INTRODUCTION

Far from a standalone clinical training experience, the global health setting presents a wide breadth of ethical questions, challenges, and dilemmas—including cultural, social, financial, and philosophical—that participants both novice and well-seasoned inevitably confront.

Our “Ethical Dilemmas in Global Health” series aims to bring to light the coexisting humanity and complexity of global health ethics while serving as scaffolding for thoughtful discussion. Written by students, coordinators, directors, and leaders over the years, this compilation features real cases encountered in our international partner sites with responses provided by global health experts in the Global South and the Global North. Our hope is that through storytelling and personal accounts, readers are called to ponder the cases in this series while investigating ethical dilemmas they may have faced in their own experiences. Together as a community, we can learn from each other’s insights and think carefully about how to navigate ethical dilemmas in the global health setting with thoughtfulness and awareness.

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There are many collaborations between the Global South and Global North, each with their own interests that must be met in order to make the collaboration fruitful. What are the key ingredients of a balanced collaboration, and what must both sides consider before establishing one?

DR. STEPHEN WINTER: The central theme must be a shared commitment to bidirectional collaboration with a clear expectation for each partner to foster the interests and goals of the other. Key ingredients must include mutual respect centered on shared intellectual capacity, anchored to a deep desire and sincere effort to gain bidirectional cultural competence and understanding. Before any partnership is established, there must be a clear delineation of financial responsibilities, research collaborations, and authorship attribution as well as communication systems that allow rapid response to problems and administrative structures that ensure mutual accountability.

DR. ROBERT KALYESUBULA: The ingredients should include a mutual understanding of the needs of each partner, ideally based on a needs assessment. There should be stakeholder engagement from both sides such that each partner appreciates and embraces the needs and benefits of the collaboration. This allows for the fast growth of the collaboration and greater ease of implementation. The partnership should be bidirectional from the outset so that neither partner feels they are giving too much. Partnership components should be geared towards capacity building and resource sharing from both sides with the goal of developing long-term citizens of global health at different levels.

Issues to consider rotate around values, finances, human resource commitment, and availability of leadership structures to maintain and coordinate the collaboration. A Memorandum of Understanding should clearly stipulate the roles of each partner, and be referred to for guidance in future interactions. It should be understood that most collaborators from the Global South may not have the funds to match their colleagues from the Global North. This should by no means be a temptation for those with greater funds to dictate or manipulate the terms of the relationship in their favor. If this is matter is well discussed, collaborators from the Global South will have many other means of contributing to an equal partnership.

Capacity building in human resources, as well as medical education and service to the underserved, should be pillars of any partnership between the Global South and Global North. Describe how these pillars can be established.
**Dr. Stephen Winter:** Capacity building must first be rooted in a shared understanding that knowledge flow must be bidirectional. Just as the Global North may have new procedures and processes to share with partners in the Global South, the Global South has much to offer in the creativity and intellectual depth required to deliver outstanding care in a resource-constrained setting. It must first be acknowledged that both sides will be learning from each other. True capacity building requires that time be taken to understand the needs and interests of our partners instead of simply imposing our own systems and approaches on theirs. The intersections of interest and ability must be found. Mutual respect for cultural, clinical, intellectual, and procedural differences is fundamental.

**Dr. Robert Kalyesubula:** It all begins with first understanding the needs of each partner and conducting a thorough baseline needs assessment. The results should divulge into three components: human resources, medical education, and services for the underserved. Once established, these pillars form the basis for the Memorandum of Understanding. This way, current and future leaders can follow through the implementation with the needs guiding the priorities.

Key players should be involved from the outset and have buy-in for the collaboration to make resource allocation easier while ensuring the sustainability of the collaboration. Lessons learned from each of the two sides should be shared such that partners appreciate the value and benefits of the collaboration.
Many students and faculty visiting other countries often deal with culture shock. How can the stress and frustration of culture shock be mitigated? What steps have you taken as a leader in global health to address the challenges of dealing with diverse participant backgrounds and expectations?

**DR. STEPHEN WINTER:** I think it is important to identify explicit points of contact through which to interact with visiting students and faculty. Among these should include scheduled formal meetings to discuss and review experiences that have led to stress or frustration, and would ideally involve a peer from the host site for regular daily interactions and a more senior mentor relationship on a less regular basis (perhaps weekly) to help participants recognize and talk through situations that have lead to emotional or social distress. I think we have done this at the senior level, for example with Dr. Luboga in Uganda, Dr. Ndhlovu in Zimbabwe, Dr. Kimphoung in Vietnam, as well as Dr. Sadigh, Dr. Jarrett, and myself in the United States. However, I think it would also be useful to promote peer mentoring at the local level to promote cultural competency and establishment of personal relationships that bridge the two cultures. Culture shock and its effects should also be addressed in pre-departure orientation activities.

**DR. ROBERT KALYESUBULA:** The key here is pre-departure orientation as well as the proper selection of candidates for global health. Unfortunately, not everyone who wants to participate in global health is well-suited for the field. For this reason, a careful selection tool to help determine appropriate candidates is crucial. Additionally, the teams on the ground should be prepared to support global health participants, particularly through the first days of their stay, and should be in frequent dialogue with them. Regular feedback sessions should be held to discuss and explain any concerns, and communication lines should be open from both parties.

*Please comment on trends you have noticed in terms of participant differences based on their country of origin. What are their respective experiences? What contributions and challenges do they bring to the program?*

**Dr. Stephen Winter:** Although it is unfair to generalize, I think certain themes have emerged, as participants from each country bring different attributes. Our Russian participants share many cultural features with their American counterparts, as many Americans of my generation have ethnic roots in Eastern Europe and Russia.
Even so, there are important nuances of interaction that can lead to misunderstanding and loss of trust. A simple phrase such as “We must get together for dinner one of these days” is a representative example. To an American, it is an idea that might lead to a firm invitation at some point. To a Russian visitor, it is a hard commitment to meet for dinner and, when not fulfilled, engenders distrust and confusion about motivation. For our colleagues from Uganda, Zimbabwe, Vietnam and the Caribbean, there are important aspects of religious belief, conservatism in dress and behavior, and family dynamics that must be understood to achieve true cultural competence.

