Ethics for International Medicine

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One of the most striking characteristics of international medicine in developing countries is the vast array of limitations faced by medical aid workers and their patients. Many medical aid workers serve in clinics that are barely functioning and have little to offer in the way of supplies. Limitations in facilities, supplies, and equipment in developing countries often force medical aid workers to perform procedures or prescribe treatments that deviate from the standard of care they would adhere to in the developed world. In addition, medical aid workers often have an explicit need to ration medications because the demand is much greater than the supply.

Beyond limitations in resources, medical aid workers in developing countries often serve patients who otherwise have little or no access to health care. The majority of people in developing countries live in severe poverty, with many surviving on less than one dollar a day (WHO 2008). Moreover, developing countries are plagued by a higher burden of disease than developed countries. An additional factor that contributes to patients’ limited access to health care is the paucity of well-trained health care providers in developing countries.

Beyond the limitations of developing countries, medical aid work itself has inherent limitations, the most apparent of which is time. Medical aid workers only serve temporarily, for weeks or months, before returning to their home practice. The nature of international medicine requires medical aid workers to leave the areas where they are serving before they can treat all the patients in need of care, or follow up with the patients they have already treated.

Limited Resources

The limitations encountered in international medicine create, or contribute to, a myriad of clinical ethical issues. One issue that comes up
repeatedly in narratives by medical aid workers is the limited supply of medical resources with which they have to work. Medical aid workers often have to decide on how to distribute the limited supply of resources to a patient population with great medical need. In developed countries, there is a relative excess of available medications, so physicians can make diagnoses and give patients prescriptions for their medications with the reasonable expectation that the medications will be available at a pharmacy. However, in developing countries, physicians must make tough decisions about whom to give medications to because they cannot treat every patient who needs them. The following case illustrates how limited medical supplies can create ethical issues in international medicine.

**Case 4.1: Chronic Hypertension**

A forty-five-year-old man presents to a clinic in El Salvador where medical aid workers are providing free health screenings and medications. This is the first time the man has seen a physician in four years. A medical aid worker examines the man and finds that his blood pressure is 160/100. This is well above the normal range, so the medical aid worker diagnoses the patient with essential hypertension. The medical aid worker asks the man about lifestyle factors that may be contributing to his hypertension. The man reports that he eats a high-salt diet with few fruits and vegetables. He is also a smoker, averaging one pack of cigarettes a day for the past twenty years.¹

The medical aid worker believes that changes in the patient’s lifestyle would have a measurable effect on his blood pressure, but when he suggests that the man quit smoking or change his diet, he is met with resistance. The patient tells the medical aid worker that he enjoys smoking and that all his friends smoke, so it would be impossible to quit. He says that he cannot change his diet because he cannot afford healthy foods like fruits and vegetables. Without lifestyle changes, pharmaceutical intervention is necessary to control the patient’s hypertension.

The medical aid worker has a six-month supply of blood-pressure medication that he can give to the patient. Because the patient relies on medical aid groups like this one for care, the medical aid worker is not sure whether a six-month supply of medicine is going to be enough to treat him until the next medical aid group visits. The local pharmacy sometimes carries the blood-pressure medicine, but it is very expensive,
so the patient would not be able to afford to buy more if he runs out. The
medical aid worker is unsure about whether he should start this patient
on antihypertensive medication without knowing if the patient will be
able to continue this treatment regimen when the initial supply runs out.

CASE ANALYSIS
The medical aid worker in this case must decide whether or not to
give a patient with hypertension a six-month supply of antihypertensive
medications. This case is complicated by the fact that the patient has
limited access to health care and will be unable to refill his medications
unless another medical aid group brings more to the area. The two cen-
tral stakeholders in this case are the medical aid worker and the patient.
In addition, the community as a whole can be seen as a stakeholder, be-
cause the lack of healthy food and the culture of smoking in the commu-
nity are contributors to the patient's hypertension. It is likely that many
other community members have hypertension, heart disease, or diabetes
because of the same risk factors.

Medical Facts
The patient visited the clinic for a general medical checkup and has
not been having any symptomatic medical problems. On exam, the medi-
cal aid worker found that the patient has high blood pressure. Techni-
cally, the diagnosis of essential hypertension would need to be verified at
a follow-up visit, but the medical aid worker will not be in the area long
enough to follow up with the patient. The medical aid worker wants to
treat the patient's hypertension because this condition puts him at risk
of myocardial infarction and stroke, both of which are life-threatening
conditions. The two general ways to manage essential hypertension are
lifestyle modifications and pharmaceutical interventions. One essential
element of hypertension treatment in developed countries is follow-up
monitoring of blood pressure to determine whether or not lifestyle modi-
fications or pharmaceutical interventions are effective. Often, patients
require additional or different medications in order to control their blood
pressure, and close monitoring is the only way to determine when this is
necessary.
Goals and Values

The goal for the medical intervention in this case is to lower the patient’s blood pressure so as to decrease his risk of stroke and myocardial infarction. The patient values maintaining his current lifestyle, which eliminates one of the two identified treatment options. He also values his health, but because he is asymptomatic, he probably does not believe that his condition is worrisome.

Norms

The ethical norm of beneficence—maximizing the benefits of an intervention and minimizing the risks—is important in this case. Pharmaceutical interventions have the potential to be effective in controlling the patient’s hypertension. However, they can also have unpleasant side effects such as dizziness, nausea, and frequent urination. Moreover, if these medications are taken sporadically, they are not effective in decreasing blood pressure. They can also cause medical problems if stopped abruptly (for example, rebound hypertension).

The professional norm of ensuring that patients are able to adhere to treatment plans is also important in this case. Physicians in developed countries discuss diagnoses, prognoses, and treatment options with patients, and allow patients to decide which option is most consistent with their values and limitations. The same approach to treatment plans should be taken in developing countries, because if physicians unilaterally impose treatment regimens, patients may not want to or be able to adhere to them.

The legal duty to treat patients with the standard of care is an important norm for the medical aid worker to consider in this case. The patient has a chronic, but controllable, medical condition. The medical aid worker has antihypertensive medications that he could give to the man for six months’ worth of treatment. In the developed world, if a patient is unable or unwilling to implement lifestyle modifications, then the standard of care is to use an antihypertensive medication and monitor blood pressure at follow-up visits. Although the medical aid worker should not be worried about legal repercussions, he should consider if he would be legally obligated to provide the antihypertensive medications to this patient if he were in his home country, and whether or not the context of the situation changes his legal responsibility.
Limitations

There are significant limitations to both of the treatment options for the patient’s hypertension. The patient is not willing to quit smoking or change his diet, meaning that he will not comply with lifestyle modifications to lower his blood pressure. The medical aid worker only has six months’ worth of antihypertensive medications. He is not sure that this will be enough medicine for the patient until the next medical aid group arrives or if the next group will even have the same medication available. Furthermore, the patient cannot afford to buy more medication if he runs out before the next group arrives. In addition to limited supplies, the medical aid worker has limited time. This means that he cannot follow up with the patient to determine if the medications are working.

