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Does Pre-Medical ‘Voluntourism’ Improve the Health of Communities Abroad?

August 1, 2012 · *Opinion*

Authors

[Lauren J. Wallace](#)

Abstract

Medical voluntourism involves medically untrained individuals travelling to a community abroad to set up health education workshops, complete observational work or even basic clinical tasks. Often, these volunteers are students who are applying to medical school and are seeking an international clinical experience. Although the ethics of global-short-term medical outreach by medical school students and health professionals has been examined, the ethical implications of international pre-medical volunteer experiences have not been well described. This article is primarily concerned with medically-untrained individuals' increased scope of practice in international healthcare settings. Specifically, this brief investigation asks: is the use of medically unskilled volunteers for clinical tasks in the developing world ethical? Ultimately, this analysis does not suggest that pre-medical students should avoid engaging with health disparities abroad, but rather that it is necessary to actively question how healthcare-related volunteering abroad is carried out.

Introduction

Medical voluntourism projects are short-term experiences abroad that combine travel to the developing world with voluntary medical work. Through a variety of sending organizations – such as universities, NGOs, or private companies – medically untrained youth travel to communities throughout the world to set up health education workshops, complete observational work, or even basic medical tasks [1,2]. Volunteers often participate for less than one month [3]. Recruitment for these projects frequently takes place online and participants tend to receive little orientation to best practices in the local cultural or medical context before they begin their mission to improve the health of communities [3].

There is evidence that involvement with medical voluntourism can lead pre-medical students to complete, or be tempted to complete, clinical tasks that they are not qualified to undertake. As Shawna O'Hearn, Director of the Global Health Office at Dalhousie University explains, it is not uncommon for undergraduate students who are not engaged in any medical training to be involved in clinical practice in the developing world [4]. For example, one student participant in such a project featured in the documentary *First, Do No Harm* describes how she was involved in delivering a baby without supervision:

“...I’m unskilled but when the baby comes out, I can cut and tie the umbilical cord and deliver the placenta. So although I’m not the most skilled person in Canada – I’d never be allowed to do that – but here, when the choice is between me and no one, there are different standards because there have to be different standards. I’m not saying it’s right, but it’s better than nothing...” [4].

When asked to discuss his experience volunteering in Uganda, another undergraduate volunteer explained how he was asked by physicians to complete several medical procedures:

“When I arrived in Uganda, there was no checking of my credentials—the colour of my skin and my nationality stood as my qualification. During my time there, I was asked to give injections, IVs and set broken bones. Explaining my ethical position regarding providing treatment was one of the most difficult things I had to deal with on my trip; standing by those ethical guidelines was even harder” (personal communication, Phillip Baker, April 4, 2011).

However, pre-medical students’ potential involvement in clinical tasks leads to a potentially problematic paradox. Obtaining a hospital-based volunteer placement in North America normally requires a fairly rigorous application process, a police check and the completion of a training course. Even after this process is finished, the tasks which volunteers are permitted to complete do not include basic medical procedures. If a group of untrained foreigners entered a Canadian community and set up medical practice, they would immediately be stopped.

The ethical issues surrounding the practice of voluntourism and the work of medical school students and healthcare professionals abroad have both been examined by global health researchers [5-9]. However, the ethical implications of pre-medical volunteer abroad programs have not been described. This brief discussion shows that the use of medically unskilled volunteers for clinical tasks in the developing world is problematic. Ultimately, the analysis does not suggest that pre-medical students should not avoid engaging with global health disparities, or that all medical volunteer abroad initiatives involve untrained individuals completing clinical tasks. Rather, it demonstrates that it is important to actively question the ethics of pre-medical student experiences abroad and improve how they are carried out.

The ethical and health implications of pre-medical volunteers’ increased clinical responsibility

In medical ethics, the principles of beneficence and non-maleficence require healthcare workers to consider both benefit and harm and to strive to produce net benefit over harm. However, in order to provide benefits effectively and understand the relative risks for harm, rigorous and effective education and training are required [10]. Medically unskilled volunteers do not possess this training and this may severely compromise their ability to ensure net benefit over harm in the completion of clinical tasks. Rather than being influenced by ideas of net benefit and harm, medical voluntourism practices of pre-medical students, not unlike other voluntourism projects, have often been influenced by the rhetoric of “good intentions”, “need,” and “making a difference.” As a result, communities become

defined primarily by their health needs and development is described as a simplistic process that demands primarily enthusiasm and labour from external groups [11]. As one non-governmental organization notes: “[y]ou’ll be making a difference for today and tomorrow through important health projects” [12]. Given factors such as the severe and debilitating shortage of health professionals in developing regions like sub-Saharan Africa, where only 3% of the healthcare workers worldwide are situated, but where 24% of the disease burden is located, well-intentioned volunteers may be overcome by a moral imperative to help [13]. As one organization suggests, “with understaffed hospitals serving low-income communities, volunteers support the over-worked staff, adding to their efficiency and allowing more people in need to be served” [14]. Volunteers may be led to believe that the provision of any medical services, irrespective of the lack of experience of the provider, will benefit people in poverty [15].

