Ethics Beyond Borders: How Canadian Health Professionals Experience Ethics in Humanitarian Assistance and Development Work

Matthew Hunt
Faculty of Graduate Studies and Research
McGill University
Montreal

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Abstract

Canadian health professionals are involved in humanitarian assistance and development work in many regions of the world. They participate in primary health care, immunization campaigns, feeding programs, rehabilitation and hospital-based care. In the course of their work clinicians are frequently exposed to complex ethical issues. This thesis examines how health workers experience ethics in the course of humanitarian assistance and development work. A qualitative study was conducted to consider this question. Five core themes emerged from the data including experiencing a tension between respecting local customs and imposing values, knowing how to respond when basic care is impossible, addressing differing understandings of health and illness, questions of identity for health workers, and issues of trust and distrust. Recommendations are made for standards and organizational strategies that could help aid agencies better support and equip their staff as they respond to ethical issues.

Resumé

Les professionnels de la santé canadiens sont impliqués dans des projets d'aide humanitaire et de développement international dans plusieurs régions du monde. Ils participent à la santé primaire, aux programmes d'immunisation, d'alimentation, à la réadaptation et soins hospitaliers. Au cours de leur travail ces cliniciens sont exposés à des enjeux moraux complexes. Cette thèse examine comment les cliniciens vit l'éthique au cours du travail humanitaire et de développement. Une étude qualitative a été faite pour examiner cette question. Cinq thèmes ont émergés des données: conflit entre le respect des coutumes locales et l'imposition des valeurs, comment répondre quand les meilleurs soins ne sont pas accessibles, des conceptions différentes de la santé et maladie, des questions d'identité, et des enjeux de confiance et méfiance. Des recommandations sont faites concernant les normes et les stratégies pour assister les agences d'aide à mieux soutenir et former leur personnel pour répondre aux enjeux éthiques.

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Chapter 1: Introduction

1.1 Introduction

When Canadian health care professionals embark on humanitarian relief or development projects in other regions of the world they are placed in a unique situation. The shift from the Canadian health care context to that of an underdeveloped nation or a country experiencing a Complex Humanitarian Emergency (CHE) represents far more than just a geographic change. In this new setting the manner in which health care is practiced will be significantly different as a result of a number of important factors. These features include knowledge and resource limitations – characterized by Michael and Zvi (2002) as "oceans of need"–, a potentially unstable health and political situation, and a more population-based focus to health care (Black, 2003). These characteristics, as well as frequent cultural and linguistic gaps between the health worker and the local population, add to the complexity of health care delivery (Bjerneld et al, 2004).

Humanitarian assistance and development work may also involve a move away from an environment where explicit professional and legal parameters guide the ethics of clinical work to one where there is less regulatory oversight and professional accountability (Slim, 1997). In Canada, the field of bioethics is well established and has an important function in informing the practice of clinical care. Bioethical discourse and health care delivery are guided by the substantial body of legislation and case law that governs medical practice in Canada. There continues to be significant debate regarding many ethical issues, particularly those at the beginning and end of life. However, there are also

widely accepted standards that guide the core ethics of clinical care. In contrast, development and humanitarian work is often undertaken by teams of individuals from a number of different countries all working with a local population or populations. Relief agencies often "find themselves making decisions in a legal vacuum" (Slim, 1997). The diversity of cultural backgrounds, and frequently of ethical frameworks, of the actors as well as the absence of firm guidance in international law and health policy heightens the difficulty of seeking resolutions to ethical dilemmas in patient care.

1.2 Development of research query

My interest in the question of how international aid workers understand and live out health care ethics has its origins in my experiences as a physical therapist working in North Africa and the Balkans. I trace the initial impetus for this research question to a specific experience. In 1999 I was involved in a project in rural North Africa to provide rehabilitation services for children with disabilities and to assist in the establishment of a health center for the care of these children. One of my colleagues was a British midwife who worked as a clinician and educator in the local hospital. After a very difficult shift she described how overwhelming it was to try to reconcile the divergence between her own ethical convictions and the accepted practices of the local health care team. Though frustrated by the shortage of resources in the maternity ward she accepted that babies with poor prognoses were not assigned the limited resources available, such as incubators, as these were reserved for children with a better chance of survival. However, she was dismayed by the manner in which newborns with Spina Bifida and other congenital deformities were treated. These babies were not shown to the mother.

Instead, they were immediately taken away at birth and left to die. This experience was extremely difficult for the midwife to reconcile with her own ethical understanding and she struggled to know how to respond to the situation. As I witnessed the angst that this experience caused for my colleague I began to apprehend the ethical complexity that cross-cultural, international health delivery entails for clinicians.

In reflecting on the experience of my colleague, and my own experiences of navigating clinical ethics in humanitarian work, I resolved that the best way to gain insight into how aid workers could be better prepared for such situations would be first to seek to understand what it is that health practitioners really experience in the field and what impact this has on them.

1.3 Humanitarian response, international development and clinical ethics

Despite growing interest in the cultural component of medicine in North America and Europe, due largely to the reality of increasing immigration and multiculturalism, many health workers still have a limited understanding of the cultural realities of medical practice (Kagawa-Singer and Khaseem-Lhaka, 2003). Indeed, Western biomedicine, though itself a social and cultural phenomena, often "ignores the importance of culture in the successful diagnosis and treatment of physical and psychological ailments" (Fagan, 2004). International health workers, despite frequently being poorly equipped to analyze cultural issues, must constantly probe and examine the cultural aspects of the health care they deliver and decide how they will conduct themselves in relation to patients, local colleagues and other expatriate health workers.

When health care workers are deployed in contexts of humanitarian assistance or development programs they are faced with difficult situations that challenge their personal, cultural and professional understandings. They may have to cope despite dire shortages of resources and personnel. They sometimes have to provide health services in the context of war, political instability, or natural disaster where the situation is unstable, dangerous and impossible to control (Bjerneld, 2004). The basic reality that their patients come from a different cultural background will also contribute to the challenge of providing adequate service due to the inevitable difficulties of cross-cultural dialogue and understanding.

Concerns over cross-cultural communication and extreme work conditions are likely to have been contemplated by most international health care workers. These issues are sometimes apparent before the health worker boards the plane to depart on her assignment. What may not be clear to the health care worker is how she will be able to navigate divergence between local moral norms and her own professional ethical convictions. As a result, she may be poorly equipped to address differing understandings of what constitutes ethically appropriate action in the clinical setting in which she will work.

Most people, including many medical personnel, tend to feel strong intuitive responses to moral or ethical situations without necessarily being able to articulate why they feel a specific action is bad or unacceptable. When the ethical judgement crosses cultural or temporal boundaries it may be even more difficult to offer justifications for our moral

intervention. For this reason it is important that international health care workers examine and discuss the nature of cross-cultural medical ethics.

A particular dimension of health delivery in humanitarian assistance is that health professionals must frequently shift their focus from the traditional individual patient focus to one that integrates a constant awareness of population-based medicine. As Peter Hakewill (1997) notes, staff must "reorient their thinking from a purely clinical approach to a constant preoccupation with public health interventions". The pull between the two foci of population and individual can cause confusion and uncertainty for some health care staff, as they may need to sacrifice the needs of specific individuals in order to address the needs of the greater population (Robbins, 1999). Frequently, a utilitarian calculus is applied. This thinking may be in opposition to the training and ethical understanding of health workers from Western countries where public health concerns receive less emphasis than the delivery of care to the individual patient.

1.4 Theoretical basis

The goals and purposes of humanitarian assistance and development work are obviously very important. The significance of this work is not just measured in the number of dollars that are donated to these causes but also in the knowledge and skills of clinicians who are engaged to provide needed health care services. The ethics of humanitarian assistance are not limited to questions of when and how to intervene. There is also the crucial, and to date under-examined, issue of clinical ethics.

As a health professional trained in the health sciences my research orientation has been that of quantitative study. However, as I considered this subject it became obvious that the most appropriate means of pursuing this topic would require the use of qualitative methodology. It is essential to develop an understanding of how these issues are experienced by clinicians in a variety of settings in order to best consider the relationship between clinical ethics and humanitarian assistance and development work. I selected a phenomenological approach as a useful method to address this topic (Patton, 2002). This approach will allow an examination of how health workers experience ethical issues and the meaning they give to these experiences.

1.5 Purpose and significance of the study

This project will seek to assess the nature and impact of ethical dilemmas that arise in humanitarian and development situations with special attention to the cross-cultural nature of this work. I conducted interviews with nine health workers from four different professional disciplines, each with significant international experience, as well as one interview with the Executive Director of a Non-Governmental Organization (NGO). The findings of these interviews will be presented in subsequent chapters in order to describe some of the lived experiences that are manifested in the field, as well as the moral reasoning and perceived impact of ethical dilemmas as reported by the participants.

This inquiry into the experience of humanitarian health workers as they engage with the ethical dimensions of their work is an important venture. By seeking the input and perspective of individuals who have lived out these experiences it will be possible to

identify strategies and methods of better equipping and supporting health workers in the field. This will assist health care teams to engage ethical issues in a way that will lead to more just and appropriate care for patients and populations, minimize harm to vulnerable individuals and communities, and mitigate against the feelings of angst and moral confusion that health workers may experience.

1.6 Outline of Chapters

In the next chapter I offer a brief historical perspective on the rise of the modern humanitarian movement. I also give an overview of the bioethics literature relating to ethics and culture, particularly in regards to clinical care in multicultural societies. Many international organizations provide guidelines and encourage standards of practice for health care delivery around the world. These documents and initiatives are reviewed and considered in relation to my research question.

The third chapter summarizes the research questions and delineates the methods employed in the implementation of the research project. The processes of how the data was collected and the means of data analysis are described and discussed.

In the fourth chapter I examine the results of the research study. In particular, I review the themes that emerged from the interviews. These themes include the tension between respecting local beliefs and imposing values, how to respond when adequate care is impossible, differing understandings of health and illness, questions of self conception

and identify, and finally issues of trust and distrust between expatriate workers and the local population.

The fifth chapter includes a discussion of the results of the research, outlines some of the limitations of the study and describes the implications of the study for humanitarian assistance and development work. Recommendations are given for future research and organizational strategies for addressing ethics in humanitarian action. Chapter 5 pays particular attention to the question of how NGOs might better support and equip their staff for the ethical dimension of their work.

Chapter 2: Review of the literature and background considerations

2.1 Introduction

The involvement of Non-Governmental Organizations (NGOs) in the international response to Complex Humanitarian Emergencies (CHEs) and situations of underdevelopment has increased enormously over the past decades (Slim, 1997). In 1993 alone there were over 120 different NGOs registered in Kigali, Rwanda (International Federation of the Red Cross and Red Crescent Societies, 1995). Natural disasters, such as earthquakes, floods and tsunamis, also lead to the need for humanitarian response. In 2002 disasters affected approximately 608 million people worldwide (ECHO, 2005). Health professionals are a crucial element in relief efforts following natural disasters, armed conflict or in situations of chronic underdevelopment. In these varied settings the roles that health workers are called upon to perform are diverse and can include screening and immunization, feeding programs, control of communicable disease, primary care delivery, and more (Hakewill, 1997).

