

Ethics Pre Departure Training Manual

in collaboration with UNESCO Chair in Bioethics





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Imprint

This training is a result of a collaborative work of health students around the world, working under the umbrella of the International Federation of Medical Students' Associations (IFMSA) and its National Member Organizations.

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The International Federation of Medical Students' Associations (IFMSA) is a non-profit, non-governmental organization representing associations of medical students worldwide. IFMSA was founded in 1951 and currently maintains 137 National Member Organizations from 127 countries across six continents, representing a network of more than 1.3 million medical students.

IFMSA envisions a world in which medical students unite for global health and are equipped with the knowledge, skills and values to take on health leadership roles locally and globally, so to shape a sustainable and healthy future.

IFMSA is recognized as a nongovernmental organization within the United Nations' system and the World Health Organization; and works in collaboration with the World Medical Association.

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Ethics Training with UNESCO Chair in Bioethics

Introduction Letter

In recent decades, medical education curricula have undergone many modifications for a variety of reasons. Despite these changes, ethics education has not received adequate attention in medical schools throughout the world. In order to overcome this deficiency, both administratively and professionally, UNESCO established a unique Chair in 2001. The UNESCO Chair has established and activates more than 180 centers (Units) in medical schools worldwide. The aim of these Units is to encourage teachers and students through the "Students' Wings" to advance their involvement in the ethics discussions.

The IFMSA UNESCO Pre-Departure Training for students attending exchanges/electives abroad has been pioneered with the goal of increasing students' ability to face ethical and cultural challenges in their host countries with greater confidence and to protect the patients they encounter. The training does this by exposing students to ethical and cultural realities that are different from their own, and by opening a dialogue through which students are able to identify their own personal bias in treating patients. This process contributes to the development of a generation of future physicians better skilled at treating patients from cultures different from their own, which is crucial in the context of a world in which health issues are increasingly transnational.

The training features sections on basic medical ethics, culture shock and cultural competence, exceeding level of skills, and basic research ethics. It is a combination of theory and case studies (12 case studies and 2 examples) that participants discuss in small groups.

The UNESCO Chair values the collaboration with IFMSA for this Pre-Departure Training, as well as for other activities, such as: The annual World Bioethics Day (WBD), and the annual World Conferences of the Chair. Through this letter, the UNESCO Chair recognizes the Pre-Departure Training as an important tool both to educate future physicians about cultural safety and to sensitize medical students towards the ethical issues intrinsic to electives abroad.



United Nations
Educational, Scientific and
Cultural Organization



• UNESCO Chair
in Bioethics
• University of Haifa

Prof. Amnon Carmi, Head
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Purpose:

As technology, communication, and international trade continue to shape the global scene, health issues have become increasingly transnational. Between waves of immigration and increasing health workforce mobility, it becomes more and more important for future health care professionals to receive training in global health and to be able to adapt their practice to the differing needs of their patients, who may come from different cultural backgrounds. As a way to address this need for training in cultural competence among medical students, IFMSA (The International Federation of Medical Students' Associations) offers over 15,000 international professional and research exchanges annually to supplement the standard medical curriculum. International exchanges develop competencies in students that would not otherwise have been developed by the standard medical curriculum. These exchanges aim to develop humanism, cultural competence, social responsibility, the skills required to service differing populations, and a more global understanding of health and its determinants among their participants.

In the context of international exchange programs, Pre-Departure Trainings are put in place to help prepare for your exchange as much as possible, and to guarantee both your safety and the safety of the patients and communities you will encounter on your exchange. In order to make sure you, an IFMSA outgoing student, can benefit from your exchange in a safe and useful way, we are happy to present to you the following Pre Departure Training.

Basic Ethics: “First, Do No Harm”

As a medical practitioner, your first duty towards a patient is to not cause harm. This is especially true as a medical student, when your ability to help can be limited by your lack of experience, and your lack of experience has the potential to make you dangerous to patients. It can often be difficult to make ethical decisions, which is why it is important to have a few principles in mind when considering ethical situations.

Autonomy: the patient has the right to make their own decisions, regardless of whether they conflict with the doctor's own recommendations, personal beliefs, and desire to help. This is especially complex to navigate in a culture different from one's own where patient decision may be based on a different value set and so can seem inadequate when evaluated with our own value lens. In some cultures, patients usually make decisions in accordance with their family or community; this must also be respected by the physician, always taking into account the best interest of the patient and referring to the legal structure concerning health care decision making in the country.

Decisions must be made free from coercion and coaxing. The patient must be adequately informed and be able to understand the consequences of their decision.

Beneficence: the doctor has the responsibility to act in the best interest of the patient and with good intentions.

Non-maleficence: the doctor must not cause harm to the patient.

