Ethical Considerations in International Health Electives

TO THE EDITOR:

International Health Electives (IHE) are growing in number—fueled by student interest and the potential benefits in developing more well-rounded, culturally competent physicians in the primary care setting. In the article “Effects of International Health Electives on Medical Student Learning and Career Choice,” the authors examine the potential role of IHEs in medical student learning and career choice. In their systemic review, the authors fail to address an important concern—the potential ethical dilemmas inherent to putting medical students in clinical roles in IHEs. This includes the deleterious effects that a seemingly altruistic effort may have on both the student and on the hosting population. Based on previous literature reviews of IHEs and my own personal experience, often medical students with limited clinical experience may be expected and willing to carry out medical assessments, medical treatments, and surgical treatments under limited or no supervision. These ethically questionable situations can lead to poor patient outcomes, greater work burden for local staff to address sequelae of poor outcomes, negative impact on the local health care system, and related student guilt. In our enthusiasm to train compassionate and well-rounded medical students, it is imperative that publications and curriculae addressing IHEs include this ethical caveat.

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REFERENCES

AUTHORS’ REPLY:
We agree with Dr Sinha that there is a paucity of research on the ethical issues inherent in developing, conducting, and assessing the impact of IHEs on undergraduate medical education. There may be unintended consequences that may arise when medical students with limited clinical experience go to host countries that are resource poor and present unfamiliar environments (ie, challenges related to learning social norms and the health profiles of the host countries’ populations). To date, the evidence base has focused primarily on the medical student experience with less emphasis on the benefits or burden of these electives on host countries. Our findings in the recently published article reflect this limitation in the literature.

We believe that the future direction of the ongoing dialogue on developing effective and sustainable IHEs should move toward a more comprehensive approach that takes all involved parties (ie, medical students, sending institutions, and host country patients, staff, and institutions) into consideration. This approach should incorporate more lessons learned from IHEs that did not go as expected or planned, including the unintended effects of these experiences on medical students and host countries. There is an emerging body of literature that has raised the necessary ethical considerations related to IHEs and lessons learned from IHEs that have resulted in student frustration and disappointment. However, it is clear more research is needed in this area.

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REFERENCES

Answers to US Health Care Issues From Other Countries

TO THE EDITOR:
I really enjoyed reading Dickerman’s and Raye’s recent letter to the editor of Family Medicine, a proposal that suggested offering post-internship years of public service practice (in the military, community health centers, the
Indian Health Service, or senior health clinics, etc) in return for financial reimbursement for further training made possible by restructuring GME funds. Given my current work teaching in El Salvador, I thought to myself, “This is great, a recommendation that will borrow from years of experience in Latin America. What a true example of reciprocity in global health!”

For decades, most countries south of the Rio Grande River have required 1 year of post-interprofessional practice with medically underserved populations as a condition for licensure. Were such a proposal as Drs Dickerman’s and Raye’s to take hold in the United States, serious consideration should be given to examine how such policies have played out over the years in these countries and what the intended and unintended consequences of these policies have been.

Then I thought, “What other innovations from around the world could we learn from as we seek to promote the kinds of educational and practice principles Drs Dickerman and Raye describe in their letter, such as professionalism and primary care?” In Latin America alone, several possible examples came to mind:

(1) Brazil’s family health program, begun in 1994, uses interdisciplinary teams (including physicians, nurses, nurse assistants, community health workers, dentists, and dental assistants) to provide primary health care to geographically defined populations and has become the basic structure of their health care system.

(2) The Barrio Adentro (“In the Neighborhood”) program in Venezuela has since 2003 placed undergraduate medical education in community-based sites linked with community practices, some core characteristics of which are already being implemented in one US school of osteopathic medicine.

(3) Opened in 1998, Cuba’s Latin American School of Medicine (Escuela Latinoamericana de Medicina in Spanish, or ELAM) accepts medical students from around the world (including the United States) and trains them, tuition free, to return to their countries of origin to serve as primary care clinicians in medically underserved areas.

Political will, funding, and ideology all clearly would play significant roles in whether any idea borrowed from elsewhere would succeed or fail in the United States. However, especially given the current challenges facing family medicine at home, maybe we can begin to consider prospective answers from the wealth of experiences other countries have had in dealing with their own health care issues. It is worth thinking about.

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5. Huish R. Going where no doctor has gone before: the role of Cuba’s Latin American School of Medicine in meeting the needs of some of the world’s most vulnerable populations. Pub Health 2008;122(6):552-7.

**AUTHORS’ RESPONSE:**

We greatly appreciate Dr Ventres’ comments and suggestions. Examining how other countries have addressed the issues of promoting primary care, providing care for the underserved, and developing a sustainable educational funding structure has great merit. In developing new strategies for GME, we should include discussions with physicians like Dr Ventres and others who can help us to think “out of the box” and “out of the country.”

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**Gender and First Authorship: More Than Just Numbers**

**TO THE EDITOR:**

The recent article by Schrager et al provided information on the frequency of female first authorship in family medicine journals from 2006–2008. This informative piece raised awareness as well as questions about what the information means.

Reading the article resulted in some questions. When did men become the gold standard for success? Should men and women always have the same markers for “success”? Same opportunities, absolutely yes; but the same metrics—really?

From experience and observation, on the average, many women have different social desires/goals and different career desires/goals compared to men. Not all women but enough to observe a group difference in relationship to men as a group.

Many of my female colleagues and peers design or alter their career plans to facilitate or accommodate their family structure or work-life balance goals. Some of these changes include choosing to work part-time and/or switch to fixed-hour jobs (eg, hospitalist, urgi-center, emergency care, administration). Sometimes these changes are temporary and other times permanent. It depends.

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1. Huish R. Going where no doctor has gone before: the role of Cuba’s Latin American School of Medicine in meeting the needs of some of the world’s most vulnerable populations. Pub Health 2008;122(6):552-7.

**LETTERS TO THE EDITOR**

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