Health professionals who are employed by NGOs to deliver health care to populations in need are routinely placed in situations that are significantly different from both their previous experience and the formal training that they received prior to deployment overseas (Bjerneld, 2004). Though organizations have developed that are uniquely oriented towards international health and humanitarian work most of the field staff they employ have been trained in the practice of health care in stable political and social environments where clear legal and professional guidelines provide parameters for

clinical decision-making. The carryover from health care training in the West to work in a refugee camp in an underdeveloped country has important limitations. International medical personnel work in an environment where human rights, public health, medicine and ethics interact in different ways than that with which they were familiar in their home country (Mann, 1997).

In the course of their professional responsibilities health workers confront many clinical and organizational challenges. Clinical health care is frequently complicated by unstable security situations, political obstacles to care delivery and rapidly changing health needs of the population (Banatvala and Zwi, 2000, Bjerneld et al, 2004). Health workers may even experience threats to their own security as has been evidenced in both Iraq and Afghanistan with the kidnapping and killing of aid workers (ECHO 2005). As a result of these different factors health professionals experience new forms of ethical dilemmas that they may be poorly equipped to analyze and resolve. For many humanitarian workers the reality of new types of practical ethical problems may be unanticipated and can lead to the destabilizing effect of undercutting some of the presumed foundation for their work. In the face of unresolved ethical issues some health workers may move from a feeling of ambiguity to one of moral angst.

To better situate the question of how clinicians experience ethics in humanitarian relief and development I will briefly review the development of the humanitarian enterprise as well as the literature regarding bioethics in multicultural societies, global bioethics, the ethics of humanitarian intervention, international initiatives to promote standards of

practice for NGOs, and some of the guidelines and resources available to international aid workers.

2.2 The humanitarian enterprise

The global discrepancy in health and health care is dramatic. There is a vast disparity of access to health resources in different countries of the world. Health services that Canadians take for granted may seem inconceivable to a villager in rural Nepal. Numerically the discrepancy is stark. World Bank statistics reveal that Nepal had 0.1 physicians per 1000 people and an under 1 year infant mortality rate of 61 per 1000 live births in 2003 (World Bank, 2005). In contrast Canada, in 2002, had 2.1 physicians per 1000 people and an under 1 year infant mortality rate of 5 per 1000 (World Bank, 2005). One of the main impetuses towards the humanitarian enterprise has been a concern to address this inequality of health and health resources throughout the world.

The international humanitarian movement has existed for around 150 years as a conscious movement of humanitarian action (HAP and WHO, 2002) and has grown enormously in the last decades. The presence of NGOs has been a central phenomena associated with the development of international medical work. The number and diversity of NGOs involved in humanitarian action continues to increase (Slim, 1997). Global organizations, first the League of Nations, and later the United Nations and the World Health Organization have sought to frame, guide and encourage international humanitarian assistance.

Thousands of health workers are involved in humanitarian projects annually, working with hundreds of NGOs. The nature of the work that these organizations engage in is enormously diverse and complex (Banatvala and Zwi, 2000). NGOs have varied mandates and often quite different core values (Slim, 1997). To date there has been a dearth of discussion regarding what should constitute best practices for the varied work that is carried out globally (Banatvala and Zwi, 2000). Guidelines and policy from international bodies concerning how humanitarian projects are to be established and run also remains limited (HAP and WHO, 2002).

2.3 Bioethics and humanitarian work: a neglected topic

There has been little discussion in the literature of bioethics and related disciplines about the inter-relationship amongst culture, ethics and clinical health care as experienced by humanitarian workers. However, several qualitative studies have been conducted that relate more generally to the experience of health care workers in humanitarian assistance projects. Two articles discuss the experience of health professionals providing care for refugees from countries experiencing Complex Humanitarian Emergencies (Griffiths et al, 2003, Fowler et al, 2005) who have been evacuated to Australia and Canada, and a third article examines perceptions of humanitarian work by returning Swedish health professionals (Bjerneld et al, 2004).

Griffiths et al (2003) interviewed nurses who were involved in the care of Kosovar and Timorese refugees evacuated to Australia. They conducted a series of focus groups and identified a number of staff needs including improved clinical skills related to refugee

health, cultural competency skills and trauma-sensitive care. Nurses experienced "moral distress" in response to the care that they had to provide to these populations and a number of ethical dilemmas specific to working in the cross-cultural context of the Safe Haven program (Griffiths et al, 2003).

In a similar study Fowler et al (2005) interviewed service providers (health professionals and others) who were involved in the care of Kosovar refugees who had come to Canada as part of a Humanitarian Evacuation Program (HEP) during the Kosovo War. Most of the participants in the study reported feeling "overwhelmed" by the magnitude of the task of settlement for the refugees. They described the need for better communication and coordination but noted that the experience was successful overall. However, this study did not examine in much detail the impact of this experience on the service providers. Instead it focused on the technical aspects of assisting the settlement of refugees.

The third article by Bjerneld et al (2004) examined the perceptions of Swedish nurses and doctors who had been involved in humanitarian relief work. The authors identified six themes from the interviews. Participants had positive feelings regarding their work but also experienced feelings of frustration and stress. Many stressors were identified including security concerns, heavy workloads, isolation, cultural issues and language barriers. Health workers described being presented with unexpected tasks for which they were inadequately prepared. Many of the participants also expressed feelings about other actors, both positive and negative. One of the findings of the study was that "disillusionment was associated with a perceived lack of appreciation and respect by the

local population, as well as behaviors contrary to Western mores" (Bjerneld et al, 2004). The final themes were a consideration of factors that affected success in the field and the role of the recruiting organization. The clinicians had strong expectations of support and training from the NGO that often went unsatisfied. This study identifies the varied experiences of health workers in humanitarian relief and highlights a number of ethical issues that were part of their field experiences.

Though the topic of clinical ethics and humanitarian work has yet to receive much attention in the literature the articles discussed above suggest that ethical issues are, implicitly or explicitly, an important concern of health care workers in relationship to humanitarian responses either amongst evacuated populations or during interventions in affected countries. In addition to these studies there are a number of topics in the literature of bioethics that relate to this project. Several distinct areas of scholarship relating to the ethics of clinical care in humanitarian and development work can be identified and will be reviewed in the following sections.

2.4 Medical ethics in multicultural societies

The first area of study considers the increasingly multicultural nature of North American and European nations. As a result of increased global immigration and the resulting cultural plurality of Western nations, health professionals are faced with new ethical dilemmas. Immigrants from other regions of the world frequently have different ethical understandings from that of the dominant medical culture in their new nation. This difference of ethical understanding may reflect an underlying divergence in how health

and illness are understood between the cultures. These differences can result in great tension for both health professionals and immigrant communities. Much of this literature discusses the need for the health care system and its practitioners to be respectful and tolerant of other cultures and, where possible, to adapt health care delivery to accommodate the perspectives of immigrant groups. The literature also considers the limits of this accommodation and what standards should not be compromised.

It is widely recognized that there are sometimes substantial incompatibilities between Western medical culture and the culture of immigrant communities in regards to values and beliefs related to health care (Ells and Caniano, 2002). In recent years the training of health care practitioners has included a greater focus on the cultural reality of health care provision in multicultural societies and particularly the development of cultural competence (Paasche-Orlow, 2004). This training has focused on increasing the awareness of the impact of culture on health care and developing skills in cross-cultural communication.

2.5 Ethical frameworks and global bioethics

A second area of scholarship is that of global bioethics. This literature consists of discussions regarding the possibility of forming cross-cultural moral judgments and the establishing of a "global bioethics" that would have universal applicability. This literature is linked in significant ways to discussions of human rights and universal ethical codes. There is considerable debate about the justifications for advancing an

international global bioethics. Recently, discussion of international research ethics has been a central point of debate in this regard (Abratt, 2001, Christakis, 1992, Macklin, 2004)

Different approaches to global bioethics are related to the ethical frameworks of the commentators who advance them. Universalists appeal to mid-level principles rather than meta-ethical theory to propose a "common morality" that is shared by all moral societies and individuals (Beauchamp 2003, Macklin 1999). However, other commentators are skeptical of the possibility of identifying this common morality (Turner, 2003). Baker argues for a negotiated bioethics that is related to social contract theory and situates the locus of whether an action is wrong on whether it is inherently unacceptable to the potential victims or objects of the action (1998). A further framework that can guide global bioethics is a feminist analysis. Feminist ethics is skeptical of the appeal of "respect for culture" and insists that cultures are not morally neutral. In this view cultural practices that harm people, especially women and children, should not be accepted (Hellsten, 2001). Two further ethical frameworks, relativism and absolutism, are rare positions to be expressed by bioethicists today. The discussion of global bioethics is ongoing in the literature and consensus has yet to be achieved.

2.6 Ethics of humanitarian response

Finally, numerous scholars and organizations address issues related to the ethics of humanitarian intervention. This has been a particularly important topic in the wake of some of the troubling experiences of the humanitarian community in the past 20 years

(Black, 2003). Slim (1997) notes the increasing commitment to engage with humanitarian ethics: "To their credit, humanitarian practitioners and commentators have taken up this task and the subject of humanitarian ethics is moving rapidly up the agenda of relief agencies and academics alike". This body of literature is concerned with macro level issues related to humanitarian relief. The scholarship of humanitarian ethics is substantial and many questions have been raised. These questions include whether the presence of NGOs prolongs conflicts, how a lack of cooperation amongst organizations can lead to inefficiency and confusion, how organizations should withdraw from projects, how the presence of NGOs can impede the establishment of social order and whether NGOs may downplay issues of rights to ensure access to certain populations (Black, 2000, Callamard, 2003, Michael and Zwi, 2002). As a result of these issues there have been calls for the continued development of standards of practice and the establishment of an evidence base through research (Banatvala and Zwi, 2000). A number of core principles for humanitarian response have been advanced in the hope of responding to these concerns including impartiality, neutrality, independence, solidarity, sustainability and accountability (ECHO 2005, Black 2003).

2.7 Professional guidelines

Most Canadian health care practitioners who are involved in humanitarian or relief projects are members of professional organizations at home. Each of these organizations such as the Canadian Medical Association, the Canadian Physiotherapy Association and the Canadian Nurses Association, has standards of ethics that are required of its membership. These requirements may prove challenging for health professionals to

honor in settings where local expectations and norms of practice are significantly different from the Canadian context of health care delivery.

Professional moral norms are closely tied to the professional identity of health workers. Clinicians often note that maintaining the standards of their profession is essential to their own self-concept as a competent, ethical professional. It is unlikely that disciplinary action would follow from a health professional transgressing the code of practice of her professional organization while working in a different country. However, a professional who contravened her professional code would certainly be in an ambiguous moral position. The professional moralities of Western biomedicine may have a significant impact on the deliberation and choice of action of humanitarian workers. Some locally accepted practices may be felt to be anathema to the profession of a particular health worker. For instance a practice such as Female Genital Cutting (FGC) may be seen by a local group as ethically acceptable. However, participation in FGC may be perceived by a Canadian nurse as counter to the professional morality of Western biomedicine.

