Clinical Frontiers and Cowboy Medicine: Excerpts and Vignettes from Fieldwork

> *There were no preauthorizations. There's no lab. You're required to be really understanding or in tune with the patient. Not a lot of paperwork. And not a fear in the background, if you did overstep a little bit by prescribing this or prescribing that, its not… you're not looking at the lawyer coming in the next day. The whole idea was not looking at all the bureaucracy we look at in today's medicine up here [in U.S. medicine], but looking at how can I truly help this individual. I guess that it was more pure. (Dr. Peterson)*

During my fieldwork, a number of volunteer surgical teams came to work on projects for one to two weeks. Each team worked on one type of surgical problem and these included cataracts, cleft lip and palate, and uterine vaginal prolapse. Generally teams were fairly large and included not just the surgeons, but also operating room staff, nurses, and in the case of the religiously oriented teams, evangelists. In addition, family members often accompanied the medical staff members, with several surgeons including their children as part of the team, even in the operating room. The teams varied greatly in their work style, organization, and comfort in the community, however, in several important ways they were similar. Despite variations in the organization and practices of the teams, they aimed for common stated objectives of providing as many surgeries to the community as possible within the time available and relied on similar organization of hospital space and personnel.

> I walked in on a discussion in the operating area between several of the team members. They were talking about patient privacy because one of the team members was taking pictures. Someone asked if they needed to get permission. They collectively decided that it probably didn't matter, because someone asked, "Does HIPAA [Health Insurance Portability and Accountability Act] apply here?!" laughing. They all laughed together. Later in the day, Temesgen [an Ethiopian surgical tech who also worked for the team as a patient recruiter and translator] brought by consent forms and explained that the patients had to sign them. "It's a legal issue," he explained. Although this happened after several surgeries had already been completed, he insisted on it, stapling the consent forms to the team's screening forms. Several team members expressed surprise about the consent forms. (Fieldnotes November 22, 2013; ophthalmology team)

The presence of established regulations and standards of practice, made obvious here by Temesgen, presented a conundrum for the team members. The volunteers' assumptions of emptiness and desperate include assumptions of a lack of formalized procedures and requirements, such as Patient Privacy Laws or official consent forms. Interestingly, despite language barriers and very limited informed consent, the patients were assumed to have lower expectations for their surgical outcomes and comfort.

> I think the patients here have much more basic expectations. I think some of them are going into surgery and they might die and they're worried about that, but they're also somewhat fatalistic about it. And you know obviously the patients in

> the United States are much more demanding of a certain level of quality and attention and local anesthetic. (Dr. Hope)

Almost all of the Ethiopian physicians I worked with actively sought opportunities to go abroad in some capacity and were severely limited in their ability to do so at many levels. International requirements for licensure privileges those trained in Western countries, allowing westerners to obtain medical licenses, at least temporary ones, with little effort beyond proving their licensure in their home countries. Even long-term licensing is only a matter of submitting paperwork to the correct agencies and paying a nominal fee. For Ethiopian doctors to practice in the United States, on the other hand, they must pass the United States Medical Licensing Exams (USMLE), as well as meet a number of paperwork and training requirements, which are difficult to accomplish under present conditions. This is both a time and cost-intensive process. According to one Ethiopian physician who wanted to do a surgery residency in the United States, there was no way to take the USMLE in Ethiopia, because the government did not allow it, purportedly in an attempt to limit the ability of their physicians to go abroad. The nearest location to sit the examinations was Nairobi, Kenya, 725 miles away from Addis Ababa. Thus, mobility was severely restricted for Ethiopian physicians, who are unable to engage in reciprocal projects in the global North. Indeed, even in "global health partnerships" touted by many university and hospital programs, physician participants from the global South are generally relegated to observerships.

American physicians assumed their ability to move and practice medicine. Several expressed surprise at the few regulations that did exist, including that of obtaining a temporary medical license. This is in contrast to the requirements in the United States, which requires state-specific medical licensing. Physicians reported being more able to engage in projects transnationally than to volunteer within the United States.

> But when you're doing international trips, there's a lot of opportunities to go a lot of places where you do a 1 or 2 week trip, *where you can kind of drop in, deliver surgical care, and leave*. But in the United States, that's just not as… issues with licensing and credentialing and malpractice really complicate your ability to do that. Even though there's areas like in Appalachia… in some really rural areas, particularly in the South, but it just not… the red tape is huge. So if I go to any other state I have to have a medical license to do that. *But you can go most places internationally with a U.S. license and operate.* (Candace – American gynecologist)

Many volunteers assumed that there were no already established guidelines and furthermore that their moral position as volunteers and Americans exempted them needing to follow either American standard guidelines or inquire about Ethiopian ones. A poignant example of this was the discussion within one of the teams of volunteers regarding the necessity of adhering to the use of a "surgical pause" or "Time Out" during project surgeries.

