THE ETHICS OF MEDICAL BRIGADES IN HONDURAS:

Who Are We Helping?

by

Amanda J. Bradke

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THE CENTER FOR BIOETHICS AND HEALTH LAW

This thesis was presented

by

Amanda J. Bradke

It was defended on

May 8, 2009

and approved by

Alex London, Ph.D.

Philosophy Department, Carnegie Mellon University

Jeannette South-Paul, M.D.

Chair of the Department of Family Medicine, University of Pittsburgh

Thesis Director: David Barnard, Ph.D.

Center for Bioethics and Health Law, University of Pittsburgh

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The current thesis poses a focused critique and ethical analysis of medical brigades as they currently

operate in Honduras. The first chapter defines the concept of medical brigades and provides an account

of their presence and actions within Honduras. The second chapter addresses the need for a theoretical

framework with which to ethically analyze the endeavors of these brigades. Due to an insufficient

amount of attention and scrutiny, no authoritative standard yet exists for evaluating the ethics of

developed countries providing health care interventions in developing countries. In order to overcome

this challenge, the current thesis creates a hybrid framework by looking to established codes of conduct

from several pre-existing models of engagement with potentially vulnerable populations, all of which

have already addressed some pertinent aspect of medical brigades. Through examining the principles,

ethics and relevance of the doctor-patient relationship, Standard of Care debates and Community-Based

Participatory Research, this thesis places certain obligations on medical brigade participants and their

affiliated organizations, which must to be fulfilled in order for their actions to be considered ethical. In

the third chapter, I maintain that medical brigades fail to fulfill these obligations based on the harms

they pose to the communities and community members they serve. Fundamentally, these brigades pose

a risk because of their short-term nature that does not provide accountability or follow-up care, nor

addresses community-relevant health care needs. Finally, the fourth chapter demonstrates the ways in

which the developed world can improve upon this model and carry out ethical health care interventions

in the developing world, specifically by avoiding these harms and fulfilling the aforementioned

obligations. To facilitate this discussion, I will present the Shoulder to Shoulder model, the Community-Oriented Primary Care model and SEED-SCALE as ethical alternatives to the medical brigade model. These examples collectively provide a solid platform on which to base a much needed change in the current medical brigade model, and a bright future for the direction of health care provided by volunteers in developing countries.

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1.0 MEDICAL BRIGADES AND THEIR CONTEXT IN HONDURAS

In the current thesis, I am defining a medical brigade as a group of people travelling from a developed

country to a developing country, for a short period of time, with the express purpose of providing

healthcare in impromptu clinics (also known as medical missions). A medical brigade can include any

person, but is often comprised of undergraduate, high school or medical students, residents, physicians,

nurses, pharmacists and sometimes dentists. [1] While the medical brigade is a separate phenomenon

from religious missions that have the main objective of "spreading the word of God," these missions do

often involve a medical brigade as part of their initiative. In fact, many brigade groups that travel to

Honduras originate from Christian churches of the developed world. In "Duffle Bag Medicine," Maya

Roberts presents a useful scenario in conceptualizing the basic realities of a medical brigade from the

point of view of the host community:

> A foreigner sets up a clinic in your city. He does not speak much English, he will leave
> after week or so, and he is not very likely to ever return. This foreigner tells you that he
> is a physician in his home country, but that he has never been to your community
> before and is not going to work with your family physician or with other health

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[1] Student participation in medical brigade groups is distinct from international medical school rotations in existing health care facilities of the developing world. Medical brigades present unique considerations different from providing care in established health care facilities. However, much of the discussion throughout this thesis, such as student participation and skill level, could also be applied to the ethics of these international rotations.

professionals in your local health care structure. Would you take your children to see him if you had any other choice?[2]

Roberts' commentary points to the beginning of many pitfalls in the current medical brigade model. Medical brigade groups provide mostly acute care to as many people in a community as their clinic can accommodate in a day or two, and then move on to the next community, without continuing a further relationship. Nonetheless, medical brigades are becoming increasingly popular. These initiatives are allowed, accepted and often glorified because the plight of developing communities is so severe, and because the ethics of these brigades have been insufficiently addressed as of yet. The current thesis specifically focuses on the context and effects of medical brigades that serve the rural, impoverished communities of Honduras.

Many medical brigade initiatives have adopted Honduras as their main focus, among other reasons, because it is the poorest country in the Americas, especially after the devastating damage caused by Hurricane Mitch. When Hurricane Mitch struck Honduras in 1998 it wreaked such havoc on the country that it was claimed to have set the country's progress back two decades; over twenty percent of Honduras' population was left homeless, severe crop shortages left many villages on the brink of starvation, and approximately twenty-five villages were reported to have been entirely destroyed by the accompanying landslides, among other damages.[3] Recognizing the plight of Honduras caused by this destruction, most medical brigade organizations currently active in Honduran communities began their initiatives sometime after the destruction caused by Hurricane Mitch. The nature of medical brigades makes it seem as if many of these efforts were started as a means of emergency relief effort, and just

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[2] Maya Roberts, "Duffle Bag Medicine," *Journal of American Medical Association* 295:13(2006): 1491

[3] National Climatic Data Center, "Mitch: The Deadliest Atlantic Hurricane Since 1780," http://lwf.ncdc.noaa.gov/oa/reports/mitch/mitch.html

never stopped or evolved. The work of medical brigades provides "band-aids" to communities, hopefully

allowing a community to get by until another medical brigade is able to come the next time, without

truly changing the condition of Honduras. It appears ten years later Honduran communities are still

experiencing the basic realities of "emergency disaster relief," which becomes an inappropriate long-

term solution.

An internet search for medical brigades that travel for an average of a week at a time reveals over

one hundred twenty-five organizations that serve Honduras alone[4]. This is likely even an underestimate

however, as usually only repeat and more organized groups have websites to tell about their mission

and recruit volunteers. Also, relying on news articles and blogs, it is evident that many additional groups

travel to Honduras on a more informal basis to provide medical brigade interventions[5]. It is also

probable that a number of medical brigade groups remain unaccounted for in widely available

documentation. This uncertainty and variety in medical brigade organizations makes it difficult to

estimate the number of individual brigade groups active throughout Honduras, as well as where they

serve.[6] For instance, while most of these documented medical brigade groups travel annually or

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[4] See Appendix I. Note Global Medical Brigades has over seventy-five independently affiliated student groups.

[5] See Appendix II for a few examples

[6] Using the available information from the websites provided in Appendix I, an approximate distribution of brigades throughout Honduras is shown in the following map: (http://www.google.com/maps/ms?ie=UTF8&hl=en&msa=0&msid=111547103793237895362.00046a1bbd955174 60e0d&z=7). At first glance it seems that brigade activities are spread throughout Honduras, however the information collected from these websites may be misleading. Not all groups provided their place of service, and those that did, did not necessarily specify if they serve the same community each trip and/or how many community members are served. The surrounding communities in Tegucigalpa, Honduras were listed as service areas for five of the websites. Much more research would be needed to get a clear picture of exactly where and who brigades serve.

biannually to the developing world, some hold clinics much more frequently.[7] For example, the

Honduras Baptist Medical Dental Mission sends a different group of volunteers every other week to

various communities. It is also unknown how many Honduran villages have experienced brigade

interventions, although it appears that once a community hosts a medical brigade they tend to do so

repeatedly, albeit sporadically and sometimes with long time lapses in between . Some of the medical

brigade websites provide a record of the Honduran communities in which they have and plan to hold

clinics, while others do not. Some groups serve the same communities each time they travel, although

still lacking an offer of support in between trips, while other groups choose new communities for every

brigade. Some groups have a large base of repeat participants, although many are in need of new

volunteers each trip. While there is variation in the details of individual brigades, and a gradient to the

type of interventions provided and how effective they are in the medical brigade context, it is the

characteristics common to the occurrence of these brigades that are most important for the current

ethical analysis.

When participants travel to developing countries to provide medical care on short-term trips such as

these, their general organization is quite similar. Whoever is responsible for organizing the brigade first

works to recruit the desired number of participants for an upcoming trip, while trying to balance the

number of health professionals with the number of lay volunteers. All participants are expected to pay

their own trip expenses, such as airfare, vaccinations and in-country costs, thus making brigade

participation a very expensive endeavor, and likely limiting the number of times a person is able to

volunteer. Before the trip, recruited participants are also relied upon to gather donated medications and

any other clothing or supplies they wish to take with them from their home countries. Often this

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[7] The information presented in this section was generalized from an overview of the content from the websites listed in Appendix I

includes recently expired medicines or samples from local physicians' offices or hospitals. Sometimes funds are raised to also purchase certain medications, such as antiparasitics, which are not commonly readily available in developed countries. The majority of brigade websites did not report any formal training for participants before leaving the country besides a few short logistical meetings.

Once in Honduras, these brigade groups usually travel to three to six communities in one trip, providing day long clinics in whatever facilities are made available. Sometimes this causes the closing of a school or other community building within which to run the clinic. Communities are commonly alerted ahead of time to the coming arrival of a brigade and potential patients line up in the hundreds in anticipation. Normally each person who is seen is first brought to the triage area where participants are taking patient vitals and a short history. The patient is then led to see the physician for a short consultation, and next to the pharmacy with a list of medications, usually written in English to accommodate non-Spanish speaking volunteers. Sometimes dental work is also available, and often a station with hygienic supplies and donated clothing and shoes is included. How individual brigade groups choose to distribute these supplies and select the order in which patients will be seen depends on the organization and preferences of the individual group and its in-country hosts.

Patient information may be recorded, but past information is rarely, if ever, brought along on the next brigade to keep track of former patients. This data is most likely used to keep track of brigade activities, such as the number of patients seen and the most common disease afflictions. Sometimes this information is kept by the group travelling, sometimes by the in-country hosts, and some groups have even reported that they submit this data to the Honduran government. At the end of the clinic day, those who were not seen are sent away to wait for the next medical brigade trip to their community, or to use any other community resources that may be available. The group then travels back to their in-

country accommodations, usually a hotel or dorm provided by their in-country hosts within a nearby city, and prepares supplies for the next community they will visit the following day.

1.1 STUDENT INVOLVEMENT AND GLOBAL MEDICAL BRIGADES

While the current thesis addresses all brigade groups, it also places special emphasis on medical brigades that are led by student groups at undergraduate universities and medical schools, and often work through, or in conjunction with, other organizations both in their home country and situated abroad. Student-led medical brigades are referred to as such because they are initiated and organized by student groups, although recruited healthcare providers and in-country hosts are mostly in charge once the group reaches their destination. I have chosen to emphasize these groups for two reasons. First, students add an interesting ethical dimension to the discussion of medical brigades because they do not yet have sufficient medical training to treat patients and are unlikely to have significant experience in developing countries. Second, a large portion of the active brigades in Honduras are comprised of university student groups, or include students in their makeup, thus making these groups especially relevant to a complete ethical analysis of Honduran medical brigades.

Medical brigades, and international health electives, are becoming increasingly popular among undergraduate and medical students. As one indicator, "According to data collected by the Association of American Medical Colleges, 27 percent of medical school graduates had some international experience during their first four years of medical school. Twenty years ago, the number was closer to 6 percent. And the trend doesn't seem to be letting up."[8] This phenomenon has been attributed to such

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[8] Avery Hurt, "Hidden Ethics of Overseas Electives," *The New Physician*. 56:9 (2007). http://www.amsa.org/tnp/articles/article.cfx?id=407

sources as the publicity of work like Paul Farmer's in Haiti and the image of Dr. Albert Schweitzer

devoting himself to patients in his African Clinic, among other romantic notions of providing healthcare

in the developing world. Simply typing in "medical missions" to any online search engine will yield

thousands of opportunities for students to participate in short-term medical clinics throughout the

developing world, some requiring only an online application. Even with the high personal expenses

incurred, such as the plane ticket and in-country costs, it has become so common place for medical

applicants to have a medical brigade experience on their resume that it no longer even sets them apart.

Global Medical Brigades (GMB), an "international" network organization for medical brigades, is the

largest student-led international relief organization in the world, with forty community sites exclusively

in Honduras. GMB was founded in 2006 by members of Sociedad de Amigos de los Niños (Sociedad), a

Honduras based group who has long provided medical brigades as part of their social services, and a

former participant of the first University of Michigan undergraduate student medical brigade group.

Since its creation, GMB has grown rapidly; boasting more than seventy-five university clubs, and

continues to actively recruit new schools and groups. In 2007, GMB volunteers provided aid to nearly

40,000 patients in low-income villages who would otherwise have limited to no access to medicine.[9] In

the beginning, GMB gained recognition by advertising to premedical students through connections at

Inquarta, a test preparation organization that provides Medical College Admissions Test review courses,

by informally emphasizing medical brigades to Honduras as a meaningful addition to medical school

applications.[10] The CEO of Inquarta, Don Osborne, serves on the advisory board of GMB.[11]

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[9] Global Medical Brigades, "Medical Brigades," http://www.globalbrigades.org/project/medical/

[10] Stephanie Garbern, personal communication, Feb 2009.

[11] Global Medical Brigades (*Ibid*), "Medical Brigades."

Once registered with Global Medical Brigades, the student group signs up for a week and a community, or communities that are available. GMB sponsors as many as nine groups in Honduras at a time and arranges in-country accommodations, but has a limited role in each individual group prior to the brigade's arrival in Honduras. A member of Sociedad does, however, often travel with the medical brigade group to their assigned community for the day clinics, and has travelled to these communities prior to the groups' arrival in order to advertise the coming brigade. GMB has a six person in-country medical brigade staff which includes two medical brigade coordinators, although their role is unclear and it is not evident how communities come to chosen to host brigades.[12]

Prior to the trip, student group leaders have access to weekly conference calls to learn from the experience of other brigade participants, and to ask any questions they may have. Individual brigade leaders may also hold informational sessions with participants to learn basic information about Honduras and practice Spanish skills; Due to schedules and other obligations however, recruited clinical personnel are unlikely to be available for these meetings. Prior to the trip student participants are responsible for recruiting all medical personnel and, as mentioned above, for some fundraising and collection of all medication to be handed out during the brigade. During the brigade, student roles usually include working in the triage area taking patient histories and vital signs, translating for health care providers, filling prescriptions in the pharmacy and handing out other non-medical supplies to community members.

Most GMB brigades have anywhere from thirty to fifty student participants travel on each trip. Many of the communities serviced through these organizations host a few different, uncoordinated, medical brigade groups each year from multiple institutions. It is the goal of Sociedad and GMB to host a

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[12] *Ibid*.

brigade in each of their communities every three to four months; as they state, this usually comprises

most, if not all, of the communities' accessible medical care. Sometimes however this is not always

possible and a community can go much longer between medical brigades, depending on the availability

of foreign medical volunteers and need present in other communities. Because it is mostly

undergraduate and medical students organizing and participating in these student-led brigades, there

are multiple groups throughout Honduras during common school breaks such as late December to early

January and summertime, and few if any brigades during such months as October and November. For

the purpose of this thesis, there is no way of knowing how often communities are seen in actuality,

except for a few specific examples discussed below.

1.2   BRIGADE COMMUNITIES AND ILLNESSES: SPECIFIC EXAMPLES

As previously mentioned Global Medical Brigades (GMB) works closely with Sociedad de Amigos de los

Niños (Sociedad) as its in-country contact. Gerardo Enrique Rodríguez, "Quique," the operational

director of Sociedad's medical brigade department, and Duffy McGee Casey, the executive director for

the medical brigade department, put together a "January 2005 Medical Relief Report" summarizing the

care provided by one of the medical brigades that served Honduras in 2005.[13] This report delineates the

number of patients seen, some demographics, the most common diagnoses and the treatments

prescribed. While the information provided is not exactly reflective of the work performed by all

brigades, it offers an illustrative look at exactly who was seen and what was treated during an individual

brigade, as well as facilitates a conceptualization of the detailed operations of other medical brigades.

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[13] Sociedad de Amigos de los Niños. "January 2005 Medical Relief Report." *Letter from GE Rodriguez and DM Casey*. (2005).

This section will also show the strong similarities in common illnesses reported by the three community surveys, indicating a possible similarity with other rural, impoverished Honduran communities.

Five communities surrounding Tegucigalpa, Honduras were visited during this brigade, with a total of 1,770 patient encounters recorded. The most patients seen in one day were 591 community members of La Ceiba, a village in the south of Honduras with a population of 1,750. When Quique visited La Ceiba to gather pre-brigade information for reporting[14], he described the conditions he saw:

> The people in this community is poor and work in agriculture for self subsistence , there is one school only, there is one bus that comes and goes to Tagus once a day. The young people from the community emigrate to the big cities to work leaving behind children and old people and coming back only a couple of times a year because lack of jobs and educational opportunities.[15]

When La Ceiba was visited in January 2005 it had been eight months since it had hosted its last brigade. In the interim (as reported in July 2005), the community has one nurse that staffs a local clinic and provides primary care, vaccination and child health control.[16] There is also one doctor that sometimes comes to the village to attend to community members that are "very sick". Members of this community have reported that if they become sick and need health care they go to this local clinic or use home remedies. The most common reported illnesses and problems in the community include parasites, "general stomach" illnesses, poor nutrition, cough and cold, skin problems and respiratory problems, among others. Although the details are not completely clear, it appears brigades in this community are

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[14] As reported by personal communication with Stephanie Garbern (*Ibid*), Quique went to at least three different communities in 2005, yet did not continue these surveys in subsequent years.

[15] Sociedad de Amigos de los Niños. "La Ceiba Community Research Survey." *Medical Brigade Department*. (Jul 2005), 3.

[16] *Ibid.*

operated out of their one school house, and tickets to be seen by brigade providers are given out ahead of time to both people in the community, and those who are sick in surrounding communities. Some community members were involved in handing out numbered tickets, cleaning the school house and assisting with the general organization of the brigade. There were also three main community contacts which included two community treasurers and the community nurse. From the community survey however, it is unclear what role these contacts played in the planning and implementation of the brigade.

This provides a picture of just one of the five communities served by the particular brigade outlined in the January 2005 report. Overall the brigade group saw patients who were approximately sixty percent female, fifty-nine percent older than eighteen years of age and less than one percent who reported pregnancy.[17] The top ten most common diagnoses, in order of the most cases to least, were parasites, cough, cold, headaches, gastritis, arthritis, dermatitis, fungus, malnutrition and otitis. Notably, fifty percent of the patients seen were infected with parasites, sixty percent of which were twelve years of age or younger. The most common treatments provided to community members by brigade groups were, in order from most prescribed to least, for respiratory illness, for parasites, for pain, vitamins, antibiotics, for dermatological ailments, for gastrointestinal and stomach and others less commonly. The brigade also treated thirty cases of diabetes, twenty-seven of hypertension and thirty four of anxiety and/or depression. The survey did not specify what treatments were used for these cases of chronic diseases.

Two additional communities, which were not serviced by the brigade group discussed above, were visited by Quique in 2005 for a pre-brigade survey. The information collected provides a useful

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[17] Sociedad de Amigos de los Niños (*Ibid*). "January 2005 Medical Relief Report."

look at the condition of two more communities who either had been served by brigades in the past or had been selected for possible future brigades. The first community Granadilla, southwest of Tegucigalpa, has three hundred and twenty inhabitants.[18] They are eight kilometers from the nearest health care center, which provides fee-for-service consultations with one doctor and two nurses including general care, a healthy child program, a birth control program and a pharmacy. When community members are sick they reported going to this health care center or another clinic, using home remedies, or purchasing over-the-counter medications. As of 2005, the community had no water system or electricity. Again, for this community the most common health problems reported were parasites, stomach problems, malnutrition, respiratory issues and cough and colds. The community contacts for GMB are a community school teacher, a member of the community water committee and a member of the community electricity committee. These leaders agreed to help with organization and advertising of the brigade, including crowd control and readying of a make-shift clinic building. As of 2005, this community had never been served by a brigade.

