

MEDICAL ETHICS**A Wolf in Sheep's Clothing? A Closer Look at Medical Tourism**

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ABSTRACT

In this era of global travel, Western health care workers have seized the opportunity to combine travel with seemingly exotic work opportunities. This has led to an explosion of medical tourism, consisting of short-term medical work in countries of the global South. Though the intentions of those engaging in such work are undoubtedly laudable, important limitations persist: lack of relevant knowledge on the part of the Western care providers; the potential for medical tourism to take the form of neo-colonialism; the potential for this work to potentiate inequality; and, the possibility that this work can actually harm those it sets out to help. Despite these limitations, this paper argues that these concerns are not sufficient to justify indifference toward the problems of the global South, and that there are tactics to allow for more responsible engagement with the global South. These include a mindset attuned to global inequities and the power gradients between the North and South, the acquisition of locally relevant and transferable knowledge and skills, and the development of a multidisciplinary global consciousness, in which the macro-scale forces affecting health are considered so that inequity can be addressed and redressed.

As the speed of globalization accelerates, the blurring of transnational boundaries has made worldwide travel more accessible than ever to the affluent populace. Previously untouched territories now top the list of fashionable places to visit, and health care workers have seized the opportunity to combine this travel with seemingly exotic work opportunities. The result has been an explosion of 'medical tourism', in which Western health care workers provide short-term medical work in countries of the global South. This work typically takes the form of consultant, relief or aid work in volunteer health programs, government agencies, or non-governmental organizations (NGOs). Medical students make up a significant proportion of those interested in medical tourism – through various elective programs – and for many students, these electives are often the gateway to future careers in international health. This article will discuss the issues surrounding medical tourism, and provide a framework through which one's motivations, appropriateness, and preparedness for such an endeavour can be ascertained.

MEDICAL TOURISM: HELPFUL AID, BENIGN INTERVENTION OR HARMFUL EXPLOITATION?

It is always difficult to objectively critique humanitarian or aid work, a category into which medical tourism often

falls. The difficulty lies within the prevailing notion that this work is just that – humanitarian – and that any criticism is unjustified, offensive, and is a direct attack to those with a "desire to serve fellow humans",¹ who sacrifice "'holiday' in order to offer their services."² Indeed, organizations such as 1999 Nobel Peace Laureate *Médecins Sans Frontières* (MSF) have done remarkable work in addressing the needs of those in crisis, and have been instrumental in expanding access to essential medicines for countries of the South. But while beneficence underpins the work of most global health workers, important limitations persist.

Medical tourists don't necessarily have relevant knowledge

Like any medical specialty, global health work requires a certain level of experience and training before one is able to make a meaningful contribution. The mere possession of Western training or a Western medical degree does not automatically confer upon someone the requisite skills required to practice useful – or even *safe* – medicine in another country. An epidemic occurring in Rwanda during the beginnings of the genocide provides a striking example of this. In 1994, civil conflict between Hutu and Tutsi tribes in Rwanda led to the deaths of almost one million people, and resulted in the migration of an estimated two million Hutu people to sur-

rounding countries, including areas around Goma, Zaire (now the Democratic Republic of the Congo).³ Inadequate sanitation and low water supplies quickly resulted in an epidemic of cholera and the response to this epidemic from the international community came primarily from United Nations agencies, NGOs, and military forces.⁴ Between mid-July to mid-August 1994, estimates placed the death rate in Goma between 6% to 10% of the refugee population, averaging a crude mortality rate of 20-35 per 10 000 per day, with the highest fatality rate for a single day reaching 48%.³⁻⁵

According to Siddique, with the developments that have occurred in rehydration therapy over the last three decades, the fatality rate of cholera “can be and should be 2% or less, whether in a sophisticated urban hospital or in a makeshift treatment centre in a rural area.”⁶ To illustrate this point, he cites the example of the 1971 cholera epidemic among Bangladeshi refugees in India, where conditions were worse than those in Goma, but where the mortality rate was less than 2%. Overall, the authors reporting on the Goma epidemic suggest that the death rates remained higher than they should have been, and argue that the reason for this could be attributed to a lack of expertise among health workers – particularly those from the West – in rehydration skills. Inappropriate use of intravenous fluids (e.g. hypotonic solutions) and equipment (e.g. needle gauges that were too small), as well as a lack of hydration-status follow-up were named as specific problematic issues. In fact, at the time of the epidemic, stories were circulating about one American physician who started an intravenous drip on someone in one of the temporary camps, then could not find the hut when he returned to check on the patient. Though it is plausible to assume that local health workers from crisis-affected areas can adjust to changes in disease patterns given their knowledge and understanding of the local context, the same cannot be assumed about – or expected from – an international aid worker. The latter may face an insurmountable task in trying to provide assistance in an unknown, highly disorganized, and constantly changing environment.

