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ETHICAL CONSIDERATIONS IN MEDICAL VOLUNTOURISM:
APPLICATION TO SPEECH-LANGUAGE PATHOLOGY

by

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A Thesis Submitted in Partial Fulfillment
of the Requirements for a Degree with Honors
(Communications Sciences and Disorders)

The Honors College

University of Maine

May 2016

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ABSTRACT

Medical voluntourism is becoming increasingly popular among various health disciplines. The volunteer work is typically short-term and occurs outside of the home country. This paper reviews the literature regarding medical voluntourism in developing countries and discusses the ethical implications and barriers that arise around the quality of care. Its primary focus will be volunteer work in the field of Speech Language Pathology. The goal of this paper is to provide a new approach to medical voluntourism that aids in bettering the experience of volunteer Speech Language Pathologists (SLPs) and also improving the quality of care given. In addition to discussing current practices surrounding the work of SLPs, it will challenge these practices by analyzing the ethical issues and barriers that are specific to this field. It concludes by suggesting a new approach for medical voluntourism in the Speech Language Pathology field that aims to overcome these issues.

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International Aid

Humanitarian aid, which refers to those who seek to promote human welfare by providing assistance to those in need (New Oxford American Dictionary, 2005), has become increasingly popular in the 21st century (Wearing, 2001). This assistance can be given through various disciplines such as education, disaster relief, medical practice, etc. and can range from governmentally funded organizations to volunteer work. This type of aid can occur domestically as well as internationally. For the purpose of this paper, focus will be on international humanitarian aid specific to the medical field that occurs through the use of volunteers.

Aid that is implemented through the use of volunteers falls within the realm of volunteer tourism, otherwise known as voluntourism (Wearing, 2001). Voluntourism is defined, in general, as those who travel in order to voluntarily assist those in need. This volunteer work has been attributed to alleviating poverty, restoring environments, providing medical care to resource-deplete areas etc. As previously mentioned, this paper will focus on volunteer work that involves providing medical care through humanitarian aid. While the field of medical voluntourism includes work within religious mission trips, this paper will exclude the work done in mission trips and focus on work done by non-governmental organizations (NGOs). This choice to exclude religious mission trips was made for various reasons; the first to allow this paper to focus on a medical model of voluntourism without the involvement of a religious purpose. The second reason is based on minimizing the scope of the paper to a manageable amount of resources.

This paper will acknowledge that humanitarian volunteer work has its benefits, including attracting attention to global health disparities, increasing medical personnel in

areas that are often understaffed and resource deplete, and also further educating both the volunteers and the professionals from the host countries. However, it will also pose the question “Are we helping?” These volunteer excursions appear as though they provide benefit to both the volunteer as well as the host country (Hickey, 2012). Not only does the volunteer gain experience in his/her field and reap the rewards of participating in a selfless act, but the host country is provided with resources and help in areas that are often scarce. With this in mind, how could these volunteer trips not be a win-win situation for both parties? (Hickey, 2012)

Through an extensive literature review, this paper will analyze the current model of humanitarian aid and raise questions regarding ethical considerations that may be overlooked in our current efforts. Due to the lack of empirical research regarding medical voluntourism, the majority of the research that will be reviewed revolves around personal testimony and observations regarding a medical voluntourism experience. The primary focus of this paper is Speech Language Pathology. However, little research has been done surrounding medical voluntourism in the Speech and Language field. Therefore, this paper will parallel the focus of Speech Language Pathology with research surrounding medical voluntourism in other disciplines. Through this parallel, the author will provide a new approach to medical voluntourism, different from the typical “medical model,” in the field of Speech Language Pathology that aims to overcome some of the ethical considerations surrounding this volunteer work.

The Current Model for Medical Voluntourism

Before delving into the issues surrounding international medical aid, it is important to describe the current model of medical voluntourism; the “medical model”

This model, pioneered by Medecins Sans Frontieres (MSF) in 1971, is now one of the most commonly recognized international aid models. MSF's primary focus is providing emergency medical care to the developing world. Kouchner (1971), one of MSF's co-founders states the premise behind MSF "[was] simple really: go where the patients are. It seem[ed] obvious, but at the time it was a revolutionary concept because borders got in the way. It's no coincidence that we called it Medecins Sans Forntieres." ("Medecins Sans Frontieres," 2013) Medecins Sans Frontieres is also referred to as, "Doctors without Borders," the English translation.

Medecins Sans Frontieres originated after the Parisian revolt of May 1968. During this time period, images of children dying from hunger, in the midst of the Parisian revolution, was brought forth into the public eye by the French media. The focus of the war was primarily in Nigeria in the province of Biafra. Biafra had broken away from Nigeria and was, in turn, surrounded by the Nigerian army and struck by warfare and famine. The French Red Cross called for a need for volunteers for an International Committee of the Red Cross (ICRC) mission to Biafra. It was doctor's Max Reclaimer and Bernard Koucher, along with 4 other medical personnel, that volunteered to travel to Biafra. They were thrown into the war in Biafra and were placed in situations in which they would be forced to provide surgery "in hospitals that were regularly targeted by the Nigerian armed forces" ("Medecins Sans Frontieres," 2013) The traumatic experience of witnessing brutal civilian murders and extreme famine inspired them to speak out. They spoke up against the Nigerian government and the Red Cross. Reclaimer believed that "contrary to popular belief, the Red Cross is not medical organization at all." ("Medecins Sans Frontieres," 2013) With the help of other doctors, known as "Biafrans" and

journalists Phillipe Benier and Raymond Borel, within 3 years from their experience in Biafra, Recaimer and Koucher were able to change the face of humanitarianism. They aimed to create an emergency response group whose focus was in the welfare of those suffering, not political or religious agendas, Medecins Sans Frontieres.