Another factor that may prevent the adequate weighing of benefit and harm by volunteers is their enthusiasm for an early exposure to medicine. Similarly to medical students, it is possible for pre-medical volunteers to see medical voluntourism trips as an opportunity to perform medical techniques that they would never be permitted to undertake in their home-developed country [16]. Medical voluntourism groups, who provide early opportunities for volunteers to gain clinical know-how, tend to also support volunteers’ enthusiasm for an early exposure to medicine. Moreover, the previously-mentioned case study in which an undergraduate volunteer was encouraged to practice beyond his skill level by local health workers demonstrates that perhaps it is not only volunteers and medical voluntourism organizations that may play a role in supporting volunteers’ clinical role. Whether local healthcare workers are overburdened and are looking for clinical assistance, or overestimate volunteers’ clinical skill level is unclear.

The idea that good intentions are enough, as well as volunteers’ enthusiasm for early exposure to medicine, combined with pressures from local healthcare workers, may lead untrained volunteers to accept offers to perform clinical tasks that they are not trained to complete. The literature on global health electives for medical students reveals that these types of ethically problematic clinical situations can harm patients and place volunteers in circumstances that are potentially psychologically damaging [17]. For example, if while in delivery, a mother experienced peripartum complications that an unsupervised volunteer was not able to address, this could result in negative outcomes for the mother, infant and volunteer.

Such rhetoric can also affect medical voluntourism organizations, leading to health initiatives that are not integrated within local health infrastructure and are harmful to communities. While in Guatemala, Roberts, a nutritional researcher, witnesses a transient medical voluntourism initiative in which volunteers enter rural areas with bags full of children’s multivitamins. They provide them to every parent, emphasizing that vitamins make children healthy and strong, and depart when their “good” work is complete. Her work reveals that this initiative, while it may appear harmless, is not integrated within the local healthcare infrastructure and can cause severe harm to local children, especially when parasitic infections are rampant [18].

As she explains, this harm can occur in three ways:

1. *The child eats the vitamins, but, like many children, eats most of the bottle in one sitting and gets constipated. The vitamins do not eliminate the parasites, which continue to inhabit his gut, and the child now has the unenviable combination of persistent parasitic infection and vitamin-induced constipation.*
2. *The child takes the vitamins and also happens to feel better. The next time an illness occurs, the mother drags the child down to the permanent clinic, because there is no field clinic that day, and tells the physician she needs vitamins. The physician explains that what the child really needs is metronidazole. She explains that she will give her child both. The physician writes both prescriptions, assuming that the vitamins will not harm the patient. The mother heads to the pharmacy, where she is told that the metronidazole is 14Q (queztales), and the vitamins are 50Q. She has enough for the previously suggested vitamins but decides to skip the unfamiliar drug.*
3. *Many Guatemalan-produced vitamins are not in chewable form; they are injectables. Local health promoters tell me that vitamin B12 is thought to give a high upon injection. Following the volunteers' encouragement of vitamin use, there is a subsequent increase in complications from nonsterile injections [18].*

Ultimately, Roberts shows that the good intentions behind medical voluntourism initiatives can be harmful. Although the aforementioned volunteers intended to improve health, their initiative failed to provide culturally sensitive health education. In addition, it was not integrated within the local medical infrastructure. As a result, the program was not comprehensive and provided no continuity of care, exacerbating poor health.

Medical voluntourism initiatives also potentially undermine patient autonomy. The principle of autonomy states that the health-care provider-patient relationship is based on trust. Patients must be consulted in decisions made about their treatment and must not be deceived [10]. Due to the socioeconomic vulnerability of the patients in most of the rural, developing world, patients are likely unaware of a volunteer's educational status [18]. The power imbalances in the relationship between patients and volunteers in the developing world may result in volunteers being trusted simply due to their developed world background and assumed healthcare knowledge. If a volunteer wears surgical scrubs, for example, this could be interpreted by local populations as an indication of medical professional status [19]. Even if a patient is aware that a volunteer is practicing beyond their skill level, it is unlikely that the patient will be in a position to demand or access better care. This is because communities in the contexts in which medical voluntourism projects operate often have many medical problems and meager options to address them. Moreover, to achieve the principle of autonomy, those involved in healthcare must be able to communicate well with patients [10]. Thus, patient autonomy in medical voluntourism settings can be further complicated by volunteers' lack of cultural competency and inability to speak the local language [8].

