A professional virtues–based ethical framework for medical missions

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BACKGROUND: More than 1.6 million physicians participate in medical missions each year. This effort is part of a long history of volunteerism and service to those in need in the form of medical missions to low-income countries. The Children's Health International Medical Project of Seattle has provided the following 7 guiding principles of sustainable short-term international medical missions: "mission, collaboration, education, service, teamwork, sustainability, and evaluation." The role of professional virtues in grounding these principles and thus guiding medical missions is underappreciated.

OBJECTIVE: To provide a professional virtues–based ethical framework for medical missions, this article addressed the question, "How should physicians design and implement a medical mission in a professionally responsible way?" Reference is made to one of the authors' experiences as a point of reference.

STUDY DESIGN: The authors addressed the questions on how to design and implement a medical mission based on 5 professional virtues: compassion, integrity, humility, self-effacement, and self-sacrifice. A concise, historically based explanation of each virtue was provided, and the implications of the aforementioned principles for medical missions were identified.

RESULTS: Compassion motivates the mission and its team members, whereas integrity, humility, self-effacement, and self-sacrifice guide team members as they act on the professional virtue of compassion.

CONCLUSION: These 5 professional virtues can be used to provide a practical framework for the professionally responsible design and implementation of medical missions.

Key words: Achi, global health, humility, integrity, medical mission, Nigeria, professionalism, professional virtues

Introduction

Physicians have a long history of volunteerism and service to those in need in the form of medical missions to low-income countries. The Children's Health International Medical Project of Seattle (CHIPS) has provided the following 7 guiding principles of sustainable short-term international medical missions: "mission, collaboration, education, service, teamwork, sustainability, and evaluation."[1] Bassey-Akamune[2] succinctly stated that "Medical missions focus on assessing the medical needs of the population encountered and providing medical opinions/consultation, medications, and surgeries." The role of professional virtues in grounding these principles is underappreciated, especially when ethical concerns in medical volunteering have grown tremendously over the last years, highlighting the need for appropriate guidelines.[3] This article provided a professional virtues–based ethical framework for medical missions by addressing the question, "How should physicians design and implement a medical mission in a professionally responsible way?"

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Methods

To develop the proposed professional virtues–based ethical framework for medical missions, this article deployed a key component of ethical reasoning, known as ethical analysis. Ethical analysis proceeds in a stepwise fashion to articulate pertinent concepts as clearly as possible, the concept of a professional virtue in medicine. Subsequently, we linked this ethical analysis to the CHIPS principles. The experience of one of the authors with organizing, funding, and leading an annual medical mission to Achi, Nigeria, was used to illustrate the pertinent professional virtues.

Results

Ethical analysis of 5 professional virtues

The first step of the required ethical analysis is to clarify the concept of a virtue. Virtues are traits or habits of character that create ethical obligations, actions that ought to be undertaken because they are right or good things to do.

The second step is to clarify the concept of a professional virtue in medicine. To do so, we turn to the history of medical ethics. The concept of a professional virtue was introduced into the history of medical ethics by Drs John Gregory (1724–1773) of Scotland and Thomas

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Why was this study conducted?

This narrative review of a medical mission to Nigeria addressed a question central to the professional ethics of medical missions: how should physicians design and implement a medical mission in a professionally responsible way?

Key findings

There are 5 professional virtues: compassion motivates the mission and its team members, whereas integrity, humility, self-effacement, and self-sacrifice guide team members as they act on the professional virtues of compassion.

What does this add to what is known?

The 5 professional virtues that we described can provide a powerful, practical framework for the professionally responsible design and implementation of medical missions.

Percival (1740–1804) as transnational, transcultural, and transreligious.[4,5] Therefore, professional virtues provide a previously unexplored ethical foundation for an ethical framework for medical missions that applies regardless of the national politics, culture, or religious communities of the country from which the mission originates and that of the host country.

The third step is to identify the professional virtues pertinent to medical missions: compassion, integrity, humility, self-effacement, and self-sacrifice.

