ABSTRACT
In recent years, the growth of interest in global health among medical students and residents has led to an abundance of short-term training opportunities in low-resource environments. Given the disparities in resources, needs and expectations between visitors and their hosts, these experiences can raise complex ethical concerns. Recent calls for best practices and ethical guidelines indicate a need for the development of ethical awareness among medical trainees, their sponsoring and host institutions, and supervising faculty. As a teaching tool to promote this awareness, we developed a scenario that captures many common ethical issues from four different perspectives. Each perspective is presented in case format followed by questions. Taken together, the four cases may be used to identify many of the elements of a well-designed global health training experience.

INTRODUCTION
In recent decades, international commitment to global health has received unprecedented international attention, marked by the Millennium Development Goals, vast increases in public and private funding for global health initiatives, and diverse partnership efforts to strengthen health care capacities worldwide. Concurrently, increasing numbers of medical students and residents have sought training in global health, usually through short-term educational experiences in low-resource environments. In 2011, 65% of entering medical students anticipated participating in global health education or service activities during medical school.1 Residency programs in Pediatrics, Family Medicine, and Emergency Medicine cite opportunities for global health electives as significant factors in their rankings.2

Short-term global health experiences are often life-changing events for professionals-in-training, providing invaluable experience in primary care; raising awareness of health disparities, the importance of cultural competence, and aptitude in public health, and sometimes motivating career choices.3 But while the benefits of these experiences have long been recognized, less attention has been given to the impact of visiting medical trainees on host personnel, institutions, and communities. Given the disparities in resources, skills, and infrastructure of sending and host institutions, conflicts between their respective needs can generate novel ethical challenges. Sending institutions must consider student safety, that curriculum standards are upheld, and that trainees are supervised appropriately. They may rely on host personnel for much of this oversight, unaware of the logistical

challenges these expectations may impose. Host personnel and institutions must balance the needs of their own faculty, staff, patients, and communities with the needs of visiting trainees. In low-resource environments, this may include sacrificing their own short-term interests in hopes of benefiting from their visitors or institutional partnerships in the future. Host personnel may also be unaware of the limited skills of visiting trainees and may encourage them to participate in patient care in ways that exceed their training and qualifications. Similarly, visiting trainees may not always be able to interpret what is going on around them or sufficiently mindful of the limitations of their expertise, potentially disrupting clinical practices or risking harm to patients. In short, given the different cultures, resources, and needs of visitors and their hosts, we can assume that short-term training experiences vary widely in the degree to which both learning and service are meaningfully achieved, and that these experiences raise ethical conflicts for which institutions, faculty and students are often unprepared.

A growing awareness of the logistical and ethical challenges common to these experiences has led to a small literature and recently, a set of best practice guidelines. These guidelines were developed by an international group of medical educators with extensive experience in global health and ethics, known as the Working Group on Ethics Guidelines for Global Health Training (WEIGHT). Their goal was to identify the optimal ethical expectations and best practices for mutually beneficial global health educational experiences, given the needs of sending and host institutions and participating trainees.

The WEIGHT Guidelines reflect the diverse institutional, logistical, and ethical needs of stakeholders, which include administrators, program directors and faculty at sending and host institutions; trainees from both sending and host institutions, and medical staff, patients, and others in host communities. The Guidelines pertain to activities of any duration pertaining to education, clinical service, public health, or research. Expectations are delineated for sending and host institutions, trainees, and program sponsors, focusing on the need for negotiated partnerships that provide clear expectations and mutual benefit. Given the social and economic disparities between visitors and hosts and the costs and burdens that visitors may impose, eliciting the concerns of host institutions and communities is a priority.

While the WEIGHT guidelines are an important, ground-breaking step toward ensuring that global health training experiences are responsive to the needs of host institutions, they do not substitute for the ethical and cultural awareness visitors must possess to navigate unfamiliar cultures and health systems safely and productively. For this, predeparture training is essential. This training should include examination of the assumptions, expectations, and cultural differences that can result in strained relationships and unsatisfactory partnerships.

In order to raise awareness of these attitudes and assumptions, we developed a fictitious scenario for small group case analysis that captures many of the most common ethical challenges that students and faculty experience in short-term training experiences. We presented this scenario at the GHEC/CUGH Conference in Montreal in 2011 to medical faculty, residents and students from diverse countries and backgrounds. Participants found the discussions effective and encouraged us to publish our scenario. We do so here.

