable local legal norms, they would be able to consider the legal norms from their home country. The United States began setting legal precedents and statutes regarding the care of seriously ill newborns in 1982, following the case of Baby Doe (Furrow et al. 2001, 1419). Baby Doe was born in Indiana with Down syndrome and a tracheoesophageal fistula. His parents refused to consent to surgical repair of the fistula, and he died six days after birth. The physicians did not do the surgery because of the parents’ refusal, and the parents’ refusal was largely based on the fact that Baby Doe had Down syndrome. After this case was reported in the media, several political groups
were outraged. The Department of Health and Human Services issued emergency regulations to assure that no hospitals would deny care to seriously ill newborns. Through a series of iterations, these regulations became part of the Child Abuse Amendment Act of 1984. This act defines medical neglect as “the withholding of medically indicated treatment from a disabled infant with a life-threatening condition.” It qualifies this statement by saying that there is no obligation to provide care to an infant who is comatose when the treatment would merely prolong death and not correct the underlying problem or when the treatment would be futile. Using this law as a guide, it would be important to determine whether or not resuscitation would merely prolong death or be futile because of the limited resources for sustaining the infant’s life.

**Limitations**

There are several limitations that complicate the ability of the medical aid workers and the local medical doctor to provide adequate care for the infant. Time is a limiting factor in the sense that they must make a decision about whether or not to attempt resuscitation quickly. In addition, the clinic is lacking several supplies necessary for supporting a seriously ill newborn. It does not have a mechanical ventilator, incubator, or oxygen tank available. It is unclear whether antibiotics, laboratory facilities for blood testing, or ultraviolet lamps, all of which might be needed, are available. One important factor for the stakeholders to determine is whether or not there is a hospital with adequate supplies and facilities that they can transfer the newborn to after resuscitation. If a hospital were available, they would also have to determine if there is a means for safe transportation, if the hospital will accept a transfer, and whether or not the family would be able to afford to have the infant cared for at the hospital.

**ANALYSIS AND JUSTIFICATION OF OPTIONS**

At this point in the case, it is important to keep in mind that the neonate may not need resuscitation. Because the medical aid workers and local doctor do not know if the fetus is in distress or how long the fetus has been in distress, the extent of injury and potential for permanent disability are also not known. Assuming that the neonate will require resuscitation for survival, the two main options are to attempt to
resuscitate the newborn or not to attempt to resuscitate the newborn. The justification of options examines both of these choices, taking into account the possible preferences of the patient and her family as well as the potential for the infant to need ongoing care for survival.

The first step in justification is to determine whether the options will be effective in achieving the goals of the stakeholders. The goal of the local medical doctor is to preserve the life of the mother. Regardless of what the stakeholders decide with respect to the neonate, the goal of the local medical doctor will likely be achieved by delivery. The option of attempting resuscitation might achieve the ultimate goal of the medical aid workers, which, besides survival of the mother, is long-term survival of the infant. However, the local medical doctor does not believe that this goal is realistic, given the limited supplies at the clinic. He believes that successful resuscitation will merely prolong the infant’s death. The option of not attempting to resuscitate the infant will definitely not achieve the goal of the medical aid workers.

The next step in justification is to determine if the benefits of the option outweigh its infringement on identified norms and values. The primary benefit of attempting resuscitation is that the infant will be given the chance to survive, at least in the short term. After the initial resuscitation, the infant may be able to survive without ongoing care. However, given the circumstances, it is likely that the fetus has been deprived of oxygen and will need ongoing support, which the clinic cannot guarantee. This option infringes on the professional norm of the local medical doctor, who does not routinely attempt to resuscitate infants because of the limited resources to provide ongoing support. It would also infringe on the autonomy of the mother and her family to make decisions regarding the care of her infant if they decide against attempting to resuscitate. This option would infringe on nonmaleficence if resuscitation merely prolongs the death of the infant, thereby being harmful without providing benefits. If there is some potential for benefit, then the stakeholders have to weigh the risks and potential benefits of resuscitation in order to determine whether or not it is warranted. If the infant is likely to require interventions that cannot be provided at the clinic and there is no hospital available, then resuscitation would most likely infringe on beneficence. However, if the infant has a reasonable chance of being able to survive without ongoing interventions or can be transferred to a hos-
hospital that will provide ongoing care, then this option may not infringe on beneficence. One significant challenge in this case is that medical personnel cannot accurately predict what the infant’s needs will be immediately following birth or successful resuscitation, so they cannot definitively determine the potential for long-term survival or disability.

The option of not resuscitating the infant would have the benefit of not putting the infant through resuscitative measures without a reasonable chance of long-term survival. This option would infringe on the standard of care that the medical aid workers are accustomed to. In addition, it would infringe on respect for autonomy if the woman or her family requested resuscitation attempts. This option would infringe on beneficence if the alternative of attempting resuscitation offered more potential benefits and fewer harms. Although medical neglect, as defined by the Child Abuse Amendment of 1984, is not part of Haitian law, the medical aid workers could at least use this norm for guidance. Not attempting resuscitation infringes on medical neglect if resuscitation is medically indicated.

The next step in justification of the options is to determine if the option must necessarily infringe on identified norms and values. Attempting resuscitation would necessarily infringe on the standard practice of the local medical doctor by going beyond what is usually done. Because resuscitation goes beyond the standard rather than being substandard, infringement would not necessarily be negative. This option would also necessarily infringe on autonomy if the woman or her family refuse resuscitation. It would only necessarily infringe on nonmaleficence if there were no potential benefits, and on beneficence if this option had an unacceptable risk-benefit profile. The option of not attempting resuscitation would necessarily infringe on the standard of care practiced by the medical aid workers in their home country. It would also necessarily infringe on autonomy if the woman or her family request resuscitation. It would necessarily infringe on beneficence if the risk-benefit profile were less acceptable than that of attempting resuscitation.

The next step in justification is to determine if infringement on the norms and values has been minimized. Contacting a local hospital, if available, and arranging for transfer of the infant and payment for the hospital’s services in advance could minimize the infringement of attempting resuscitation on beneficence. If there is no hospital available,
the medical aid workers could attempt resuscitation and then evaluate the infant to determine if further care is required and possible. This would give them a better sense of the needs of the infant before making a decision about withholding or withdrawing medical care. The option of not attempting resuscitation has a set risk-benefit profile, so infringement on beneficence would be minimized if the alternative option were less attractive.

The final step in justification of the options is to determine whether or not the stakeholders would be comfortable sharing their decision-making process with others. In order to be comfortable sharing their decision, it would be important for the medical aid workers and the local medical doctor to ask the woman and her family what they believe should be done. In addition, they should contact a local hospital, if available, to determine if transfer is a feasible option before attempting resuscitation. In reality, when faced with an emergent situation, the medical aid workers may not have time to consult family members or a local hospital, so they would have to make a decision without involving all of the important stakeholders.