Analysis and Justification of Options

The realistic options that the medical aid worker has in this case are either to give the patient a six-month supply of hypertension medication, hoping that he will be able to get more before it runs out, or not to give him the medication. The medical aid worker could try to counsel the patient further on the importance of lifestyle modifications, but this is unlikely to be effective, since the patient is not motivated to make these changes, and the medical aid worker cannot follow up with the patient to hold him responsible for the changes.

The first step in justification is to determine whether the options will be effective with respect to the goal. The goal in this case is control of the patient’s blood pressure. The option of providing the patient with the six-month supply of medications may result in short-term blood-pressure control. However, essential hypertension is a chronic disease that requires long-term control to effectively decrease the risks of myocardial infarction and stroke. Not giving the patient the medications will not result in blood-pressure control, even in the short term. Neither option available in this case is guaranteed to achieve the goal of long-term blood-pressure control.

The next step in justification of the options is to determine whether the benefits of the option outweigh its infringement on the identified norms and values. The option of giving the medications has the potential benefit of controlling the patient’s hypertension for a couple of months. It infringes on the norm of ensuring that patients can adhere to treatment plans, because the medical aid worker is not sure whether or
not the patient will be able to continue the treatment for more than six months. This option may also infringe on the norm of beneficence. The risks of giving the hypertension medication include side effects such as dizziness, hypotension, and electrolyte abnormalities, as well as adverse effects from abruptly stopping the treatment, such as rebound hypertension. If the patient takes the medications sporadically in order to make them last longer, they will not be effective in controlling his blood pressure. Not only are there risks to giving the patient the medications, there is also no mechanism for following up with the patient to determine if he is taking the medications, if he is experiencing side effects, or if the medications are effective in controlling his hypertension.

The option of not treating the patient has the benefit of not exposing him to the risks of antihypertensive medications. It may, however, infringe on beneficence. By not giving the patient the medications, there is no potential short-term benefit of blood-pressure control. At the same time, this option does not pose the same risks of adverse effects as giving the medication. This option may also infringe on the legal norm of providing the standard of care, because antihypertensive medications are considered standard for essential hypertension in patients who cannot modify their lifestyle or whose blood pressure does not respond to lifestyle modifications.

The next steps in justification are to determine if infringement on the identified norms and values is necessary, and if so, how it can be minimized. The option of giving the medications necessarily infringes on beneficence in the sense that the treatment is suboptimal. The medical aid worker cannot maximize the benefits and minimize the harm to the patient in the same way that he would be able to in the developed world. He could minimize infringement by explaining the potential side effects to the patient and instructing him to discontinue the medications if they occur. In addition, the medical aid worker could train community members to check blood pressure so that the patient can follow up with them to see if the medications are working. This option also necessarily infringes on the professional norm of making a treatment plan that patients can adhere to. Infringement on this norm could be minimized by communication with the next medical aid group about what medications it should bring and which patients need follow-up.

The option of not giving the medication to the patient necessarily in-
fringes on beneficence because it has a relatively unfavorable risk-benefit ratio. Without hypertension control, the patient is at risk of myocardial infarction and stroke, both of which can be life threatening. Infringement could be minimized by encouraging small lifestyle changes, such as decreasing salt intake or getting more exercise, so as to try to improve the man’s blood pressure. The problem with this approach is that the patient may agree to change his lifestyle, but without follow-up the medical aid worker will not be able to determine if the patient has made these changes or if the changes have had an effect on the patient’s blood pressure. This option does not necessarily infringe on providing the standard of care, because the medical aid worker cannot provide the standard of care with either option. Hypertension is a chronic disease, so there is not much difference between controlling blood pressure for six months versus not controlling blood pressure at all with respect to the risks of stroke and myocardial infarction.

The final step in justification is to determine whether or not the stakeholders would be comfortable sharing their decision-making process with others. Because the medical aid worker cannot make a plan for the patient to receive blood-pressure medications over a prolonged period, and there is no capacity for monitoring the patient for medication adherence, side effects, and efficacy, he should be reticent about starting the patient on the blood-pressure medication. A six-month course of treatment without any follow-up is useless for the chronic control of blood pressure. If the medical aid worker cannot ensure that the patient will be able to continue an antihypertensive medication regimen with regular clinic follow-up, then he should be comfortable sharing with others his decision not to start antihypertensive medications.

CASE COMMENTARY

This case illustrates one of the major shortcomings of temporary medical aid experiences: they are not designed to address the needs of patients with chronic medical conditions. Because some medical aid missions aim to see patients who do not have reliable access to health care, medical aid workers cannot guarantee that the patients will continue to receive medications and monitoring after they leave. While medical aid workers can offer curative treatments for acute conditions, they cannot provide a lifetime’s supply of medications to control chronic
diseases. Medical aid workers should recognize these limitations, consider the risks of providing temporary treatment for chronic diseases, and decide whether or not limited interventions will truly help patients.

If medical aid workers find that a particular chronic disease is rampant in the community where they are serving, they may be able to take steps toward providing appropriate and continued treatment. For example, a medical aid group could return to the same area regularly, bringing supplies of medications that will allow patients to continue treatment. If the individual medical aid workers cannot return to the area, they could work with local medical personnel to provide essential medications for chronic disease management. This can be logistically difficult because it requires a steady supply of medications and education of local medical personnel about these medications. Medical aid workers could, alternatively, bring this need to the attention of their organization so that the organization can arrange regular medical aid missions to the area that ensure a continuous supply of medications to meet the needs of patients with chronic conditions.

**Limited Access to Health Care**

The patients whom medical aid workers encounter in developing countries often have little or no access to health care. To complicate this situation, developing countries bear a higher burden of disease than developed countries. Limited access to health care creates many medical problems. Patients are often sicker or have advanced diseases by the time they are seen by medical aid workers. In addition, they generally have more comorbid conditions, which can affect or complicate treatment plans. Patients who have limited access to health care often have limited access to other resources such as clean water, adequate shelter, and food. These poor living conditions can contribute to the medical problems of patients and put constraints on treatment options. The following case illustrates a situation in which a patient has limited access to health care and subsists in poor living conditions, both of which complicate the medical aid worker's ability to provide her with optimal treatment.

**Case 4.2: Treating Tuberculosis**

A twenty-eight-year-old woman complaining of a persistent cough with intermittent hemoptysis, fever, and weight loss presents to a clinic
staffed by medical aid workers in Peru. The medical aid worker that she sees suspects the woman has tuberculosis (TB) and collects a sputum sample. The laboratory confirms that the woman has TB, but that it is a strain susceptible to all first-line medications. In accordance with World Health Organization standards, the medical aid worker plans to start the woman on directly observed treatment, short course (DOTS). He tells her that she must come back to the clinic three times each week for the next six to eight months to receive medications to treat her TB. He also tells her that she needs to sleep in an open room away from others in order to make sure that she does not spread the disease.²

The woman tells the medical aid worker that she lives in a small one-room house with her husband and four children and that she does not have an open room to sleep in away from the rest of the family. She also works most days during the hours that the clinic is open, so she can only come to the clinic once a week to take her medications. She cannot give up her job to follow the treatment plan, because she has to help support her family. Given these limitations, the medical aid worker wonders whether or not he should begin treating her for tuberculosis, since it is likely that she will not be able to adhere to the treatment plan.

