Solving ethical dilemmas in international healthcare professional education: A case study using a revised ethical model in East Africa

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Abstract

Ethical issues frequently arise during the practice of clinical medicine and when providing medical education. These issues become particularly challenging when practicing and teaching medicine cross-culturally. In this case study in a family medicine residency program in East Africa, a structured approach to managing ethical challenges effectively was found to assist in overcoming a conflict about potentially removing a seemingly incompetent medical trainee from a residency program. The step-wise approach includes identifying relevant stakeholders; agreeing on actual background facts; understanding the various goals and values involved in the situation; reviewing locally applicable ethical, professional and legal standards; acknowledging limitations in various options to resolve the issues; and analyzing risks and benefits of the various courses of action.

Key Words: Ethics, medical education, intercultural dilemmas, East Africa

Introduction

When facing ethical dilemmas in an international healthcare professional educational setting, it is helpful to have some guidelines to make ethical decisions. Dr. Anji E. Wall's book "Ethics for International Medicine" outlines a helpful method for evaluating ethical situations and provides a template to aid in making these difficult decisions.[1] For the 2017 Global Missions Health Conference's pre-conference workshop on "Professional Moral and Ethical Dilemmas in International Health Care Education," we modified the method she presented to cover educational as well as clinical dilemmas. Dr. Wall's method is a modification of Dr. Jonsen and colleagues' approach to identify, analyze, and resolve ethical issues in clinical medicine.[2] Wall's approach uses a critical analysis of the case looking at five areas: 1) Who are the stakeholders in this situation? 2) What are the medical or educational (as modified for this workshop) facts involved? 3) What are the goals and values involved in this situation? 4) What are the ethical, professional and legal norms in this setting? 5) What are the limitations encountered in this situation?

Once these steps have been discussed, one must analyze options being considered as to whether they are feasible. Then the stakeholders must go through a process of evaluation for each option and decide which option is the most justified. At the conclusion of the process it is hoped one option will be more justifiable than the others. Finally, the decision makers should be comfortable sharing their decision-making process with the community with which they are working but also with peers and colleagues in their home practice-setting.

Method

An ethical dilemma in resident education

Teaching and remediating a resident who is struggling academically can be challenging in any culture. When the resident belongs to one culture and the faculty to another, the obstacles multiply. Dr. S., a second-year family medicine resident in this East African country was in his third probationary period and not meeting requirements. Each probation period's structured remediation program attempted to correct these deficiencies: multiple exam failures, recurrent failures to complete patient care duties (arriving late for call, forgetting to give patient hand-over reports, not performing physical exams, not completing documentation), "misleading" faculty (as to his activities, falsifying patient records), and poor judgement in patient care (poor differential diagnoses, wrong treatments, wrong medication doses, not precepting cases). Each time the faculty placed him on probation, he corrected his deficiencies briefly, but then the same problems reemerged. The faculty worried about the growing and blatant disregard for feedback and correction in all forms. As he was finishing his third probationary period, he attempted to perform a Cesarean section independently and without authorization, resulting in a poor surgical outcome. In the past, the faculty met repeatedly with the resident to discuss his remediation. After the unauthorized Cesarean section incident, the faculty retained no hope for rehabilitation. They feared the

problem involved insufficient motivation to be a competent physician and possibly a character flaw as exhibited by recurrent indifference for patient safety. After lengthy deliberation, the faculty unanimously decided to have the resident leave the program. However, the following day, Dr. Y., the medical school dean who oversaw the residency program, informed the program director that this resident could not be removed from the program, but he would speak with Dr. S. about his behaviors.

Applying Wall's framework

When first faced with a moral dilemma, the emotional response often initially clouds the mental ability to problem-solve effectively. In this situation, the faculty, after failing to effectively remediate a struggling resident despite their best attempts, learned from Dr. Y. that they were obligated to keep the resident within the training program. Wall provides a framework to deliberately and succinctly work through difficult ethical questions, which can be effectively applied to moral dilemmas in international medical education.

Who are the stakeholders?

At first glance, this case involves the resident, the family medicine faculty, and the medical school dean. A closer look reveals the other stakeholders: the patients and their families for whom the resident provides care; the resident's family who expect the resident to bring them honor and a paycheck; the other residents requiring attention, supervision, and teaching from the faculty; the community expecting the university to graduate competent physicians; the other university officials who want to produce an adequate number of physicians for the country and to retain qualified expatriate teachers (medical and nonmedical); and the faculty's organization which has a long term relationship with Dr. Y. and the other university officials.

What are the facts?