In this case, the medical aid workers have to quickly make a decision because of the emergent nature of the situation. Given the limited information about the woman, her preferences, and the possibility for transfer to a local hospital, it would be reasonable for the medical aid workers to default to attempting resuscitation. This would give them time to gather needed information, assess the infant's needs, and make decisions regarding further interventions in a more controlled environment. Afterward, it would be important for them to discuss the case with local medical personnel so as to determine how best to address situations like this in the future.

**CASE COMMENTARY**

Neonatal resuscitation and intensive care are standard practices in the developed world because the resources and technology to achieve them are readily available. However, this is not generally the case in developing countries, so medical aid workers cannot assume that aggressive neonatal resuscitation is a standard practice where they are serving. It is very hard for medical aid workers to lower their expectations when working in the developing world because it is instinctual for them to set the same
goals as they would in their home countries. However, the reality of limited resources, facilities, and funding can make the goals of medical aid workers unachievable. Attempting heroic measures to save the life of a patient may ultimately be a futile act if resources are not available to support the patient’s ongoing needs.

One lesson that medical aid workers can learn from this case is that it is important for them to be aware of the local standards of care and resource limitations before emergent situations arise. Rather than waiting for emergencies to occur, they should determine the common emergencies they need to be prepared for, discuss protocols with local medical personnel, and take inventory of the resources available to them. If medical aid workers are aware of their limitations in advance, they will be better able to make informed decisions in emergency situations and they will more likely set goals that are compatible with those of local medical personnel. In addition, it is essential that medical aid workers recognize that they are guests serving under local medical personnel. As guests, medical aid workers should be guided by the goals, values, and standard practices of local practitioners.

Different Organizational Goals

Because of the various needs of developing countries, there are often multiple humanitarian aid organizations working with the same community. Medical aid workers are likely to encounter groups working to improve infrastructure, public health, and education. In general, the goals of each group either do not overlap with, or are compatible with, the goals of other groups. However, sometimes these goals or the actions required to achieve these goals conflict with each other. The following case illustrates one such situation in which researchers want to conduct a clinical trial in a community where a medical aid worker is serving.

Case 2.2: Research Participation

A group of researchers from the United States arrives in a small town in Gambia where a medical aid worker is developing a project to eradicate malaria. The researchers would like to study the efficacy of a new antimalarial drug in this community because malaria is prevalent in the area, and the population has no access to antimalarial medications. The medical aid worker meets with the researchers to learn about the study.
She finds out that it is a randomized controlled trial, with the new drug being tested against a currently available drug. The new drug that the researchers are studying will be cheaper than currently available antimalarials, and the researchers believe that it will also have less-serious side effects. The research trial is scheduled to last for six months. Subjects who enroll in the trial will receive comprehensive medical exams along with the malaria treatments. They will also have blood tests to monitor the efficacy of the drugs during the trial. The researchers ask the medical aid worker if she will refer her malaria patients with malaria to participate in the study.

CASE ANALYSIS

Stakeholders

In this case, the medical aid worker has to determine whether or not the goal of the research study is compatible with her goal of eradicating malaria in the community. In addition to the medical aid worker and researchers, the community is a major stakeholder in this case, so eliciting their goals would be essential in order for the medical aid worker to be able to make a decision about what to do. This analysis focuses on the medical aid worker and the researchers, but comments on the community stakeholders when appropriate.

Medical Facts

The medical facts in this case are clear. Many community members have been infected by malaria, and this trend will likely continue. In order to eradicate malaria, patients who have contracted the disease need to be treated, and preventive measures should be instituted for those who have not contracted the disease. Patients with malaria can be effectively treated with pharmaceuticals. Without treatment, they are at risk of lapsing into a coma and dying. In addition to treating patients with active disease, measures should be taken to prevent those who do not have malaria from contracting it. Pharmaceutical prophylaxis and mosquito nets can be used to prevent infections in areas of high risk. The research study promises patients access to needed antimalarial drugs, which they do not currently have. However, it does not have provisions for instituting preventive measures that would be necessary for the eventual eradication of malaria in the community.
Goals and Values

The medical aid worker’s goal in this case is to eradicate malaria in the community, while the researchers’ primary goal is to develop generalizable knowledge about the medications that they are studying. The individual and cultural values of the medical aid worker and the researchers are not apparent in this case. In addition to defining their own goals and values, the researchers and medical aid worker should consult community leaders and community members to get a sense of their goals and values before making a final decision.

Norms

With respect to bioethical norms, Emanuel and colleagues (2004) propose eight conditions that are required to make research trials in developing countries ethical: collaborative partnership, social value, scientific validity, fair selection of study populations, favorable risk-benefit ratio, independent review, informed consent, and respect for recruited populations and study communities. To form a collaborative partnership, researchers should partner with local researchers and community members so as to share the responsibilities of research, design a trial that respects community values, and ensure that the research participants and communities benefit from the research trial and its results. Social value requires that research is valuable to the community through the development of knowledge, products, continuing collaboration, or health system improvement. A scientifically valid trial is of sound design, is feasible given the setting of the developing world, and has objectives important to research participants. Fair selection of research subjects requires that vulnerable populations are protected from exploitation. The ratio of risks to benefits should be favorable as compared with the health risks of the study population. Independent review ensures that the researchers are held publicly accountable for their research and that the trial is transparent. Informed consent requires that potential participants are given information about the trial, given a choice about whether or not to participate, and allowed to withdraw from the trial at any time. Finally, respect for recruited participants requires that privacy and confidentiality are respected, participants are provided with information that arises during the trial, and participants are monitored and treated for medical
conditions that they develop during the trial. If these conditions are met, the trial should be considered ethically acceptable.

The primary professional interest of the medical aid worker is her fiduciary duty to her patients. This means that her decisions should be based on what is in the best medical interests of her patients. The primary professional interest of the researchers is to generate generalizable data that will hopefully prove the efficacy of the new antimalarial drug. These two interests are not necessarily at odds with each other. It might be in the best medical interests of patients with malaria to enter the trial because this is the only way in which they can receive treatment. However, it is important for patients to understand that researchers have an interest in generating reliable data, so their treatment decisions are dictated by study design rather than by individual patient needs.

There are many legal guidelines governing human-subject research worldwide. The Belmont Report governs the protection of human research subjects in the United States (USCPHSBBR 1979). It requires that researchers adhere to the basic ethical principles of respect for persons, beneficence, and justice. The Declaration of Helsinki lists eighteen basic principles for medical research, which include ensuring informed consent, respecting the integrity of research participants, ensuring that research subjects participate voluntarily, and providing a reasonable likelihood that the population upon whom research is done will benefit from the results of research (WMA 1964). In addition, the Nuremberg Code (1947), which was the first international guidance document for research ethics, has ten recommendations for human-subject research, including informed consent, societal value, basis in animal models, a knowledge of the natural history of disease, avoidance of unnecessary suffering, and conduct of research only by scientifically qualified persons. In assessing the research protocol, the medical aid worker and researchers should determine if the clinical trial is in accordance with international human-subject research guidelines as well as with any legal guidelines in Gambia.