**DR. ROBERT KALYESUBULA:** Differences among participants largely depend on differences in character. It is not the country of origin as much as the universities and the cultures of respective institutions that differentiate participant attitudes. Most participants from the Global South tend to be more adaptive and humble while those from well-to-do universities feel more entitled and tend to think they are doing the Global South a favor by “visiting” them. They also tend to think that locals do things the “wrong” way and it is their obligation to correct all wrongs and Westernize the practices. Although they may have good intentions, these tendencies have often made the hosts from the Global South withdrawn, rendering the experience less productive on both sides. Proper induction and orientation, as well as humility, can mitigate this issue.

*How should one approach a participant from the Global North who is passing judgment on his or her observations without discerning the underlying reason for what they are observing?*

**DR. STEPHEN WINTER:** I would sit down privately with the participant and attempt to understand his/her point of view before engaging in a detailed discussion about the situation and the most appropriate response.

**DR. ROBERT KALYESUBULA:** They should help them be oriented. This should be done in a careful way by a senior member of the team.
Imagine a junior medical student from the Global North at a National Referral and Teaching Hospital in the Global South, her first time out of her home country. Most of the patients she encounters are very young and desperately sick with limited chances of survival. Staff in the wards are sparse and visibly overworked and overwhelmed. One patient begins to convulse, and the relatives start calling “Musawo, musawo! Our patient is dying.” The only nurse on duty is attending to another very sick patient who needs a blood transfusion. The visiting student wishes she could help but has neither knowledge nor experience in dealing with a convulsing patient. The patient dies just as the nurse reaches him. The student is depressed and overcome with feelings of guilt that all she could do was stand there and watch.

What ethical dilemmas does this case bring to your mind?

DR. STEPHEN WINTER: This case conjures the ethical dilemma of feeling pressure as a student to act outside of one’s scope of knowledge or experience, and avoiding actions that may cause harm (nonmaleficence).

DR. ROBERT KALYESUBULA: This is a case of global health resource scarcity and vulnerability. The collaborators from the Global South have limited staff and may also lack established protocols with which to manage emergencies. Avoidable deaths in young patients do not sit well with anyone, but do occur and should be an inherent part of the global health learning process.

Limitations such as being present but unable to help and consequent feelings of helplessness should be expected in all global health programs. The extent to which these feelings arise will vary, but this scenario will occur on all sides. The same scenario is likely to occur to a doctor from any country in a hospital in another country with all the necessary skills but without a license to practice.

Was guilt an appropriate response on the part of the student?

DR. STEPHEN WINTER: Certainly not! Unfortunately, guilt is likely the most common response for students and even very experienced faculty like myself. This feeling is usually coupled with a sense of helplessness complicated by our uncertainties of the most appropriate boundaries to respect when operating in another culture.
Dr. Robert Kalyesubula: Yes, it is part of the process of recovery. The main issue of concern is how the situation is handled afterward. The student needs to be supported through this ordeal in order to draw lasting lessons that can enable growth. The student may also contribute by striving to ensure that resources reach those in need in the future.

What would you suggest should be done to prepare visiting students for such incidents, which they may encounter from time to time?

Dr. Stephen Winter: The experience described is relatively common. Preparation should include discussion groups and scenario simulations to inform students of how they may handle this type of situation, their potential emotional response, and held expectations for behavioral and emotional responses. Pre-travel orientation and preparation are essential for beginning the process of dealing with these very difficult situations.

It would be meaningful to have sessions discussing ethical dilemmas together with local faculty and trainees during the in-country experience. While in Zimbabwe, I lead a session with senior faculty and Zimbabwean trainees comparing end-of-life decision-making and family interactions in the care of very ill patients in the Intensive Care Unit—including how we were personally affected and influenced by the cultures in which we worked. Hearing the heartfelt responses of the Zimbabwean house officers was one of the most powerful and meaningful teaching experiences of my career.

These ethical dilemmas are not unique to members of the Global North going to the Global South. These dilemmas are universal. As doctors, we share the uncertainties and emotional pain caused by seeing our patients suffer and die. There are many complex ethical problems that we all experience in our work. These questions do not only concern our students. We all benefit from this kind of intercultural exploration.

Dr. Robert Kalyesubula: The collection of vignettes should be prepared and shared with students, and constantly grow with contributions from visiting students. Because partners from the Global South are often left out on this issue, efforts should be made to include the dilemmas they face, some of which are often bordered on technology and access. Additionally, global health program alumni should be encouraged to mentor and help prepare the new teams.

If you were her supervisor/attending/advisor what would you say to her at the end of the day?

Dr. Stephen Winter: I would say little and listen a lot to allow the student to ventilate feelings and find her intellectual and emotional response to the event—with my guidance if necessary. The way in which the student frames her thinking will give insight as to whether she is at risk for an adverse psychological response during the rotation and may require more intensive counseling or even removal from the environment.

Dr. Robert Kalyesubula: I think I would let the student know that what she is feeling is a normal reaction, and that the experience can lead to the resolve that such scenarios and injustices be minimized—through the effort of the student and others—in the future.
ETHICAL DILEMMAS
ETHICAL DILEMMAS
A wide range of ethical dilemmas is integral to global health experiences. Please comment on the following scenario:

A young patient with tetanus suffers from painful generalized muscle contractions every five minutes. The medication that would ease these symptoms is neither accessible nor affordable. A global health participant may be inclined to prescribe this medication for this patient even with a fatal prognosis, thereby hindering access to this medication for another patient who may need it for a nonfatal condition. How should this ethical matter be best discussed with a medical student or resident?

DR. STEPHEN WINTER: This is a good example of a dilemma that we do not yet frequently confront in the Global South: the means of allocating scarce resources in a way that meets the ethical principle of justice. Resource triage lies outside of the traditional doctor/patient relationship and is a societal construct that must be adjudicated by local law, cultural practice or organizational policy. It is not an appropriate decision for a visiting medical student, resident or faculty member. What would you think if a Ugandan Global Health Scholar visiting Norwalk Hospital argued against, or even tried to prevent, the transfer of a ninety-year-old patient with metastatic cancer to the Intensive Care Unit in accordance with the patient’s clearly expressed wishes, as an inexcusable waste of resources that could be better used in East Africa?

DR. ROBERT KALYESUBULA: The drug is not available in the first place and needs to be purchased by the patient’s family. Therefore, I think the global health participant needs to assess the family’s needs and capacity depending on the context. After losing a loved one, most African families would find solace knowing they did all they could to save them.