The resident consistently performed at a substandard level despite multiple remediation and probationary periods. This led directly to significant and recurrent compromises in patient care and safety. The resident's actions dismissed multiple foundational values to which the training program formally ascribed and of which all trainees were fully informed; the values included patients first, integrity, respect, life-long learning, and excellence.

The resident's family held power and influence in the community and was distantly related to Dr. Y. All the faculty members came from the same culture but lived in a foreign country. The resident and all other stakeholders belonged to this country, and they held a significantly different worldview than the faculty members. The faculty members worked for the university as volunteers, but they were part of a larger humanitarian organization. This organization, which had other non-medical personnel volunteering within the university, enjoyed a long and deep relationship with the university officials and the dean.

What are the goals and values of each stakeholder?

What does each person or group want? What is important to each of them? For simplicity, this discussion includes only the resident, the patients, their families, the dean (who represents the university officials), and the faculty as the major stakeholders.

The resident wanted to graduate and enjoy the status as a specialist physician within the community. He valued upholding his family's honor, which included the dean, and knew his family's status in the community helped him maintain his position within the residency program.

The patients and their families wanted the patient's health to improve. They desired healing. In the situation involving the woman who needed a Cesarean section, the family wanted a live and healthy mother and baby. The patients and families valued physician competency and patient safety. Dependent upon physician availability (or lack thereof), they only held the power to accept the care offered or to refuse it.

Dr. Y. wanted to see the residency program succeed in the cultural context by graduating competent family medicine doctors who served their communities. As a physician and community leader, he desired to see improved health status and outcomes for his fellow community members and countrymen. He wanted to avoid a permanent breach in his relationship with the resident's immediate family, the faculty, and the community. He valued his relationship with the resident and the faculty, and viewed himself as the mediator between the two parties directly involved in the conflict. He also valued his position as a spokesperson for and a member of the community and university leadership. In addition to the goals and values held by the dean, university officials also enjoyed a good working relationship with the faculty's humanitarian organization. While they valued and depended on the faculty's expertise to administer the residency program, the program belonged to the university. Although long-term partners, the faculty remained expatriate guests within the university system.

The faculty wanted to graduate competent family medicine physicians able to achieve high objective standards in patient care and professionalism. While the other residents watched to see if the program's educational standards were upheld, the faculty knew residents' future performance would diminish if substandard performance was accepted without remediation. They valued whole person care and growth for patients and residents. They upheld honesty and integrity in both themselves and in their learners, the residents. They valued Christ and His glory, and desired their words and deeds to reflect Jesus Messiah to those around them, especially as no other Christian witness existed within the region.

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What are the ethical, professional, and legal norms in this setting?

In this situation, the familiar biomedicine ethical considerations applied, including autonomy, beneficence, non-maleficence, and justice. Professional standards included patient safety and competent care. Legal norms defining confidentiality, patient's rights, and malpractice varied drastically between the two cultures. As often encountered in international health educational settings, different cultures and their contrasting approaches to resolve conflicts played a major role in this ethical dilemma. The local culture upheld honor and avoided shame to such a high degree that it affected every relationship, even in ways that were incomprehensible to the faculty. In this culture, relationships held more importance than truth. Conflict resolution occurred indirectly, between third parties, to restore honor and minimize the shame attributed to the individuals directly involved in the conflict.

What are the limitations?

The stakeholders belonged to two different cultures and embraced different worldviews. The faculty maintained the responsibility to teach and train but held limited authority to make employment decisions. Dr. Y.'s relationships with the faculty, their organization, the community, the resident and his family varied in depth and significance, and influenced his role as a decision-maker. Faculty members perceived limitations in time and personnel to teach all the residents effectively and thoroughly. The faculty also admitted to personal limitations in their waning goodwill towards the resident.

Moving towards resolution: identify possible options

To solve this dilemma, what solutions were available? Were there only two options – keep the resident or have him leave the program? Was a compromise achievable? Other possible responses included refusing to train and supervise the resident,

allowing the resident to graduate and practice medicine despite his inability to meet the qualifying standards, quietly negotiating with the dean and resident's family to find another honorable position/employment, requiring the resident to repeat a year of residency training with increased supervision from local physicians, and improving the faculty's ability to provide culturally appropriate feedback, assessment, and evaluation.

Moving towards resolution: analysis and justification of options

During the analysis and justification of options, major stakeholders need to agree on a solution that effectively reaches the desired goal. While evaluating each option, it is best to consider if the benefits outweigh the risk or infringe on the values and norms of each stakeholder. Is infringement even necessary? How can the infringements be minimized? Can each stakeholder communicate his/her decision-making process or rationale with the other stakeholders?