The other community evaluated was Quiscamote, northeast of Tegucigalpa with a population of three hundred.[19] (At the time of the survey two hundred and fifty were reported ill.) This community does have a potable water system, but is still burdened with the same common illnesses as those listed for the community of Granadilla. These community members also live approximately eight kilometers from a health care center with fee-for-service consultations. Community members utilize this center when possible, or make home remedies and buy over-the-counter pills. Community contact

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[18] Sociedad de Amigos de los Niños. "Granadillas Community Research Survey." *Medical Brigade Department*. (Aug 2005).

[19] Sociedad de Amigos de los Niños. "Quiscamote Community Research Survey." *Medical Brigade Department*. (Aug 2005).

collaboration is similar, including handing out tickets to community members to be seen by the brigade group. As of 2005, it had been four years since this community hosted a brigade.

Both in these reports and in the above presentations of medical brigades it is unclear not only how communities are chosen to host medical brigades, but also who in the community is contacted and how the medical brigade organizations present themselves. From the community surveys it is evident that in some instances there are contacts within the community that work with the brigade organization. In these cases it appears to be mostly logistical. But it is not clear whether other community members are involved prior to the day of the brigade. This likely depends on the brigade organization as well as the individual communities.

1.3 POSSIBLE OBJECTIONS TO THE CURRENT PRESENTATION OF MEDICAL BRIGADES

I can anticipate a few objections to the current presentation and critique of Global Medical Brigades operations, as well as other brigade groups. Some of their websites boast other, separate, interventions and planned improvements for the near future. For example, it is the goal of GMB to build a permanent clinic in each of their communities by the year 2012.[20] However, while this is a step in the right direction, without staffing this clinic on a more regular basis, this improvement really only takes care of the issue of where to hold the medical brigade clinics. It still does not address the issues of sustainability or accountability. The actual clinics would be less impromptu; however the interventions they provide will not have significantly changed.

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[20] Global Medical Brigades (*Ibid*), "Medical Brigades."

Global Medical Brigades, and some other independent medical brigade groups, have also begun to include public health initiatives in conjunction with the clinical care interventions of their trip. Global Medical Brigades is one program of a larger non-profit Global Brigades, Inc. Other programs provided include Water Brigades, Law Brigades, Public Health Brigades and Environmental Brigades, among others.[21] Nevertheless these brigades are undertaken separately from Global Medical Brigades, and their existence does not negate many of the issues presented by medical brigades. The impromptu clinic portion still poses a problem for the communities served. Moreover, even well organized initiatives and organizations can run into problems when staffed by one-time volunteers who are unfamiliar with the culture and illnesses of the patients they encounter, as will be further discussed in the third chapter of this thesis. Despite these interventions, and others not mentioned here, I believe an ethical critique of the current medical brigade model is still valid and pertinent. Without accountability and sustainability medical brigades continue to present a real and alarming risk to Honduran communities.

Furthermore, in addition to the risks they present, brigades rise to a level of significance that necessitates scrutiny and regulation because of the size, scope, and standardization of the operating procedures characteristic of these brigades. The functioning of medical brigades goes beyond that of individuals travelling spontaneously to provide healthcare in developing countries to a large venture that encourages certain actions in others and particular health care delivery for rural Hondurans. Global Medical Brigades in particular as an organization recruits students and volunteer health professionals for its specific and standardized operation that is growing exponentially within Honduras. Global Medical Brigades is championing a predetermined way of providing healthcare to community members of Honduras to groups in the United States who hope to make a difference, yet likely know very little about

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[21] *Ibid*.

Honduras, nor how to help improve the health of Hondurans. While I believe there is an individual moral obligation to act ethically within the global health arena, medical brigades in Honduras, just as any corporation or large entity, ought to be subjected to greater scrutiny specifically because of their ability to have significant influential power and impact. The size and scope of medical brigades in Honduras would not be what it is without the promotion and influence of Global Medical Brigades Inc; whatever results are produced through the undertaking and participation in medical brigades in Honduras, they are greater because of this organization and others like it. On a final note, GMB is a registered 501(c)(3) non-profit that also ought to be accountable for the ways in which it is using both the monetary and in-kind donations it receives, and needs to be regulated to ensure it uses these contributions ethically.

I have tried my best to accurately capture the presence and reality of medical brigades, and their organizations, throughout the communities of Honduras. Admittedly, due to the multiplicity and small variances in organizations and groups, I likely have not accurately represented each individual medical brigade group that serves Honduras communities. I have used some generalizations and applied what is more well known of some brigades to the descriptions of others, but have supported these claims to the best of my ability from what is documented. Overall, I do not believe that I have misrepresented medical brigades in any significant or important way for the coming ethical analysis. The most important things to take away from this complete presentation are that medical brigades are a string of short-term clinics run by foreign volunteers and in-country hosts, often involve students, provide acute care that most commonly treats parasites, cough and cold and malnutrition in the communities that host them, and do not routinely provide follow-up care or long-term collaboration. In the coming chapter, I will establish a framework with which to carry out the ethical analysis of medical brigades.

2.0   A FRAMEWORK FOR THE ETHICAL ANALYSIS OF MEDICAL BRIGADES:

OBLIGATIONS AND RESPONSIBILITIES OF BRIGADE PARTICIPANTS

The attention given to the ethics of acting within the global health arena has markedly increased in

recent years. A pair of articles published in 1997 in the *New England Journal of Medicine*, for example,

sparked a still unsettled and widely publicized debate regarding the standard of care owed to research

participants in the developing world.[22] More recently, the "brain drain," or migration of medical

professionals from developing countries, has become an often discussed concern within bioethics

literature. Unfortunately, however, this interest in global health ethics has yet to be translated into a

significant discussion regarding the provision of clinical care in developing countries. While multiple

articles have been written with the intent of proposing guidelines for planning and executing a

successful medical mission trip (or brigade) , [23] no authoritative standard yet exists for evaluating the

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[22] Marcia Angell. "The Ethics of Clinical Research in the Third World." *The New England Journal of Medicine*. 337 (1997): 847-49; Peter Lurie and Susan M. Wolf. "Unethical Trials of Interventions to Reduce Perinatal Transmission of the Human Immunodeficiency Virus in Developing Countries." *New England Journal of Medicine*. 337 (1997): 853-56.

[23] For some examples, reference: Robert Scott, Jane Bates, and Jessica Mark. "Can I Help You?" *British Medical Journal*. 335 (Jul 2007): 202; Parminder Suchdev, Kym Ahrens, Eleanor Click, Lori Macklin, Doris Evangelista, and Elinor Graham. "A Model for Sustainable Short-Term International Medical Trips." *Ambulatory Pediatrics*. 7:4 (2007): 317-20; Jeff Solheim and Penny Edwards. "Planning a Successful Mission Trip: The Ins and Outs." *Journal of Emergency Nursing*. 33:4 (2007): 382-7.

ethics of developed countries providing healthcare in developing countries. This being the case, it is difficult, and incomplete, to employ any one current standard of conduct to carry out an ethical analysis of medical brigades, as no one existent framework is sufficient or wholly applicable to the phenomenon of short-term medical mission trips.

The current chapter attempts to overcome this challenge by developing a theoretical framework with which to critically analyze medical brigades. It does so by parsing out the relevant sources of ethical guidance from several pre-existing models of engagement with potentially vulnerable populations, mostly in resource-poor settings. The usefulness of these examples lies in their already established codes of conduct, based on their interactions with these vulnerable populations, which can be drawn upon to create a unique, hybrid framework relevant to the analysis of medical brigades. To begin, I will discuss the ways in which each tradition is analogous and disanalogous to the work of medical brigades, and thus how their principles are applicable to an ethical analysis of these brigades. Next, I will present the details of each of the three chosen pre-existing models of engagement. In particular, I will examine the obligations of healthcare providers within the doctor-patient relationship, based on the specific nature of the medical transaction, and inherent power dichotomy between healthcare provider and patient. Secondly, I will draw upon the standard of care arguments, most recently debated in the international research context, to examine the level of care owed to Honduran communities by medical brigade participants. Lastly, I will present the established code of ethics for investigators engaged in community-based participatory research, which includes an obligation to address community-specific needs.

Through exploration of these established codes of conduct for working with vulnerable populations, and comparisons to the medical brigade model, I will argue for the obligations,

responsibilities and standards that ought to be expected of those travelling to the developing world with the express purpose of providing healthcare. While none of these models of engagement are wholly identified with medical brigades, taken together they provide a solid platform with which to evaluate the important aspects characteristic of medical brigades interacting with developing countries. They also provide argumentation for the need to better serve these developing communities and improve upon the current medical brigade model. At the end of this chapter, I will also delve into the notion of what it means to provide a fair or sufficient benefit within the medical brigade context.

2.1 ANALOGIES AND DISANOLOGIES TO THE MEDICAL BRIGADE MODEL

The following models of engagement with potentially vulnerable populations have been selected because each has an established code of conduct with which it has already addressed a different aspect pertinent to the ethical analysis of medical brigades. As mentioned previously, this is useful because the medical brigade model, or clinical care provided in the developing world by the developed world, does not have its own established code of conduct with which to carry out an ethical analysis. However, in order to look to these models for ethical guidance, it first needs to be established how each is similar to the medical brigade context, and therefore why it is appropriate to rely on the relevant principles from each model. Additionally, because the medical brigade model is a hybrid phenomenon and no one existent framework is wholly applicable to the context of medical brigades, there are important differences between the medical brigade context and each of these three models. By presenting the ways in which each model is analogous as well as disanalogous to the context of medical brigades, I will set the stage to parse out the ways the ethical principles from the following three models can reasonably apply to and inform the current ethical analysis. I will also specifically aim to show that

despite the acknowledged differences, each of the three models remains a worthwhile contribution to the proposed ethical framework.

The first model detailed below will be that of the interaction within the doctor-patient relationship. This model is relevant and similar to medical brigades based on the clinical care context of the medical brigade model. Medical brigades travel to Honduras with the express purpose of providing healthcare to members of the developing communities they serve. As delineated in the last chapter, participants set-up make-shift clinics in order to consult with, and treat, the people who come to the brigade looking for help with their unmet healthcare needs. For that moment in time, medical brigades operate somewhat similar to the basics of a primary care medical service, with an attached pharmacy. The specific portion of medical brigades during which individual Honduran community members meet one-on-one with a healthcare provider (and possibly a translator) is quite comparable to the interaction that commonly takes place during a doctor-patient visit in the developed world. For each patient diagnosed during a medical brigade, a health care provider consults with the patient and listens to the problems and ailments concerning him or her at that time. The health care provider then diagnoses the patient and prescribes a treatment for his or her ailments, when possible. Insofar as these inner workings of the medical brigade model resemble the doctor-patient relationship, citizens of the developing world have a right to expect that those who approach them in the capacity of healer will also uphold the obligations that will be shown to be attributed to health care providers by virtue of the doctor-patient relationship. It is because each healthcare provider within the medical brigade context, and the medical brigade as a group, is holding itself out to the community as healer that the community members trust brigade participants with their health and wellbeing.

The medical brigade context also notably *differs* from that of the doctor-patient relationship insofar as the present ethical critique of medical brigades focuses on the obligations and responsibilities of all medical brigade participants, and not just the doctors and nurses recruited for the trip. Many of the ethical obligations placed on health care providers via Pellegrino's ethical analysis to come are based upon the direct interaction within the doctor-patient encounter as described above.[24] Students are not, or should not be, the integral persons in these interactions. No matter what their future profession, these students are still learning and are not full-fledged practitioners. Therefore, because students and other non-health professionals are an important part of medical brigades, the ethical contours of the doctor-patient relationship are not wholly applicable to the entire medical brigade model.

Nonetheless, even though the doctor-patient relationship piece of the current framework more directly applies to certified health care providers, overall this model of engagement is still useful to establishing a framework with which to carry out an ethical analysis of medical brigades. In presenting the basis for his morality of medicine on which I will rely, Edmund Pellegrino states that "while the physician will be used as the example, it must be understood that we believe these principles are intrinsic to, and binding upon, all who profess to heal."[25] While Pellegrino is here referring to the inclusion of all health professionals, such as nurses, pharmacists, dentists etc., because he is including "all who profess to heal," I would argue this stipulation can also be reasonably extended to all brigade participants. Although not all brigade participants will be examining and diagnosing patients, all have put themselves out as a health care resource for the Hondurans seeking their help. Even though this is

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[24] Edward D.Pellegrino and David C. Thomasma. "A Philosophical Reconstruction of Medical Morality." In *A Philosophical Basis of Medical Practice: Toward a Philosophy and Ethic of the Healing Professions*, 192-219. New York: Oxford University Press, 1981.

[25] *Ibid*., 193-4.

facilitating healing in a different way, as a group a medical brigade is offering its services and holding itself out to community members with the specified aim of improving the health of its patients, within all the capacities and interactions the participants undertake.

Furthermore, because of the cultural divide, the Honduran patients may not fully understand the role and training differences between the physician, the medical student in a white coat, and the undergraduate helping in the pharmacy, who are all working to provide them care. The brigades' patients and potential patients may thus place equal trust in every brigade participant and rightly expect all to act in their best interest with regards to their healthcare needs. Additionally, even if Hondurans do understand a student's training and role, it is plausible that the community is trusting the medical brigade group as a whole to act in its best interest in regards to its health care. Therefore, insofar as this model relies on the truth that providers hold themselves out as healers (in some sense) it applies to all brigade participants; however, in that it relies on the profession of medicine as a source of ethical obligation it is applicable to those specifically presenting themselves as health care providers. That being said, even if this piece of the framework was considered to only be applicable to the health care providers directly treating patients, it is still a useful part of the ethical analysis as the health care providers are an integral part of the medical brigade model and the well being of the patients it serves.

In the second model I will examine the ethics of standard of care debates, specifically as addressed by Alex London.[26] While these debates have most recently been taken up in regards to research in the developing world, the concerns they present and the issues they address are not unique to this context. The most evident connection between undertaking research and providing healthcare in

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[26] Alex .J.London. "The Ambiguity of the Exigency: Clarifying 'Standard of Care' Arguments in International Research." *Journal of Medicine and Philosophy*. 25 (2000): 379-97.

the developing world is that in both instances the developed world is providing a certain standard of

care, whatever that may be, upon traveling to these countries. Therefore the relevant link between

these two models, in regards to the current ethical analysis, is not the similarities to the research

context itself but rather the level of care owed to the developing world through interventions carried

out by the developed world. As will be presented and further explained below, London claims this

obligated level of care is the *de jure* standard of care.[27] London justifies this claim by demonstrating that

basing the provision of a certain level care on what a group currently has is an arbitrary distinction, and

asserting that certain obligations arise from initiating an interaction with a specified group. These

principles can also be shown to apply in the clinical care context of a medical brigade.

For instance, the stand alone fact that medical brigades provide more healthcare than a

Honduran community would otherwise have is not sufficient to validate any intervention that a group of

travelers wish to provide. Without employing standard of care considerations in the context of medical

brigades, for example, it would be considered acceptable to go to a developing country for a short-

period of time with the express purpose of only providing three Tylenol to every community member.

This *would* give a community more than what they otherwise would have had, but would not uphold the

standards of medical practice in any meaningful sense, for any population. Nor would it improve the

health and wellbeing of community members in any significant sense. Similarly, because the medical

brigade model, which lacks follow-up care and accountability, would be considered unethical if

undertaken in the developed world, it is a double standard to employ this type of care in the developing

world. Furthermore, as will be shown to be relevant to the standard of care debate below, medical

brigade groups are also initiating an interaction with a developing community upon agreeing to hold a

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[27] *Ibid.*

brigade in that community, and are therefore taking responsibility for these community members within this context.

However, because this debate *was* carried out in the research context, there are important differences that arise when applying the standard of care arguments from the international research context to the clinical care context of medical brigades. I would argue the conclusion reached by London has an even stronger foothold in the clinical care context because of these differences. The overarching goal of research is to develop or contribute to generalizable knowledge, while the practice of medicine "refers to a class of activities solely to enhance the well-being of an individual patient or client."[28] Researchers may contest their obligation to provide the *de jure* standard of care in the research context based on the argument that they are not healthcare providers, or in this context it is not their role, and therefore providing clinical care above what the population already has access to is not their responsibility. Alternatively, healthcare providers travelling to developing countries for the express purpose of providing healthcare cannot similarly make this claim. In the medical brigade context, care is exactly what is professed to be provided. Thus, standard of care arguments are relevant and very important to an ethical analysis of the medical brigade context. Nonetheless, the standard of care model does not cover all aspects important to a complete ethical analysis of the current medical brigade model. Standard of care refers to the particular treatments obligated to be provided to individuals within a certain context. The medical brigade model, however, also deals with and affects communities, as well as community members the medical brigade group does not treat.

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[28] Robert J. Levine, *Ethics and regulation of clinical research* (Baltimore, Maryland: Urban & Schwarzenberg, 1986), 3.

For the third model, I will present the established code of conduct for Community-Based

Participatory Research, which will address the necessary inclusion of the community level lacking in the

model above. Part of the issue with (and danger of) medical brigades is that their lack of sustainability

and responsiveness to community-specific needs jeopardizes their ability to be useful to the

communities they serve. Because the kind of work accomplished is piecemeal acute care, and does not

address the underlying causes of disease and illness in any one community, any positive effects of

medical brigades have likely already dissipated a short time after participants leave. Community-Based

Participatory Research has already addressed this concern of sustainably improving the health and well

being of communities, within the research context, by being responsive to community-defined needs

and enabling community participation through collaboration with those who are affected by the issue.

Participatory Research has long been practiced in developing communities and was developed "to

address the failure of other approaches to ameliorate social and economic conditions or effect

change."[29] This model aims to enhance "the relevance and validity of health research *by ensuring that*

the social, cultural and economic conditions of the community are included."[30] These issues are also

paramount for medical brigades which are undertaken in poverty stricken developing communities that

lack many basic necessities and have many powerful economic determinants affecting their health. The

notion of community-specific needs is particularly important for developing communities because the

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[29] Macaulay, Ann C., William F. Freeman, Nancy Gibson, Melvina L. McCabe, Carolyn M. Robbins, and Peter L. Twohig. "Responsible Research with Communities: Participatory Research in Primary Care." *North American Primary Care Research Group*. (1998) http://www.napcrg.org/responsibleresearch.pdf, 4.

[30] Ibid., 1. Emphasis Added.

issues and conditions affecting their health manifest in such a large variety of ways, some of which are unique and unexpected.[31]

Participatory Research also requires that a considerable time commitment be given of all collaborators so that each is equally invested and all understand and have a part in defining the underlying reason and aims for the intervention. The short-term nature of brigades, with many one or two-time volunteers, does not accommodate well (if at all) for this needed knowledge or understanding. Although some participants may have personal background knowledge of the community or country they are aiming to help, the medical brigade model does not provide it. How can brigade participants expect to be responsive to a community's healthcare priorities or cultural beliefs if they do not know what they are? By applying the principles from this model to the medical brigade context, community-specified health care needs can be effectively and ethically addressed. Involving a community in the clinical care provided in the developing world will ensure that it is responsive to the goals, values and needs of the community, and thereby significantly increase the chance that it will be able to effect significant, positive change, and not exploit the community served.