If this drug were purchased by the hospital, the discussion should be centered on resource allocation. Shortly after returning from the United States, I proposed purchasing a dialysis machine to save critically ill patients in urgent need of dialysis. The permanent secretary to the Ministry of Health asked me how many malaria cases could be treated with that money. I stared at him straight in the face and left... But of course, I understood him well. Thanks to the Kidney Foundation I founded shortly afterward, we now have eighty dialysis units in the country, fifteen of which were purchased by the Ugandan government.

Palliative care should always be an option in medical care, but there are exceptions that should be approached with care and contextual and cultural understanding. Global participants should understand that whenever a pen is put to paper someone has to pay and it is, more often than not, an out-of-pocket expense. This simple fact can help guide the practices of global health participants.
Involving the family in a discussion and helping them make an informed decision is an ideal approach to this issue. However, doing so may present the additional challenge of communicating essential information in an understandable way. ICU and palliative care treatment options should be presented. It should be emphasized that palliative care, while having a different, perhaps less desirable outcome than the curative intervention in this particular case, is not in any way an abandonment or a failure of care but rather an alternative form of care and caring in which the patient’s comfort and quality of life continue to be highly valued.

Honesty and reassurance of continued care in the ICU or elsewhere may help the family cope with what must be an unimaginably difficult decision for them to have to make, and will likely help build trust between the family and the healthcare worker. Discussing and modeling good communication, the techniques and skills of shared decision making, the value of support for the family’s decision and struggle, and the potential therapeutic benefits of being there for the family and of symptom management in the face of an inability to select the life-saving option will undoubtedly leave a strong impression on the visiting medical student or resident and will serve him or her well throughout his/her medical career.

While lack of knowledge about palliative care in the public domain may influence current cultural norms, there is an active campaign by the African Palliative Care Association, based in Kampala, to broaden the understanding of palliative care among the public and medical professionals. As such, it is important to clarify that palliative care should not be thought of as a second-rate alternative appropriate only for dying patients. Rather, palliative care is focused on symptom management as well as honest and compassionate communication, and may be delivered in different situations in concurrence with curative treatment in an effort to alleviate patient suffering from disease and treatments. It is care directed at the whole person that extends to include families, thereby providing a framework for considering the impact of the recommended treatment on the well-being of both patient and family.

In contrast to the idea that palliative care may lead to a perception of insensitivity among physicians, most families, once familiar with palliative care, are appreciative of the efforts made to help the patient and the family, even when their loved one dies.

**A young patient with a treatable disease can be cured by being admitted to the Intensive Care Unit, but doing so would render the family bankrupt, thereby causing significant harm. How should this ethical matter be best discussed with a medical student or resident?**

**DR. STEPHEN WINTER:** My approach to this problem is similar to that of the last question, with an emphasis on family dynamics and cultural norms. Who should get to decide these things in any society? Certainly, the answer is never the visiting medical student.

**DR. ROBERT KALYESUBULA:** The key here is to involve the family in the discussion and help them make an informed decision. These issues are deeply rooted in culture, and not necessarily the individual. Though the tendency here would be to persuade the family not to pursue treatment, the decision needs to be discussed with care because the family may consider this option as abandonment by the medical fraternity and failure of the medical system to provide care when it was most needed.
RESPONSE: ALLEVIATING SUFFERING FOR A DYING PATIENT, BY RANDI DIAMOND

I am currently here in Uganda seeing palliative care patients and wanted to respond to a recent case that others have written about, but from the perspective of a palliative care physician.

For visiting students and health workers, it is often frustrating to accept the resource limitations of the health system in a resource-limited environment, and humbling to come face-to-face with individual/family resource limitations that at times result in the inability to treat what might be a curable illness in a different circumstance or environment. Beyond the issue of allocation of scarce resources, and the importance of assessing the emotional and socioeconomic impact on the family of asking them to buy an expensive medication which may be futile in the face of a fatal condition, it is also of primary importance to address the issue of patient suffering—in every environment.

It is always difficult to watch a patient die, especially a young patient, and even more so if they are suffering as they are dying. However, palliative care may provide benefit to the patient, the family, and the visiting student. Although the expensive medications specifically targeting tetanus may not be available or accessible for this family, there are approaches to help mitigate some of the patient’s severe symptoms and suffering while supporting the family during this devastating experience. Morphine, available and free of charge in Uganda, would likely help manage this young patient’s pain and air hunger as respiration becomes increasingly difficult.

Attempting to alleviate the patient’s suffering in the process of dying is, according to the World Health Organization, a human right. It is our obligation as physicians to do so, and is entirely feasible even in Uganda. Presented to the family in a sensitive, respectful, and educational manner, palliative care is also a way to help the family find solace—perhaps not in doing all they could to save their loved one, but in having done all they could to ease his or her suffering. Demonstrating for the visiting global health student or resident that palliative care is available, effective, appropriate, and championed in the global setting is a valuable lesson and might also, by its nature of including the reflective process, allow the student to process the experience as an essential element of becoming a physician.
Upon entering the global health elective program, students are sometimes uneasy about their role in an underserved setting. They may feel that rather than contributing to the global health setting, their presence expends valuable time and resources that medical staff could otherwise use to care for patients. How would you respond to students who feel uneasy about their role in a global health program?

**Dr. Robert Kalyesubula:** I would explain to students that they should view the global health elective as an investment for the future and, as such, should not expect to provide any immediate contribution to the communities to which they are assigned. Rather, students should use the experience as a stepping-stone from which they can return once they are more qualified to provide patient care. Furthermore, the experience can help them exhibit strong leadership that considers global health principles when it is demanded of them in the future.

**Dr. Stephen Winter:** I would frame this in terms of students’ ongoing training and preparation for future involvement in global health, and the ways in which this experience prepares them for the time when they can give back in terms of capacity building in similar settings in the future. In other words, students are accumulating debt that they should expect to pay back at some future time. By analogy, this situation is similar to what happens on the wards in U.S. hospitals in which residents and faculty take themselves away from patient care to teach students in the expectation that they will do the same for others when they become more senior. The bedside, not the library, is where doctors learn—and other doctors must be our teachers.

