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POSITION PAPER

Ethical Obligations Regarding Short-Term Global Health Clinical Experiences: An American College of Physicians Position Paper

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This American College of Physicians position paper aims to inform ethical decision making surrounding participation in short-term global health clinical care experiences. Although the positions are primarily intended for practicing physicians, they may apply to other health care professionals and should inform how institutions, organizations, and others structure short-term global health experiences. The primary goal of short-term global health clinical care experiences is to improve the health and well-being of the individuals and communities where they occur. In addition, potential benefits for participants in global health include increased awareness of global health issues, new medical knowledge, enhanced physical diagnosis skills when practicing in low-technology settings, improved language skills, enhanced cultural sensitivity, a greater capacity for clinical problem solving, and an improved sense of self-satisfaction or professional satisfaction. However, these activities involve several ethical challenges. Addressing these challenges is critical to protecting patient welfare in all geographic locales, promoting fair and equitable care globally, and maintaining trust in the profession. This paper describes 5 core positions that focus on ethics and the clinical care context and provides case scenarios to illustrate them.

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Ethics resources and best practice guidelines for short-term global health clinical care experiences focus on medical trainees and training programs (1–8). There is a need to translate guidelines and apply ethical principles from the American College of Physicians (ACP) Ethics Manual to practicing physicians engaged in global health activities (9) in nontraining capacities.

The Ethics Manual (10) notes, "Physicians have an important role to play in promoting health and human rights and addressing social inequities. This includes caring for vulnerable populations." This is true both locally and globally. Over the past 2 decades, global health activities involving medical trainees (11–13) and practicing physicians (14–16) have expanded, with hundreds of millions of dollars in direct expenditures (4, 17, 18). With potential benefits of global health participation (19–23), including the potential to influence how and where physicians practice at home (for example, in underserved settings [13, 24–27]), come ethical challenges. These include respecting different cultural norms, avoiding unintended harms, protecting privacy, working within one's scope of practice, and managing resource constraints and priority setting (28). Evidence of positive long-term health effects has been lacking (29, 30), except in long-term, sustainable partnerships (31).

The term "short-term experience in global health" (STEGH) (12) as used here covers a range of clinical care and educational activities and is intentionally broad. "Short-term" refers to activities lasting a few days to several months. "Global health" could technically include any health-related activity anywhere in the world. This position paper follows others that have noted that global health typically emphasizes vulnerable populations in underserved settings (9). As used here, "experiences in global health" refers to circumstances where physicians from high-income countries travel to low- or middle-income countries or to underserved areas in high-income countries. Comprehensive review of ethical challenges is beyond the scope of this paper; for example, ethical challenges in international research is a rich and distinct field. This paper focuses on STEGHs, but these positions could also inform career global health work (32) or local activities in underserved settings.

Methods

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procedures (www.acponline.org/about-acp/who-we-are/acp-conflict-of-interest-policy-and-procedures), and appointment to and procedures of the EPHRC are governed by the ACP's bylaws (www.acponline.org/about-acp/who-we-are/acp-bylaws). After an environmental assessment to determine the scope of issues and literature reviews, the EPHRC evaluated and discussed several drafts of the paper. The paper was then reviewed by members of the ACP Board of Governors, Board of Regents, Council of Resident/Fellow Members, Council of Student Members, and other committees and experts. The paper was revised on the basis of comments from these groups and individuals. The ACP Board of Regents reviewed and approved the paper on 18 November 2017.

POSITIONS

Position 1: Physicians' primary ethical obligation in short-term global health experiences is to improve the health and well-being of the individuals and communities they visit.

A physician's primary ethical obligation is to the welfare of individual patients, not his or her own interests (10). The principles of beneficence and nonmaleficence ("do no harm") apply in the short-term global health setting. Evidence suggests the potential for unintended but real harms (22, 33–42) (see the Table for vignettes).

Best practice guidelines (2, 6) and recent literature (12) no longer consider short-term global health work as pure altruism or "something that is better than nothing" (43). Instead, STEGHs must demonstrate real benefit to the local community, with a goal of sustainability. Benefits could be short-term (such as relief of suffering or provision of needed medications or health care services) or long-term (such as treating to cure certain medical or surgical problems; educating local health care professionals; building health care infrastructure; or increasing awareness of global health inequalities that motivates long-term, sustainable change).

A few general recommendations can be made with regard to obligations of beneficence and nonmaleficence. First, the benefits of STEGHs should be "desired by and the interventions acceptable to" the local community (10) (Table [position 1, scenario B]). Short-term experiences in global health may involve physicians at different levels of training or students. Expected benefits must be balanced with potential risks on the basis of participant experience and training level. Because the STEGH participant cannot always determine what is most beneficial abroad, humility about one's knowledge and expertise is an important component of beneficence (44).