Our scenario presents a typical global health partnership through the perspectives of four individuals: an American medical student visiting a hospital in Kenya, her faculty advisor from her home institution, the Medical Director of the Kenyan hospital, and a Kenyan nurse who serves as a translator for the student. Each case is accompanied by discussion questions.

Rose

Rose is a first-year medical student at Midatlantic Medical School in the USA. She hopes to spend a month during the summer in Africa as she has long had an interest in global health. She has never been to Africa, but Midatlantic has a new relationship with Consuleta Hospital in Kenya and she would like to go there. Midatlantic will provide funding if she will do some research while she is there, which encourages her further. She had hoped to work in the hospital where she could see the diseases that she never sees in the US and help patients, but because she needs funding she is willing to do some kind of study.


Rose is referred to a Midatlantic faculty member, Dr. Steve Landers, who is responsible for the new partnership. Dr. Landers suggests she design a project involving local village health workers. Because Rose is interested in pediatrics, she proposes to investigate the village health workers’ care of pediatric patients and do a needs assessment of their deficiencies in this area. With Dr. Landers’ support, Rose gets a partial scholarship and raises an additional $1500 through family and friends to finance her trip.

Upon arriving in Kenya, Rose is immediately presented with several challenges. She learns that the village health workers speak two quite different languages and are scattered throughout a large geographic area only accessible by car. Moreover, most of them are subsistence farmers, busy planting this season’s crops and unavailable for interviews this time of year. Unsure of how to proceed with her research, Rose spends her first week accompanying Dr. Landers in the hospital. She is very glad he is there, as even when they speak English she rarely understands what the local doctors and their patients are saying. Often she cannot hear them at all as they speak very quietly, she assumes in order to protect patient privacy in the large open wards. When there is time, Rose asks Dr. Landers what is going on, but sometimes he doesn’t know either.

During this week, Rose meets a nurse at the hospital from one of the outlying villages who speaks English and is willing to translate for her. The nurse helps Rose find a driver and borrows the ambulance van from the hospital for a day. The road to their chosen village is impassable due to flooding, so they go to a nearby village where the same language is spoken. There Rose meets two village health workers who seem rather shy. Rose tries to ask them questions about their pediatric patients but they prefer to talk about the weather, offer Rose tea, and make lunch for their extended family. She understands that they may be more willing to talk after lunch, but then they lead Rose to another house where she meets someone she is told is a ‘village elder.’ Rose isn’t sure what to do but introduces herself and her project and the elder seems satisfied.

After her visit with the elder, Rose meets again with the two village health workers. They are still friendly and willing to talk to her, but it is hard for Rose to get clear answers to her questions. The village health workers say they don’t care for children, but visit families. Sometimes they only visit elder villagers. They sometimes talk to parents and caregivers about the children in the family, but they do not read or write and use water bottles to measure the height of children. Unsure of what she can do with this information, Rose decides to focus instead on their training. She asks them what kind of training they would like. The village health workers seem confused by this question, saying they would like to become a ‘cluster’ that is recognized by microfinance bank in the nearby town. When Rose asks what a cluster is, they say that another group of women is a cluster which allows them to buy a cow and borrow money to start a small store. By now Rose is overwhelmed. She knows nothing about microfinance and only has three weeks left to do her research project. She begins to wonder if she should have just donated her $1500 to the community health workers rather than coming to Kenya herself. Rose heads back to the hospital to offer to help care for patients until she can figure out what to do next.

**Discussion questions**

1. What did Rose expect to gain from her experience in Kenya? What did she not know about her host community when she planned her research project? What knowledge and preparation would have helped her to be more successful?

2. What can Rose learn from shadowing physicians in the hospital? How can she ‘help care for patients’? How could this experience could have been structured such that Rose’s time in the hospital would have been more beneficial for her and her hosts?

3. Like the villagers and support persons around Rose, many cultures in the world prioritize hospitality and formal courtesy. How is this different from western culture, and how might westerners interpret this? How can basic cultural differences like this complicate professional engagement with communities across cultures?