**Limitations**

One significant limitation in this case is the lack of antimalarial medications available in the community. The research trial may be the com-
munity’s best option for securing access to antimalarial medications as part of a malaria eradication program. However, the research trial is limited to six months, so it only guarantees that the community will have access to antimalarial drugs temporarily. This time constraint may also factor into the researchers’ decision about where to conduct the trial. If they are met with significant resistance from community members or the medical aid worker, they may decide to find a new location for the study. While not discussed in the case, other limitations might include lab facilities to test for malaria or inpatient hospital beds to care for seriously ill patients. If facilities are not available, the researchers may not be able to conduct the trial, or they may need to develop this infrastructure before they can begin research.

**ANALYSIS AND JUSTIFICATION OF OPTIONS**

The medical aid worker has the option of referring patients to participate in the research trial or refusing to refer patients to participate in the research trial. It would be important for her to involve community members or community leaders before making a final decision. In addition, community involvement would be important for researchers to ensure that the trial design will meet the needs of the community, is culturally appropriate, and has social value.

The first step in justification of the options is to determine whether or not the option will be effective in achieving the goals of stakeholders. The researchers’ goal of determining the efficacy and side-effect profile of the new antimalarial medication will only be met if they are able to do the clinical trial. The medical aid worker’s ultimate goal is to eradicate malaria in the community. One essential element in a program to eradicate malaria is to effectively treat patients who have already contracted the disease. This has to be coupled with other initiatives such as providing mosquito nets to community members to decrease their risk of becoming infected. Because community members do not currently have adequate access to antimalarial medications, the research trial would be one way in which they could ensure steady access, at least temporarily. Therefore, it would help the medical aid worker achieve her goal of eradicating malaria but would not be sufficient to do so alone. The medical aid worker should keep in mind that there may be alternative options for
ensuring access to antimalarial medications, such as nongovernmental organizations or foundations that will fund a pharmaceutical purchase program, so the option of not participating in the trial might still allow the medical aid worker to achieve her goal.

The next steps in justifying the options are to determine whether the benefits of the option outweigh its infringement on the identified norms and values, if infringement is necessary, and if infringement has been minimized. The primary benefit of the research trial, from the community’s perspective, is that patients will be guaranteed access to antimalarial medications for six months. The risks of the study include randomization to a treatment regimen and standardized treatment plans that cannot be tailored to the individual medical needs of the subjects. In addition, the new drugs may not be as effective at treating malaria as the current standard of care, so subjects in the experimental group risk ineffective treatment. Subjects in the experimental group will also be at risk of experiencing greater side effects than those receiving the current standard of care. Moreover, the researchers have not guaranteed the community access to antimalarial drugs after the trial has been completed. Therefore, the community risks being left in the same situation of not being able to access antimalarial medications after the trial is complete.

In order to prevent infringement on bioethical norms, the research trial should be designed so that it is consistent with the eight conditions proposed by Emanuel and colleagues (2004). If the researchers involve community members in study design and implementation, they will ensure collaborative partnership and social value. While it is important to involve community members in designing the study, the researchers are ultimately responsible for designing a scientifically valid trial. The researchers should work with the community and the medical aid worker to make sure that their choice of research subjects does not exploit this vulnerable population. Because community members with malaria do not have an alternative treatment option to trial participation, they may feel that they have no choice but to participate, even though participation entails greater risks than clinical care. On the other hand, the trial would provide a much-needed service, so rather than feeling pressured to participate in the trial, community members may welcome having access to antimalarial medications. The researchers should also have the study
reviewed by a local independent review committee (if one exists) and by their home Institutional Review Board so as to ensure that the trial is both legally and ethically valid.

There are two considerations in creating a favorable risk-benefit ratio. First, the researchers should make sure that the study is favorable for research participants. Second, they should make sure that the community as a whole will benefit from the research. One way in which to do this is for the researchers to provide study medications to the community after the trial has been completed so that they will continue to have access to antimalarial medications. The researchers should also work with community members to design a consent process that is culturally and linguistically appropriate. Finally, in order to respect participants, the researchers should design mechanisms to protect privacy and confidentiality, to monitor patients for complications, and to distribute information about trial results to study participants. The medical aid worker would be able to play an instrumental role in helping community members assess the research trial, facilitating communication between researchers and community members, and ensuring that the research meets ethical and legal standards. Even if the research trial meets these standards, participants will still be randomized to treatment groups based on trial protocol rather than on their personal medical needs. The risks of randomization could be minimized by closely monitoring data to determine if any trends arise during the trial that suggest that one treatment is more effective or less dangerous than the other.

The benefit of not participating in the clinical trial is that it avoids exposing community members to the additional risks of research. This option might also allow the community and the medical aid worker to focus on securing long-term access to antimalarial medications through nonprofit organizations or the health care system in Gambia rather than settling for this temporary solution. The risk of this option is that the community might not be able to secure access to antimalarial medications without the research trial.

The option of refusing trial participation would necessarily infringe on the goal of malaria eradication if there is no alternative for ensuring patient access to antimalarial drugs. If there are alternatives, then the medical aid worker and community should explore the risks and benefits of these options, as well as the timeline for implementing them. They
may find that it is better for the long-term success of malaria eradication to partner with a nonprofit or government organization rather than rely on the research trial to gain access to antimalarial drugs.

The final step in justifying the options involves determining whether or not the stakeholders would be willing to share their decision-making process with others. In this case, it is important to involve community members in a conversation about participation in the research study. If the community members, researchers, and medical aid worker have an open discussion about the research trial, they should be comfortable sharing their decision.

If the conversation between the medical aid worker, community members, and researchers is open and transparent, the trial is designed so as to meet community needs, and the research meets ethical and legal standards, then participating in the trial would be justified. Conversely, if the medical aid worker and community feel that their needs would be better served through an alternative approach to malaria eradication and prevention, then they would be justified in refusing to participate in the trial.

**CASE COMMENTARY**

In 1997, medical research in developing countries became a hot topic of debate in bioethics when Peter Lurie and Sidney Wolfe questioned the ethics of using placebo controls in a study of short-course zidovudine (AZT) therapy to decrease the rate of HIV vertical transmission in Uganda. This debate highlighted concerns that populations in developing countries are vulnerable to exploitation, that researchers are subject to less oversight in developing countries, and that the outcomes of some clinical trials may not be of any benefit to the populations being studied because those populations cannot afford to buy study treatments after the trials have been completed (Angell 1997; London 2000; Lurie and Wolfe 1997; Macklin 1999b; Resnik 1998).

Though medical aid workers do not generally conduct clinical trials in the areas where they are serving, they may encounter researchers who would like to work with their patient population. As advocates for their patients, medical aid workers should be aware of research studies and be available to help patients and communities decide whether to participate. In order to do this, medical aid workers should be familiar with ethical and legal requirements for research. Even though medical aid
workers and researchers have fundamentally different goals, properly designed research trials may be able to achieve the goals of all interested parties.