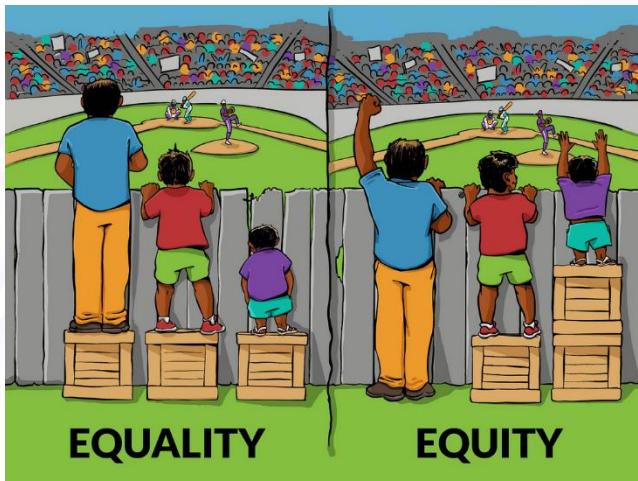
Justice: demands that the burdens and benefits of new treatments be distributed equitably among all groups of society. (N.B.: equitably does not mean equally. Imagine to have three people of different heights trying to peer over a fence to see a baseball match; if they receive



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the same box to stand on, then they are treated equally (equality), however this would not necessarily help the shortest person see the match, as he/she may need more boxes to be able to view beyond the fence. In order to receive an equitable treatment (equity), each person should be given a number of boxes according to their height)



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Free and informed consent:

In order for consent to be considered free, it must come from the patient without any coercion or external pressure. The patient must be able minded.

In order for consent to be considered informed, the patient must be well aware of the nature of his illness, of the risks of accepting treatment, and the consequences of not accepting treatment. The patient must be aware of all options of treatment available to them, as well as the pros and cons of each option.

Taking medical decisions is difficult for the average person given the complexity of the situations at hand. This is especially true when dealing with patients who have little to no medical knowledge. A good way to make sure that your patient understands their decision is to ask for them to repeat their options and to explain the pros and cons of each.

Another important aspect of consent is aptitude. In most nations, children over a certain age are considered mature enough to decide for themselves. Before that age, the parents or legal guardians are usually empowered to take decisions for the child. Things are much the same on the other end of the age spectrum - elderly patients, especially those suffering from dementia, can be incapable of truly evaluating treatment options presented to them, and may be considered inept. Here again, responsibility for the patient's well being is passed on to the legal representative as per the common/domestic law. The same is also true of patients who are incapable of communicating, such as those in a coma. Finally, despite the concept of consent being universal in the medical practice across the world, the exact criteria that make a patient apt to consent may vary, and it is important to keep this in mind when one works abroad.

**Case****[Beneficence, autonomy, free and informed consent]**

A 40 year old woman comes to a follow up appointment with her oncologist at an outpatient clinic. She is a single mother to two children under the age of 10. She has been diagnosed with stage IV breast cancer, an incurable disease, and has gone through multiple lines of chemotherapy and new lines of experimental immunotherapy. Despite this, her cancer has progressed. Today, she announces that she wishes to stop her chemotherapy. Instead, she tells you that she has found a traditional herbs specialist, and will be starting a traditional plant based treatment instead. When you try to convince her to continue chemotherapy despite her new idea, she insists that for her new treatment to work, she must not be on any form of chemotherapy. When you ask her whether she understands the implication of stopping chemotherapy, she answers that she understands that it will probably shorten her "time left". She says she would rather not spend her last days "in a hospital with a bunch of tubes stuck in me". She figures she has nothing more to lose, and is determined to stop her chemotherapy and will come to her next follow up appointment for her scheduled CT scan regardless.

What is the ethical issue involved here? Is the patient's consent free and informed?

It is always a good strategy to make sure all the criteria for a free and informed consent are met. Does the patient have the capacity to make this decision? In this case, we do not have reason to think that the woman is not able minded as she is able to understand the pros and cons of each treatment option.

Is the decision free? The decision is free because the patient is not being forced by anyone else to take this decision - the decision is in line with her values and her beliefs. She does not wish to have more chemotherapy because she does not want to spend the last portion of her life in aggressive treatment.

Is the decision informed? The patient has the right to refuse treatment as long as she understands the implications of a refusal of treatment, which she has shown by being able to tell the doctor what the consequences are. The doctor, despite his or her desire to help the patient, cannot impose a treatment onto his or her patient against her will.

In order to maintain the patient-physician relationship, good communication, respect and partnership are of utmost importance. The doctor must listen to the patient, respect and accept his/her wishes, and be always collaborative, leaving the door open for the patient to reach out. If the doctor is too biased towards the patient's decision and cannot provide a good level of care, he or she must delegate this patient to another colleague who can.

Confidentiality

One of the foundations of the patient-doctor relationship is the confidentiality of medical information, including in research settings. It is a patient's confidence in the integrity of their doctor not to reveal what is said in the medical interview that permits him or her to be completely



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truthful about his situation, without fear of any backlash. As such, breaches in confidentiality are not only legal issues, they are also harmful to the patient; a good diagnostic and treatment plan requires both parties to be fully honest with each other about the situation.

While the advent of wireless communications has brought about a lot of good for medical professionals, it has not been without its share of issues. With the advent of cell phones, it has become routine for medical professionals to send texts or pictures of patients to their colleagues - however, one must remember that the same legal constraints apply to these means of communications. It is no less a breach of confidentiality if a third party can access text messages or emails about a patient than it would be if the patient's file had been left unsupervised in the open. Another thing to remember is that evidence about a patient's state can be collected and shared with other members of the responsible medical staff only if it is pertinent and if the patient consents to it. As such, it is clearly unethical to take pictures of a patient without his or her consent, or to share these pictures with people outside the patient's medical team, even if you want to share these photos on your private social media account. Even if the patient's face is not clearly visible, such as in the context of a surgery, it is still a breach of confidentiality to post photos of a patient and abuses of the position of vulnerability of the patient, who cannot consent to the photo being taken.