4. It is often very costly for western students and faculty to travel abroad. Rose wonders if she should have donated the money she spent on the trip to the community itself. What are some arguments for and against financial donation to overseas institutions or communities versus traveling abroad to try to assist or contribute directly?

**Dr. Steve Landers**

Dr. Steve Landers is a mid-career faculty member at Midatlantic School of Medicine. A pediatrician, his research focuses on genetics. The Dean at Midatlantic School of Medicine has recently decided to strengthen the school’s involvement in global health in order to attract top medical students, residents, and faculty. The Dean has a distant contact at Consuleta Hospital in a remote part of Kenya. Knowing the hospital currently has a nursing school and plans to start a medical school, he asks Dr. Landers if he would be interested in developing a partnership with the hospital. The Dean has little money to invest in this partnership, but tells Dr. Landers that Midatlantic can probably cover his travel expenses.
and in the future give faculty time off from their clinical work for two-three weeks/year. Dr. Landers eagerly accepts the opportunity to go to Kenya. A first-year medical student, Rose, has already asked him to be her mentor in her research there and he is confident he can set up a successful research program in genetics. He agrees to support Rose’s research and travels to Kenya with her.

When Dr. Landers arrives at Consuleta Hospital he is greeted by Dr. Ghani, the medical director, who says he must finish up a surgery and asks Dr. Landers to wait for him in his office. Dr. Landers waits for over a half-hour, but then sets out to explore the hospital on his own. He puts on a white coat and wanders around the hospital, browsing charts in the packed pediatric ward, eager to get involved in patient care. He notices that the mothers sitting next to their child’s beds are watching him closely. After another hour passes Dr. Ghani comes into the pediatric ward and escorts Dr. Landers back to his office. Here Dr. Ghani recounts a history of the hospital and the diverse health needs of the area population. After listening for some time, Dr. Landers tries to ask about research. Dr. Ghani assures him they have many investigations going on, but returns to discussing the new medical school he would like to open. He asks if Midatlantic can provide any money for a new building for the school, computers, and faculty to teach. He also hopes to send medical graduates to rotate in Midatlantic’s hospital for specialty training, given that Consuleta Hospital accepted some American residents over the last year. Dr. Landers knows he will disappoint Dr. Ghani. He tells Dr. Ghani that even though the American residents could provide patient care in Kenya, Kenyan medical graduates cannot work in Midatlantic’s hospital for licensing reasons. The most they could do would be to observe without touching patients. Nor can the faculty at Midatlantic come to teach for more than a few weeks each year. Moreover, Midatlantic does not have any money for computers or a building. But Dr. Landers does offer that there may be funding for research, and asks again about the studies that are being conducted at the Hospital. Dr. Ghani shows him a closet full of notebooks containing the names, villages, dates of visits, and diagnoses for every patient seen at the hospital for many years. There are also several books of surgical case logs. None of this is useful for what Dr. Landers has in mind, but he asks Dr. Ghani if they can meet again the next day to discuss his ideas for other kinds of research.

Discussion questions

1. What are some of the assumptions that Dr. Landers and his Dean are making when they decide to invest in this trip to Kenya? Where do these assumptions come from? What might Dr. Ghani assume about Midatlantic medical school and Dr. Landers’ intentions?

2. How do training expectations, clinical demands, and legal constraints at medical schools and hospitals in high-resource countries create ethical challenges for global health institutional partnerships?

3. Whose needs seem to be driving this partnership? How can the economic disparities between Midatlantic Medical School and Consuleta Hospital create difficulties in developing a mutually beneficial partnership? How might western institutions ‘level the playing field’ to even out these disparities?

4. How might affluent, foreign physicians be perceived by patients in low-resource environments? How might the presence of foreign physicians impact how local physicians are perceived by their patients and community? What, if anything, may be accurate about these perceptions?