**CASE ANALYSIS**

**Stakeholders**

The two primary stakeholders in this case are the patient and the medical aid worker. In addition, the patient’s family and close contacts are stakeholders because they are at risk of contracting TB. The medical aid worker has identified a couple of limitations to the woman’s ability to receive optimal treatment for TB. First, she will not be able to comply with DOTS because of her work schedule. Second, she cannot keep herself quarantined from the rest of her family, meaning that she will be putting them at risk of infection and herself at risk of reinfection if they are not treated appropriately. The decision that the medical aid worker and patient must make is whether to implement the standard DOTS treatment plan given the patient’s limitations.

**Medical Facts**

The medical facts in this case are straightforward. The woman has susceptible TB, confirmed by lab testing. DOTS is an effective treatment
regimen for susceptible TB. Without adequate treatment, the patient is at risk of dying. In addition, her family members and close contacts are at risk of contracting TB. The risk of incomplete treatment is that the patient could develop drug-resistant TB, which is more expensive to treat, has a greater likelihood of treatment failure, and has a higher risk of morbidity and mortality. In addition to making sure that he knows all the medical facts, it is important for the medical aid worker to elicit the patient’s understanding of her medical condition, because it might differ significantly from what he expects her to believe. Many patients in developing countries believe in supernatural etiologies of disease and use traditional healing practices. The patient’s beliefs regarding her disease may impact her willingness to adhere to the DOTS regimen.

**Goals and Values**

The goal of the medical aid worker and patient in this case is cure of the patient’s TB. The patient values her job as a means to support her family. While not discussed in this case, the patient’s family likely values her not only as a provider but also as a person they love and want to have around them.

**Norms**

The ethical norms of nonmaleficence, beneficence, and relationality are important in this case. Nonmaleficence requires that physicians refrain from interventions that are harmful to patients, without a potential for benefit. If the medical aid worker is sure that the patient will not be able to adhere to DOTS, then giving her the medications puts her at risk of developing a drug-resistant infection without the potential for curing her TB. If the medical aid worker is unsure about the patient’s ability to adhere to DOTS, he should consider the risks and benefits of starting treatment, trying to maximize the potential for benefits and minimize the risks in order to be consistent with the norm of beneficence. The ethical norm of relationality is important in this case because the relationship that the woman has with her family members is important. She works so that she can help provide for her children. Without her job, she would be unable to fulfill this obligation.

The professional and legal norms important in this case center on the duty of the physician to provide a standard of care. Professional guide-
lines from the WHO emphasize that DOTS is the worldwide standard of care for susceptible TB. In addition, several international initiatives have made DOTS readily available to patients in developing countries. Because DOTS is the standard of care, the physician should consider whether or not he has a legal obligation to begin therapy in this patient, given that she may not be able to successfully complete it.

**Limitations**

There are two significant limitations to the treatment options in this case. First, the patient lives in a one-room house with five other family members. She cannot separate herself from the rest of the family while they sleep, which increases their risk of contracting TB. In addition, the patient’s work schedule will not allow her to visit the clinic three times a week to take her medications.

**Analysis and Justification of Options**

The options in this case range from starting the patient on the DOTS regimen and insisting that she come into the clinic three times a week, to refusing to treat her because of the likelihood that she will be non-compliant. Neither of these extreme options will be effective in achieving the goal agreed upon by the stakeholders in this case, so they must determine if they can negotiate a compromise that allows the patient to get treatment and continue to work.

The most important determination to make in justifying a treatment plan in this case is to decide whether it will be effective in achieving the goal of successfully treating the patient’s TB. In order for the plan to be effective, it must be medically appropriate, meaning that the patient must get the correct medications at the correct intervals. In addition, the plan must be sensitive to the patient’s work obligations. If a treatment plan can be formulated to be both medically appropriate and sensitive to the patient’s work schedule, then the option will not only be effective, but it will be consistent with the norms and values identified by the stakeholders, so infringement will not be necessary.

If the medical aid worker and the patient cannot agree upon a treatment plan that will be effective, then the medical aid worker will have to decide between providing partial treatment, which might provide some symptomatic relief but not be curative, or not providing any treat-
ment. If these are the only two options for the stakeholders, they should go through the process of justification to determine which one they should choose. The first step is to determine whether either option has the potential to achieve the desired goal. Unfortunately, neither of these two options has the potential to achieve the goal of curing the patient’s TB. Both will most likely result in eventual death from TB, although partial treatment may help her to survive for longer or control some of her symptoms.

The next step in justification is to determine whether the benefits of each option outweigh its infringement on the identified norms and values identified in the case. Beginning with the patient’s obligations to her family, neither of the options will immediately infringe on the patient’s ability to fulfill her obligations to support her family by working. However, her disease will eventually progress to the point where she cannot work any longer, which will probably happen more quickly if she is not treated at all. In addition, she risks infecting both her family and her co-workers by continuing to work and not getting appropriate treatment. The norms of beneficence and nonmaleficence require that the stakeholders determine the risks and potential benefits of the options. The benefits of partial treatment include an increased life expectancy and symptom control. If the patient receives partial treatment, there is a risk that she will develop drug-resistant TB, which is more difficult to treat than susceptible TB. And if she develops drug-resistant TB, there is also a risk that she will spread this infection to her family and other close contacts in the community. If she is not treated, she will continue to exhibit the symptoms of TB and will likely die from the infection. She will continue to put her family and other community members at risk of contracting TB, but not of contracting drug-resistant TB. Both of the options present significant risks to the patient and her family, so neither is ideal with respect to the norm of beneficence.

The next step in the justification process is to determine whether infringement on the norms and values is necessary, and if so, how it can be minimized. Because both of the options will most likely result in the woman’s death, they will both eventually infringe on relationality because the woman will not longer be able to support her family. In addition, neither has a favorable risk-benefit profile. While the option
of partial treatment has marginal potential benefits, it also has more-
significant risks because of the likelihood that the woman will develop
drug-resistant TB, putting her family members and other close contacts
at risk of contracting this disease. The option of not treating the woman
does not have the potential for even marginal benefits, but it also does
not have the risk of creating a drug-resistant infection. Both of these
options infringe on beneficence, and this infringement cannot be mini-
mized, given the limitations.

The final step in the justification process is to determine whether or
not the stakeholders would be comfortable sharing their decision-making
process with others. Because neither of the options that the stakeholders
have to choose from is ideal, neither will be easy to share with others,
especially the patient’s family. However, if there is truly nothing that can
be done to negotiate an effective treatment plan (such as changing the
clinic hours to accommodate patients who work), then the medical aid
worker and patient have to make a decision between two marginal op-
tions. If they have an open and honest discussion about the options, they
should be comfortable sharing with others the negotiation process, its
failure, and the rationale behind their ultimate choice.

Of the two marginal options discussed in this analysis, the option of
no treatment would be a better choice in this case versus that of partial
treatment, for several reasons. First, if the woman infects others with TB,
they will more easily be treated because their infection will not be drug
resistant. Second, when she reaches the point of being too sick to work,
she can still be treated with the DOTS regimen rather than second- or
third-line drugs, which are more expensive and less available. By holding
off on treatment, the medical aid worker will increase the likelihood that
the woman can successfully be treated in the future and that others who
contract the disease can also be successfully treated.

