



Original Article

There is clearly a need for Christian healthcare professionals with considerable experience on the mission field to promulgate a comprehensive set of standards for short term medical and dental mission trips to the developing world.

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Short Term Healthcare Missions – Legal and Ethical Considerations

There is a remarkable paucity of literature which addresses legal and bioethical considerations related to the provision of medical and dental care on the mission field.¹ It may be that medical and dental missionaries have seen first-hand the abysmal condition of healthcare in the developing world, and are focused on the provision of lifesaving measures rather than on contemplating legal and bioethical issues. From a more cynical perspective, it may be that as there is no professional liability exposure associated with providing healthcare in developing nations, there is no impetus for Western physicians and dentists to give much consideration to these matters.² Additionally, although participants in a short term medical and dental mission team will undoubtedly have the best interests of their patients at heart, Western healthcare providers will commonly engage in practices in the developing world that would be unthinkable at home. As such, these issues certainly merit reflection.

¹ Although scarce, there are some journal articles which address "best practices" in connections with secular humanitarian medical mission trips. However, these articles focus on logistical issues as opposed to legal and ethical concerns.

² A search of the Lexis-Nexis database revealed no published federal or state court medical malpractice cases arising from missionaries providing healthcare in developing nations. This is not to say that a patient in the developing world has never filed a lawsuit in the United States against a treating medical missionary; rather, no published opinions have ever been rendered by an appellate court. In contrast, healthcare missionaries treating the rural and urban poor in the United States should recognize that the potential for professional liability exposure is very real and should act accordingly.

The principles of modern bioethics were promulgated in Western institutions of higher learning and, as such, do not take into consideration the difficulties in rendering healthcare in the developing world. Nonetheless, the bioethical model does have considerable utility and, as such, its four principles -- beneficence, nonmaleficence, respect for autonomy and justice³ – will be employed as framework to explore some of the issues inherent in short term healthcare missions.⁴

Beneficence

Beneficence is defined by Beauchamp as “promoting a patient’s welfare.”⁵ Expressed colloquially beneficence is “doing good.” Within the context of short term medical and dental missions, beneficence is promoted by healthcare professionals maintaining appropriate standards of care and ensuring that highly trained specialists are able to function as generalists.

Standard of Care

According to California law, a physician’s standard of care is expressed as a “duty to use the care and skill ordinarily exercised in like cases by reputable members of the profession practicing in the same or a similar locality under similar circumstances. . . .”⁶ As such, an emergency room physician at a modern metropolitan medical center will often be held to a higher standard of care than a colleague who practices in a rural community hospital. Although this community standard of care provides considerable geographic flexibility, it can break down on a mission trip to the developing world where

³ T.L. Beauchamp and Leroy Walters, eds. *Contemporary Issues in Bioethics*. (Belmont, CA: Wadsworth/Thomson, 2003), 21-36.

⁴ The author readily admits that he is not a licensed healthcare professional. Additionally, the author has only been exposed to urban missionary work. As such, there are numerous Christian healthcare providers who are much better situated to address these issues -- if they choose to do so. However, as a licensed attorney who specializes in defending physicians in medical malpractice actions, the author believes that he has the requisite skills to begin a dialogue on this very important topic.

⁵ Beauchamp, 24.

⁶ The Committee on Standard Jury Instructions, Civil, of the Superior Court of Los Angeles County, *California – California Jury Instructions*, 9th ed., 6.00.1.

there are no local healthcare providers. For example, during a presentation at Fuller Theological Seminary in June 2005, Ron Lamb, D.M.D., president of World Dental Relief, discussed a dental mission trip in which he traveled by boat to a two-hut village located 150 miles up the Marañon River in Peru.⁷ In such a remote setting where there are no other practicing dentists, Dr. Lamb *is* the standard of care.⁸

Given the breakdown of the legal standard of care definition on the mission field, the author recommends that medical and dental mission teams *strive* to replicate Western standards of care to the greatest extent possible. Additionally, healthcare providers need to follow their profession code of ethics while on the mission field.⁹ The author will readily admit that this goal is aspirational given the inherent difficulties in practicing medicine or dentistry in remote corners of the world. For example, John McGill, M.D., then president of the United States section of Doctors Without Borders, in a 1998 commencement address at University of California, San Francisco Medical School illustrated the drastically different standards of care in developed and developing nations:

[Y]ou will have ample opportunity to confirm the medical aphorism that 80% of diagnosis is in the history, with the physical providing the majority of the remaining 20%. In the field, little separates you from your patient – not technology, not documentation, not outside consultants, nor the threat of malpractice suits. . . . You will manage gunshot wounds and reduce fractures without x-rays, operate in the open air using general anesthesia but without electricity, and treat severe sepsis with intravenous chloramphenicol costing less than \$1 per day. All with remarkably good

⁷ Ron Lamb, D.M.D., “World of Ways to Use Dentistry for Missions” (presentation at the Healthcare Missions Conference, Pasadena, California, 24-25 June 2005).

⁸ Dr. Lamb informed the author that dentistry in many parts of the developing world simply consists of a lay “tooth puller.” His or her primary marketing device consists of a glass jar containing previously extracted teeth. Per Dr. Lamb, potential customers will seek the services of an experienced tooth puller which is based on the number of teeth in the tooth puller’s jar. Ron Lamb, D.M.D., interview by author, Pasadena, CA 25 June 2005. Again, in this sort of environment, care and treatment rendered by any practicing dental missionary would represent the applicable standard of care.

⁹ Soderdahl, DW. Is a third-world mission right for you? Bull Am Coll Surg 1998 Sept; 83(9): 26-31.

results. You will arrive at your field mission wondering how you are going to take adequate care of your patients using such basic means, and return home culture-shocked by the profligate waste and medicolegal fig-leaving.¹⁰

Dr. McGill concludes that the practice of medicine in the United States has been detrimentally altered by the prevalence of medical malpractice lawsuits.¹¹ As such, given the realities of practicing medicine and dentistry in the developing world, after careful reflection, a physician or dentist may wish to jettison defensive medical or dental practices which do not compromise patient safety. Thus, a physician may very well have to make a diagnosis based solely on a history and positive physical findings without the benefit of diagnostic tests or laboratory values. Additionally, a dentist will often have no access to radiographs and will have to sterilize his or her instruments without the benefit of an autoclave.

Specialists on the Mission Field

Western medicine has become so highly specialized and technically sophisticated that even teaching hospitals in developing countries do not have the equipment, resources or capabilities to permit a short term medical missionary to practice his or her chosen specialty for the duration of the trip. For instance, a cardiothoracic surgeon would have difficulty performing an aortic valve replacement in many parts of the developing world. Additionally, there are medical specialties, such as radiology or pathology, in which the practitioners are completely divorced from providing primary healthcare.¹² As such, if a specialist is going to be an effective member of a

¹⁰ McGill J. Wherever Your Calling Takes You. *Acad Emerg Med.* 1998; 5:1138-40.

¹¹ Medical textbooks for certain "high risk" specialties will devote considerable attention to the medicolegal issues. See, e.g., Steven G. Gabbe, Jennifer R. Niebyl, and Joe Leigh Simpson, eds. *Obstetrics: Normal and Problem Pregnancies*, 4th ed. (Philadelphia: Churchill Livingstone, 2002).

¹² During the 2005 Healthcare Missions Conference at Fuller Theological Seminary, David Chon, M.D. discussed his church's short term medical mission trips to rural Kenya. During the lecture, Dr. Chon disclosed that his medical specialty is radiology. As such, Dr. Chon's practice is devoted to reviewing x-rays and imaging studies instead of caring and treating patients. This is *not* to say Dr. Chon does not have the requisite skills to provide primary healthcare on the mission field. In fact, Dr. Chon went the

medical mission team, he or she must have the requisite skills, training and capabilities to function as a generalist for the duration of the trip. If not, the specialist may very well be placing patients at risk.

Nonmaleficence

Nonmaleficence is rooted in the Latin maxim *primum non nocere* “above all, do not harm.” In modern parlance, nonmaleficence requires that a healthcare provider does not inflict evil or harm on a patient.¹³ Colloquially stated, nonmaleficence involves “not doing bad.” Within the context of a short term medical or dental mission trip, nonmaleficence can be promoted by 1) ensuring continuity of care and 2) not exceeding one’s scope of practice and 3) not training lay individuals to perform procedures which should only be accomplished by licensed professions.