Defining the scope of volunteers' clinical actions

The current discussion surrounding the ethics of the practice of medical voluntourism has been completed largely from the perspective of a Western-defined ethics. Applying the classic principles that underlie codes of medical ethics directly to developing world contexts is perhaps problematic because these principles originate in Western philosophy and are not necessarily globally recognized. What constitutes beneficence and non-maleficence or patient autonomy in one part of the world, may differ in light of cultural differences or resource limitations in another [8, 20]. For example, an Indian physician may prescribe antibiotics to a patient after a visit of only five minutes in a crowded clinic – this action might be considered bad practice in a North American setting.

Given the differences between clinical contexts, some individuals may contend that less training may be required to complete a simple clinical task, such as the administration of a vaccine, in a region with already insufficient healthcare.

However, it is important to remain skeptical of ethical relativism, in which a patient's right for quality healthcare is shifted to accommodate factors of lesser importance, such as efficiency [8,21]. This is problematic because it suggests that it is acceptable for the quality of medical care provided in the developing world to be lowered. It can legitimize a value system in which the lives of some people are considered more important than the lives of others and create a double standard for medical care [21].

Conclusions and Recommendations

Pre-medical volunteer abroad initiatives involve medically untrained individuals completing clinical tasks abroad. By examining the ethical dilemmas involved in pre-medical voluntourism experiences, this article has shown that the use of medically untrained individuals for clinical tasks in developing regions is problematic.

Volunteers do not possess the training required to weigh the harms and benefits of their actions effectively. In addition, pre-medical students may be influenced by the rhetoric of good intentions, need and making a difference, their enthusiasm for early exposure to medicine and/or pressure from local healthcare workers. The clinical tasks that untrained volunteers' complete may result in negative outcomes for both the patient and volunteer.

Medical voluntourism initiatives can also lead to a disregard for patient autonomy. However, undertaking a Western-defined discussion of the ethics of pre-medical voluntourism may be perceived as problematic because of the cultural and resource differences between Western and developing-country healthcare contexts. Due to these differences, some may argue that it is adequate for unskilled volunteers to complete basic clinical tasks. However, this rhetoric legitimizes a double standard for medical care.

Here, it is not suggested that pre-medical students should avoid engaging with health disparities worldwide, but rather, that it is necessary to actively question and rethink how healthcare-related volunteering abroad is carried out. While increased scrutiny is required, pre-medical students often provide a valuable resource to global health efforts. Many clinics and public health efforts abroad rely on the labour of pre-medical volunteers to fund their clinics, or obtain needed equipment, for

example. This allows global health efforts to provide health services to more people than would otherwise be possible, eliminating health disparities.

Although the benefits of medical voluntourism have been realized, the fact that pre-medical voluntourism introduces ethical dilemmas seems to be recognized by few physicians and medical schools. In fact, pre-medical volunteer abroad experiences are often accepted by medical schools as a sign of an applicant's humanitarian qualities and unique medical insight. Due to the potential for harm discussed, the Canadian public and medical community should be more skeptical of the assertion that medical voluntourism programs always alleviate poor health.

Given the potential ethical dilemmas inherent in volunteers' completion of clinical tasks, volunteers not engaged in medical training should not be involved in the direct provision of medical care, such as setting broken bones or providing injections [6]. However, one might ask: what types of activities *are* appropriate for pre-medical volunteers? Defining the exact scope of volunteers' clinical activity in the developing world is difficult. Depending on the level of pre-departure and on-the-ground training provided, even volunteers' provision of culturally sensitive health education can be problematic. Unskilled volunteers involved in local education, for example, risk propagating incorrect public health information [22].

Currently, there are no formal guidelines for pre-medical volunteer abroad initiatives. Creating and enforcing these guidelines is difficult because pre-medical volunteer abroad initiatives are organized by a wide variety of types of organizations – from NGOs to private companies – in a multitude of regions and healthcare contexts. The ability to discuss and understand the appropriate scope of pre-medical activities abroad is also limited by a paucity of primary research on the subject. The characteristics of programs that improve health versus those that exacerbate poor health have been seldom explored in the literature. Discussions and the development of recommendations are further restricted by inadequate research on how ethics is negotiated and understood by patients and healthcare workers in non-Western contexts.