**Conflicting Values among Stakeholders**

Along with conflicts among stakeholders regarding the goals of medical treatment, there can also be conflicts among their values. Stakeholders can value qualities, states of being, ideas, objects, and other people, among other things. These individual values often influence medical decision making. As an example, a college athlete who sustains a shoulder injury can be temporarily treated with a steroid injection or definitively treated with an operation and several months of rehabilitation. If the athlete is a senior who has a couple of games left, he would likely choose the steroid injection, because he values being able to participate in upcoming competitions. Conversely, if the athlete is a freshman who values the ability to compete for several more years, he would likely choose to have the operation.

When multiple stakeholders are involved in a case, they often have different individual values. As with goals, different values do not necessarily create ethical issues. It is only when these values, or the options most consistent with these values, conflict with each other that ethical issues arise. The following case presents one situation in which the option most consistent with the values of the medical aid worker conflicts with the option most consistent with the values of a sick infant’s mother.

**Case 2.3: An Infant with Cholera**

A woman arrives at a rural clinic in Nepal with her six-month-old infant. She left her village early in the morning and walked for two hours with the child on her back to get to the clinic. The mother tells the medical aid worker that the child has been experiencing severe diarrhea and vomiting for the past three days and has not been feeding during this time. On physical exam, the child is obtunded and has prolonged capillary refill. The medical aid worker immediately begins intravenous fluids. He does not have equipment to test the child for infectious diseases, but because there is a widespread epidemic of cholera in the area, he is comfortable making a clinical diagnosis of cholera and empirically starts the infant on antibiotics.\(^2\)
By the end of the day, the infant has improved significantly. After a few more days of treatment the medical aid worker expects that the child will make a full recovery. He communicates this to the mother through an interpreter, telling her that he will keep the child in the clinic, monitoring him closely for the next few days. Upon hearing this, the mother gets very upset. She needs to return to her village to take care of her three other children, whom she left with her sister. She also does not want to leave her infant in the clinic alone. The medical aid worker pleads with the mother to allow her child to stay, assuring her that he will take good care of the infant. Eventually the mother reluctantly gives what is interpreted as verbal assent. She stays with the child through the evening, and eventually the medical aid worker leaves the clinic to get some sleep. When he arrives at the clinic the next day, the woman has left with her infant.

CASE ANALYSIS
Stakeholders

The mother, the infant, and the medical aid worker are the central stakeholders in this case. In addition, the other children and the mother’s sister are important stakeholders to remember in analyzing this case. While they cannot be consulted because they are two hours away, they should be considered in deciding what to do. Rather than reviewing the case at the point after the mother has already left, this analysis focuses on the interaction between the medical aid worker and the mother in which they are discussing the treatment plan.

Medical Facts

The infant’s medical problem is most likely a cholera infection. His most prominent symptoms are dehydration, diarrhea, and vomiting. The infant’s prognosis is good with treatment, but he could easily die of dehydration if not treated. The medical aid worker wants to treat the infant with intravenous fluids and antibiotics at the clinic. With this care, he believes that the infant will be well enough to go home in a few days. The case does not discuss what the mother calls this medical problem, what she thinks the cause is, and what she has done to treat the infant so far. She has, however, left her other children and traveled a significant distance to the clinic to seek care. She clearly believes that the infant’s condition is serious enough that she needed to walk for two hours to the
Since there is a cholera epidemic in her village, she has probably seen others die from this disease, and it is very likely that she is afraid that her child will also die. Her fear about the treatment of the problem, as evidenced by her reluctance to leave her child in the clinic, is that it will either keep her away from her other children or force her to abandon her infant, neither of which she is comfortable doing. In coming to the clinic, she was hoping that the medical aid worker would be able to give her something to use to treat the child at home rather than keeping him as an inpatient.

**Goals and Values**

Both the medical aid worker and the mother share the goal of recovery of the infant. The medical aid worker’s primary value in this case is the ability to directly monitor the child throughout his recovery. On the other hand, the mother’s primary value is being able to care for her entire family. In particular, she values taking care of her children herself. The medical aid worker should spend the time to find out why the mother does not want to leave her infant in the clinic so as to determine whether or not these fears can be overcome. For example, she may fear that the child will be taken away from her if she leaves him at the clinic. Ultimately, the medical aid worker and the mother both value the health and well-being of the infant; they just disagree about how best to care for the infant.

**Norms**

From the medical aid worker’s perspective, beneficence is the most important bioethical norm in this case. Beneficence requires that physicians maximize the benefits and minimize the harms of medical interventions. The medical aid worker believes that inpatient treatment with intravenous fluids and antibiotics is most consistent with his duty of beneficence. One significant benefit of inpatient treatment is that the infant can be closely monitored for deterioration of his condition and treated quickly and appropriately if things go wrong. If the medical aid worker allows the infant to go home, the infant could decompensate and die before his mother would be able to get him back to the clinic.

From the mother’s perspective, the bioethical norms of relationality
and respect for autonomy are important. According to the principle of relationality, relationships are important and should be respected. The mother has relationships with all of her children and has important obligations to them because of these relationships. If she stays at the clinic with the infant, she will not be able to fulfill her obligations to her other children. If she leaves the infant in the clinic, she will not be able to fulfill her obligations to him. Respect for autonomy in the case of an infant requires respect for the decisions of parents regarding the infant’s medical care. In this case, the mother wants to bring the child home and care for him there. If this option is medically acceptable, then the medical aid worker should respect her decision to do so.

The professional norm important in this case is the standard of care. If the only adequate treatment for the infant’s condition is intravenous fluids and antibiotics, then the medical aid worker would have to determine if providing a substandard treatment is appropriate given the confounding factors. If, on the other hand, providing oral fluids rather than intravenous fluids is an acceptable treatment, then there is an alternative option consistent with the standard of care.

There are two legal norms to consider in this case. Beyond the bioethical norm of respect for autonomy is this legal right of parents to make decisions regarding their children’s health. In the United States, this right has limits, in that parental decisions that physicians feel are not in the best interests of children can be challenged in court. If the mother’s decision is within the medically acceptable options, then she is within her rights to make it. In addition, the medical aid worker should consider the legal norm of medical malpractice in determining what options are acceptable. Medical malpractice occurs when a physician fails to provide the quality of care required by the law and that failure results in injury to the patient (Furrow et al. 2001, 165). For a medical practitioner to be found guilty of medical malpractice, four elements must be proven: a duty was owed, the duty was breached, the breach caused the injury, and damages occurred. The standard of care dictates the duty that physicians owe patients. In this case, it is essential to determine what treatments are medically acceptable so as to know what options would legally be allowed in the medical aid worker’s home country and then use this knowledge as guidance for making a decision.
**Limitations**

There are several limitations in this case. The mother cannot leave her other children with her sister, especially because there is no way to contact the sister to let her know what is going on. The mother is also not comfortable with leaving her infant in the clinic, even for just a few days. The limits to acceptable treatment options from the mother’s perspective are those that can be done as an outpatient.

The medical aid worker is not limited by time. He may, however, be limited by resources. While he has the supplies necessary to provide intravenous fluids and antibiotics, it is unclear whether he has oral fluids that could be given to the mother for outpatient treatment of the infant.