The professional virtue of compassion

Medical missions draw their primary ethical justification from the professional virtue of compassion. Compassion creates the ethical obligation to prevent and respond clinically to the pain, distress, and suffering of patients. The medical mission to Achi was created in response to the direct experience as a child by one of the authors (W.O.) and his vivid memory of that experience as he became a physician. The professional virtue of compassion drove him to return to his village. Physicians without such experience rely on the power of narratives of others that have the power to engage the professional virtue of compassion. Once a physician has participated in a medical mission, the vivid memory of it further engages the professional virtue of compassion.

The professional virtue of compassion directs the physician to meet the clinical needs of each patient. Interestingly, 4 additional professional virtues complement compassion by guiding this direction in greater clinical detail.

The professional virtue of integrity

The professional virtue of integrity creates the ethical obligation to practice medicine, teach, and conduct research to standards of intellectual and moral excellence. Intellectual excellence is achieved by conforming clinical judgment and practice to the best available evidence. The notion that "some care is better than no care" is fallacious if care is not of intellectual and moral excellence. Moral excellence is achieved by putting each patient's health-related interests first and keeping self-interest systematically secondary. In addition, participants should disclose any potential conflict of interest, and voluntary participation in medical missions should not be viewed as a "checkbox" for academic advancement.

The professional virtue of humility

Humility, a corollary of integrity, creates the ethical obligation to become aware of one's limits and prevents acting on pride that ignores limits.

The professional virtue of self-effacement

Self-effacement creates the ethical obligation to recognize and not be biased by differences with patients that are not clinically relevant. Achieving self-effacement will often require recognition of the cognitive dissonance that occurs when one's habitual patterns of thought and behavior become problematic in a different cultural setting.

The professional virtue of self-sacrifice

Self-sacrifice creates the ethical obligation to take reasonable risks to one's self-interest, including those that are health-related or financial.

Implications of the professional virtues for the Children's Health International Medical Project of Seattle principles

The CHIPS has provided the following 7 guiding principles of sustainable short-term international medical missions: "mission, collaboration, education, service, teamwork, sustainability, and evaluation."[1] The unique contribution of this article will be to interpret these principles based on professional virtues.

Mission

The compassion-driven mission statement is to help the local population with their healthcare concerns in a way that displays integrity and is collaborative and sustainable. Integrity requires providing clinical management that meets accepted clinical standards, accounting for the resource constraints of the local setting.

Collaboration

Collaborative clinical care is guided by self-effacement, which requires team members to put aside their personal, cultural, and religious differences and focus on meeting the needs of each patient by coordinating skill sets of everyone involved to maximize the effectiveness of patient care. This coordination requires each team member to be aware of his or her clinical limitations, as required by humility.

Collaborative clinical care should be culturally competent but cannot facilitate unethical practices, or practices that are locally beneath the standard of care. Mission leaders (W.O. and T.I.M.) saw early the need to engage the community's elders, chiefs, and the medical

practitioners within the community. They made them a part of the mission's medical team. Self-sacrifice underscores the importance of partnering with the community so that the work of the medical mission is not self-serving and therefore minimizes the risk of appearing to be so. This approach allowed mission members to be accepted and seen as being committed to the interest and health of patients as their primary concern and motivation. Furthermore, the mission would need community collaboration to ensure continuity of care when mission members returned to the United States.

Education

Education is always a major part of the medical mission. Education of team members aimed to prepare them to be effective clinicians by adapting their skill sets to become collaborative in a more culturally competent fashion. The mission partnered with the global health division of the department of family medicine at our medical school to assist with the education of team members and preparation of educational materials for patients to use on site.[6]

Self-effacement required team members to appreciate that most patients were unaware that they had chronic diseases, such as hypertension and diabetes mellitus, until the team made the diagnosis. Subsequently, patients were treated and educated on what to do moving forward. Team members took the opportunity to share best practices with local medical practitioners, and they, in turn, educated team members on prevailing common local health illnesses, allowing for bidirectional sharing of expertise. Humility called for team members to be guided by the self-identified learning agendas of local practitioners.

