Pre Departure Training

In collaboration 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.

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Introduction

Welcome to your exchange!

We, as IFMSA, are pleased to provide you with the opportunity to go on one of 15,000 exchanges offered each year.

We designed this training in the hopes of preparing you for the ethical situations that you may encounter on this exchange.
Plan of the Training

- Basic Medical Ethics
- Culture Shock
- Exceeding Level of Skills
- Research Ethics
PART I
BASICAL MEDICAL ETHICS
« First, Do No Harm »
Principles of Basic Medical Ethics

You are a medical student – you are not yet a doctor, and your lack of training can sometimes be harmful to patients!

When dealing with ethical scenarios, it is useful to keep a few principles of basic ethics in mind:

**Autonomy:** The patient has the right to make their own decisions, even if they are against the doctor’s recommendations.
- The decision must be made free of coercion (nobody else should be telling them what to do)
- The patient must be able minded AND informed
- These decisions can be heavily influenced by the patient’s *culture* (in some cultures, decision making is done with the family or the community – this must also be respected, taking into account the best interest of the patient and the legal structure in place)
**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.  
- The principle of “Do No Harm”

**Justice:** The demands that the burdens and benefits of all treatments be distributed equitably among all groups of society and that resources be distributed fairly.  
- For example, all members of society should have access to health care services.
Equality vs. Equity

Equitably (equity) does NOT mean equally (equality)!

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Free and Informed Consent

For a consent to be considered **FREE:**
- It must come from the patient **without any external pressure**
- The patient must be **able minded**

For a consent to be considered **INFORMED:**
- The patient must understand the **risks of accepting a treatment**, and the **consequences of refusing a treatment**
- The patient must be aware of all of the treatment options available to them, and be able to weigh the **pros and cons** of each option
Strategy for making sure a patient understands consent

A good way to make sure a patient truly understands the consequences of their decision is to ask them to **repeat their options** and to explain the pros and cons of each option.
Special considerations

Aptitude:

• Children:
  In most countries, children over a certain age are allowed to make decisions themselves. Under that age, their legal guardians make medical decisions on their behalf.

• Concept of able-mindedness:
  If a patient has neurological or psychiatric problems (for example, severe dementia or psychosis), they may be unable to understand the full implications of their medical decisions. In this case, the responsibility for making decisions may be passed onto the patient’s legal representative as per the common/domestic law.
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; she does not want her children see her lose hair again, and she is determined to stop her chemotherapy. However, she will come to her next follow up appointment for her scheduled CT scan regardless.
Case #1

[Beneficence, autonomy, free and informed consent]

Should the doctor respect the patient’s decision to stop chemotherapy?

a) No – the patient is not aware of the consequences of her actions, and the doctor is in a better position to decide for her given his medical knowledge.

b) No – the patient is not able minded, and the doctor should take the steps required to have a court order to treat the patient.

c) Yes – it is never a doctor’s position to question their patient’s decisions.

d) Yes – the patient understands the consequences of her actions, and her refusal of treatment is in line with her life views.
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.
Confidentiality

One of the foundations of the patient-doctor relationship is the confidentiality of medical information, including in research settings. In order for proper medical questioning to happen, the patient must be wholly truthful with their physician. For this to happen, the patient must trust that their physician will not reveal any private information.

With the introduction of cellphones in the workplace, it is now common for doctors to transfer information to their colleagues through text messages or pictures. It is important to remember that this information remains confidential and has all the same legal constraints as the patient’s file.
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.
Case #2
[Beneficence, confidentiality]

Should you ask the doctor for the results of the gastroduodenoscopy in the elevator?

a) Yes – this will allow you to save time, and explain the patient’s situation to him as soon as possible so he can not be “in the dark”.

b) No – this is a private matter, and should not be discussed in the elevator. The information risks being overheard by people who might know the patient.
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 other students also have online photos with their patients and no one seems to mind.
Case #3
[confidentiality, differing medical practices]

If you were to take a photo with a patient, would it be ethical to post it to social media?

a) Yes – if the local customs are okay with it, you can adapt to their ways.

b) Yes – if your home country is okay with it, you can maintain your ways.

c) No – the parents of child are not aware that their child is being photographed. Their child is probably quite sick. Posting a photo breaches their right to medical confidentiality, as you are posting to a large public audience. This remains true no matter the country in which you practice medicine.

Also consider: if this were an adult patient, would your answer change? If the patient was not identifiable in the photo (ex; during a surgery), would your answer change?
Confidentiality while on exchange

IFMSA recommends:
Patients and members of your host community are not photo opportunities.

- Never photograph patients, including pediatric patients and patients whose identity you cannot identify (ex: surgery patients).

- If you take a picture with someone from your community, always ask for their consent before the photo is taken and always ask for their consent before posting it onto social media.
PART II
CULTURE SHOCK
What is Culture?