Case:

[Beneficence, confidentiality]

During an elective abdominal surgery to repair an aortic aneurysm, the surgeon discovers a mass in the patient's stomach. A biopsy is taken and sent to pathology, which confirms the presence of what appears to be a carcinoid tumour. Once the patient is awake, this finding is explained to him, and the patient is sent for a gastroduodenoscopy (scope of the stomach) the next day. You are the clerk responsible for this patient, but cannot find the report of the gastroduodenoscopy in the patient's chart during your morning rounds. When you enter the crowded elevator to go to another floor, you run into the patient's gastroenterologist, the one who performed the procedure and would have the results. To save time, you ask him about the patient and the results of the gastroduodenoscopy.

What are the ethical issues involved here?

You should not discuss a patient's information in a public space, especially elevators. Even though you might think you are helping the patient by locating his results and being able to explain to him the findings as soon as possible, it is of utmost important that the patient's identity and medical information remain private. What if someone he knew was in the elevator and overhead that their friend has a stomach cancer? The patient himself is not even aware of this finding yet! Instead, you could tell the doctor that you urgently need to discuss about a matter and get off the elevator with him, or call the gastroenterology department later in the day to ask about the results. Remember that people who might know the patient might be in the elevator, and the information you are talking about to get to him through the wrong people.



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Confidentiality while on exchange

Case:

[Confidentiality, differing medical practices]

You are doing a neonatology exchange in Poland. As part of your exchange, you regularly carefully handle small babies in the absence of their parents. One of your fellow exchange students, Alexandra, decides to take a selfie with one of the babies as she is handling it. She later posts the photo to her Facebook account, and it receives a lot of attention in the form of "likes". Nobody from your staff reacts, despite that many of them have Alexandra on Facebook and even liked the photo themselves. Many local students also have online photos with their patients and no one seems to mind.

What is the ethical issue in this situation? Why is it wrong to photograph babies or children? Is it always wrong?

Here it is important to remember that the parents are probably unaware that their child, who is quite sick, is being photographed. Not only does this breach patient-doctor confidentiality as you are revealing the identity of a patient to a large public, but you did not seek the consent of the baby's legal guardian. Regardless of what locals do or other exchange students do or even the reactions of the local staff, avoid posting photos with patients to maintain doctor-patient confidentiality. While on exchange, you should also remain mindful that in many circumstances rules that apply in your home country continue to apply even when travelling.

Case:

[Confidentiality while on exchange]

You are doing a GAP (global action project) in Sri Lanka. You work in a small community that has only one clinic. Since the village is very small, you rapidly become friends with the children, who share an interest in playing soccer with you. After a few days of playing with them, you ask for a photograph of you with lyngaran, a child you have played with for many days and whose family you know. lyngaran's mother takes the photo and says she would like a copy.

Is it ok to take the photo in this case? Is it ethical to post the photo on a social media platform afterwards?

In this situation, the mother is aware of the photo being taken, and consents to it. However, is she aware that you will be posting this photo onto social media? It would be important to ask the mother if she consents to the photo being posted on a social media platform.

Bottom line: patients and members of your host community are not photo opportunities. You should never photograph patients, including pediatric patients and including patients whose identity you cannot tell from the photo (ex; in a surgery context). If you take a picture with someone (even if they're not your patient), remember to always ask for their consent before the photo is taken. If you intend to share the photo on social media, ask the person in the photo whether they consent to that photo being shared with a large and possibly public audience.



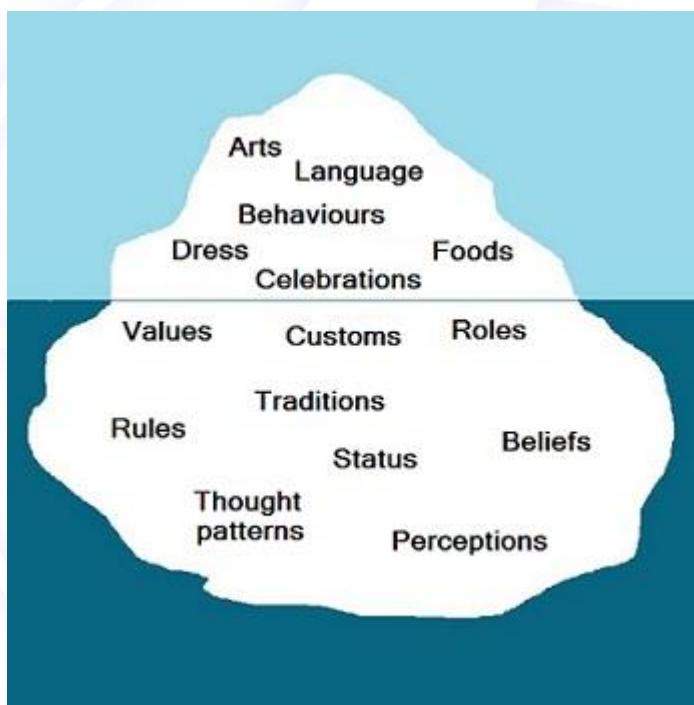
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Culture Shock: “You Don’t Know What You Don’t Know”

What is culture? **A pattern of perceptions which is accepted and expected by an identity group is called a culture** (Singer, 1971). Simply put, it is the way a group of people perceive their reality.