Ensuring Continuity of Care

Short term medical and dental missions, by their very definition, involve a group of healthcare providers who travel to a different part of the world for a short period of time and care for a group of people who, otherwise, would not be treated. As such, medical and dental missionaries should either avoid performing interventions (or prescribing any medications) which require follow up or recruiting local healthcare providers to ensure that continuity of care is maintained once the short term medical and dental missionaries have returned home. Prudence dictates that medical and dental missionary teams operate with the assumption that patients will not return for a follow up appointments.¹⁴

extra mile and obtained a Kenyan medical license enhancing his witness for Christ by demonstrating respect for his patients and submission “to the governing authorities.” (Romans 13:1 NIV)) However, this begs the question, “Should physicians with esoteric specialties that are far removed from the day-to-day practice of providing primary healthcare be allowed to resurrect these long dormant skills on the mission field?” Clearly, each physician needs to reflect on this issue before embarking on a mission trip. David Chon, M.D., “Best Practices in Short-Term Missions” (presentation at the Healthcare Missions Conference, Pasadena, California, 24 June 2005).

¹³ Beauchamp, 24.

¹⁴ The Oye, Amigos! Project consisted of a group of otolaryngologists who conducted eighteen secular humanitarian trips to Mexico. One of the “lessons learned” from the experience was to expect poor patient follow up. The authors concluded that when conducting humanitarian medical mission trips, “all

This point is illustrated with the author's experience this summer in coordinating the dental care of 300 evacuees from Hurricane Katrina housed at the Los Angeles Dream Center. The University of Southern California's School of Dentistry generously agreed to provide all dental care to the evacuees free of charge -- including advanced restorative work such as the placement of crowns and bridges. The only prerequisite was that the evacuees needed to be triaged ahead of time. In fact, three professors from the dental school spent a morning at the Dream Center in order to accomplish this task. Sadly, only a handful of evacuees were present when the dentists arrived. Unfortunately, despite considerable "dental evangelism" on the author's part, only thirty adults were triaged. (It turned out that the evacuees were taken to an amusement park the previous evening and valued a few hours of extra sleep rather than being roused out of bed and probed with dental instruments in the church's parking lot.) Almost all of the evacuees who were triaged eventually presented to the dental school. However, all of these individuals were in severe pain and required immediate dental extractions and/or drainage of dental abscesses. Unfortunately, only a handful of the evacuees ever presented for restorative work once their immediate dental pain was relieved.

Initially, the author dismissed this program as a failure. However, the evacuees who presented to the dental school were quite appreciative of the care rendered and were very impressed that an attorney took time out of his busy schedule in order to spend an afternoon with them at dental school.

Not Exceeding One's Scope of Practice

In short-term healthcare mission trips there can be very egregious examples of exceeding one's scope of practice. One healthcare practitioner recounted that during one of his short term mission trips to Mexico, he accompanied a team of physicians who

surgical contacts need to be undertaken with the idea that the patient will not return." As such, the contemplated surgical interventions were much more conservative than would be undertaken in the United States. Barrs DM, Muller, SP, Worrndell, B, Weidmann, EW Results of a humanitarian otologic and audiologic project performed outside of the United States: Lessons learned from the 'Oye, Amigos!' project 2000 Dec; 123(6): 722-7.

were concurrently cauterizing tear ducts in six operatories. The healthcare practitioner remarked that “the Lord wanted to use me and I jumped in” and then explained the mechanics of the procedure that he performed which included injecting and infiltrating the eye. As a licensed chiropractor, the scope of his practice in the United States is strictly limited by law to performing mechanical manipulations and adjustments of the spinal column and other joints – not practicing medicine. Is it right for to practice medicine in Mexico or in any other location, when it not allowed here in the United States?¹⁵ Did the physicians who trained the chiropractor to cauterize tear ducts exercise poor judgment? Was cauterizing tear ducts so simple that any non-healthcare trained individual is equally skilled, given cursory training, to perform the surgery? Finally, if any of the patients were to discover that a chiropractor was represented as a physician, would it serve as a poor witness for Christ and undermine the underlying purpose of the trip -- fulfilling the Great Commission?¹⁶