**Analysis and Justification of Options**

At this point in the case, there are two possible options: keeping the child in the clinic for treatment or sending the child home with a treatment plan. Rather than making a unilateral decision, it is important that the medical aid worker fully explore the values and goals of the mother and explain his own goals and values to her. Hopefully, through open communication and negotiation, the mother and medical aid worker can come to a shared agreement about how to care for the infant.

The first step in justification of the options is to determine whether the option or options will be effective in achieving the goals of stakeholders. The shared goal of the medical aid worker and the mother is the full recovery of the infant. Keeping the infant in the clinic for intravenous fluids and antibiotics is likely to achieve this goal. Because alternative treatment options were not discussed in the case presentation, it is not clear whether oral rehydration and antibiotics would be effective in treating the infant. If this alternative is also likely to be effective with respect to the goals of the stakeholders, it should be considered as a possible intervention.

The next step in justification is to determine if the benefits of the option outweigh its infringement on the identified values and norms. The option of inpatient treatment has the benefits of medical efficacy and allowing the medical aid worker to intervene immediately if the infant’s condition deteriorates. It infringes on the norm of relationality because it will force the mother to either leave her infant alone in the clinic or leave her other children under the care of her sister, neither of which
she is comfortable doing. It also infringes on respect for autonomy in that the mother would clearly prefer to take the infant home. The option of sending the infant home on oral fluids and antibiotics may be a medically acceptable alternative. The benefit of this option is that it does not infringe on the values of the mother or the norms of relationality and respect for autonomy. It may, however, infringe on the principle of beneficence, because the physician believes that the best way in which to maximize the benefits and minimize harm to the infant is through inpatient treatment.

The next step in justification is to determine whether or not it is necessary for the option or options to infringe on the identified values and norms. It is necessary for the option of keeping the child in the clinic to infringe on relationality, because the mother cannot stay in the clinic with the infant and go home to care for her other children. This option will only infringe on respect for autonomy if the mother does not agree to it or is pressured into choosing it. If the medical aid worker feels that it is the only medically acceptable option, he should communicate this to the mother, stating his concerns about the child and listening to her concerns about the rest of her family. Through open communication and negotiation, they may be able to come to a shared decision. The option of sending the child home with oral rehydration and antibiotics will necessarily infringe on the norm of beneficence if the risk-benefit profile of this option is less medically favorable than inpatient treatment. If it is likely to be effective in achieving the goal of the medical aid worker and mother, then it will not infringe on the professional and legal duties of the physician to provide appropriate medical care to the infant.

If the stakeholders determine that infringement on the norms and options is necessary, the next step in justification is to determine whether this infringement has been minimized, and if it has not, how it can be minimized. Some creative thinking could overcome infringement on the norm of relationality by the option of keeping the child in the clinic. For example, if there is a vehicle available to the medical aid worker, he could bring the mother home to inform her sister of the situation and either arrange for care of her children or bring them to the clinic so they can be together there. Or the medical aid worker could arrange to stay in the mother’s village so that he would be close by if anything happens to the infant. Infringement on the norm of respect for autonomy can be mini-
mized through communication and negotiation. Infringement of the option of sending the infant home with oral rehydration and antibiotics on beneficence could be minimized by scheduling either a follow-up visit in the clinic or a home visit, as well as by educating the mother about concerning signs and symptoms for which she should bring the infant back to the clinic.

The final step in justification is to determine whether the stakeholders would be comfortable sharing their decision-making process with others. If the medical aid worker and the mother are able to openly communicate and negotiate a compromise on one of the options, they should be comfortable sharing this with others. The advantage of this process is that it might encourage others from the village to seek care at the clinic because of the respect that the medical aid worker showed for the mother’s values and needs.

Even if the outpatient treatment plan would not have been effective for the infant in this case, the process of engaging the mother in a dialogue about values may have led to a better outcome. Through this dialogue, the medical aid worker would have been able to better understand the values of the mother and acknowledge their importance. From the starting point of discussing and acknowledging important values, the medical aid worker could then have explained why the option of allowing the child to go home would be ineffective in meeting their mutual goal of the child’s recovery. This dialogue may have allowed for a compromise on a treatment plan that the mother was willing to adhere to.

**CASE COMMENTARY**

In the case as it is presented, the medical aid worker insisted on inpatient treatment for the infant. He did not encourage the mother to discuss her values. When the mother raised her concern about needing to return to her village and take care of her other children, rather than exploring this issue the medical aid worker responded by pushing his own perspective. The medical aid worker’s insensitivity to the mother’s concerns and the mother’s unresolved obligation to her other children ultimately led her to abandon care.

By pleading with the mother to leave the infant at the clinic, which led to their departure before treatment was complete, the medical aid worker created a situation in which the infant received inadequate care. As a re-
sult, the infant was put at high risk of dying from the untreated cholera infection, especially because the mother would be unlikely to return to the clinic if the child’s condition worsened. Alternatively, through communication and negotiation, the medical aid worker and the mother may have been able to reach a compromise on short inpatient treatment or home treatment with oral rehydration and antibiotics. In order to monitor the infant, the physician could have asked the mother to return to the clinic for a follow-up appointment. This compromise is more favorable than no treatment, even though it is less medically favorable than the inpatient treatment desired by the physician. Even if the infant had to be kept at the clinic, an open discussion about the mother’s concerns and values may have made her more comfortable with this treatment plan.

**Conflicting Individual Values**

Not only can the values of different stakeholders conflict with each other, but the individual values of a single stakeholder can also conflict. When these values conflict in such a way that different options are more consistent with the different values, ethical issues can arise. As an example, a physician schedules his appointments to end early so that he can make his son’s baseball game. At the end of the day, he gets an urgent request from a patient who wants to be seen immediately. If the physician sees the patient, he will miss his son’s game. Alternatively, if he goes to his son’s game, then the patient will have to wait to be seen or go to an urgent care center or emergency room. Obviously, the physician would have to take into account factors such as the patient’s condition and the availability of alternative sources of care in making his decision. In making this decision, he will either have to infringe on the value of watching his son play baseball or of being available to see a patient who is in need. The following case presents a situation in which the medical aid worker’s individual values conflict with each other.

**Case 2.4: Evacuating a Dangerous Area**

A medical aid worker has been running a clinic in a small village in Kenya for six months. Early one morning, a man from the village comes to her tent to warn her that armed men from a rival tribe are heading their way. He tells her to go to community’s shelter, where she will be safe. While in the shelter, the medical aid worker radios the local United
Nations base for help. When the attack is over, she leaves the shelter to begin taking care of injured villagers. A few hours later, a UN jeep arrives in the village. The UN peacekeepers tell the medical aid worker that they expect more attacks to follow and that she is not safe staying in the village. They insist that she leave with them immediately. There are still numerous wounded villagers in need of medical attention, and if the medical aid worker leaves, they will not get appropriate treatment. She is torn between leaving these patients in order to ensure her own safety or staying to treat them and putting her life at risk.3

CASE ANALYSIS

Medical aid workers often serve in areas of conflict. Sometimes they are aware that they will be entering war zones, while at other times violence occurs unexpectedly. Because medical aid workers are temporary volunteers, they have the option of leaving the areas where they are serving at any time. At the same time, they have a responsibility to care for patients in the communities where they are serving. When faced with threats to their own lives, medical aid workers must determine the extent of their responsibility to patients in developing countries. In this case, the medical aid worker must make a challenging decision, which is compounded by the urgency with which she needs to make it.