Medical tourism may be a form of neocolonialism

One danger inherent in global health work is its potential to become a forum in which the ‘helper’ engages in activities characterized by colonialist traits: hierarchical, top-down approaches to problems, no sharing of resources, and exploitation. While undertaking an HIV research project in Burkina Faso, West Africa, I stated to a psychologist staffing one of the HIV clinics that the project I was undertaking felt tantamount to neocolonialism, since I was collecting vast amounts of data to bring back to Canada, but did not feel as though there was any contribution being made to the community. The psychologist humbled me by readily agreeing.

Herein lies the crux of the ideological problem with medical tourism, as well as – arguably – the easiest point to overlook. When someone visits another country and encounters death, poverty and sickness, there is invariably a desire to do “anything to help.” This desire to help certainly explains why Western physicians visiting the global South often feel that whatever aid they provide constitutes a meaningful, lasting contribution. In her article, Scarisbrick – herself a Western physician working in Ghana – describes this as “the arrogant way of the West”, citing examples of physicians arriving at her hospital and disrupting wards, then expecting a warm reception and leaving “confused and resentful” when they do not receive it.² This example makes obvious the colonial nature of Western physicians taking ownership of the situations in which they find themselves when overseas.

Another example involves a South African surgeon that I met at a recent international health conference. This surgeon recounted how every summer, a group of European surgeons arrives at his hospital, displaces the local surgeons from the operating rooms, and for essentially a period of two weeks, the OR is off-limits to the local surgeons. Further, after a full day of surgery, the European doctors would retire to their hotel, do some local sightseeing, and actually refused a request from the local health care staff to do some teaching around various surgical skills that were unfamiliar to many. This last example demonstrates many hallmarks of colonialism: foreigners coming in and ‘taking over’, with no instances of knowledge sharing, no connections with the local people and no attempts at long-term partnerships. Anger and resentment on the part of this South African surgeon are certainly justified, as this example epitomizes the ‘medical tour’ as a self-serving holiday.

Medical tourism can disrupt the local dynamic and potentiate inequality

Medical tourists often introduce new health services into a previously underserved area. Despite these good intentions, the broader impacts of such actions are often not considered. The availability of new services in an area of need instantly creates new categories of ‘haves’ and ‘have-nots’, which may potentiate inequality. This phenomenon has been well described in the analogous literature about refugee camps. In describing the experience of a long-time MSF volunteer in a refugee camp in Zaire, one article describes how a proposed, MSF-sponsored meningitis vaccination for Burundian refugees upset some of the local Zairian community leaders.⁷ It is well-documented that aid provided in internationally-sanctioned refugee camps is often superior to the standard of service provision and access to health care in local, neighbouring communities.^{8,9} For this reason, the very structure and organization of refugee camps has come into question, and some propose that limits be imposed on the allowed time for which a refugee camp be allowed to

operate, in an attempt to minimize its effects on the local dynamic.^{8,9} Although international aid agencies providing care in established refugee camps hardly constitute an example of medical tourism, the analogy to foreign medical teams ‘parachuting in’ to a region and potentiating inequality is clear.

Medical tourism can worsen the health of those it sets out to ‘help’

In some cases, medical tourism will consist of benign or neutral interventions that could be considered harmless at best. Yet, examples abound of specific instances where one’s ‘helpful’ actions have unintentionally detrimental results. One report tells the story of an American physician vacationing in Nepal, who came across a person with what seemed to be tertiary syphilis, carrying a bottle of amoxicillin from a pharmacy in New Jersey.¹⁰ Another describes “trekking doctors” in the Nepalese Himalayas, who set up ad-hoc, trailside clinics. In these cases, the authors point out the danger of these short-term, single consultations, which often involve the administration of short-course antibiotic treatment, potentially propagating drug resistance in endemic pathogens, notably tuberculosis.¹¹ Moreover, these “trekking doctors” provide health care in such a way (e.g. no documentation, single-dose therapies) that does not allow for any patient follow-up or any long-term monitoring of treatment response. This leaves the local caregivers with the formidable task of picking up the pieces once these physicians depart, usually with no idea of what has already been done or attempted with the patients in question.

ENGAGING WITH COUNTRIES OF THE GLOBAL SOUTH: A CHECKLIST

An engagement with the international community, be it in the capacity of physician, medical student, or other professional, requires a clear understanding of the potential impact of our actions on the community served, as outlined above. Yet, it would be quite easy – based on the preceding discussion – to discount any role for Westerners in global health work. However, it is important here to distinguish medical tourism as a negative entity, from responsible global health work. From the privileged position one finds oneself in the Northern hemisphere, there is much that can be done to address the problems of the South.