2.8 International guidelines for health care ethics

A number of different bodies offer guidelines to aid health workers in assessing the ethics of their work. These guidelines are merely guidance documents that are not enforceable by law. They do not have any provision for the punishment of those professionals who contravene them. However, these guidelines are important and they can be of great benefit in assisting health professionals in fulfilling their professional duties.

Some of the most important of these guidance documents are those produced by the World Medical Association (WMA). Several of these documents relate to the provision of patient care. The WMA International Code of Medical Ethics (revised 1983) divides duties of a physician into three categories: duties in general, to the sick, and to other physicians. The code asserts that doctors worldwide are duty-bound to provide technically competent care, while treating their patients with compassion and maintaining respect for human dignity. In regards to rights doctors are expected to "respect the rights of patients, of colleagues, and of other health professionals and ... safeguard patient confidences" (WMA, revised 1983). However, the code does not further amplify which rights are to be maintained towards these various moral agents. It is of note that the duty to ensure confidentiality is one of the more specific requirements in this important document.

The World Medical Association's Declaration of Geneva (WMA, revised 1994) stipulates other ethical principles by which physicians pledge to practice their profession. This includes the pledge to "Not permit considerations of age, disease or disability, creed, ethnic origin, gender, nationality, political affiliation, race, sexual orientation, or social standing to intervene between my duty and my patient." (WMA, revised 1994). This pledge may be especially important when working with different cultural groups where a social hierarchy would normally dictate access to care.

The WMA also has a policy document specific to disaster response that dictates

relations with the victims are governed by first-aid medical care and the state of

> need, with the result that the need to protect patients' best interests shall be respected, if possible, by obtaining their consent in the immediate emergency. However, the physician should adjust to the cultural differences of the populations concerned and act in accordance with the requirements of the situation (WHO, revised 1994).

The issue of consent to treatment is one that will likely challenge health workers who are involved in emergency response work. Just how they are to adjust to cultural differences is unclear. As in the Declaration of Geneva the policy on disaster response makes explicit that non-medical factors should not affect the care of patients. Specific to triage in an emergency setting physicians should select patients by a process in which they "consider only their emergency status, and should exclude any other consideration based on non-medical criteria" (WHO, Revised 1994).

Two manuals on medical ethics with an international perspective are available to aid health workers involved in patient care around the world. In January 2005, the WMA published a volume entitled *Manual of Medical Ethics* (WMA, 2005). The objective of this manual is to "sensitize the conscience" of physicians and equip them to respond to ethical dilemmas in their practice. The second document, the *Training Manual on Ethical and Human Rights Standards* (CMA, 1999), was created by the Commonwealth Medical Association with the goal of improving the educational material available to health practitioners throughout the world in regards to bioethics.

2.9 International efforts to promote accountability in humanitarian response

In the introduction to their Code of Conduct the International Federation of Red Cross and Red Crescent Societies (1995) noted:

> What few people outside of the disaster-response system realize is that all these agencies, from the old to the new, from multi-million dollar outfits to one-man shows, have no accepted body of professional standards to guide their work. There is still an assumption in many countries that disaster relief is essentially 'charitable' work and therefore anything that is done in the name of helping disaster victims is acceptable.

Since that time a number of different projects have been initiated by international bodies and NGOs themselves to improve accountability and refine the principles and standards of member organizations. Many of these initiatives originated in the 1990s in response to the experience of aid delivery during and following the Rwandan genocide in 1994. Agnès Callamard, Director of the Humanitarian Accountability Project described the importance of these endeavors and stated that "to claim humanitarianism back from militarisation or instrumentalisation, we must insist that humanitarian work is based on, and guided by, ethics and accountability" (Callamard, 2003). These efforts are part of a movement to encourage aid agencies to adopt standards and to be accountable both to donors and to affected populations (Banatvala and Zwi, 2000).

2.9.1 The Sphere Project

The Sphere Project was created by a coalition of NGOs who sought to establish a set of minimum standards for the delivery of humanitarian aid, as well as to encourage the

humanitarian community to abide by fundamental humanitarian principles. As stated in the introduction to the Humanitarian Charter of the Sphere Project (2000),

> The Charter is concerned with the most basic requirements for sustaining the lives and dignity of those affected by calamity or conflict. The Minimum Standards... aim to quantify these requirements with regard to people's need for water, sanitation, nutrition, food, shelter and health care. Taken together, the Humanitarian Charter and the Minimum Standards contribute to an operational framework for accountability in humanitarian assistance efforts.

The first principle considered by the Sphere Project is the "right to life with dignity". In the description of this principle it is specified that this includes a right to life, to an adequate standard of living and not to be subjected to cruel, inhuman or degrading treatment or punishment. Though much of the Project is focused on operational standards there is an underlying concern for the ethical treatment of affected populations and individuals who are the recipients of aid and particularly on how organizations can operationalize ethics (Buzard, 2002).

2.9.2 Humanitarian Accountability Project

The Humanitarian Accountability Project (HAP) was created in 2000 and lasted until 2003. Its goal was to address issues of accountability of humanitarian organizations to the populations that they serve. The HAP undertook a number of different projects during its mandate including a series of three field trials to evaluate different methods of promoting accountability during humanitarian interventions. A project of the HAP that is closely related to the subject of this study was the Roundtable on Medical Ethics and

Humanitarian Work that took place in 2002 in collaboration with the World Health Organization (HAP and WHO, 2002). The roundtable brought together academics, representatives of UN organizations, NGOs and Donors and resulted in a very interesting discussion of how medical ethics relates to humanitarian work. This project represents one of the most focused attempts to map out the intersection between bioethics and humanitarian action.

2.9.3 People in Aid

A third organization that has been established to improve the functioning of NGOs is People in Aid. This organization was begun by aid workers themselves and has articulated a Code of Practice that signatory NGOs commit to respect. The Code focuses on principles of management and support of personnel. This group make the important call for NGOs not just to be responsible to their donors and to aid recipients, but also to the staff that they employ. Some of the elements of the Code include ensuring that staff have the appropriate training and support to do the work that they are called to perform. Standards of feedback and managerial support are described. These standards have an important relationship with the ethics of humanitarian work. It follows from the Code of Good Practice that signatory organizations are responsible for ensuring that their staff have adequate resources both of training and support to respond to ethical dilemmas that arise in the course of the practice of their professional duties.

2.10 Summary

In considering the question of the relationships amongst bioethics, humanitarianism and clinical ethics it becomes evident that there is a lack of discussion in the literature about this topic. Several qualitative studies have considered how health workers experience international humanitarian work and the humanitarian response to refugees fleeing areas of conflict. There are also important insights that can be drawn from the literature related to ethical provision of health care in a culturally diverse society as well as from the ongoing debate over the establishment of a global bioethics. The literature of the ethics of humanitarian response provides a framework for understanding many of the front line issues faced by clinicians as their origins may be traceable to much broader organizational issues. Further resources that are available to aid and assist humanitarian health workers include guidelines that have been published by international organizations such as the World Medical Association, and ethics manuals by the World and Commonwealth Medical Associations. On a policy level initiatives such as People in Aid, the Sphere Project and the Humanitarian Accountability Project have the potential to promote greater accountability and better practices for the support and training of clinicians for ethics. However, their effectiveness relies on the willingness of NGOs to participate in these initiatives and to commit to abide by the principles that are set forth as standards of practice.

Chapter 3: Research Questions and Methodology

3.1 Introduction

Given my objective of exploring the moral experiences of international humanitarian workers, a qualitative study was the most suitable methodology to examine the central questions of my project. When Bjerneld et al (2004) assessed how returning Swedish health care professionals perceived humanitarian work they found that the qualitative aspect of their study yielded "much more complex findings than the descriptive results". By utilizing a qualitative design I was similarly able to access narrative accounts of the experiences of health workers in humanitarian and development settings, and to pursue in greater depth the complex elements of how they experienced and understood their own participation in humanitarian health care delivery. This design is particularly suited for this project as it probes the process of how individuals give meaning to their own experiences (Patton, 2002). In addition, it enables consideration of the values of Canadian humanitarian health workers as a social process (Inui, 1996). The qualitative nature of the study enabled me to gain a greater appreciation of the practical moral issues that individual health workers encountered.

3.2 Research questions

The primary research question that I sought to answer in this study was the following:

How do Canadian health care professionals experience clinical ethics in humanitarian relief and development settings?

Two sub questions were also part of the objectives of the study:

Which moral frameworks do Canadian health workers use to assess and examine ethical issues?

How do Canadian health professionals perceive that Non-Governmental Organizations (NGOs) could better equip and support their staff for the ethics of humanitarian and development health care delivery?

3.3 Methodological framework

The theoretical framework that was employed in this study was the lens of phenomenology. The study focused on the phenomena of individual health worker's lived experience of cross-cultural clinical ethics. The methodology of this study was oriented towards discovering the firsthand experience of health professionals involved in humanitarian assistance and gaining a deeper understanding of the nature and significance of ethical issues in humanitarian relief (Brenner, 1994). Central to this study was the question of what gives meaning to these experiences for those who have lived them and how the participants themselves interpret these experiences (Patton, 2002).

3.4 Research organization

The research study consisted of a series of semi-structured interviews with ten participants. Each interview was audio recorded and then transcribed. The interviews were 50 to 85 minutes in duration. At the conclusion of the interview each participant was asked if she would be willing to speak to the interviewer by phone or email at a later date if any clarification or further details were required.

The interviews were divided in three sections. The first part of the interview was a brief survey of the participant's professional training, experience prior to their first international mission, and details of their experience in humanitarian assistance and

development work. The second part of the interview was organized using an "interview guide" format with a series of seven open-ended questions that were directed toward each participant (Appendix A) in a consistent order. The interview guide was refined through discussions with a group of health care professionals taking part in a Qualitative Research Methodology course at McGill University. The questions related to the nature of the participants' professional responsibilities with the NGO, their experience of clinical ethics and the impact this had on them, how ethical issues were or could have been resolved, and finally recommendations for how NGOs could better support and equip their staff for the ethics of their work. The questions were altered somewhat over the course of the interviews as I gained more insight into the questions. However, these changes were relatively small and the focus of each question was preserved. The phrasing of the questions varied slightly for each participant as I attempted to relate the question to the participant's experience and previous answers, as well as using their own vocabulary when possible (Bitten, 1995). Each of the questions was connected with a series of probes that were utilized when necessary to seek more complete answers to the questions.

The third part of the interview consisted of a more open-ended "informal conversational" component. This portion of the interview allowed me to pursue in greater depth any issues that were not strictly delineated in the interview guide but were still pertinent to the research question. During later interviews the participants' perspectives were solicited on topics that had emerged from early analysis of the initial transcripts.