Second, beneficence requires adherence to existing ethical standards. For example, the dilemma of whether to use expired medicines sometimes arises in this context (Table [position 1, scenario A]). Existing guidelines from the World Health Organization usually prohibit such use, citing unintended harms and an ethical double standard (45), although some prescription drugs may retain potency after the manufacturer's expiration date (46).

Third, physicians should not exceed their scope of practice, even though local regulations may be less restrictive in other countries. When the need is urgent enough to raise consideration of exceeding one's scope, careful forethought and informed consent (47) are required at a minimum. Medical students, residents, and postgraduate trainees should not exceed their level of training. Local licensing requirements must be adhered to.

Finally, physicians' actions should not detract from local clinicians and resources. Supporting the local community may foster long-term, sustainable change (Table [position 1, scenario B]).

Patient and community welfare has primacy, but that does not mean that educational benefit for physician participants does not matter ethically. However, STEGHs can occur in contexts of power imbalance for historical, political, resource, and other reasons. Special efforts may be required to ensure unequivocal focus on benefits to the community as decided by the community (see position 3).

Position 2: The ethical principle of justice requires partnering with local leaders to ensure that the potential burdens participants can place on local communities abroad are minimized and preparing for limited material resources.

Justice requires that physicians "seek to equitably distribute the life-enhancing opportunities afforded by health care" (10). In many STEGH settings, certain material resources may be far more limited than in physicians' usual practice settings (Table [position 2]), presenting ethical challenges. Clinical resource limitations may be the most obvious, but ensuring that physician participants do not burden the host site is equally important. Examples of potential burdens include tangible costs (such as licensure; lodging; food; transportation; care in the event of acute illness, such as travelers' diarrhea; or measures to protect the physical safety of physician volunteers) and intangible ones (for example, causing local practitioners to shift their time and efforts toward the visiting team or expanding or supplanting their usual obligations).

Managing such burdens requires first recognizing them. Volunteers may lack knowledge of local circumstances, necessitating partnership with local community leaders. The full cost to local communities should be calculated and reimbursed (2). Protecting the safety of physician volunteers (such as during travel or using personal protective equipment) may require actions on the part of the local community, the organization, and the volunteer, but financial responsibility rests with the organizations that send volunteers. Although organizations typically provide reimbursement, individual physicians must be cognizant of potential burdens created by their presence (Table [position 2, scenario A]), take steps to minimize them, and report them to the sending organization. Responsibility for medical care of physician participants, including medical evacuation if necessary, rests with the sending organization.

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Ensuring just distribution of limited resources is another possible ethical challenge. This may occur for many resources, such as diagnostics, therapeutics, and personal protective equipment. Managing ethical tensions among the welfare of the individual patient, efficiency, and equitable distribution with special concern for vulnerable patients is challenging. The best balance should be decided among all stakeholders, with appropriate deference to local community values (**Table** [position 2, scenario B]) and in advance rather than during an individual patient encounter when possible (10).

Position 3: The ethical principle of respect for persons, including being sensitive to and respectful of cultural differences, is essential to short-term global medical experiences.

Physicians are obligated to provide culturally sensitive care that does not presume the correctness of any one culture's view (the physician's or the patient's) (10). Global health clinical activities in unfamiliar or under-

