

Ethical Challenges in Medical Community Internships: Perspectives from Medical Interns in the Philippines

AIMEE LORRAINE C. CAPINPUYAN AND RED THADDEUS D. MIGUEL

Abstract

The Philippine community internship program, originally created to supplement the country's thinning health workforce while providing training to student doctors, poses a legal and ethical challenge for medical interns. Inherent characteristics of the program—such as financial disparities and burdens, the lack of supervision by senior doctors, the competence of student doctors, and short rotation times—can predispose interns to cause harm to the patients and communities they serve. As currently designed, the internship program has the capacity to leave interns unsupervised, at risk of legal ramifications, constantly questioning the correctness of their interventions, and perpetually straddling conflicting role virtues. By failing to ensure that the community internship program has appropriate safeguards in place, the government not only jeopardizes the welfare of interns but also threatens the quality and continuity of care that patients and communities receive, potentially violating their right to the highest attainable standard of health. One medical school recently started a novel internship program that could address the issues mentioned.

AIMEE LORRAINE C. CAPINPUYAN, BSc HSc, is a medical intern at the Ateneo School of Medicine and Public Health, Pasig, Philippines, where she is undertaking the Community Enhanced Internship Program.

RED THADDEUS D. MIGUEL, BSc HSc, MD, MBA, is an independent health policy researcher with focus in health financing.

Please address correspondence to Red Thaddeus D. Miguel. Email: red.upmanila@gmail.com.

Competing interests: Aimee Capinpuyan is currently enrolled as a medical intern at the Ateneo School of Medicine and Public Health. Red Miguel received his doctor of medicine from the same school.

Copyright © 2019 Capinpuyan and Miguel. This is an open access article distributed under the terms of the Creative Commons Attribution Non-Commercial License (<http://creativecommons.org/licenses/by-nc/4.0>), which permits unrestricted non-commercial use, distribution, and reproduction in any medium, provided the original author and source are credited.

Introduction

Through the Philippine community internship program, medical interns are posted at small-town health centers in select—typically poor—communities, where they act as junior physicians. The program's intentions are noble, tackling the lack of physicians in underserved communities while providing training to medical interns. However, inherent characteristics of the program pose ethical and legal challenges for medical interns. During the program, distraught interns find themselves in a position that could threaten the rights of the patients they encounter. We examine such situations using examples gathered from our own community internship experiences and those of our peers. We conclude by offering our insights on a potentially improved system recently implemented by the Ateneo School of Medicine and Public Health.

The Philippine community internship

In the 1970s, the community internship was established as a component of the Comprehensive Community Health Program in the Philippines.¹ Interns were required to rotate in accredited community sites under the direct supervision of faculty members. While the original program was eventually phased out in the 1980s, the inclusion of community-based medical training became a formal requirement for medical colleges nationwide in 1994. During this time, the Association of Philippine Medical Colleges, the national organization that supervises and monitors internship programs, created guidelines for implementing the community internship. According to the guidelines, the internship program may take on the following forms: “a formal community health program of the hospital, a program of the local health department or health center, a school health program, a health program of NGOs, civic, and religious groups, and other creative community health programs.”² While there is flexibility in implementation, the most common format is a two-month rotation for interns.

The ethical complexities of medical internships in communities

“Internship year,” which is a medical student's final year of formal training, has been found by several studies to be fraught with ethical and legal challenges. One study found five specific challenges: telling the truth, respecting patients' wishes, preventing harm, managing the limits of one's competence, and addressing the performance of others that is perceived to be inappropriate.³ Another study found that the most common issues experienced by students were professionalism, confidentiality, the doctor-patient relationship, informed consent, and the doctor-peer relationship.⁴ Further, the mistreatment and abuse of medical students by more senior staff can also add to these ethical challenges.⁵ In the Philippines, these challenges seem to be magnified in light of several inherent limitations of the community internship program.