(Could be an interesting opportunity to ask students to reflect on their own culture and cultural values)



The cultural iceberg: parts of culture are visible when you first meet someone, such as they way they dress and their behaviours. However, the majority of how culture influences a person is not visible at a first glance, much like the majority of the iceberg - people's values and customs are also regrouped by their culture.

Impact of Culture on Health:

Culture determines how a person will:

- Define health and illness
- Understand the cause of their illness
- Choose the best treatment option for them, one that is in line with their beliefs
- Adhere to their treatment plan
- Seek out preventative medicine



- Experience and express pain
- Feel stigma regarding certain behaviours or medical conditions
- Determine their relationship with healthcare professionals

People tend to be unaware of their own values and attitudes until confronted with values and attitudes that differ from their own. With this being said, students affronted with new cultures may develop what is called **culture shock**. Though the immediate consequences of culture shock appear negative, the process of being immersed in another culture allows for personal development as one comes to understand how perspective and identity are shaped by culture, and that many realities may exist simultaneously.

Symptoms of Culture Shock include:

- Feelings of loneliness, confusion, irritability, frustration, and helplessness
- Unstable temperament
- Paranoia
- Criticism of local people and cultures
- Changes in eating and sleeping habits
- Excessive concern over drinking water, food, or bedding
- Overreaction to minor difficulties

Cultural Adjustment: Imagine that you're a toddler again, in the process of learning how to navigate your environment. You're unsure of what to say and how to say it. You're unsure of how people will react to what you will do. You're unsure of what people expect from you in terms of etiquette. That's sort of what it's like being in a completely new culture - you're going to be acutely aware of everything you say and do for a little bit, and feel negative emotions when people find you odd because you say or do the wrong thing. But don't worry, it gets better! Cultural adjustment comes in phases:

1. **The Honeymoon Phase:** you will arrive to your destination and be enchanted by the novelty of the fact that everything is "new" and "exotic". At this point, you may focus more on similarities between your culture and your host country's culture rather than differences.
2. **The Crisis Phase:** differences between your culture and the host culture will become more apparent, and you may begin to feel alienated from locals. You may find yourself clinging onto other people from your own culture on exchange with you as a way of coping, but this will only prolong the Crisis Phase. This is the period during which the symptoms of culture shock (irritability, criticism of locals, etc) will be manifested.
3. **The Recovery Phase:** without realizing, you will begin to form a routine in your new culture as you become more familiar with it. As you become more able to understand and work in your new culture, you will be more and more able to read social cues and successfully navigate your social environment. You will simultaneously become less critical of the local culture and more open to integration.
4. **The Adjustment Phase:** you will become able to function within the new culture and regain self-esteem by doing so. Since you are now able to participate in the new society more fully, you may feel integrated into the host culture and identify with it.



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5. **Re-entry Phase:** when you arrive back to your home country, it is possible that things will not be as you remember them. It is possible that you go through “reverse culture shock”, in which you have difficulty adjusting back to your home country and your home routine.

Ways to Cope with Culture Shock:

- Acknowledge that these impacts exist
- Know that the symptoms of culture shock are temporary
- Be humble and assume nothing
- Learn the rules, body language, and social norms of your host culture
- Learn the language of your host culture
- Watch TV shows and movies from this culture
- Involve yourself in the new culture in some way (take up a class, go out with locals, etc)
- Develop friendships
- Keep contact with people back home
- Do something that reminds you of your home country
- Avoid idealizing your home country (ethnocentrism)
- Go out with your Local Exchange Officer (LEO), Local Officer on Research Exchange (LORE) and contact person as much as possible. Participate in the Social Program if one is organized
- Email your contact person before your exchange and ask them for advice about your host country before you arrive - do not be afraid to ask them questions, as it is their job to answer you! If you ever have questions or need a cultural perspective, do not be afraid to ask them.
- Attend the Upon Arrival Training if your host country organizes one

Ethnocentrism: when you idealize your home country. Just because you've never thought about doing things differently, doesn't mean the way you do things is necessarily the best way! Do not idealize medicine in your home country and denigrate your host country's system. Never dismiss or ridicule how people approach situations because you don't agree with it or because it would be “the wrong way” in your culture. You're living in a different reality, one which requires an adapted perspective and adapted solutions.

Reverse ethnocentrism: At the same time, you should not idealize your host country's culture and health system and denigrate yours. In some cases, you might have the impression that culture and medicine in your host country are more advanced. Remember that you are an ambassador for your home country, and may be the only contact people have with people from your culture. It is normal to question your own values, but you should not actively try to adopt all of the values of your host country and abandon your own.

Case:

[Beneficence, culture shock, cultural relativism]

You are a female first year clerk conducting a gynecology elective in the United Arab Emirates. A veiled pregnant woman and her husband come in for a prenatal follow up appointment. You begin by asking her if she feels the baby moving. Her husband answers



that she does, and very regularly. You ask the question to the woman, and she nods that everything her husband said was correct. You ask her whether she has noticed any discharge or bleeding. Once again, her husband answers on her behalf, and she nods in agreement. In fact, every time you ask a question, her husband answers on her behalf. You try to redirect your gaze towards the woman, who does not seem to be distressed at all. You ask the husband to leave the room so you can question the woman alone. Later, your supervisor tells you that you shouldn't have done that.

