Real-Life Struggles with Medical Ethics in the Developing World

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Objectives

- Present and discuss actual cases of ethical challenges faced by family physicians in developing world settings.
- Identify applicable principles of medical ethics and the extent to which they apply.
- Recognize how these situations can be intensely disturbing to the treating physician, and explore potential ways forward in each case.

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Four Basic Principles of Medical Ethics

- **Beneficence**: do the most possible good for the patient
- **Nonmaleficence**: avoid causing harm
- **Justice**: fairness in allocating medical resources
- **Autonomy**: informed, competent adults have the right to make their own decisions regarding healthcare

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  - Need to ask questions/discuss with knowledgeable cultural navigator

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Additional Principles

- **Mutual Respect**: Recognize the value of others' beliefs, experience and practice, and work toward a mutually acceptable understanding/practice.
  - Need to ask questions/discuss with knowledgeable cultural navigator
- **Maintain Appropriate Scope of Practice:** Avoid providing treatment or performing procedures that are beyond our level of training or experience.
  - Must assess availability/accessibility of more experienced providers/centers

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- Principal of autonomy geared toward individualistic societies

Vignette #1

- A 24-year-old married father of 4 presents to your hospital with fever, leukocytosis, a gangrenous foot and cellulitis of the lower leg 12 days after suffering a machete wound to the foot. You advise amputation in your hospital's well-equipped OR by your experienced surgeon (who concurs), but the patient refuses.

Vignette #2

- Three months ago your mission hospital leadership had tense negotiations with local health authorities which led to an agreement to open your OR to local physicians for their use on a prn basis.
- Late one evening a local OB/GYN arrives at your hospital with a term primip in latent phase labor, requesting permission to perform an urgent C-section "since she is HPV-positive". A C-section has been planned throughout the pregnancy, and the OR at the OB-GYN's hospital is closed indefinitely due to maintenance issues.

Vignette #5

- You are working as the only physician at a recently-reopened district hospital located 10 hours by road from the nearest hospital, which is in the capital city. A 17-year-old male presents with classical findings of acute appendicitis. You have never done an appendectomy yourself, but first-assisted on 3 or 4 during a surgery rotation 2 years ago. Hospital staff state that they think there are scalpels, suture and instruments in the OR storeroom, and that the autoclave was working fine a few months ago.

Vignette #3

- A 43-year-old woman presents to the ER of your rural hospital in Ecuador after being involved in a motor vehicle accident in which she was the driver. She was wearing a seat belt and driving about 30 km/hr, and both vehicles had minimal damage. She has no complaints, sustained no injuries, and your physical exam is entirely normal. As you prepare to discharge her she states that she has some chest pain, and would like to be hospitalized.

Vignette #6

- A multiparous woman from a remote area presents to your hospital apparently at term after having been in labor for two days. She appears exhausted. Vital signs are normal, VE: 7 cm/0 station/80%, with clear fluid. FHR is 105 with minimal variability, and contractions occur every 2-3 minutes. You advise the woman that she may need a C-section, but she says she cannot have surgery without her husband's consent, and that he "should arrive soon". You give an IV fluid bolus, and adjust her position several times. One hour later her vaginal exam is unchanged. Her FHR is 100 with prolonged variable decels to the 50s-60s and no variability. Her husband has arrived, but refuses a C-section.

Vignette #4

- A woman in her early 20's presents to your mission hospital requesting a syphilis test. She says she was recently treated with more than 5 injections of IM penicillin. She has lab reports from a variety of hospitals showing several positive FTA-ABS tests and declining RPR titers over the past 2 months. HIV, HBSAg and GC tests have been negative. Her RPR is positive today, with a titer of 1:1.
- After you tell her that she does not need treatment now, she returns with her employer, who says that she cannot return to work at the brothel without a negative syphilis test, and requests that you write a letter to the ministry of health stating that her RPR test is negative.

Vignette #7

- A middle-aged man presents to your hospital (which is run by an American mission organization) with a 2-year history of a reducible inguinal hernia that becomes uncomfortable with manual labor. After being examined by your German surgeon he is sent to the administrator's office to schedule surgery. He is told that he must come up with $150 (half the cost of the surgery) before being admitted, and returns to the surgeon's office to plead his case. The surgeon storms into the administrator's office, irate that "this man is being denied care because he is poor."

Slide 17

MS1 Lancet, May 11, 2019

Maternal and perinatal mortality and complications associated with caesarean section in low-income and middle-income countries: a systematic review and meta-analysis

Soha Sobhy, et al
Manock, Stephen, 5/10/2019

MS2 Sub-Saharan Africa: 10.9/1000 mortality with C-section.
Manock, Stephen, 5/10/2019

MS3 1/4 of all women in LIMCs die from having a C-section.
Manock, Stephen, 5/10/2019

Vignette #8

- You are counseling a 38-year-old G6P5004 at 34 weeks on birth control options. She has had two previous C-sections, and the plan is to eventually perform a scheduled C-section for this delivery. She is interested in having a BTL done at that time. You ask the nurse in the outpatient clinic for a consent form, but she advises you that it cannot be signed today because the patient's husband is not present to co-sign.
- Surprised, you do a quick internet search and discover that the country you are working in passed a law 2 years ago that allows a woman to access birth control services (including surgical sterilization) without her husband's consent. You are appalled at the misogynistic hospital policy, and gear up for battle to get your patient the tubal ligation she deserves.

Conclusions

- Ethical challenges in the developing world often involve cross-cultural differences in values/beliefs/experiences.
- Mutual respect is an important principle to apply.
- Importance of physician humility/openness to learning/taking the long view

Vignette #9

- American Jehovah's Witness missionaries have recently made great strides in a town about 2 hours from your rural hospital. One morning one of these missionaries arrives with a young man who has had several episodes of hematemesis during the past two days. His vitals are normal and his hgb is 9.1. His abdomen is soft with minimal epigastric tenderness and no rebound. Stool is brownish-black and heme positive. You advise hospital admission for IV PPI administration, prompt upper endoscopy, and close monitoring, and warn that blood transfusion and/or surgery may eventually be required.
- At this point the missionary presents you with a pamphlet that describes how there are many other forms of treatment for anemia, making blood transfusion unnecessary in all situations. Looking to the missionary (who is offering to pay for treatment), the patient refuses any potential blood transfusion. The Jehovah's Witness missionary presses you to promise that transfusion will not be done under any circumstances.

Additional educational resources

- SUGAR: "Ethics Mini-Cases" sugarprep.org
- John Hopkins/Stanford University: "Ethical Challenges in Short-Term Global Health Training" ethicsandglobalhealth.org
- Doobay-Persaud et al. Practising beyond one's scope while working abroad. Lancet Glob Health. 2019 Aug;7(8):e1009-e1010.

Vignette #10

- You are working in labor and delivery at busy public tertiary care hospital in sub-Saharan Africa. The department has 3 OR's. One is used for urgent/emergent C-sections, one for GYN cases, and one for scheduled C-sections. It is common for 2-3 patients to be in the queue for an urgent C-section. Just prior to bringing a stable, non-laboring patient to the OR for a scheduled section, you learn that there is a woman with persistent fetal bradycardia. A C-section is underway in the urgent C-section OR. You instruct the OR nurse to substitute the emergent case for the scheduled case. The OR nurse informs you that this is against hospital policy, and that emergent cases are not to be done in the scheduled case OR.


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