Personal safety issues often arise in the context of large cities in both the Global North and Global South, some of which may be relevant to particular international rotations. For example, using boda boda transportation in Kampala comes with a risk of head trauma, as does walking in the wrong neighborhood at night in New York or Harare. Is it enough to warn students of the situations they should avoid, or should we be more proscriptive and possibly punitive (terminate rotation for example) if they do not comply?
**Dr. Robert Kalyesubula:** It is better to be strict in this respect because students always want to experiment. It is better to be safe than sorry. One bad event can easily terminate an otherwise very promising collaboration.

**Dr. Stephen Winter:** I would recommend that issues involving high-risk behavior be discussed in the pre-departure orientations, and that their importance be emphasized in the program materials. I would also recommend that participants be required to sign a document acknowledging the risk of specific behaviors and promising that they will not participate. Beyond that, I would not be punitive at the level of rotation termination.
How should we screen potential program participants for what we perceive to be potential limitations to cultural integration? For example, should a history of depression or other psychiatric disease be exclusion to participation? Is it fair to exclude a highly motivated candidate based on our biases?

**Dr. Stephen Winter:** I recommend screening candidates for at-risk limitations and having frank discussions with them regarding their motivation and capacity to function in a culturally complex environment. If concerns remain, I would be in favor of risk assessment by a mental health expert, the candidate’s own psychiatrist or mental health specialist if possible. If the candidate is then cleared, I recommend putting together an explicit plan for how they can seek support and assistance while in the field. Although this seems somewhat intrusive, it comes down to a matter of their personal safety and potentially that of our other participants or their hosts.

**Dr. Robert Kalyesubula:** I think the screening tool for participants should be standardized, and a candidate excluded from participation once considered not fit unless the host institution is briefed, ready, and able to give special attention to such a candidate.

Due to the shortage of medical personnel, global health elective participants often find themselves left unsupervised with patients. This situation is compounded by the fact that participants coming from the Global North may be viewed as more experienced or knowledgeable, and may lead to involuntary engagement in an activity that participants are not trained for. What are the possible solutions?

**Dr. Stephen Winter:** As part of pre-departure orientation, participants must be prepared for these situations and counseled not to act beyond their knowledge, training, or comfort level.

**Dr. Robert Kalyesubula:** Global health partnerships should ideally have a knowledgeable coordinator/resource medical person who is willing to step in when such scenarios arise. If finances allow, a key person should fill this role in every collaboration. Alternatively, candidates can be paired with doctors-in-training along with the attending to help reduce the likelihood of such scenarios.

The program coordinators should also be selective when sending candidates to different wards and specialties. Those with long-known histories of absenteeism should probably be left out unless the host institutions have the competencies to manage this. Students should always be advised not to exceed their limits and to maintain the same ethical standards they have back home. Global health teams should teach students some key basic skills based on their level of training to help minimize such scenarios.
Many women’s health issues are driven by cultural and social forces that global health participants may or may not be aware of, and some of which they may be encountering for the first time. Take for example, (1) a chaotic OB/GYN ward where multiple patients are delivering on the floor unattended, (2) a patient is dying from massive bleeding due to lack of blood transfusion, or (3) a patient has an infection from a self-induced abortion, or finally (4) a patient seeks treatment for a fistula she has been suffering from for several years. How do we help participants deal with these issues, reconcile associated cultural differences, and manage their emotional reactions?

**Dr. Stephen Winter:** While pre-departure discussion groups and scenario training may help attenuate the emotional response, there also needs to be an opportunity for venting, reflection, and self-examination of emotional response in real-time in the field as outlined in the response to the previous question.

**Dr. Robert Kalyesubula:** Proper preparation and orientation are key components of managing these issues, along with careful selection of candidates, as participants need to be able to handle such shocks of life that they are likely to encounter. These unfortunate scenarios are not due to cultural reasons, but rather a mere lack of resources. No one culturally or socially accepts this kind of treatment; it is just the circumstances. Advocacy should be played on the part of all concerned parties.

Many global health participants sometimes feel overwhelmed by the variety of challenges they face. How do we differentiate between those who need further encouragement and support, and those who are simply not fit for global health?

**Dr. Stephen Winter:** I don’t think that we presently have the tools to make this determination. The best we can do is use our existing tools including reflections, interviews, and evaluations by observers as discussed elsewhere. When there is sufficient concern that action such as removal from a clinical site is contemplated, the Director of Global Health should convene a committee of faculty involved in program administration to review the available evidence and come to a consensus conclusion. In order to avoid any appearance of bias or lack of due process, such a decision should not be made by a single individual.

**Dr. Robert Kalyesubula:** Strict selection criteria, as well as regular feedback sessions, can help make this differentiation.
In a hospital in the Global South, a twenty-three-year-old woman was admitted to the cardiac intensive care unit (ICU) with severe mitral stenosis leading to pulmonary edema during her second pregnancy. This was the second time she was admitted to the cardiac ICU due to acute pulmonary congestion in the setting of severe mitral stenosis from untreated rheumatic fever in her childhood. Because her symptoms were exacerbated with each pregnancy, she had been asked to avoid future pregnancies given the risk to her life. However, her husband wanted more boys so they could help with the work on the farm. The family could not afford a mitral valve replacement for her. The medical students asked why she was unable to avoid endangering her life by receiving a tubal ligation.

**Dr. Stephen Winter:** This vignette raises several ethical issues. It is particularly interesting in that it is a situation that could arise in the United States where access to care and inequities in healthcare delivery could lead to a similar ethical dilemma, with many of the same issues applied.

The first applicable principle is autonomy. The patient and her husband have the right to make decisions related to her future health that may be against the recommendations of the treating physicians. We may discuss alternative approaches to treatment and make recommendations for care, but the final decision rests with the patient. A tubal ligation provided without the consent of the patient would be a profound violation of her autonomy.

An understanding of cultural context is also important. A woman who cannot conceive may be considered “damaged” in many societies, and lose her role as a wife, mother, and community member. In addition, a family without sons in a rural agricultural setting may lack the resources to generate a sustainable income to support an extended family, which may include elderly parents and relatives, who cannot contribute to the economic support of the household. Forcing an intervention such as tubal ligation in this setting may violate the principle of nonmaleficence by disrupting the social and economic integrity of the family.

