

distaste, these types of reality TV shows epitomize the commodification of medicine, in which such programs act as infomercials for hospitals hoping to increase their market share in a health industry—the same hospitals that pay top administrators multimillion-dollar salaries, where physicians are now called “providers,” and patients are now called “clients” or “consumers.”

However, in 2015, the New York hospital was ordered to pay \$2.2 million in a settlement after it was alleged that the hospital violated the Health Insurance Portability and Accountability Act (HIPAA) rules by allowing the TV show “NY Med” to film patients without their consent (Schenker 2016). In 2016, the U.S. Department of Health and Human Services (DHHS) Office for Civil Rights determined that

health care providers cannot invite or allow media personnel, including film crews, into treatment or other areas or facilities where patients’ protected health information (PHI) will be accessible to the media, without prior written authorization from each individual who is or will be in the area or whose PHI otherwise will be accessible to the media. Only in very limited circumstances does the HIPAA privacy rule permit health care providers to disclose PHI to members of the media without prior authorization signed by the individual. (U.S. DHHS 2016)

The irony of the case report by Wardrobe and Reuber was that the broadcasting allowed recognition of a serious diagnostic error in an individual with a common condition. Perhaps this could be a public service. In our professional experience as pediatric neurologists, we frequently observe the misdiagnosis and harmful mismanagement of psychogenic nonepileptic seizures (PNES). Misdiagnosis is often the failure to distinguish PNES from epilepsy (and vice versa), but

also the misdiagnosis of both PNES and epilepsy from other conditions such as certain paroxysmal movement disorders (Takasaki, Diaz Stransky, and Miller 2016). Medical practice still requires a knowledgeable differential diagnosis—the thoughtful consideration of alternative diagnoses and their different etiologies. Imagine “reality TV” providing a follow-up fact check leading to truth and learning. Unfortunately, broadcast media portraying emotional distress and personal humiliation attract larger audiences than educational programming and well-researched documentaries. ■

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Global Health: Ethical Responsibilities of Health Service Volunteers

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In “Diagnosis by Documentary: Professional Responsibilities in Informal Encounters,” Wardrobe and Reuber (2016) discuss health workers’ professional responsibilities in informal encounters and explore the grounds upon which the claims of professional obligation are morally binding. To make the argument for action, they examine principles from both internalist and externalist approaches of moral responsibility, and apply them to a situation in which a clinician witnesses the likely misdiagnosis and mistreatment

of a long-term condition while watching a documentary film. They further note that this conception of learning virtue may have important ramifications for ethics and professionalism teaching in health care. Indeed, the instrumental virtue-ethical approach has cross-disciplinary importance, and can be applied to other informal settings as well (Leavitt, Peleg, and Peleg 2005). One such example is when volunteers travel abroad to provide health care but have no formal clinical training.

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THE RISE OF GLOBAL HEALTH EDUCATION AND HEALTH SERVICE VOLUNTEERS

The number of global health education and training programs has risen dramatically since 2000 (Matheson et al. 2014). Student demand for global health education is often cited as a key driver of program growth in U.S. universities from undergraduate to medical residency (Rowson et al. 2012). Nearly half of all global health curricula include field experience that involves traveling abroad. Although exact figures are elusive, it is estimated that more than 1 million Americans and Europeans volunteer outside their home country each year, and hundreds of thousands participate in health service trips (Lasker 2016). Despite these numbers, the medical professional associations in the United States and the United Kingdom have no specific recommendations regarding the training of these volunteers, to the best of my knowledge. As universities continue to develop and expand their global health programs, ethical questions are being raised about the training and experiences of these volunteers (Fu 2016). In response to these concerns, several groups have developed working papers and online training courses to help prepare volunteers before going abroad. For example, in 2010 the Working Group on Ethics Guidelines for Global Health Training (WEIGHT) drafted guidelines to help develop best practices for training programs in global health (Crump, Sugarman, and the Working Group on Ethics Guidelines for Global Health Training [WEIGHT] 2010). Because virtue-based understanding of professional responsibility comprises skills to be learned and is not a set of rules to be followed, however, expanded training methods in ethics are needed. Therefore, in addition to developing guidelines on ethics and best practices in these settings, academic institutions, trainees, and sponsors of field-based global health programs should consider adopting the methods advocated by Wardrope and Reuber (2016) when training health service volunteers about their moral responsibilities when traveling abroad.

