

## Ethical dilemmas encountered while operating and teaching in a developing country

Mark Bernstein, MD, MHSc

One can't argue with the goodness of an act of medical philanthropy, whether it be *pro bono* work for 1 uninsured patient or larger-scale efforts like doctors and other health care workers from developed countries volunteering time and losing income to help patients and doctors in the less fortunate developing world. The highest-profile example of the latter is Médecins Sans Frontières (Doctors Without Borders), which won the 1999 Nobel Peace Prize for its admirable work.

When busy surgeons become involved a long way from the relative comfort of their practice in the more industrialized world, effects can be dramatic for the patients, surgeons and trainees in less privileged settings. Yet there may be hidden difficulties and, at minimum, ethical dilemmas encountered along the way.

Recently I spent a month working in a developing country. I went to an Asian city with a large residency program in neurosurgery based at the main teaching and public hospital. With 40 residents and only 4 surgeons, they had a strong need for a committed teacher as well as a neurosurgeon with expertise. It was a fabulous and incredibly rewarding experience, and I plan to do it 1 month every year for the rest of my career.

Nevertheless, in the course of all

the good I felt I was able to do for patients and for the staff and residents, I encountered many situations that gave me moral angst, which on further reflection were ethical dilemmas exemplifying breaches of classic ethical theories and principles. Rather than the ethical issues inherent to health care delivery in the developing world, I focus herein on the ethical dilemmas visited upon the visitor by simple virtue of his or her presence. This series of observations is certainly not exhaustive, but rather a sampling of the many thorny issues that can arise.

### False advertising

A common situation was that of being introduced inaccurately by my well-meaning hosts. "This is Dr. Mark from Canada, an expert in..."—by the time my month was over, I had been introduced as an expert in almost every subspecialty area of neurosurgery! My actual areas of focused expertise had, of course, been communicated to my hosts in advance. Misrepresentations like this violated Kantian deontology, to say the least.

My hosts had a true desire to help patients, but they also had 2 ulterior motives for building confidence in patients and their families so surgery would proceed: to learn more about how to do surgeries they were not

comfortable with, and to be able to take a case they could not otherwise have handled—thus incurring financial gain, as most patients had no health-care insurance and paid the surgeon directly for any operation.

The medically and morally awkward situations this put me into were exemplified on my very first day. A case of complex intracranial aneurysm confronted me with this ethical question: "Shall I operate to repair the aneurysm, recognizing that (in this era of subspecialization) this is not one of my areas of prime expertise, and which I could not do as well as some of my colleagues back home who focus in this area? If I don't operate, the patient has no chance to survive, or else the family will incur a huge financial loss to send her abroad. If I do the operation locally, her chances are reasonable."

It was like an orthopedic surgeon who specializes in shoulder repairs being asked to do a lumbar decompression and fusion, or a plastic surgeon specializing in burn repair being asked to operate on a complex cleft lip. Such issues would be even more pronounced for surgeons working in academic health sciences centres who tend to subspecialize and for more senior surgeons who are further removed from their generic residency training and early years of practice.

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Division of Neurosurgery, Toronto Western Hospital, University of Toronto, Toronto, Ont.

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**Correspondence to:** Dr. Mark Bernstein, Division of Neurosurgery, Toronto Western Hospital, 399 Bathurst St. 4W451, Toronto ON M5T 2S8; fax 416 603-5298; mark.bernstein@uhn.on.ca

Being falsely advertised is unethical not only because it is dishonest, but also because it creates false expectations in vulnerable patients. In North America, we no longer even introduce medical students as “Dr.” or “a young doctor” for fear of misrepresenting them to the patient. “A neurosurgeon from Canada” was how I introduced myself when given the chance and how I should have been introduced. I often reminded my hosts of my areas of expertise, hoping it would not happen again.

### Settling for second-best

Another situation that caused me medical and moral unease almost daily was performing surgery with equipment and assistance so inferior to that back at my Toronto hospital that it simply felt “wrong” to do it, knowing that I would very likely perform an operation inferior to what I knew I was capable of. But I knew in advance this would happen and had to accept that “second best” was superior to the alternative for these patients. My ethical justification in these cases was utilitarian: I judged that my performing the surgery would bring about the greatest good for the greatest number of people.

### Accepting local priorities

Elsewhere more than at home, heart-wrenching situations can arise simply in the realm of priority setting or resource allocation. Many situations arose where I could have improved an outcome with an expenditure of money—while undermining the system in place and putting an unfair burden of responsibility for the future onto my neurosurgical hosts.

One example will illustrate. A teenage girl fell off a motorcycle and was becoming comatose with the typical clinical picture of an epidural hematoma, easily diagnosed with computed tomography and easily cured with an operation having excellent prognosis. Even at the public

hospital, people had to pay for most tests; her family could not pay for CT imaging, and the patient died over the next several hours. In Toronto, she would have been walking out of a hospital 3 days later.

I was tempted to offer to pay for the CT imaging, but realized that doing this a few times during my stay wouldn't change the big picture and would undermine the local neurosurgeons. The system had to be forced to change, to become more humane so that hospitals would absorb the costs of treating such patients. I couldn't cure the problems of inadequate social programs in a developing country by opening my wallet for a month.

### Impersonalizing patients

Other commonplace examples of behaviour disrespectful to patients that breaches most of our bioethical codes included inadequate follow-up and lack of personal interaction with patients who had undergone surgery.