The ethical obligation to provide the best possible care continues even when a patient does not follow our primary treatment recommendation. Once the team has determined that the husband and wife are committed to future pregnancies without a mitral valve replacement, and that a lower cost approach such as mitral valve repair is not feasible, the family and local health providers in their village should be counseled on how to recognize early signs of cardiac insufficiency in the event of another pregnancy so that monitoring, observation, and treatment can be instituted early in hopes of attenuating her heart failure and optimizing her potential for a safe outcome.

**Dr. Robert Kalyesubula:** This scenario involves several ethical dilemmas that underlie the practice of medicine in resource-limited settings. First is the issue of poverty and resource limitations, and the ways in which this influences the choices of patient and doctor alike. The second is the gender balance and power dynamics
within many impoverished families. The third is the doctor-patient power balance and its influence on healthcare delivery. The fourth is the girl Child and society norms and beliefs. All these factors influence autonomy.

It is actually a good start that this particular setting had a cardiac intensive care unit and that the patient could actually access it. Most centers in resource-limited settings do not have access to such care and would struggle to make such a diagnosis of heart failure in pregnancy. The previous episode could have aided in early diagnosis in this particular case. As opposed to patients and doctors in high-resource countries, those in low-income countries have to make decisions about the choice of care provided based largely on the social status of the patient—especially for conditions that are out of the realm of “free” healthcare. Whereas Global North clinicians look for the best evidenced care, most of us have to settle for the most cost-effective.

Financial status has a lot to do with the care given or received. Because this family could not afford a vulvular replacement surgery, the patient ended up needing intensive care for the second pregnancy, which would not have been the case had a vulvular replacement been done after the first. With these facts in mind, the medical student feels she or he can help implement a permanent solution by ensuring that this woman gets a tubal ligation and never has to deal with the risk of getting pregnant again, and therefore never endanger her life in the process. It is fair to say that this would be a good approach in the medical student’s view, but it would impinge on the principle of autonomy which is essential to medical care. The underlying social circumstances beyond this simple solution is the husband’s influence on the patient’s choice as well as the family’s future plans in terms of looking at children as major sources of financial support.

What was not mentioned in this scenario is the fact that families still look at the boy child as the heir who will carry the family lineage forward. This notion is shared by both men and women from this part of the world. I have met women struggling to have a tenth child because all the first nine children are girls, and take the risk of pregnancy knowing that the tenth child could also be a girl. It is important to appreciate this concept and be culturally sensitive in global health. It is also important to appreciate that men wield more power in most relationships despite the fact that it is the woman who carries the child for nine months. In Uganda for example, all children belong to the man and his clan. This means that the decision maker, who is often the man, needs to be on board with most family choices. Unfortunately, most men are never present for the birth of their children, and often do not accompany their wives for antenatal visits. They do not hold the hand of the wife to witness the most beautiful gift of children taking their first breath.

This dichotomy is due to cultural issues, also to lack of space for such “luxuries.” Because one room is often shared by four women in labor, men are not welcome and have to wait outside to receive the baby, if they show up at all. For the medical student, this would be a good time to reinforce the ethics around patient autonomy. She or he should be able to give all the information to the family while respecting the decisions made by the patient and her family members. The student should focus not only on the woman in labor but also include the man in the conversation, and not shy away from sharing alternative sources of income for the family while emphasizing the fact that girl children have the same value as the boys. If the student is supported to pass on this information to the family, it may encourage the family to undertake a more informed tubal ligation, thereby shifting the balance onto the mother’s well-being. In any case, if the mother dies in labor, the highly sought-after boy child has low odds of survival in most resource-constrained countries.

That being said, the decision made by the family should be final and respected without judgment.

The student should also use this case to learn that the patient has the ultimate say in regards to their health and it is not only up to the doctor(s) to determine what is good for them.
ETHICAL DILEMMAS
A 30-year-old woman was admitted for small bowel obstruction of unclear etiology. Her hospital course was complicated by sepsis, requiring admission to the Intensive Care Unit. During the course of her hospitalization, it became apparent that a laparotomy was required to relieve her small bowel obstruction. However, her family was unable to pay for the surgery, thereby deciding to forfeit her life. My medical students and I considered paying $100 USD each to pay for her laparotomy, but the Vietnamese doctors deterred us from doing so, explaining that this was a daily occurrence and fact of life.

**Dr. Stephen Winter:** This represents a situation that is not uncommon when visitors from the Global North come face-to-face with the reality of true resource limitation. I think we often struggle with a response that speaks to our own emotional reaction when witnessing a death that could be prevented. What does it mean for physicians from the Global North doctors to pitch in enough money to save this patient? Perhaps it signals to the patient and others who know her that their doctors and system of care must be inferior to that of the Western doctors who have intervened with curative (albeit financial) treatment. What does that mean for the next patient who needs an intervention, and the hundreds after that? How does one justify not also helping the next one? How do local physicians caring for this patient deal with their own feelings of distress from being unable to provide care to their patient, and having to watch them die for lack of resources? How do they feel when you directly point out the inadequacies of their system with a handful of cash?

I think it is an expression of cultural insensitivity that attacks the dignity and emotional resources of the treating local physicians that may even lead them to feel that the systemic inadequacies are somehow their own inadequacies. Just because the physicians are able to stoically deal with their own realities of patient suffering and death due to resource limitations does not mean that they are unaffected or unbattered by the emotional distress and grief inevitable with these situations. Helping provide compassionate emotional support and symptom palliation to the patient, along with support for her family and even her physicians, is the more relevant intervention. If the visitors have financial resources that they wish to share, they should explore ways to extend it through the institution. Or perhaps they can contribute to a fund that supports care for patients without resources (most hospitals have funds for this) or find another way to improve overall patient care. We should not be palliating our own emotional discomfort by amplifying the distress of others.

**Dr. Robert Kalyesubula:** This is really a tough scenario which brings tears to my eyes. I would start by saying that every life counts in its own right. I would like to be nonjudgmental and maintain clear-headedness, but I feel like this is really a very sad situation and therefore a tough decision. I would like to avoid echoing what I have already said, but allow me to repeat the fact that money really matters in decisions made by both doctors and patients.
Let’s first deal with the family in this scenario. The family gave up and decided to forfeit her life because they could not pay. There, you have it, the barrier of finances! Could this decision have been different if the patient was a man, breadwinner, and head of the family? I think the likely answer is yes, the family would have sold all they have to save the man. The family decision was purely influenced by lack of resources. They had very little choice.