Having both an "interview guide" portion to the interview, as well as an "informal conversational" component, provided greater depth to the interviews. The use of the interview guide provided a sequence of questions that were asked of each participant. In this way each participant was able to respond to a specific set of topics. The more open-ended conversational component in the latter half of the interview ensured that material that was not fully developed in the first portion of the interview was explored to provide a more detailed characterization of the experience of the participants.

3.5 Data collection

3.5.1 Background and role of the researcher

I provide the following information to explain the potential impact of my own experience and perspective on the research design and analysis. I am a physiotherapist trained at McGill University, Montreal, Canada. I received my degree in 1997. Since graduation I have worked as a pediatric physiotherapist in acute, rehabilitation and school settings in Montreal. I have participated in three clinical trips to Inuit villages in Northern Quebec. I have twice taught courses in Physiotherapy at the University of Prishtina, Kosovo in collaboration with Queen's University, Kingston, Ontario. In 1999, I spent four months in Tunisia providing physiotherapy services for children with disabilities and helping establish a treatment center for their care.

3.5.2 Sample selection

I adopted a purposeful sampling strategy to recruit a set of research participants whose experience and professional disciplines were diverse. Nine of the participants were

health professionals who had in the past seven years spent at least eight months working with an NGO providing clinical services in a cross cultural humanitarian relief or development context. The other participant was the Executive Director of an NGO that specializes in health promotion and capacity-building projects related to health care in developing countries. The clinician participants had a range of between 11 and 42 months of experience in this type of work during the previous seven years. Amongst the participants were six nurses, one physical therapist, one physician and one social worker. The Executive Director of the NGO had received training as a nurse and epidemiologist. Eight women and two men participated in the study. In total the participants had collectively taken part in 27 different missions. The duration of these assignments was from six weeks to one and a half years. Participants had worked in many different regions of the world including Africa, Asia, Central America and Eastern Europe. Prior clinical experience varied considerably. One of the participants was a newly graduated nurse when she began her work overseas, whereas another participant had 20 years of clinical experience in Canada prior to his first international involvement. The participants had worked for a total of eight different NGOs.

The study participants worked in many different settings and had diverse responsibilities. Most of the participants worked in war or post-war situations. Some participants worked in underdeveloped countries on development projects. Nine participants were involved in direct clinical care but many also had management and teaching responsibilities. The work settings included refugee camps, feeding programs, government hospitals, NGO-run hospitals and small health clinics. Participant 8 did not provide clinical care; in her

role as Executive Director of an NGO she was responsible for developing and managing projects and supporting field staff.

To recruit the participants for the study I contacted a number of individuals that I knew who had connections with humanitarian work. Several of these key informants became participants in the study. Many of them were able to refer me to other individuals involved in humanitarian work. I also directly contacted several NGOs. Though two NGOs agreed to advertise the study to past employees no participants were recruited by this method. Health workers who participated in the study were asked if they could identify other individuals who might be appropriate candidates. In certain cases this approach led to the recruitment of further participants. A sample size of 10 interviews was selected in order to allow an adequate diversity of respondents and achieve a broad spectrum of experience and professional backgrounds.

3.5.3 Interviews

The interviews were conducted in English and took place between January and June, 2005. All interviews were carried out by myself. Eight interviews were conducted face-to-face and two were conducted by telephone. The interviews were transcribed as soon as possible after each session (within two weeks of the interview). I also took field notes during the interviews to supplement the taped transcripts.

Interviews were conducted at a time convenient for the participant. Interviews took place in a private, quiet location chosen by the participant. Interview sites included an office at

McGill University, offices at several health centers and at participants' homes.

During the process of transcribing one interview I contacted the participant by email to clarify the details of a clinical intervention that was described in the interview but was unclear. The recording of one telephone interview was incomplete due to technical problems with the recording device. The transcript for this interview was partial. Fortunately, I had taken extensive field notes during this interview.

The mother tongue of four of the participants was French, and though the interviews were conducted in English, when they felt unable to adequately communicate an idea or phrase in English they were encouraged to speak in French. These sections of French text were retained in the transcribed text and were not translated.

3.6 Data analysis

Analysis of the data was begun concurrently with the ongoing interviews to ensure that new insights from the data analysis could be incorporated in the later interviews when appropriate.

As the interviews were transcribed I began the process of content analysis to identify codes and recurring themes that emerged from the data. These common elements and paradigmatic stories were highlighted. A total of 40 codes were initially identified but this was gradually decreased to 28 as codes were merged or removed. Codes were then grouped into larger categories. Eight codes relating to the participants perceptions of

how NGOs could better support or prepare future colleagues were separated from the others and analyzed apart from codes relating to the participants' own experiences. I then organized the remaining 20 codes in a graphic format. This arrangement helped reveal the relationships between the various codes and categories. From this analysis five central themes were identified and the relationship between these themes was described. The choice of codes and categories was reviewed with Dr. Leigh Turner in order to increase the validity of the analysis that was done.

3.7 Ethical considerations

This study was reviewed and accepted by the IRB of the Faculty of Medicine of McGill University (Appendix B). A detailed consent form was read and signed by each participant (Appendix C). Confidentiality and anonymity of the participants was preserved. Audio recordings of the interviews and the contact information of the participants were kept in a locked office.

3.8 Summary

This inquiry into how Canadian health care professionals experience ethics in humanitarian assistance and development work is based on a series of ten qualitative interviews. The health professionals who participated in these interviews have varied professional backgrounds and a wide spectrum of international experience. A phenomenological framework was employed in analyzing the data and a number of important themes were identified emerging from the collected data.

Chapter 4: Results

4.1 Introduction and overview of themes

The health professionals who participated in this qualitative study were involved in a broad spectrum of humanitarian relief and development projects. They lived amongst very different cultural groups and provided care in a variety of professional settings, in environments of varying political stability, and for organizations with diverse mandates and expectations. During the interviews it was evident that each of the participants had experienced complex ethical issues related to their international work. The personal and professional impact of these ethical dilemmas varied amongst the health workers.

In considering ethical dilemmas that were faced by humanitarian workers involved in disaster response Wilson (1997) described three types of dilemmas that are commonly experienced. These dilemmas include deciding between options that have conflicting merits and costs, dilemmas of how to act when the values of aid recipients differ from those of the Non-Governmental Organization (NGO), and dilemmas that exist when moral obligations conflict. Most of the study participants reported being faced with ethical dilemmas in all three categories.

When evaluating the ethical issues associated with the clinical responsibilities of the participants it is essential to acknowledge the extreme conditions under which these dilemmas frequently occurred. Participant 10 described the very difficult situation in the hospital where she worked during one of her missions: "We were dealing with a civil war and physical conditions that were terrible. No electricity, no water, no bathrooms. Room

for 70 children and there were about 200. Rarely oxygen, no lab tests, no x-rays. Almost nothing. Nurses who wouldn't even go into the room to treat children" (P10.6.2). Working and living in difficult situations such as those described above raises many ethical issues (Slim, 1997). All the participants described ethical issues that were present in their clinical work, as well as ethical issues that they experienced in living cross-culturally as humanitarian workers. Participant 3 noted the prevalence of ethics in her work as "many times, all the time... we are faced with ethical issues" (P3.2.1). However, for many of the participants the ethical dimension of their work was not discussed on a regular basis with colleagues or sufficiently acknowledged on an organizational level.

NGOs have an important role in supporting their staff in responding to ethical dilemmas (Slim, 1997). However, many participants did not feel that the organization they worked for was adequately aware of the effect of ethics on clinicians. This seemed particularly so in the case of organizations working in acute emergency settings. One participant described that for the NGO it was "just emergency, emergency. Even when it is a middle term project, or a 5 year project, I don't think issues of ethics is on the top of the pile, somewhere maybe there, at the bottom. It is not a word we are pronouncing very often. 'This is not ethical'. No it is more: 'is there a job to do something?' Because we are so overwhelmed we are just trying to solve the problem and pass to another one" (P3.16.2). Another participant articulated a similar experience when she said "I don't think the word ethics was ever used because I think we were functioning on need." (P10.5.3). This sense of being overwhelmed or rushed in the work that needed to be done was an impediment to staff being able to fully examine or comprehend the ethical dimension of what they

were doing, or sometimes even to grasp the effect of cultural issues on clinical care. Another participant felt that she did not have the time to reflect or assess the implications of clinical decisions and was functioning more on instinct.

> It depends, sometimes it is just you don't think, you just act, sometimes you will never know if you did the right thing. I am sure I didn't see many other situations because I didn't think or I didn't ask enough questions" (P1.8.1).

Many of the participants of this study noted that there was little opportunity for ethical reflection and discussion, and that they were part of organizational cultures that under-emphasized ethics. In certain settings ethics seemed to be perceived as a luxury that was not possible due to the immensity of the health needs of the local population. Banatvala and Zwi (2000) report that the emergency aid sector "is characterized by rapid staff turnover" and "the perception that there is little time to learn lessons given that there is always another emergency". Slim (1997) also notes that relief agencies are part of a "predominantly activist culture which sometimes values action over deliberation". These observations are consistent with the experience of the participants in regards to ethics in rapidly changing emergency situations.

Several central themes emerged during the analysis of the data relating to how clinicians experience the ethical dimensions of their work. The first theme was that clinicians struggled between a concern to respect local customs and beliefs, yet not compromise their own values. Second, health workers frequently faced ethical concerns relating to how to respond when what they perceived as basic care was impossible. The third theme that emerged from the data was that participants were confronted by differing

understandings of health, illness and death between themselves and the local population. The fourth theme related to how ethical issues impacted on the participant's identity as a moral person, health professional and humanitarian worker. The final theme that was present in the interviews was issues of trust and distrust between humanitarian workers and the local community.

4.2 The tension between respecting local customs and imposing values

All participants expressed a strong desire to respect the customs, values and beliefs of the local population. Ethical dilemmas arose when acting in accordance with the local values would be contrary to core moral convictions held by the participants. This theme was evident in numerous ways during the interviews as participants considered the ethics of their work in Complex Humanitarian Emergencies (CHEs) and amongst underdeveloped communities.

Most of the participants described important differences in ethical perspectives between themselves and the local population, as well as with humanitarian workers from other nations. When asked if he felt there was a difference in ethical understanding between himself and the local population or other international workers Participant 7 responded "Yes to both ways that you asked the question and I am going to tell you that it was blatant... my understanding and the local people and some of the other international people with whom we worked" (P7.2.5). The theme of how to respond to these differences in an ethical manner runs strongly through each of the interviews and had an important impact on the participants.

Participants were critical of other humanitarian workers who they perceived as having imposed their own values and who failed to express flexibility in adapting to the local ways of working. Participant 7 described his concern for health workers who arrived and lacked adaptibility. "Because we get some people who come and say 'I am from Minneapolis', to use an arbitrary place, 'and this is how we work and this is how we are going to do. You are going to do it that way'" (P7.10.3). This same participant contrasted this with an ideal that he perceived as a better model for working in a cross-cultural setting: "It is more a kind of flexibility and being clear of who you are but not rigid in how you are going to apply that and adapt to the needs of those people there. You still feel that you are who you are, and doing what you are doing, and it is meeting their needs" (P7.8.1). The participants consistently made clear their desire to not impose their own way of working or seeing ethical issues. Though it was difficult to avoid value conflicts few of the participants expressed feeling comfortable overriding local perspective and customs in clinical decision-making.