Table. Case Scenarios

Position	Statement	Contrasting Case Vignettes	
		Scenario A	**Scenario B**
1	Physicians' primary ethical obligation in short-term global health experiences is to improve the health and well-being of the individuals and communities they visit.	During a short-term medical trip to Latin America, a physician notices that the supporting organization sent a 30-day supply of presorted packets of donated antihypertensive medications that recently expired. The community will have no access to these medications after the team leaves. The organization also sent electronic sphygmomanometers, but without reliable electricity, they are rarely used. During the trip, the physician observes that patients preferentially see the U.S. physicians over the local physicians. She wonders whether they have done more harm than good.	A physician with vast experience in HIV care engages in a short-term global health project related to improving HIV care in an African country. The organization's primary mission is to partner with the local health community. As a result, the physician supports the local clinical staff and their patient care and does not administer direct care or dispense medications. This allows the community to develop the skills to care for their population in the way locals see fit.
2	The ethical principle of justice requires partnering with local leaders to ensure that the potential burdens participants can place on local communities abroad are minimized and preparing for limited material resources.	During a short-term medical trip, a team member notices that the local community is going out of its way to provide lodging, food, and transportation. "I don't want to be rude," he thinks, "but wouldn't these resources be better used elsewhere?" At the same time, as the clinic runs out of HIV medication, he begins to wonder whom he should treat first and what the effect will be on patients later that day, week, or year.	While planning a short-term medical trip, a physician volunteer notices that the sponsoring organization has a relationship with local community leaders. The volunteer works with these leaders to determine which costs the visiting group could reimburse or offset (e.g., travel, licensure, and salaries of the host abroad). They make contingency plans in case resources, such as medications, run out. During the STEGH, the physician senses how the process led to a deeper understanding of and partnership with the local community.
3	The ethical principle of respect for persons, including being sensitive to and respectful of cultural differences, is essential to short-term global medical experiences.	A female physician travels abroad believing that she is fluent in the local language and aware of local customs, but quickly notices that she has trouble understanding the local dialect. Moreover, her attire—skirts above the knee and sleeveless shirts—offends local patients and staff. Out of concern for alienating a global partner, the locals do not feel they should inform her of this.	Before a short-term medical trip, the team prepares by learning about not just the local community's language but also its health beliefs and culture. During the STEGH, a physician team member remarks to another how their health education effort was therefore well-received and likely more effective.
4	Predeparture preparation is itself an ethical obligation. It should incorporate preparation for logistical and ethical aspects of STEGHs, including the potential for ethical challenges and moral distress.	A physician who is less than a year out of residency arranges a short-term medical trip to rural Africa. The STEGH has a supporting organization but no predeparture preparation. After arrival, she notices that the clinic is significantly understaffed. The lone physician in the clinic, who has not had a day off in months, orients her briefly and asks to take time off for needed and deserved rest. The visiting physician feels obligated to stay but quickly becomes overwhelmed by not having the resources she is accustomed to at home. She even witnesses a patient die of a condition she could have treated at home. She wonders whether she did the right thing.	A physician returns from a short-term medical trip with residual concerns over her experiences—the limited resources, cultural differences, and concern over whether she made any difference. Fortunately, in advance of the STEGH, the organization prepared her for this possibility, and she established a relationship with a mentor experienced in global health. She maintained contact with her mentor when difficulties arose during the STEGH. The organization sponsoring her STEGH included posttrip debriefing to relieve this distress.

STEGH = short-term experience in global health.

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served settings may make cultural differences more evident (**Table** [position 3]).

Cultural sensitivity respects individual and community choice, privacy, and truth telling. Respect is also a critical component of global health ethics frameworks that emphasize solidarity (collective obligations based on social reciprocity) (48, 49). Local communities may place greater importance on STEGHs as expressions of solidarity than on the tangible benefits they provide (50, 51).

Respect for persons is important in its own right; physicians must demonstrate not only cultural competence but also cultural humility (10). This entails being respectful of different cultural views about the role of medicine in society and its goals. At the same time, certain values may transcend cultures, and being abroad does not reduce their importance. For example, physicians abroad should respect individual patient choice, privacy, and confidentiality by not sharing images or other personal health information without consent, including on social media (52, 53).

Respect also helps facilitate the obligations stated in positions 1 and 2. By humbly respecting cultural differences, STEGH physicians can help mitigate power imbalances between local communities and sending organizations (which may have more financial resources) or between volunteer physicians and local communities (who may perceive the volunteer team as inherently "better" physicians). Either could inappropriately influence decisions about mutual benefit and fair resource allocation. One way to fulfill these obligations is to partner with local community members (and other overlapping global health efforts if applicable [54]) before, during, and after STEGHs (55, 56).

Respectful partnership helps ensure that efforts are consistent with community values and self-identified needs (position 1), which increases the likelihood of lasting benefit (**Table** [position 3, scenario B]). Finally, partnership reveals burdens on the host through ongoing dialogue (some burdens may not be readily apparent to STEGH participants) and is also necessary for difficult discussions about fair resource allocation (position 2).

The physician's general orientation abroad should be one of a humble visitor who is respectful of cultural differences. However, physicians should not shirk their ethical duties and are "not required to violate fundamental personal values, standards of medical care or ethical practice, or the law" (10). For example, radical differences in how some cultures treat persons of different genders may cause a physician to wonder whether to conform, tolerate the treatment, try to change it, or even leave. Potential differences of such gravity must be elucidated and explored in advance of STEGHs. When such differences do occur, physicians should reach out to trusted mentors and peers in their home country, at the sponsoring organization, or in the local community to learn how best to respond.

Position 4: Predeparture preparation is itself an ethical obligation. It should incorporate preparation for logistical and ethical aspects of STEGHs, including the potential for ethical challenges and moral distress.

Many ethical guidelines and recommendations exist for STEGHs (2, 4, 6, 12, 28, 57–60). Predeparture training has been (61) and continues to be (62) ethically necessary to help physicians avoid some of the ethical pitfalls of short-term global health work (63).