Having the appropriate mindset

Like any field of medicine, global health work requires training in order to acquire the relevant skill-set and level of experience that translates into meaningful contributions. Being aware of one’s own motivations for engaging in such work, as well as the limitations of one’s knowledge, are fundamental steps in critically reflecting on one’s appropriateness for global health work.

Though good intentions are important, they are by no means sufficient. In his seminal work, *Pedagogy of the Oppressed*, Paulo Freire reminds us of why good intentions are not enough, by warning of the dangers of ‘false charity’: “...[i]n order to have the continued opportunity to express their ‘generosity’, the oppressors must perpetuate injustice as well. An unjust social order is the permanent fount of this ‘generosity’, which is nourished by death, despair and poverty.”¹² Freire argues that the very act of giving may betray an oppressive mindset, since any form of charity necessarily presupposes an unequal social order. One could not ‘give’ if there were not already people who ‘need’ us to ‘give’ to them. This is an interesting example in that the implied mode of analysis is a direct attack on how many of us view aid work both locally and abroad. Though not problematic in what the person in question is doing, this example argues the point that the problem lies with the mentality and the approach. Taken to the extreme, this argument may seem defeatist: if any act of helping may be misinterpreted as oppressive and patronizing, then why bother trying at all? Perhaps Freire’s words are best taken as a reminder that health care workers must approach their work with a clear understanding of the inherent power gradients between themselves and their patients. High quality care necessitates a mindset attuned to social injustice and requires constant efforts to address and redress inequality.

Learning locally relevant information

Global health work requires building partnerships, promoting local capacity and developing positive, productive relationships with the local people – processes that can take years to develop. Learning about the country and the community beforehand, including the local language, local health problems as well as the systems of traditional and ‘introduced care’¹³ are important steps. Reliance on local expertise for guidance is another critical factor. Too often, visitors adopt the patronizing attitude that foreign experts know better than local leaders. An initiative by a German NGO in Rwanda provides a good example of the importance of relationship-building and long-term involvement.¹⁴ During the Rwandan crisis in 1994, the NGO, *Care Germany*, sent a team of 250 personnel – many of whom had no training in international health work or tropical medicine – to Rwanda for a two-week ‘assignment’. About 40 of them were forced to return before their short time was up, for reasons cited by *Care* as “organisational difficulties.”

From a more pragmatic standpoint, this example, as well as the refugee cholera epidemic example cited earlier, highlights the importance of the acquisition by global health workers of locally relevant “hard” skills. Armed with a toolkit of chronic disease management and the latest in digital imaging techniques, physicians from the West are often ill-equipped to deal with common scourges of the global

South. To cite the above Rwandan example again, an unacceptably high case fatality rate from diarrheal disease in the Rwandan refugees was attributed to a lack of coordination and relevant knowledge on the part of the aid organizations.^{3,4,6} The importance of locally-relevant, practical knowledge acquisition is again made glaringly obvious by an example cited by Siddique: in a community-run temporary treatment centre, run by volunteers who had received two weeks of specific practical training, a case fatality rate of less than 1% was achieved during a cholera epidemic.⁶

Developing a multidisciplinary global consciousness

In reflecting on the lives of those living in the global South, it becomes clear that there is a need to identify and address the broader determinants of health, including the political, economic, and social factors at work in making the individual ill. In essence, one must uncover linkages between seemingly unrelated phenomena.

It has long been argued that inequity is one of the key determinants of health. Not surprisingly then, diseases settle on the poor of the global South because they are often forced to live a life marked by inequity; forced to endure hunger, sickness, famine, violence, and political instability. In an ethnographic account of AIDS in Haiti,¹⁵ for instance, medical anthropologist Paul Farmer describes the example of 'Anita', a young HIV-positive girl. Formerly, her family's homestead – and livelihood – was located on fertile land adjacent to a stream. Several years ago, the completion of a dam flooded the valley where Anita lived with her family, causing the family to plunge deeper into poverty. Shortly thereafter, Anita's mother died, and this event, coupled with the mounting poverty and rising tensions at home eventually forced the young girl to flee to the Haitian capital, Port-au-Prince. Once in the city, a completely impoverished and homeless Anita found refuge in the homes of various strangers in the city's slums, eventually securing meagre employment in the informal market economy.