Participant 5 clearly articulated her desire to respect local customs and to remain non-judgemental.

> I think I am the guest. I have the right to question. I am the learner. I am there to learn. I am allowed to question, but if there is something very ingrained in their culture... There are some things that I don't have the right to... well I have the right to question, but not to say that it is wrong" (P5.12.3).

However, this same participant also described her great conflict when locally accepted views and practices were contrary to her own deeply held values. When patients received

less care because of their social class or caste and were treated with distain by the national health workers the participant experienced considerable distress.

> Sometimes when patients would die or things were done really wrong I would have to shelter myself and cry or just be mad for a bit and then go back. It does take a toll on you. I think when it is things that are so important and so basic to how you view humanity. When it is such an affront to things that are so right" (P5.10.1).

Despite her perception that she couldn't say that local practices were "wrong" she tried to find ways to identify the injustice she perceived in local practices without openly condemning them. The impact of this experience was very great as she considered herself a guest while having strong universalistic understandings of what is wrong and right.

This struggle to recognize one's role as a "guest" and a "learner" and yet not compromise values that are inherent to one's own self-concept is a profound one and may take a heavy toll on the health worker. Participant 5 relates that

> all the basics that you come with, that you find are truth, are real, equality of people – that is something that is almost instinctual. Ya, everyone believes that... At least you have to look like everyone is equal, even if you don't believe it. That is what our culture asks for, but there it doesn't even ask for it. That was very, very hard. I found that very, very difficult. People were just treated really bad and I would be very different. So I was really against the current and because of that it was very emotionally draining because on any given day you have, what?

> Twenty patients on a normal day? And you know patients die and go home without having any treatment (P5.10.1).

The participants struggled when their cultural expectations of fairness and justice were not shared by the local population. For some participants the reality that some of what they conceived of as universal values were in fact not recognized as such by the local population was particularly difficult.

Another participant described differences in how her fellow workers responded to the tension to respect local culture or impose values.

> Working with both expatriates and local folk... we had some staff who had been there for 20 years, and their perspective on things aligned itself a lot more with the local perspective. The newer they were the more their approach to ethical issues sort of aligned itself with where they were coming from. There seemed to be kind of a progression. To be a little more specific, some of this would come out in the way that we would react to the way things were done and considered normal there in reference to female circumcision, or FGM [female genital mutilation], also in relation to male circumcision (P2.2.1).

The participant noted that some of the newer workers would respond more quickly and critically to local customs whereas those with more experience would not be as aggressive in their response. Describing a midwife with 20 years experience in the country Participant 2 stated: "Not that she said 'Oh, that is just the way things are here so that is OK', but 'that is the way things are so you have to work with that'" (P2.2.2). The participant observed that field workers with greater experience were often more reflective

and less reactionary in their response to cultural practices that differed from their own expectations. Several participants noted that as they gained more experience in the community they gained greater insight and understanding of local values. This suggests that health workers that remain for longer periods in the same community will be more effective in providing culturally appropriate care. The present practice that many aid workers serve for short periods and frequently move between projects may not provide adequate time for health professionals to develop sufficient cultural understanding (Banatvala and Zwi, 2000). However, longer serving staff may also become more resigned to accepting local mores.

It bears noting that the participants appeared to adopt local values in regards to certain practices that conflicted with the norms of Western biomedicine. For instance, several clinicians, when faced with situations where privacy was difficult to obtain, and where it was not culturally required, seemed quite unperturbed to overlook the requirement for confidentiality. This was the case even in circumstances where significant medical information, such as disease status, was discussed. In contrast, they found other practices very diffficult to reconcile with their own core values. Many clinicians found it very difficult to respond in situations where members of the community were marginalized from making decisions for their own care due to their gender, ethnicity, or status. It is interesting that guidelines such as the WMA's International Code of Medical Ethics (WMA, revised 1983) clearly indicate that respect for confidentiality is an obligation of health professionals in all contexts and yet this is one of the ethical practices that participants expressed the least concern over setting aside. Issues of justice were much

more important for participants and were frequently the source of ethical dilemmas in their clinical practice. It appears that the participants of this study perceive their conception of justice to be a core value, while considering respect for confidentiality as a less central commitment. This is at odds, however, with the international guidelines cited above.

4.2.1 Ethical frameworks of participants

Though the theme of tension between respecting local beliefs and imposing their own values was present in each of the interviews it was addressed in different ways by the individual participants. The different manner in which they responded to this theme was influenced by the divergent ethical frameworks that were held by the participants. These frameworks were not explicitly described by the interviewees but were evidenced by their perception of how ethical dilemmas should be resolved.

As was expressed by Participant 5 those interviewed often evidenced strong conceptions of "things that are so important and so basic to how you view humanity" (P5.8.1). Many of the participants described principles or values that they perceived as having universal application. One of the results of this sense of "core" values was that a number of participants felt justified in seeking to affect change over cultural practices that they considered to be wrong or harmful. For example, Participant 9 was working in a maternity ward in West Africa, amongst a cultural group where men were not involved in the care of babies, and she related how

> a woman who had twins and she was really old and her husband was very old

> also. I just took the first baby and bring it to the family and the father was there and I said 'take the baby'. And he said 'no, no, no' and the grandmother was there and said 'no, no, no'. And I said 'why not?'. This is the father. So I said 'if you don't take him I will put him on the floor'. So he said 'OK I will take him'. And then it was one of my best experiences in West Africa. The man started to talk to the baby in his own language. Really slowly, like a wish for this baby. If I was African never I could do that but because I am a foreigner ... I could ask some things (P9.5.2).

The participant does not seem at all conflicted in challenging the cultural norm that she found objectionable, and in fact identifies this episode as one of her most positive experiences in that country. Other participants elected more subtle means of seeking to influence cultural practices that conflicted with their understanding of universal values. The participants often felt challenging local norms was a particularly delicate situation and they acted with a sense of reserve and caution.

A different perspective was offered by Participant 3 who felt that ethical norms are personal and different for everyone. Rather than appealing to universal principles to justify her actions she perceived that moral norms are internally defined and different for every person. "But the problem we have with ethics... there is no answer. For a medical person you want to raise your hand and say 'what is the good answer?' and there is no good answer. It is personal to everyone. On the field, on a day to day basis, that is difficult" (P3.13.3). She considered that when there was a disagreement on ethics between the local health workers and the expatriate health care team the latter's

perspective would always trump, not because of the moral force of their arguments, but because they controlled the money and therefore had the power. "Unfortunately, or fortunately, I don't know, it is always going to be the ex-pat side who is going to win... because we have the money" (P3.14.3). This participant recognized that this clash of values created many problems and she advocated for discussion and consensus-seeking but maintained a bottom line that the NGO's values would prevail over local concerns when agreement was not possible. "Yes you are in Africa. Yes you don't have the same way to think. But at one point we are a white organization. Basically you bring your white values in an African context and that brings a lot of problems" (P3.15.1). This participant acknowledged her concern over imposing outside values. However, she expressed her perception that ultimately the values of the NGO and its staff members will be those that guide and inform humanitarian interventions because of the position of control that they have over the projects.

Most of the other participants expressed a conviction that local values should be respected as much as possible. Seeking to discuss issues that arose, and striving to reach a common agreement, were seen as ideals for resolving ethical issues. These participants also identified limits to what they were willing to participate in without compromising their own integrity. In fact, the word "compromise" was a difficult word for several of the participants. "Compromise. Maybe it is the wrong word? It is more a kind of flexibility and being clear of who you are but not rigid in how you are going to apply that and adapt to the needs of those people there" (P7.7.3). "I don't know if I'd call it compromise. Be understanding, being aware" (P1.9.2). The goal of remaining flexible

and adapatable was advanced by all of the participants, yet most also described the need to not compromise their own core values. Often participants had the greatest difficulty when local practices or beliefs went against their own conception of justice.

4.2.2 And what about justice?

Frequently the situations that provoked the greatest dilemmas between respecting local practices and imposing values occurred when participants perceived injustices to have occurred in the delivery of health care. Though some of the health professionals seemed willing to accept a certain degree of injustice as being "the way things are" in a particular culture they would often draw a line concerning what they were willing to accept.

In a society where racism was deeply entrenched, and led to systematic discrimination within health care, Participant 8 noted that the "tension and lack of cohesion is horrifying" (P8.6.3) within the medical establishment. To get a well-qualified specialist appointed for a capacity-building training program that her NGO was running, the team had to resort to the following tactics for him to be approved:

> Maybe this is ethical, or maybe not, but the Minister of Health had to have a bypass done and he was up in New York, and the acting deputy minister was on our side. It was approved. When he came back and we were meeting, the guys at the other end of the table were wondering if they would have to get the paddles out because he was apoplectic (P8.6.2).

The participant felt justified in circumventing the normal channels of decision-making because she considered that the previous administrative decision was based on prejudice.

Another participant was also confronted by systematic forms of discrimination within the delivery of health care. Participant 10 worked in a country where the government limited health resources as a means of controlling a minority population. In making a judgement rooted in the language of international human rights she asserted that "health is a political decision. People who keep others under control by limiting access to health care and basic care, these people are criminals. They are war criminals. As much as one who kills you with other forms" (P10.11.3). This is a strong indictment of what she perceives as a justice and rights issue of access to health care.

Other justice issues caused great stress and angst to health workers as they struggled to work amongst cultural groups where social structures were sometimes rife with power imbalances. For example, in the country where Participant 5 was living the husband must consent to his wife's medical treatment. In one instance a woman did not receive a needed eye surgery from an itinerant surgical camp in rural Nepal because her husband was not available to agree to the procedure. Several participants also described their great difficulty when girl children were less well cared for than boy children. "In Afghanistan they will not kill them [girl children] but what I have seen is the boy babies are breast feeding longer and have more care. People will be much more gentle with them" (P9.6.2). Inequality based on gender was frequently reported by participants and was a situation that they found very difficult to respond to in a neutral or non-judgemental fashion.

Another form of injustice noted by the participants related to rigid hierarchies within society or in the structure of the health care system. In certain settings some members of society had privileged access to health care due to their position or status in the community. At the clinic where Participant 2 worked a heated debate occurred amongst the international workers after one of the NGO doctors refused to treat the chief of police before other patients who had been lined up outdoors for hours waiting to be seen in the clinic. Frequently, strict hierarchies existed within local health structures. These hierarchies made it difficult for subordinates to question their superiors and, in a few instances, mistreatment of nurses by doctors was noted. Participants struggled with how to respond to hierarchies present in society and in health-care institutions.