MSF was founded on the belief that “all people have the right to medical care regardless of gender, race, religion, creed or political affiliation and that the needs of these people outweigh respect for national boundaries.” (“Medecins Sans Frontieres,” 2013) On December 22, 1971 a “new” international aid organization had become official. It being comprised of 300 volunteers who included the 13 founding members, Dr. Jacques Beres, Philippe Bernier, Raymond Borel, Dr. Jean Cabrol, Dr. Marcel Delcourt, Dr. Xavier Emmanuelli, Dr. Pascal Greletty-Bosviel, Gerard Illious, Dr. Bernard Kouchner, Dr. Gerard Pigeon, Vladan Radoman, Dr. Max Recamier, and Dr. Jean-Michel Wild. (“Medecins Sans Frontieres,” 2013) Some of MSF’s first missions as Medicins Sans Frontieres included work in Nicaragua after an earthquake (1972) destroyed it’s capital, Managua, and killed over 10,000 citizens as well as providing medical care to civilians seeking sanctuary during a refugee crisis (1975) in Cambodia. Today MSF has grown from a few doctors looking to make a difference to a full-fledged international aid organization that provides medical aid to more than 60 countries around the world. MSF services range from access to medicine in areas that have a complete absence of medical treatment, providing vaccinations against diseases such as the measles, women’s health care including obstetric care and treatment of victims of sexual violence. They “employ” various medical professional’s such as RN’s, physicians, midwives, surgeons, mental

health specialists, pharmacists etc. as volunteers in their medical aid missions.

(“Medecins Sans Frontieres,” 2013)

However, it is important to note that the model of MSF, the “medical model” of medical voluntourism, is in relief work. Volunteers from developed countries travel to host communities for a short time period, no longer than 2 years, and provide medical care to those in need. One must pose the question that if this model was implemented to give “all people the right to medical care” (“Medecins Sans Frontieres,” 2013), than why are the organization’s efforts focused in short term relief work? One must also ask that if the focus is in short term emergency medical care, why has the organization increased its efforts over the last 45 years? At what point, do efforts in humanitarian aid actually create a dependence on that same aid? This paper will propose that instead of using the current “medical model” of medical voluntourism, exemplified by MSF, that these volunteer efforts may be better suited to implement training programs to allow these developing countries to succeed on their own.

Medical Voluntourism in Speech Language Pathology

Medical Voluntourism within the field of Speech Language Pathology has progressed from the traditional model “medical model” exemplified through MSF. Relief work that has been implemented through cleft palate repairs. This work in cleft palate repairs not only provides surgical repair to cleft palates but also implements both awareness and education regarding care after the surgeries. An example of this relief work can be seen through the organization *Smile Train*. Smile Train focuses on providing cleft palate/lip repairs to children suffering from untreated clefts in developing countries. Undeveloped clefts can cause issues with a child’s speech, swallowing, and social status.

Smile Train notes that over 170,000 children are born with undeveloped clefts in resource deplete areas and that the repair for these clefts takes a short 45 minutes to execute (“Smile Train,” 2016). Smile train provided these cleft palate repairs 100%-free to children in developing countries. They have also implemented training for local doctors to provide cleft palate care in these resource-deplete areas. (“Smile Train,” 2016)

Although cleft palate voluntourism exemplifies progress in international aid efforts, it is important to note in the field of Speech Language Pathology cleft palates are a noticeable and “easily fixable” issue. However, there are many speech and language related disorders that are not as easily identified or rectified, especially without the proper training. According to a study done by Jaramillo et. al (2015) regarding global speech-language health in Belize, the country struggles with it’s ability to meet the needs of the children with special needs, including those with speech and language disorders. In fact, “the special education department that services all 55 primary schools, plus 5 secondary and one vocational school consists of two special education teachers who make visits into the different villages where children have been referred” (Jaramillo et. al, 2015, p. 46). Jaramillo et. al (2015) found although Belize had the two special education teachers that would have worked with children with speech and language disorders, Belize lacks any training programs for speech-language clinicians. In a study done by Molrine et. al (2013) that focused on speech and language services in the twin island nation of Trinidad and Tobago (T&T) it was for that Speech Language Pathology training programs also did not exist. However, unlike Belize, T&T had 12 Speech Language Pathologists (SLPs) that provided services in areas such as speech, language, cognition and swallowing. It is important to note that “all 12 SLPs are foreign educated. Nine of the SLPs were educated

in either bachelor (n=1) or graduate (n=8) SLP programs in the United States. Three of the SLPs were educated in either bachelor (n=1) or graduate (n=2) SLP programs in the United Kingdom” (Molrine et. al, 2013, p. 15). The training of the SLPs in T&T is important because it has been found that speech language pathology services are present in developed countries, but not in many developing countries. (Lubinski & Hudson 2013)