Is it your place to ask to question the patient alone? Is this behaviour normal in the host country's culture? Is it your place to react to the host country's culture to align with your own values?

What to do to prevent this: become familiar with the cultural norms of your host country. If people don't seem distressed by something and it is commonplace in that culture, it is not necessarily your place to react and comment on it. Your role is to observe and understand, not to impose your idea of what is wrong and what is right onto your patients.

Case:**[Beneficence, culture shock, cultural competence]**

You are a final year medical student completing a clinical medicine elective in Montreal, Quebec. A Native (Indigenous) patient from a nearby Indigenous community comes into a walk-in clinic complaining of leg pain. When you examine the patient, you realize that the patient has a wound in his leg from a hunting accident, and that the wound is purulent. Your supervisor examines the patient and notices that a black pomade (cream) has been smeared over the infected wound. When he inquires about the pomade, the patient replies that his grandmother had given him a plant-based cream to fight the infection. Your supervisor rolls his eyes and tells the patient that the cream won't do anything, and that the patient needs antibiotics to treat the wound "the right way." He prescribes an oral antibiotics to the patient, tells him to take it twice a day, and leaves the room.

What are the ethical issues involved in this scenario? Do you think the patient will take the antibiotics? What was the outcome of this encounter? How could the doctor have better acknowledged the patient's perspective for treatment and negotiated a treatment plan more in line with the patient's values?

In this case, it is fairly easy to see that the patient will probably proceed to not take the antibiotic. In this sense, the outcome of this medical visit was absolutely nothing. The doctor adopted an ethnocentric behavior and, through his words and eye-roll, he showed disregard for the patient's values. To have made this meeting more impactful, the doctor could have carefully listened to the patient's story and inquired about the ingredients of the pomade and acknowledged the patient's perspective, paying attention to both his verbal and non verbal cues. It is important to remember that even natural remedies can have side effects, and physicians must always inform themselves as to the possible side effects of these herbal remedies. Then, he could have proposed a treatment plan which respected the patient's cultural values (for example, saying it's alright to continue using the pomade as long as the wound is cleaned and dressed) and explaining his own logic behind proposing the antibiotic.



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He could have taken the time to explain to the patient what an infection is, and how an antibiotic in particular would be able to treat it, instead of simply imposing a treatment onto the patient and not providing any context.

Case:

[Beneficence, culture shock, cultural safety]

You are a final year medical student completing a rotation in family medicine in Morocco. A woman and her unmarried daughter consult because the daughter has been having abdominal pains. The pains are in the right iliac fossa, and have been increasing over the past few days. Wanting to rule out an ectopic pregnancy, you ask the daughter's mother to leave the room, and question her sexual history in the presence of two other male clerks who are also on exchange with you. Your supervisor hears about this from the mother, who is his patient and found it abnormal that her daughter was questioned separately. He pulls you aside and tells you that the daughter will be judged by her mother for what you just did, as she will now assume that her daughter has "something to hide".

Wanting to be benevolent, you wanted to figure out what was going on with the patient and diagnose her correctly. For this, you thought it would be best to question the patient alone. However, you did not take the patient's cultural context into perspective, and now this will have consequences for the patient because her mother will believe that she is "hiding" something. Always consider what is best for the patient in their particular cultural context.

Case:

[Beneficence, free and informed consent, culture shock, cultural competence]

You are a clerk level medical student completing a clinical surgery rotation in Brazil. A 50 year old man comes in complaining of severe back pain. After an abdominal CT with contrast is completed, it becomes apparent that the man has an aorta dilated to 6.0cm. The vascular surgeon meets with the patient, and explains that an emergency procedure to replace the aneurysmal portion of the aorta is necessary to avoid a rupture, which is often rapidly fatal. The doctor, being aware that she must explain all the possible risks and complications of the operation, tells the patient that there is a high probability that a blood transfusion be necessary at some point during the operation. At this point, the patient reveals that he is a Jehovah's witness, and cannot receive any blood transfusions. He refuses the operation and signs the refusal of treatment form.

What ethical issues are important in this scenario? What is it important for the patient to understand in this scenario? Is it the doctor's role to continue to push the patient given that he is young and would likely have few long term complications from an aortic aneurysm repair?

Once again, what is important in this situation is that the patient understands what a refusal of treatment means. If he does, and is able to repeat this to you, then his consent is free and informed. If you have doubts with regards to the patient's mental competence for whatever reasons, a psychiatric evaluation is required. However, in this case, the patient shows no



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signs of not being able to comprehend his problem or his treatment options. From the patient's perspective, receiving a blood transfusion is equivalent to a religious condemnation, which is perceived as worse than death. It is not your role as a doctor to challenge this vision, but rather to provide medical assistance which respects the patient's world views. Instead, you could work with the patient to optimize the medical treatment of the aneurysm if the patient continues to categorically refuse an operation.