One of the particular challenges for the professionals was when their role included training local health workers or local staff for their projects. This was frequently a situation when ethical issues became starkly evident. Participant 7, a social worker, was responsible for training local staff for a psychosocial counseling program in a country that had recently experienced civil war. He had a great deal of difficulty sharing a notion of service with the local staff because of their different cultural expectations. Culturally there was a "one up, one down" (P7.6.2) attitude. The team tried to train their staff in a model of work that was "more egalitarian. They are a person in need. You are a person that has a service to give them. Not that they are completely helpless and you are the one 100% in power. Trying to share the power with them. They come from a background in society that is not like that. That is the training and background that we have. It may be totally inappropriate over there but that is how we work" (P7.6.2). When the participants

were responsible for training local health workers they often felt a strong need to impart values of service, honesty and caring that they considered as crucial for being an ethical professional. As in the case of Participant 7, these values were not always perceived in the same way by the local population and this discrepancy presented difficulties for the staff and the participants. In certain settings the participants were also reponsible for hiring and training local staff for non-clinical duties such as translating and logistics. In these situations the participants seemed even more concerned to impart this ethos of service to those hired as they would represent the organization to the local population.

4.2.3 Contravening local authorities

Three of the participants described situations when they felt compelled to contravene local authorities because of the dictates of their moral convictions. In the first situation the health care team chose to disregard the orders of a health inspector whose ruling would, they felt, endanger the health of their patients. In the second instance government regulations were limiting the ability of the team to provide medications for their patients and the staff chose to smuggle medication into the region. In the third example the team went against a strike action by the national health care workers that was preventing the care of a very sick patient.

In the clinic where Participant 2 worked it was standard practice to use recently expired dry medications. Most of the medication was donated by European pharmaceutical companies as it reached the end of its shelf life. The clinic operated in a country where there were chronic shortages of most medications. The participant expressed that she

would have taken the medications herself in the situation, and suggested that there was no concern over safety but only perhaps for efficacy of the drugs. However, when a government health inspector came to the clinic he ordered all expired medications to be thrown out, including expensive and rare drugs like malaria prophylaxis and antibiotics. Many of the international workers responded by "hiding medication in their rooms, in their jackets" (P2.6.3) despite the health inspector accusing them of unethical practice for stocking these medications. Participant 2 described the staff's motivation coming "out of a sense that they needed to do that. A moral sense that it is what is right. Clearly people who were not trying to anger anyone or create cultural barriers, they just had a real sense that people needed it, and people who didn't need it are going against it" (P2.6.3). The health team chose to deliberately disregard the official's orders and continue to provide medications that they viewed as safe and potentially of great benefit to their patients.

In the second instance Participant 10 was working in a tense political situation where the government imposed limitations on the health care available to a minority population. This created a situation where

> in terms of resources in [the region], it was very difficult to get medication. Impossible to get approval for medication for pain control. I have to say this. I don't know if it should be publicized, but do what you want. The second time I went to [the region] all of us who were going there by boat we taped the medication on ourselves. We smuggled the medication. Against the government rules. Because [the NGO] thought that it was very important to combat pain after surgery" (P10.10.2).

The expatriate workers and the NGO felt justified in smuggling medications as they deemed the government rules to be unjust. They considered contravening these regulations to be morally preferable compared to accepting the chronic shortage of medications.

A participant was also involved in a situation where a general strike had been called which was to shut down all services, including the hospital. Hospital staff had even taken the measure of locking the operating room with a padlock. When a pregnant woman arrived with placenta previa the participant and her colleagues tried to convince staff members to open the OR and perform life-saving surgery. It took several hours to find a surgeon who was willing to defy the strike and when they couldn't get the key to the padlock they eventually broke down the door. The surgery was performed and the mother survived but the baby died. After the experience the participant expressed

> God! I was really sad. After that I said to the doctor [who had refused to treat the patient] 'you have the wrong job. You should go drive a taxi' I was so sad. ' Life is so hard in a country like this. It is so hard. How can you be so rude with the people from your own community' (P9.9.3).

The participant considered that those involved in the strike were behaving with disregard for the lives of their fellow citizens. She judged the inaction of those who refused to help this patient as immoral.

These three examples demonstrate that a number of the participants considered that when local regulations or officials failed to respect principles that the participants conceived of

as just and ethical they were justified to act in defiance of these local authorities. Each of these participants acknowledge the moral ambiguity of disregarding the requirement of local authorities but still felt that they had acted ethically.

4.3 What to do when adequate care is impossible

All the clinicians who participated in the study experienced situations in which they were unable to provide what they considered adequate, or basic, care to their patients. In certain circumstances they were unable to provide any care at all. Four sub-themes were evident in this regard. One of the principal constraints faced by the participants in regards to providing adequate care was limitation of resources. Several participants also had to decide how to respond when care by local staff was incompetent. Third, participants expressed the difficulty of caring compassionately for individual patients while being conscious of the larger needs of the population. A final consideration that became very prominent for the health workers was the question of how to contextualize standards of care in a way that was both realistic and fair.

4.3.1 Limited resources: "People need a lake and you are offering a glass of water" (P7.5.3)

The participants worked in settings where resources were severely limited. The limitations affected all aspects of health care delivery including supplies, infrastructure, training and personnel. In most cases the people also lacked basic essentials such as food, shelter and security. For those populations who had experienced war or natural disasters there was often a great deal of psychological trauma that had never been

addressed (Robbins, 1999). Some of these groups were refugee populations who were still displaced from their homes. Participant 7 eloquently describes the situation. "You go to these places and the needs are enormous... People need a lake and you are offering them a glass of water. But that is the way it is" (P7.5.3). The participants had to consider what resources to make available and to whom they would be offered. The health workers also faced the challenge of improvisation and adaptation to maximize the material resources in the face of important shortages.

One example of this drastic disparity in need versus resources is the story of Participant 3 who worked in a rural health clinic in rebel controlled territory in a civil war. The health clinic, the only health center in the entire region, was not equipped with a surgical suite but provided primary care to the local population on either side of the conflict. She described the motivation for her work and her concerns about the team's ability to care for their patients:

> I think we have to do our possible to save lives... If that is not the main reason we are there than we just have to go. Sometimes we don't have the means to do it, we don't have the resources to do it and it is pretty frustrating. At one point I was wondering if being there, being on the field and just telling them we are giving free healthcare is it not sometimes a trap because we can't do everything? (P3.3.3).

The participant found it distressing that patients would travel great distances to reach the clinic only to discover that the health team was unable to offer many services. Simply traveling to a health center in a conflict zone places patients and their families at

increased risk (Banatvala and Zwi, 2000). This is especially problematic when the clinic is unable to respond to their health needs. For instance the clinic would frequently receive patients who were experiencing difficult deliveries and numerous patients died because the team was unable to perform the needed surgery to assist these women. The toll on the staff was enormous. In one situation a mother arrived with a pregnancy that wasn't progressing and the baby was becoming septic inside the mother. The participant described that

> you are just looking at the family... I don't know how to describe that you are just banging your head on the wall because you cannot do anything. For a medical person you cannot just look at someone dying – it is not in our profession. You have to cut your own arm if it means you can do something. There is nothing you can do! We know she is dying and we are just doing palliative care. To let someone die from something that is so easy to do something about... She wasn't having cancer, she was having a baby, that is the only thing. So, no I am not getting used to it. It is three years, four years after and I still think of it, I have to [wipes eyes] , I have to control myself because it is not acceptable, not possible. At one point, after a couple of women like this, we just call the capital and say 'If you don't give us the means to do something, a delivery service, a surgery, then, well, we are leaving' (P3.10.2).

The participant found it greatly distressing to be unable to assist patients simply because there was not the equipment available that would have allowed them to perform the basic surgeries that might have saved these patients. Many other participants also experienced

great frustration when they were prevented from providing good care because they lacked needed supplies or personnel.

4.3.2 What to do when local staff give incompetent care

Most of the participants worked alongside health workers who were members of the local community. In some instances there was an expectation that the international workers train the local staff. In other situations international workers and local caregivers labored as colleagues. The participants often experienced ethical dilemmas when they witnessed incompetent care being given to patients. It was very difficult for participants to decide how to respond and extremely frustrating when they were met with resistance and defensiveness. Participant 8 recalled touring a hospital facility with a Canadian doctor who had recently arrived in the country:

> I remember we walked into this ward. 30 beds and the wind was blowing, and the TB guys were upwind from the HIV guys. And he was like 'no, no, this is not right. You have to move these people'. He was going on and on and he just expected that everyone was going to move the people. He was just having a fit. Then we went into this other room for highly infectious patients and there was a TB guy coughing on an HIV/AIDS guy. At the end of the first week he was almost unable to talk – just blithering (P8.15.5).

The sense that local clinicians were reluctant to accept their recommendations was often very frustrating to the expatriate health workers. Some of the participants responded to this resistance with disappointment and incredulity. Other participants seemed resigned to this situation and resolved to do their best despite the opposition. The causes of this

resistance were varied and participants perceived that a sense of fatalism, a general passivity or cynicism, and distrust of the international workers were contributing factors.

Participant 10 relates the many levels that must be considered in addressing quality of care issues. She witnessed both system-level mismanagement and individual incompetencies that compromised care and endangered the patients in the hospital where she worked.

> They [the local nurses] would distribute medications three times a day, no more. They would call the family. They would go in the corridor with their trolley and medications. If it was a pill the mother would come with a cup and they would put the pill in the cup and the mother would find a way to give it to the child. If it was a shot that the baby was supposed to have they would have a needle with a lot of the medication and give a shot to a kid and then reuse it for another child. That was terrible. It was terrible for many reasons. You never knew if the kid was given the medication. The schedule was often very wrong. If the mother was not in the room the child would not get the medication. The nurse never looked at the child. There was never any temperature or checkup of the child. If the child was dying no one would know but the mother, and the mother may not always recognize it. Giving pills to children is not easy so if the mother crushes it, lots of the medication stays in the cup. When they were giving the IM shot they were using the same needle. Infection control was terrible. And when they were treating the malaria, which was the most common cause, some of the young physicians working there always wanted it intravenously, so they put an

> intravenous line. They give the quinine quickly, which is a very wrong mode of administration, with not enough sugar. They remove the needle. When it is time to give the next dose they have no IV. Imagine 70 children who need quinine every 8 hours and you have 4 nurses. It is not done. So these kids don't get better (P10.6.2).

Despite the systematic fashion in which care was compromised the participant's suggestions on how care could be improved were ignored. Local staff appeared resentful of the participant's presence and reluctant to listen to her input. Even as the mortality rate declined on the wards that the participant was responsible for other physicians would still not accept her comments. This situation of inadequate care was also frustrating for the families of the children admitted to the center and they would come to the participant from other wards in the hospital to ask her opinion or assistance.