The lack of training programs and professionals in developing countries leads to a ethical question regarding medical voluntourism in cleft palate repairs. “Are our efforts cleft palate repairs helpful, if these developing countries can not provide communication rehabilitation?’ Although these cleft palate repair teams such as Smile Train, provide training in patient care following the surgery, without additional speech and language services the host communities cannot follow through with a sustainable treatment plan for those patients who receive cleft palate repairs. According to Salas-Provance et. al (2014)

“For the field of communication disorders the capital assets which are important to a sustainable livelihood are social and human capital. In terms of social capital, if continued services are needed after the volunteer leaves the country, the individuals or their family should have the networks available to manage their care along with the accompanying mutual trust and understanding necessary to sustain these relationships. For example, the children with cleft palate who are identified for further speech therapy or secondary surgeries are referred to these medical and professional specialists in-country who continue the care and with whom the individuals can establish these relationships. (p. 70)

Therefore, it is important to note that although cleft palate repair teams are progressing in terms of medical voluntourism, the hierarchy of need does not end with cleft palates. Not only does the patient who receives cleft palate surgery require continual speech and language services to maintain a sustainable lifestyle, but as do the children

who suffer from speech and language disorders that are not as easily noticed or recognized.

Ethical Concerns Relative to International Aid

Although this paper recognizes that international aid efforts provide benefit to both the host community and the volunteer, it aims to draw into light some of the ethical concerns that may not also be considered when providing the traditional “medical model” of international aid. As medical professionals, whether a doctor, surgeon, nurse etc., one must often taken an oath to provide the best care possible to patients. One has promised to uphold a sense of ethical decision making that requires “practices that are culturally safe and sustainable” (Hickey, 2012, p. 41) In a study on medical voluntourism in Honduras done by McLennan (2014) a health professional from Canada (Michel) provides testimony that states “Do some volunteer groups (mostly Medical Brigades, in my opinion) behave like black market health care providers? They drop out of the sky with their Rubbermaid storage bins loaded with medicines and descend on remote villages. Sure they help, sure they are needed BUT where is the sustainability and consistency?” (p. 163). This testimony exemplifies the imposing ethical dilemma that international aid has on a medical professional’s moral responsibility to provide the highest quality of care possible. The first area of interest to start, in the ethical concerns in international aid is the motivations behind the volunteers and the organizations.

Motivation

As seen through the MSF, medical volunteer work was implemented on the notion that all people have a right to medical care, including those in resource deplete areas. In fact, “the delivery of health care in the poorer countries is reliant on

international aid organizations.” (Katz, 2005 p. 60) This reliance is due to the fact that the patients encountered in the poorer countries have little or no access to health care without these organizations. (Wall, 2012) These limitations include a scarcity in medical equipment, personnel, medicine etc. Without access to health care, the residents of these poorer countries are at an increased risk for higher disease and mortality rates than those who reside in developed countries. However, through the use of medical voluntourism these developing countries are provided with access to healthcare. The organizations that participate in voluntourism provide these poorer countries with medical personal, knowledge, and medication that may never have been available without this aid. However, it is important to note that the limitations to health care that plague these resource-deplete areas also pose ethical concerns for the medical aid workers and organizations. These concerns will be discussed in greater detail throughout this paper.

When asking ourselves why medical voluntourism is executed, we must also pose the question why one volunteers for such work? The motivation of the volunteers plays a consequential role in the success of international aid work. In fact, poor motivations, such as focusing primarily on travel or self-development, may have unexpected consequences for the host communities. These consequences can include a disregard for the locals’ culture, providing less than satisfactory care, and inattentive professionals. These consequences will also be discussed in greater detail later in the paper.

So who is a volunteer tourist? Through their review of the voluntourism literature Hickey et. al, (2012) defines a volunteer tourist as “an individual who willingly works abroad, typically in developing countries, for less than what he or she would have be earning at home (and sometimes even paying for the experience)” (p.42). Within the

purview of literature pertaining to volunteer tourism, Wearing (2001) has been attributed to making a substantial contribution. Throughout his work with voluntarism literature, including his book *Volunteer Tourism: Experiences that Make a Difference* and contribution to the article by Godfrey et. al (2014) *Medical Volunteer Tourism as an Alternative to Backpacking in Peru*, he aims to look at why volunteer tourism has become the experience of choice for those who want to travel. Godfrey et. al (2014) discusses the choices for alternative forms of travel. In the study, the author's compare medical volunteer tourism and backpacking as the alternative forms of travel. "The research findings suggest that there is a substantial overlap in the travel patterns and behaviors of backpackers and VTs/MVTs." (Godfrey et. al, 2014, p. 113) Godfrey et. al, therefore attributes the increasing interest in participating in medical volunteer tourism to members of Generation Y, i.e. those born in between 1980 and 2000, and states that it has gained popularity because it appeals to those who "got tired of regular backpacking." (p. 111)