Case:

[Beneficence, culture shock]

You are a 5th year medical student completing a community medicine rotation in Haiti. You work in a small village at a walk-in clinic. A 35 year old man, Dieudonné, walks in while staring downward. When you question him about the reason for his visit, he tells you that his wife forced him to come because he has felt increasingly tired the last few months. When you question him about his appetite, he reveals he eats less. He has also noticed that he is less able to focus when people speak with him. When you specifically ask Dieudonné whether he has felt sad lately, he admits that he has and often finds himself crying alone. When you ask him whether anything new has happened in his life or if he has any idea why he might be feeling this way, he explains that he thinks someone has put a curse on him. The curse probably comes from his brother-in-law, he explains, who has always been jealous of his successful farm and his many children. At this point, you feel that you have enough evidence to diagnose a major depressive disorder according to the DSM5's criteria. You announce to the patient that you believe he has a depression, and that he should consider taking antidepressants in order to help with his symptoms. The patient is outraged by this diagnosis; he insists that his tiredness is from the curse, and would just need extra vitamins for the time being. As you try to explain what depression is to the patient, he becomes even more angry, and leaves the clinic while screaming that he should have seen a *houngan* (Voodoo priest) healer instead.

Was this the best way to handle the situation? Is mental illness openly accepted and embraced in Haitian culture, or is it something that is still heavily stigmatized? How will this encounter affect Dieudonné's future relationship with medical doctors and other health professionals? How does the patient understand his illness and how does he envision its treatment?

Certain societies are not open to the concept of mental illness and believe that such sadness is the product of curses. To be depressed can be openly stigmatized, so patients may react poorly to its diagnosis. Many Voodoo practitioners will refer to traditional healers (*houngan*) before contacting a doctor, which is why their relationship with their health practitioner is precarious. In this case, it might have been useful to explore Dieudonné's understanding of his illness - is there anything in particular that happened in his life that could explain these symptoms other than the curse? Did he have these symptoms before? If so, how did he manage them? Did the vitamins help in the past? Does he think contacting a traditional healer will help? Would you be willing to see the patient again if his symptoms persist despite spiritual healing? It is important to remain open minded with patients who understand their illness from a different perspective and develop treatment plans that take their worldviews into account.



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Exceeding Level of Skill: Do Not Do Things You Wouldn't Do To Your Grandmother

Since medicine is practiced and taught differently across the world, you should not be surprised that the roles and responsibilities of clerks vary between countries. As such, clerks in one country may be expected to perform certain procedures and assess patients alone, while clerks in other countries may only shadow during their rotations. Despite this, it is extremely important that you never perform procedures that you would not be comfortable performing in your host country, even if clerks in that country do and even if your supervisor expects you to do so.

Case:

[Exceeding level of skill]

You are a final year medical student doing a SCOPE clinical rotation in urology. During your morning rounds, you often follow up postoperative patients, many of whom still have surgical drains in place. Your supervisor is rounding the patients with you. Just as she is about to remove a nephrostomy drain (postoperative drain) from a patient, her pager begins to ring. The procedure to remove the drain is simple: you must cut the stitches that keep it in place with sterile scissors, remove the drain quickly in one fluid motion, and then cover the wound with gauze and a bandage. You are familiar with the procedure, and have seen your supervisor remove many drains before. Your supervisor motions that she has to go because there's an emergency, but that you can remove the drain since all the materials are already out and she knows that you've watched the procedure be done many times.

Why didn't you ever perform the procedure requested by the professor in your home country?

Do you have the necessary skills to perform it? Even without supervision? If you decided to perform the procedure, do you think you are putting your patient or yourself at risk?

It is not ethical to perform a new procedure without supervision under any context, including if your supervisor expects you to and including if other clerks do it. Instead, it is your job to tell the supervisor that you are uncomfortable, and propose doing the procedure under his or her supervision for the first time. If you are nervous about asking your supervisor for help, you can always explain that you are concerned for your patient, and would really appreciate their feedback anyhow, both of which are qualities one looks for in a professional medical student.

Case

[Exceeding level of skill, language barrier, differing medical practices]

You are a 5th year medical student completing a pediatrics rotation in Honduras. You work at a hospital in a small village 2 hours away from Tegucigalpa. As part of your responsibilities, your supervisor tells you that you must vaccinate young children. The hospital you are working at is highly understaffed, and your supervisor expects you to vaccinate the children as of your first day. You have never done the procedure before, and tell your supervisor this. He says not to worry, that it's simple enough, and that this a good opportunity for you to learn



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how to vaccinate. Besides, he says, they really need your help because of the lack of medical personnel. He hands you the needle and says the nurses will show you the technique, and leaves the room. The nurses are all unilingual Spanish speaking and you are not able to understand what they are trying to explain to you. Moreover, you notice that many of the needles are being reused.

What are the ethical issues at play in this situation? How would you react in this situation?

Let's start with the lack of skill: you don't know how to vaccinate, and wouldn't feel comfortable vaccinating patients back home. You have not been trained for it in a controlled environment. The supervisor has provided you with people who could supervise your first vaccinations, but due to a language barrier, you are not able to understand what they are trying to teach you and would not be able to receive any form of advice.

Secondly, you notice that there is a medical practice here that differs from your home country. Is it normal for needles to be reused? What is the sanitation protocol in this particular country? In some contexts, it might be common to reuse the needles due to lack of resources, but there must be a process for sanitizing them between each use. If there are no other options, it might not be your place to question this. However, it is best to clarify procedures at the beginning of your rotation so you can be aware of the country's standards for sanitation as early as possible.