Inequalities and financial burdens

Medical interns experience pressures from an entirely new work environment as they transition to their new community internship in conditions where systemic inequalities subject their poor patients to dire health outcomes. This makes the community internship program a difficult situation for both interns and the communities they serve.

According to a 2015 World Bank study, more than one-fifth of the Philippine population, or 22 million people, lives below the national poverty line.⁶ Roughly 8.2 million people cannot afford basic food requirements. Economic inequities make poor Filipino households susceptible to employment shocks (such as job losses and lower wages) and health-related shocks (such as illness, death, and unplanned pregnancies).⁷ Moreover, poor households often have limited access to basic services, such as sanitation, clean water, electricity, and household assets, including communication and mobility tools.⁶ As a result, poor communities have weak bargaining power when it comes to accessing quality health care. For lack of better options, communities are eager to accept any additional health

resource that comes their way, including medical interns still in training.

The interns, on the other hand, usually work without pay at their assigned community health centers. In many cases, students pay out of pocket for daily transportation costs, medical equipment and medications for their health centers, and programs they wish to implement. Consequently, the quality of care interns bring to their communities could depend on their personal financial capacity.

Lack of supervision and role models

In many iterations of the community program in the Philippines, interns are assigned to a local government-sponsored health center. Although health centers do have regular doctors in their employ, the thinning workforce in local health networks forces senior physicians to divide their time among several neighboring health centers. Consequently, it is not uncommon to have days where community interns are left to their own devices in the health centers. Even on days when physicians are present, the amount of support that interns receive from them is contingent on the individual physician's willingness to teach, as well as his or her workload. When interns are fortunate enough to be assigned to a health center with an accommodating consultant, cases are reviewed and lessons are shared regarding cases seen. Unfortunately, it is more often the case that overworked senior physicians are unable to be the role models that community interns need them to be.

In instances where there is a lack of supervision from a senior physician, the intern may be forced to take on the role of primary health care provider despite lacking a license to practice. This poses a legal quandary, as only those who have passed the Physician Licensure Exam are legally allowed to practice medicine, according to the Philippine Medical Act of 1959.⁸ Interns—medical students who have completed the first four years of medical studies—are legally allowed to practice medicine only during epidemics or national emergencies, and even then only with special authorization by the Secretary of Health.⁸ Furthermore, the lack of supervision has been found to potentially introduce unnecessary

harm to patients brought about by systematic errors, an inability to demonstrate compassion, and the provision of futile treatment.⁹ Hence, the lack of supervision in the scenario of the Philippine community internship may compromise the safety of patients, as well as that of the larger community.

Competence of student physicians

Interns' lack of experience and knowledge further enhances the risk of the internship program introducing harm to the communities being served. One example is the rotation system that is in place in most internship programs throughout the Philippines. Under this system, groups of interns rotate through different fields of medicine, including community medicine, over the course of the program. For example, a group may be in internal medicine one week, surgery the next month, radiology after that, and so on, until all rotations are completed. By the end of the year, every group would have experienced and learned from each rotation. If an intern is assigned a rotation schedule in which community medicine is last, then the intern brings many of the new skills, experiences, referral networks, and knowledge from past rotations. However, if the intern draws a rotation in which the community program is first, and he or she is not supervised, then the intern is left to rely on knowledge and skills from medical school, which may be insufficient for the cases encountered in the community.

To address knowledge gaps throughout the year, interns often develop referral systems among internship groups. These networks also arise from interns' fear of being ridiculed by senior consultants and their lack of access to supervising physicians. Interns consult with fellow interns instead of senior doctors, potentially leading to the propagation of false information or inappropriate management. Worse yet, erroneous practices that are not caught early on may even propagate through the next set of interns, given that it has become a custom for fourth-year medical students, before commencing their internship year, to turn to outgoing interns for notes and tips.

Lastly, community interns often prescribe

medications despite lacking a medical license. In such cases, interns write the health center doctor's name and license number on the prescription beside the intern's name. Some doctors entrust their name stamps to the health center interns for the express purpose of prescribing drugs in their absence. While formal studies have not been conducted on the safety of this practice, it is ethically and legally questionable to allow a medical student to prescribe medications.