This case takes an extreme position in that it recommends not pro-
viding a standard treatment to a patient who has a serious illness. In
real situations like this case, medical aid workers should focus on figuri-
ning out how to get the patient appropriate treatment, only choosing not
to provide treatment if this is absolutely the sole option. There are sev-
eral strategies that aid workers can implement to provide needed medi-
cations, such as having a health care liaison bring medications to the
patient daily or having the patient come to the clinic weekly for a full week's worth of medicine. If the clinic has the supplies to provide treatment, medical aid workers should be able to work with patients to provide appropriate treatments.

CASE COMMENTARY

Socioeconomic and environmental factors can significantly impair patients’ ability to access health care and comply with treatment plans in developing countries. This case illustrates how medical aid workers may be left with unsatisfactory options in the face of patient limitations. The complicating factor in this case is that ineffective treatment not only puts the patient at risk of developing drug-resistant TB but also puts her family and other close contacts at risk. In this scenario, drug-resistant TB could spread through the community, exponentially increasing the costs of treatment and decreasing the potential for effective treatment. Partial treatment is not only ineffective at achieving the goal of treating the patient’s TB, but is also potentially harmful to the patient and to others that she comes into contact with.

If medical aid workers recognize that treatment noncompliance is a common problem in an area where they are serving, they may be able to make changes that help patients adhere to treatment plans. For example, Partners in Health employs community health workers to visit the homes of patients with AIDS and TB, bringing them their medications so as to ensure compliance (Lyon and Farmer 2005). In addition, this organization has shown that providing food aid along with medication is correlated with a high rate of patient compliance (Farmer 2005; Mukherjee et al. 2006).

When medical aid workers encounter patients who require long-term treatments, it is important that they are aware of the barriers to adherence and that they work with patients and communities to minimize these barriers. They should also recognize that partial treatment can cause significant harm when it has the potential to create drug-resistant strains of diseases that are less easily treated. The notion that any treatment is better than no treatment is not an appropriate mind-set in international medicine, especially when patients risk developing more serious problems with substandard treatments.
Limited Medical Personnel

In addition to limited medical resources and limited patient access to health care, developing countries are plagued by a shortage of trained medical personnel. Measured by the standards of developed countries, the most highly trained medical personnel in developing countries are often untrained or undertrained, having been exposed to medical work through apprenticeships rather than through formal education (Campbell 2003; Leo 2003; Nijssen-Jordan 2007). This problem is magnified because many of the best-trained health care professionals in developing countries move to developed countries to work. This leaves responsibility of providing medical care and performing surgical procedures to less trained personnel such as nurses, clinical officers, and medical assistants (Levin 2007; Nijssen-Jordan 2007; Pham and Tollefson 2007).

Ethical issues can arise as a result of limited, or inadequately trained, medical personnel. For example, the lack of medical personnel, or their lack of training, can create situations in which medical aid workers are the most qualified individuals to perform procedures, even if they would not be considered qualified to do this at home. Especially in emergent situations, medical aid workers may be the only people able to intervene. Given the unfamiliarity that medical aid workers have with some of the interventions they are asked to perform, they must determine when it is appropriate to intervene. The following case illustrates an emergent situation in which a medical aid worker is asked to provide care beyond the scope of his training.

Case 4.3: Protracted and Obstructed Labor

An emergency medicine physician from the United States, serving in Zambia, hears a large commotion outside of the clinic door. When he checks on what is happening, he sees two men running toward the clinic carrying a pole with a blanket tied to it. As they near, he sees that there is a woman lying in the blanket, moaning. The men tell the physician that the woman has been in labor for two days. She seems to have grown weaker and is in a lot of pain, so they decided to bring her in. At the physician’s home institution, all pregnant women who present to the emergency department are immediately sent to the obstetrics service, and the only training that the physician has received in labor and delivery was during medical school and one month during his residency. The last
time that he delivered a baby was fifteen years ago. There are no other physicians at the clinic, so he cannot get help or bring in someone more experienced.³

Using what little knowledge he has of emergency obstetrics, the physician examines the woman. She has a fever, indicating possible infection. Using his stethoscope, the physician is unable to detect a fetal heartbeat. He does not have a Doppler machine to better assess fetal heartbeat, but he suspects that the fetus is already dead. In order to save the woman’s life, the physician determines that the fetus must be removed immediately. Transporting the woman to the local hospital would take three days, during which she would surely die. The physician has access to a textbook of primary surgery, which explains how to perform a cruciate craniotomy, a procedure that he thinks will be necessary to allow him to remove the fetus. He believes that this procedure is the only hope that the woman has for survival, but at the same time, his lack of experience decreases the likelihood that it will be successful.

CASE ANALYSIS

In this case, the medical aid worker must quickly make a decision, so it is unlikely that he will be able to go through the entire case analysis process. However, this book provides the opportunity to fully analyze the case without the time constraints of an actual emergency situation. This section presents a thorough analysis of the case, recognizing that this would not be practical during a real emergency.

Stakeholders

The primary stakeholders in this case are the medical aid worker, the woman, and the fetus (if it is viable). Other stakeholders to consider include the woman’s family, community members who will learn about the outcome of the case, and the medical aid worker’s organization.

Medical Facts

The important medical facts in this case are that the woman is in serious danger of dying, and the only way to prevent this is by delivering the fetus. From his limited physical exam and the history provided, the medical aid worker believes that the fetus is already dead. The medical aid worker wants to intervene in an attempt to save the woman’s life. How-
ever, his lack of experience in emergency obstetric procedures limits his competence to perform the necessary intervention.

**Goals and Values**

The goal of the men in bringing the woman to the clinic is to get her medical help. They likely desire successful delivery of the fetus as well as preservation of the life of the mother. The medical aid worker, on the other hand, believes that the fetus is already dead, so his goal is to preserve the life of the mother. It is essential that the medical aid worker communicate this to the men and the patient, because if he goes forward with the procedure and delivers a dead fetus, they may believe that he caused the death during the craniotomy.

**Norms**

Beneficence is an important ethical norm in this case, because the medical aid worker has to weigh the risks and potential benefits of intervention versus nonintervention. A fetal cruciate craniotomy followed by removal of the fetus has the potential to save the woman’s life, or at least to be the first step in this process. The risks of the intervention include pain and the potential to hasten the woman’s death. Additionally, the men who brought the woman in, or other community members, may not understand that the fetus is already dead and may assume that the medical aid worker killed the fetus during the procedure. Unless the fetus is removed, the woman will not survive.

Two professional norms important in this case are a duty to rescue and a duty to provide competent care. In situations where a physician has the ability to help an individual in need of emergency medical care, he generally has a duty to intervene, unless there is someone more qualified to provide the care or there are significant risks to the physician. At the same time, physicians should generally limit their interventions to those that they have been trained to do in order to ensure that patients receive competent care.

