Reflections on a Medical Service Trip: Did we do the right thing?

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ABSTRACT

Medical service trips have a long and distinguished history. In the United States, interest in medical outreach trips has grown substantially, as medical schools and non-governmental organizations support numerous overseas endeavors at an estimated cost of 250 million dollars a year. Although providing care to those in need is a rewarding experience, the question that needs to be answered is whether these trips do more harm than good. We describe our experience during a medical service trip to Ensenada, Mexico. We treated over 500 people for numerous problems, but due to the lack of services were not able to monitor or ensure follow-up. Did we do more harm by providing medications that can have serious side effects? Recommendations have been developed to help short-term international medical service trips provide the best overall experience for the participants and the best care for the patients.

Key words: *service trips, medical education, international rotations*

It is clear that poverty, lack of education, shortage of resources, and limited access to quality health care create a breeding ground for disease and poor health. It has long been a tradition in medicine for physicians and other health care personnel to travel to areas lacking quality medical services, whether in the United States or in developing countries, to help provide state-of-the-art medical care to those in need. As exemplified by the tale of the Good Samaritan, caring for those in need dates back to biblical times. In the more modern era, Dr. John Scudder travelled to Ceylon in 1819 and later to India to provide medical care.[1] Dr. Peter Parker, under the sponsorship of the American Board of Commissioners for Foreign Missions, sailed to China in 1834 and performed many of the first surgical procedures there, training many young students in medicine long before medical schools had been established.[2] In the United States, medical outreach trips have grown substantially. Medical schools and non-governmental organizations support numerous overseas endeavors at an estimated cost of 250 million dollars a year.[3] In 2010, thirty-one percent of graduating U.S. and Canadian medical students had participated in an international service rotation.[4]

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In keeping with this outreach tradition several of us had the opportunity to take part in a weeklong medical trip to Ensenada, Mexico, located in Baja California. Our mobile day clinics were held in various sites in the outlying low-income settlements around

town, known as the Colonies. Together with a local physician, we were able to use a formulary assembled entirely with donations to treat over 500 patients with a wide variety of pathology. To be able to provide needed care to this underserved population was truly rewarding. However, after we returned home we began to think about the medical treatment we had just provided to these 500 patients. Was this trip more about making us feel good for our charitable deed or was it truly to provide care to those in need? Did we do the right thing by providing medical attention to patients who may have no follow-up? Is starting an angiotensin converting enzyme inhibitor (ACEI) on a known diabetic appropriate without knowing the current potassium and renal function? Should we have given antibiotics for presumed infectious diarrhea or treatment of supposed *H. pylori* infection? These are tough questions to think about when you feel like you're saving the world, but could it be that we did more harm than good.

Surgeons can repair a cleft lip and palate using the tools of their trade and almost instantaneously change a life both physically and psychologically. Ophthalmologists can prevent or even reverse blindness. In disasters, appropriate trauma care, the provision of acute renal replacement therapy, and infection control measures can make the difference between life and death. As internists, however, although our tools are much sharper and better honed, the care we provide may have little immediate positive impact and may even have long term negative consequences. Was what we did more like placing a Band-Aid on a gaping wound? We believe we did some good in at least providing physical exams and treating acute illnesses, but for many of the patients it is unclear whether the medical care we delivered was better than offering no care at all. If, as a medical team, we are not able to teach or address basic preventive aspects of certain diseases, then the treatment we provide is nothing more than patchwork and not the most important part of medical care.

The medications we prescribed on a daily basis can produce injury that is not easily seen. Our team treated hundreds of patients with hypertension. Many of these patients were started on ACEIs without having the benefit of simple blood tests. We prescribed antibiotics for presumed infectious processes but had no way to monitor the effects of taking these medications.

In retrospect it is demoralizing how very real the possibility is that our team did more harm than good, and so major changes in approach must be made to avoid repeating the same mistakes. When caring for disadvantaged patients who have so much to gain from basic medical attention, it can be easy to overlook the principle of non-maleficence. As we prepare for a return trip to Ensenada, our team will focus on providing complete medical care to the patients we meet. Obtaining portable functional lab equipment is essential in the appropriate and ethical treatment of each patient we encounter. In addition, it is important that before embarking on a short term medical service trip, we develop plans to sustain the care provided either by setting up return trips or ensuring that local health care personnel are available for follow-up. Recommendations have been developed to help short term international medical service trips provide the best overall experience for the participants and the best care for the patients.[5-7] These include proper organization, an appreciation of cultural diversity, education and appropriate follow up, understanding of the consequences of prescribing medications, collaborating with the local community, and setting realistic expectations. These recommendations need to be followed. As physicians we personally feel that it is our duty to provide medical care to those less fortunate, but this does not come without a responsibility for patient education and disease prevention along with appropriate pharmacotherapy where indicated.

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