Case:

[Exceeding level of skill, language barrier, non-maleficence]

You are a first year clerk doing a SCOPE exchange in internal medicine. On your first day, you are placed under a local resident and assigned a series of patients to round and evaluate. When you arrive to evaluate them, one of your patients, known for cardiac arrhythmia, suddenly falls over. You have already been trained in cardiac resuscitation, but this is your first real event, and have never seen the actual procedures before. In the meantime, a nurse comes in the room, and appears to be asking questions about the patient in the local language, which you don't understand. She begins compressions.

What would be your first reaction in this situation? Have you ever been exposed to emergencies in your home country? Do you know the emergency protocols in your new country?

If something goes wrong, are you able to communicate it to other healthcare workers?

Whenever you are faced with an emergency situation, the first thing to do is call for help. Allow the personnel to step in and they will alert you if they need assistance. Trying to initiate a code is complex and management of crisis situations is absolutely dependent upon clear communication between the personnel. In this situation, there is a clear language barrier, and you could be actively detrimental to the management of this situation.



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Case:

[Exceeding level of skill, differing medical practices]

You are a first year clerk doing a SCOPE exchange in intensive care. After a few days, you start to integrate into the team. A local doctor, knowing you are a foreign student interested in intensive care, decides to teach you as many techniques as he can during your short stay. One day, one of your patients suffering from renal failure is set to be dialysed, and requires the installation of a central venous line. The doctor, knowing you have seen him do a few, decides to let you do the procedure under his supervision. You have never seen this particular procedure performed before. For extra challenge, and to teach you how it was done "in the good old days", the doctor instructs you to do it without echographic guidance. After many unsuccessful attempts, you manage to install the central catheter. However, on the following chest x-ray, a new pneumothorax is clearly visible right under where you installed the central line.

Knowing you were not experienced and the patient's health was at risk, would you have done the procedure back home? What steps could you have taken to have prevented this? Was it acceptable to put a patient through a more dangerous procedure for educational purposes?

If you are not trained in something, it is generally recommended to observe the procedure before attempting it. Once you are comfortable with the theory of the act, you can attempt the technique as long your supervisor is guiding you. However, it would have been a good idea in this case for you to have spoken up to your supervisor about not being comfortable performing the procedure without having watched it first. It would also have been a good idea to have refused a more technically complex procedure, even if your supervisor justified it as being better for your medical training.

Burdens on the Host Country

International medical exchanges can be extremely enriching experiences for students and host communities. Nevertheless, the fact that you are a medical student can impose certain burdens on the host country's medical system.

Case:

[burdens on the host country, differing medical practices]

You are a 4th year medical student doing a SCOPE clinical rotation in Pneumology in Italy. You don't speak Italian, and you require frequent assistance from your supervisor and the local staff with interpretation. During a morning round, you follow your supervisor dealing with a case of COPD that requires regular adjustment of oxygen saturation. You help your supervisor by taking the patient's pulse and blood pressure, then your tutor performs an arterial blood gas. You are unfamiliar with the environment and the language and you are still a medical student, therefore you take repeated measurements and leave the patient's room after 30 minutes. From that moment, you realize that your supervisor tries to avoid your help and spends very little time in explaining the other patients' conditions. At some point,



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you ask your tutor to be more involved in the examinations and he replies abruptly: "You are too demanding. I have to take care of 12 patients this morning, then fill in tens of paper sheets for their therapies and finally talk with their relatives. If I assisted you in everything and translated every single conversation with my patients, I would never accomplish my tasks within the end of my shift!"

What ethical issues may arise from this scenario? Are you sure your demand for assistance and supervision is reasonable compared to the amount of work the local staff needs to handle?

It is important to consider that, in this case, the supervisor is partially diverted from his responsibilities in order to provide you with assistance. Your presence, therefore, poses a burden on the host institution, and this is an aspect you should be aware of. Being unfamiliar with the language may create an additional burden for the local staff.

In this case, it is advisable to make reasonable expectations for both local staff and visiting students in advance, in order to minimize the burdens on the host institutions. It is important to recognize that the primary obligation of physicians is towards their patients, thus you should think carefully about the realistic level of supervision that can be provided by the local staff in your host institution.

Research Ethics

Research is a pillar to the advancement of the scope of medical knowledge. Without research, it would be impossible for the medical field to improve treatments for patients. In light of this, it goes without saying that research exists to better human society. This leads to an interesting duality - research has the capacity to better society, but also has the capacity to harm some of its most vulnerable members. With this in mind, it is absolutely essential that ethical guidelines be adhered to in the creation and implementation of research protocols, so that the balance of potential benefits of research are not outweighed by its risks.

Autonomy: The same principles that apply to a free and informed consent for a medical treatment apply to participation in a research study. The patient must be aware of the risks of participation and potential benefits of participation, and be free to choose to leave the study at any point in time. It has been shown in previous social experiments that participants in research studies tend to follow orders from people in positions of authority for fear of upsetting them, so it is especially important to make sure that the patient understands that they will not receive a lower level of care if they refuse to participate and are free to leave the study at any time. Also consider the relationship between the doctor and the patient - is the patient only participating as a favour to the doctor because they feel indebted to them? The patient must be aware of the methods to be used, the source of funding, and any potential conflicts of interest. The patient must consent without any external pressure; this can be especially dubious if the patient is being offered treatments that they would not have access to outside of the study - for example, if the patient could not afford treatment outside of a trial, or receives special benefits for participation.