Let us next move to the visiting doctor and medical student. Likely influenced by their previous experiences seeing people survive after even very serious illness, they were willing to do what was in their power to try to save this woman’s life. They could also have been influenced by the fact that this was a very young woman with a whole life ahead of her. Could it be that it was purely out of the goodness of their hearts? These are all possibilities. Because they would probably never face this scenario in their home countries, they may feel compelled to do whatever is in their power.

I don’t think they were wrong, however their decision would have far-reaching consequences, particularly on the relationship between the patients and primary doctors. The family could easily perceive that the local doctors are not doing enough and visiting doctors have the “magic.” This perception could promote distrust and lack of appreciation for the local doctors even though the barrier to care is largely systematic. The visiting doctor and students need to be culturally sensitive.

Now we get to the last issue of the Vietnamese doctors. I have never been to or practiced medicine in Vietnam so my thoughts are only informed by what I have read and heard. I can only use my experience from a shared background of limited resources to imagine what might be going on in the doctors’ minds. They had probably seen so many such patients die in the ICU that they had developed the notion that nothing could be done. Death is so common that they feel powerless to do anything about it, and see it as inevitable. “Why waste the little money on such, when more patients could be saved? The patient is going to die anyway and that is a fact of life.” By seeing patients die on a daily basis, their value for life has probably been affected negatively, having accepted the systems inefficiencies and the costs that come with it.

The major dilemma here is how to reconcile these two extreme positions largely informed by previous experiences. “How do you let someone die when you have the power to save them? Life has no price tag!” On the other hand, “Why waste very scarce resources on an inevitable death? So many other lives could be saved instead. Death is normal and should be accepted.” I feel that this conversation should involve the family. What do they think is in the best interest of the patient? Surely they would want to give it a shot and see if their loved one could be saved. I feel the opportunity to save this woman should elicit a debate on how life is valued. If the doctor decides that death is inevitable, it has a lot of bearing on how they will react and the care they will subsequently offer.

Even in resource-limited settings, all efforts should be undertaken to ensure that life is saved. Discussions need to be held about what life really means, and the time taken to explore the possibilities of rejuvenating interest and value for life. On the other hand, the visiting doctors need to reevaluate and look beyond the impact of the single patient. What happens when the next patient comes with similar complaints? Perhaps the best way is to solve this issue by engaging the leadership so that such funds are channeled through a central pool from which they can be disbursed to address problems from the higher end of the system. The visiting doctors and students should have a mechanism for dealing with extreme grief, and this situation should be addressed through the feedback sessions.
RESPONSE: ON SAVING LIFE, BY MAHSHEED KHAJAVI

Originally posted on June 24, 2018

Reading this case moved me to tears. However, I feel that allowing a human being to die a preventable death is not morally consistent with medical mission work.

The very fact that we choose certain countries and see a limited number of patients—as many as humanly possible in the allotted time, which still leaves hundreds unattended—implies that we are already making a decision regarding the allocation of resources. To carry the argument of nonfinancial intervention is antithetical to what is already being implemented: choosing a country and a select group of patients who will receive care.

This begs the question: how do we choose to help one person but not the next? Yet we do this every single time we work in resource-limited settings.

We make a decision to go to Vietnam, for example, and help this particular group of individuals. In doing so, we decide that these same resources are not going to, for instance, Guatemala. The physician who chooses to intervene for one group of people has, by her own decision, left others without the same opportunity.

Many years ago in Shiraz, I saw a woman bring in her child who had a fever of 41°C and was actively seizing in her arms. Lacking the funds to pay for the visit, she was told that she had to go to another facility. My mother ran over and immediately paid the fee, and continued to do this over the next month. She used all the money we had and emptied her bank accounts from previous years. Did she save everybody? No. Her response did not even amount to a drop of water in a vast ocean of need. But she did what she could with the resources and time she had. This, of course, implies that there were hundreds of others who would continue to be turned away from the hospital.

We travel with the understanding that our resources—time, finances, and personal affects—are limited. Yet we make a conscious decision to go abroad, and in doing so choose to help as many as we can with the resources and time we have. This is a choice. It leaves many unattended. We choose to help some live with the awareness that others will die. Implicit in the travel and time spent is that we are morally responsible for those who come onto our path. One can argue that it may cause feelings of resentment of inferiority among the people and staff who reside in those particular areas. Yet why would they allow us to come if they did not believe that we could be of some small benefit?

My decision to pursue medicine was made well after university, where I studied philosophy. The subject allowed me to ponder the existential questions of the human condition, at the center of which is life and all the messy, chaotic scenarios in which one must listen, learn, and decide. To allow one to die from sickness when one can intervene is not only outside of any morality to which we subscribe as physicians and human beings, but it is inconsistent with the larger premise: the fact that every decision we make is with the understanding that to help those with whom we have chosen to congregate means that there are those who will be left without.
We cannot save the world. We make choices to help those we can with the implicit understanding that there are others—millions of others—that we will never reach. In the film “The Blade Runner,” the replicant reaches out as he approaches death to pull the protagonist up off the ledge...the two men who were, just some moments earlier, trying to kill one another. The replicant gives one of the most emotionally moving monologues in cinematic history, Tears in the Rain. Harrison Ford is left in a moment of empathy and clarity and finally speaks:

“I don’t know why he saved my life. Maybe in those last moments, he loved life more than he ever had before. Not just his life, anybody’s life, my life.”

To save one life while being unable to save all is a given. To let one life go because on some level we may not acknowledge this fact violates all that makes us human. I must respectfully disagree with the responses to this ethical dilemma. We make choices that help others and in doing so leave others in need. We do this every single day with every single choice. But when we can help one human being, we have a moral responsibility to do so. To allow one to die simply because we know there is not enough for everyone means that we have been complicit. To help one person live knowing others will die means that we have still saved one person.

As written in the 32nd verse of the 5th Sura of the Quran:

“Whoever saves one life, it is written as if he has saved all humanity.”

I leave you with this: what does it mean to have the ability to do so and refrain?

RESPONSE: Upenyu Honokosha, by Tendai Machindaize

Originally posted on August 2, 2018

What does it mean to have the ability to save a life and not do so?

In Shona, we say “Upenyu hunokosha!” Life is precious! We cannot save the world, but we can certainly save a world—we can save a mother or a father or a child, and in so doing save a family, a world.