Nevertheless, like the standard of care debates, this framework is presented in the language of research initiatives. It refers to the importance of research outcomes and results to be relevant, useful to and useable by the communities in which the research is undertaken, specifies the importance of the community defining its own research problem, and "attempts to negotiate a balance between the development of valid generalizable knowledge and meaningful community benefit."[32] However, these

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[31] As one example, in the following chapter I will refer to a survey undertaken in Utila, Honduras which discovered the top three most pressing community-defined health needs were less drugs, an airport, and electricity twenty-four hours per day. (Utila, Honduras citation)

[32] *Ibid*., 4.

concepts can be easily applied to the medical brigade context by recognizing research outcomes as brigade outcomes, research problems as health care problems, and the balance between generalizable knowledge and meaningful community benefit as a balance between convenience to brigade participants and a meaningful community benefit, without any significant differences.

With a clear understanding in place of how each of these models does and does not apply to the medical brigade context, I will now turn to the ethical obligations incurred through each of these models. Finally, by taking these obligations together, a framework with which to ethically analyze medical brigades will become available for use in the coming chapters.

2.2 OBLIGATIONS INCURED THROUGH THE CLINICAL CARE RELATIONSHIP

The interaction of the doctor-patient relationship is often regarded as a unique phenomenon, with an inherent power dichotomy (both because of knowledge inequities and vulnerability), during which one person in special need divulges intimate details about herself to another who professes to provide the guidance and care necessary to help. Because of the unique characteristics of this relationship, when people meet with their primary care physician or other healthcare provider, they often assume and expect certain standards to be true of this interaction. For example, we typically trust in our physicians to act in our best interest, and expect that they possess the competence and understanding to do so.

Edmund Pellegrino, in his article "Toward a Reconstruction of Medical Morality: The Primacy of the Act of Profession and the Fact of Illness," and later in a chapter adapted from this article, validates these expectations by arguing for certain obligations placed on the healthcare provider.[33] Pellegrino sets

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[33] Pellegrino and Thomasma (*Ibid*), "A Philosophical Reconstruction of Medical Morality."

forth a theoretical framework for "the morality of the professional acts of professed healers" with which

to make these claims. By examining three phenomena that are specific to medicine, the fact of illness,

the act of profession and the act of medicine, Pellegrino contends that "the interrelationships of these

three phenomena are sufficiently unique to medicine to constitute a specific and special kind of human

relationship which ought to be conducted in certain specific ways to be morally defensible."[34] In other

words, Pellegrino claims that based on the specific nature of the medical transaction, certain, universal

obligations are required of physicians for their actions within the doctor-patient relationship to be

considered ethical. The examination of these phenomena leads Pellegrino to ultimately conclude that

"those who profess to heal" have the obligation to be competent (in a broad conception of the term),

obtain proper consent from the patient, respect the individualized nature of the transaction within the

doctor-patient relationship, and to put the patient's interest before that of the interests of all others.

Further exploring each of these three phenomena will serve to demonstrate how each is also

true of the doctor-patient encounter within the medical brigade context, as well as make evident how

Pellegrino is able to claim that the nature of the phenomena places these certain obligations on

healthcare providers. The fact of illness, the first of the three aspects specific to medicine presented by

Pellegrino, is the underlying reason for every medical transaction. A person approaches a healthcare

provider for help when she recognizes a sign that she is no longer in her usual state of wellbeing or

health. Pellegrino describes this state of illness as "one of wounded humanity, of a person compromised

in his fundamental capacity to deal with his vulnerability."[35] This state of vulnerability goes beyond a

patients' deficit in technical knowledge and capabilities, to one in which their coping mechanisms,

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[34] *Ibid*., 207.

[35] *Ibid*., 208.

capacity to make decisions and self-image are compromised. The patient is therefore in a unique state

of being, with a special dimension of anguish, within which she is reliant on another:

> This ontological assault of illness is aggravated by the loss of specific freedoms which we
> identify as peculiarly human. The patient is no longer free to make rational choices
> among alternatives. He lacks the knowledge and the skills necessary to effect a cure or
> fain relief from pain and suffering. In many illnesses, the patient is not even free to
> reject medicine, as in severe trauma or overwhelming emergencies. Voluntarily or not,
> the patient is forced to place himself under the power of another health professional,
> who has the knowledge and skills which can heal – but also harm. This involuntary need
> grounds the axiom of vulnerability from which follows the obligations of the physician.[36]

Because of these unavoidable realities for a person experiencing illness, and therefore for the medical

transaction, healthcare providers have a heightened responsibility to ensure their actions are in the best

interest of their patients. Fulfilling this responsibility in the context of medical brigades is even more

essential due to the pervasive, and often multiple, illnesses experienced by community members,

compounded with their decreased ability to access other available healthcare resources.

Pellegrino further contends that physicians have certain obligations to their patients because of

the act of profession unique to medicine. Pellegrino describes this act of profession as follows:

> In the presence of a patient in the peculiar state of vulnerable humanity which is illness,
> the health professional makes a 'profession.' He 'declares aloud' that he has special
> knowledge and skills, that he can help, and that he will do so in the patient's interest,
> not his own… Health professions make this act of profession publicly when they accept a
> degree at graduation, when they take the oath of their profession, and most
> importantly, every time they present themselves to a patient in need who seeks their
> assistance in healing. They make the act of profession implicitly, but nonetheless

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[36] *Ibid*.

undeniably. The expectation is thus induced in the ill person that the declaration will be

true and authentic, that the professional knowledge and skill are there, and that the

professional concern for the patient's interest will be truly exercised.[37]

The health professional is therefore voluntarily assuming these responsibilities by virtue of becoming a

health professional, and again every time she presents herself to a person in need. By introducing

themselves as doctors, and asking community members to share with them their ailments, the

healthcare providers that participate in medical brigades are also accepting certain responsibilities.[38]

They are inducing the belief in those they interact with that they will act responsibly and in good faith

within the doctor-patient relationship.

Lastly Pellegrino examines the central act of medicine as a source of physician obligation:

All the science and art of the physician converge on the choice: among the many things

that *can* be done, that which *should* be done for this person in this particular situation of

life. It is a choice of what is *right* in the sense of what conforms scientifically, logically

and technically to the patient's needs, and a choice of what is *good*, what is worthwhile

for this patient.[39]

It is the act of clinical judgment, which combines technical and moral decision making, for which the

patient seeks a physician. It is this decision making process that leads to the desired end of medicine, "a

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[37] *Ibid*., 209-10.

[38] It is unlikely that the majority of student participants are introducing themselves as doctors to the patients served, unless the student is already in engaged in medical training. One such instance of a medical student introducing himself as a physician, which will be further discussed in the next chapter, has been documented in the American Medical Association's Virtual Mentor, although I am unsure exactly how common an occurrence this is. Naheed R. Abbasi and Michael Godkin. "Limits on Student Participation in Patient Care in Foreign Medical Brigades." *American Medical Association: Virtual Mentor*. 8:12 (2006): 808-13.

[39] Pellegrino and Thomasma (*Ibid*), "A Philosophical Reconstruction of Medical Morality," 211.

right and good healing action taken in the interest of a particular patient."[40] Without performing this act

of medicine responsibly, a person is not truly fulfilling the role of healthcare provider.

The interrelationship of the three phenomena presented above necessitates placement of

certain obligations on all physicians in order for the physician to fulfill the roles inherent to medicine and

act in an ethical manner. The first obligation that arises from this construal of the patient-physician

relationship is the requirement of the healthcare provider to afford competence. Although technical

medical knowledge is essential for this requirement, Pellegrino uses the concept of competence to

include more, "Competence must itself be shaped by the end of the medical act – a right and good

healing action for a particular patient. Competence must be employed in the best interest of the patient,

and wherever possible that interest must conform to the patient's values and sense of what it is to be

healthy."[41] By this definition it can be assumed that for a physician to make competent medical

decisions she must have an at least rudimentary understanding of a patient's culture, values and goals.

This requirement is congruent with the second obligation claimed by Pellegrino, that of

informed consent. This claim requires the health care provider to clearly present all relevant

information, in the patient's language, and to remedy the patients' knowledge deficit as completely as

possible, "The patient must know the nature of his illness, its prognosis, the alternative modes of

treatment, their probable effectiveness, cost, discomfort, side effects, and the quality of life they may

yield. Disclosure must include degrees of ignorance as well as knowledge and the physician's own

limitations. The physician who is conscious of the special nature of his act of profession will not easily

excuse himself from the obligation on the grounds that the patient cannot understand or will be harmed

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[40] *Ibid*.

[41] *Ibid*., 213-4.

by the information."[42] Pellegrino acknowledges that unlike the standard golden rule, to treat others as you want to be treated, "the golden rule in medical decisions is to be observed rather differently: *We should so act that we accord the patient the same opportunity to express or actualize his own view of what he considers worthwhile as we would desire for ourselves*."[43]

Overall, through this discussion Pellegrino concludes that health care providers, and brigade participants insofar that I have shown the inner workings of medical brigades resemble the doctor-patient relationship, are obligated to provide competence, informed consent and put the interests of the patient before the interest of all others. By not upholding these standards, any doctor- patient interaction, including within the medical brigade context, is inauthentic at best and utterly negligent at worst. There is no reason to expect, or accept, that the professional responsibilities of healthcare providers would change simply because they cross borders. In the next section I will argue that the standard of care owed by these healthcare providers also ought not diminish merely because they are in a developing country.

2.3 OBLIGATIONS INCURED THROUGH STANDARD OF CARE ARGUMENTS

This section reflects on the standard of care[44] that ought to be required in a specified context and responds to the question: If the care provided in a certain context is better than what the community would otherwise receive outside of that context, is this "good enough"? Or in other words, is the mere

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[42] *Ibid*., 214.

[43] *Ibid*., 216.

[44] In this discussion, standard of care refers to the level of care required within a given context in order for the actions taken to be considered ethical and upholding the commonly accepted guidelines of a profession or intervention.

fact of providing any benefit to people in the developing world adequate, along with the fulfillment of

consent requirements, to justify an intervention? Through presenting Alex London's argumentation for

the appropriate standard of care required of these travelers in the international research context,[45] and

relying on the relevant analogies and disanologies between the research and medical brigade contexts

presented above, I will present the level of care that is necessitated in the medical brigade context as

well. Namely, brigade participants and their sending institution have the responsibility to provide the

Honduran communities they serve with the best known treatment, *effective for that population*, when

offering healthcare in their country. This standard of care is what London refers to as the *de jure*

standard of care.

The *de jure* standard of care is in contrast to two other commonly held viewpoints, local and

global standards of care. Proponents of what London calls the local *de facto* standard of care arguments

in international research ethics, argue that the relevant standard of care is to be determined by the local

practices of the host community. This is the care the population would receive if the researchers were

not present. This viewpoint is supported by the argument that employing this as the control condition,

research subjects are no worse off than they otherwise would have been, and may even be better off in

the research context because ancillary medical care is often provided. It is also claimed that, by

espousing the local standard of care as the relevant reference point, one will be better able to address

the healthcare issues of the local community. When wealthy, technologically developed groups'

standard of care is allowed to place arbitrary restriction on important international research, regulations

could be said to be unnecessarily paternalistic. The populations of developing countries should be able

to undertake research initiatives that will result in the kind of interventions that will best address their

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[45] While the standard of care debate in the research context had been taken up by many and is far from settled, for
the purpose of the current thesis I adopt Alex London's framework, as I believe he has most effectively addressed
this issue.

health care concerns. Conversely, the global *de facto* standard of care argues that a local reference point allows researchers to provide an inferior standard of care to research subjects and thereby exposes them to foreseeable and preventable harms. The global reference point entitles research subjects to the best, proven-effective treatment available anywhere in the world.

London claims these arguments are debating the ethical standard of care based on the wrong question; the relevant point of reference is not what is at issue. A *de facto* interpretation of standard of care of a community assumes "the *standards* of medical practice for that community are set by the *actual* medical practices of that community."[46] This is problematic because the medical care a community in a developing country routinely receives is unlikely to coincide with the standard of care that community wishes to uphold. The Nuffield Council report also acknowledges this ambiguity: "while the term 'standard of care' is used in law to refer to the standard treatment that a court would conclude that a reasonable physician would provide in the circumstances, the term is used here to describe what happens in practice, whether or not is could be considered reasonable or appropriate."[47] London claims that medical experts, both in the developed and host countries, know which diagnostic and therapeutic interventions have been proven most effective, and see this as best for the population in question as well.

London recasts this standard of care debate by presenting the *de jure* framework with which to appropriately address the standard of care issues in international research. The *de jure* standard focuses on what the individual community wishes to uphold, as opposed to what it or another country

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[46] London (*Ibid*), "The Ambiguity of the Exigency: Clarifying 'Standard of Care' Arguments in International Research," 382. Emphasis Added.

[47] Ruth Macklin. *Double standards in Medical Research in Developing Countries*. (New York, New York: Cambridge University Press, 2004), 41.

currently has, in terms of healthcare. What matters for this viewpoint is whether there is a known

effective treatment, anywhere in the world, *for a given illness within a specific population*, not where in

the world it is currently available. It aims to provide a framework within which host countries can carry

out research initiatives specific to their relevant healthcare needs, as well as assure they do not receive

a standard of care below that which they would endorse (assuming there is a proven-effective

treatment available elsewhere). London's *de jure* standard "requires researchers, their sponsoring

agencies, and relevant political bodies to ensure that conducting a clinical trial represents a responsible

means of addressing the healthcare priorities of the population in question."[48] It is not that the

intervention is required to be the same as that of the developed world, but it does need to be equitable

to the level of care enjoyed by the developed world, in that it is effective and relevant. Simply because a

community does not have access to a certain level of care does not mean they do not have a right to

that level of care.

Thus far, I provided an account of the *de jure* standard of care and demonstrated that it is an

appropriate framework with which to evaluate whether an intervention provided in the research

context is ethical. I will now address why London is able to claim that the communities in developing

countries have a right to a *de jure* framework standard of care. In other words, why are we required to

provide a proven treatment that would be effective for a population, if it is not something to which they

already have access? The right of research participants to receive the *de jure* standard of population-

specific care is first justified because dividing up communities solely by the standard of care they are

experiencing (the local *de facto* standard of care) can be shown to be a completely arbitrary factor for

determining whether research is or is not ethical. Consider that using this reason to draw a distinction

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[48] London (*Ibid*), "The Ambiguity of the Exigency: Clarifying 'Standard of Care' Arguments in International
Research," 394.

gives socially and economically oppressed groups differential access to a standard of care in the research context, simply because it is more than what they are currently receiving. This could occur even within national boundaries. For instance, using the routine care a group receives as the relevant criterion for what they are entitled to in the research context, would put homeless U.S. citizens in a different category than middle class U.S. citizens with regard to what research it is ethical to test on them. For example, the same research study that would be considered unethical in the suburbs of Pennsylvania may be ethically permissible for the inner-city poor because the participants are "no worse off" than they otherwise would have been. This kind of situation has already been deemed as unethical in the developed world. In fact, the Tuskegee syphilis experiment, a paradigm case for unethical research, was similarly argued to be justified because it was only observational and did not make the research subjects any worse off than they already would have been, "since the poor African-American men probably would not have been treated anyway."[49] The defendants of this experiment even claimed that the research was valuable for the subjects themselves, since it was addressing a relevant health concern of this impoverished rural population with a very high rate of untreated syphilis.

Secondly, research participants have a justified claim on researchers to uphold this right insofar as researchers can be held partially responsible for an unmet health care need of the developing nation population. Therefore they are responsible for providing the treatment in the research context, if it exists, which would address the health care issue. This argument appeals to broader claims dealing with theories of justice (such as that espoused by Rawls in A Theory of Justice). London suggests that simply by being a citizen of the developed country that is in a higher position of social and economic power, one has the ability to affect the lives of distant people, and is therefore partially responsible for the plight into which persons of the developing world are born. While London recognizes that these

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[49] Angell (*Ibid*),"The Ethics of Clinical Research in the Third World," 848.

arguments may be controversial in applying broadly to people of the developed world, medical

researchers may incur obligations to the developing world "insofar as they are citizens of basically

democratic nations whose policies have contributed to stark global inequalities, or insofar as they are

funded by entities with such obligations."[50] Even though researchers are unable to provide the *de jure*

standard of care to the entirety of the developing world (just as brigade participants cannot treat every

community), it is still the standard of care researchers are obligated to provide, and research subjects

have a right to receive, by virtue of the fact that they have initiated an interaction with the host

community involved. By doing so, they are taking responsibility for the participants within the context in

which they engage them and therefore have an obligation to provide the *de jure* standard of care to the

populations they serve.

While this presentation has clearly defined the standard of care debate in the language of

research interventions, the overall concepts and conclusions of the *de jure* standard of care can also

independently apply to the clinical care context insofar as the above discussion demonstrated the

relevant similarities between the two models. The touched upon notions of addressing community-

relevant healthcare issues, and affording the same dignity and heeded expectations of the developed

world to the developing world are further addressed and supported in the next two sections.

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[50] London (*Ibid*), "The Ambiguity of the Exigency: Clarifying 'Standard of Care' Arguments in International
Research," 32.

2.4 COMMUNITY BASED PARTICIPATORY RESEARCH AND COMMUNITY-SPECIFIC NEEDS

The last established framework for dealing with vulnerable populations that I will examine is that of the

Community- Based Participatory Research model. The aim of the participatory research (PR) approach is

to increase the voice of communities in identifying health issues through equal collaboration with

researchers, and ensure that the social, cultural and economic conditions of the community are included

in the research model. In order to discuss the commonly accepted guidelines of Community-Based

Participatory Research, I will rely on the document "Responsible Research with Communities:

Participatory Research in Primary Care," which was adopted by the North American Primary Care

Research Group (NAPCRG) as organizational policy in 1998.[51] This policy document encourages NAPCRG

members "to seek opportunities to work in partnership with communities to ensure that theoretical and

applied benefits are clear and significant to both the researcher and the community."[52]

The PR approach requires that communities play a true collaborative role in these partnerships;

meaning communities are intimately involved in the decision making process and discussion from early

on in the research project and continuing throughout. This model strikes a balance between the

development of generalizable knowledge and meaningful community benefit by addressing research

ethics in a new way:

> The initial development of research ethics concentrated on the researcher's
> responsibility to individual research subjects. Current approaches address the additional
> challenge of meeting the ethical needs of researchers, individuals and communities…
> the community to be studied should be represented in the review process… it should
> not be considered that lack of formal education disqualifies community members from

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[51] Macaulay et al (*Ibid*), "Responsible Research with Communities: Participatory Research in Primary Care."

[52] Ibid. 3.

joining in constructive discussion on issues relating to the study and application of its

findings .[53]

The PR approach views facilitated community involvement as necessary to undertaking a research

endeavor in an ethical manner. Without this component, it is argued, the communities are used by

research initiatives because they are not meaningfully benefited. Conversely, by involving communities,

not only is the process then responsive to community needs, but it makes the intervention more

sustainable and likely to succeed by giving communities a place in and commitment to the outcome.

Long after the researchers leave, the community can still be reaping the benefits of the outcome.

As previously mentioned, the PR strategy was developed to address "the failure of other

approaches to ameliorate social and economic conditions or effect change."[54] It provides a framework

that responds to health issues within a social and cultural context, "This is in contrast to approaches

wherein health issues are framed only in clinical terms, defining illness in relation to individual

behaviors."[55] By committing to the policies delineated above of addressing community-specific needs

and involving communities in the process, research initiatives can improve the health and wellbeing of

individuals and families long-term, and transfer knowledge and skills to the community. The PR

approach takes a considerable amount of time to carry out in the intended manner. To be able to effect

real community change, this model requires a clear and defined understanding of community needs.

Understanding these needs requires not only community collaboration, but also includes a background

understanding of the culture and social conditions of the community you are trying to help.

Collaborating with the community to be served, and addressing their healthcare priorities, needs to be

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[53] *Ibid.*,7.