Douglas W. Soderdahl, M.D.’s article “Is a Third-World Mission Right for You?” is accompanied with a photograph of a surgeon performing an operation with a medical text displayed prominently in the foreground. The photograph contains the following caption, “The expatriate surgeon’s credo: ‘Have text, will operate.’”¹⁷ In the United States, a surgeon with hospital staff privileges may also have privileges to perform a circumscribed set of surgical procedures specific to his or her specialty. For example, an obstetrician would have surgical privileges to perform an operative vaginal delivery, but not an aortic valve replacement. In this hypothetical situation, if an obstetrician from the United States were to perform a surgical intervention which would normally be performed by a cardiothoracic surgeon, the obstetrician would, in all likelihood, lose his or her medical staff privileges and subject himself or herself to tort liability and discipline by the state medical board.

¹⁵ David Chon, M.D., “Best Practices in Short-Term Missions” (presentation at the Healthcare Missions Conference, Pasadena, California, 24 June 2005).

¹⁶ “Go therefore and make disciples of all nations, baptizing them in the name of the Father and of the Son and of the Holy Spirit.” (Mt 28:19)

¹⁷ Soderdahl, 28.

Just because a physician is on the mission field, that does not give that individual a license to perform an unfamiliar surgical procedure simply with the aid of a medical textbook.¹⁸ Rather, if there is another physician who is more qualified to perform the contemplated operation, a physician has an affirmative duty to refer the patient to that specialist. To the extent that there are no qualified physicians, nonmaleficence may require that the physician not perform a contemplated surgical procedure.¹⁹

Not Empowering Lay Individuals to Perform Interventions Which Should Be Performed by Licensed Professions

While attending the 2005 Healthcare Missions Conference at Fuller Theological Seminary, there was considerable interest in Dan Romo, D.D.S.' presentation, "Dentistry 101: What Do You Do When a Dentist Isn't Around?" Per one of the attendees at Dr. Romo's identically titled presentation at a previous healthcare missions conference at Fuller, Dr. Romo, taught the audience how to extract teeth and to perform other interventions normally accomplished by general dentists.²⁰ Yet, at the 2005 conference, Dr. Romo's presentation simply focused on how a missionary can conservatively manage dental pain before presenting to a dentist.²¹ When asked about the change in materials between presentations, Dr. Romo remarked that empowering

¹⁸ See, e.g., Dupuis CC: Humanitarian missions in the third world: A polite dissent. *Plast. Reconstr. Surg.* 113(1): 433-5, 2004. ("One should never perform operations abroad that one would not do on one's own private patients at home. . . .")

¹⁹ In *Jesus, MD*, author David Stevens, M.D. devotes considerable attention to his time on the mission field in the Kenyan highlands. Germane to this article is Dr. Stevens' recounting of his first time on-call when two trauma patients presented to the mission hospital requiring two entirely different emergent surgeries never before performed by the then-neophyte family practitioner. In a remarkable display of surgical chutzpa, Dr. Stevens performed the two operations which ideally should have been undertaken by two different specialists -- a neurosurgeon and an otolaryngologist. Fortunately, Dr. Stevens had surprisingly good results. However, if the two patients expired on the operating room table, the author questions whether this story would have figured so prominently in Dr. Stevens' book. Stevens, D. *Jesus, MD*. Zondervan, 2001.

²⁰ David Campbell, D.D.S., interview by author, Pasadena, CA 25 June 2005.

²¹ Dan Romo, D.D.S., "Dentistry 101: What Do You Do When a Dentist Isn't Around" (presentation at the Healthcare Missions Conference, Pasadena, California, 25 June 2005).

lay people to practice dentistry on the mission field is a “touchy” area.²² It is worrisome to think about the possibility of a lay missionary, armed with Dr. Romo’s lecture notes, breaking off someone’s tooth with a metal object in order to provide someone with pain relief.