A first step in improving pre-medical volunteer abroad programs is to shift programs' current focus on clinical work in under resourced contexts to social justice. A social justice orientation would allow organizations and volunteers to see beyond the clinic to understand and act upon broader issues such as the political and economic concerns that underlie inadequate healthcare and lead to dependency on external support. More commitment to social justice would also entail focusing on solidarity. Solidarity involves developing empathy and sensitivity to the needs and suffering of others and ensures that volunteers' and patients' goals and values are aligned. Thus, a greater focus on solidarity would help to ensure that patients and communities are not further marginalized [8]. A social justice orientation to pre-medical voluntourism could be better recognized if volunteer abroad organizations improved and expanded their pre-departure training.

In order to develop guidelines for evaluating program safety, and to incorporate a greater focus on social justice, research on pre-medical voluntourism and global health ethics must be expanded. Researchers from a wide variety of disciplines

should be involved, including those from both the medical community and the social sciences. In this way, best practices can be discussed and pre-medical students can be encouraged to become involved with only those global health initiatives that truly deliver quality, effective medical care.

References

1. Let's Volunteer Abroad [Internet]. Program Details: Health Care Project, [cited 2012 Jan 11].
[REFERENCE LINK](#)
 2. Volunteer Abroad [Internet]. Pre-Medical Student Volunteer Opportunity-Hospital Sangolqui Ecuador: General Placement Details, [cited 2012 Jan 11]
[REFERENCE LINK](#)
 3. Volunteer Abroad [Internet]. Health and Medicine, [cited 2012 April 8]
[REFERENCE LINK](#)
 4. First, Do no Harm. Tim Holland and Alyson Horne-Douma. Dalhousie University, 2010.
 5. Cho, Rhyanna; Edge, Jennifer; and Keng, Alvin. Crossing Borders and Pushing Boundaries: The Ethics of International Volunteering. *The Meducator* 2010; 1(17), Article 10.
 6. Crump, John A & Sugarman, Jeremy. Global Health Training: Ethics and Best Practice Guidelines for Training Experiences in Global Health. *American Journal of Tropical Medicine and Hygiene* 2010; 83: 1178-1182.
 7. Guttentag. The possible negative impacts of volunteer tourism. *International Journal of Tourism Research* 2009; 11: 537-551.
 8. Pinto, Andrew D. & Upshur, Ross E.G. Global Health Ethics for Students. *Developing World Bioethics* 2009; 9: 1-10.
 9. Shah, S. & Wu, T. The medical student global health experience: professionalism and ethical implications. *Journal of Medical Ethics* 2008; 345(5): 375-378.
 10. Gillion, Raanan. Medical ethics: Four principles plus attention to scope. *BMJ* Jul 16; 309: 184-8.
 11. Simpson K. 'Doing development': The gap year, volunteer-tourists and a popular practice of development, *Journal of International Development*. 2004 Jul 1;16(5):681–692.
 12. ProWorld [Internet]. Volunteer Abroad/Health, [cited 2012 Mar 8].
[REFERENCE LINK](#)
 13. World Health Organization [homepage on the internet]. Geneva: World Health Organization; c2007 [cited 2012 Apr 7]. The global shortage of health workers and its impact.
[REFERENCE LINK](#)
 14. Cross Cultural Solutions [Internet]. Healthcare: Volunteer abroad and support
-

organizations in healthcare, [cited 2012 Mar 8].

[REFERENCE LINK](#)

15. Shah, S. & Wu. T. The Medical Student Global Health Experience: Professionalism and Ethical Implications, *Ethics* 1008; 34: 375-378.
16. Banatvala N, Doyal L. Knowing when to say 'no' on the student elective: students going on electives abroad need clinical guidelines, *British Medical Journal* 1998 May 9;316(7142):1404-1405.
17. Levi A. The ethics of nursing student international clinical experiences. *Journal of Obstetric, Gynecologic, & Neonatal Nursing* 1994 Jan 21;38(1):94-99.
18. Roberts M. Duffle bag medicine. *Journal of the American Medical Association* 2006 Apr 5;295(13):1491-1492.
19. Maina-Ahlberg, E. Nordberg & G. Tomson. North-South Health Research Collaboration: Challenges in Institutional Interaction. *Social Science and Medicine* 1997; 44: 1229–1238.
20. T. Takala. What is Wrong with Global Bioethics? On the Limitations of the Four Principles Approach. *Camb Q Healthc Ethics* 2001; 10: 72–77.
21. M. Angell. The Ethics of Clinical Research in the Third World. *New England Journal of Medicine* 1997; 337(12): 847–849.
22. Unite for Sight. 2011.Global Health Online Course. www.unitesforsight.org.

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