Another participant, a nurse, was the only international worker in a government-run hospital. She frequently experienced situations where the care given was inadequate and sometimes inappropriate. When she would identify lapses or errors in care she would then be punished by the doctor "for two weeks anything I would do that wasn't perfect I would hear about it from the doctor" (P5.5.3). She noted that "authority is so important even when they are doing really stupid things. Sometimes I had to bite my tongue and say nothing" (P5.6.1). Because of the strict hierarchy the participant could only address some of the mistakes in care, usually in regards to medication errors, for fear of reprisals from the doctors. She had to ignore less drastic errors so that the physicians would listen to her when errors of greater magnitude were made. The participant felt forced into

making this ad hoc evaluation of error severity. She noted that none of the local nurses would dare mention any lapse of care because of the strict hierarchy that was enforced.

4.3.3 Compassion and population-based health care

Another thread that ran through the experiences of the participants was the shift that they perceived towards an ethos of health care that was constantly considering issues of population-based health. The health workers were very cognizant that their decisions for individual patients would have an important impact on their capacity to provide care for others.

During one of the projects that Participant 3 was involved in there was an organizational policy whereby only patients who were evaluated as being contagious for TB would be treated for the disease. All those patients with active forms of the disease but who would not spread it to others would not be treated because the supplies of the medication were limited. The participant, a nurse, found this very difficult and she related how she would often try to convince those in charge to take non-contagious patients into the program on compassionate grounds. She would argue that "this child is the only surviving child of this family. If the child dies this mother doesn't have anybody anymore, and your treating the Mom, why not treat the child?" (P1.7.2). At first she succeeded in getting care for these patients but then the policy was enforced on a more rigorous basis and no exceptions for compassionate reasons were tolerated. She found this very difficult as she felt that individual circumstances should be considered in such decisions. This participant found it particularly disconcerting to reorient her thinking to a population

perspective of decision-making. However, this scenario also highlights the fact that a strictly utilitarian approach to public health may lack a flexibility to respond to concerns of justice.

In another situation the same participant was able to make a different decision. Despite their poor prognosis and the fact that they did not fit the admittance criteria she accepted into her health center a baby, her mother and her grandmother.

> The baby was maybe a week old. The baby and the mother had HIV and TB. Well, the baby was HIV positive for sure, and the mom had TB, and the mom was dying of AIDS... We all knew that she would die, and the baby would die without her mom because she was so young... I took this patient in and she died, the baby died. But the grandmother came and told me 'at least you tried, and you did do something'. Even though I didn't do much for that family I gave hope to the grandmother. Even though the ethical choice may have been not to take her and keep the space for somebody else I still feel it was the right thing to do because the grandmother left knowing that at least we tried to do something for her child and her grandchild. It is difficult! (P1.4.2).

In this situation the participant was directly responsible for admission decisions and was able to select who to admit to the treatment center. She acknowledged the ethical issue of accepting patients with poor prognoses but felt that she made a good decision in accepting these patients into the center.

Another nurse, Participant 5, was responsible for deciding which patients would be transferred to the regional hospital. She had worked intensely with a child who had suffered a serious head injury after falling from a tree. She was very conflicted about whether to transfer this patient, whom she knew well, and whose family she felt deep sympathy for.

> If we gave money for this we would be giving a lot of rupees for that and it would take a long time and maybe nothing would come out of it. And there are a lot of kids with pneumonia that need resources and if you give them the resources they will get better. So I decided not to transfer the kid and he went home. I will always remember that kid. I think I made a right decision. I let him down, I may not have let these other kids down in the sense that those resources were available for others, but I let him down (P5.8.1).

This participant resolved that the ethical response to this situation was to ration the resources available to be able to provide care for future patients for whom the money could have a greater impact at a lesser cost and for whom the prognosis would be better. This type of decision making was one of the aspects of the participant's experience that she felt least prepared for. She notes that she had no guidance or criteria on which to base such decisions and that she found it a difficult and distressing process to make these treatment choices.

Both Participant 5 and 1 struggled with balancing the competing needs of individual patients and the larger needs of others in the community. These two participants experienced difficulties in deciding how to proceed and they made opposite decisions

though both felt they had made the right choice in the situation. It is of note that Participant 1 recognized that others might not consider her decision "ethical" yet still felt that giving hope to the grandmother, and providing compassion to the baby and mother as they died, was the right action.

On other occasions the participants chose to use their own money to pay for the care of patients that they were unable to provide care for in the clinic or hospital. In one case Participant 5 paid for formula for a baby whose mother had died in her care. She elected to make this gift anonymously by having her cleaning lady bring the formula to the grandmother as a gift "from a friend" (P5.17.1). Participant 1 payed for the care of several patients who would otherwise not have been treated. In one case she paid for the care of a baby who, while being held by her mother, was hit in the arm by a bullet that also killed her mother. The participant paid for the surgery and after it was performed took the baby back for the post-operative care. She questioned her own actions as being "not ethical... you don't think about it. You just know you can't do anything for the child in our little hut" (P1.5.1). Several of the participants adopted this strategy of using their own funds when they felt incapable of caring for patients in other ways. As Participant 5 recognized by making her gift anonymously there is the potential for creating expectations and obligations that could be difficult to satisfy. Health workers should be careful when deciding how and when they choose to use their own money to help their patients.

4.3.4 Contextualizing standards of care

What is the appropriate standard of care in a particular humanitarian relief or development context? To apply global best standards is destined to fail and may cause more problems for both the care providers and the local population. Should standards of care be established on the basis of what is possible in the short term or by what is realistically sustainable in the community over the long term (Michael and Zwi, 2002)? It is difficult for health professionals in Complex Humanitarian Emergencies to establish standards that are appropriate to the situation, and reflective of the local reality. One of the participants framed the ethical dilemma in this way: "The ethical issue is that we always said that there is a baseline where they are, then there is a crisis and they go down. Our job is to make them back to the baseline. But the baseline is not very high. Do you stop there or do you try and go higher? That was always one of the questions that we had on our mind" (P4.3.4). Clinicians may feel that returning patients to the local baseline, particularly in regards to nutritional status, may lead to a self-perpetuating problem as the patients risk deteriorating again if food supply, sanitation or security are poor.

The issue of standards of care has many nuances. A complex situation results when the relief mission is focused in refugee camps. Difficulties often ensue when the standards in a refugee camp are higher than what the surrounding population can access. Participant 4 described how local villagers tried to pass themselves off as refugees in order to access the services available in the camp. In another situation local villagers were suspected of sabotaging the water supply at the refugee camp out of frustration over the inequality of care between the refugees and the local population. Health workers and NGOs should be

attentive to the needs of both the refugees and the surrounding population (Wilson, 1997).

In certain instances international guidelines exist and may help to clarify what standards should be applied. This is the case for nutritional interventions. The World Health Organization (WHO) details objective admittance and discharge standards in regards to weight per height per age, for emergency food programs. However, even though the standards are explicit a dilemma is created for staff when external food security is unstable. "If the [external food] situation is a problem than you are just doing the same type of intervention over and over because they will come back because they will go down again. That is always the question but in a situation of civil war there is no sustainable situation, for a long period of time you know crisis will happen again" (P4.4.2).

Another participant who was training traditional birth attendants did not feel that she could follow the guidelines set forth by the WHO for training local midwives. The guidelines delineate standards and procedures that should be taught to local birth attendants. Participant 9 felt that many of the attendants would not be able to be sufficiently sterile to safely perform more invasive procedures such as vaginal touch in the evaluation of pregnant women. Some of the older midwives had practiced for over 40 years and continued to wash their hands with opium. Therefore she chose not to follow the WHO guidelines because she felt they were inappropriate in the local context. The participant recognized that the international standards could not be applied safely

and chose to ignore this part of the guidelines as the risk for the procedure would outweigh its potential benefit.

One of the missions of Participant 10 took place in a country where the national Ministry of Health had issued guidelines that were to guide certain aspects of care. Participant 10 found that the local staff were not even following their own national guidelines, yet she was still unable to convince them to adopt these standards.

> If you go to the management [of the hospital] and say from what we have seen in Africa, from the research, there are other ways that we could practice medicine, what is in the books and the literature. They even had guidelines given by the government, basic guidelines for health care workers, that were beautiful but they wouldn't follow them (P10.7.2).

In most circumstances the participants were attempting to apply NGO or international guidelines. In this situation locally negotiated guidelines existed yet they were not being applied in the hospital. The participant felt helpless in being able to convince local authorities to apply their own basic guidelines.

The participants of this study struggled in different ways with how to establish, follow or teach standards of care that would be responsive to the local situation and resources, and fair to those receiving the assistance. Even when guidelines were explicit there were still frequent difficulites because they were difficult to contextualize to the particular clinical setting, they didn't take into account broader issues of population health, or they were not accepted by local clinicians and officials.

4.4 Differing understandings of health and illness: "All the basics that you come with"

Many ethical issues experienced by the participants resulted from different cultural understandings of health, illness and death between the local population and the NGO workers. Participant 5 felt that "all the basics that you come with" (P5.9.3) had to be reexamined in her work with the local population. Another participant characterized the way she and her colleagues perceived ethical norms as part of "the medical, white mind" (P1.10.1) and contrasted this to local conceptions and expectations of health and health care.

The participants were all deeply immersed in a cultural context for which they had little advance knowledge or preparation. Most reported difficulties integrating themselves socially and professionally with the local community. Many of the participants also reported making errors of cultural etiquette and, in some cases, of having offended local people by their culturally inappropriate actions. This type of cultural misunderstanding had more important significance when the issues occurred in professional contexts and related specifically to the care that was provided to patients. Participant 4 noted that "Many ethical issues originated with differences of understanding. You know the concept of 'do no harm'? Therefore we always want to do that. When you don't know the culture you know that you can have interventions that have consequences that you didn't know about. Social harms or clinical harms" (P4.5.1). The participant makes an important observation that cultural values are present in all health care interactions. This is accentuated in the context of humanitarian and development work.

As the participants gained understanding of the cultural norms of the community they were able to be more effective in their clinical responsibilities. One nurse noted that some of the interventions with the greatest long-term impact were educational programs that were narrative and performance-based because they related to the local story-telling culture. Expatriate workers had to gain a greater understanding of local values and culture before they could initiate effective programs.

> The bottom line I guess is that I was working in a clinic and dealing with things that people wouldn't necessarily have access to if the clinic wasn't there. What I'm saying is they couldn't continue on their own without the clinic being there. So for instance you have an ultrasound machine that can tell you if the baby is in a breach position and needs to be rushed down to the hospital by ambulance. If the ultrasound machine is on the fritz they don't have that information. How useful is that information in the long run? Well it is useful for that one person. But the education, people go in there and pass it on. It's a story-telling society. They tell stories. You tell things to your children. So the approach of the educators. Those were things where they could really make a change (P2.9.1).

Cultural learning was an important process that allowed clinicians to be more effective in their interventions towards the local population. Participant 2 notes that as health workers were able to pass on knowledge and skills to local people there was great increase in the long-term benefit of their interventions. To achieve transfer of knowledge the expatriate workers had to learn culturally appropriate methods of sharing with the local population. Some of the specific differences of cultural understanding that were identified by the participants were divergent conceptions of death, the role of traditional

healers, the importance of cultural practices related to health, and the role of the community and family in health care decision-making.