Wearing, not only defines who these volunteers are, but also why they do what they do. The motivations behind participating in voluntourism range from altruism to professional development. Wearing (2001) found altruism to be a common motivator for most volunteers; focusing on their eagerness to make a worthwhile difference to those less fortunate. This motivation included "improving the lives" of the members of the host country as well as "doing something constructive or helpful, rather than just going and looking." (p. 66) Although the notion of "giving back" was the most commonly mentioned motivator for the volunteers, it is not always the primary motivation. Other motivations include travel/adventure, personal growth, cultural experience, professional development, and self-enhancement. In some cases these motivations can be symbiotic;

Godfrey et. al (2014) discusses this phenomenon in the case of medical volunteer tourists (MVT's), "unlike backpackers, the MVTs were able to offer their time, and in the case of qualified MVTs, their medical skills, to aid the community they were visiting, while simultaneously enhancing their own professional and personal development." (p. 120). This symbiotic relationship could be exemplified through the benefit of medical care to the resource deplete host community, while the volunteer also benefits from the trip by understanding medical care in areas with limited access to health care, enhancing their cultural awareness and foreign language skills etc. Again, posing the ideal win-win situation.

However, like previously mentioned, the idea of international medical aid is not as perfect as we may hope it to be. Godfrey et. al, (2014) goes on to explain that this symbiotic relationship is most often not the case. In fact, most of the MVT's that were researched in the study done by Godfrey et. al (2014) felt they had not contributed to the host community as much as they would have expected. In fact, a particular volunteer, Emma, that was observed in the study done by Godfrey et. al stated " the first [placement] was at a clinic, the second was at a hospital, and the third was at a school for disabled children... I really liked the first two places but I didn't really think I was helping them... it was interesting for me to see how they do healthcare and how everything works here so it was awesome, but I was just kind of standing there and *not* helping them. And so that's not really what I wanted to do here." (p. 116) They found that the MVTs gained more from their volunteer experience than the host communities had. This poses an ethical issue regarding international aid that Hickey et. al (2012) calls attention to; the motivations of volunteers play a crucial role in the implementation of

medical aid. Because these resource-deplete areas rely on these organizations to provide health care, the motivations of the volunteer “staff” can have unexpected negative consequences on the host community. For example, if the volunteer is focused more on self-enhancement or travel experiences, there is greater likelihood of a threat to the host community. These dangers include missing volunteer work to devote time to travel, focusing only on what the host community can do for the volunteer’s professional development or self-enhancement, etc. All in all, these distractions effect the time the volunteer has to devote to the host community and can in turn effect the quality of care given by the volunteer.

Language Barriers

Major barriers involved in international medical aid include potential cultural and language discrepancies between the host community and the medical volunteers. It has been found through various studies (Wearing, 2001; McLennan, 2014) that voluntourists are typically culturally assimilated to the Western Culture and are English speaking. Both of these attributes can pose unexpected threats on the quality of care given by the professional. Because most volunteers are English speaking the communication that occurs between the volunteer and the patient is dependent on the use of translators. Not only does the use of a translator utilize more of the voluntourists valuable time, but it does not always guarantee the information will be accurately translated. This poses a major ethical concern for voluntourists because one of the contingencies of upholding the best possible care for the patient is consent. This consent is reliant on the accuracy of the communication between the practitioner and the patient about the procedure. However, the host community may not always recognize the procedures and medical language that

are specific to the field of practice. An example of this can be seen through the work of the Trinh foundation and their work in Vietnam. The Trinh Foundation, which will be discussed in further detail later in the paper as a case study for international aid, implemented the field of Speech Language Pathology in an area that was completely unaware of the profession, Vietnam. Therefore, the language that is specific to the field of Speech and Hearing, such as words like aphasia and stuttering, did not exist in the Vietnamese language. In the case of the Trinh Foundation, whose goal is to generate the field of Speech Language Pathology in Vietnam through implementing the education to train Speech Language Pathologists, they created a *Glossary of Terms* that was an English to Vietnamese translation of language specific to the speech, language and hearing field. The Trinh foundation is slowly changing the cultural understanding of this medical language. (“Trinh Foundation: Australia”, 2015) Although a great answer to the problem, the creation of translated language that does not exist is a far-fetched goal for a short-term medical mission. Therefore, as of now, the medical aid organizations are left reliant on translators and at risk for inaccuracy of communication.