Definition:

“A pattern of perceptions which is accepted and expected by an identity group is called a culture” (Singer, 1971).

Discussion: can you identify a few items from your own culture?
What is culture?

[Image of an iceberg illustrating various aspects of culture such as Arts, Language, Behaviours, Dress, Celebrations, Foods, Values, Customs, Roles, Traditions, Rules, Status, Beliefs, Thought patterns, Perceptions.]

IFMSA PRE DEPARTURE TRAINING (PDT)
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
Culture Shock

People tend to be unaware of their own values and attitudes until confronted with values and attitudes that differ from their own. When people are confronted with new cultures, they may develop what is called “Culture Shock.”

**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
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 while 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.
Stages of Cultural Adjustment

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 appear.

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 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.

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.
Stages of Cultural Adjustment

- Honeymoon Phase
- Crisis Phase
- Re-entry Phase
- Adjustment Phase
- Recovery Phase

IFMSA PRE DEPARTURE TRAINING (PDT)
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 your host 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)
Ways to Cope with Culture Shock:

• 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.
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.
Case #4: [Beneficence, culture shock, cultural relativism]

How would you address this situation?

a) Ask the husband to step outside of the room so you can question your patient alone. It does not make sense that he should be answering on the behalf of his wife, as this would not be accepted in your home country’s culture.

b) Ask to leave the room, and confront your supervisor. Tell him or her that you suspect an abusive relationship since the woman will not talk in the presence of her husband.

c) Continue directing your questions to the wife and hope that she begins answering questions instead of her husband.

d) Continue the interview as is – you are practicing medicine in a different culture, and the woman does not appear to be distressed by the situation.
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.
Case #5: [Beneficence, culture shock, cultural competence]

Was the doctor right to have reacted this way?

a) Yes – it is a doctor’s role to promote health, and to advocate against the use of non-medical treatments and to promote the use of evidence-based treatments.

b) Yes - the doctor was right to have made a comment about the cream to put its usefulness into question. He should not have done it in such a rude way.

c) No – he should have spent more time explaining the antibiotics to the patient.

d) No – it is not the physician’s role to challenge the patient’s world visions and impose his own. He should have sought to understand the patient’s treatment and explained the treatment he proposed in order to involve the patient in his treatment plan.
Case #5:
[Beneficence, culture shock, cultural competence]

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?

He could have paid attention to his verbal (words) and non-verbal (eye roll) cues, avoiding to adopt an ethnocentric behavior and disregard the patient’s values.

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.

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.
Concept: Ethnocentrism

Definition: 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 put down 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 going to be living in a different reality, one which requires an adapted perspective and adapted solutions.
Concept: Reverse Ethnocentrism

At the same time, you should not idealize your host country’s culture and health system and put down your own culture and health system.

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 host 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.
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”.
Case #6: [Beneficence, culture shock, cultural safety]

What do you respond to your supervisor?

a) You absolutely needed to rule out an ectopic pregnancy in the patient, and so had no choice but to question her alone. There was no other solution.

b) You acknowledge the consequences that your action had on the patient – in her culture, being questioned about her sexual history in front of two men has bad connotations. You should have considered the patient’s cultural context before questioning her alone in front of two male clerks and should have approached the situation differently.

c) You do not back down on your decision – this is what you would have done in your home country, and it should be no different here. Male medics questioning sexual history is a reality of the hospital.
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. 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.
Case #7:
[Beneficence, culture shock]

Is the patient’s reaction understandable given his encounter with you?

a) No – the patient is at fault for denying his depression, and it is not your fault that he refuses to accept his diagnosis.

b) Yes – your approach to the situation did not respect his understanding of the situation, and the diagnosis of ”depression” may be heavily stigmatized in Dieudonné’s society.

c) Yes – the patient’s world views are completely untrue, and he has no understanding of medicine. This is why he reacted the way he did.
Case #7: [Beneficence, culture shock]

How will this encounter affect Dieudonné’s future relationship with medical doctors and other health professionals?

a) He will probably come back when he needs medical assistance: the relationship will be unchanged.
b) He will be more likely to come back when he has a medical problem.
c) He will be less likely to come back – his last encounter may have left him feeling disrespected and misunderstood.
Case #7: [Beneficence, culture shock]

How does the patient understand his illness and how does he envision its treatment?