THE INSTRUMENTAL VIRTUE-ETHICAL APPROACH AND ITS APPLICATION TO GLOBAL HEALTH TRAINING

The moral challenges described by Wardrope and Reuber (2016) are useful to global health educators and those who teach medical ethics for several reasons. First, they provide a useful framework for exploring what it means to be a professional, and under what circumstances one should act. Second, "Diagnosis by Documentary" is an entertaining case presentation that can be used in ethics training as a cross-discipline example. Finally, educators can apply the instrumental virtue-ethical approach to other informal medical situations (e.g., curbside diagnosis and global health) to help young professionals identify the ethical issues associated with a specific case, and to help them determine whether and when to act. One of the hallmarks of being a professional is knowing the limitations of one's

skills, when to act or not act, and when to seek assistance from others.

As discussed by Wardrope and Reuber (2016, 44), "The first moral challenge is simply to notice what is morally salient in the world around us, and how our interactions with it spread out to affect those around us." Applied to the issue of volunteers who travel abroad to provide health care but have no formal clinical training, the morally salient issues will depend upon several factors. Space limitations prohibit a full analysis here, but educators teaching ethics in the global health setting may want to consider the following points that are highlighted in the guidelines developed by the Working Group on Ethics Guidelines for Global Health Training (WEIGHT): "clarify[ing] the trainees' level of training and experience for the host institution so that appropriate activities are assigned to ensure that patient care and community well-being is not compromised"; "establish[ing] effective supervision and mentorship of trainees by the host and sending institution"; and "learn[ing] appropriate language skills relevant to the host's locale as well as the socio-cultural aspects of the host community" (Crump, Sugarman, the Working Group on Ethics Guidelines for Global Health Training [WEIGHT] 2010, 1180–1181).

Education about informed consent is particularly important for the training of global health workers. The right of patients to be informed about care decisions in clinical practice is under scrutiny around the world, and medical paternalism is giving way to a patient-centered standard (Spatz, Krumholz, and Moulton 2016). Patients receiving care in informal settings have a right to the same information about treatment options and their risks and benefits as patients in traditional medical practice. In the global health care setting, informed consent should be prospective and as robust as possible within the constraints of language and culture. Organizations sponsoring global health initiatives should provide training programs to educate volunteers about the need for informed consent, the nature of the informed consent process, and the underlying ethical reasoning.

Determining which activities volunteers can be allowed to participate in during their health service trip will depend on a range of factors. Although the WEIGHT guidelines make no direct mention of need for informed consent training, they contain language recommending that trainees "participate in the process of communicating to patients and the community about their level of training and experience so that appropriate activities are assigned and patient care and community well-being are not compromised" (Crump, Sugarman, the Working Group on Ethics Guidelines for Global Health Training [WEIGHT] 2010, 1180). This recommendation is appropriate, but much more is needed. One way to refine the WEIGHT guidelines would be to incorporate Wardrope and Reuber's (2016) instrumental virtue-ethical approach into education and training programs by using insights from both internalist (e.g., virtue ethics, care ethics) and externalist accounts (e.g., social contract) to engage with volunteers about their professional responsibilities.

This mixed approach may help volunteers better understand their responsibilities to the individual, the sponsoring agency, and the host community they are serving. By engaging in a process of reflective deliberation, educators can explore professional responsibilities and examine the potential benefits and risks to all the parties involved, including trainees, patients, and the community in host countries. Finally, in addition to refining and extending the WEIGHT guidelines, educators can measure the effectiveness of ethics training programs on volunteers through the systematic collection, evaluation, and publication of data.

Organizations and sponsors of global health care programs should develop a robust process of informed consent, and volunteers who are interested in ethical issues can assist with their implementation onsite. In keeping with recent policy efforts to encourage shared decision making, volunteers on health service trips abroad can help in providing information to patients—for example, using patient decision aids such as illustrations and charts, when appropriate (Stacey et al. 2014). Such strategies are improvements over many current informed consent procedures in the United States because they incorporate elements of what a reasonable patient would deem important (Spatz, Krumholz, and Moulton 2016, 2063). They also provide opportunities for patients to share any concerns that may be specific to local custom or practice and to reflect on their preferences, values, and goals.

CONCLUSION

Sound ethics training programs should help prepare volunteers for their experiences abroad and introduce a range of issues they may confront. Case presentations and training material should help volunteers know the limits of their expertise, and help them feel empowered to act (or not) in appropriate situations. The internalist and externalist accounts of professional responsibility discussed by Wardrobe and Reuber (2016) may provide an approach that can be used by educators and organizers of these medical missions to explore the salient ethical issues with volunteers, and teach them how best to respond to situations that lie outside their level of training. This approach may help incorporate ethical discussions into best practice standards for volunteers who serve in global health programs and lack formal clinical training.

ACKNOWLEDGMENTS

I am grateful to Dr. Robert M. Sade for his comments on an earlier draft of this commentary. ■

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