Cultural Barriers

Cultural barriers are another concern regarding international aid work. This is a major ethical concern because more often than not the foreign culture gets imposed on the host community. The volunteers come with expectations about the power and importance of Western medicine. Hickey et, al. (2012) defines these inflated ideas as having “a neo-colonialist attitude.” This attitude correlates to the idea that coming from a more-fortunate area gives the volunteers “better education” in comparison to local practitioners. The volunteers may also believe that they can provide “real expertise” and that they are

the “only solution” to the host community’s access to health care. McLennen (2014) defines this same phenomenon as “promoting an image of a ‘Third World other’ that is dominated by an ‘us and them’ mind set.” (p. 165) This mind set poses an ethical concern for a couple of reasons. The first reason being that, by focusing on Western practices, as volunteers we may be implementing medical care that is irrelevant to host communities. For example, in a study done by Carter et, al. (2005) it was found that the use of the assessments for language and cognition that utilize picture stimuli, was not culturally appropriate for the children of Kenya. Even though, the common assessment tool for Western children is those that include picture stimuli, because they learn to perceive pictures while simultaneously learning to speak and listen through the use of picture books, this is not a common practice for children of Africa. Because picture books are not common in the African culture, especially outside of the school environment, they “found that rural Kenyan children, especially those not attending school, had difficulties interpreting picture stimuli” (p. 394). The lack of culturally appropriate assessment and treatment can result in inferior or inaccurate care. This can result in further detriment to the patient. This cultural barrier, poses the ethical question “Are the volunteers and organizations providing culturally relevant care to the host communities?”

The second reason that why this mindset can negatively affect the host community, is because it can cause a reliance on international aid organizations. If the volunteers maintain the mindset that they are the only answer, this same mindset may be passed on to members of the host community. In her study, McLennan (2014) analyzes the complexities of volunteer tourism through the observation of voluntourism in Honduras. McLennan discusses an instance in which a patient waited for a medical brigade to arrive

instead of receiving care in the host community. The patient stated, “I came (to see the brigade) because I heard they were giving glasses and I need glasses. I also need medication that a local doctor prescribed for me, but I don’t have the money to buy (it).” (McLennan, 2014 p. 169) Although, in some instances the patient waits for the medical mission because the host community completely lacks the resources to provide care, McLennan discusses the potential for reliance on international aid organizations that can occur at both the individual and national level. At the individual level, exemplified through the patient who waited for free medication because he/she couldn’t afford it, a few different consequences can ensue. The first consequence, is the worsening of the individual’s severity of illness. The second consequence, may be a decrease in local resources. If a patient waits for resources that will arrive with a relief mission because it is cheaper for the patient, this in can cause local resources, if available, to be underutilized. “For example, when patients are screened and scheduled for a procedure only to obtain that procedure from a volunteer team [instead of by a local practice]” (McLennan, 2014 p. 169). At the national level, the same reliance on international aid efforts can be seen as well. McLennan (2014) also discusses the views of the Honduran Department of Health on medical aid brigades; “the Honduran Secretaria de Salud (Department of Health) sees considerable benefits in the presence of medical volunteers, and encourages teams to come, trying to keep procedures and requirements simple for them” (p. 169) This reliance on international aid missions that McLennan discussed poses the ethical question “Do the current practices create a dependence on medical aid?”

Unexpected Circumstances

Another concern regarding International aid work can be unexpected circumstances. This may be due to the fact that the volunteer is still in “training” to become a medical professional or as previously mentioned, the illness may be worse than what the professional is used to in their home country. In a case study Wall (2012), discusses a case in which a Western urogynecologist who practiced in the United States, traveled to Ghana on a short term medical mission with the purpose of performing vesicovaginal fistula repair surgeries. The urogynecologist was sent to this area of Ghana specifically because the obstetric care in this area was primarily absent and many of the women in the area suffered from complications of pregnancy and labor. In this case, the urogynecologist had experience performing this particular repair hundreds of times in the U.S. and would be considered an expert in the field. Due to this expertise; the urogynecologist had anticipated allowing for 10 surgeries a day; this ideology was based on the time frame in which it took the team to perform this same surgery in the United States. However, when the team arrived in Ghana they encounter a particular patient who had developed a vesicovaginal fistula three years prior to the medical mission. This fistula resulted from complications to childbirth, these complications left the patient in the midst of a lengthened and obstructed labor, in which the fetus was lost. The death of the fetus caused necrosis that pushed against the patient’s pelvis that remained in the patient’s body for 3 years. This eventually caused an increased amount of scar tissue that the urogynecologist was not expecting. The urogynecologist repaired the fistula as he normally would have, even though the conditions of the surgery varied greatly from what he was used to in the U.S. The urogynecologist remained unsure of fact that the closure he had performed would succeed long term. Under the circumstances, the

urogynecologist had evolved from an expert in the field to being unaware of his competency to perform the vesticovaginal repairs. (Wall, 2012)

In this case study, the patient receiving the vesticovaginal repair had an excess amount of scar tissue and necrosis that was typical to the patients the urogynecologist would have encountered in the U.S. This extreme case presented by the patient is a result of the limitations in the developing world. These limitations include resources, healthcare, medical professionals, time etc. The patient, in the case study, had no access to the kind of health care she needed. She had to wait three years to receive the surgery, when the medical mission arrived, whereas the patients the urogynecologist would have encountered in his home country would have received treatment immediately following the trauma. Therefore, the degree of severity to her condition was far greater than what the surgeon expected.