But who is doing the saving? And how is it perceived?

Growing up in Zimbabwe, I experienced the lingering effects of colonialism on a daily basis, as do many doctors and patients in low-resource settings that are sites for global health work. To put it bluntly, colonialism ingrained in us that “white is better.” With the British bringing books, medicines, and technologies from abroad, we believed their ideologies. In so doing, we subconsciously scorned ourselves and our “backward ways.” Even today, despite efforts in education to overcome this colonial mindset, a vendor on the street in Harare, for example, will call a white woman “madam” and will interact with her in a manner noticeably deferential compared to a black customer in the same situation.
In such a context, a white doctor from overseas, with all the good intentions of serving the underprivileged in global healthcare, going to a village and overriding local black doctors by saving a life where they could not, inadvertently reinforces the notion that “white is better.” That the black doctor is not as smart as the white doctor. That the white doctor is more capable than the black doctor. That what is Western is superior to what is African. This doctor is not just a savior. He/she is a “white savior,” along with all that that encompasses.

Global health is about moving forward, improving, and advancing, and thus should not be constrained by the mistakes of the past. However, in order to not repeat or exacerbate the haunting effects of colonial prejudice and paternalism, we need to keep the past in our minds as a guide for our actions today.

I would not be true to myself or my calling to be a doctor if I did not act in a manner that upholds the fundamental truth that upenyu hunokosha. Whether we are from the Global North or the Global South, in all situations, I believe that life trumps cultural sensitivity and socio-political concerns. To have the ability to save a life and not do so is to do harm.

We cannot, however, forget that our actions occur in a context that we simply do not fully comprehend as visitors and that the ramifications of our actions will not fall upon us, but on those who call that place home. I have used race as an example here because it is relevant today on both sides of the world (for different reasons), but this is by no means only a racial issue. The scope of the consequences of acting in such situations is varied and complicated.

The challenge, then, is for us to create new avenues through which to save lives within the cultures and institutions that we partner with across the globe—ways that are informed not just by financial differences, but by history and contemporary circumstances. Ways that foster sustainable local development of medical practice despite limited resources, and that will endure long after we have left.

Without hesitation, always save a life if it is in your power to do so, whatever the context. Upenyu hunokosa! But afterward, in that warm glow that comes with helping another human being, don’t forget to ask yourself: What is my broader and long-lasting legacy in this community? Then, use the answer to that question to pave a better way forward.

RESPONSE: EVERY PHYSICIAN MUST MAKE A DECISION THAT IS BEST FOR THE PATIENT, BY CYRUS KAPADIA

Originally posted on September 1, 2018

I was deeply moved by the post “Reading “Ethical Dilemmas in Global Health: Financial Barriers and Interventions” and disagreed with the points of view expressed until I read Dr. Mahsheed Khajavi’s perspective, which is exactly my own. As physicians, we definitely do need to be engaged in discussions that eventually
lead to decisions made at a societal level. If we do not, then others will. However, faced with an individual situation involving the sacrosanct trust inherent to the doctor-patient relationship, every physician MUST make a decision that is best for the patient.

Had I been in that situation, I would without a doubt had done what that noble lady, Dr. Khajavi’s mother did in another instance. I would have paid (if allowed to do so) for the treatment of the young patient with intestinal obstruction without for a moment caring about hurting the feelings of doctors working in that institution. Too bad! A young woman’s life was on one side of the balance, being weighed against the sentiments of doctors on the other. I know which way I would have come down.

While this decision would not have benefited the society in which she lived, it may have benefited that particular patient and her family. If it had, hurting the feelings of a few doctors would not have mattered to me one little bit! I am very clear about that.

RESPONSE: RESPONSIBILITY = RESPONSE + ABILITY, BY LAURIS KALDJIAN

Originally posted on September 29, 2018

I recently spent two weeks at a mission hospital in rural Kenya, where detailed cost considerations are part of the daily experience of every patient. It is humbling to learn that a peasant farming family would have to sell two cows, worth about $150 each, to pay for an EGD plus stent to palliate dysphagia and prolong life in the setting of an inoperable esophageal cancer. But it is also highly encouraging to be at a hospital that demonstrates compassion and respect for life, one patient at a time, even in the midst of needs that regularly outpace resources—and where physicians, surgeons, and administrators provide any available emergency care whenever it is needed, even if payment cannot yet be provided (and, perhaps, will not be provided).

I don’t doubt the many facets to the questions that are raised in these trying financial circumstances. But like Dr. Kapadia stated in his post, I believe that one should always try to help one patient at a time, and begin with the patient who is before us, here and now. This, I think, is what responsibility entails (a word that is made up of “response” + “ability”, i.e., the ability to respond). So if we do have the ability (or money) to care and perhaps cure, we should do what we can—and, of course, do so with sensitivity to the needs of all concerned but always with primary focus on the needs of the person who is our patient, especially when life or limb is at risk.

In case it is of interest, and even though it flips the world the other way ‘round, I attach an article that pertains to such issues, from the vantage point of hospitals in this country that wrestle with the burden of “uncompensated care.”
Participants of our Global Health Program are required to write weekly reflections about their experiences. While the sharing of these reflections with the administration of the Global South could be beneficial for quality improvement, it may also prevent participants from honestly expressing their views. Given these considerations, how should participant reflections be shared with the Global South? What do you think about synthesizing a short summary of site-specific reflections to share with the leadership every six months?

**Dr. Stephen Winter:** I think that a regular summary of reflections should be produced either to provide feedback toward promoting the improvement of the rotation, or give positive feedback to the host participants. If Withholding of negative characterizations of the experience would be inconsistent with our program goals of honesty and transparency. The reflections should be viewed as a quality improvement, rather than a marketing tool.

**Dr. Robert Kalyesubula:** I believe that the sharing of a synthesized summary is more conducive than that of personal stories. However, I feel that this may remove the spirit and feel of the writer, and should therefore be left to the judgment of the Global North to decide what is appropriate. Another possibility is to anonymize the reflections, which may inspire resolution of the issues expressed. I think it is somewhat unfair for participants to be asked to write reflections if they are not going to be shared. Doing so defeats the spirit of shared values and transparency, which in turn denies local teams the opportunity to improve.