Service

Integrity requires that clinical management aims to produce net clinical benefit, by ameliorating the burden of disease and minimizing the complications of treatment for each patient. The success of the mission was directly proportional to the amount of medication, equipment, and healthcare providers assembled for the work. Preparation for the medical mission took many months before departure.

Professional integrity and compassion justified the goal of the coordinated approach to patient care: providing culturally competent, effective clinical management to the largest number of patients each day. Patients would start lining up early each morning. "First come, first serve" has been criticized in the literature on the ethics of access to limited resources, principally because this approach can be biased or reinforce health disparities that unjustly limit access. A lottery has been proposed as an antidote to these ethical concerns.[7] In the setting of this mission, a lottery would risk suspicion or even rejection by the intended patient population. Put another way, advocates of a lottery assumed that this approach would automatically have moral authority in other cultures, based on American ideals of equality. This assumption could not be made in Achi. The concept that everyone had to stand in line and be served when it was his or her turn was already well accepted in this community. "First come, first serve" became a culturally competent approach, because it would create the least disruption of community values and therefore minimize the potential for mistrust.

This approach would not have been effective in addressing certain barriers, for example, those experienced by elderly and disabled patients with mobility impairment. We provided the clinics of the medical mission in 4 rotating sites attempting to minimize the mobility barriers and prevent undue health disparities from adversely influencing access to the clinics.

Teamwork

Team members had defined roles: navigators (moving patients from area to area), admitters (logging in patients and updating their records), clinicians (providing the clinical care), and medication dispensers (led by a pharmacist, providing medication as prescribed by the clinicians). There was a premeeting to discuss the flow of operations and to review the most common causes and management of illnesses in the region. Available resources for referral were discussed and questions were answered for those who were uncertain about their roles. Moreover, cultural awareness was taught to minimize the risk that team members might inadvertently offend the patients and their family members during the process.

Global health programs that produce long-term transformative change rather than transient relief are more likely to be sustainable and in ethical harmony with expressed needs of a region or community.[8] Therefore, to ensure the sustainability of medications, for example, the mission limited its formulary to the World Health Organization's list of locally available medications in the region. These medications were reviewed during the premeeting. It is not consistent with either compassion or professional integrity to provide patients with chronic care medications that they will be unable to continue after the mission ends.

The patients' names would be recorded, and they would each be assigned a number. These numbers determined the order in which they were seen. When called, each patient would be admitted by the admitters and then sent to a clinician. The clinician would assess the patient and document the findings and the proposed clinical management. Subsequently, the patient would be sent to the pharmacy area where their prescriptions were filled. Furthermore, patients would be escorted out of the makeshift clinic by the navigator.

The navigators' role was not limited to escorting patients; they would assist all members of the team. For example, should supplies run low, the navigators would be sent to retrieve more supplies. Should the need for a clinician with expertise in basic procedures arise, the navigators would take the patient to the clinician with the appropriate skill. In the event of the need for translation, the navigators would secure a translator for an English-only clinician working with a patient with no or insufficient English.

Evaluation

Several hundred patients were seen, and most patients were referred to the local and regional healthcare providers, as required by integrity and humility. Documentation of prevailing conditions and treatments were compiled for analysis and to use for subsequent management by the local practice community and by future international teams. Each patient was given a short survey to determine whether the patient felt the service provided by the team was of benefit.

Debriefing is an important process of the evaluation of a medical mission because debriefing implements compassion for the team members and helps them to maintain their professional integrity. Note that one of the prerequisites for the students and learners was to participate in a global health orientation course.[6] Some first-timers experienced significant culture shock as they had never seen deep poverty. Some were surprised at the lack of healthcare. Throughout the clinical encounters, experienced attending physicians supervised the inexperienced team members, attending to their physical, mental, and emotional needs, ensuring they were not overwhelmed by what they were seeing and experiencing, all as required by compassion of medical educators for their learners.