[54] *Ibid.*, 4.

[55] *Ibid.*

accomplished through long-term, equitable partnerships. Without this piece, there is no real benefit

gained, and no real reason for the community to participate.

A PR project is deemed successful when all collaborators are satisfied with the research process

and the results it produces, and when the action to which it leads brings about better conditions for life.

This is a good guideline with which to evaluate the success of medical brigades as well, as will continue

to be addressed in the next section of this chapter.

2.5   PROVIDING A FAIR BENEFIT IN THE CONTEXT OF MEDICAL BRIGADES

Who are we ultimately helping? This question has often been raised by those concerned with the

outcomes of medical brigades. On short-term humanitarian trips such as these, the amount of good

accomplished by participants often pales in comparison to the overwhelming poverty and sickness

present in most developing communities. Many students, and other interested parties, have recognized

this lack of long-term impact, and questioned the usefulness of these interactions. Some have framed

this question in terms of who is receiving more of a benefit from the relationship created by medical

brigades, the communities or the participants from the developed world? As one student reflected on

his Honduran medical brigade experience:

> 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?[56]

As a premedical student I also felt I had benefited greatly from a personal medical brigade experience in Honduras; I learned a lot, felt privileged to spend time in the Honduran communities, had the opportunity to tour other social service facilities in Tegucigalpa, and gained clinical experience important for medical school applications; but I left Honduras wondering if I had made a difference. There are many studies in fact, that show how global health experiences benefit the students involved, as well as their home medical systems, by increasing the students cultural competence, awareness of the social determinants of health, global perspective, and the likelihood that their subsequent career will focus on the underserved in primary care settings, a large benefit for the United States whose current medical system is disproportionately staffed with specialists.[57] It would seem then that one of the fundamental flaws in medical brigades is that the parties involved are disproportionately benefited, with brigade participants gaining much more than they provide to Honduran community members in return.

As time has passed since my medical brigade experience, however, I have come to question the supposed benefit I received, and the benefit claimed to be gained by all brigade participants. If my goal was to improve the health of these communities, and I did not succeed, then did I truly receive any

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[56] Matthew Decamp. "Scrutinizing Global Short-Term Medical Outreach." *Hastings Center Report*. 37:6 (2007): 21-23, 21.

[57] Hurt (*Ibid*), "Hidden Ethics of Overseas Elective;" Michael Godkin and Judith A. Savageau. "The Effect of Medical Student's International Experiences on Attitudes Toward Serving Underserved Multicultural Populations. *Family Medicine*. 35:3 (2003): 273-78; Michael Godkin and Judith A. Savageau. "The Effect of Global Multiculturalism Track on Cultural Competence of Preclinical Medical Students." *Family Medicine*. 33:3 (2001): 178-186; Lauren T. Wasson. "Journal discussion." *American Medical Association: Virtual Mentor*. 8:12 (2006): 826-30; S. Shah and T. Wu. " The Medical Student Global Health Experience: Professionalism and Ethical Implications." *Journal of Medical Ethics.* 34 (2008): 375-78; Conrad, Craig J., Mark J. Kahn, Karen B. DeSalvo, and Lee Ham. "Student clinical experiences in Africa: Who are we helping?" *American Medical Association: Virtual Mentor*, 8:12 (2006): 855-58.

meaningful benefit (or one that could not have been just as easily gained through travel or volunteering locally)? The debate over fair benefits in the international research context, for example, has been an important issue because the aims of researchers and participating communities are often at odds. Researchers' main objective is to generate generalizable knowledge, test therapies and possibly be published, while communities aim to obtain community useful knowledge and other associated community improvements. In almost all cases, however, incongruent objectives are not characteristic of medical brigades. Despite the possible gain of the benefits presented above, the overwhelming majority of the students and providers travelling to deliver healthcare in these developing communities are doing so because they *want* to help these communities. The communities accept the offer of the medical brigades, or individual patients come to these clinics, because they want to be helped. The motives of both the brigade participants and developing communities are working towards the same end and by not achieving this goal, I would argue, *both* groups are actually being harmed. In this respect, no one is receiving a fair benefit.

This being the case, one need not only consider the consequences of the medical brigade relationship for the Honduran community members, but also the effects this arrangement has on the brigade participants. If in fact, as stated above, international experiences do serve to increase the students' cultural competence, awareness of the social determinants of health, global perspective, and the likelihood that their subsequent career will focus on the underserved, what does this mean for a student whose first experience with global health is less than optimal? Not only are these students not attaining their goal of improving the lives of community members, but they are developing a skewed view of what it really means to help a community. For instance, what attitudes are these participants acquiring with respect to the standards we ought to uphold in providing care to poor or vulnerable people? What are these students learning, if anything, about the social determinants of health and

culture of these communities? If students return home after a medical brigade with a feeling of

satisfaction at the "help" they provided, then they are walking away with a grossly misguided

conception of what it means to be an ethical and helpful participant in the global health arena; thereby

doing a disservice to both the communities and the brigade participants, and putting communities at an

even greater risk of receiving inappropriate interventions in the future. If these participants, assuming a

continued passion to make a difference, do plan to continue with a career in global health and/or with

the underserved, they will be further disadvantaged by having to unlearn these principles and take the

time to gain experience with the appropriate standards.

A broader, and possibly more detrimental, effect of relying on medical brigades as an adequate

model of intervention in the developing world is the perpetuation and reinforcement of Western

superiority as an acceptable phenomenon or belief. In this scenario, brigade participants are leaving the

developed world to graciously rescue a primitive Other, and do for them what they are unable to do for

themselves. In his book *Pathologies of Power*, Paul Farmer speaks to the problem of relying on this

model of charity as an appropriate approach to relieving poverty and suffering; "Those who believe that

charity is the answer to the world's problems often have tendency – sometimes striking, sometimes

subtle, and surely lurking in all of us – to regard those needing charity as intrinsically inferior."[58]

Reflecting on the work of Paulo Freire, Farmer further goes on to say:

> The approach of charity further presupposes that there will always be those who have
> and those who have not. This may or may not be true, but, again there are costs to
> viewing the problem in this light. In *Pedagogy of the Oppressed*, Paulo Freire writes: 'In
> order to have the continued opportunity to express their 'generosity,' the oppressors

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[58] Paul Farmer. *Pathologies of Power: Health, Human Rights, and the New War on the Poor*. (London, England: University of California Press, 2005), 153.

must perpetuate injustice as well. An unjust social order is the permanent fount of this 'generosity,' which is nourished by death, despair, and poverty… True generosity consists precisely in fighting to destroy the causes which nourish false charity.'"[59]

Medical brigades, and similar interventions, perpetuate the burdens borne by the underserved by allowing citizens of the developed world to give little more than nothing and feel good about it, solely based on the belief that what they are providing is better than what the population currently has, and therefore anything they give is above and beyond what is required. Touting this attitude as acceptable puts the developed world in the precarious position of feeling comfortable with the gross injustices characteristic of developing countries. It is a false sense of goodwill that ignores the role of the developed world in creating and contributing to those very injustices, and potentially assumes developing communities are victims of innate shortcomings rather than victims of structural violence. In an article contributing to the standard of care debate in clinical research, Graaf and Delden reflect on the relevance of Thomas Pogge's argumentation for universal standards on the subject of global economic justice to other roles of the developed world in developing countries:

> Pogge writes that affluent countries easily accept double standards with regard to the massive poverty in developing countries. People in rich countries often subject the economic order of developing countries to weaker moral demands than their domestic economic order in order to rationalize the divergence. Pogge argues, however, that the burden of proof lies on defenders of double standards to demonstrate that the global poor are subjected to weaker moral demands than the global rich. According to Pogge we might formulate a double standard. We might even find a plausible rationale for it. However, *morally* we will always have to explain why we treat people differently.[60]

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[59] *Ibid*., 153-54.

[60] Rieke Graff and Johannes J. M. van Delden. "What is the Best for the Standard of Care in Clinical Research?" *The American Journal of Bioethics*. 9:3 (2009): 35-43, 39.

Endorsing the care provided by medical brigades as a satisfactory or sufficient intervention for developing countries concurrently endorses the acceptability of these communities experiencing a standard of living far below that which would be regarded as adequate in the developed world. As recounted by Avery Hurt in the American Medical Students Association's *New Physician*, co-directors of the Kunde Hospital in Nepal write, "It is inappropriate arrogance to assume that anything that a Western doctor has to offer his less developed neighbor is progress… If an unregistered Nepali doctor on holiday in the United Kingdom offered general medical consultations in a shopping centre, there would be a public and professional outcry."[61]

Not only does this double standard and these misconceptions threaten the wellbeing of developing communities, they jeopardize the future global health careers of the driven and passionate students who are ready to save the world, and believe they are taking the first step in doing so. As I have argued for above, both the individual participants and the sending institutions or in-county sponsors have an obligation to ensure the brigades in which they partake are ethically responsible to the communities they serve. In addition, I am asserting that these organizations also have a responsibility to the students they are recruiting to provide ethical and meaningful interventions that are modeled to meet the goals of both those who receive the care, and those who provide it, thereby mutually benefiting everyone involved.

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[61] Hurt (*Ibid*), "Hidden Ethics of Overseas Elective."

2.6 THE MEDICAL BRIGADE FRAMEWORK

The above examples were presented in order to conceive a theoretical framework relevant to the ethical analysis of medical brigades. In addition to arguing that the current medical brigade model does not effectively serve the goals of any of the relevant stakeholders, I have delineated the obligations placed on medical brigade participants by examining other models identified to ensure ethical treatment of the vulnerable parties involved. The most important parts of the established medical brigade theoretical framework rest on the obligations of brigades participants and organizers to provide medical care that addresses *community-specific* health care needs, puts the patients first and acts in their best interest, provides the appropriate standard of care, and gives a fair benefit to the patients and communities concerned, as well as the students and physicians involved. With these responsibilities in mind, the next chapter will parse out the plausible and likely negative effects medical brigades have on their patients, their potential patients, and the larger community within which they reside, and demonstrate how these responsibilities are not fulfilled. The last chapter will then demonstrate how these negative consequences can be avoided, and the obligations heeded, by presenting ethical alternatives to the current medical brigade model.

3.0   A CRITIQUE OF THE MEDICAL BRIGADE MODEL

The first chapter of this thesis described the presence of brigades in rural Honduras and how they

currently function. Given that presentation and the ethical obligations placed on brigade participants

and their affiliated organizations (via the theoretical framework of the previous chapter), I will now

present the likely and plausible negative effects that need to be addressed in order to fulfill those

obligations and improve the current medical brigade model. [62] The following harm-benefit analysis of

medical brigades will serve to concretely delineate the serious issues presented to individuals and

communities when they are served by these brigades, and further make it evident that change is

needed. This chapter will also specifically demonstrate how the medical brigade model does not fulfill

the requirement to provide medical care that addresses community-specific health care needs, puts the

patients first and acts in their best interest, provides the appropriate standard of care, and gives a fair

benefit to the patients and communities concerned, as well as the students and physicians involved.

It is important to state that the problems of medical brigades by and large lie within the overall

structure and organization of the trip, and present serious issues despite the medical competency (or

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[62] Here I have referred to these harms as "likely and plausible" due to the nature of brigades; because medical
brigades are short-term interventions that lack follow-up care, not much data exists on demonstrated harms, as no
one is around to witness or record brigade outcomes.

student supervision) and well-meaning intentions of brigade participants[63]. This thesis is not meant to be a critique or criticism of individuals who partake in this work (although participants would do well to consider how their individual role can have a large aggregate effect), but rather is meant to present the downfalls of using the medical brigade model as a means of addressing the extraordinary health care disparities in the developing world. As echoed by a critique of medical missions presented by Laura Montgomery:

> The shortcomings of these short-term efforts reflect the cultural assumptions that inform their design and implementation, rather than local health realities… I would like to emphasize that the quality of the medical and dental care provided is not what is at issue…the practitioners were licensed and board certified in various fields of medicine, nursing, and dentistry, and non-medical volunteers worked directly under their supervision. What is at issue, however, is the appropriateness of the delivery model; it can erode as well as enhance health[64].

Medical brigades, and other short-term medical interventions in the developing world, have been critiqued and criticized on many levels; at best these trips have been referred to as misguided, ineffective and inappropriate, and at worst as harmful, self-serving interventions that neglect to address communities' needs and priorities. In the previous chapter I argued there is an ethical obligation to improve upon and change the current medical brigade model; now I will aim to show why and in what ways that change needs to be made.

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[63] The following discussion *will* delineate some issues presented by student medical competency and participation. While it is likely these issues are also present in other medical care models, the discussion will show how the medical brigade model and organization encourages their presence. Therefore, the problems arise not only because students may be providing care beyond their medical capabilities and cultural knowledge, but because they are doing so within the medical brigade context.

[64] Laura M.Montgomery. "Short-Term Medical Missions: Enhancing of Eroding Health?" *Missiology.* (Jan/Feb 2000): 1-5, 1.

3.1 HARMS AND CONCERNS PRESENTED BY THE MEDICAL BRIGADE MODEL

The current thesis is in response to a personal brigade trip to Honduras for ten days to provide medical care to a few selected communities surrounding Tegucigalpa, with the first Honduras medical brigade undertaken by undergraduates at the University of Michigan. As many students who travel on short-term medical trips for the first time, I was completely unprepared for what I was to encounter. I had never been to a developing country, had no significant medical experience, and knew nothing about the history and culture of Honduras; I came back wondering if I had really made a positive difference for the communities we served, or more importantly, if I had left them in a worse condition than they were in prior to my visit.

Below I delineate some of the experiences from the brigade that instigated this doubt in the ability of the current medical brigade model to affect change in health care status and provide a meaningful contribution to the communities served. While there are clear limitations to relying on personal experience as a guidepost for an overarching ethical analysis of all medical brigades, examples from my time in Honduras will allow for the inclusion of first-hand experience and details that would otherwise not be possible. I also believe this point of view is appropriate because, as the presentation in the first chapter acknowledged, the organization and realities of my brigade were quite comparable to other Honduran medical brigades, and can therefore be reliably extrapolated to other medical brigades in general.[65] Although the details of my experience will not apply exactly or wholly to the experiences of

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[65] The first medical brigade undertaken by undergraduates at the University of Michigan, Ann Arbor was based through a campus student group, Biotechnology Education on Campus. This first brigade was coordinated through Sociedad de Amigos de los Niños, and was in many ways the beginning to Global Medical Brigades. It was one of the coordinators from this trip that went on to found GMB. Therefore my personal brigade experience was very similar to, and the start of, GMB's brigades. Since that time the University of Michigan has initiated a GMB affiliated student group that travels annually to Honduras.

others, they provide a vivid image of the kinds of issues that can arise within the context of a medical

brigade. This discussion will also include and rely upon interwoven examples and concerns brought forth

by a myriad of published articles, including others' experiences, in order to further validate and add to

the current argument. A combined account of these experiences and a discussion of additional plausible

harms with respect to the nature of brigades is all the information that is readily available with which to

carry out an analysis, as mentioned above. However, I believe it will prove to be sufficient in making a

solid case for the need to improve upon the current medical brigade model.

3.1.1 Personal Experience with Medical Brigades and Student Participation

Many of the aspects of my personal brigade experience create a valid cause for concern. One of the first

things that surprised me as I arrived on site to the first community we served during this medical brigade

was the large percentage of Hondurans wearing t-shirts adorned with English sayings and popular US

cartoon characters. Most of the hundreds of people lined up along the dirt road had already been there

for hours, knowing that not everyone who came was likely to be seen, and many would be there for

hours more before it was their turn. Some had food with them, although many did not. The entire

community had shut down for the day, hoping to receive some much needed medical care. It became

evident that there had been brigades there before us, would be brigades anticipated after us, and that

these community members were already well versed in what to expect. Whatever effect we were

having, it was clear it was affecting the whole community.

Once a patient was finally led to be seen by one of the few physicians travelling on our brigade, each

would inevitably list off five or more maladies he or she hoped to be treated or given medication for. It

was not that a patient was currently experiencing a headache, diarrhea, a cough, stomach pains and

fatigue simultaneously, but that the patient had at sometime in the past had each of these symptoms

and knew that he or she would be unlikely to access medical care the next time one of these problems

returned. These community members had come to depend on medical brigades, the free medication

and supplies they brought with them, and acted accordingly. Unfortunately, this reality can make it

difficult for physicians to make accurate diagnoses, and can cause confusion for the patient who is given

multiple medications, many of which he or she will not need until a later date. This learned and adaptive

behavior initiated by repeated exposure to the medical brigade model can put patients at a high risk of

misdiagnosis and inappropriate medical treatment, especially if the health care providers are not used

to, or are unaware of this type of scenario. Due to the limited amount of donated medications we were

able to carry with us abroad, our group also aimed to distribute medications somewhat evenly between

the patients and anticipated patients; meaning an individual patient may not receive care or medication

for every malady he or she listed off, and the patient's most pressing and important needs may have

been neglected.

The potential risks presented by this situation are often further complicated by brigade participants

operating outside their level of expertise, either culturally or medically, or both:

> In resource-constrained health care settings, trainees from resource-replete
> environments may have inflated ideas about the value of their skills and yet may be
> unfamiliar with syndromic approaches to patient treatment that are common in settings
> with limited laboratory capacity. These challenges may be compounded by language
> barriers impeding communication, cultural barriers to understanding the meaning of
> patients' statements or actions, lack of mutual understanding of training and

experience, and the possibility that inexperienced or ill-equipped short-term trainees
are given responsibilities beyond their capability[66].

Personally, when I was working in the pharmacy one day during my brigade, I was encouraged by the

member of Sociedad accompanying our group to "practice" my subpar Spanish skills by explaining to

patients how to take prescribed medications. We did not have prescription instructions written in

Spanish, or English for that matter, and this was the only time the multiple prescriptions would be

explained to an individual patient. Even vitamins can have negative effects if, for instance, a hungry child

eats them like candy to fill an empty stomach. Or, if only half of a bottle of antibiotics is taken in hopes

of saving some for later, it could potentiate the prevalence of resistant disease strains within the

community. Language barriers can also pose a serious risk for patients within the other roles students

commonly assume during a medical brigade, such as taking patient histories. If a physician or student

were to misunderstand a patient's past medical history, current symptoms or allergies it could have

serious consequences for the patient. On my brigade, less than half of the volunteers spoke any Spanish

and none of the physicians were proficient. None of the brigade websites that I encountered made the

ability to speak Spanish a requirement for volunteering.

Additionally, the charitable nature of brigades can cause a heightened power dichotomy in

which patients are unlikely to question a diagnosis or directions they did not understand, or they may be

more willing to trust foreign physicians[67], and the fast paced reality of brigades rarely allows for

questions even if the patients are willing to ask. It is also worth taking into account that "the mere

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[66] John A. Crump and Jeremy Sugarman. "Ethical Considerations for Short-term Experiences by Trainees in Global Health." *Journal of the American Medical Association.* 300:12 (2009), 1456-58, 1456.

[67] Decamp provides one examples of Honduran community members placing greater trust in foreign physicians. Decamp (*Ibid*), "Scrutinizing Global Short-Term Medical Outreach," 22.

presence of students can impact a clinic or hospital setting, even when the student does little more than shadow local clinicians. Students would do well to consider what it is like for a patient to be observed by a comparatively wealthy young foreigner, often of a different race or gender"[68]. While some patients may find a student's presence reassuring, others may feel inhibited and will therefore not provide full disclosure during the clinic consultation. In the United States patients are often asked if a student who is shadowing can remain in the room. Comparatively, in the medical brigade context this is option is likely rarely, if ever, presented to the patient. It may be assumed that all volunteers have an appropriate place in the medical interaction, and more often than not their presence is necessary to translate for the health care providers. These hindrances of communication (language, time, the presence of foreigners, and cultural divides) create a greater likelihood that a potentially dangerous misunderstanding between patient and caregiver will occur.