Stakeholders

The stakeholders in this case are numerous. The medical aid worker and the wounded villagers are the central stakeholders. The other villagers who are at risk of harm from subsequent attacks and who will be left to care for the wounded villagers if the medical aid worker leaves are also stakeholders. The United Nations peacekeepers, the United Nations, and the organization that the medical aid worker is representing are stakeholders as well.

Medical Facts

The important medical facts in this case are related to the number and extent of injuries as well as the resources and personnel available to treat the wounded. There are many injured villagers currently in need of medical attention. The medical aid worker has been able to treat some of the victims, but more are in need of her care. While there are no details about
exactly how many people have been injured or the extent of their injuries, it is likely that some of the victims will die or suffer significant disability without medical intervention. The only medically trained person in the village capable of treating the injured villagers is the medical aid worker.

**Goals and Values**

The immediate goal of the medical aid worker is to treat the wounded villagers. After serving in the village for six months, the medical aid worker has probably developed strong relationships with villagers and been accepted into their community. She values these relationships as well as the lives of the villagers. At the same time she values her own life and has the goal of preserving it. In addition, she has relationships with family and friends at home, which she also values.

**Norms**

The central bioethical norm in this case is relationality. The medical aid worker has forged important relationships with villagers during her six months in the community. On the other hand, she also has important relationships with her patients, family, and friends at home. The obligations that come with all of these relationships make the decision about whether to leave challenging.

The professional norm that the medical aid worker must consider in this case is whether leaving constitutes patient abandonment. Patient abandonment occurs when a physician relinquishes care of a patient without ensuring that the patient has an alternative source of care. If the medical aid worker leaves, the wounded villagers will not have anyone to care for their medical needs. However, because she is a temporary volunteer, the villagers understand that she will be leaving at some point, even if there is no one to replace her. In international medicine, patient abandonment is, in a sense, a norm. If the medical aid worker decides to leave immediately, she may not be perceived by villagers as abandoning them. However, given the acuity of the injuries, they may at least expect her to stabilize the injured before leaving the village.

The legal norm important in this case is the duty of physicians to treat patients. In general, physicians are only expected to treat patients with whom they have a prior relationship. The medical aid worker has been in the village for six months, which means that she has a professional re-
relationship with community members, all of whom might be considered potential patients. However, as with the norm of patient abandonment, this duty is different in international medicine because the villagers understand that the medical aid worker is a visitor who will eventually leave their community. They do not believe that she has an unending duty to care for them.

**Limitations**

The most significant limitation in this case is time. The UN peacekeepers want the medical aid worker to leave immediately. It is unclear whether or not they would allow her to stay long enough to stabilize the wounded villagers. An additional constraint on time is the threat of another attack. If another attack comes soon, then the medical aid worker will have to seek shelter again and leave the wounded villagers behind. A further limitation is the lack of trained medical personnel. The village does not have anyone who can take over for the medical aid worker if she leaves. If she stays and is injured or killed in a subsequent attack, the villagers will also be unable to treat the wounded.

**Analysis and Justification of Options**

The medical aid worker has three possible options at this point: to leave the village immediately, to treat the wounded villagers before leaving, or to stay in the village. The second option is only possible if the UN peacekeepers are willing to wait for her to treat the wounded. All three options are examined below with the justification criteria.

The first step in justification is to determine whether the option will be effective in achieving the goals of the stakeholders. The two goals of the medical aid worker are to preserve the lives of the wounded villagers and to preserve her own life. The option of leaving immediately does not give the medical aid worker the opportunity to achieve her goal of preserving the lives of the wounded villagers. However, it does give her the best opportunity to preserve her own life. The option of treating the wounded villagers before leaving may allow her to achieve both goals. However, she will only be able to provide acute interventions, without any follow-up care. In addition, if another attack occurs after she leaves, she will not be able to treat the newly wounded villagers. If the medical aid worker elects to stay in the community, she may also have the opportunity to achieve
both of her goals. However, she will significantly increase the risk to her own life, and if she dies or is severely wounded, she will not be able to treat wounded villagers.

The next step in justification is to determine whether the benefits of the option outweigh its infringement on the identified norms and values. The option of leaving immediately has the benefit of ensuring the medical aid worker’s safety from subsequent attacks on the village. It does, however, infringe on the ethical norm of relationality, because the medical aid worker has developed relationships with the villagers. Leaving them when they are in acute need of her care could greatly damage these relationships as well as relationships between the villagers and medical aid workers who serve them in the future. In addition, she may infringe on the professional norm of patient abandonment, as well as the legal duty to care for her patients. This depends on whether or not her position as a temporary volunteer obligates her to care for patients in this situation. Patients in developing countries are aware that medical aid workers are going to leave after a given period of time, regardless of whether or not all of their health care needs have been addressed. The duty of medical aid workers to care for patients is limited to the time during which they are serving. In this case, the villagers may believe that the medical aid worker has a duty to them following the attack and that she is abandoning them if she leaves immediately. On the other hand, they may not expect her to stay and risk her own life to care for them.

The option of treating the wounded before leaving has the benefit of allowing the medical aid worker to fulfill her duty to the villagers in need of acute care as well as to maintain her own safety if the village is attacked again. Similar to the previous option, this option may infringe on relationality in that it could strain the relationships that the medical aid worker has with villagers. In addition, it could infringe on the norms of patient abandonment and the duty to treat patients if the villagers perceive her departure as a breach of her duty to them. Specifically, while she is able to treat the acute needs of the villagers, she will not be able to provide follow-up care.

Finally, the option of staying in the village is beneficial in that it allows the medical aid worker to treat the wounded villagers in need of emergent care, provide follow-up, and treat villagers who are injured in subsequent attacks. This option has the potential to infringe on the norm of
relationality in a way opposite to that of the previous two. If the medical aid worker stays and puts her own life in significant danger, she may be infringing on her obligations to family, friends, and patients at home. Moreover, if she is killed or wounded she cannot help the villagers in the future.