The other instance in which unexpected circumstances may occur for the volunteer is if the volunteer is in “training.” According to Crump & Sugarman (2008) regarding the ethical considerations for global health trainees, 47% of accredited medical schools have established global health initiatives. These initiatives were implemented to educate prospective medical professionals about global health issues and to allow them firsthand experience in resource-poor countries. The benefits of these programs are to better train health professionals in areas pertaining to global health and also increase the manpower in these resource-deplete areas. However, the use of a trainee for global health work, may also pose a threat to the host community. “Those in training may lack experience in recognizing serious of unfamiliar conditions and skills in performing particular procedures” (Crump & Sugarman, 2008 p. 1456). In addition to unexpected

circumstances in aid work as previously mentioned, those who participate in international aid work may have a neo-colonist mind set and have inflated ideas about the value of their skills, this concept is a great risk for those who are still training. There is also the possibility that inexperienced trainees may be given responsibility that falls outside of their capability. This can be caused by the host countries lack of resources. For example, the local staff may be overburdened and “may see the presence of short-term trainees as an opportunity to take a break or to allocate their effort to other activities” (Crump & Sugarman 2008, p. 1457) This can not only leave patients with an inexperienced clinician who may not be trained to perform certain procedures, but also without a clinician who is experienced in the language and culture of the host community. The use of inexperienced professionals, discussed by Crump & Sugarman (2008), poses the ethical question “We do not allow inexperienced professionals, such as medical students, to perform certain procedures in Western hospitals. Why do we send these students overseas to perform these same practices?”

Ethical Questions

Through the review of the issues surrounding medical voluntourism, the research provides the background to pose three primary ethical questions surrounding the international aid efforts in western culture:

1. We do not allow inexperienced professionals, such as medical students, to perform certain procedures in Western hospitals. Why do we send these students overseas to perform these same practices?
2. Are the volunteers and organizations providing culturally relevant care to the host communities?

3. Do the current practices create a dependence on medical aid?

Ethical Questions Related to Speech Language Pathology

Inexperience

In relation to trainees participating in global health initiatives, the Teachers College of Columbia has implemented an international elective in their MA-SLP degree, in which students travel to either Bolivia or Ghana to participate in a medical volunteer missions. This international program is a 5- day course that addresses cleft palate speech and post-palate repair, it allows the students to assist and/or participate in training with local SLPs. (“International Programs, Teachers College Columbia University”) There is no empirical research surrounding this particular international health elective (IHE), but a study done by Elit, et al. discusses the ethical issues of medical students involved in IHE. For some respondents in the study “the potential level of responsibility given to them on their IHE might exceed that which is possible (and, sometimes, that which is acceptable) for a medical student in Canada.” (p. 707). In fact, some respondents noted receiving responsibility of providing procedures outside of their clinical training.

Another area in which inexperience can occur in the field of Speech Language Pathology is with inexperienced professionals. As previously mentioned, due to the lack of speech and language training in Belize, the treatment provided for those with speech and language disorders comes from two special education teachers that service 55+ schools (Jaramillo et. al 2015). A study done by Pierce (2012), which discusses Speech Language Pathology in Peru, states “clinicians who have received their training via distance education have limited or no internship opportunities. Many of these individuals may have inadequate training in performing diagnostics.” (p. 15)

Relevance

As previously mentioned, medical voluntourism within field of speech and language can experience issues surrounding culturally appropriate assessments. Another example of this issue can be seen through the study *Speech and language sequelae of severe malaria in Kenyan children* by Carter, et. al, (2002). In this study the speech and language of Kenyan children suffering from malaria were assessed. All children were from rural areas and spoke Kigiryama, the local language. “There are no pre-existing, standardized assessments of speech and language in Kigiryama” (Carter, et. al, 2002 p. 218) The study derived assessments from common assessments in the UK that assessed the children in areas such as comprehension, syntax, lexical semantics, higher level language, pragmatics, and phonology. It was found that “particular difficulties were experienced in selecting culturally-appropriate tasks... In hindsight, it is recognized that several questions were inappropriate: for example Kigiryama has very few synonymms and figurative language is rarely used among children, so few children scored anything on these questions.” (p. 222)

Dependence

It has been established that most developing countries lack clinical practice of Speech Language Pathology. Although, humanitarian work, such as Smile Train, is implementing education in care of post-cleft palate repairs. A considerable lack of aid in speech and language services still remains. Pierce (2012) states “many international programs that provide speech-language pathology services are extremely valuable resources for developing countries. The service provided may be the first time a qualified person has been able to treat people with communication disorders in the community, and

the first time local service providers have received such training (pp. 17-18). Therefore, by leaving resource-deplete areas without the services to provide care in speech and language, the host communities are left waiting for the medical teams, that include speech and language pathologists, to get these communication services.

A New Approach to Medical Voluntourism: Case Studies

This paper will analyze two separate non-profit organizations as case studies in order to develop a proposal to improve our efforts and overcome some of the ethical boundaries associated with medical aid efforts in Speech and Language Practices. Both these organizations, Nora Health and the Trinh Foundation: Australia, utilize a different model than the traditional “short term relief” model that was examined earlier in this paper.