Gaps in continuity of care

Continuity of care can be defined as a seamless transition among health services and providers over time.¹⁰ Ensuring continuity of care is essential for quality care, but its importance is largely unrecognized in the Filipino medical internship program. The current setup wherein interns rotate across fields, spending only two months at a time at community health centers, could lead to complications and adverse reactions caused by the prescribed treatment going unnoticed.¹¹ Similar to the case of short-term volunteerism, this set-up fails to achieve an optimal continuity of care, characterized by regular contact between providers and the communities they serve.

An example of this can be seen in our own experience. We once had an elderly patient who would routinely visit the health center for a refill of his hypertensive medications. He had an extremely hoarse voice that made him difficult to understand, but when probed for details about it, he would repeatedly insist, "I'm fine, I'm fine. Nothing is wrong with me." It was apparent that he simply wanted to receive his medications and leave. We later learned from the health center's regular doctor that this man was an old patient of hers who had been diagnosed with suspected laryngeal cancer. He needed urgent hospital attention but had always refused to seek such care out of fear of being intubated. This information was crucial in guiding our plans when he followed up a month later—we were able to counsel him regarding his condition, focusing on his hospital-related fears, with the goal of allowing him to make a more informed decision regarding his management. It was fortunate for us that the health center's doctor had

been around at the time; other interns, especially those who work as health centers' only doctors, know the struggle of managing chronic patients with an unclear clinical history.

One way to alleviate the effects of the rotation system is to have the outgoing community interns properly endorse their patients to the incoming group. Endorsements (also known as "handovers" or "handoffs") are when the outgoing team of caregivers relates crucial patient-specific information to the incoming team. Caregiver-to-caregiver endorsements are crucial in patient care, and ineffective handoff communication has been found to be the most common cause of adverse hospital events.¹² Accordingly, in rural settings, effective handover practices have been found to significantly improve perceptions of patient safety.¹³ However, the reality is that patient endorsements rarely happen as interns rotate through their assigned fields. The high volume of patients seen at community centers makes endorsing each patient who needs long-term care a tedious and time-consuming task. Instead, interns tend to rely on patient records, which can vary in quality and often lack important data.

Discussion

Coming from clerkship year, in which students are focused on fulfilling academic requirements and handling ward work, interns confront a complicated situation. All at once, the intern experiences overlapping roles: a health professional and a learner, a student and a member of the workforce. These coexisting expectations create tensions and can lay the ground for moral distress.

This phenomenon can be explained in the light of conflicting role virtues.¹⁴ As student doctors, interns are expected to be benevolent, compassionate, truthful, just, humble, and self-sacrificing.¹⁵ As medical learners, they are expected to prioritize cooperativeness, curiosity, commitment to one's education and development, responsibility, and motivation.¹⁶ As employees (of the hospital or health center), they are expected to emphasize efficiency, flexibility, competence, and dedication to the job.¹⁷ Interns want to do "good," but the

definition of “good” varies depending on the role. Often, characteristics inherent to the community internship program make it difficult for interns to simultaneously and equally uphold these many virtues, creating an internal conflict that precludes them from accomplishing the objective of the community internship program. Taking these roles together, the community intern is expected to be efficient, competent, and benevolent. However, practicing in extremely resource-deficient settings with high numbers of patients and little to no physician support can prevent interns from fulfilling this vision. Even in the presence of regular doctors, interns can still lack role models who exemplify the kind of humility, compassion, and courage needed to effectively practice in resource-limited settings. Thus, the entire experience causes unnecessary stress that could negatively affect interns’ mental health, their perception of what it means to be a physician, and the quality of care they provide to the community. As interns complete their studies, they are left to wonder whether they were indeed able to uphold any of their roles during the community internship program.