Organizations that sponsor or support STEGHs may be primarily responsible for predeparture training. It should be tailored to the community where the experience will occur. Recommended topics include logistics (such as immunizations and predeparture medical screening, travel insurance, and appropriate licensure); planning for adequate supervision (especially for trainees); personal safety (such as road and travel safety or personal protective equipment needs); and, where applicable, malaria prophylaxis or health information needed to stay well while abroad. Education in local health and health system issues, history, culture, language, and ethics is also essential (64, 65).

Physicians should explicitly prepare for the possibility of ethical dilemmas and moral distress before, during, and after STEGHs (22, 66–68). Moral distress can occur if physicians are unable to act in ways that are consistent with ethics and their professional values or if they feel complicit in a moral wrong (**Table** [position 4, scenario A]). Moral distress is frequently accompanied by a sense of powerlessness, which can lead to deprofessionalization, burnout, decreased quality of care, or lasting negative emotions (69).

Organizations sponsoring or supporting STEGHs should prepare physicians for the ethical challenges they are likely to encounter and should formally debrief the experience afterward (70) (**Table** [position 4, scenario B]). Individually, physicians can develop and apply strategies for moral resilience. Physicians should have a mentor in their home country (who may also be a fellow traveler) and in the local community to discuss ethical concerns before, during, and after the STEGH and may find moral resilience strategies (71, 72) helpful. For example, regularly assessing one's emotions and actions surrounding the experience of ethical challenges abroad, documenting them in a journal, and sharing them with peers could help build moral resilience (72). Mobile technology and increased connectivity make this possible in real time.

Self-paced online resources on a range of global health topics allow participants to supplement organizational preparation (73–75). More specific ethics preparation (76–79) and book-length manuals (80) are also available. Although many resources focus on medical trainees (medical students, residents, and fellows), "trainee" should be interpreted broadly. Any STEGH participant with limited global health experience should, for the sake of humility, consider themselves a trainee.

In the future, predeparture training for STEGHs should be improved to target seasoned clinicians and evaluate the effect of training and training method on participant knowledge, skills, attitudes, and beliefs, as well as the long-term sustainability and effectiveness of

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short-term programs (81). Greater attention to monitoring and managing ethical challenges for all STEGH participants, including partners abroad, is also needed.

Position 5: Physicians should participate with organizations whose STEGHs are consistent with ethics and professionalism as exemplified in these positions.

Physicians who engage with organizations that sponsor short-term global health work may not be in the best position to influence decisions about such issues as benefits or resource allocation. Nevertheless, by choosing organizations that sponsor ethical STEGHs, physicians can maintain their professional integrity, serve underserved populations, and indirectly influence how short-term global efforts are organized.

No single checklist exists for physicians to use in guiding their choice, although some have been proposed for medical trainees (82). Best practice guidelines and resources can help physicians articulate questions to ask before committing to a particular organization that sponsors STEGHs. Physicians are obligated to report problematic STEGH practices to the administrative leadership of the organization sponsoring the trip (and, if necessary, to medical licensing bodies when applicable). For-profit global medical volunteer or tourism organizations may require special scrutiny because of the tension between profit margins and maximal benefit to communities abroad.

Although STEGHs with long-standing partnerships with host communities and organizations abroad are preferred, there is no "one-size-fits-all" approach to ethics in STEGHs. For example, natural disasters or severe pandemics may pose additional or different ethical challenges. Therefore, evaluation must also be sensitive to local context and needs. Short-term experiences in global health may initially not be fully sustainable (due to uncertain funding, local political circumstances, or other factors), but they may lead to sustainable, partnered efforts in the future or be ethically justified by short-term benefits, such as relief of suffering in areas of violence or humanitarian crises. In contrast, more can reasonably be expected in terms of positive effect, capacity building, and sustainability from a program that has operated for several years in the same location.

Evaluation is therefore itself an ethical obligation. Organizations that sponsor STEGHs should evaluate their effect, and physicians should choose organizations that are committed to evaluation. Progress toward the goals described in these positions requires evaluation timelines and benchmarks that create accountability for STEGHs. These should include process measures (such as the number of patients seen or local community involvement), outcome measures (for example, local health outcomes, capacity built, or relationships developed), and full cost accounting. Ideally, evaluations should be designed and conducted by or with the local community.

Conclusion

Physicians who participate in STEGHs have ethical duties and special obligations to advocate for sustainable, mutual benefit; a fair and equitable distribution of resources; and partnership with and respect for the individuals and communities they serve. These principles inform physician decision making surrounding short-term experiences and can positively influence how STEGHs are done. By adhering to these principles, physicians can help maintain trust in a profession committed to protecting patient well-being and improving health equity at home and abroad.

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