Case Study: Nora Health

The first organization to be examined is Noora Health (“Noora Health”, 2014). Nora Health was founded by Edith Elliot and Katy Ashe; it began as a project developed by two graduate students at Stanford University, but quickly grew into something more. Like Doctor’s Without Border’s, Nora Health originated through the passion of two people who each had a goal to change the face of international medical efforts. The founders of Noora Health focused their efforts in India, where they found hospitals to be overcrowded and understaffed. They took note that these hospitals encountered issues relating to patients being released to families who live hundreds of miles from the nearest medical care or not having enough doctors to be able to spend the time going over the discharge information with the patient and family members. And because of these downfalls the hospitals had a large number of readmissions. Elliot and Ashe also saw a

huge resource that was underutilized in these areas; the family member. They had hoped that by utilizing this resource they would be able to change the healthcare system in India. Noora Health's mission stands to "train patients and their families with high-impact health skills to improve outcomes and save lives" ("Noora Health", 2014)

Noora health focuses on training patients and family members with basic skills, that are aimed to stop the turnaround on readmissions to the local hospitals. These skills can include physical therapy exercises, the recognition signs related to medical emergencies, hygiene and discharge information needed for particular patients. Noora Health features a story about Ajrun who has just undergone heart surgery. Noora Health taught him about his disorder and with that information Ajrun has played a consequential role in his own health. Noora Health emphasized his ability to be the constant reminder for the nurses to keep sanitized as well as his role in the design for the discharge materials that were created for his parents. ("Noora Health", 2014) The goal of this patient-centered care is to allow for benefits such as round the clock support outside of hospital, improved recovery and a reduced dependence on the health care system.

Noora Health is able to utilize patient's families through the use of video-based training courses and hospital hallways. The video based training was created to decrease the amount of language and culture barriers. Instead of being told what they needed to do and how they needed to do it, Noora Health created interactive training courses that allowed the family to see what they needed to do. Edith Elliot speaks at a Poptech conference, similar to Ted Talks, ("From Hallways to Classrooms," 2015) about the Noora Health. She speaks about the cultural norm of families stopping their lives and moving into the hallways of the hospitals during the stay of their loved one. The hallways

become overpopulated with family members and they as an organization aim to “turn hospital waiting rooms into classrooms and take people out of the hallways and next to the bedside of their patient” (“Noora Health”, 2014) By providing training while the family is at the hospital waiting for their loved one, it limits the time needed for the doctor to try and provide instructions for discharge. It allows for the family to have more time with these concepts before making the journey back home. Instead of a doctor stopping the family as they are leaving and describing the need to practice safe hygiene and to watch out for various warning signs, the patient and their family members are immersed in this information through the entirety of their stay.

Noora Health, which originated in 2014, has made great strides in the last two years. Based on the data the NGO has collected since it’s start in 2014, they have trained over 45,000 family members with loved ones that have received care in the hospital. This training has resulted in a 36% reduction to readmissions of patients to the hospital in India. It has also decreased the anxiety levels of caregivers by 6 times. (“Noora Health”, 2014) Noora Health has not only aided in the overall health of patients in rural India, but has boosted the confidence of caregivers of these patients.

Case Study: Trinh Foundation Australia

The second case study is a non-profit organization that is based out of Australia. The Trinh Foundation Australia is an international aid organization that provides services in Vietnam specific to the field of Speech-Language Pathology. The goal of the foundation is to aid in the establishment of speech therapy in Vietnam. The Trinh Foundation is different than the typical model of “international aid.” Like previously noted, Doctors without Borders exemplifies the “norm” within international aid

organizations. They provide aid by sending Western professionals to the developing world to administer the health care. However, the Trinh Foundation provides medical aid by training professionals in the field of interest. Instead of sending professionals from Australia to provide services in Speech Therapy for a short period of time, the Trinh Foundation sends professionals to Vietnam to train the Vietnamese people to provide these services themselves.

The foundation, similar to Noora Health and Doctors without Borders, originated from a group of people who wanted to change the face of international medicine. Sue Woodward, one of the founders of the Trinh Foundation, traveled to Vietnam in 2007 as a part of team of specialists, including two orthodontists Peter and Aziz Sahu-Khan, who provided successful cleft palate repairs. However, it was during this trip that Sue noticed that the patients she came in contact with not only needed the quick in-and-out repair that they provided, but also noticed that the patient's would benefit from speech therapy in order to learn how to adjust to speaking after the surgery.

Less than a year after Sue's first trip to Vietnam, on March 27 2008, that The Trinh Foundation was established. Sue, Peter, and Aziz founded the foundation with the help of Professor Nguyen Thi Ngoc Dung and Professor Lindy McAllister. Professor Dung, the director of the Ear, Nose and Throat Hospital in Ho Chi Minh City, also saw a need for Speech and Language Services in Vietnam. At the time, speech therapy was not a field that was familiar to Vietnam and it wasn't until Dung was an ENT intern in Lyon, France that she became aware of the benefit speech therapy would have in Vietnam. In fact, it is "estimated [that] 13 million people in Vietnam need speech therapy to enable them to communicate, eat and drink." ("Trinh Foundation: Australia", 2015) It was the

vision to bring speech therapy services to Vietnam that brought Sue Woodward and Professor Dung together. And it was in the ENT Hospital in Ho Chi Minh City, in which Dung was the director, that the first six-week postgraduate course in Speech Therapy was established.