In the grand scheme of national health delivery, the Philippines, as a party to the International Covenant on Economic, Social and Cultural Rights, is obligated to uphold the rights of its constituents to attain “the highest standard of physical and mental health.”⁸ Furthermore, the country’s Republic Act No. 11223 (more commonly known as the Universal Health Care Act) states that it is the “policy of the State to protect and promote the right to health of all Filipinos and instill health consciousness among them.”⁹ For policy makers unaware of the aforementioned shortcomings of the community internship program, these internships appear to offer a magic bullet for strengthening the country’s weak medical workforce and producing excellent future physicians. In addition, the program seems to be aligned with the government’s mandate to improve health outcomes for communities. However, as described earlier, in its current iteration, the community internship program poses the risk of harm to patients and interns alike. By maintaining the flawed design of the program, the government

is failing to uphold its legal obligation to provide health for all.

The Philippines’ community internship program has the potential to provide much-needed care where health inequities thrive, as well as to hone the abilities of the nation’s future physicians. However, as currently designed, it also has the capacity to leave interns unsupervised, at risk of legal ramifications, constantly questioning the correctness of their interventions, and perpetually straddling conflicting role virtues. When the government fails to ensure that the community internship program has appropriate safeguards in place (for example, an adequate number of senior physicians, compensation for interns, and proper referral systems), it jeopardizes not only the welfare of interns but also the rights of communities. For patients and their communities, the design of the internship program threatens the quality and continuity of care that they receive, potentially violating their right to the highest attainable standard of health.

Redefining the community internship program

As discussed, medical students’ community internship experiences can be laden with ethical and legal challenges stemming from the government’s failure to ensure adequate support for interns. In turn, the situation of the interns and the conditions in which they work have the potential to harm patients in the communities being served. As we wait for the government to take measures to improve the national curriculum, one medical school is currently testing a restructured community internship program that, if successful, could provide a desirable alternative for other medical schools.

The Ateneo School of Medicine and Public Health, established in 2012, recently created a program to address these challenges. Recognizing the immense potential of health centers to serve as effective instructional settings for medical education, the school partnered with the Quezon City local government to create a novel community track for fifth-year medical students called the Community-Enhanced Internship Program (CEIP).

Under the CEIP, fifth-year medical students rotate between a partner health center and the school's partner hospitals for 12 months. At the health center, their main task is to run a community clinic where specialty consultations are made available through the presence of consulting faculty from various fields of medicine.

The program innovates on the usual community internship format in three ways. First, interns are provided constant supervision through the regular presence of consulting faculty in the health center. Unlike in most community internships, in which interns are left to their own devices at community health centers, this method ensures that interns carry out safe and appropriate patient management. Second, CEIP interns spend a total of six months in their community instead of the usual two. The longer duration of the program allows for closer follow-up of patients and minimizes the need for patient handoffs. Third, CEIP interns' hospital rotations alternate with their community rotations on a monthly basis, unlike the usual program in which interns spend two consecutive months in a community and ten consecutive months in a hospital. The alternating community and hospital months in the CEIP allow interns to supplement the knowledge and skills learned from hospitals with that learned from their communities, and vice versa. In this way, the CEIP may offer an answer to the ethical challenges described earlier, for its constant supervision of interns, longer program duration, and alternating hospital-community rotations aim to promote quality and safe patient care, with the possible long-term effect of upholding communities' rights to quality health care. However, as of writing, the new program is only on its tenth month of operations, with a pioneer cohort consisting of just 12 interns rotating at one health center. The school administration plans to continue the program for two more cohorts before conducting an evaluation.

In conclusion, medical students' completion of their community internship can be fraught with ethical and legal issues. Interns—with their multiple and sometimes conflicting roles as clinicians, learners, and employees—are placed in a complex

ethical position when they practice medicine in poor and vulnerable communities. The lack of support for interns perpetuates these problems, consequently threatening the rights of the patients they serve. The Ateneo School of Medicine and Public Health's CEIP may provide a desirable alternative to the existing format of community internships given its longer program duration and more extensive supervision scheme, but in light of the novelty of the program, no solid recommendations can yet be made. If successful in alleviating the limitations of the current community program, the government may consider implementing the CEIP design, or a version of it, in all medical schools with the hopes of upholding its constituents' right to the highest attainable standard of health.