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Concern for welfare: as a researcher, you are responsible for the physical and mental well-being of your patient participants. You must always act with the perspective of benevolence, and take into account the economic and social reality of your patient throughout. Ask yourself, will participation in this study harm the patient in any way? Are they being denied the best possible treatment by participating? Will they be stigmatized by their family or friends for participating? Could they lose their job? Will it affect their insurance policy? Will the level of involvement be harmful to them? You are equally responsible to protect the patient's private information collected in the context of the study, as breaches in data privacy can have harmful effects on participants.

Case

[Data collection, data privacy, confidentiality]

You are a second year medical student completing a study evaluating the different factors contributing to the prognosis of colon cancer. As part of your project, you have access to a database containing all of the personal and medical information of your participants. Since you have a lab presentation due tomorrow, you decide to transfer some of the data onto a USB key, and onto your personal laptop. Later that night, you go to a bar with your friends and leave your bag unattended. When you return to your bag after a few hours of latino dancing, you realize that your laptop has been stolen.

What are the ethical issues involved in this scenario? Should you have transferred the data onto a USB key or onto your computer? What is the issue now that your laptop has been stolen? What are the possible consequences for the participants of this study?

Here is an issue of data privacy and confidentiality. Now that the bag is stolen, it is difficult to know what will happen with the participants' information.

How could you have prevented this from happening?

It is generally advised to never take data home with you, or put it on a personal laptop, where the security of the information is not guaranteed. You should also pay attention to your research institution's policy on this matter, as some institutions have already forbidden this practice.

Justice: are the burdens of this study being shared throughout all members of the population equally, or are some subgroups being targeted more than others? Are some members over or under represented in the population study? It is acceptable that some people be excluded from research studies on the basis of pre-existing conditions, but it is a researcher's responsibility to make sure that their exclusion criteria does not discriminate against certain groups in particular and are justified based on scientific evidence.

Two examples:



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The Tuskegee Study

In 1932, the Public Health Service of the United States began a study called "Tuskegee Study of Untreated Syphilis in the Negro Male". The study involved 600 black men - 399 with syphilis, and 201 without syphilis. The men were not told the purpose of the study - they were told that the research team was investigating "bad blood". In exchange for their participation, they received free medical exams, free meals, and free burials. However, the men were not receiving treatment for their syphilis throughout the study, which lasted for 40 years. Keep in mind that penicillin had become the treatment of choice for syphilis in 1947 after its advent. The advisory panel that began investigating the study in 1972 found that the participants were never given the option of leaving the trial. The study was halted in October 1972.

What are the ethical issues involved in this scenario?

1. The participation of the men was free, but not informed. The participants were unaware as to the true purpose of the study, and unaware that they were not receiving any form of treatment despite that such a treatment existed.
2. The patients were not receiving the standard of care - in any research study, it is completely unethical to deny patients the standard of care, as this is actively harmful to their immediate health and long term prognosis.
3. The patients were not allowed to leave the trial, which means they lacked autonomy in their participation.
4. The patients were exclusively black men in difficult socioeconomic conditions, and thus the burden of this research was not evenly shared by the American society as a whole. It is not acceptable to use minorities for research purposes and to prey on their difficult living conditions as a way to coerce them into participating in a trial by offering them "treatments" and benefits.

In Cancer Trials, Minorities Face Extra Hurdles

Immunotherapy is a new and promising treatment for certain forms of cancer. However, access to immunotherapy is mostly through research studies. Preliminary trials have demonstrated that nivolumab, an anti-PD1 monoclonal antibody, provides survival benefits above chemotherapy alone. In the one study, out of 582 participants with lung cancer, 92% were Caucasian, 3% were Asian, and only 3% were black. In another immunotherapy study, out of 821 participants with kidney cancer, 88% were white, 9% were Asian, and only 1% were black. According to the US 2015 census, Caucasians represent 77% of the population, blacks 13.3% and Asians 5.6%.

What is wrong with these numbers? Which principle of ethical research is not respected here?

As we can observe, there is a clear discrepancy between the black population of the United States (13.3%) and their representation in these immunotherapy trials (3% and 1%). What



we understand from this example is that minorities are less recruited and have less access to new experimental treatments, which have the potential of improving their prognosis.

Researchers who seek “rapid” results might be biased against including minority patients, who can be considered more difficult to follow over the long term.

Discussion: what steps can researchers take to ensure that minorities are represented among their participants?

Make recruitment forms available in multiple languages, make sure recruitment occurs at multiple centres, make sure research assistants are not actively biased against minorities

Conclusion

In order to be a doctor who is able to treat patients with beliefs different from your own, you must be **culturally competent, and have sufficient medical knowledge and skills for the activities performed**. Being culturally competent means to avoid making assumptions or generalizing, to ask questions and to learn about the individuals within the context of their culture.

Your exchange in another country may be your first encounter with people whose approach to health and medicine differs from your own - don't be afraid to immerse yourself into this new environment and understand health from a new perspective. Hopefully, this experience will allow you to become aware of your own culture and its potential to bias you in your treatment of patients who do not share the same culture as you.

You must always keep in mind the impact that socio-cultural determinants have on a patient's relationship with health, and propose medical interventions that are acceptable to a patient given their cultural background. More than this, you must try to understand health from your patient's perspective, and try to actively involve them in their healthcare decisions.

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SCOPE
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SCORE
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