The legal norm of interest in this case is Good Samaritan legislation, which protects health care professionals who provide emergency care from civil liability for damages for any injury they cause or enhance during the provision of that care. The idea of Good Samaritan legislation is that if a physician comes across a person in need of emergency medical
care outside of his clinic or hospital, and he provides the best care he can, given the situation, then he is legally protected from malpractice litigation. While this generally applies to physicians outside of the hospital or clinic, there is case precedent in the United States to support the application of Good Samaritan laws to emergency situations within a hospital (Furrow et al. 2001, 231–34). While Good Samaritan legislation is not likely to be part of the Zambian legal code, the medical aid worker could at least consider whether or not he is able to act in good faith to provide emergency care or if the necessary care is too far beyond his comfortable scope of practice even in an emergency.

**Limitations**

The most apparent limitation in this case is the lack of trained medical personnel available to respond to this emergency. In addition, there is no nearby hospital available for patient transfer. In the United States, the medical aid worker would be able to transfer the patient to the care of a trained obstetrician. Unfortunately, the medical aid worker does not have this luxury in Zambia, so he must decide whether or not it is appropriate for him to intervene personally. While the case does not describe the state of the clinic, there may be resource limitations that make it difficult or even impossible for the medical aid worker to successfully perform a cruciate craniotomy.

**ANALYSIS AND JUSTIFICATION OF OPTIONS**

The medical aid worker has two options, which are to intervene, attempting the cruciate craniotomy and removing the fetus, or to refrain from intervening, letting the woman die. If the medical aid worker chooses not to intervene, he could aid with transfer to the nearest hospital, hoping that the patient does not die en route. This analysis assumes that the patient’s death is imminent, so transfer is not a realistic option.

The first step in justification is to determine whether the options will be effective in achieving the goal identified by the stakeholders. As discussed above, the medical aid worker and other stakeholders may have different goals for intervention. Before deciding on an option, the medical aid worker should communicate his belief that the fetus is already dead and the best that they can hope for is to save the woman’s life, which might not even be realistic. The option of intervening has the potential
to achieve the goal of saving the woman’s life, while not intervening will not. Even though the option of intervening has the potential to achieve the goal of saving the woman’s life, the medical aid worker’s lack of experience, coupled with limited resources in the clinic, may make this potential very small.

The next steps in justification are to determine whether the benefits of the option outweigh its infringement on the identified values and norms, and if the infringement is necessary. The option of intervening has the potential benefit of saving the woman’s life. This is a significant benefit, especially because there is no alternative way to achieve it. The intervention also has the risks of causing or hastening the woman’s death. This option is consistent with the professional norm of physicians’ duty to rescue, but infringes on the professional norm of providing competent care. However, it is important to recognize that, in this case, the medical aid worker is the most competent individual to intervene and that a Good Samaritan law would theoretically protect this intervention, if this type of law exists in Zambia. The option of not intervening has the benefits of not creating a more traumatic situation for the woman and of not hastening her death, but she will certainly die if this option is chosen. This option, while not infringing on the norm of competence, might infringe on the duty to rescue. Because of the limitations in this case, both options infringe on the identified norms and values in some way.

The next step in the justification is to determine whether infringement on the identified norms and values has been minimized, and if it has not, what can be done to minimize it. If the medical aid worker decides to intervene, this choice will infringe on the professional norm of providing competent care. However, if the medical aid worker is the most competent person to intervene and there is no option to transfer the patient or to bring in a more competent provider, then infringement on this norm has been minimized. If the medical aid worker decides not to intervene, this choice will infringe on the professional norm of a duty to rescue. However, if the medical aid worker believes that he is truly unable to intervene in a way that has a meaningful chance of benefiting the patient, then he would not have a duty to rescue.

The final step in the process of justification is to determine whether the stakeholders would be comfortable sharing the decision-making process with others. In reality, the medical aid worker would not have the
time to go through the assessment questions and make a decision after thinking through the justification. However, a quick accounting of the risks and potential benefits of the intervention and the limitations of the case should help the medical aid worker determine whether or not to take action. If he makes a decision based on this brief assessment, it should be something that he is willing to share with others. Either option could be justified in this case, with the main considerations being the level of confidence that the medical aid worker has in the success of the intervention, the availability of resources for performing the intervention, and the wishes of the patient and other important stakeholders. If the medical aid worker does not believe that intervening will be successful, then the option of not intervening would be appropriate. On the other hand, if there is an acceptable chance of success, given that the alternative is death, then the option of intervening would be appropriate.

CASE COMMENTARY

This case illustrates an ethical issue that would rarely occur in the developed world. The medical aid worker is not qualified to provide the care required by a patient, and he cannot call in a more qualified provider or transfer the patient to a more appropriate facility. In developed countries, when physicians are not qualified to intervene, they generally have the option of transferring care to a more appropriate provider. In this case, consultation and transfer are not realistic options, so the medical aid worker must determine whether or not he is competent enough to perform the intervention.

One element that complicates this case is the emergent nature of the woman’s medical problem. The medical aid worker does not have the luxury of postponing the intervention until a more competent provider is available. The imminence of death changes the balance of risks and potential benefits. While patients may not be willing to risk death to have an elective procedure, they may be willing to take on more risk in a situation in which they will surely die without intervention. Patients may also be willing to accept a lower likelihood of benefit when death is imminent than they would if they had a condition that was not acutely life threatening.
Limited Time

An inherent limitation of international medicine is the limited time that medical aid workers have to spend working in developing countries. Medical aid workers are often frustrated by having to go home knowing that they have left behind numerous ailing patients. Because medical aid workers have limited time, they must determine what interventions and treatments are appropriate, given their inability to provide long-term follow-up. Often this means providing quick-fix treatments, such as antibiotics for infections, vitamins for malnutrition, and analgesics for pain. The problem with quick fixes is that medical aid workers are only able to give patients short-term relief from their acute conditions. When medications or vitamins run out after a couple of weeks or months, patients’ problems will return. Quick fixes often do not address the root causes of patients’ medical problems, and the limited time that medical aid workers have often prevents them for working toward providing more permanent solutions.

Considering that medical aid workers are generally unable to provide long-term solutions with medications and vitamins during short-term medical aid missions, these missions seem to be the ideal setting for routine elective surgeries that provide definitive cures, such as cleft-lip and palate repairs, vesico-vaginal fistulae repairs, and orthopedic surgeries. Surgeries can fix the root causes of patients’ conditions, unlike quick-fix medical treatments. While the temporary nature of international medicine lends itself to curative surgical procedures, limited time can also have negative effects on surgical patients. Because medical aid workers are only available to perform operations for a couple of days or weeks, some surgeries are done under less-than-ideal conditions. For example, surgeons may see their patients for the first time when they are brought into the operating room (Albrecht 1992). In addition, limited time may also encourage surgeons to operate on patients who are not ready to be operated on (Lehnerdt, van Delden, and Lautermann 2005). Surgeons may also choose to perform staged procedures more rapidly than they would if they were not limited by time (Sechriest and Lhowe 2008). Limited time can also negatively affect the management of patients following an operation when medical aid workers leave postoperative care in the hands of local medical personnel who may not have the training or re-
sources necessary to appropriately provide care. The following case illustrates a situation in which medical aid workers have to decide whether or not to perform elective surgeries on patients who are not good surgical candidates.