Dr. Ghani

Dr. Ghani is an orthopedic surgeon and the Medical Director of Consuleta Hospital in Nkori, Kenya, where he has worked for over 10 years. Two years ago, he met the Dean of Midatlantic Medical School at a conference. Several months later the Dean wrote Dr. Ghani inquiring about the possibility of sending medical students and residents from Midatlantic to work and conduct research at Consuleta Hospital. Dr. Ghani was excited about the potential partnership. He had always dreamed of opening a medical school as there were none in his region of Kenya. A partnership with Midatlantic might be a source of financial, technological, and clinical support for the school. This would not be his first experience with US institutions. Because Consuleta Hospital was founded by a Christian ministry there had been several productive visits from medical missionaries, and last year the hospital had hosted surgery residents from a Californian medical school. So when the Dean at Midatlantic informed Dr. Ghani that a member of his faculty, Dr. Steve Landers, would be coming to the hospital for a visit and to explore possibilities for a new partnership, Dr. Ghani was optimistic.

Unfortunately, the night before Dr. Landers arrived, there had been a large traffic accident and Dr. Ghani had to operate on five patients through the night. When Dr. Landers appeared, Dr. Ghani had to excuse himself to return to the OR to help a less experienced physician with the last surgery. When he returned to his office, he found Dr. Landers gone. Dr. Ghani was concerned, but eventually found him in the pediatric ward, looking through patient charts. There, the nurses were confused because they did not know who Dr. Landers was. Postponing several cases, Dr. Ghani decided he should quickly introduce Dr. Landers around the hospital. Returning to his office, Dr. Ghani told Dr. Landers what he thought was most important about the hospital...
and patients’ needs. He then stated his hopes that Midatlantic would be open to bilateral exchange of residents so Kenyan medical graduates could get high-quality specialty training in the US. He was disappointed when Dr. Landers told him that for legal reasons, unless they passed the US licensing exams, Kenyan graduates could not work in the US. Dr. Ghani then asked if Midatlantic could at least send faculty to teach for several months at a time. Dr. Landers told him that faculty could only come for a few weeks, if that. The best Midatlantic could do, it seemed, was to try to obtain research funding, some of which could come to the hospital if the hospital would host the research. It seemed Dr. Landers wanted to conduct genetic research at the hospital. Dr. Ghani had little interest in research, particularly in genetic research that had no clinical relevance for his patients, but he found himself agreeing to help Dr. Landers with his project in hopes that it would eventually lead to support for his new medical school.

Discussion questions

1. What does Dr. Ghani have to consider when agreeing to work with Dr. Landers and Midatlantic? What might Consuleta Hospital stand to gain or lose from this partnership?
2. How might medical schools in high-resource countries benefit from developing partnerships with medical institutions in low-income countries? How would these benefits differ if the focus is on medical training, as opposed to clinical service or research?
3. What might Consuleta Hospital stand to gain or lose from hosting research initiated by Midatlantic Medical School? What would Consuleta Hospital be expected to contribute? What would Midatlantic contribute? Who would benefit from the research, and how? Who might be burdened, and how?
4. What might an effective long-term partnership between Midatlantic and Consuleta Hospital look like? What might be the most productive goals of such a partnership for both institutions? What kinds of understandings, agreements, and logistical structures would be necessary on both sides for such a partnership to be feasible? What are some challenges to developing and sustaining such a partnership?

Nilly

Nilly is a nursing student at Consuleta Hospital in Nkoli, Kenya. One day, one of her instructors told her she would need to leave her post in the consultation area in order to translate for a visiting American medical student. It seemed the student wanted to do some kind of research project out of town. Nilly was instructed to accompany the visiting American, Rose, to her home village to interview some village health workers there. Nilly had not been back to her village for several months and was excited at the opportunity to see her family. She also hoped that by doing this work she might be paid an extra stipend or that the American could be a helpful contact in the future. At the same time, Nilly saw the lines of mothers, babies, and elders waiting to be seen and felt badly about leaving all the work to one other nurse.

Nilly’s first impression of Rose was that she was very nice but very young and anxious. She was clearly eager to get started on her project and did not want to take time for tea with the driver, which Nilly felt was common courtesy before embarking on a journey. When they got in the car, Rose also seemed stressed. She was upset that the seatbelts were not working and seemed uneasy when the driver picked up and dropped off other passengers along the way. Sadly, the road to Nilly’s village was blocked by flooding so Nilly would not get to see her mother and sisters, but when she saw the disappointment on Rose’s face, she suggested they visit a neighboring village that used the same language. Within an hour, they arrived.