Final resolution

In this real-life scenario, Dr. Y., as the university's representative, held decision-making power. Like the faculty, he valued graduating competent physicians; however, cultural norms dictated removing a resident from the program was an inconceivable and impossible option because the resultant shame would cover everyone involved – the resident, his family, the university, the faculty, and the community. The faculty refused to advance Dr. S. to his third year and recommended he repeat his entire second year since he could not be removed from the program. After deliberation, Dr. Y. agreed to require the resident to repeat his second year. To a lesser degree, this option also brought shame upon Dr. S. but allowed him to remain as a member within the family medicine residency program. This option also incorporated the dean and faculty's value and aim to graduate competent physicians. During a private meeting with Dr. S., Dr. Y. realized Dr. S.'s

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inability to immediately restart his second year: Dr. S. needed a reprieve from the constant pressure under academic scrutiny. Dr. Y. demanded Dr. S. take a one-year leave from the residency program to contemplate if he really wanted to be a family medicine physician. For the year, Dr. Y. found employment for Dr. S. where he could serve in a remote community with no modern healthcare access. After a year, Dr. S. could elect to return to the residency program and repeat the second training year or seek employment elsewhere. The resident, his family, and the faculty agreed to this solution. The remote community accepted the resident gratefully because Dr. S. possessed more skills and competency than any other practitioner available. After a daunting yet growth-provoking year, Dr. S. returned home and rejoined the training program motivated and eager to learn. Two years later, he graduated as a family medicine physician, fulfilling all the program's training and competency requirements.

Discussion

In this scenario, the successful remediation for this physician far exceeded the faculty's expectations. On his return, Dr. S. displayed humility by willingly receiving corrective criticisms and consistently requesting feedback. When reviewing the entire process, the faculty identified several factors which they believed contributed to the successful outcome and could be instituted in other international medical education settings to curb ethical cross-cultural quandaries before they arise.

As previously mentioned, the faculty valued their witness of Jesus in a society that rejected Him. Working within a community that knew of their claim to be followers of Jesus Messiah, the faculty realized their response to the resident and this ethical dilemma had to mirror their beliefs. Upon review, the faculty identified the most important factor leading to a favorable outcome — prayer. From the start, when the faculty first contemplated the terms of the initial probation, praying had also begun. The

faculty requested their non-medical colleagues from the same organization join them in prayer for Dr. S., themselves, and the difficult situation. Together, they offered praise to God for His Sovereignty even in trying circumstances and requested wisdom, love, forgiveness, integrity, and peace. During the resident's year away, the prayers continued on his behalf.

Another contributing factor to this successful story involved establishing a strong educational foundation for the residency program before problems presented themselves. Since its creation, the residency program stood rooted within a values-based education system. The faculty discussed these values often with the residents and frequently applied them to clinical cases. The program kept easily accessible written expectations for the residents and reviewed them at the beginning of each academic year and each rotation. The residents received routine oral and written evaluations and feedback. The main sections within the written evaluations were derived directly from the program's values. Over time, the residents learned how their performance as physicians reflected these values. All patient safety and disciplinary incidences received a documented review at the time they occured. The faculty enumerated these educational factors as contributing to a successful outcome in this ethical scenario: the dean, the faculty, and the resident clearly understood the expectations and the resident's delinquencies. Another institutional factor, the Disciplinary Advisory Board, also contributed to this success. The dean and other university leaders served as board members and retained final decision-making authority. Although the faculty recommended removing the resident from the program, the Board, fully versed in their own cultural norms, decided to retain the resident within the program to avoid unacceptable shame. The faculty also identified providing the resident with a knowledgeable advocate (in this case, the chief resident) which led to a successful remediation. Finally, as Christ's image-bearers, the faculty recognized their need to constantly remember: love

CHRISTIAN JOURNAL for GLOBAL HEALTH

is patient, kind, does not dishonor, keeps no record of wrongs, always protects, always trusts, always hopes, always perseveres.[3] This persistent determination to allow love to motivate actions enabled the faculty to receive the resident after the year's leave and see him fully remediated, growing into a competent family medicine physician.

Conclusion

Wall's approach to ethical and moral dilemmas may work well when applied to other medical education problems, even in an international setting involving different cultures and divergent worldviews. In our experience, following this method leads to improved clarity when attempting to address challenging educational situations.

Establishing a values-based educational system assists in identifying and defining problems early in the process. Once an ethical dilemma emerges, praying for wisdom and permitting love to motivate actions enables one to maintain a God-glorifying witness even in difficult circumstances.

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