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Ethical Conduct of Humanitarian Medical Missions

I. Informed Consent

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Altruistic and socially conscious physicians are dedicating a portion of their professional lives to humanitarian relief of disadvantaged populations in increasing numbers. These efforts are primarily carried out through short-term medical missions (STMMs) throughout the international community.[1] There is a great deal of professional and personal reward to physicians who participate in medical missions, and their experiences as related to colleagues may serve to encourage others to participate as well. Indeed, there is an increasing interest in, and enthusiasm for, medical students to participate in international volunteer electives during medical school, particularly in developing countries. Their positive experiences often shape their future commitment to volunteerism as a physician.[2]

However altruistic and compassionate are the physicians' intentions, there are ethical rules of conduct that should direct their actions in these humanitarian efforts, and failure to comply with them can violate international standards of care. While the rules of conduct have their basis in the fundamental principles of medical ethics, owing to the particular circumstances under which STMMs are carried out, their ethical conduct requires articulation and review.

INTERNATIONAL ETHICAL RULES OF CONDUCT

The foundation for the ethical care of international patients is in the World Medical Association's (WMA) *Declaration of Helsinki*. Developed after the Nuremberg Trials for the specific purpose of providing ethical standards for conduct of research, it also addresses the general ethical responsibilities of physicians toward their patients:

It is the duty of the physician to promote and safeguard the health of patients, including those who are involved in research. The physician's knowledge and conscience are dedicated to the fulfillment of this duty.[3]

The implication of this statement, and of this Declaration, is that duty to patients applies not just to those in one's place of practice, but to all patients the physician is treating, no matter the location or setting.

As further indication that the international medical community believes global standards should be applied to the care of individuals, no matter where on this planet they live, the United Nations Educational, Scientific, and Cultural Organization (UNESCO) ratified a Universal Declaration on Bioethics and Human Rights, UNESCO stressing the need to reinforce international cooperation in the field of bioethics, taking into account, in particular, the special needs of developing countries, indigenous communities, and vulnerable populations.[4]

The importance of these documents' standards and resolutions is that the physician is bound by common bioethical duties when caring for patients during international humanitarian medical missions. The expectation for observing the fundamental bioethical principles of autonomy, beneficence, nonmaleficence, and justice remains inexplicably joined to expressions of the professional

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virtues of integrity, truthfulness, compassion, and trust. However, caring for patients in the unique settings of international STMMs will often pose exceptional challenges to adhere to these expectations. Understanding these challenges, based on the special socioeconomic, cultural, language, and medical milieu of a particular country, will better prepare the altruistic physician for the ethical conduct of an STMM. The issue of informed consent in humanitarian efforts is one such consideration.

INFORMED CONSENT

In the United States, physicians practice under federal, state, and professional regulations and guidelines regarding informed consent. During STMMs, there are a number of confounding factors that often make informed consent less than informed and the consent process out of accord with the international codes. While patients being treated in another country should be afforded the same standard of care as in the volunteer's home country, a number of barriers can potentially exist for obtaining proper consent:

