Editorials

Boost or burden?

Issues posed by short placements in resource-poor settings

BACKGROUND

An estimated 40% of medical students seek out experiences working in resource-poor settings during their training and significant numbers also contribute after graduation.[1] It is argued that this benefits their hosts and, some believe, the UK too.[2,3] In this issue Elnawawy *et al* report on the complex issues identified through qualitative study of one such voluntary primary care scheme in Nepal.[4] Despite a small number of respondents from a single non-governmental organisation in one country, these interviews highlight a number of important issues that chime strongly with our experiences, including the risk of significant unanticipated negative impacts. We argue that elective students, doctors seeking out-of-programme experiences, and experienced GPs should be encouraged to deeply consider what they are hoping to achieve, and how they can ensure their contributions are positive, both for themselves and their hosts. 'Donor' organisations facilitating placements (including medical schools and deaneries) should also plan, prepare volunteers, and carefully consider contextual issues as part of their responsibility.

Elnawawy *et al* offer few specific solutions, so in this editorial we seek to increase awareness among medics wanting to work in resource-poor settings and argue for more considered models. Collectively we have witnessed highly-effective, positive outcomes as well as poorly conceived and misguided visits. We discuss some of these and conclude that there should be more organised 'fair trade' type opportunities, perhaps including a 'kite-mark' system to improve standards or to be in line with the efforts of the Tropical Health and Education Trust (http://www.thet.org).

CLINICAL

Elective hosts report that even senior students can make a welcome contribution to clinical service delivery provided they stay for 6 weeks or more in one area, can be supervised adequately, and communicate without utilising key staff time. Postgraduate placements can more obviously contribute to service delivery, but still require effective engagement with service providers or risk negative consequences. For example, naïve or overly enthusiastic attempts to help can disrupt existing systems, waste scarce resources, and even compromise services. In particular, ill-conceived short-term surgical missions have been seen to exhaust sterile supplies and leave wards overflowing to such an extent that emergency capacity is depleted. However, other examples with close local collaboration have shown positive effects. In Sierra Leone there is no reconstructive surgery but huge post war demand. A UK charity, ReSurge Africa trains and educates Sierra Leonean staff aiming to develop a self-sustaining reconstructive service. The commitment involves surgical/training missions and overseas education. We are also aware that a number of doctors make annual visits of 4–6 weeks to Malawi. Knowing the host site, volunteers can settle swiftly and their contribution will typically be used to free up local staff to pursue other initiatives. Such arrangements require close collaboration plus intermittent local oversight, so continuity of care is maintained.

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EDUCATIONAL

Most returnees are clear that they have personally learned far more than they left behind, but appropriately delivered education or staff training has a potential impact beyond direct care and elective students can help here too. Unexpected learning in both directions is common and attitudinal or professional behaviour, the 'how' rather than the 'what is done', can be very powerful. For instance sharing differences in working practices, such as 'named clinician' boards, and students can be buddied with local clinical officers or nursing students, who translate and facilitate patient interactions while learning examination skills in exchange.

It is difficult to deliver training in a poorly-resourced environment and postgraduates will often find themselves teaching informally 'on the job'. Support for local tutors cannot be underestimated and adequate preparation in the challenges of education may be important too. For example PowerPoint® is obsolete without reliable power or a projector. Students have limited access to textbooks or other resources and learning is often very 'traditional'. College lecturers in Sierra Leone dictate while students copy and classes of over 100 bring challenges; creativity, flexibility, and passion are necessary attributes for a volunteer. Adapting teaching methods is a necessary skill but preparing and gathering resources in advance can help; role play or 'skit' can depict clinical scenarios very effectively.

In Malawi one unit holds weekly educational meetings for all clinical and nursing staff to which visiting doctors are invited to give short presentations, which can be very valuable. The sessions aim to improve knowledge and skills as well as sharing experiences and can help take some pressure off senior local staff. But it must be a relevant topic at a suitable level.

ETHICS

Ethical issues in resource-poor clinical settings can be very difficult and all volunteers can expect to meet considerable

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challenges.[5] However, if cultural sensitivity has any credence it is surely that societies are entitled to create their own customs and practice. So expecting to work within local norms is essential. Challenges might include sex bias, and women can find it more difficult to contribute their views equally. Corruption can also be the norm; students might bribe lecturers, patients might expect to do the same as standard. This may drive the local health care economy and if, when, and how a visitor challenges these is a delicate matter. Leading by example with consistency and perseverance can be successful ways to improve practice but dealing with issues such as these practically and emotionally requires preparation and self-awareness. Coping with uncertainty is core to the experience but sound preparation reaps rewards. Appropriate clinical competences should be considered and in place.[6]

Resources are also a major problem for hospitals and will always be a potential ethical issue, 'transaction costs', using up the sterile gloves or even arriving bearing gifts can create issues. Communication between the volunteers (or organisers) and the host partner is vital; misinterpretations can leave lasting bad feeling affecting other volunteers and placements. Even donations of expired drugs or outdated medical books may be well intended but can be unhelpful, cause offense or even harm.[5,6]

CONCLUSION

Host units generally appreciate and value visits from western staff and students, otherwise they would not accept them. However they can clearly be a mixed blessing and factors such as associated funding, the hope that some will eventually return to work there in the future, or even an element of moral support for isolated ex-patriot staff may be at play. Sending organisations have a responsibility to formulate goals for both hosts and volunteers, aid preparation, provide support, and measure the outcomes, both good and bad.

So, if interested, how might you try to ensure that you support or choose more responsible placements? We suggest you:

- try to choose an organised placement through known frameworks rather than 'do-it-yourself' (see http://www.thet.org);
- the longer the placement the better;
- consider your objectives and motives thoroughly and prepare well (for example, take time to speak to previous volunteers and learn about the placement);
- remember the placement should not primarily be about you, show respect and cultural sensitivity by fitting in; and
- approach the placement with a sense of humility, you may discover better ways of doing things, even with limited resources.

Overall the majority of volunteer placements are highly positive for the individual concerned, and welcomed by host sites. The bottom line here is whether you become more of a boost or a burden ... and that is largely within your control.

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Provenance
Commissioned; not externally peer reviewed.

DOI: 10.3399/bjgp14X679945

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