References

1. C. Dimacali, "The University of the Philippines College of Medicine: Pioneer in medical education innovations in the Philippines," *Acta Medica Philippina* 51/4 (2017), pp. 360–362.
2. R. L. Arcadio, "R. L. Arcadio to all hospital directors of APMC accredited internship programs and all deans of medical schools," (July 31, 2018).
3. R. McDougall and D. K. Sokol, "The ethical junior: A typology of ethical problems faced by house officers," *Journal of Royal Society of Medicine* 101/2 (2008), pp. 67–70.
4. N. N. Fard, F. Asghari, and A. Mirzazadeh, "Ethical issues confronted by medical students during clinical rotations," *Medical Education* 44/7 (2010), pp. 723–730.
5. F. Cook, V. M. Arora, K. A. Rasinski, et al., "The prevalence of medical student mistreatment and its association with burnout," *Academic Medicine* 89/5 (2014), pp. 749–754.
6. World Bank, *Making growth work for the poor: A poverty assessment for the Philippines* (Washington, DC: World Bank, 2018).
7. J. R. Albert, J. C. Dumagan, and A. Martinez, Jr., "Inequalities in income, labor, and education: The challenge of inclusive growth," Philippine Institute for Development Studies Discussion Paper Series (2015). Available at <https://dirp4.pids.gov.ph/webportal/CDN/PUBLICATIONS/pids-dps1501.pdf>.
8. Republic of the Philippines, *Republic Act No. 2382 (as Amended by Republic Act No. 4224): The Medical Act of 1959* (1959). Available at https://www.lawphil.net/statutes/repacts/ra1959/ra_2382_1959.html.
9. P. A. Clark, "What residents are not learning: Observations in an NICU," *Academic Medicine* 76/5 (2001), pp. 419–424.

10. H. J. Biem, H. Hadjistavropoulos, D. Morgan, et al., "Breaks in continuity of care and the rural senior transferred for medical care under regionalization," *International Journal of Integrated Care* 3 (2003), p. e03.
11. I. Bauer, "More harm than good? The questionable ethics of medical volunteering and international student placements," *Tropical Diseases, Travel Medicine and Vaccines* 3/5 (2017).
12. E. Manias, F. Geddes, B. Watson, et al., "Perspectives of clinical handover processes: A multi-site survey across different health professionals," *Journal of Clinical Nursing* 25/1 (2015), pp. 1-2.
13. D. Piper, J. Lea, C. Woods, and V. Parker, "The impact of patient safety culture on handover in rural health facilities," *BMC Health Services Research* 18/1 (2018), p. 889.
14. R. McDougall, "Understanding doctors' ethical challenges as role virtue conflicts," *Bioethics* 27/1 (2013), pp. 20-27.
15. J. F. Drane, *Becoming a good doctor: The place of virtue and character in medical ethics* (Kansas City: Sheed and Ward, 1988), p. 32.
16. M. Parker, "Autonomy, problem-based learning and the teaching of medical ethics," *Journal of Medical Ethics* 21 (1995), p. 307.
17. L. Ryan, "The ten qualities of outstanding employees," *Forbes* (August 20, 2018). Available at <https://www.forbes.com/sites/lizryan/2017/08/20/the-ten-qualities-of-outstanding-employees/#2afaoa59738f>.
18. Committee on Economic, Social and Cultural Rights, General Comment No. 14, The Right to the Highest Attainable Standard of Health, UN Doc. E/C.12/2000/4 (2000).
19. Republic of the Philippines, *RA no. 11223: An Act Instituting Universal Health Care for All Filipinos, Prescribing Reforms in the Health Care System, and Appropriating Funds Therefor* (2019). Available at <https://www.officialgazette.gov.ph/downloads/2019/02feb/20190220-RA-11223-RRD.pdf>.