**Case 4.4: Ear Camp**

A medical aid group travels to Uganda for a two-week mission focused on performing tympanoplasties on children with chronic ear infections and deafness. Before leaving for Uganda, the group communicates with local medical personnel, asking them to identify children who they think need tympanoplasties. Because the children that they plan to treat suffer from chronic ear infections, many will have to be treated for active infections before surgery is performed.4

When the medical aid workers arrive in Uganda, their equipment and medical supplies are held up in customs for a couple of days, which delays antibiotic treatment for children with active infections. When the supplies arrive, the medical aid workers immediately start the children with infected ears on antibiotics. They also start performing procedures on children who do not have active infections. Within a week, the children with mild infections have cleared them and are ready for operative intervention. Two days before the end of the trip a couple of children, those who started with the most severe infections, still have not cleared their infections. The medical aid workers only have one more day of operating scheduled, so they must decide whether or not to perform tympanoplasties on the children who still have infections.

**CASE ANALYSIS**

In this case the medical aid group must decide whether or not to perform the tympanoplasty operations on the children with active ear infections. In their home country, the medical aid workers would just wait until the infections resolve before performing the tympanoplasties. However, because of the time constraints of the mission, the medical aid workers must either do the surgeries immediately or not do them at all.

**Stakeholders**

The primary stakeholders in this case are the medical aid workers, the children with active infections, their families, and local medical person-
nel. Other stakeholders to consider are other community members and the aid organization that the medical aid workers represent.

*Medical Facts*

The two children suffer from recurrent ear infections, and they currently have active infections. There are two treatments available for the children. The first is to continue using antibiotics to clear the infections. This will address the acute problem of the active infections but will do nothing to prevent future infections. The other treatment option is to perform the tympanoplasties even though there is still active infection. This treatment has the potential to prevent future ear infections but could be complicated by the active infections because of the risk that the infections will spread intracranially.

*Goals and Values*

The overall goal of the medical aid group in this case is to prevent future ear infections and further ear damage in the children that they treat. They are trying to achieve this by performing tympanoplasties, which are onetime curative interventions. The goal of the children and their parents is relief from chronic ear infections. The medical aid workers value doing as many tympanoplasties as they can, because the number of children treated serves as a proxy for the number of successful outcomes, since they will not be able to follow up with the children to determine if the interventions were actually successful.

*Norms*

The bioethical norms of beneficence and nonmaleficence are important in this case. Nonmaleficence requires that the medical aid workers do not harm patients without a compensating medical reason to do so. Beneficence requires that the benefits of the procedure are maximized and the harms are minimized. The potential benefit of tympanoplasty is the prevention of future ear infections. This can provide a permanent fix for the children. They would no longer suffer from the pain or further permanent damage of chronic ear infections. This benefit is especially important in an area where access to antibiotics for ear infections is limited. The risks of the procedure include failure of the graft, bleeding, infection, and hearing loss. While these are also the risks of a tympano-
plasty in an uninfected child, the risks of failure and infection are greater in patients with active infections.

The professional norm important in this case is the duty of physicians to provide the standard of care to their patients. Tympanoplasties in children with active infections would not be done in developed countries because of the increased risk of failure and intracranial infection. It is standard to wait until patients do not have active infections before performing elective surgeries on them.

One important legal question in this case is what level of responsibility the medical aid workers have for the postoperative care of patients and for complications that occur as a result of their interventions. In developed countries, surgeons are responsible for the postoperative care of their patients, as well as for the care of complications that arise following surgery. If surgeons cannot provide this care, they are responsible for transferring patients to a qualified provider. Because medical aid workers are temporary volunteers, they are often not present to treat postoperative complication or revise failed interventions.

**Limitations**

There are several limitations to consider in this case. The most apparent is the amount of time that medical aid workers have in Uganda. In addition, the medical aid workers should be aware of the resources available at the clinic for postoperative care, as well as the availability and capability of local medical personnel to provide it. From the children’s perspective, they have limited options for having their chronic ear infections treated. This may be their only opportunity for a long time, or ever, to have a tympanoplasty.

**Analysis and Justification of Options**

The two options that the medical aid workers have are to offer the tympanoplasty procedure to the children with active infections or not to offer the procedure. If they choose to offer the procedure, it is important that they seek individual informed consent from the parents or guardians of these children, making clear the additional risks of performing this procedure on children with active infections.

The first step in the justification of options is to determine if the option will be effective in achieving the desired goal. The goal identified
by the medical aid workers is to prevent future ear infections and further damage to the children's ears. The first option of offering the procedure might be effective in achieving this goal. It may, on the other hand, result in more damage to the children's ears or cause the infection to spread intracranially, which would leave the patients worse off than they were before the procedure. The option of not offering the procedure will not be effective in achieving the goal, but it does not risk leaving the children worse off than they were when the group arrived.

The second consideration for justification is whether the benefits of the option outweigh its infringement on the identified values or norms. The most significant potential benefit of doing the operations is that they might permanently resolve the children's chronic ear infections. This option would infringe on nonmaleficence if the children's active infections make successful tympanoplasty impossible. If the infections will increase the risks, but the operations will still have the potential to benefit the children, then medical aid workers would have to determine if this is acceptable as compared with the option of not doing the tympanoplasties. The option of operative intervention infringes on the professional norm of adhering to the standard of care, because elective operations are not generally done in patients with active infections. In addition, this option may infringe on the legal responsibility of physicians to transfer the care of their patients to qualified providers when they can no longer care for them, because the medical aid workers will be leaving the day after doing the operations.

The option of not doing the tympanoplasties has the benefit of ensuring that the children will not be left worse off than they were when the medical volunteers arrived. It may infringe on beneficence if the alternative option offers a more favorable risk-benefit ratio. It may also infringe on the professional norm of providing patients with the standard of care, because tympanoplasties are standard interventions for children with chronic ear infections. After the medical aid workers leave, there may not be another medical aid group following them that can do these procedures, so the children may never again have the opportunity to receive these interventions.

The next considerations for justification are whether infringement on the norms and values is necessary and, if so, how it can be minimized. Regarding the option of offering the procedure, the time constraints re-
quire that medical aid workers infringe on the standard of care. With both of the options, there may be ways to minimize infringement on the identified norms or values. If the medical aid workers decide to offer the procedure, they should consider how far they are away from the standard of care. Because they have been trying to achieve the standard of care by giving antibiotics, they may not be radically deviating from the accepted approach to tympanoplasties. They would also be able to minimize infringement on the standard of care by ensuring that the children continue antibiotic therapy after the procedure, and that local medical staff are competent and willing to provide high-quality postoperative care and follow-up. If they choose not to offer the procedure, the medical aid workers could provide extra antibiotics to the children to be used for future ear infections. They could also plan another medical mission in which they would have local medical personnel begin the antibiotic treatments before the team arrives, to increase the chances that the children with the most severe infections will clear them in time for operative intervention. This option is obviously costly and may not be realistic for the medical aid workers. If the medical aid workers cannot personally plan another trip, they could ask their organization to plan future trips with other medical aid workers who can do these procedures. If this is possible, the medical aid workers could make the two children with active ear infections a priority for the next group.