At fifteen, Anita met a man named Vincent, "one of the few men in the neighborhood with anything resembling a job", and began a relationship with him.¹⁵ The two were together for a few months, until Vincent began to exhibit signs of wasting. Shortly after nursing him through, and watching him die of AIDS-related complications, Anita fell ill herself, and died. Stories such as these demonstrate not only how HIV infection impacts negatively on human health, but also how HIV and other diseases spread along the fault-lines of society. With no choice but to leave home, Anita was essentially forced into a sexual union by poverty. She was predisposed to HIV infection and all its attendant socio-economic disadvantages because of her gender, her poverty, her social status, and her country's place in the political economy of the Americas. Digging deeper and

attempting to uncover the linkages in this example, it is clear that there is far more to the story than the pathogenesis of HIV, and that this woman's illnesses are due to forces far greater and far more global than any retrovirus.

Unravelling the socio-economic context of every patient one sees, and of every community one visits as a global health worker, permits a more insightful understanding of the ethical responsibility of addressing gross inequities. Dissecting out these macro-level forces does not preclude the more pragmatic work of treating patients' suffering and providing health care, but an informed global consciousness is a prerequisite for any enduring career in effective and responsible global health work.

A FINAL WORD

Medical tourism, as a twenty-first century reality on the global health scene, seems to be an increasingly frequent occurrence. Though the intentions of those engaging in such work are perhaps laudable for the most part, a common criticism of medical tourism is that it can become dangerous if its limitations and potential problems are not recognized and addressed. As the above discussion has implied, a vital element of doing this involves a keen awareness of one's limitations and the inherent potential for harm in global health work. Just as applicable to global health work as to any field of medicine is the Hippocratic ideology *primum non nocere* – first, do no harm. But does the responsibility of doing no harm preclude one's responsibility as health care providers in a rapidly globalizing society of addressing the scourges of the global South?

Certainly, rationalizing indifference by invoking the potential problems must not be used to placate Western apathy in responding to the health problems of the global South. The medical and social science literatures are awash with evidence that globalization should be galvanizing everyone to locally and globally relevant action, and awakening a collective sense of global citizenship. Part of this calling includes a dedication to what amounts to responsible global health work, characterized by a number of things mentioned above. Possessing a mindset attuned to the problems inherent in aid, as well as having an appreciation for the acquisition of locally relevant information are critical first steps. Further, an acceptance that one's 'Western' skills and knowledge may not be transferable, and the development of a multidisciplinary global consciousness that recognizes inequity as a key determinant of health are essential as well. The fact remains that the West is never divorced from any of the world's problems, and, in the absence of a 'magic bullet', these problems will continue to devastate populations. Clearly, the Western world is not – and *cannot* – be absent from the list of players working toward a solution. †

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REFERENCES

1. Lluberas, G. (2001). "Letter to the Editor." *Wilderness and Environmental Medicine*. 12: 63.
2. Scarisbrick G. (2002). "Medical tourism should be banned." *British Medical Journal*. 324(7328): 7S.
3. Goma Epidemiology Group. (1995). "Public health impact of Rwandan refugee crisis: what happened in Goma, Zaire, in July, 1994?" *The Lancet*. 345: 339-344.
4. Siddique AK, Salam A, Islam MS, et al. (1995). "Why treatment centres failed to prevent cholera deaths among Rwandan refugees in Goma, Zaire." *The Lancet*. 345: 359-361.
5. Boelart M, Suetens C, van Soest, M, et al. (1995). "Cholera treatment in Goma (Letter)." *The Lancet*. 345: 1567.
6. Siddique AK. (1995). "Failure of treatment centres to prevent cholera deaths in Goma (Letter)." *The Lancet*. 346: 379.
7. Lavery J. (1993). "A Canadian doctor in Zaire." *Canadian Medical Association Journal*. 149(4): 474-476.
8. Harrell-Bond BE. (1990). "Deployed Like Chessmen: Spontaneously Settled Refugees in Southern Sudan." In: *Refugee or Asylum? A Choice for Canada*, Adelman A and Lanphier CM (eds). York Lanes Press: Toronto, pp. 123-149.
9. Harrell-Bond BE. (1986). *Imposing Aid: Emergency Assistance to Refugees*. Oxford University Press: Oxford.
10. Ripley, RG. (2000). "Required reading (Rapid response)." *British Medical Journal*. Retrieved 12 February 2003, from the World Wide Web: <http://www.bmj.com/cgi/eletters/320/7240/1017#7527>.
11. Bishop RA and Litch JA. "Medical tourism can do harm." *British Medical Journal*. 320(7240): 1017.
12. Freire P. (1970). *Pedagogy of the Oppressed*. Continuum: New York.
13. Bezruchka S. (2000). "Medical tourism as medical harm to the third world: Why? For whom? (Editorial)." *Wilderness and Environmental Medicine*. 11: 77-78.
14. Tuffs, A. (1994). "Rwanda aid wrangle." *The Lancet*. 344: 676.
15. Farmer P. (1992). *AIDS and Accusation: Haiti and the Geography of Blame*. University of California Press: Berkeley.

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