Before the initiation of a graduate program at Pham Ngoc Thach in 2010, Vietnam did not have any Speech Therapists or formal training course in Speech Therapy. (“Trinh Foundation: Australia”, 2015) Due to this absence, Vietnam also had a lack of language relevant to the field of Speech, Language and Hearing Sciences. The Trinh Foundation is credited for providing that language. The Trinh Foundation created a “Glossary of Terms” that terminology that would be common in Speech Pathology from English to Vietnam. This includes anatomy that ranges from the head to the neck and well as terms specific to a Speech Language Pathologist. Some examples of this language is:

“aphasia: mất ngôn ngữ
augmentative and alternative communication (AAC): giao tiếp tăng cường và thay thế
dementia: sa sút trí tuệ
Eustachian tube: vòi nhĩ
hearing loss, conductive: mất thính lực dẫn truyền”
(“Trinh Foundation: Australia”, 2015)

The addition of this medical language to the Vietnamese culture has truly provided the backbone for the Trinh Foundations success. Although, the *Glossary of Terms* is an ongoing project for the foundation, it has helped to bring the field of Speech Language Pathology to an area that was unaware of the profession.

This postgraduate course focused on training professionals including doctors, nurses and physiotherapists in aspects of Speech Therapy that would allow them to treat for speech, voice and swallowing disorders in patients of all ages. From that first six

week course, training of Speech Therapists in Vietnam has evolved through the Trinh Foundation. In 2010, a 2 year postgraduate training program in Speech Therapy at the Pham Ngoc Thach Medical University. As of now, the Trinh foundation, has graduated 33 speech therapists in Vietnam.

Within the work of Noora Health and the Trinh Foundation: Australia there are two premises that set these organizations apart from the “typical” model of medical voluntourism. The first can be seen through Noora Health, Elliot and Ashe have utilized the resources in the host community. Noora Health saw a fault in the system, a high readmission rate to hospitals in India, and instead of bringing in resources, such as equipment, medicine and medical personnel into India to provide relief work for these patients. Noora Health harnessed the convenience and potential of local community members (friends and family of hospital patients) and implemented a plan to better utilize their skills. What sets Noora Health apart from the traditional model of relief is the absence of a “neo-colonist view.” Elliot and Ashe veered away from the thought process that “western medicine is the answer,” and instead empowered the hospitals and families to succeed on their own.

The second premise that sets these organizations apart from the model of medical voluntourism exemplified by MSF, is the implementation of training programs for local professionals. As previously mentioned, the use of training programs has been utilized in small focuses of the speech, language and hearing field such as audiology and cleft palate repairs, but the Trinh Foundation has taken it a step beyond and implemented training for the entire profession.

Conclusion: A New Approach to Medical Voluntourism

Through the review of literature pertaining to international aid efforts, it has been found that these medical volunteer missions provided by the Western culture may not be as beneficial as they seem. By considering that premise, this paper proposes a revised model for medical voluntourism that utilizes the focal premises of Noora Health and the Trinh Foundation: Australia:

1. The utilization of locals in the host community
2. The implementation of training programs

The first ethical question posed through the research was “We do not allow inexperienced professionals, such as medical students, to perform certain procedures in Western hospitals. Why do we send these students overseas to perform these same practices?” This question has been previously analyzed by Elit, et. al (2011) and Hickey, et. al (2012) where both studies proposed to implement pre-trip training to evaluate the motivations of the students participating in global health initiatives. It was proposed that by evaluating the motivations of inexperienced professionals, focusing on those who have a more altruistic and selfless motivation versus a motivation that focuses on personal development, would decrease the ethical concerns related to international aid efforts. It was also proposed that pre-trip training programs would also implement cultural training prior to the placement to also decrease the potential cultural barriers that can occur in international aid work. Although, this paper acknowledges the benefit global health initiatives have on the training students; the new approach to medical voluntourism implemented in this paper proposes the removal of the use of student trainees in procedures and treatment within the volunteer tourism experience. Unfortunately, until the host community and participating university can better monitor the students

responsibility in the host community, the use of global health trainees, in procedures and treatments, may pose a larger threat to the inhabitants of the host community than they do benefit. It may be more beneficial to utilize them primarily in terms of observation.

In reference to the other two ethical questions, this paper proposed that by continuing to be the “Western savior” in international medical aid, we are sustaining a dependence on aid organizations. We are guaranteeing that these resource-deplete areas continue to require aid from those more fortunate. If we instead focus our efforts on the two premises emphasized in Noora Health and the Trinh Foundation: Australia first, utilize the resources of the host communities, i.e. local residents, and secondly, implement training programs, we will be providing these communities with the ammunition to succeed on their own.

Specific to Speech Language Pathology, the research has shown that the international aid efforts within this field have already progressed to include training in areas such as post-cleft palate repair. However, the need for other areas of speech and language services still remains. This paper proposed the necessity of implementing speech and language training, in addition to the work in cleft palate teams, to ensure sustainability of communication for those who receive these volunteer services. Many resource deplete locations lack speech and language services completely and the implementation of speech and language training will lead to the development of the profession in developing countries.

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