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.
PART III

EXCEEDING LEVEL OF SKILLS
Exceeding Level of Skills

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 #8:  
[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.
Case #8:
[exceeding level of skill]

What do you do in this situation?

a) Perform the procedure – you’ve seen it done before, clerks here do it, and your supervisor asked you to do it. This means she thinks you’re capable of removing the drain safely.

b) Do not perform the procedure – you have never done the procedure before under supervision.

c) Ask your supervisor if it would be alright if you waited to remove the drain under her supervision. Explain that you are concerned for the wellbeing of your patient, and would rather wait.
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 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.
Case #9:  [exceeding level of skill, language barrier, differing medical practices]
What would you do in this situation?

a) Do not perform the procedure – the needles are reused, and you would never vaccinate a child with a reused needle in your home country.

b) Perform the procedure – there are nurses there to supervise you, despite that you cannot communicate with them very well due to the language barrier.

a) Do not perform the procedure – you have never vaccinated a child before, and the supervisors are not able to communicate with you.

b) Perform the procedure – there is no one else to vaccinate these children, and they are probably more at risk of having complications from the diseases they’re being vaccinated against than from your vaccination.
Here, we are dealing with a medical practice 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.

In order to avoid being in this unclear situation, 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.
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 put on dialysis, 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.
Case #10: [exceeding level of skill, differing medical practices]

What should you have done?

a) Refused to have done the procedure – you have never done it before, and now is not a good time to try.

b) There was nothing more you could have done – you were being supervised by your tutor, and the consequences are his fault.

c) Asked to have observed the procedure before trying it. You should never undertake procedures you have never seen done before.

d) Accepted to have done the procedure under supervision, but under ultrasound guidance. It is never acceptable to make procedures more dangerous for the patient for your learning benefits.
Burdens on the Host Country

Sometimes, the fact that you are a foreign medical student can impose certain burdens on the host country’s medical system.
Case #11: [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, 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!”
Case #11:
[burdens on the host country, differing medical practices]

What do you respond to your supervisor?

a) You are simply a medical student who is trying to learn from this experience. You are on exchange and the department accepted to host you, therefore you are only requiring the necessary level of supervision you expect from the staff.

b) You understand the doctor’s perspective and realize you are posing a burden on the host institution - in this case, the supervisor is partially diverted from his responsibilities in order to provide you with assistance. Being unfamiliar with the language creates an additional burden for the local staff. Therefore you try to understand what is the reasonable level of supervision that you can receive compared to the amount of work the local staff needs to handle.

c) You explain that clinical rotations in your country and physician supervision are organized differently and you wish to receive supervision the same way as it is provided to all other medical students in your country.
How could you have prevented this answer from your supervisor?

It is generally 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.
Do not attempt to do procedures you have not done before, even if clerks in the host country do and even if your supervisor expects you to.

Ask to observe first, and then attempt under supervision.

The fact that you are a foreign medical student may cause increased burdens for the host country, but this is not an excuse for a lack of supervision.

It is your responsibility to tell your supervisor what you are and are not comfortable doing.
PART IV

RESEARCH ETHICS
Research Ethics

Research is a pillar to the advancement of the scope of medical knowledge.

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 and benefits of participation
- The patient must be free to leave the study at any time
- The patient must understand that they will not receive a lower level of care if they refuse to participate
- The patient must be aware of the methods used and any potential conflicts of interest
- The patient must consent without any external pressure. This can be difficult in the context of a patient who could not otherwise afford their medical treatment, or receives special benefits for participation
Principles of Research Ethics

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 participating in this study harm my patient in any way?
• Are they being denied the best possible treatment by 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.
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**.
Case #12:
[data collection, data privacy, confidentiality]

Discuss in a group:

What are the potential ethical issues of having patient information on a USB key?

What would have been the consequences for the patients had your USB been stolen or lost?
Case #12:
[data collection, data privacy, confidentiality]

How could you have prevented this?

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.
Principles of Research Ethics

Justice: as a researcher, you must ask yourself whether the burdens of this study being shared throughout all members of the population equally, or whether some subgroups being targeted more than others.

Ask yourself, 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.
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 here? List them.

1) Was the men’s participation free and informed?

2) Were the researchers concerned about the welfare of their patients?

3) Was the principle of autonomy respected in this trial?

4) Was a particular subgroup of society targeted by this study, or were the burdens shared equally throughout society?

Example 1: The Tuskegee Study
What are the ethical issues here? List them.

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.
Example 1: The Tuskegee Study

What are the ethical issues here? List them.

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.
Example 2:
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%.*
Example 2:
In cancer trials, minorities face extra hurdles

Is the principle of justice respected in this trial?

a) Yes – the researchers were not actively discriminating against certain races, since race was not an exclusion criteria.

b) No – the treatment is being offered less to minority patients than to Caucasian patients. It is the researcher’s responsibility to take steps to ensure representation of various minorities among their participants.

c) Yes – the researchers cannot help that patients from certain minorities are less likely to be recruited. This can be explained by cultural differences.
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 happens at multiple centers
- Make sure research assistants are not biased against minority patients
CONCLUSION
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. Always learn in **safe environments** and **do not exceed your own level of skill**.
Conclusion

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.
ENJOY YOUR EXCHANGE!
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. It has been reviewed and approved by the UNESCO Chair in Bioethics.

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