Overall, any student participation should be closely monitored to assure it is not putting patients at an increased risk. Roles and responsibilities given to students, and allowed for students, need to be appropriate to their medical and cultural skill level, as is the case for all medical interactions. However in the medical brigade context this can become, or seem to be, more difficult. Most students participating in medical brigades, both undergraduate and first and second-year medical students, have not yet had much, if any, significant medical training. However in the medical brigade setting, where there is much more need than can be accommodated by the small, short-term team, students may feel a pull to do whatever they can, which often means going beyond their capabilities. This may be because they feel some care is better than none, overestimate their skill level in the face of such poverty, or are too

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[68]Mary T.White and Katherine Cauley. " A Caution Against Medical Student Tourism." *American Medical Association: Virtual Mentor*. 8:12 (2006): 851-54, 852.

uncomfortable with what they see to not take action where others are not. The appropriate boundaries of participation may not be discussed with students ahead of time, or may be forgotten in times of stress, and the limited number of participants in comparison to the patients and roles can create a situation of sparse supervision. In effect, the medical brigade model puts students in roles of increased responsibility just when they have a decreased understanding of their surroundings and less supervision.

Even more worrisome are the documented situations in which health care providers actually *encourage* inappropriate participation of students, because of the lack of health care resources available in developing communities. One such occurrence was recounted by the American Medical Association, of a medical student who traveled to El Salvador with a group of surgeons to help staff a local clinic.[69] This student was given a white coat, told to introduce himself as doctor, and was provided a brief lesson on suturing technique, before being allowed to independently treat patients. Later in the week one of the student's former patients returned with a severe wound infection. When the student talked with one of the surgeons about whether it was appropriate for him to be performing these procedures on patients, the surgeon replied, "Relax, the rules here are different then they are at home. No one tells us what to do here. Besides, if you weren't here to help us out, we wouldn't be able to see as many patients and some people wouldn't get the help they needed. Is it better for a patient to get less than expert care or no care at all?"[70] This student, a third-year medical student, was practicing a technique that in the developed world is a responsibility usually reserved for third and second year residents, meaning five years additional training would be required in the United States and most developed countries. Even though this scenario may sound appalling to the reader (especially the surgeon's

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[69] Abbassi and Godkin (*Ibid*), "Limits on Student Participation in Patient Care in Foreign Medical Brigades."

[70] *Ibid*., 808.

pejorative attitude towards his hosts), to an over-stressed, under-staffed medical brigade group who may be witnessing severe poverty for the first time, these actions may have seemed completely warranted and a legitimate way to provide entirely absent medical care at the time. Even though I would assert this surgeon's attitude, and similar sentiments, is misguided and inaccurate, the realities created and experienced through reliance on the current medical brigade model underlies the majority of problems presented, not simply the attitudes of some brigade participants. Not all brigade participants would justify similar actions with the claim that "no one tells us what to do here." I believe the medical brigade model itself, which lacks accountability, adequate resources and personnel, and time for appropriate training and action, encourages these types of behaviors in both students and healthcare providers who believe they are doing the right thing for the limited time they are there and the level of poverty they are attempting to ameliorate. Students and health care providers alike are put into situations they are not ready for and do not know how to handle responsibly.

Notably, it has also been claimed that in *some* situations it *is* appropriate for a student to function differently in a developing community because of the scare resources available, such as during an emergency situation in which immediate action is required and no one else is around.[71] However, in one commentary that makes this claim, the author also makes a caveat that the actors should only intervene beyond their training level but not beyond their capacity; giving an example of a medical student who acted when she found herself alone with a patient in respiratory distress, "although [the student] had not encountered such a patient before, the senior student had a critical base of knowledge, ability and problem-solving skills to go beyond her training but not beyond her capacity

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[71] *Ibid*.

level."[72] The student may be trying something for the first time, but not necessarily practicing on the patient. This scenario, a medically educated student intervening during an emergency, would likely be considered acceptable in the developed world as well, albeit would be less likely to occur. While this is a particular and special situation, which may occur comparatively frequently, in all cases strict scrutiny should be applied to the roles allowed of students in the medical context. As cautioned by an article published in the Journal *of Medical Ethics*:

> We recognize that students may be able to participate in more surgeries and procedures in the underserved communities for many reasons. Increased participation in operations is not problematic on its own; the concern is with students partaking in procedures without sufficient supervision... Yet it is worth considering the reasons why underserved populations serve as educational tools.[73]

Not all the training and expertise enjoyed in the developed world is necessary for safe and effective health care. Many techniques and procedures can be effectively taught to lay caregivers, and do not always require the level of training mandatory in the United States or other developed countries. Yet if the student is unprepared or not allowed to undertake a medical treatment in her host country, it then becomes a concern that the student is using the developing communities' and their members as a way to participate and practice long before she would otherwise be able. This discussion goes back to the notion of "the Other" and Western superiority that was presented in the previous chapter. Allowing students greater responsibilities simply because they are in the developing world indicates a belief that these communities are somehow less and less deserving of an appropriate standard of care and a level

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[72] *Ibid.*, 813.

[73] Shah and Wu (*Ibid*)," The Medical Student Global Health Experience: Professionalism and Ethical Implications," 377.

of dignity, which is obviously threatening and dangerous to the wellbeing of these communities on

many levels.

These kinds of situations are also unfair for the students involved, as they can cause potentially

emotionally devastating consequences. As accurately captured by Naheed Rehman "it is a cruel irony

that medical trainees working in developing communities may find themselves elevated to levels of

heightened responsibility precisely at the times when their potential errors may be the least

remediable."[74] These students do not have the same luxuries as they would providing care in the United

States or other developing countries; if a mistake is made or something goes wrong in one of these

developing communities, they cannot simply "call a code" or go find immediate help. The students are

unlikely to have experience providing health care in these resource poor settings, where the biggest

health issues, for example, are the absence of clean drinking water and inadequate nutrition, and likely

lack the expertise to practice the art and science of medicine without all the "bells and whistles" readily

available in the developed world.[75] Being placed in a situation for which the trainee is not yet ready can

result in considerable stress and later guilt over what decisions were made. As one student brigade

participant recounted:

> After finishing my first year of medical school, I participated in a mission trip to Mexico.
> Before flying to Mexico, I was not given any cultural, medical, or other training, nor
> could I speak Spanish. Upon arriving, I was assigned to a clinic where there were
> thousands of patients but only one physician. I remember vividly seeing a frail 11-year-
> old boy with polyuria, polydipsia, and nocturia. My lack of medical training limited my
> differential. With only a scattered history and no other tests, I told him to limit caffeine

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[74] Abbassi and Godkin (*Ibid*), "Limits on Student Participation in Patient Care in Foreign Medical Brigades."

[75] Eric Berger. "Emergency Medicine Goes Global: Specialty Steps Up Humanitarian Role." *Annals of Emergency Medicine.* 47:4 (2006): 344-47, 347.

intake and see if that helps. Thinking back, he could have had a urinary tract infection, any number of renal abnormalities, or worse, I sent him out without ruling out diabetic ketoacidosis.[76]

While this is not the case for every student participant, many of my colleagues have also voiced concerns after similar trips regarding not only whether they really made a difference for the patients they served, but if actions they took and participated in made these community members worse off. The desire to help combined with relative inexperience poses ethical conflicts and leaves both patients and students vulnerable to negative outcomes such as these.

Volunteer health care provider participants are also often unfamiliar with the specific community needs and appropriate care in rural Honduras. As was mentioned in the first chapter, many are recruited by relatives and other student brigade participants and have never been to Honduras nor have sufficient knowledge or experience providing appropriate health care in a developing community. Just because medical providers' are competent in their home countries, does not mean they are competent in the medical interventions that are appropriate for the host community they are visiting:

> [A] characteristic of short term missions is both naïve realism and ethnocentrism which assumes that approaches suitable in one setting are appropriate in another. Project designers often assume that if their own situation does not have the same problems as the ones they are encountering in another, then the solution is to duplicate their own situation. These attitudes also manifest themselves through an assumption that no special planning or localized knowledge is needed and participants frequently have a lack of awareness and training regarding other medical systems, beliefs, or practices.[77]

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[76] Shah and Wu (Ibid), "The Medical Student Global Health Experience: Professionalism and Ethical Implications," 376.

[77] Montgomery (*Ibid*), "Short-Term Medical Missions: Enhancing of Eroding Health?," 3.

Full cultural understanding cannot be appreciated over-night, and not simply from second-hand

information or education. It takes a considerable amount of time and experience to really understand

what is going on in any one country or community in both a social and cultural context. It requires a full

appreciation of the history, values and, for the medical care context, a solid understanding of health

determinants, to provide effective and appropriate health care. The short-term nature of medical

brigades that recruits volunteers only for a very specific, often one or two time, commitment does not

routinely include room for this level of understanding and appreciation. Many times, simply different

economic realities and related life experiences can create differences of opinion, misunderstandings and

miscommunications between groups, and caregiver and patient. The medical brigade model

fundamentally assumes that acute care is an appropriate remedy to the illnesses and ailments present in

the developing world, as is the common approach in the developed world where basic necessities are

already readily available to most.

The above discussion began to highlight a concerning mentality that for people in poverty some

medical care, *any* medical care, is better than no medical care at all. This perception, that underlies the

basic actions within medical brigades, can cause many problems for the patients seen, who often have

no other options and may not realize the risk they are taking, "When someone visits another country

and encounters death, poverty and sickness, there is invariably a desire to do 'anything to help.' This

desire to help certainly explains why Western physicians visiting the global south often feel that

whatever aid they provide constitutes a meaningful, lasting contribution."[78] This belief can manifest

itself within the medical brigade context in many concerning ways. For example, in addition to the

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[78] Troy Greenan. "A Wolf in Sheep's Clothing? A Closer Look at Medical Tourism." *Medical Ethics.* 1:1 (2003): 50-55, 51.

illustrations presented above, at the end of our clinic days, we would hand out whatever medications

we had left, especially to those who had stood in line all day and were not able to see a doctor. I

suppose we felt too guilty to let them walk away empty handed.[79] When we ran out of labels for the

multiplicity of medications we were handing out, we started to indicate which medications were in

which plastic baggies with masking tape and ink pens; a likely bad combination for the muddy, humid

huts they would be stored in. In poorly planned situations requiring immediacy, it is easy to do whatever

works for the time being without considering the possible dire consequences. By being overwhelmed by

the enormous poverty, and not fully understanding the culture and daily life of the communities in

Honduras, it was all too easy to overlook these issues, and put the patients at risk. In an opinion piece

published in the Journal of the American Medical Association, Maya Roberts reflected similarly on her

experience with medical brigades in Guatemala, "Our aspirations to do good will not automatically

translate into net good accomplished. I do not argue that we should never donate vitamins – I argue

that all medical care carries with it the responsibility to provide long-term accountability. It matters less

what you pack in your duffle bag than how you unload it."[80] Understanding, and respecting, the culture

and daily life of the community you are trying to help is paramount in providing helpful, appropriate

and, at the very least, not harmful interventions. The short-term nature of brigades, with many one or

two time volunteers, does not accommodate for this need well, if at all. Believing that anything one

provides is better than nothing does not leave any room for acknowledgement of this key element.

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[79] Granted we did not hand out antibiotics to patients who had not been diagnosed, we did hand out Tylenol, vitamins and cough and cold medications to community members who never saw a health care provider. Often proper instructions were not provided in this last-ditch scenario, and labels were scarce.

[80] Roberts (*Ibid*), "Duffle Bag Medicine," 652-3.

3.1.2 Relying on the Literature

While our brigade was in its first year, and has likely improved and learned from mistakes in subsequent years, a fair amount of literature exists, including many of those articles already mentioned above, that discusses the ethical implications common of short-term medical mission trips such as these[81]. These articles delineate a variety of concerns and considerations, and call for better regulations and a new approach to providing healthcare and humanitarian aid in developing countries. While the concerns presented above deal mostly with individuals acting beyond their capabilities in a particular environment and the risks this causes for individual patients, there are also risks presented to the aggregate community that exist even if those above are remedied. These articles agree that even when medical brigades are well planned for their purpose and provide quality medical care there are still a number of problems presented. First of all, many have recognized that the interventions provided by medical brigades are unlikely to improve a person's overall health or be effective long-term. Shoulder to

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[81] Roberts (*Ibid*), "Duffle Bag Medicine;" Hurt (*Ibid*), "Hidden Ethics of Overseas Elective;" Abbassi and Godkin (*Ibid*), "Limits on Student Participation in Patient Care in Foreign Medical Brigades;" Conrad et. al. (*Ibid*), "Student clinical experiences in Africa: Who are we helping?;" Decamp (*Ibid*), "Scrutinizing Global Short-Term Medical Outreach;" Shah and Wu (*Ibid*), "The Medical Student Global Health Experience: Professionalism and Ethical Implications;" Wasson (*Ibid*), "Journal discussion;" Berger (*Ibid*), "Emergency Medicine Goes Global: Specialty Steps Up Humanitarian Role;" Crump and Sugarman (*Ibid*), "Ethical Considerations for Short-term Experiences by Trainees in Global Health;" Greenan (*Ibid*), "A Wolf in Sheep's Clothing? A Closer Look at Medical Tourism;" Montogomery (*Ibid*), "Short-Term Medical Missions: Enhancing of Eroding Health?;" White and Cauley (*Ibid*), " A Caution Against Medical Student Tourism;" Kelly Anderson and Fadi Hamadani, "What is Our Responsibility? Global Health Ethics in Practice." *Canadian Federation of Medical Students.* Conference Power Point Presentation, 2006; Stephen Bezruchka. "Medical Tourism as Medical harm to the Third World: Why? For Whom?" *Wilderness and Environmental Medicine.* 11 (2000): 77-78; Rachel A.Bishop and James A. Litch. "Medical Tourism Can Do Harm." *British Medical Journal.* 320 (2000): 1017; Michael N.Dohn and Anita L. Dohn. "Short-term Medical Teams: What They Do Well… and Not So Well." *Evangelical Missions Quarterly*. (2006): 217-24; Claire Panosian and Thomas J. Coates. "The New Medical "Missionaries" -Grooming the Next Generation of Global Health Workers." *New England Journal of Medicine*. 354 (2006): 1771-73; Adam J.Wolfberg. "Volunteering Overseas – Lessons from Surgical Brigades." *New England Journal of Medicine*. 354:5 (2006): 443-5.

Shoulder, a group that provides sustainable medical care in Honduras, takes up this question of whether medical missions provide "band-aid brigades or cure?"

> Developing countries enjoy a regular stream of energetic and talented health care professionals traveling to help poor countries. U.S. Academic health centers bring eager medical students, residents, nursing students and affiliated health students for short-term medical service. Despite this talent, goodwill and infrastructure for raising funds and in-kind donations, poor communities in developing countries rarely realize significant and sustainable improvement in their health status from short-term efforts. Academic health centers do not have the understanding, knowledge or experience required to forge long-term relationships with a needy community in the developing world[82].

Short-term missions are aimed towards acute care and short-term solutions. They take care of some currently present problems, but do not address the underlying issues that cause these problems in the first place. Therefore the problems return and will be present the next time the brigade returns to treat them again. Often the health problems common to underserved communities , including those in the developed world, are so complex that "providing a few weeks of medication and consultation will be relatively little benefit even if it causes no direct harm" to the communities served.[83]

The inability to engender significant change is a common thread prominent throughout the short-term medical mission literature:

> If the success of these teams is measured in terms of the number of patients seen, successful surgeries, or prescriptions filled- which is how the participants tend to

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[82] Shoulder to Shoulder. "Serving the Poor in Rural Honduras." http://www.shouldertoshoulder.org/ (Accessed Apr 2009).

[83] Hurt (*Ibid*), "Hidden Ethics of Overseas Elective," 3.

evaluate them – they are highly effective. If one, however, assesses their contribution in terms of a change in the incidence and prevalence of disease or long-term improvement in access to medical services, their effectiveness is less clear-cut… much of the curative efforts in both cases merely delay morbidity or mortality rather than reduce them. For example, while it is important to repair individuals with congenital malformations, such as cleft palates, the number of cases needing surgery could be radically reduced through improved prenatal care and nutrition. If short-term missions devoted more of their budgets to supporting preventative measures, over time, the need for the services they provide would be reduced or even eliminated.[84]

The acute care common to the medical brigade model not only lacks the capacity to engender change, but also puts communities at risk of receiving inappropriate care. Preventative care, public health interventions and follow-up care are largely absent from the services and capabilities of the medical brigade model, all of which are indispensible the overall wellbeing and health of individuals, as well as communities. Roberts agrees, stating, "Public health and preventative measures are not part of the overarching goals for the transient clinics; this inhibits the project's long-term potential and puts the community at risk of receiving inappropriate care."[85] Dohn, providing one illustration of this inappropriate care, gives the example of treating for macroparasitic infections which are common, easy to treat and likely to reoccur in rural communities of the developing world. By treating these infections with antiparasitic medications, and not by purifying the water supply or finding a way to provide shoes for instance, the source of the worms remains present and "mass treatment of a community will likely result in a mini-epidemic with increased abdominal symptoms as people reacquire the worms."[86] Antiparasitics were the number one medication we brought on our brigade, at the urging of Sociedad.

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[84] Montgomery (*Ibid*), "Short-Term Medical Missions: Enhancing of Eroding Health?," 3.

[85] Roberts (*Ibid*), "Duffle Bag Medicine," 1491.

[86] Dohn (*Ibid*), "Short-term Medical Teams: What They Do Well… and Not So Well," 220.

We were treating the symptoms and not the cause, providing acute care but not care appropriate to the underlying health problems of the community.

Medical brigades are also largely ineffective at screening and treating chronic illnesses, such as hypertension and depression, which are becoming more and more recognized in developing countries and cannot be realistically or responsibly treated by a single consultation.[87] (Although, as shown through the January 2005 Survey discussed in the first chapter, some brigades still do attempt to treat these illness in a single consultation). Additionally, because the medications taken on the brigade are donated from the developed world and are often newly expired or samples from drug companies, they can be inappropriate and ineffective for the target population; for example, when a brigade hands out second and third generation antibiotics to a community that may never have had access to first generation antibiotics. As delineated in the first chapter, the most common ailments addressed by medical brigades are parasites, malnutrition, pain and respiratory illnesses such as cough and cold. These ailments are treated with antiparasitics, vitamins, pain killers such as Tylenol, and common cough and cold medicines, respectively. All of these are short-term fixes that do not provide any lasting relief for the community members involved. In the developing world where the most serious issues derive from a lack of basic necessities and severe poverty compared to the developed world, it is worthwhile to ask, "If equity is the key determinant of health, what role does foreign assistance play?"[88]

The problem of short-term and inappropriate care is an even larger issue than at first may be evident because of the opportunity cost for the communities hosting medical brigades, and the

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[87] Bishop and Litch (*Ibid*), "Medical Tourism Can Do Harm;" Bezruchka (*Ibid*), "Medical Tourism as Medical harm to the Third World: Why? For Whom?"