> During the team meeting, operating room procedures were discussed. Hope, one of the anesthesiologists, brought it up because she wanted to know how they would be identifying patients. "When we do our time out, I want to make sure that we have the right patient, for the right surgery. Not so we're doing an abdominal

> incision on someone who doesn't need one," she said. There was some discussion about whether or not someone in the last group had had made and then left wristbands. Candace, the team leader, said that it generally wasn't a problem, because "we" talk to the patient, screen the patient, and then do the surgery, so we know the patient. Also, she explained that's why they keep them separated on the third floor of the hospital, so they can easily identify their own patients. (Fieldnotes, February 4, 2014).

Joint Commission (JC) safety guidelines regard the use of a "Time Out" immediately before beginning a surgical procedure as an essential safety procedure and part of the "Universal Protocol" for accreditation in the United States since 2003 (Dailey 2003). The World Health Organization (WHO) includes the "Time Out," also called a "Surgical Pause" on their surgical safety checklist. It is thus a standard part of American and international surgical practice that all operating room staff members are accustomed to. Indeed, it is also a part of Ethiopian surgical practice, introduced in 2010 as part of the Ethiopian Hospital Reform Implementation Guidelines (EHRIG).

The team as a whole was unconvinced by the anesthesiologist about the need for "Time Outs" and they were infrequently done during the two weeks of the project. A few days after observing this initial conversation, I was reflecting on the project thus far with Laura, another anesthesiologist working with the same team. I paraphrase below Laura's comments about the situation, in which she expressed how both she and Hope are very dedicated to safety procedures, such as time outs before surgery:

> Its frustrating because there is no reason not to do them, especially because they are an important part of safety in the U.S. Some of the surgeons have been getting annoyed after the surgery starts because they don't have the right tools available, which is what the time out is for. The wristbands are another example, like time outs, of important safety tools. Hope wanted to use them, but Candace [the team's lead surgeon] said it was unnecessary because we have never had a problem like that before [of confusing patients or procedures]. You do these things to *prevent* the problem from occurring. In fact, just yesterday there was a case in which the patients were mixed up on the board on the ward and there was confusion about whether the right patient was in the OR. I told her [Candace] that this is exactly what we were trying to prevent with the wristbands. People think this is like the *"Wild West"* and so rules that apply at home do not apply here.

The standards of "best practices" not applying extended into issues of informed consent. This became a particularly difficult issue for volunteers who were dedicated to providing high quality and life-transforming surgeries to patients but were faced with factors beyond their control, including language and social barriers to communication. Several team members took this potential undermining of the Hippocratic Oath's tenet of "first do no harm" seriously and discussed at length the contradictions inherent in the medical mission practices. This contradiction reveals the failure of the mission projects to remain disentangled from the sociopolitical contexts of the space into which they moved and yet volunteers continued to erase the legal and ethical systems in place that constrained Ethiopian physicians and protected their patients.

> Well in the States you… spend a lot of your time counseling patients on all aspects of complications. Here we didn't talk to them. We just talked to them about their procedure, but I don't feel like my practice would be different here than in the States. And then here, so… there's not much paperwork and time spent counseling patients on things that probably won't happen, so they don't get the benefit of hearing about possible complications, even though they're small… A good provider will always try to figure out what the patient really needs, like just for prolapse for example, we really think what they need is surgery, but they're not bothered by it. So really they don't have to be treated, you know? Some… and that's why I worry about these patients, we were trying to ask them, so you want this fixed? Because they may come in here thinking they have prolapse and they have to go get this free procedure, but if it doesn't really bother them, why would they? They really don't need surgery, if it doesn't bother them… we turned patients away with mild prolapse and if we were a provider that just wanted to get numbers, we could have operated on more patients that came in the door, because they did have some prolapse, but not enough to justify surgery… I mean we're treating conditions that are not necessarily… not acceptable, but not life-threatening, you know, especially here. (Lisa – American gynecologist)

One of the other physicians on this team also expressed doubts about how well the women were being educated about their disease and medications. "… we were doing discharges and trying at the level of 'you need to take these medicines all the time and then go back to your physician, make sure you have these medicines all the time.' But there's very little conversation about what are the ramifications of them taking their medicine or not taking their medicine" (Jacob – American gynecologist/family practitioner).