The next steps in justification are to determine whether infringement on the identified values and norms is necessary and has been minimized. The option of immediately leaving the community necessarily infringes on the relationships that the medical aid worker has with villagers. In addition, it most likely infringes on patient abandonment and the duty to treat patients, because it would be reasonable for the villagers to expect the medical aid worker to stay and treat the wounded. One way in which the medical aid worker could minimize the infringement on her duty to care is to leave all of her supplies with villagers who can use them to treat the wounded. In addition, she may be able to return to the village after the situation has stabilized. However, if leaving hurts her relationship with the villagers, then returning may not be a possibility. The option of treating the wounded villagers before leaving has less of a risk of infringing on the norms of relationality, patient abandonment, and the duty to treat patients than the previous option. As with the previous option, the medical aid worker could minimize infringement on the norm of relationality by returning to the village after the situation has stabilized in order to provide follow-up care. She could minimize infringement on patient abandonment and a duty to treat by teaching villagers how to treat the wounded and leaving them her supplies. The option of staying in the village necessarily infringes on the medical aid worker’s relationship with friends, family, and patients at home only if she puts herself into a dangerous situation that could easily disrupt these relationships. If she can ensure that she will be able to find adequate shelter during subsequent attacks, or is able to create an escape plan, this will minimize infringement on the norm of relationality.

The final step in justification is to determine whether stakeholders would be willing to share their decision-making process with others. Given the emergent nature of this case, the medical aid worker may not have a lot of time to go through the full process of assessing the situation, justifying the options, and deciding on a plan of action. Ideally, she would be able to get the UN peacekeepers to stay for a while so that she
can continue treating the wounded and make a decision. If she then decides to leave, she would have time to explain her choice to the villagers and teach them how to treat the wounded. Also, parting with an explanation may make returning to the village easier than if she leaves immediately. If she decides to stay, she may have time to plan an evacuation with the UN in the case of escalating violence.

**CASE COMMENTARY**

Many areas of the developing world are plagued by wars and violence. When medical aid workers agree to serve in dangerous areas, they should prepare themselves for violence and unrest. Rather than waiting for an emergency situation like the one described in this case, medical aid workers should establish community expectations for their actions in the case of an attack. Medical aid workers should determine when it is appropriate for them to leave and if they should return when the situation stabilizes. Medical aid workers should also teach community members how to intervene in traumas so that if they must leave, the community can still care for wounded individuals.

**Competing Cultural Values**

In addition to personal values, cultural values can influence medical decisions. Cultural values are the ideals, customs, and institutions of a group that members collectively regard as important. The cultural values of medical aid workers and their patients in developing countries can differ greatly. Often, medical aid workers are not familiar with the cultural values, traditions, and rituals of the population they are serving. Differences in cultural values do not necessarily create ethical issues. However, when these differences conflict with each other or influence stakeholders to make opposing decisions, ethical issues can arise.

A specific cultural difference that medical aid workers may encounter is a ritual that appears harmful to those who participate in it. One example of an important cultural ritual in some developing countries, but widely condemned outside these societies, is female genital mutilation (FGM). FGM has been documented as a traditional practice in twenty-eight countries, twenty-two of which are categorized as least developed countries by the World Trade Organization (UNCTD 2006). More than one hundred million women and girls have undergone some form of
FGM (OHCHR 2008). FGM is often a central part of cultural identity, and it encourages cultural continuity and solidarity (Nussbaum 1999, 125; OHCHR 2008). It is also a rite of passage for girls into womanhood, allowing them to join secret societies of women and learn about the roles of adult women (Gibeau 1998). Some cultures view this practice as a religious requirement as well as a requirement for marriage (Boyle 2006; Gately 2005; Lane and Rubinstein 1996).

However, FGM can also be a harmful practice, causing significant morbidity and mortality. Immediate health consequences of this procedure include pain, hemorrhage, infection, and even death (Lane and Rubinstein 1996; Macklin 1999a, 67; OHCHR 2008). Because anesthesia is not generally used, FGM can be incredibly painful for the girl. There are also long-term consequences associated with FGM, including abscesses, disfiguring scars, cysts, pain during intercourse, infertility, and chronic urinary tract infections (Macklin 1999a, 67). One of the most significant long-term consequences of FGM is an increased risk of adverse events during childbirth (OHCHR 2008; Nussbaum 1999, 120). FGM increases the risk of obstructed and protracted labor, vaginal tearing, and fistula formation during childbirth (Macklin 1999a, 67; Nussbaum 1999, 120). While medical aid workers are generally not asked to participate in or perform rituals like FGM, they may come into contact with communities who practice these rituals. The following case shows how a medical aid worker has to confront the practice of female genital mutilation in the community where she is serving.

**Case 2.5: Providing Supplies for Female Genital Mutilation**

A physician, after applying for a six-month medical aid experience, is notified that she will be working in a rural village in Mali, Africa. In the orientation session preceding her trip, the physician is told about the organization’s health initiatives in this village, one of which is handing out sterile scalpels to women who perform female genital mutilation (FGM). Another initiative in the village is providing tetanus shots to girls before they participate in FGM. In the orientation session, the organizational representative explains that they do not agree with FGM or allow medical aid workers to participate in these rituals, but they do want to make FGM safer for the girls who are subjected to it.  

In preparation for the trip, the physician reads several articles about
FGM to gain an understanding of what it is and why it is so controversial. Through her readings, the physician is shocked by the barbaric nature of this ritual and by the significant immediate and long-term complications associated with FGM. She cannot understand why anyone would subject a child to this practice, and questions whether or not she should participate in initiatives that could legitimate or encourage it.

CASE ANALYSIS

Before arriving in Mali, the physician can begin by reflecting on her own perceptions of female genital mutilation using the assessment questions. Because this case addresses an ethical issue that arises before she arrives on location, the analysis focuses on the physician’s perceptions of the practice. Before making a final decision, it is important that the physician learns more about the community’s practice of FGM, because there can be wide variations in this ritual, some of which are not excessively harmful to participants.

Stakeholders

The physician is the central stakeholder at this point in the case because she is in the process of considering how to address a cultural practice in the community where she will be serving. After she gets to Mali, she will have to identify the other main stakeholders, which will likely include community leaders, women who perform FGM, girls who have had or who are planning to have FGM, and community members who oppose this practice.

Medical Facts

From what the physician has read about FGM, it can lead to serious medical problems, such as bleeding, infection, and complications in childbirth. These potential medical problems may not be prevalent in the community where the physician will be serving, depending upon how extensive the local FGM procedures are. So it is important for her to learn about the adverse medical effects of FGM in the community before judging it as dangerous. If the women and girls in the community do not experience the adverse effects associated with FGM, then their ritual may not be as dangerous and barbaric as the physician perceives it to be.
**Goals and Values**

Assuming that the practice of FGM in the community does result in serious adverse medical outcomes, the physician would have the ultimate goal of ending this practice. However, given that she is only serving for six months, she would also need to have realistic short-term goals such as making FGM safer and opening up communication about FGM with community members. Through communication with community members, the physician could learn about their goals for FGM and the values that make this practice important. The main value of the physician in this case is improving the health of the community members. She also values protecting her own moral integrity by not encouraging the harmful practice of FGM.