In the operating room at home, when a resident has failed to meet and examine a patient preoperatively, I gently invite him or her to leave and not scrub, saying “If it was your mother undergoing surgery, would you want her brain tumour removed by someone who had never made eye contact with her?” They always seem to understand and appreciate this, and it seldom happens now.

But I frequently found myself being picked up at my hotel in the evening by a resident and whisked off to one of the private hospitals to scrub and help the staff and residents remove, for example, a spinal cord tumour on a patient whose laminectomy had already been performed. So I effectively ended up violating a personal rule that I impose upon others and that I hold dear.

In these and other cases, I seldom was able to see patients postoperatively, which would be considered poor medicine and disrespectful behaviour back home. When I specifically asked to see a patient, my hosts

were very obliging about driving me to the various hospitals. But when I could not see patients, simple principles of respect and beneficence were not being well served, and I was left feeling uneasy.

### Surgical teaching issues

Other ethical dilemmas arose in the area of teaching. Like many surgeons back home who work in teaching hospitals, I allow residents to operate under my supervision as long as they are doing as well as I feel I could in their place; I scrub only when I am needed. But surgical education is less advanced in developing countries. My hosts often asked me to scrub and just do the procedure while the residents watched rather than helping them to do it themselves, which would take much longer and, in my hosts' view, might result in a poorer outcome. This was held to be particularly important when it involved a private patient.

Perhaps my hosts felt that techniques could be learned adequately by observation, but I felt morally obliged to help empower the young residents with first-hand experience. On a few occasions I had to respectfully disagree with my hosts. Fortunately, our relationship was friendly and they were gracious enough to tolerate my way of doing things.

Another teaching-related issue was whether North American techniques could be translated in good conscience to the developing-world setting. I usually try to stimulate my residents to “think outside the box,” but this may be inappropriate in the developing world, at least in certain situations.

For example, one can teach residents that conservative therapy is a treatment option that must always be considered by surgeons and one that often works. But can one expect local doctors to treat conservatively a patient who is clinically tolerating a sizable blood clot on his brain from trauma when one knows the nursing

is inadequate to recognize when and if the patient deteriorates, requiring urgent surgery? In other words, if surgery is not used as the first line of treatment, the patient may ultimately suffer, even though in our medical microcosm in the developed world such a patient could be well monitored in an intensive care unit by experienced nurses and perhaps saved surgical intervention.

### Concluding thoughts

In the course of my month in a developing country, I learned how many ethical dilemmas can arise. Some of my formal lectures to the staff and residents were on ethical issues like medical error and its disclosure. But I believe we can expose our colleagues less formally, day-to-day on the job, to the bioethical principles that we have developed and practise.

I do not imply that health care professionals in the developed world are more ethical than elsewhere, but our opportunities to think about and attend to bioethical issues are much more generous than in developing countries. I will close with one con-

crete example of teaching bedside bioethics.

One day a patient came to one of the private hospitals with a complex neurosurgical problem. Although the hospital was handsomely appointed, its surgical equipment was ironically the poorest in town, including by far the worst operating microscope. A young staff neurosurgeon was operating on the patient the next day and asked me to help, meaning that the bulk of the responsibility of getting this patient through the difficult surgery would fall to me.

I felt the patient's chances would be far better at the public hospital, which at least had a decent operating microscope. However, I realized that for my host this would produce a complicated negotiation with the administration of the private hospital as well as causing him to lose some income, since the surgical fee at the public hospital would be less than at the private hospital. But I insisted, explaining that if the patient were not transferred to the public hospital I could not morally agree to help him with the operation.

It was a coercive tactic. The surgeon ultimately did transfer the pa-

tient, who had a successful operation and a good outcome. My relationship with the neurosurgeon was possibly strengthened; the residents learned an important lesson about being strong advocates for their patients; and the patient had the best care available.

Being able to muse about ethics is still a relative luxury to health care workers in developing countries. These men and women are dedicated people working under difficult circumstances that we almost never experience. Yet I found them very open to different ideas, even requesting a parting lecture on "Ways of Improving Neurosurgery Here" and responding very graciously to my forthright comments.

During my month I came to realize how ordinary ethical dilemmas can take a very different shape in the developing world. When working with our peers in other countries, we should remain alert to the challenges. By being ever prepared to try to "role-model" our values, we can fulfill many opportunities to teach important lessons—lessons beyond the science and art of surgery.

**Competing interests:** None declared.

## LE PRIX MACLEAN-MUELLER

### À l'attention des résidents et des directeurs des départements de chirurgie

Le *Journal canadien de chirurgie* offre chaque année un prix de 1000 \$ pour le meilleur manuscrit rédigé par un résident ou un fellow canadien d'un programme de spécialité qui n'a pas terminé sa formation ou n'a pas accepté de poste d'enseignant. Le manuscrit primé au cours d'une année civile sera publié dans un des premiers numéros de l'année suivante et les autres manuscrits jugés publiables pourront paraître dans un numéro ultérieur du Journal.

Le résident devrait être le principal auteur du manuscrit, qui ne doit pas avoir été présenté ou publié ailleurs. Il faut le soumettre au *Journal canadien de chirurgie* au plus tard le 1<sup>er</sup> octobre, à l'attention du Dr J.P. Waddell, corédacteur, *Journal canadien de chirurgie*, Division of Orthopædic Surgery, St. Michael's Hospital, 30 Bond St., Toronto (Ontario) MTB 1W8.