The final consideration for justification is to determine whether the stakeholders would be comfortable sharing their decision-making process with others. Whichever decision they make, the medical aid workers will have to discuss it with the parents of the children awaiting the tympanoplasties. If the aid workers decide not to offer the procedures, they should expect to be faced with disappointment and be ready to explain their reasoning. They should still provide the children with antibiotics to treat the acute infections and try to return to the area or to send another team to the area to address the continued needs of these children. If they decide to offer the procedures, they should be prepared to explain the additional risks to the parents who will ultimately make the decision about whether their children will undergo the procedure. In this case, determining which option to choose is largely dependent on the potential risks and benefits of the procedure. While medical aid workers, and medical personnel in general, have a desire to intervene to help patients,
it is important that they realize that interventions may do more harm than good, and they must be willing to refrain from potentially harmful interventions.

In this case, either of the options may be justified, depending on which additional contextual features are present. If the risks of the procedures are not significantly increased, there is adequate postoperative care available, and there is no other aid group scheduled to visit the area to perform more tympanoplasties, then the medical aid workers would be justified in offering the procedure. If, on the other hand, the risks of the procedures are significantly increased, there is limited postoperative care available, and there is another group scheduled to come to the area to perform tympanoplasties, then the medical aid workers should not offer the procedure, but rather make these children a priority for the next medical aid group.

**CASE COMMENTARY**

Time is one of the most apparent limiting factors in international medicine. Medical aid workers often have to leave the area where they are serving without meeting even a small fraction of the medical needs of patients. This case illustrates one of the most challenging decisions that medical aid workers encounter: whether it is appropriate to do a procedure that has the potential to provide permanent benefits but also carries significant risks. The desire to intervene is especially strong in medical aid work because this may be the only opportunity for patients to have a procedure done. Intervention is not, however, the only option in situations like the one described in the case. The intervention that is being offered is an elective procedure, meaning that it does not need to be done immediately. Risky interventions may significantly harm patients who have to live with these consequences long after medical aid workers have returned home. It is essential that medical aid workers are aware that their interventions may cause harm and that there may be situations in which it is better for patients that medical aid workers refrain from providing these procedures.

**Multiple Limitations**

Each case in this chapter focuses on one limitation that medical aid workers might encounter while serving in a developing country. In reality,
however, medical aid workers are more likely to encounter multiple limitations in trying to provide care to their patients. They often find that they are working with limited resources and facilities, surrounded by local medical personnel who have limited training, and treating patients who are victims of severe poverty. The following case illustrates the myriad limitations that medical aid workers must consider when deciding whether or not to provide medical interventions in developing countries.

**Case 4.5: Postoperative Care for Cleft Lip and Palate Surgery**

A medical aid group travels to Guatemala for a ten-day cleft lip and palate surgical mission. The team coordinates its trip with the medical personnel at the hospital where the operations will be done. The local doctors identify people with cleft lips and palates who would be good surgical candidates before the team arrives so that the team can quickly evaluate these individuals and get started with surgeries immediately. This is essential for the mission to reach its goal of performing at least fifty operations.5

On the final day of the mission, the team identifies one particularly challenging case of a twenty-six-year-old man with a cleft lip and palate. He was cast out of his community because of his appearance and forced to beg on the streets for survival. Overcome by sympathy for this man’s predicament, and knowing that if they do not do the procedure the man will be left waiting for the next team to show up (which could be months, years, or not at all), the team members decide to go ahead and do the operation.

The procedure itself goes well, and the man is sent to the ward for recovery. The surgical team instructs the local medical personnel about how to care for the man postoperatively, changing bandages frequently and giving antibiotics to help avoid infections. The medical team, having performed seventy surgeries, exceeding the mission’s goal, gets on the plane the next day with a sense of pride and accomplishment. Meanwhile, the doctors at the clinic realize that they do not have enough bandages to change the wound dressings as often as suggested by the medical aid workers. They also have a limited supply of antibiotics, which has been overwhelmed by the needs of all the postoperative patients.

Because of the limited antibiotics, the local doctors decide to give all of the postoperative patients half of the course of antibiotics recommended
by the medical aid workers. Over the next couple of days, the twenty-six-year-old man's wound becomes severely infected and dehisces. The local doctors do not know how to manage a ruptured wound and decide that they cannot do anything else for the patient. In addition, there are many sick patients in need of beds in the ward. So, the local doctors discharge the patient from the clinic without antibiotics or dressing supplies.

CASE ANALYSIS

Stakeholders
The main stakeholders in this case are the medical aid team, the patient, and the local medical personnel. While the team members decided to do the operation in this case, the ethical question is whether they should have done the surgery. Therefore, this case analysis focuses on the point at which the medical aid workers are deciding about whether or not to intervene.

Medical Facts
The patient has a cleft lip and palate that are not causing medical problems but have made him an outcast from his community. The medical aid workers believe that he can be treated successfully with an operative intervention. The risks of the operation include poor wound healing, wound rupture, and infection. Because he is older than a typical patient who has cleft lip and palate repair, the operation will be more technically difficult. However, if the operation is successful, it should correct his appearance and potentially allow him to return to his community.

Goals and Values
The goal for the intervention is to correct the patient’s cleft lip and palate. The medical aid workers value helping patients in need who may not otherwise get treatment. The patient values being part of his community and being able to work.

Norms
The bioethical norms important in this case are beneficence and relationality. The stakeholders should weigh the potential benefits and risks of the procedure in order to determine if it should be done. The patient's cleft lip and palate are not causing any medical problems at this point,
so the primary potential medical benefit is cosmetic improvement. The patient believes that cosmetic improvement will allow him to rejoin his community and get a job. The risks of the operation are bleeding and infection. In addition, there is a chance that the operation will not be successful in improving the patient’s appearance. The norm of relationality states that relationships are important and should be respected. The patient’s appearance has made him an outcast. The patient is unable to have meaningful relationships with his family and community because of his appearance. He believes that if his cleft lip and palate are repaired, he will be able to form the relationships that he has been missing and become a contributing member in his community.

The professional norm important in this case is ensuring that patients who undergo operative intervention get appropriate postoperative care. In developed countries, surgeons manage the care of their patients postoperatively. They follow patients while they are in the hospital and then see them in clinic after discharge. Because medical aid missions are so short, surgeons cannot personally oversee postoperative patient care, so they have to ensure that local medical personnel can competently provide it.

The legal norm important in this case is that of avoiding patient abandonment. Legally, patient abandonment occurs when a physician, without giving timely notice, ceases to provide care for a patient who is still in need of medical attention (Jonsen, Siegler, and Winslade 2010, 99–100). The time-limited nature of international medicine makes patient abandonment a norm for medical aid workers. Medical aid workers often have to leave before all patients in need have been treated or all patients who have been treated have recovered. Because medical aid workers cannot personally oversee patient care forever, it is important that they are able to ensure that patients are able to follow through with treatment plans and that appropriate postoperative care is provided. While there is no legal responsibility for physicians to ensure transfer of care, this should be considered a professional norm in international medicine because of the temporary nature of medical aid in developing countries.