Respect for Autonomy

Respect for autonomy is an ethical principle that individuals have an “intrinsic value” and, as such, are “entitled to determine their own destiny.”²³ Respect for autonomy forms the underpinning of the legal concept of informed consent. Specifically, under California law, a physician has an affirmative duty “to disclose to the patient all material information to enable the patient to make an informed decision regarding the proposed operation or treatment.”²⁴ If a physician performs a treatment or operation without first obtaining the patient’s informed consent, the physician has committed an intentional tort called a battery.²⁵

Just because a physician or a dentist is on the mission field and the patient is uneducated and conversant in an obscure dialect, does this relieve the physician or dentist of the responsibility of finding an interpreter and having an informed consent discussion with the patient and honoring the patient’s wishes concerning whether to undergo a contemplated procedure? Anything less than obtaining informed consent in a language that the patient understands shows a disdain for the patient’s autonomy and serves as a very poor witness for Christ.

Additionally, respect for autonomy requires that informed consent discussions also address alternative modalities of treatment. This point is illustrated with David

²² Dan Romo, D.D.S., interview by author, Pasadena, CA 25 June 2005.

²³ Beauchamp, 23.

²⁴ The Committee on Standard Jury Instructions, 6.10.5.

²⁵ See, e.g., 5 Witkin, *Summary of Cal. Law* (9th ed. 1988) Torts, §§ 357-358.

Campbell, D.D.S.' urban missionary work.²⁶ Dr. Campbell is the proprietor of a chain of Southern California dental offices and has devoted considerable time in treating indigent patients housed in three Los Angeles-area missions. Due to financial concerns, Dr. Campbell cannot perform the same interventions when providing free dental care to these individuals. For example, as a cost saving measure, after extracting teeth, Dr. Campbell will fit patients with dentures instead of fabricating and placing permanent crowns or bridges. "The use of dentures has the advantage of instantly resolving the Western social stigma associated with visible missing teeth," commented Dr Campbell. However, Dr. Campbell will discuss these treatment options with the patient in advance. To the extent that the patient desires a crown or a bridge, Dr. Campbell will only treat the patient as a part of his private practice. Clearly, if Dr. Campbell did not discuss treatment options in advance when performing missionary work, there would be the potential for unhappy patients and dental malpractice lawsuits.

Justice

According to Beauchamp, there are multiple theories of justice, i.e., egalitarian, libertarian and utilitarian; however, the concept of justice requires that "like cases should be treated alike."²⁷ As such, there is an inherent injustice in the fact that a child with a disease in a developing county, in all likelihood, will not have access to the same medical care provided to a child with the exact same disease in a developed county. Conversely, worldwide efforts to eradicate deadly diseases, such as smallpox and polio, promote justice. The author believes that absent Christ's return to establish his millennial kingdom, we will always live in an unjust world in which a great segment of the world's population will live in abject poverty and are denied access to the things that people in the developed world take for granted. However, short term medical and dental missionary teams can promote justice by devoting their undivided attention to their patients, providing them the best care possible under the circumstances and

²⁶ Campbell interview. It is well worth noting that as a result of the Fuller Healthcare Missions Conference, Dr. Campbell is now treating graduates of a one-year adult residential discipleship program run by the Los Angeles Dream Center.

²⁷ Beauchamp, 26.

showing them compassion.²⁸ Most importantly, medical missionaries should take to heart Jesus' own words when he said, "whatever you did for one of the least of these brothers of mine, you did for me." (Matthew 25:40, NIV)

Conclusion

The four bioethical principles -- beneficence, nonmaleficence, respect for autonomy and justice -- were used as a starting point to explore some of the ethical and legal issues inherent in short term healthcare missions. Unfortunately, despite their best intentions, Christian healthcare providers will often cut corners on the mission field and will engage in practices that are unacceptable at home. As a result, patients may receive substandard care and opportunities to spread the Gospel are lost.

There is clearly a need for Christian healthcare professionals with considerable experience on the mission field to promulgate a comprehensive set of standards for short term medical and dental mission trips to the developing world. This would serve as a benchmark and planning tool for future healthcare missionary teams.

²⁸ Whatever you do, work at it with all your heart, as working for the Lord, not for men, since you know that you will receive an inheritance from the Lord as a reward. Colossians 3:23-24 (NIV).

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