[88] Bezruchka (*Ibid*), "Medical Tourism as Medical harm to the Third World: Why? For Whom?"

organizations in Honduras that help host these brigades. As one former Honduras medical brigade

participant stated, "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 outreach."[89] This issue manifests in two

ways, one concerning the ways in which brigade participants use their time and resources, and also in

considering the resource allocation of Honduras and its communities and organizations. Sociedad de

Amigos de los Niños, for example, is involved in many social service activities for the people of Honduras

such as multiple orphanages, a school for girls, and an AIDS home for young boys. The time and

resources this organization expends to host medical brigades throughout the year takes away from

these other endeavors (which are all important for the communities' health and wellbeing), as well as

other opportunities to contribute to the health care of these communities. Not all the days Sociedad

spends with the groups they host are even spent assisting with the medical portion of brigades. During

my brigade for example, Sociedad spent three days entertaining our group and taking us on tours of

their other service facilities and a local market. While this served to further increase participants'

awareness of the social conditions in Honduras, it gave very little, if any, direct benefit to the people we

encountered on these side trips. It did, however, interrupt their activities for the day.

GMB now also offers a standard "extension trip," marketing brigades as adventure holidays and

taking the time to plan the vacation portion for the group.[90] Additionally, they recently built, and paid

for, a brand new dorm to house brigade participants. The resources that are being used to support and

host medical brigades, the resources used to run medical brigades, including the personnel, and the

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[89] Decamp (*Ibid*), "Scrutinizing Global Short-Term Medical Outreach."

[90] Global Medical Brigades (*Ibid*), "Medical Brigades."

untapped resources of the community itself who is reliant on medical brigades, can all be used to

achieve something different and more effective. There is also an opportunity cost for what students

could be contributing instead. The price participants pay to travel for medical brigades is money that

could be spent another way in support of international outreach. Appropriately, The Canadian

Federation of Medical Students reflects on their role in medical brigades and asks, "Should we use our

power as physicians to advocate for global health from within Canada? And if not, why are we not

interested in this approach?"[91] Choosing and using the medical brigade model means not choosing and

accomplishing something else. When medical brigades only supply acute care, this is a large problem.

Dependency of a community on medical brigades is also at issue because of the problems

delineated above and because it discourages change. Having free care periodically available may be just

enough access to keep a county's own resources disinterested in a solution, a community from starting

its own initiative, and/or the rest of the world from recognizing the severity and urgency of the grave

health care disparities present in these communities. The number of news articles and accounts

published in the developed world praising the wonderful things accomplished during these trips seems

to be growing, and skewing the public opinion, while concerns are largely present only in academic

journals[92]. Being a repeat recipient of charity may also breed feelings of inability and disempowerment

for the community members hosting these brigades[93]. There has been an increasing recognition of the

importance of community involvement in identifying its own health care needs and being intimately

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[91] Anderson and Hamadani (*Ibid*), "What is Our Responsibility? Global Health Ethics in Practice."

[92] For examples of such articles, reference Appendix II

[93] Specifically I got this feeling and impression when community members served during my brigade were pushing, shoving and begging for clothing items and hygienic supplies of which we had a limited supply. We had managed to compromise their dignity just by being disorganized and unprepared for the circumstances.

engaged in the process to address them, in order for the intervention to prove effective in the long-term.[94] By not initiating long-term collaboration or working closely with existing health care resources and personnel in the host community, the medical brigade model works against this involvement and thus encourages dependency. Additionally, because the effects of brigades are short-term, there is always a need for their services. This issue of dependency also brings to light many additional concerns:

> 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 Honduran 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.[95]

In what ways are medical brigades affecting the social situation in which they are entering, even for the resources and individuals they do not directly encounter? As the above commentary begins to consider, if a community becomes dependent on medical brigades and the health care they provide, what does this mean for the local health care staff and resources surrounding the community?

The effects medical brigades have on local health care staff and resources, and the communities' perception of this personnel, is an important issue:

> While these teams provide temporary but sporadic access to health care, overall, they do not improve long-term access and they may, in fact, undermine existing services. It is unclear whether the short-term projects are treating only individuals who under current

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[94] Alice Running, Kathlee Martin, and Lauren Woodward Tolle. "An Innovative Model for Conducting a Participatory Community Health Assessment." *Journal of Community Health Nursing*. 24:4 (2007): 203-13, particularly pages 204-6.

[95] Decamp (*Ibid*), "Scrutinizing Global Short-Term Medical Outreach," 22.

circumstances would have absolutely no access to medical care because of an inability

to pay for it, or if they are diverting some otherwise paying or potentially paying

patients from local practitioners and facilities.[96]

In the Honduran community surveys presented in the first chapter of this thesis, community members

reported that they do access some other health care resources, such as relatively nearby clinics, lay care

givers or over the counter medications. If this is the case in many communities, medical brigades may

restrict access to health care even more by putting local health providers, who cannot afford to compete

with free care, out of business. As the prevalence of brigades continues to grow this becomes an even

greater concern. Furthermore, Montgomery continues, "In individual cases, there may even be an

erosion of health status if the person waits for the foreign physicians and free care and medication

before seeking medical attention, thus resulting in a deteriorated condition that could have been

avoided with more timely attention."[97] By not collaborating with the other health care resources being

utilized, medical brigades put both the patients and these resources in danger.

No matter what a brigade does right while in Honduras, once they leave accountability and

follow up care are largely absent. Lack in continuity of care and communication, such as patient records,

could cause conflicting treatment and redundancy. A reaction to a medication after the brigade leaves,

for example, especially since it is unrecorded, can cause an undue burden on any local health resources

that are already scarce and particularly difficult for these patients to gain access to. A specific illustration

of the danger posed by lack of continuity in care was presented by Decamp in his article critiquing

Honduran medical brigades, "Someone receives an antibiotic and experiences an unrecognized first

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[96] Montgomery (*Ibid),* "Short-Term Medical Missions: Enhancing of Eroding Health?," 3.

[97] *Ibid.*

exposure reaction that indicated a second exposure could be deadly."[98] Prescribing a common antibiotic

may be good practice in the United States, but can cause unexpected harm in developing countries

when no follow-up care is provided. As one article points out, "this leaves the local caregivers with the

formidable task of picking up the pieces once these physicians depart, usually with no idea of what has

already been done or attempted with the patients in question."[99] Additionally, treatment given by

visiting physicians may interfere with traditional treatments commonly used by local health care

providers, which on their own are usually effective but used together can cause significant harm.[100] (As

discussed in the first chapter, all three community surveys discovered home remedies were commonly

used in Honduras to treat ailments.). Global Medical Brigades specifically points out on its website that

under Honduran law, US medical professionals do not assume liability for the medical care they

provide.[101] They come, they do, and they leave. All in all, "serving communities 'every 3 to 4 months'

with fewer than half of the volunteers speaking the local language does not provide the local population

with accountable medical providers, nor does it necessarily reinforce self-sufficiency. Because we cannot

positively reshape a country through periodic interventions, we must address the risks and benefits of

short-term aid in concert with the development of long-term local infrastructure."[102]

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[98] Decamp (*Ibid*)s, "Scrutinizing Global Short-Term Medical Outreach," 22.

[99] Greenan (*Ibid*), "A Wolf in Sheep's Clothing? A Closer Look at Medical Tourism," 52.

[100] Hurt (*Ibid*), "Hidden Ethics of Overseas Elective."

[101] Global Medical Brigades. "Medical Brigades."

[102] Maya Roberts. "International Volunteer Medicine." *Journal of the American Medical Association*. 296:6 (2006): 652-53, 652.

As a final note on these harms caused by medical brigades, the general lack of recognition of the serious issues presented by their continued use is just as worrisome as the problems caused. As presented by the Canadian Federation for Medical Students, "In a recent survey (pending publication) completed by 76 Canadian physicians who engage in global health, no respondents indicated that their projects created any potentially negative impacts in the short or long-term."[103] I believe this speaks to the importance of this project, as well as the immediacy and awareness needed in working towards a solution.

3.2 UNFULLFILLED OBLIGATIONS

As I have begun to demonstrate through examples and discussions above, the obligations placed on brigade participants and their sending institutions, via the theoretical framework presented in the previous chapter, are not fulfilled by the current medical brigade model. For instance, many of the harms delineated above would not exist if the patients and their interests were truly given precedence above all else. It seems the main advantage to the medical brigade model lies in the opportunity for individuals from the developed world to be able to volunteer their services, yet still only have to donate a small amount of time and effort, compared to what is really needed to improve the conditions in the underserved communities of the developing world. A model conceived instead in the interest of community needs would have to look quite differently.

The obligation to act in the patient's best interest was derived from Edmund Pellegrino's framework for "the morality of the professional acts of professed healers" presented in the previous

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[103] Anderson and Hamadani (*Ibid)*, "What is Our Responsibility? Global Health Ethics in Practice."

chapter.[104] Through this presentation medical brigade participants were also obligated to be competent

and to obtain proper consent from the patients they serve. Pellegrino uses a broad conception of

competence that includes having the knowledge to undertake "a good healing action for a particular

patient."[105] Pellegrino also stipulates that a health care provider must conform to a patient's values and

their conception of what it means to be healthy, whenever possible.[106] Through the previous discussion

of such issues as cultural incompetence and the inappropriate care provided by medical brigades, it is

evident that participants are unable to fulfill these obligations within the resources of the medical

brigade context. Pellegrino's obligation of informed consent requires the health care provider to clearly

present all relevant information, in the patient's language, and to remedy the patient's knowledge

deficit as completely as possible. As already alluded to previously, often in the context of medical

brigades the healthcare provider does not take the time to fulfill this requirement of consent. This may

be because the providers assume their knowledge base is far above that of the community members,

and therefore they already know what is best for the patients they encounter, or likely because the long

lines and fast paced nature of brigades make them feel they do not have the time for lengthy consults.

Additionally, the language barriers discussed above could create an obstacle to fulfilling this obligation.

However, each patient needs to be given the opportunity to understand and contribute to the actions

taken in regards to their healthcare. Therefore medical brigades do not fulfill this obligation of informed

consent.

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[104] Pellegrino and Thomasma (*Ibid*), "A Philosophical Reconstruction of Medical Morality."

[105] *Ibid.,* 213.

[106] *Ibid.,* 214.

Pellegrino's obligation of acting in the patient's best interest is related to the next obligation

that is unfulfilled in the medical brigade context: that of providing medical care that addresses

community-specific health care needs. As has already been mentioned in this chapter, the biggest

problems jeopardizing the health of developing communities are not those that can be resolved through

the provision of acute care. Rather the most important elements to improving the health and wellbeing

of a developing community can reasonably be assumed to include at least a clean water supply,

sufficient nutrition, and preventative care ,such as prenatal care, above all else. Many communities'

needs for improving their health and wellbeing do not even include s specifically "medical" intervention.

One study undertaken in Utila, Honduras that surveyed the community defined needs provides a good

example.[107]

This survey asked residents of Utila a variety of open-ended questions to determine what they

perceived to be healthy about living in their community, what was not very healthy about their

community, and what the community needed to be healthier. The survey answers were then grouped

into the most common themes mentioned and participants were given twenty-five, one dollar bills and

asked to allocate them to these various themes based on what they viewed as most important and

influential for the health of their community. The top three themes identified by the community

members were less drugs, a better airport and electricity twenty-four hours per day, in that order. A

doctor was ranked fourth, followed by less trash, less violence and better teachers and schools. The

authors reflected on the results of this research, commenting:

> Although the themes endorsed by the participants were predictable, based upon Utilas
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> resources, the order in which the participant prioritized health needs was surprising,

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[107] Running et al. (*Ibid*), "An Innovative Model for Conducting a Participatory Community Health Assessment."

thereby reinforcing the importance of gaining community involvement to guide health

care services… [Providers'] greatest contribution to the health of a community may be in

a nontraditional role, such as initiating a program to decrease illiteracy or campaigning

for funds to build a new airport.[108]

While medical brigades do not promise to provide interventions other than acute medical care, that is

part of the problem with the medical brigade model, and it does not absolve these groups from

providing interventions relevant to the communities they serve. Obviously brigades, or other visiting

medical volunteers, cannot be expected to do anything and everything for a community, and may only

have expertise in certain areas. However, whatever interventions they do provide still need to be useful,

and not harmful, for the people they aim to help. This speaks to the third unfulfilled obligation to

provide a fair benefit to the patients and communities concerned. Again, how can a community gain a

fair benefit if its self-defined needs are not being addressed? Additionally, how can brigade participants

gain a fair benefit for their efforts if they are not reaching their goal of helping these communities, and

may even be emotionally scarred in the process of trying?

Lastly, as demonstrated above, the medical brigade model does not provide community

members with an appropriate standard of care. Using this analogy to the *de* jure standard of care, rightly

argued to be obligated in the research context, was not meant to argue that medical volunteers need to

provide developing communities with every medical technology enjoyed in developed countries, or that

they should not go. But rather it was alluding to the arguments presented above that some care is not

always better than no care, especially when this care is inappropriate for the context or community. As

Alex London stipulates, the *de jure* standard of care is the best standard of care effective for any one

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[108] *Ibid*., 210 –11.

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community.[109] Each community has a conception of the standard of care they wish to uphold. This is the appropriate standard of care that ought to be provided for individual interventions in developing communities, not simply anything "better" than what they are currently experiencing.

3.3   OBJECTION AND CONCLUSION

I can anticipate one objection in particular to this overall analysis based on the unknown of how brigades present themselves to the communities they serve. If a group of people from the developed world offer their services to a community in the developing world, and are clear and honest about what they do and do not provide, should not the community be able to choose to host a medical brigade, as they are now? After all acute care is an important *part* of an individual's health care, and the free medication and supplies provides resources the community might not have had otherwise. However, although it is not entirely clear how brigades present their services to communities, even if medical brigades *are* only claiming to provide support, and not the entirety of a community's healthcare, this does not change the reality of brigades, and therefore their ethical obligations. It needs to be acknowledged that in most instances in rural Honduras there is nothing to "support." While this does not change the fact that the brigade is not offering to provide all of a community's healthcare, it does change the reality of what role the brigade is playing in the lives of these community members. You cannot take on a supporting role in a play that has no star actor. The brigade therefore still is providing the entirety, or at least a significant portion of the community's healthcare, although not taking overall responsibility for it. Even if community members were to have access to some other health care

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[109] London (*Ibid*), "The Ambiguity of the Exigency: Clarifying 'Standard of Care' Arguments in International Research."

resources, the brigade group is not integrating into or collaborating with these resources in any useful

manner. If this was not the case the care provided may not present the same serious issues, but

brigades cannot absolve themselves from considerations of the overall social context in which they are

voluntarily placing themselves. Brigade participants, and their sending institutions and affiliated

organizations, must consider the ethics of their intervention with the recognition that what they are

providing, how they are providing it, and when they are providing it, most likely *is* the *only* healthcare

community members are able to access, whether or not this is how they intended it. Medical brigade

participants need to consider their actions within the realities of rural Honduras.

Therefore, as delineated by the previous chapter and further demonstrated above, all brigade

participants, and their affiliated organizations, have a responsibility to fulfill certain obligations in order

to interact ethically with the communities they serve. As previously mentioned, while not much

empirical data exists on *documented* harms caused by medical brigades, because of a lack of presence

and observation once the brigade leaves, the acknowledged possible and likely risk that brigades do

cause harm to their patients, the communities they reside in, and other stakeholders, should be

sufficient to necessitate regulation, scrutiny and change. Humanitarian aid in the form of clinical care

continues to be one of the few arenas regarding the actions of developed countries intervening within

developing countries in which some recognized ethical or regulatory framework is lacking. Research,

conversely, especially when dealing with vulnerable populations, is highly regulated and scrutinized

partially because of the *potential* risks presented, even when those risks are comparably small to those

presented in this thesis.

The next chapter of this thesis will turn to a discussion of how these interactions with the

developing world can function in order to fulfill these obligations and be beneficial to all involved.

Admittedly, some brigade groups and organizations have begun to try and address some of these issues

through reorganization and implementation of new initiatives, as was acknowledge in the discussion of

the first chapter. Others, however, have not, and many still have a long way to go. I referred to this

discussion as a harm-benefit analysis of medical brigades and thus far have only presented the harms.

The benefits provided by brigades lie somewhat in the sometimes useful acute care and free

medications provided, but mostly in the appreciation by community members of the show of good will

and recognition of their plight by their visitors. These benefits can be obtained from other more useful

and ethical interventions as well. The following chapter will discuss these topics further, as well as

examine examples and models that have already achieved successful, long-term health care interactions

within the developing world.

4.0   ETHICAL ALTERNATIVES FOR UNDERTAKING HEALTH CARE INTERVENTIONS

IN THE DEVELOPING WORLD

All of the ethical issues presented by the medical brigade model portrayed in this thesis do not present a reason to cease intervening in the developing world's health crises; rather, they provide a multiplicity of reasons to do it right. Thus far, this thesis has argued that medical brigades, as they are currently operated in Honduras, are a broken system, and that it is an ethical imperative that significant changes are made to this model. The aim of the current chapter is to demonstrate ways in which the developed world can improve upon this model and carry out an ethical health care intervention in the developing world. Specifically, this can be accomplished by fulfilling the obligations that were placed on medical brigade participants via the theoretical framework established in the second chapter. As previously delineated, the most important aspects of this overall framework rests on the obligation to provide a medical care intervention that addresses community-specific health care needs, puts the patients first and acts in their best interest, provides an appropriate standard of care (the best known treatment, effective for that population), and gives a meaningful benefit to the patients, communities and volunteers involved. More succinctly, interventions ought to appropriately, effectively and sustainably address community-defined health care need(s).

In order to fulfill these obligations, there are certain harms presented by the current medical brigade model that have to be avoided. These are the harms that were discussed in the first section of

the previous chapter. Namely, the harms, or potential harms, caused by volunteers operating outside their level of expertise, either culturally or medically, the provision of context-inappropriate care, a lack of accountability and follow-up care, and the failure to collaborate with communities and existing health care or other community resources. Through avoidance of these harms and fulfilling the aforementioned obligations, participants from the developed world can improve upon what medical brigades have to offer and begin to ensure that all health care interventions in the developing world are ethical endeavors.

Currently, there is a wide variety in the types and organization of health care provided by developed countries in developing countries, and a gradient of how sustainable and effective these interventions prove to be. There are medical brigades commonly organized the way in which this thesis presented, longer-term interventions that still integrate a form of medical missions, organizations that more formally support a community or communities for a period of time, and on up the gradient. While there is still much room for improvements to be made, many groups have already shown that effective, ethical interventions are possible. To facilitate the coming discussion, I will rely upon a few particular examples of established models that have already addressed the need for ethical participation and have accommodated long-lasting interventions and community collaborations. All of the following examples fulfill the above obligations, with few exceptions, and are valuable ethical alternatives to the current medical brigade model. First I will present each model, its purpose, principles and operations. Then I will discuss the ways in which each model benefits the populations they serve and fulfills the aforementioned obligations, in contrast to the current medical brigade model.

4.1 SHOULDER TO SHOULDER

Shoulder to Shoulder, an organization involved in providing health care to some of the underserved

communities of Honduras, is a good example of a standard medical brigade model that has evolved to

become a more sustainable and effective intervention for the communities served. Specifically, this

organization integrates short-term volunteering by health professionals and other travelers from the

United States with community health boards and a small international staff in Honduras, to create a

long-term collaboration.[110] Short-term efforts through this model are multiple and longitudinal in a

single Honduran community. They work through established infrastructure to accomplish goals defined

by rural community health committees, which are created in collaboration with the local health boards

and volunteer clinicians. As described by Shoulder to Shoulder, "This new model of short-term

volunteerism, which involves a long-term commitment from the organizations providing volunteers, is a

collaboration with the community and broadly views the social determinants of health results in a model

that contrasts sharply with the traditional model."[111]

Shoulder to Shoulder operates through a network of partnerships between family medicine

training programs in the United States and resource-poor communities in Honduras. Since 1996

Shoulder to Shoulder has worked in collaboration with Hombro a Hombro, a grass-roots, community

based, non-profit non-governmental organization (NGO) formed by local Honduran community leaders,

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[110] Jeffery E.Heck, Andrew Bazemore, and Phil Diller. "The Shoulder to Shoulder Model – Channeling Medical
Volunteerism Toward Sustainable Health Change." *Family Medicine*. 39:9 (2007): 644-50. Shoulder to Shoulder has
sites in other developing countries as well, but for the purpose of this thesis I will be focusing on the organizations
presence in Honduras.