**Limitations**

This case illustrates a scenario in which there are numerous limitations to consider in the decision-making process. First, the medical aid
workers have limited time. They will be leaving Guatemala the follow-
ing day. Second, the local medical personnel are not trained to manage
postoperative complications such as wound dehiscence. In addition, the
clinic has limited medical resources, specifically antibiotics and ban-
dages, for the provision of adequate postoperative care.

The patient has limited options for intervention. He is poor and an
outcast from his community, so he cannot afford to pay for an operation.
His only option for cleft lip and palate repair is to rely on a medical aid
group that will do the surgery for free. Because the medical aid workers
did not ask local medical personnel about their ability to manage post-
operative complications or the resources available for patient care, they
did not recognize all of these important limitations.

ANALYSIS AND JUSTIFICATION OF OPTIONS

There are two options for the medical aid workers at the point at
which this case is being analyzed. They can either perform the cleft lip
and palate surgery or not. While the medical aid workers decided to do
the surgery in the case presentation, this analysis discusses the justifica-
tion of both options.

The first step in justifying the options is to determine whether the
option will be effective in achieving the identified goal. In this case, the
goal is to correct the patient’s cleft lip and palate. Operative intervention
has the potential to achieve this goal, although the likelihood of effec-
tiveness is not clear, and there are several risks associated with the proce-
dure. If the team members decide not to perform the procedure, they will
not achieve the goal of correcting the man’s cleft lip and palate. While
only the option of operative intervention has the potential to achieve
the goal, it is important for the medical aid workers to recognize that the
man’s medical condition is not acutely life threatening, so there is no im-
mediate medical need for an operation.

The next step in justification of the options is to determine if the bene-
fits of the option outweigh its infringement on the identified values and
norms. The greatest potential benefit of operative intervention is that it
may result in the correction of the man’s cleft lip and palate. However, it
may infringe on beneficence if the risks of the procedure outweigh the
potential benefits. It may also infringe on the professional norm of en-
suring adequate postoperative care. In addition, it could infringe on the
legal norms of not abandoning patients. While medical aid workers do not generally risk legal repercussions for abandoning patients in developing countries, it is important for them to consider whether they are violating this norm. The time-limited nature of medical aid work requires that medical aid workers leave before all patients have been treated or have recovered, so there is an expectation of patient abandonment in international medicine. Nevertheless, medical aid workers still have a professional obligation to transfer patients still in need of care to appropriate medical personnel.

The option of not performing the operation has the benefit of not leaving the man worse off medically than he was before the medical aid workers arrived, although it is unclear whether the man thinks that a failed procedure is better than no procedure. This option would infringe on beneficence if the risk-benefit profile of the alternative is more favorable. This option infringes on relationality because it does not give the patient an opportunity to return to his community.

The next steps in the justification of the options are to determine whether infringement on the identified values and norms is necessary, and if so, how it can be minimized. The option of operative intervention will infringe on beneficence to some extent because the medical aid workers cannot personally oversee the patient’s postoperative care, which would be the best way to minimize the risks of postoperative complications. Because the medical aid workers are on a two-week mission, they have already set the expectation that they will be leaving before their surgical patients have fully recovered. Therefore, they will not technically infringe on the legal norm of patient abandonment. However, if the aid workers do the operation on the last day of the mission without having planned for appropriate postoperative care, they will infringe on the professional norm of ensuring adequate transfer of patients. If they had planned ahead by preparing local medical personnel to provide appropriate postoperative care and ensuring that they had the resources to do so, the medical aid workers would not have to infringe on this norm.

There are several strategies to minimize the infringement created by the option of operative intervention in cases like this. Because some of these strategies require planning ahead, they are not applicable in this particular case, but they would be applicable to help minimize the ethical issues encountered in similar cases or to prevent these issues from
occurring. First, the medical aid workers could make sure that part of
their mission involves training local medical personnel in how to provide
competent postoperative care to patients after cleft lip and palate surger-
ies. Second, they could take training a step further and teach local medi-
cal personnel how to do cleft lip and palate procedures so that the com-
munity is not reliant upon medical aid groups. Third, they could make
sure that they bring enough wound care supplies and antibiotics for their
postoperative patients. Conversely, they could limit the number of proce-
dures that they do to match the availability of supplies. Fourth, medical
aid workers could make themselves available by phone or e-mail to local
medical personnel after they return home, in order to help local medi-
cal personnel if complications occur. Finally, medical aid workers could
plan longer trips that build in time to provide postoperative care, or send
another medical aid team to provide this care if the local medical person-
nel are unable to do so.

The option of not performing the operation infringes on the norm
of relationality because it precludes the possibility of the patient being
able to return to his community. It is important to keep in mind that it
is not clear whether or not the man will actually be accepted back into
his community even if his cleft lip and palate are repaired. As discussed
above, the need for operative intervention is not acute. So the medical
aid workers could minimize their infringement on this norm by plan-
ning a return trip in which they will do the procedure. Alternatively, if
they know that other groups are planning to visit the area to do cleft lip
and palate procedures, then they could make this man a priority for the
next medical aid group. While it is not an option in this case, they could
also make the purpose of their mission to train local medical personnel
in cleft lip and palate surgeries so that the community is not dependent
upon medical aid workers for these procedures. This type of option may
be difficult to accomplish in some settings, particularly when local medi-
cal personnel have limited education and experience in surgical proce-
dures.

The final step in justification of the options is to determine whether
the stakeholders would be comfortable sharing their decision-making
process with others. By involving local medical personnel and being real-
istic about the risks, potential benefits, and limitations of performing
the procedure, the medical aid workers should be comfortable in sharing
their decision-making process with others. In this particular case, because the medical aid workers cannot ensure that the patient will receive adequate postoperative care because of limited supplies and limited medical personnel training in postoperative management, there is an increased risk of morbidity and failure of the surgery. In addition, the surgery is not emergent, so medical aid workers should not feel obligated to do it immediately.

CASE COMMENTARY

Because of the temporary nature of their work, medical aid workers often leave before they are able to see the final results of their interventions. Although they do not see these results, it is important that they are aware of the possibility that complications may occur as a result of their interventions, and that they take steps to avoid these complications. If medical aid workers’ interventions do result in complications after they have left, this could significantly compromise future medical aid interventions in the community. Patients may distrust future medical aid groups. Additionally, local medical providers may be unwilling to work with these aid groups because they were left to deal with the unfortunate consequences of previous medical aid interventions.

Medical aid work has the potential to significantly change the lives of patients in developing countries. It is important that medical aid workers ensure that this change is positive and that future interventions are welcomed. While it is understandable that medical aid workers are motivated to intervene whenever possible, it is important that they consider the risks, benefits, and limitations of their interventions, especially when these interventions are not immediately medically necessary. There are so many limitations encountered in international medicine, ranging from time to resources to the availability of trained medical personnel. In each case, it is essential that medical aid workers are aware of all the limitations that could affect patient care so that they are able to intervene appropriately. While it is a hard concept for medical aid workers in international medicine to come to terms with, not intervening is sometimes a better option than intervening.