Debriefing is part of the curriculum provided by the global health faculty that participated in the mission and should involve local individuals and institutions to share true results: successes or failures. Consequently, the debriefing took place in the home compound and included local individuals to discuss events that resulted in both success and failure. This approach was used to ensure that the team members would be away from the clinical sites and experience a safe environment where they could express themselves more freely. After dinner, everyone gathered to review the clinical work of the day—what went right, what went wrong, and how to adjust for the next day's mission. This meeting provided an important opportunity for the team members to decompress and relax. Team members were given opportunities to discuss what they saw, what they did, and how it made them feel. Support was given as needed.

Moral distress

Moral distress is defined as the experience of knowing what the right thing to do for a patient is but encountering obstacles beyond one's control to fulfilling this ethical obligation.[9] No matter how prepared the team is, the members need to understand early on that they are going to fall short and leave patients on the line untreated. There will be health conditions beyond their ability to treat with limited resources and capabilities available at this medical mission. This feeling of hopelessness is an expression of moral distress.[9,10]

An example is when a patient presented with severe breast pain and ulcerations, a clear case of advanced breast cancer. Other than basic cleaning, bandaging, and antibiotics, there was nothing else to offer. She was referred to a nearby hospital, knowing her chances of actually going were slim to none. She had no means of transportation, and she had no resources to afford the care needed.

Another instance was an occasion where the clinic door had to be shut in front of a desperate mother with her 2 sick children, fighting to enter the little clinic that had no more room. Had she been allowed to enter with her 2 children, there was a possibility that the pressing crowd behind her would have rushed in, causing a chaotic and dangerous situation. It had to be accepted that not everyone, no matter how sick, would get care.

Pretravel training should identify moral distress as an inherent risk of caring for such patients. One strategy is to assure team members that the care they provide will be clinically and culturally competent and effective and therefore make a real difference in the lives and health of the patients seen. Another strategy is to sustain the confidence of team members that they are doing the best they can for their patients in a low-resource setting. They should understand this as doing the right thing for the patients in Achi.

Sustainability

Integrity requires that a key question be addressed: "What happens when the mission ends?" Team members have educated the patients that they have chronic conditions, such as hypertension and diabetes mellitus. Patients may have been given medication for 30 days at best, but what then? They still do not have resources for continuity of care. A global health program that produces long-term transformative change rather than transient relief is more likely to be sustainable,[8] and a short-term approach that results in a clinical benefit that could be undone on the departure of the mission team may inadvertently be incompatible with integrity in the long run. In addition, acknowledging the clinical and financial contributions of the host countries and following national guidelines, such as for Nigeria,[11] are both a duty following from the principle of justice and an important factor in long-term program building.[12]

To prevent this outcome, sustainable compassion is required by professional integrity. To achieve sustainable compassion and therefore the integrity of the annual medical mission to Achi, mission leaders started a continuity clinic there, now run by 2 attending physicians from the university hospital. They work at the clinic twice per month, treating patients and distributing donated medications to patients free of charge. An ophthalmologist was recently added because of the great need for eye care.

The clinic is currently funded by the family of the mission leader (W.O.), as a way of giving back to the community that nurtured him and allowed him to grow to the level where he could emigrate and become successful in the United States. W.O. has introduced his extended relatives to the process to allow them to participate. Fundraisers are held by the global health departments in the United States, and the global health team makes visits to the sites yearly when possible. The use of

telecommunication has been of value to keep in touch with the clinic while not on site. For now, the local Achi community is being encouraged to partner with the Nigerian government so that the services can have local support to ensure sustainability moving forward.

Conclusion

The 5 professional virtues should guide physicians and nongovernmental organizations to design and implement medical missions in a professionally responsible way. Compassion motivates the mission and its team members, whereas integrity, humility, self-effacement, and self-sacrifice guide team members as they act on the professional virtues of compassion. These 5 professional virtues give substance and direction to the 7 CHIPS principles. The authors believed that medical missions that abide by the 5 professional virtues are clearly worth the manpower and financial efforts in these challenging times. ■

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