Students sometimes have difficulty dealing with cultural differences and respond in ways that may be harmful to them emotionally or to the relationships with their international peers. At WCHN we try to monitor for these kinds of emotional or cultural conflicts by requiring weekly reflections and reviewing them in real-time for signs of an evolving problem. With the most junior students, we have on-site residents and senior attendings from the program as part of a team structure to identify and respond to problems. Do you have any other approaches or insights that might help monitor potential problems?
Dr. Stephen Winter: I think these approaches have been effective for our program. The only addition might be to ask the host country site directors to provide regular evaluations of rotating students and residents. However, I think this is likely to incur an unacceptable level of additional work for clinicians and administrators who already have a host of other responsibilities. Perhaps they could instead advise the directors here at home to identify trainees that may be a risk for us, so they can be given extra support. This could also be an additional role for homestay families.

Dr. Robert Kalyesubula: I believe that pairing global health participants with local peer mentors can provide an open space for participants to freely share what they feel. This exchange can go a long way in terms of monitoring potential problems.

Some participants post their daily observations, accompanied by photos, on their personal blogs. To help address this issue, our Global Health Program has included in the Code of Conduct that any participant must obtain approval from the director at both host and home institutions before posting any such material. Would you consider this censorship, and is it necessary?

Dr. Stephen Winter: Yes, it is a type of censorship, however, uncensored social media can be very destructive to individuals and relationships. I think Facebook should not allow neo-Nazi rants and we should not fail to exercise some control over the content of expressions about the program. Part of the substrate of global health is the development of cultural competence for our trainees. We should not hand them scalpels without prior supervision and surgical training. In the same vein, let’s not hand them a potentially harmful tool without supervision and training.

Dr. Robert Kalyesubula: Given that posts can be damaging and/or reactionary, some level of control in the form of censorship or guidance is needed. Another issue is the breaching of confidentiality, which I believe is the idea behind laws such as HIPPA in the United States.
A twenty-three-year-old female is admitted to the cardiac Intensive Care Unit (ICU) with severe mitral stenosis leading to pulmonary edema during her second pregnancy. This was the second time that she was admitted to the cardiac ICU due to acute pulmonary congestion in the setting of severe mitral stenosis from untreated rheumatic fever in her childhood. She had been asked to avoid future pregnancies given the risk to her life from every pregnancy exacerbating her symptoms. However, her husband wants more boys so that they can help with work at the farm.

The family cannot afford a mitral valve replacement for the patient. The medical students asked if she should be required to get a tubal ligation to prevent any further pregnancies and avoid endangering her life.

Who should decide on the tubal ligation? The patient? Her husband? The doctors?

Does autonomy apply? Is autonomy a Western construct or a global one?

Does this patient actually have agency (the capacity to act independently and make free choices)?

Dr. Stephen Winter: “This is a case that I really wanted to explore a part of because it speaks to one of the prime ethical issues of autonomy. I can’t answer this question. I need some of you from other parts of the world. Is this inappropriate that this is the husband’s and not the wife’s decision, not the patient’s decision? Anyone? Do you think autonomy is a westernized idea and not a global one? Anne?”

Dr. Anne Doughtery: “I think that the basic idea of who can decide a tubal ligation is a complicated one. I’ve thought a lot about autonomy, not in this case but when we talk about new American women refusing C-section for fetal distress this comes up a lot. What I’ve come to realize is that while the individual is the most valuable decision-making unit in our, or in my culture, in many other cultures, family or the community is much more important. Although the ways in which that plays out makes me very uncomfortable, especially as someone who wants to advocate for women’s rights. I do think we have to acknowledge that there are other things that are more valuable than the individual in other cultures.”

Dr. Stephen Winter: “I think it’s really important to recognize that this is a decision that is not only personal but affects the family. Their economic health and the family structure. I think it’s really different in other parts of the world. I’m hoping that someone from other parts of the world might want to comment. Professor Masangansie perhaps?”

Professor Masangansie: “There is another aspect people don’t think about. Some people want to lay the blame on someone else. Quite a number of times when you sit down with the woman, she will always say, ‘It’s my husband who wants this,’ when as a matter of fact she is the one who wants it, but should things go wrong, it is her husband’s fault. So we need to think about that.”
The other thing I want to talk about, not particularly for this one but for the previous case, is engagement with the hosting institution physician is critical. If you are trying to come as one who is superior, you are starting from the wrong end. It is not you who should decide on the treatment, but you can discuss treatment options. Why? Because the physician is the one who will continue running the institution. When the regulations operate properly, the visiting consultant has no right to treat the patient. The same applies to the monetary situation. I think if you engage properly, it is very possible that the patient could have benefited from the money given because no one would deny money given the opportunity. Someone never asks where the money came from. All we do is deliver service. My feeling is if it is done properly, it is fine to give the money and fund the operation.”

**Dr. Stephen Winter:** “Any other final comments?”

**Ms. Estherloy Katali:** “Thank you. So who should decide a tubal ligation? I think it’s the patient. The patient needs to know. In the vein of cultural sensitivity, sit down the patient and talk to her openly. Give her information about the dangers of another pregnancy. She will often make a rational decision. Who else needs to know in her life? She will know. Who doesn’t need to know? Again she will know, because there are many women, for example, who use other forms of contraceptive without their getting their husbands involved because they don’t want their husbands to see them taking pills. They are going to choose any other method, including tubal ligation, without telling their husbands. One has to be sensitive to all of these issues around the woman. Who does she want to know? If she wants to inform the husband but she has challenges with him, she can voice them and you can help get the husband involved. It is important to try to understand the circumstances and be sensitive to them.”

**Dr. Stephen Winter:** “I think it’s difficult to know in regard to the third question whether she has agency, and whether she can make a decision with the family and husband hovering over her. I think it just illustrates the complexity of what we’re talking about. Last chance? We are right on time.”

**Audience Member:** “Thank you. I think every question has been answered. The second question is, does autonomy apply? The first time I learned about this term was when I was studying for my first step exams. I don’t think we have autonomy in India. It’s always the men in the family who dominate and decide the fate of the women. If she wants a tubal ligation or if she should go for a C-section, it’s all about the men. So I think this is a western cultural construct rather than a global one.”

**Audience Member:** “Not in every part of India, but definitely in a lot of rural hospitals and a lot of cities, women tend to please their family and husbands, and are obligated to do that.”

**Dr. Stephen Winter:** “Thank you all for participating. Thank you all so much.”
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