[111] Ibid., 645.

through the help of Shoulder to Shoulder.[112] These groups work together to achieve a single mission, "to develop educational and health programs to help poor, rural communities in Honduras achieve sustainable development and improve the overall health and well being of its residents."[113] In an article delineating the aspects of the Shoulder to Shoulder model, the authors acknowledge the opportunity to improve global health presented by the rapid growth in volunteerism, but also recognize the challenge and importance of ensuring "that the good intentions of volunteers are channeled effectively into endeavors that generate locally acceptable, sustainable changes in health."[114] Shoulder to Shoulder and Hombro a Hombro have found a practical, reproducible way to accomplish this, without requiring too much more of volunteers who wish to be involved short-term.

A key component to the Shoulder to Shoulder model is a health clinic, the first of which was established in Santa Lucia, Honduras (the founding community partnership). This clinic provides a center of support for twenty thousand rural inhabitants.[115] It offers year-round assistance and boasts four full-time physicians and a dentist, plus a staff of nurses and assistants that are ready to help those in need who come to the clinic twenty-four hours per day. This clinic is able to effectively provide health care services through the utilization of six examination rooms, an emergency room, radiology and ultrasound equipment, a laboratory and a dental clinic. Through financial assistance from it academic health center partners and private donors, this clinic is able to provide care to approximately six thousand patients

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[112] Shoulder to Shoulder (*Ibid*), "Serving the Poor in Rural Honduras."

[113] *Ibid*.

[114] Heck et al. (*Ibid*), "The Shoulder to Shoulder Model – Channeling Medical Volunteerism Toward Sustainable Health Change," 644.

[115] *Ibid*.; Shoulder to Shoulder (*Ibid*), "Serving the Poor in Rural Honduras."

each year.[116] Since the inception of this project, Shoulder to Shoulder and Hombro a Hombro have also

collaborated in building and operating three other comprehensive health care centers (in the villages of

San Jose, Santa Ana and San Marcos de La Sierra). Collectively these four clinic sites provide primary

health care and community support to over twenty-five thousand people.[117] Additionally, Shoulder to

Shoulder has a growing number of academic health care partners in the United States who are working

to replicate this model community health plan in collaboration with other needy, rural areas of

Honduras.

As an organization, Shoulder to Shoulder has also expanded greatly to include programs that

address multiple health determinants affecting the overall well being of the communities for whom it

provides care. In doing so, this organization has begun to be able to address the health, education,

economic, and social needs of underserved communities in the poorest areas of Honduras. Many of

these indispensable initiatives are also operated through the community health care clinics, allowing for

integrated and comprehensive health care services that address multiple determinants of health in the

community. Included in these services are a feeding center with extensive, school-based feeding

programs, home-based water filtration systems, cervical cancer screening, family planning, a maternal

and child health project and lay-midwifery training. In the spirit of embracing community-health

improvement by addressing root causes, Shoulder to Shoulder has also initiated the Yo Puedo (I Can or I

Am Able) Program, which is designed to improve the self-esteem of underserved girls through

entrepreneurial activities and scholarships.[118]

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[116] Heck et al. (*Ibid*), "The Shoulder to Shoulder Model – Channeling Medical Volunteerism Toward Sustainable Health Change," 648; Shoulder to Shoulder (*Ibid*), "Serving the Poor in Rural Honduras."

[117] Shoulder to Shoulder (*Ibid*), "Serving the Poor in Rural Honduras."

[118] *Ibid*.

There are five key principles that inform the Shoulder to Shoulder model: Empower communities through partnership, address determinants of health broadly, pursue sustainability, leverage resource partner money and skills, and realize economies of scale through intra-institutional coalitions.[119] The first principle, empowering communities through partnership, is achieved by forming local health boards and community health committees, as mentioned above; "These committees are then nurtured to become capable of collaborating with their academic partners and the US communities they represent, so they can set the vision for the project and define the governance of the organization."[120] The second principle, address determinants of health broadly, was well demonstrated through the discussion above. Specifically, Shoulder to Shoulder focuses on addressing the determinants of health care, oral health, nutrition, water sanitation, empowerment and education.[121] In order to pursue sustainability, US partners and volunteers return to the same place every year and engage in projects that are a community priority, have approval from the community board and can be realistically sustained with available resources and support. The fourth principle, leveraging resource partners' monies and skills, is an important component to this model because it allows for the interventions to be on-going, "The national organization of Shoulder to Shoulder supports the development and startup of new programs. The US health center and it supporting community provides the financial support and volunteer efforts needed to sustain the partnership."[122] Lastly, the principle to realize economies of scale through intra-institutional coalitions indicates the ability of this model to combine an educational

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[119] Heck et al. (*Ibid*), "The Shoulder to Shoulder Model – Channeling Medical Volunteerism Toward Sustainable Health Change," 645-6.

[120] Heck et al. (*Ibid*), "The Shoulder to Shoulder Model – Channeling Medical Volunteerism Toward Sustainable Health Change," 645.

[121] *Ibid.*

[122] *Ibid.*

mission of training future health professionals with long-term community development. To facilitate this piece, the US communities also form an organization with which to share staff, supplies and ideas, and support all of these common principles.

Shoulder to Shoulder has been successful in engendering real change in the health status of the communities they serve by being attentive to the needs of the community and by collaborating with local *Hombro a Hombro* health boards. Through its initiatives, Shoulder to Shoulder has been able to attain its broader vision and articulate and fulfill its "tri-part mission" which includes sustainable community health and development, learning opportunities for medical trainees and opportunities for reflective personal growth for group participants.[123]

4.2   COMMUNITY-ORIENTED PRIMARY CARE

Shoulder to Shoulder embraces and follows the principles of another model called the Community-Oriented Primary Care (COPC) model, which was developed and demonstrated to be effective in improving population-defined health problems more than sixty years ago.[124] Although this model has been incorporated into the Shoulder to Shoulder approach, which was just presented above, it is worthwhile to discuss COPC as a separate source of guidance and as an option for improving a community's health and wellbeing. In a how-to manual put together for parties interested in implementing this model, the basics of COPC are succinctly described:

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[123] Shoulder to Shoulder (*Ibid*), "Serving the Poor in Rural Honduras."

[124] Heck et al. (*Ibid*), "The Shoulder to Shoulder Model – Channeling Medical Volunteerism Toward Sustainable Health Change," 645.

Community-Oriented Primary Care (COPC) is a systematic process for identifying and

addressing the health problems of a defined population. It can be implemented with the

resources available in most communities. In COPC, a team of health professionals and

community members work in partnership over a long period, diagnosing and treating a

community in much the same way as does a primary care physician with an individual

patient. Primary care practitioners are not required in every project, and they are

usually too busy to lead such an effort, but they must be involved.[125]

In order to carry out this process, a five-step model had been identified: "(1) define and characterize the

community, (2) involve the community, (3) identify community health problems, (4) develop an

intervention, and (5) monitor the impact of the intervention."[126]While this process may seem

commonsensical and obvious, COPC calls for dedication, long-term collaboration, accountability, and a

clear understanding of the community with which the group is planning to work. A key element in this

process is the community partnership which necessitates community involvement at every step. This

includes engaging the community in identifying health care priorities to be addressed, determining

resources and potential barriers, selecting relevant community social networks and leaders to consult

and include, and sharing the responsibility of outcome evaluation.[127] By following these steps in

conjunction with community partners, the COPC model has found that it can improve community health

and wellbeing much more efficiently and effectively than when the community was just assumed to be

the target population.

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[125] Robert Rhyne, Richard Bogue, Gary Kukulka, and Hugh Fulmer. *Community-Oriented Primary Care: Health Care for the 21st Century*. (Washington, D.C.: American Public Health Association, 1998), 1.

[126] *Ibid.*

[127] *Ibid.,* 88.

This model excels specifically at addressing health problems that are a community-defined priority. It also recognizes this may mean providing interventions that were not originally expected to be a main concern, and that may not fit the "medical model," as it is commonly conceived; "The priority health problem may not be the one with the worst morbidity or mortality statistics, yet since it came from community consensus, it will be the problem the community is motivated to solve."[128] To effectively discover community-defined health priorities, the COPC model aims to initiate the formation of a group interested in developing a community partnership first, and then defining the specific goals and projects to be tackled in collaboration with that community partner. In this way, communities have the chance to articulate their needs and steer the aim of the project, prior to the group deciding on a vision and focus. Groups first form with the general goal of improving the health of a particular community, and then the details are worked out together.

The COPC model provides sustainability in that, "it is actually a means to empower a community to address selected problems using a logical, systematic approach," and because communities are more likely to stay interested and involved in interventions aimed to address their self-defined healthcare needs.[129] Additionally, because COPC works through a "logical, systematic approach", it grants the opportunity to evaluate and reevaluate the success, outcomes and direction of each project time and again. While the "PC" in COPC stands for Primary Care, this model can be used to address any community-defined health problem identified. The COPC model works first and foremost by engaging a group and a community who are interested in engendering meaningful change, "Most

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[128] Ibid.,102. A specific example was given of a community partnership in Sunland Park, New Mexico. In this collaboration, when the health center began asking people of the community which health problems were the most urgent, it discovered it was not diabetes or lack of prenatal as suspected, but rather street lights and a recreation center.

[129] *Ibid*., 7.

basically, it requires an interest in the health and well-being of the *population* being served. It also

requires a deliberate well-planned approach, a willingness to evaluate the outcomes of one's efforts

critically, and a willingness to relinquish some control over the process."[130]

4.3   SEED-SCALE: JUST AND LASTING CHANGE

Another example that has been presented with promising results is that of SEED-SCALE, a community-

supported action model parsed out by Daniel Taylor-ide and Carl E. Taylor in <u>Just and Lasting Change:</u>

<u>When Communities Own Their Futures</u>.[131] The SEED-SCALE approach is not specifically tailored to health

care needs, as are the COPC and Shoulder to Shoulder models; however, it has a solid track record of

improving the health of communities when that is the specified aim. SEED-SCALE is a form of action that

individuals can launch in their own communities, and governments or other outside entities can enable

on a larger scale. This approach emphasizes three basic principles for community action: a three-way

partnership between the community, officials and experts, action based on locally specific data, and

changes in community behavior[132]. SEED-SCALE stands for "Self-Evaluation for Effective Decisionmaking

and Systems for Communities to Adapt Learning and Expand." There are two components necessary to

the success of SEED-SCALE, the SEED and the SCALE.

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[130] Ibid., 17.

[131] Daniel Taylor-ide and Carl E. Taylor. *Just and Lasting Change: When Communities Own Their Futures*.(Baltimore Maryland: The John Hopkins University Press, 2002).

[132] Ibid., 34-36.

The SEED component refers to choosing a vision for the proposed project.[133] This includes

evaluating the community's situation objectively and gathering information on present problems and

resources (*Self-Evaluation*). Further, it requires a discussion of the underlying sources of problems and

their possible solutions, with the result of the community defining their priorities (*Effective Decision

Making*). The coming together of the community and proposed group to articulate and address

community defined needs is reminiscent of the COPC model process. In contrast, however, SEED-SCALE

requires a more systematic data collection, in order to create a community-specific database that avoids

reliance on people's opinions of the community's most pertinent health care needs. Community

members collect this data, allowing for increased community investment and ownership, and usually

resulting in more accurate and complete information; as stated by Taylor-ide and Taylor:

> Decisions not grounded in local data often are isolated from the people; they are made
> by officials who tend to be out of touch and out of date, and the experts' thick reports
> are usually based on earlier studies done elsewhere and on deductions from theory.
> Focusing on local data, community members, with guidance from officials and experts,
> can blend practical local realities with the best of worldwide understanding.[134]

Additionally, by engaging community members and engendering feelings of investment and ownership,

SEED-SCALE aims to better accommodate behavior change that will bring about a positive, long-term

impact on health. SEED-SCALE interventions follow a cycle within which communities and partners build

capacity, choose a direction and take action on a yearly basis, in order to keep change positive and

happening.[135]

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[133] Ibid., 21.

[134] Ibid., 35.

[135] Ibid., 44-46.

The other necessary component of this model (SCALE) is the aim to replicate successful projects in other communities by "going to scale." Through this capacity, SEED-SCALE can effect positive change in many surrounding communities at an increasing pace, with adjustments for specific community needs, once it is engendering positive change in the original community. There are three dimensions to SCALE: SCALE one selects, learns from, and promotes successful community projects, SCALE squared transforms demonstration projects into learning centers for others, and SCALE cubed promotes systematic extension through regions and societies. These components do not have to occur in any particular order, and commonly starts with SCALE cubed creating an enabling environment.[136] SEED-SCALE was defined after its processes were recognized to already be taking place in communities all over the world. Often its initiatives will start in communities without express reliance on the model itself, and then the principles or next dimension of SEED-SCALE, along with outside assistance, can further support the community in achieving success. In this way, communities are the start as well as the most important part of the process:

> To achieve successes, communities must form partnerships with outsiders, officials and experts. But infusions of outside resources (such as money, training, and technology) do not guarantee a better life. Resources from outside can create jobs, improve health indicators, send children to school, and construct roads, but do not necessarily mobilize community energy. In fact they often drain away self-reliance and make a community dependent… Community energy can be neither bought nor coerced. It is internal. Outsiders and outside resources are crucial to it, but their role is to stimulate commitment and practical alternatives, not to do the actual work.[137]

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[136] *Ibid.*, 37.

[137] *Ibid.*, 33.

The dimensions of SCALE are particularly useful and innovative in engendering community change because they allow a community to witness the changes and interventions that have already been successful within other communities that have similar resources and needs. Not only does this allow for a "we can do it" attitude, but it imparts communities with ideas and methods that they can tailor to their own community's needs. People then become empowered to being to make positive changes in their own lives and the lives of those around them, "When people become aware that they can benefit from change, their self-concept, capacity, and conviction grow."[138]

SEED-SCALE presents six criteria to help participants in a community effort monitor and evaluate whether the progress they are making, particular events and changes, will be positive for the community, or whether it will create later problems. These criteria are collaboration, equity, sustainability, interdependence not dependency, holistic action, and iterative action. They are specified to only be a guideline and are not as firmly established as the other three principles described above, thereby allowing communities to tailor the criteria and define them according to their own needs and projects. The examples presented in Just and Lasting Change fulfill these criteria and provide accounts of successes in assisting communities to improve the health and wellbeing of their inhabitants through engendering and supporting community involvement and change.[139] The interventions presented are less concerned with the actions of outside assistance, and more concerned with what the communities themselves are able to accomplish (through the adjunct of outside assistance). The basis for SEED-SCALE is the claim, and belief, that a just and lasting future is possible for all, but only through true community involvement.

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[138] *Ibid.*, *37.*

[139] *Ibid*,. For specific examples of successful SEED-SCALE interventions refer to chapters 6-19.

4.4 BENEFITS AND FULFILLED OBLIGATIONS

Collectively, these three examples provide a solid platform on which to base a much needed change in the current medical brigade model, and a bright future for the direction of health care provided by volunteers in developing countries. While there was some redundancy and repetition among the accounts of each, it further goes to show that multiple groups have found that sustainable, effective health care interventions in the developing world are possible, and that many have identified the same necessary components to engendering positive change in the health and wellbeing of communities. Through a presentation of the inner workings of these models, I have aimed to set the stage for a discussion of how each of these models specifically improves upon the current medical brigade model, and thus provides an ethical alternative for interested volunteers. Simply through this previous presentation, it becomes intuitively evident how each model avoids the harms that were shown to be posed by medical brigade interventions. To further demonstrate this, however, I will look to the benefits of these models and delineate how they successfully fulfill the obligations that medical brigades do not.

As is true of all of these examples, Shoulder to Shoulder has been successful in addressing many of the ethical concerns presented by the previously defined medical brigade model. Through a presentation on their website, Shoulder to Shoulder provides a telling account of the benefits gained through its evolution from the traditional medical brigade model to the new Shoulder to Shoulder model, as it was presented above:

> A short-term relationship (a medical brigade, for instance) is relatively easy to organize and brings care for acute medical conditions and short-term care for chronic conditions. However, such interactions have little, if any, long-term impact on health status or community stability. A long-term sustainable relationship opens possibilities for continuity of care, health promotion and disease prevention. Long-term relationships

also lay a foundation for health education, public health issues (including family planning and reproductive health), economic development, agricultural development, nutrition, improvement in schools and many other activities that impact the health of the community. It is this broader, comprehensive vision of sustainable community growth that poor communities deeply desire.[140]

In the previously mentioned article delineating the aspects of the Shoulder to Shoulder model, the authors provide a table that parses out the differences between traditional short-term volunteer efforts and the new model, in order to show how specific facets are improved.[141] In doing so, they directly demonstrate how many of the issues delineated in the previous chapter are addressed by the new Shoulder to Shoulder model. For example, by changing from a one-time visit to multiple visits, only providing acute care to including prevention and health education, only addressing biomedical determinants of health to addressing multiple determinants of health, and no continuity in care to follow-up care available twenty-four hours a day in a stable clinic, Shoulder to Shoulder has addressed the sustainability, accountability and provision of community-appropriate care that medical brigades have been shown to lack. In this way, the Shoulder to Shoulder model fulfills the obligation to provide a medical care intervention that addresses community-specific health care needs, puts the patients first and acts in their best interest, provides an appropriate standard of care and gives a meaningful benefit to the patients and communities.[142]

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[140] Shoulder to Shoulder (*Ibid*), "Serving the Poor in Rural Honduras."

[141] Heck et al. (*Ibid*), "The Shoulder to Shoulder Model – Channeling Medical Volunteerism Toward Sustainable Health Change," 646.

[142] Namely, the obligations placed on medical brigade participants via the theoretical framework presented in the second chapter of the current thesis.

Additionally, Shoulder to Shoulder, in conjunction with Hombro a Hombro, also provides a meaningful benefit to the student brigade participants involved. Through requiring a long-term commitment and responsibility from the organization sending the volunteers, the Shoulder to Shoulder model is able to provide learning opportunities for students, both in the form of international rotations and short-term volunteer efforts, without compromising accountability or doing a disservice to their Honduran community partners. Also, as previously mentioned, these volunteers service the same community year after year, allowing the group to grow with the community, even before it begins to intervene, and better understand the values and culture of those it aims to serve. Additionally, in offering international experiences to students, the Shoulder to Shoulder organization is able to benefit from the financial assistance of their academic health center partners, as well as from the helping hands of extra volunteers during their support trips. This collaboration also benefits the Honduran community, and all involved, by exposing students to an ethical, comprehensive experience, which will hopefully positively impact their future actions and decisions within the global health arena.

