Scrutinizing Global Short-Term Medical Outreach

About five years ago, I was among a dozen or so medical and nursing students involved in a short-term medical outreach trip to Honduras. By “short-term medical outreach trip,” I mean those brief trips to developing countries taken by medical professionals and often organized by health professional schools in the United States. The idea behind them is that they expose students and faculty to people in developing countries, often for the first time, and bring much-needed care to the countries. The visitors run an acute care clinic or ambulatory surgery center, distribute donated medications, engage in health education, and learn about health care in the developing world.

At the time, I assumed that what I was doing was “ethical” and maybe even commendable. I thought it was altruistic. No doubt many with me shared this belief. But as time passes, the value of what the Hondurans gave me, in moral and educational terms, seems to surpass the value of the acute medical care I helped deliver. I did not intend this; in fact, I thought my participation would help Hondurans much more than it would help me. But if I was wrong, and the benefit went mainly to someone outside the local community, then was the trip fundamentally different from the international AIDS clinical trials that years before received such scrutiny? If so, why did our trip—and others like it—escape the ethical scrutiny applied to clinical research in developing countries?

Not Research?

I wondered at first if my questions were misguided: perhaps global short-term medical outreach is just clinical care, and not “research” at all. From the perspective of those who go on these trips, how best to understand it is less than obvious. Health care personnel from a developed country organize a visit with local contacts in a developing one. The team travels to a community. With them are medical supplies, including medications and educational materials. They stay for a short period and operate something resembling a clinic or surgical center in their home country. Many individuals (though of course not all in need) receive some basic medical care. The team departs. Some time later, the medications and supplies run out (unless another team arrives and brings more). More or less continuing contact exists.

Does this situation describe research or clinical care? If this scenario were research, it might have gone through ethical review by institutional review boards in the developed and developing country. In addition, the researchers would have obtained informed consent (written or oral) from the study participants. If the scenario were a short-term medical outreach trip, neither would have happened. This lack of oversight might not be a problem if short-term outreach is unequivocally good or does not raise any interesting ethical issues. However, once we move beyond the trivial claim that outreach is different from research simply because it is handled differently, interesting ethical issues arise.

Appeals to Benefits

For example, I wondered if the crucial difference between research and clinical practice might lie in outreach’s goal. Unlike research, the goal of global short-term medical outreach is not to gain “generalized knowledge” but to provide tangible medical benefits to individuals in the community (a distinction between research and clinical care equally applicable in the United States).

This is probably what many people think when they consider outreach. I thought this, too, before my trip to Honduras. But there are a couple of problems with this view. First, well-designed clinical research often provides medical benefit as well. Second, in outreach, we tend to avoid spelling out exactly what we mean by “benefit.” In fact, we are tempted to act as if any benefit counts ethically in favor of the trip, or that simply intending to provide benefit is enough. Both are too permissive. The former would endorse a short-term medical outreach whose only goal, for example, was to administer ten ibuprofen capsules to each individual in a community (even as we scrutinize a clinical trial that helps sustain a local pharmacy merely because it involves research). The latter is philosophically challenging, and it would endorse an outreach that could result in substantial harm simply on grounds of “good intent.”

Beyond rejecting this overly permissive standard, however, the way forward is murky. First, we need some idea of how

much benefit is “enough.” Whatever standard we might choose, it should neither be too permissive nor too restrictive—we do not want to prevent outreach altogether. Second, we should consider the kind of benefit and who determines what counts as a benefit. For example, does the community need mebendazole to treat parasitic infections, or does it need water purification devices and tablets to ensure its water is safe to drink? And which does the target community want? Does it matter if the benefits are short-term (as with ibuprofen) or long-term (as with education)? Outreach is sometimes criticized on the grounds that it leads to donations of medicines and other items that are not really needed; they are given because they are all one has (or is willing) to give.

These questions raise another: Does it matter who benefits? How does one choose the population that receives the outreach team when neighboring communities might be equally in need? Additionally, what role should educational benefits to the developed country team play in evaluating outreach? While everyone acknowledges that these benefits occur, few suggest that they matter in deciding whether a short-term outreach trip is worth doing. Why? One reason might be that these benefits sound like generalized societal benefits; they do not accrue to the target population. And claiming this type of benefit is often what those involved in short-term medical outreach want to avoid, at least initially, just as I did.

In fact, good reasons exist to include these benefits in our ethical calculus. The educational benefit of understanding the plight of those in the developing world helps develop one’s own moral capacities. The stories and presentations one can later give might also develop the moral imagination of peers. Problems addressed in short-term medical outreach are only symptoms of broader inequalities in health that require more radical solutions at the national and international level. Therefore, short-term medical outreach might be an investment in human capital to achieve lasting solutions. To be sure, appealing to this benefit must be tempered, lest we engage in mere educational tourism. And if this “investment” partially justifies outreach, we should document how much “return on investment” outreach actually produces.

Thus, in thinking about the benefits of global short-term medical outreach, we need to at least consider how much benefit matters, what kind of benefit matters, who determines the benefits, and how to weigh benefits to those other than the target community. We scrutinize benefits in research; why not for outreach?

Risk of Harm?