Rose’s research project included interviewing village health workers about their care of pediatric patients and the training they wished for. Nilly thought Rose asked good questions, but she wanted to know about children, not knowing that the village health workers were usually only concerned with the health of adults. Furthermore, the village health workers measured children’s heights in lengths of water bottles, which seemed to bother Rose. Worst of all, it was planting time and the village health workers wanted to be working their fields, not answering strange questions from a young foreigner. But some did stay. Nilly tried her best to translate, but Rose seemed frustrated that her questions were not easily answered. In addition, it seemed that Rose and the village health workers had different ideas about what counted as training. When Rose asked them what training they wanted, they said they wanted to become a cluster that could be recognized by a microfinance bank. The village health workers thought this was why Rose had come, and was why they gave up their time in the fields to meet with her. This misunderstanding was awkward for Nilly because it was clear to her that Rose could not provide this kind of assistance.

It was a long day and Nilly and Rose returned to town after dinner. Nilly did not get to eat because the student cafeteria was closed. Nor did she get the stipend that she hoped for, although Rose did ask her to help translate again the next day. This would again pull Nilly away from her clinical duties and study time, but she still hoped that Rose might give her something to compensate for her time.
Discussion questions

1. What kinds of choices does Nilly have in this scenario? What do her supervisor, her family, Rose, and the village health workers respectively expect from her? How might the choices she made impact her relationships with these people? What were her alternatives?

2. What did Nilly need and want from Rose? Did she get it? If not, is Nilly better or worse off at the end of the day? Did Rose appear to have any idea of what Nilly’s concerns were, or what it cost her to spend the day away from the hospital?

3. How did Rose’s presence impact the clinical and support staff at Consuleta Hospital? How might western medical trainees minimize the disruption they impose on the under-resourced institutions and communities they visit?

4. How might visitors or sending institutions ensure that host institutions, colleagues, and support staff are fairly compensated for their time and work? How ought compensation to be incorporated into global health educational experiences and/or institutional partnerships?

Through the perspectives of the four protagonists, these cases illustrate some of the differences in needs, values, and expectations commonly found between visiting medical personnel from high-resource countries and their hosts in low-resource environments. These cases are designed to draw attention to the unrecognized assumptions that can be held by both visitors and their hosts. These assumptions include expectations of goals to be accomplished, how time and resources should be used, needs for accountability, and styles of interpersonal communication. Most importantly, first-time visitors may not be able to anticipate what is and is not possible in their host institution or community or how their presence can impact established routines. They may assume that they will be able to learn and contribute productively regardless of their skill level or language difficulties. They are unlikely to reflect in advance on how they may be perceived or that their needs for support may burden their hosts. Even experienced clinicians and researchers may not grasp that what seem to them legitimate clinical or research questions may be viewed by their hosts as low priorities. Moreover, for visitors, the experience is usually optional; if they fail to accomplish their goals, only they are the loser. But for their hosts, visitors represent possibilities that are potentially transformative. Given the high stakes, host personnel may be willing to agree to costly sacrifices in hope of future benefit. The economic disparities between external and host institutions thus eliminates the possibility of parity in negotiations, creating opportunities for further disruption.

The conflicting needs and interests represented in these cases are but a small subset of the ethical concerns found in global health training activities and partnerships. Visiting clinicians may experience conflicts involving professionalism expectations, resource allocation and risk management practices. Post-graduate training partnerships must resolve matters of reciprocity, supervision, and assessment. Ethical issues in research extend beyond appropriate study design and participant protection to the demands of external researchers on host personnel, dissemination of results, and benefit sharing. Long-term capacity-building initiatives must be responsive to fluctuating national politics and health policies, funding priorities, and international relations.

We are only beginning to grasp the ethical complexities involved in academic global health partnerships. As global health receives increasing public and private support, the need for a workforce that is familiar with local cultures and sensitive to diverse ethical challenges cannot be overstated. Experience is always the best teacher, but as depicted in this scenario, it may come at a price. Given the enormity of the need, the lack of a level playing field in negotiations, and the often complex incentives underlying visitors’ interest in global health, the challenges to mutually beneficial, sustainable partnerships are immense. But despite the many missteps that are being made today, the commitment to improving global health and health care shows no signs of abating. And a generation hence, the aggregate experience of the thousands of medical trainees who have taken part in these opportunities may be the catalyst necessary for the sustainable improvements that are so desperately needed.

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Biography

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