Furthermore, by integrating the medical brigade model into the new model, Shoulder to Shoulder is able to retain volunteers, such as students, who may not have more time to give but still want to help with the time that they do have. In this way, Shoulder to Shoulder assures accountability without costing the communities any man power. Admittedly, it follows from my analysis that the Shoulder to Shoulder model, with half of all its volunteers being short-term and comprised of medical trainees, still may run into the pitfalls caused by sending Honduran communities individuals who have little knowledge of local culture and needs, and are not yet proficient with medical skills. However, because of the greatly increased supervision, community participation and accountability, this is unlikely to create any more problems than would be expected from educating medical trainees in the United States. Overall, "by developing strong community boards in poor areas and a consistent local paid staff,

Shoulder to Shoulder offers volunteer health professionals the infrastructure on which to build lasting programs that can influence the health of a community."[143]

The SEED-SCALE model presented in Just and Lasting Change supplies an entirely different concept than medical brigade models as they currently manifest throughout the developing world, but in doing so provides an ethical alternative to medical brigades that solve most, if not all, of the inherent problems within the current medical brigade model. The similarity and relevance between these two models lies in their aim to assist communities who lack adequate or comprehensive health care services.[144] In contrast, however, SEED-SCALE is a multi-step initiative that requires a long-term community partnership and includes governmental or other organizational levels as promoters of an enabling environment. SEED-SCALE, as well as the other two models presented, automatically provides follow-up care and accountability by virtue of the collaboration between volunteers and communities that is a continuous partnership that allows for constant communication. Implementing SEED-SCALE, and "going to scale," would also allow the developed world to have a positive impact on health care conditions throughout rural Honduras. Shoulder to Shoulder provides this benefit as well, by replicating successes in Santa Lucia within other places in rural Honduras, in a community-specific manner.

The COPC model has also evolved in a way that would benefit the current medical brigade model: from viewing a community as primarily a target population to incorporating community participation and partnership as a core element for success. This mindset has allowed COPC initiatives to

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[143] Heck et al. (*Ibid*), "The Shoulder to Shoulder Model – Channeling Medical Volunteerism Toward Sustainable Health Change," 645.

[144] As previously specified, while this is not always the aim of SEED-SCALE, health care improvement is commonly a defined goal.

address community-specific needs by collaborating with the communities they aim to help.[145] In fact,

one of the most evident and important aspects these models have in common is the inclusion and

integration of the communities themselves in the process of the initiative. The importance of this aspect

in interventions cannot be overemphasized; first because, as elaborated above, if the community is not

in support of the action being taken, it will never be able to engender real change, and also, because the

intervening group may be surprisingly off base when prioritizing what they think the community most

needs and desires in terms of improving their health. As the survey undertaken in Utila, Honduras,

which was discussed in the previous chapter, showed, an outside perspective can be very different from

what a community itself defines as important or the priority.[146] By empowering communities to

articulate the needs that will be addressed through a partnership, each of these three models addresses

the issue of opportunity cost posed by the current medical brigade model.

In order to addresses community-specific needs, all three of these models also recognize the

need for communities to not only have a place in the process, but also have shared control of the

projects goals and actions. Taylor and Taylor-ide describe this need for SEED-SCALE:

> The most vital management feature of this process is that those in authority must
> relinquish control, gently and more quickly than they may think comfortable…It is hard
> for leaders and experts to let go as fast as communities fain capacity to act on their own.
> But when the right organic process is found, change can radiate rapidly across a region,

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[145] Additionally, the COPC model provides a benefit by finding and addressing the root cause of the community health care problem, instead of just treating the symptoms as they present themselves, such as the acute care provided by medical brigades.

[146] Running et al. (*Ibid*), "An Innovative Model for Conducting a Participatory Community Health Assessment."

and it does this best when outsiders restrict their roles to enabling that change instead of prescribing how it must occur.[147]

There is a phenomenal difference between doing something for someone and doing something with someone. Medical brigades travel to a specified place to do for a community what the travelers have decided the inhabitants need. The interventions presented in this section work with communities to help them do for themselves what they have defined as their own priorities, but do not have the resources to accomplish on their own. The role of the outsider in these two scenarios is entirely different, and everything to what the interventions are able to accomplish. It is the difference between having community collaboration, support, and success, and not. As pointed out in the Shoulder to Shoulder article, "there is a growing body of literature suggesting that… poor communities value self determination more than outright and unilateral support."[148]

Most important for the current analysis, I believe, are the mechanisms included within these models to evaluate and reevaluate the progress and outcomes of their initiatives. It is partially because medical brigades lack this framework that they pose such a great danger to the communities they serve. Without an honest evaluation of a given model, there is no way to know the effect it is having on and for the community in which it intervenes. By taking cues, ideas and principles from any of the three models presented (especially the Shoulder to Shoulder model whose specific purpose is to improve the current medical brigade model), medical brigade participants and their affiliated institutions can begin to interact ethically with communities in the developing world, and be mindful of the possible impacts of their proposed actions.

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[147] Taylor-ide and Taylor (*Ibid*), *Just and Lasting Change: When Communities Own Their Futures*, 9.

[148] Heck et al. (*Ibid*), "The Shoulder to Shoulder Model – Channeling Medical Volunteerism Toward Sustainable Health Change," 644.

4.5   CONCLUSION

Although some of the models' principles presented in this chapter go above and beyond what I would argue is necessary to reach the threshold required for an ethical intervention, the more that can be done the better. The majority of students, and all volunteers, who travel to developing countries on service missions do so with the hope and aim of making a significant difference in the lives and health of others. Beyond showing that it is an ethical imperative, I believe that these volunteers would want to do better and will get behind a model that allows them to be true to their purpose. Nonetheless I will specify that in order to carry out an ethical clinical care endeavor in the developing world, a group needs to provide the following three components at a minimum: accountability, some arrangement for follow-up care and interventions that are relevant to the community's specific healthcare needs (which includes understanding and respecting the culture they are acting within). Without these pieces participants are not fulfilling the ethical obligations presented through the current thesis, they are not providing a meaningful and useful service to the people they aim to help, and they are putting their recipients at risk of receiving harmful and inappropriate care. The third section of this thesis presented a long list of likely harms to a community by the presence and action of brigade participants. The few weeks or months of relief that brigades commonly provide from parasites, or the few Tylenol they distribute to provide a couple headache free days, are very unlikely worth the risk. Medical brigades, which are aimed at acute care, are not even effective against the most serious acute care cases because they lack the infrastructure or access to hospitals necessary to effectively treat these patients.

An article entitled, "None So Naïve as the Well Meaning," tells the story of a physician from the United States looking for an organization seeking her volunteer services for relief efforts in Sri Lanka,

after it was devastated by the Indian Ocean earthquake and tsunami.[149] After hours upon hours of

calling organizations already in Sri Lanka providing assistance, the physician was unable to find anyone

willing to make use of the services that she was offering. Even though Sri Lankans were urgently in need

of care, these organizations were still leery to make use of her offer. One organization specifically told

the physician that it was currently only accepting people with experience in public health advocacy.

Upon reflecting on these attempts, the physician commented:

> It's all very well wanting to help, but it is pointless unless it is done in an organized way.
> The story above belies the longer conversations I had with several people who explained
> that most of the infrastructure was washed away by the tsunami and that the there was
> no point sending medical staff who couldn't reach anywhere or be able to treat with
> even the most basic of drugs. That's why organizations such as Medecins du Monde
> exist, to avoid haphazard reliance on well meaning individual doctors who jump on
> aeroplanes to go off on their own to save the world. And if they don't need me, I still
> have a down payment on a water pump to offer.[150]

Sri Lanka, which was in a state of emergency, was likely in worse circumstances than the day to day lives

of most Hondurans living in rural communities (most of which have at least rudimentary infrastructure).

Nonetheless, the same principles apply; this commentary serves to make obvious one last time that not

all "help" is helpful, especially if it is disorganized or out of context. Simply travelling to the developing

world wanting to make a difference is not useful unless the manpower and resources are directed

towards appropriate interventions that are meaningful to the people they aim to help. This means

evaluating and reevaluating how the developed world is intervening in the developing world, and finding

worthwhile ways for all who are interested to contribute, before they get on the plane.

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[149] Penelope Bryant. "None So Naïve as the Well Meaning." *British Medical Journal*. 330 (2005): 263.

[150] *Ibid.*

As demonstrated throughout this chapter, addressing community specific health needs may require interventions brigade participants are not accustomed to providing, such as public health solutions to community health care issues. For groups which are largely student based, such as those affiliated with Global Medical Brigades, these types of interventions may be even more appropriate to be undertaking, as long as they are organized and well thought out. In finding a role for all who wish to provide their services, medical care can still be ethically and responsibly donated to communities in need, as shown above by such interventions as those provided by Shoulder to Shoulder. The critical piece lies in bringing together what volunteers wish to provide with what communities need and want, in order to provide a benefit to all involved. Discouraging individuals from travelling haphazardly and taking short-term trips is very unlikely to cause a loss for the developing communities concerned, neither with regards to willingness of people to help nor the positive outcomes gained. By harnessing this substantial manpower and directing it towards appropriate interventions, the developed world can begin to make a meaningful and positive impact on the health disparities of the developing world.

A fellow medical brigade participant, who remained involved with Honduran brigades long after my trip was over, commented that what community members said they appreciated most during her medical brigades was simply the presence of brigade participants; not the medications or treatment they provided, and not the clothes and toothpaste they supplied, but just the fact that volunteers demonstrated interest, compassion and solidarity by travelling the world to show they cared. She had been told by multiple people in these Honduran communities that they appreciated the show of goodwill, and the knowledge that someone else was recognizing their plight, above all else.[151] This same sentiment was reflected in another's account of Honduran medical brigades:

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[151] Personal communication, Stephanie Garbern (*Ibid*).

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.[152]

The main benefit provided by medical brigades has actually nothing to do with the work of the brigade itself. These communities do not need mass quantities of our expired medications every three months, they need to know that the show of solidarity is genuine, and they need us to care that their situation is not changing. We need to show that our demonstrated interest and compassion for their plight is real and can be directed in a way that will make a lasting and positive difference. This show of support is not unique to medical brigades and can be even more effectively demonstrated to communities through health care interventions that address community-specific needs effectively and ethically. Regulation may be one way to improve the intervention models of groups travelling from the developed world, but I believe it is first the responsibility of the brigade participants, or travelers from the developed world, and their affiliated institutions, to consider the ethical implications of their planned intervention, long before they plan to travel. The title of the current thesis poses the question: Who are we really helping? I do not believe the current medical brigade model is *really* helping anyone.

The presence of medical brigades in Honduras needs to change. The arguments presented in this thesis point to the claim that the communities in Honduras would be better off if medical brigades and their activities were shut down. With the size and scope of medical brigades operating in Honduras however, it is unlikely these groups will disappear overnight, nor rise to the level of the other models

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[152] Decamp (*Ibid*), "Scrutinizing Global Short-Term Medical Outreach," 23.

presented in this chapter instantaneously. Instead, in this final chapter and conclusion I have chosen to

more realistically advocate that these groups improve to provide more worthwhile and sustainable care

to the communities they aim to help, and thus slowly evolve into a Shoulder to Shoulder-type model, as

did Shoulder to Shoulder. Even though change is desperately needed, significant, meaningful change

never comes quickly.

In the meantime, specific recommendations for immediate improvements are feasible, and

necessary, to create a transition period. These changes can take place within existing organizations, such

as university affiliates of Global Medical Brigades, to make a significant difference in the health care

delivery provided by brigade groups, even as they are currently conceptualized. A first improvement

that could be implemented relatively easily is increasing the supervision of students and other non-

clinical volunteers by health care providers. This can be accomplished by requiring a health care provider

for every three to four students travelling on a brigade trip, in order to ensure students are not putting

patients at risk by acting beyond their capabilities. Current brigades should also integrate more

effectively with local health care resources both by staying in close communication with these resources

and heeding their input, as well as providing assistance to these resources while in Honduras. In

addition, the brigade ought to consult with community members as well. By undertaking a thorough

needs assessment to determine local priorities, community involvement can be obtained and

subsequent interventions will more effectively address community-specific needs. Further, current

brigades desperately need to implement a mechanism for outcome evaluation and quality

improvement; without this piece brigade groups will not know the effects they are having and thus will

have a difficult time improving their services. All of these changes are attainable by student-led brigade

groups and others, to begin improving while they begin to look for more resources and abilities to excel

further.

In order to hold brigade organizations such as Global Medical Brigades more accountable for their actions, students and others ought to be encouraged to only participate in brigades hosted by organizations who have shown they are taking measures to offer ethical, worthwhile health care and improve their practices. One way to facilitate this is for medical schools to make it known that they look poorly on participation in groups that do not provide developing communities with accountable, sustainable or community-relevant health care interventions. As mentioned in the first chapter, one of the ways Global Medical Brigades first gained recognition and increasing numbers of participants was by promoting brigades as a great addition to medical school applications. For many pre-medical students this seems to be a win-win situation; they believe they can make a positive impact on the health of others at the same time as they increase their chances of securing a place in medical school. If it is made known to these students that participation in a medical brigade, as they were described throughout this thesis, would instead work against applicants, potential participants would be very likely to avoid these brigades and find ethical alternatives to which to donate their time. Brigade organizations would be forced to improve their practices, or would no longer have enough participants to stay operational.

As a final note, in order to be thorough and clear, the current thesis had a somewhat narrow focus of medical brigade groups that travel specifically to Honduras. However, it is my hope that the frameworks and arguments presented here will be recognized as applicable to similar situations in international clinical care as well. Not only does this discussion apply to the same occurrence of medical missions in other developing countries, but also, in many ways, to the ethics of medical student international rotations and individuals travelling for a short period of time to provide other forms of health care, such as fistula and cleft palate surgery, among other scenarios. This discussion was also meant to speak to the ethics of interactions between the developed world and the developing world in general. I hope it serves as a much needed caution to closely scrutinize the possible impacts of proposed

actions, and the beliefs they perpetuate, before initiating any interaction within the developing world. It

seems to be an all too common belief that anything one can do for the developing world would be a

welcomed and worthwhile intervention because of its devastating poverty and unmet health care

needs. However, it is partially because of these gross injustices rampant throughout developing

countries that one ought to be especially careful when aiming to help. Improving the current medical

brigade model can be the next step towards providing only ethical and worthwhile health care

interventions in the developing world. These communities deserve better, and we can do better. We

have done better.

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Appendix I: Honduran Brigade Websites

Adventures In Missions - http://www.adventureinmissions.com/involvement.html#trip

Alabama Honduran Missions - http://honduranmissions.com/Projects/medicalmission.htm

Asbury United Methodist Church - http://www.asburyumc.ws/missions/eoe/honduras.htm

Baptist Medical & Dental Mission International - http://www.bmdmi.org/service/index.html

Cape CARES - http://www.capecares.org/indexa.html

Casa Corazon - http://www.ccorazon.org/teams.php

Catholic Medical Association - http://www.cathmed.org/medicalmissions/index.htm

Christ the King Catholic Church Honduran Mission - http://www.ctkhondurasmission.com/news.cfm

Christian's Medical and Dental Association Global Health Outreach - http://www.cmda.org/AM/Template.cfm?Section=Global_Health_Outreach&Template=/CM/HTMLDisplay.cfm&ContentID=19810

Church of the Epiphany - http://www.epiphany-richardson.org/ministries/home.asp?id=521

Church of the Nativity - http://www.nativityonline.org/outreach.htm

Emory University - http://www.gaithersburgnazarene.org/GCNweb/Honduras.html

Episcopal Diocese of Mississippi - http://sunset.backbone.olemiss.edu/~sasisson/medical.html

Fairview Health Services - http://www.fairview.org/Foundation/What_we_do/c_098142.asp

First Baptist Church: Jasper, Texas - http://www.fbcjaspertx.com/index.pl?id=2469&isa=Category&op=show

Friends of Barnabas Foundation - http://www.fobf.org/

Friends of Honduran Children - http://www.honduranchildren.com/difference_brigades.html

GCN Mission to Honduras - http://www.gaithersburgnazarene.org/GCNweb/Honduras.html

Gehlen Mission Honduras - http://www.gehlenmissionhonduras.org/

Global Medical Brigades - http://www.globalbrigades.org/project/medical/

Global Medical Brigades Student Clubs - http://www.globalbrigades.org/project/medical/clubs/

Global Outreach International - http://www.globaloutreach.org/opportunities

Healing Hands International Ministries - http://hhim.us/

Heart for Honduras - http://heart4honduras.org/site/index.php?option=com_content&task=view&id=24&Itemid=38

Heart for Honduras Missions of Mercy - http://www.heartforhonduras.org/hfh.nsf/content/missiontrips

Helping Hands for Honduras - http://www.handsforhonduras.org/projects.htm

Honduras Baptist Medical Dental Mission - http://medicaldental.org/index.php?option=com_content&task=view&id=12&Itemid=26 (every other wk)

Hope for Honduras - http://www.hopeforhonduras.org/home.html

International Health Service - http://www.ihsofmn.org/

La Cima World Missions - http://www.lacimaworldmissions.org/

Medical Ministry International - http://www.mmint.org/CentralAmericaandtheCaribbean/Honduras/tabid/83/Default.aspx

M.E.D.I.C.O. - http://www.medico.org/index.php

Mission on the Move - http://www.missiononthemove.org/home.aspx?igid=55008

Operation New Life - http://www.operation-new-life.org/about.html

Peace Lutheran Church - http://www.plchurch.org/widerchurch.html

Propapa Missions America - http://www.propapa.org/

Rice Foundation - http://www.ricefoundation.us/Home_Page.html

Send Hope - http://www.send-hope.org/

S.M.A.R.T. - http://www.smartteams.org/index.htm

Sociedad de Amigos de los Niños - http://www.saninos.org.hn/

Southeastern Louisiana University - http://www.selu.edu/acad_research/programs/ii/study_abroad/programs/nursing_in_honduras/index.html

Southwood Lutheran Church - http://www.southwoodlutheran.org/serve/global/honduras/honduras

St. John the Baptist Episcopal Church: Breckenridge, CO - http://www.stjohnsbreck.org/summit_in_honduras

St. Stephens Episcopal Church- http://www.ssecdurham.org/honduras-health-mission

Virginia Hospital Center Medical Brigade - http://www.vhcmedicalbrigade.org/messages.html

Volunteers in Medical Missions - http://www.vimm.org/

Washington Overseas Mission - http://www.overseasmission.org/medical_dental_brigade.html

West Side Ministries - http://www.gowestsideministries.org/

World Baptist Missions - http://www.wbmonline.org/trips_index.htm

World Gospel Outreach - http://www.wgoreach.org/html/medical_brigades.php

Worldwide Heart to Heart Ministries - http://wwh2h.org/missions/

Appendix II: Commentaries and News Stories

In Our Own Words - http://medscapenursing.blogs.com/medscape_nursing/2008/04/giving-to-hondu.html

Grand Blanc father-daughter learned major lessons through medical trip to Honduras - http://www.mlive.com/flintjournal/index.ssf/2008/10/grand_blanc_fatherdaughter_lea.html

Indiana University School of Medicine - http://web.indstate.edu/thcme/Web_Center_Line/Honduras09/HondurasSpringBreak09.htm

Cuban, US and Honduran Doctors Work Together on Medical Brigades to Honduras - http://www.indybay.org/newsitems/2006/07/17/18288880.php

Spring-breakers Serve in Honduras - http://www.marquettetribune.org/home/index.cfm?event=displayArticlePrinterFriendly&uStory_id=8ba0372c-8840-492a-8b5e-e39363e61673

Medical Brigade is Welcomed Home - http://www.rmh.org/content/view/784/397/

Medical Mission to Honduras a Success - http://www.lutheranmedicalcenter.com/News/PressReleases/Detail/?id=66

The Tale of Two Doctors – A Story of Dedication and Decision - http://www.maltausa.org/files/newsletter_hospitallers_13_medical_brigade.pdf

SVJ Students Take Spring Break in Honduras - http://www.ahherald.com/index.php/Schools/SJV-Students-Take-Spring-Break-in-Honduras.html

Fones student brings her caring to remote villages of Honduras - http://www.bridgeport.edu/pages/3218.asp?item=3184

Medical Mission to Honduras - http://www.medscape.com/viewarticle/461604