The benefits, however, cannot be considered in isolation. They must be balanced against potential harm resulting from the trip; harms, of course, figure prominently in discussions of research ethics. Unfortunately, just as little guidance exists on how to consider the benefits of an outreach trip, precious little exists on what harms might occur as a result of the outreach or on how to deal with them. In fact, while we laud any benefit, many fail to consider even the possibility of harm.

Because of this, elaborating some potential harms might be helpful. Consider the following scenarios: After the team leaves, someone develops a stomach ulcer from taking too much ibuprofen on too little food and water. Someone receives an antibiotic and experiences an unrecognized first-exposure reaction that indicates a second exposure could be deadly. Children take too many multivitamins and become temporarily ill; when food is scarce, the sweet tablets are candy, too tempting to resist.

Others might occur over a longer period. Does medical outreach contribute to a sense of false hope in Western medicine, and does this play a role in the “brain drain” of skilled workers into developed countries? Might it foster dependency on foreign aid or disenfranchisement with the local health system? For example, during one of our Honduras trips, women in the community preferred to get their medical care from the American student rather than the local physician when the two jointly ran a prenatal clinic.

These harms, while speculative, deserve consideration. They are worrisome enough that we must weigh them against potential benefits and try to reduce their likelihood. But this recognition is far from where I started. We scrutinize, document, and minimize harms for clinical research; why not for outreach?

Responsible Resource Use?

Issues of benefit and harm themselves matter, but in this area they are critical because resources might be used in other ways—ways that arguably contribute more to long-term individual or community health benefit than short-term medical education.
outreach. Well-designed research asks questions that are appropriate, answerable, and affordable; well-designed outreach should do the same. Here, too, our thinking is unsophisticated. I once told a friend the price of my plane ticket to Honduras. He responded, “Several hundred dollars? That would buy a lot of medication and postage stamps.” Perhaps he overstated the case, but the basic point is simple and important: Why do outreach at all when other ways of using those resources might be more cost-effective?

Many would object to my friend’s proposed “medical outreach by mail,” and not just because it would be a logistical nightmare. Such a strategy ignores the inextricably human experience of present suffering at the same time that it depersonalizes the solution. Part of what is valuable about global outreach is the expression of mutual caring or solidarity. "Medical outreach by mail” is impersonal; it lacks the expression of mutual caring found in many short-term medical outreach trips. Anti-inflammatory medications and antibiotics might be important for their medicinal properties, but they are also important as an expression of caring.

Does evidence suggest that target communities might agree? Anecdotally, experienced individuals in international development report that the communities give thanks, not just—or even primarily—for the medicines and donations, but for what they express. In Honduras, community members thank outreach team workers for caring to come, listen, and understand their lives. Similarly, a friend who spent time in Sudan reported how a community leader thanked him, not for his charitable giving, but for the hope that others, somewhere, care.

Such reports suggest that the “medical benefits” might not even be the ones that those in the target community most value. They realize that ibuprofen and multivitamins are not a panacea for inequalities in global health. They realize that the only way to successfully reduce global health inequities might be by fostering a normative sense of solidarity, that their suffering is our suffering, as a result of our “common humanity.” The communities understand the significance of an ethics of mutual caring and solidarity—notions of “we” versus “us” and “them”—more than many who offer aid.

To be sure, we should not make too much of these sentiments. Truly developed mutual caring and solidarity must be backed up by real efforts at sustainable change. “Real efforts at sustainable change” might require short-term outreach as a catalyst to expand the education of those who participate and express caring to individuals in need, but outreach cannot become an end in itself.

**Toward Practical Ethics Guidance**

To summarize: All too often, those (like me) involved in short-term global medical outreach uncritically assume that their actions are good. They may be right, but not because they have grasped the ethical complexity of their outreach, including the potential benefits and harms to the local community, the significance of benefits to the outreach team, and how immediate relief of suffering should be balanced with efforts to affect policy change. Even just considering such factors is an improvement over my original appeal to benefits (and certainly over my naïve “altruism”). Better yet would be to combine this understanding with a recognition of the mutual caring that underpins this work.

Many other concrete ethical issues arise in outreach. These occur before the trip (“Has the community been involved in the planning?”), during it (“Is the trip culturally sensitive, and what does this mean?”), and after it (“How important is sustainability? Has long-term evaluation of the effect of outreach on the community, and on the outreach team, been followed through?”).

At present, few formal ethics guidelines address these issues, and many leave it up to individuals’ professional guidelines. This approach was rejected for the design and conduct of clinical trials in developing countries; we should also reject it for short-term medical outreach. Interdisciplinary dialogue could create a more systematic and practical ethics framework to help those involved with global outreach examine these general questions and ask others. For example, is formal, institutionalized oversight by something like an IRB necessary, would something less suffice, or could we get by with nothing at all? Does it matter whether the trip is organized within the public or private sector, in the academic or the corporate world?

I began by drawing a comparison between global outreach and clinical trials in developing countries, but whether short-term medical outreach trips are like clinical trials is not the main issue. The comparison merely highlights our failure to consider the ethical issues of medical outreach. What matters is that we can make progress on these issues, just as we did with clinical trials, and that progress is necessary for better global health work. We are more likely to cause lasting harm when we fail to critically evaluate our actions.

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