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Editorial comments on Short Term Healthcare Missions – Legal and Ethical Considerations by Joseph B. Henderson, Esq.

Editorial

In his thought-provoking article, Joseph Henderson underscores the lack of sufficient ethical guidelines for medical missions in general and short term medical mission ventures in particular. He states, “The principles of modern bioethics were promulgated in Western institutions of higher learning and, as such, do not take into consideration the difficulties in rendering healthcare in the developing world.” This has created an atmosphere highly susceptible to litigational disasters. It also makes possible unethical medical practices by well-motivated professionals “in a hurry to do good.” The excellent article by Drs. Michael and Anita Dohn : “Short Term Medical Missions : Some Quality of Care Issues,” (Crossnetwork Journal, Vol. 1, No. 2, pages 31-45, 2006) also addresses this issue and makes positive suggestions as to how to improve the practice of short term medical missions.

Short term medical missions (from one to several weeks in duration) occur for varying reasons, and these include, among others:

1. Teaching missions, where specialists go to teach host-country colleagues new concepts in the particular specialty areas
2. Locum tenens missions, to relieve ex-patriate or host-country professionals during conferences or to provide rest and recreation
3. Learning experiences for team members, to acquaint them with healthcare in cross-cultural contexts
4. Provide clinical services for underserved populations

The ethical issues would vary according to the goals and objectives

Proposed Guidelines For Short-Term Medical Mission Trips

Here are some suggested guidelines that may improve the legal and ethical nature of short term medical mission trips.

1. Develop a relationship ahead of time with the host-country partner who will then share the responsibility for the mission – church, community, medical facility, university.
2. Find out ahead of time host-country healthcare practices and regulations and try to conform to them.
3. Develop links with local host-country practitioners so that the mission can complement the services they give and perhaps transmit new ideas and practices to them.
4. Seek official government permission from the host country for the mission. This should be standard practice because missions are guests in the host country.
5. Follow as much as possible standard ethical practices of care applicable in the US
 - informed consent for any procedure
 - respect for the autonomy and dignity of each sick person
 - careful and clear explanations of the treatment and procedures
 - avoidance of any coercion, manipulation, or undo persuasion
6. Be sure that each member of the team is competent professionally to do the task assigned to him or her. Each team member should function only within the limits of his or her competence.
7. Develop a standard record form in English and the host-country language to be filled out for every person seen or treated – see the Dohn's article. This would include
 - brief history of the present illness
 - previous and current illnesses and complications
 - other medical care being followed currently
 - allergies, drug reactions, etc
 - physical and lab findings
 - treatment prescribed and given
8. Develop standard protocols (algorithms) for the common illnesses and procedures
9. Document every case and be sure records are kept intact. If a complaint does arise, these documents will be essential.
10. Maintain a register of all sick persons seen and treated. A local trained volunteer can do this.
11. Make an overall report at the end of the trip, preferably in two languages
12. Be sure all professional team members have copies of their professional documents – diplomas, licenses, etc.
13. Any untoward incident, unfavorable outcome, or accident should be carefully documented in English and the host-country language. If appropriate, local authorities should be involved in evaluating the incident and the proper reports made to local authorities.
14. Host-country volunteers can be used for logistics, health education, and community liaisons

15. Insofar as possible, the expected case load should be determined prior to the mission. If the expected case load exceeds the capacities of the team, consider the following options:

- Recruit more team members
- Ask the host-country partner to invite host-country colleagues to help
- Ask the host-country partner to restrict the number of persons to be seen
- Cancel the trip
- Remember that only rarely are we ex-patriates the only available health providers to people in other countries. We must not hide behind the excuse that “we were just too busy to do what we should have done.” Even Jesus refused to go back to the clinic in Capernaum and on occasion withdrew from crowds when the demands were too great.

Follow-up is important, as Henderson stresses in his article. Follow-up likewise needs to be developed for the short term mission team members. We hear much about the benefits to home churches and team members of short term mission trips, but who has done studies to see what these benefits are? Whatever they are, or aren't, the benefits could be improved if team leaders would remain in contact with team members and sending churches over time to encourage further interest in missions and their possible long-term involvement as career missionaries.

The medical missions community should come together to develop a more comprehensive set of legal and ethical guidelines for both long-term ministries and short term medical missions. Such guidelines would be beneficial to all who want to bring healthcare to needy people and might even prevent some unfortunate situations from developing.

Those responsible for both long and short term health missions should engage in study, reflection, and careful seeking of the mind of God along the following lines:

1. What are the real and long-term health needs of people and communities in the area to be served – physical, social, and spiritual needs?
2. How will the mission envisaged be able effectively to meet some of those needs on a sustainable basis?
3. Can we undertake more effective measures to enable and empower host-country medical services, churches, and communities to meet these needs themselves?
4. What training do we need in spiritual, cultural, and developmental dynamics in order to do a better job? Jesus spent many years in quiet preparation in Nazareth and then 40 days of intensive prayer, fasting, and strategic planning in the wilderness before beginning his three-year term of service. Should we not be following his example?

I have one final comment about Henderson's reference to bringing surgical textbooks into the operating theatre. During my 35 years of service in the Congo, I did this on numerous occasions. Textbooks replace unavailable consultants. However, they permit no one to operate beyond their level of competence, but they can enable a health professional to cope with a problem for which he or she has as yet has little experience.

I thanked God many times for Cutler and Zollinger's Surgical Atlas, Schwartz's Textbook of Medicine, DePalma's Atlas of Fractures, and Maurice King's marvelous texts on primary surgery. Outcomes were much improved because my non-verbal but clearly outlined "consultant" helped me cope with problems within my competence but beyond my level of experience.