- "Essentially, consent reflects the creation of a partnership between the healthcare professional and the person who needs care. The contractual process can be very different depending on the norms of the culture."[5(p4)] Some subpopulations are inexperienced with paper contracts and prefer informal agreement after becoming comfortable with the physician. In a busy mission clinic where scores of patients are being seen, it is not always possible to spend the requisite time with a given patient as is customary in our country. The time required for informed consent must be balanced against caring for as many individuals as possible in a short time frame. However, it is important to make a reasonable effort to inform the patient and family of the goals, risks, and burdens of any procedure so they might consider and discuss them while the volunteer sees other patients, with a plan to revisit the consent process with them later.
- The Nuffield Council on Bioethics[6] in 2002 developed extensive guidelines for obtaining consent in developing countries. Basically, due to cultural issues and a high level of illiteracy in many countries, the Council supported the concept of "genuine" consent, which allows for verbal consent by the patient and/or other parties as required by the culture, properly witnessed and documented. Properly authorized written consent should remain the norm for procedures performed on patients during STMMs. Although some leeway must be available in special procedures, they should never be performed without permission.
- Special issues of consent common to the United States also may apply to international communities—parental consent for minors (with "assent" by minors with capacity), proxy consent for those not judged to be competent, and legal requirements of the state or country. The role of the family is very important in some cultures, and it may be necessary to explain a complex procedure to a number of family members so they can express their opinions prior to a decision being made. Such societal dynamics require time for making a decision, and concepts may have to be reexplained to the family on occasion. Although of legal age, women in some countries, notably the Middle East, may have consent given on their behalf by a male member of the family, such as a father or husband. "The exact balance of consent (communal, family and/or individual) needed in traditional societies is uncertain."[7(p774)] The volunteer physician must be sensitive to such nuances prospectively so as to properly engage the patients in giving consent while still being sensitive to their cultural norms.
- It is not inappropriate to consider a patient who presents to a medical mission clinic seeking care as giving "implied" consent—but, one must be cautious not to extend this concept beyond the initial evaluation and consultation process. Verbal consent or assent for accepting drug therapy needs to be obtained after a brief discussion of the pertinent potential risks and adverse effects of the medication. However, should a surgical or other invasive procedure be recommended to the patient, then implied consent is not effective and proceeding without a formal consent, either written or verbal, and witnessed, may be a medical liability issue, as well as a professional ethics issue, particularly if a complication or death results from the procedure.
- Subtle forms of coercion or pressure might cause the patient to feel compelled to consent to a given treatment, even though that individual may not wish to have it performed.[8] That is, authoritarian or paternal concepts of physicians in a particular country might make it difficult for a patient to refuse a physician's recommendation for therapy, and if the visiting physician is not aware of this cultural concept, then informed consent may not be completely autonomous.

CONCLUSIONS

It is altruistic for physicians to volunteer to serve in STMMs around the world. Not only does the physician volunteer benefit professionally and personally from caring for patients in disadvantaged or vulnerable populations, there is an opportunity to leave behind a positive health care impact (footprint), which is enhanced through a return over time to the same location. Cultural differences, religious practices, language barriers, and low socioeconomic conditions can be challenges to the successful conduct of an STMM. However, by applying the principles of bioethics and exhibiting the virtues of a physician in the same manner as one would practice in the United States, the physician volunteer shows compassion and respect for human dignity and rights. Practically speaking, these virtues will be foundational to understanding the proper obtaining of an informed consent from a patient in another country.

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REFERENCES

1. Maki J, Qualls M, White B, et al. Health impact assessment and short-term medical missions: a methods study to evaluate quality of care. *BMC Health Serv Res*. 2008;8:121 http://www.biomedcentral.com/content/pdf/1472-6963-8-121.pdf. Accessed December 18, 2011.
2. Allcauskas MP. From medical school to mission: the ethics of international medical volunteerism. Virtual Mentor. *AMA J Ethics*. 2006;8:797-800. http://virtualmentor.ama-assn.org/2006/12/pdf/fred1-0612.pdf. Accessed August 4, 2011.
3. World Medical Association. Declaration of Helsinki—Ethical Principles of Medical Research Involving Human Subjects. 1964 (Helsinki), amended 2008 (Seoul). A3. http://www.wma.net/en/30publications/10policies/b3/17c.pdf. Accessed April 21, 2011.
4. United Nations Educational, Scientific and Cultural Organization. Universal Declaration on Bioethics and Human Rights. 2005. http://unesdoc.unesco.org/images/0014/001461/146180e.pdf. Accessed April 21, 2011.
5. Yorgin P, Johnson N. Center for the Study of Health in Mission. Best practices for short-term healthcare missions. http://csthmbestpractices.org/ConsensusDocuments/Expired2.1c.pdf. Accessed April 20, 2011.
6. Nuffeld Council on Bioethics The ethics of research related to healthcare in developing countries. Chap. 6, section 6.18, Consent. http://www.nuffieldbioethics.org/sites/default/files/files/HRRDC%20I%20Chapter%206%20-%20Consent.pdf. Accessed April 20, 2011.
7. Bhutta ZA. Beyond informed consent. *Bull World Health Organ*. 2004;82(10):771-777.
8. Andanda P. Module two: informed consent. *Dev World Bioeth*. 2005;5(1):14-29.

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