**Norms**

The central ethical norm in this case is beneficence. The principle of beneficence aims to maximize benefits and minimize the harms that result from interventions. The primary potential medical benefit of the initiatives—handing out sterile scalpels and providing tetanus shots—is a reduction of the rate of infections that result from FGM. An additional potential benefit is the encouragement of communication about the practice of FGM, which could eventually lead to its elimination. One potential harm of the initiatives is that they may encourage the continuation of FGM and create the perception that the physician agrees with this practice. If the physician does not agree with FGM as it is practiced in the community because of the adverse medical effects of the procedure, handing out scalpels and providing tetanus shots may undermine her opposition to the practice. She will ultimately need to get more information about FGM from the community before she can accurately balance the risks and potential benefits of the initiatives.

The professional norm important in this case is that of performing interventions and providing treatments that are medically indicated and promote health. These initiatives are medically indicated in that they decrease the girls’ risk of developing an infection following FGM. As preventive measures, they promote health. However, they do not address other adverse consequences of FGM, especially risks during childbirth, which can be very serious. If the initiatives legitimize FGM and encourage its
continuation, then they may not be promoting the long-term health of community members.

Legally, it is important for the medical aid worker to know that female genital mutilation has been outlawed by the United Nations. While she is not directly participating in the FGM rituals, she should make sure that her opposition to this practice is known and that the initiatives are not perceived to be encouraging FGM.

**Limitations**

The main limitation for the physician in this case is that she is only staying in the community for six months. This may not be adequate time to gather information about FGM, become trusted within the community, and begin encouraging community members to stop this practice. The physician also may not have adequate time to assess whether or not the initiatives are effective in achieving the goals of making the practice of FGM safer and encouraging communication. One significant limitation within the community is that community members lack health care resources. They have been relying on the medical aid organization for tetanus shots and sterile scalpels. Without these initiatives, the community will continue to practice FGM, but will do so in a way that is less safe for the girls who undergo the procedure.

**Analysis and Justification of Options**

The question that the physician is trying to answer in this case is whether she should participate in initiatives to hand out scalpels for FGM procedures and provide tetanus immunizations to girls planning to participate in these rituals. There are several things she needs to learn from the community before making a final decision. For example, she should investigate the adverse medical effects of FGM in the community, as well as the impact of the initiatives on these effects so far. She should also determine if the initiatives encourage communication with community members about the practice of FGM. In addition, she should learn about the values of the community members with respect to this ritual so that she can try to understand the cultural benefits of this practice. While all these facts will be important in her final decision, the physician can preliminarily examine her options. This justification focuses on the physi-
cian’s options without specific knowledge of the community’s FGM rituals. Her two basic options at this point are to continue the initiatives or to stop them.

The first step in justification is to determine whether the options will be effective in achieving the goals of the intervention. There are two short-term goals for the initiatives: medical effectiveness and communication. In order to determine if the initiatives are medically effective, the physician could speak with local medical personnel about whether they have experienced a decrease in infection rates since the initiatives have been in place. She could also ask them if she will be allowed to communicate with the girls who are planning on participating in this procedure, their families, and the women who perform FGM. If the physician cannot ask someone about effectiveness, she could continue the initiatives for a trial period to determine if they are effective with respect to the goals that she has identified. Not participating in the initiatives may achieve the goals of the physician. She may still be able to communicate with community members, discouraging FGM, thereby improving the health of women in the community in the future. However, not participating in the initiatives could negatively influence the relationship between the physician and the community, closing off communication and having no impact on the community’s practice of FGM.

The next step in justification is to determine if the benefits of the options outweigh their infringement on the identified values and norms. The option of participating in the initiatives will likely be beneficial in that it will decrease the rate of infections following FGM procedures. This option has the potential to infringe on the physician’s value of protecting her own moral integrity if she feels that her participation is encouraging or legitimating FGM. This option may also infringe on the professional norm of providing interventions and treatments that encourage health because it will not affect some of the serious health risks of FGM. It could infringe on international law if perceived by authorities to be encouraging FGM. The option of not participating in the initiatives has the benefit of separating the physician from a practice that she disagrees with. In addition, if she chooses this option, she will not have to worry about infringing on international law. However, this option could infringe on beneficence in that the physician would not be minimizing harm to the girls who are going to have FGM procedures regardless of if there are teta-
nus shots and sterile scalpels available. Similarly, it may infringe on the professional norm of providing interventions and treatments that encourage health, because it would not be protecting the girls who participate in FGM from infections. In addition, it may create a barrier to communication between the physician and community members if they feel that she is judging their practice unfavorably. The physician has not yet identified the values and norms of the community, which may be one of the outcomes if the initiatives encourage communication. As community values and norms are identified, the physician should revisit the question of proportionality to determine if the chosen option infringes on the values and norms of the community.

The next consideration in justifying the options is whether infringement on values and norms is necessary, and if so, how it can be minimized. If the option of participating in the initiatives is effective in opening up communication between the physician and community members about their practice of FGM, then it may not infringe on the physician’s value of protecting her moral integrity or on international laws banning FGM. However, communication will take time to establish, so this option may initially infringe on these norms. The physician can minimize these risks by making her opposition to FGM known to the community from the beginning. The option of not participating in the initiatives will necessarily infringe on the norm of beneficence, at least in the short term, because the girls who have FGM procedures will be at higher risk of infection than they would be if the initiatives were in place. The physician could minimize infringement on this norm by making sure that she has adequate supplies for treating infections as well as the other complications that result from FGM.

Finally, it is important to determine if the stakeholders would be comfortable sharing their decision-making process with others. The physician in this case is making a decision about whether or not to participate in initiatives that may encourage or legitimate a cultural ritual that she disagrees with. If she chooses the first option and it encourages communication with the community, negotiation with those who practice FGM, and safety for the girls who participate in this ritual, then she would likely be comfortable sharing this decision with others. This option would allow the physician to walk the fine line between respecting a cultural practice and voicing concern about its harmful effects. If she
chooses to stop handing out sterile scalpels and giving tetanus shots because she believes that participating in these initiatives violates her personal integrity as well as professional and legal norms, then she should be comfortable sharing this decision. However, it is important for her to consider that this option will probably not be effective in discouraging FGM, because it has little likelihood of encouraging communication with community members.

CASE COMMENTARY

Medical aid workers may encounter situations in which they disagree with a cultural value or practice in the area where they are serving. In cases like this, it is important that medical aid workers put the situation into perspective. Cultural rituals are often deeply ingrained in community life and have been practiced for generations. It is unrealistic to believe that an outsider visiting a community for a few weeks or months would have the influence to significantly change or eliminate this type of practice.

The United Nations, which has been working for more than a decade to eradicate the practice of FGM, emphasizes the need for sustained, community-led, multi-sector interventions for the successful elimination of this practice. The UN recognizes that the eradication of FGM is not something that will happen immediately or result from the intervention of one medical aid worker. While medical aid workers have important roles in raising awareness about the harms of traditional practices like FGM in the communities where they serve, they should not expect to be the only players in the effort to eradicate FGM. Participation in initiatives that make practices like FGM safer and allow for a conversation to begin about both the benefits and harms of the practice may be the best option for temporary medical aid workers, even if their ultimate goal is to eliminate the practice altogether.