4.4.1 Death and Dying

The nurses and doctor interviewed had to grapple with the much higher rate at which patients were dying in their care during their international missions compared to their previous experiences in Canada. They frequently struggled with being unable to provide the quality of care they would have wanted because of limitations of resources and personnel, as well as difficulties related to unstable food, safety and shelter concerns. An added consideration that may have impeded care delivery was that the clinicians often had a different understanding of death than the local population. As clinicians grew in understanding of cultural views related to death and dying they were better able to care for their patients as they died.

Participant 5 experienced a very different clinical reality in rural Nepal in regards to the understanding of death than was present in her training in Canada.

> Death was viewed differently. There is not *l'acharnement thérapeutique* [life-sustaining treatment]. There they don't have that idea, not with the resources that we have. But one patient, I could see that he was about to crash and the family was very stressed about it, very unhappy about it. I brought him back, he crashed and I did CPR and I brought him back, not very strong, CPR without medications isn't going to hold. But I brought him back and I told them this is not going to last, this is it. It is just the time you have. They said OK we are going to pick up

> our father and bring him home. He will die at home. Hopefully they arrived. They carried him on their backs. When we positioned him on their backs he was still breathing so I hope he got home. There are certain kinds of things – like dying beside a certain type of tree, for them that are important. (P5.9.2).

As the participants learned more about the cultural norms and expectations around death they were better able to assist patients and their families during the process of dying.

Another participant, a pediatrician, made sure to ask upon her arrival about local approaches to death. She noted that she was glad to have spoken of this on her second day because on day 3 a baby died.

> What I was able to understand was if the baby is dying we tell the mother. It turned out that the mother just walked in and the baby was doing poorly and we gave the mother the baby. We were all there; the nurse, the mother, myself, and we were almost hugging each other holding the baby. It was just a beautiful experience. From there I was called sister (P10.3.1).

Discussion with the local health workers allowed the participant to gain a better understanding of their conceptions of death and dying. When health workers were able to understand how the local people conceived of death and dying they were able to offer culturally-appropriate care.

Participant 10 found that her experience internationally gave her a different perspective on dying.

> People in our society have forgotten that we are born to die. That nature is never

> perfect. And people here [in Canada] just want affection and death is never acceptable. They have forgotten some of the basics. I'm not saying that dying when you are three because you don't have antibiotics for meningitis is normal, that is not what I want to say, but sometimes I think we tend to become excessive. You see all the plastic surgery and stupid stuff like that (P10.10.1).

The exposure to living and working in another culture had a profound impact on the participant's own notions of fundamental issues related to living and dying. These experiences challenged the participant to evaluate her own cultural values and has influenced how she practices medicine in the Canadian context.

4.4.2 Traditional healers

In many of the communities where the study participants worked there was both "traditional" medicine, as well as "modern" medical services. Many of the participants expressed ambivalent feelings towards the presence of traditional healers and even shamans working in the community. Several participants noted certain areas in which these traditional practitioners had strong skills and yet there was often great reservation and concern when patients forsook being treated at the clinic in favor of traditional treatments from the village bone-setter or healer.

The interaction between traditional and modern health care caused concern for the health workers in a number of ways. Some interviewees felt they should have protected their patients from the adverse effects of traditional treatments gone wrong. Participant 1 had prescribed antibiotics for the treatment of a child's throat infection. She sent the child

away without considering the possibility that the parents would forgo the drug course in favor of the traditional practice of making a small cut in the area that was swollen and red. The child died from blood loss as a result of the traditional treatment. "I didn't even consider that the mother would not take my advice as good advice. I didn't even ask if there were other ways of treating it. I felt like I didn't do my job right and the child died because of me. I have often thought about how I could have done things differently" (P1.6.1). The participant was deeply affected by this experience and she mentioned this incident repeatedly in the interview. This seemed to be emblematic for the participant of the cultural gap between herself and the local population. She strongly emphasized that health workers need to learn about culture. In fact she advocated that newly arrived health workers should "just shut up and listen" (P1.3.1) during their first month and not try to impose change but simply try to understand the complexities of how local culture impacts on health and, in particular, the presence of traditional medicine.

For other participants, difficulties arose when traditional treatments impeded the process of caring for their patients. For instance, traditional healers would treat burns with mud or animal dung.

> They are mixing all the time traditional and modern medicine. Sometimes before they are coming to you they have tried a lot of things and so one example was, I don't know what was happening but everyone seemed to be burning themselves... In one week I think I had ten people burned to different degrees. One it was just the arm, one the whole body. So they were going first to a traditional healer and he was putting mud on the burn. It was cutting the air and so is less painful but is

not healing at all. So basically when I was receiving these patients I was removing the mud, slowly, slowly with tons of water. It delayed the treatment by weeks. Sometimes it would take a whole week for them to understand that they weren't doing very well and they were coming to see us (P3.7.3).

Participant 3 described other traditional treatments and her reaction when she discovered patients who were mixing both traditional and modern treatments:

> For parasite of the bowel they were taking herbs and then when they came to see us we would have to hospitalize them. Sometimes even during the hospitalization they were mixing the treatment. We discovered people, like the mother who was boiling herbs and they were taking them at the same time as the antibiotics, and I'm trying to understand. But sometimes I am not really rude but 'You come to see us to seek modern medicine. Can you just give us a chance and let the treatment do its job? Please!' I understand it is the cultural context. But for the first few cases it is fine but after ten, and it is not working, and then you discover that they are just using traditional medicine and they are not getting better, and you are like 'just go home if you are not happy, you know it is free but it's not enough'. Sometimes you have to say, 'well, we are in Africa'. But sometimes it is difficult, like with those burns that were coming to us. It takes three days just to remove all the mud and it is so painful for you. 'Why didn't you come see us first? It is free!' (P3.7.3).

The participant was greatly frustrated by the way in which patients would mix traditional and modern treatments. For this participant and others it was very difficult to be neutral

to the practice of traditional medicine whenever it delayed or impeded modern medical practices.

Some of the incidents that were most disheartening for the humanitarian workers were when local colleagues chose to utilize traditional healers rather than coming to the health center for treatment. Participant 2 was "shocked" when one of the local staff went to a bone-setter when he had an accident rather then coming to the NGO-run clinic where he worked. "You know, that was his first stop, he didn't go to the clinic, one of the government clinics, he went to the bone-setter and he got infections. Not to say that bone-setters don't do some amazing things. But for him to come from an academic environment that showed some of the dangers of these traditional practices. That was where he went first. My first question is 'Why? Why would he go there first?'" (P2.3.1). Again this participant found it very difficult to understand why individuals, particularly those trained in modern health care practices, would choose the traditional healer.

A further challenge for some of the participants was local conceptions of the spiritual dimension of health. One nurse caused a great uproar when she described a newborn baby as beautiful in the birthing room. The effect was dramatic as "everyone started panicking because you never say a baby is beautiful in the first month or the spirits are going to come and take the baby away" (P1.3.1). The effect of spirits on health was also observed by Participant 5: "But also there is the whole spiritual, and spirits, and the evil eye. Things like that. That is probably why they go to the shaman to get the curse off them. I think there is a lot of that. I was fascinated to hear their interpretations"

(P5.16.2). These explanations concerning the causes of health and illness need to be considered when clinicians seek to educate their patients. To be effective, humanitarian health workers must consider culturally-defined health practices whose rationale is rooted in alternative understandings of health and disease.

4.4.3 Importance of cultural practices

Many societies have cultural practices or beliefs that relate to health care (Ells and Caniano, 2002). These practices may sometimes be detrimental to the health of those involved and so cause difficulties for humanitarian aid workers who are striving to improve the health of the individual and the population. However, other cultural practices may be truly innocuous and most participants found that such practices are easily accommodated within the delivery of health care.

In certain circumstances cultural practices related to explanations of health.

> Many of them don't know what germs are, they don't understand how these things work, have very little education. Their interpretation of illness was very interesting to me when they would explain. They thought their illness was just completely off the wall. They also have hot/cold ideas – when do you eat hot food, when do you eat cold food. After you are ill you shouldn't wash for a few days. Lots of practical habits. When they do not respect those habits they believe very strongly that it causes illness (P5.16.2).

In this setting the participant learned not to challenge the local beliefs directly but to try

to educate patients to care for themselves in ways that were more consistent with the understanding of modern medicine, health and hygiene.

Other customs presented more challenges for the health workers. One of the participants worked in a community where both female genital cutting and male circumcision were important tribal rituals. There was a big issue when it was discovered that one of the local male nurses was performing the ritual of male circumcision without using sterile razors despite the availability of clean equipment. The international workers were quite shocked by the unsafe manner in which this man, though a health worker, continued to practice the tribal rites. The same participant was also involved in training student nurses and the curriculum included a session on female genital cutting (FGC) which was given by a local nurse. After the session, in which the risks of FGC were outlined to this group of students, the instructor asked the students how many were against the practice. Only one student raised his hand. The participant was "shocked" though she acknowledged the "cultural pressure and status" (P2.2.1) that was associated with the ritual of FGC. She experienced it in this way:

> It is totally counterculture to us: 'We just talked to you about this. All the dangers. Why don't you try to change things in your culture and try to make it better?' But obviously it just goes so much deeper than that. Obviously the whole idea of ethnocentrism – and that is so much a part of the West. You just go in there thinking that is the way that it works, and then they don't. Actually for me it was quite humbling (P2.2.1).

Through this experience the participant gained a greater understanding of the complexity

of cultural practices such as FGC. She was dismayed by the health consequences associated with the practice of FGC but she also realized that many important cultural factors contributed to its perpetuation amongst the community.

Participant 9 advocated for harm-reduction strategies when responding to cultural practices that were harmful to health but entrenched in the culture of the population. When training birth attendants she tried to convince them not to take sand from the ground and put it in the baby's mouth which was the traditional method of blessing a baby. She asked if there was another way to bless the baby and the midwives decided that to put the sand on the baby's foot would be sufficient. She felt that this type of strategy might be replicated by other aid workers in parallel situations.

4.4.4 Role of the community and the family in decision-making

The family and community were often very involved in health-related decision making. As Participant 1 observed: "you don't just treat one person – you treat the family" (P1.10.1). This interviewee noted that the concept of family was also much broader than a traditional Canadian perspective. "It is not just families, it is everybody is family. Everyone is a cousin, even if they are not a cousin. So, yes, it does change the way you do, because often the decision is made by the family" (P1.10.1). Conceptions of consent may be directly affected by this family-focused process. It was obvious for many participants that the treatment decisions for one family member had a large impact on the rest of the family. Participants were very sympathetic to families who had to choose between competing concerns in caring for their children.

> If the dad comes to the nutrition center for 4-6 weeks it means the dad is not able

> to go the fields and the other six kids don't get as much. But is it the mom or the dad who is going to come to the center? Is it the big sister who is going to come to the center? For sure those families did make decisions. Some families chose not to get treatment. Because treating one child meant that the other children, or the grandmother, or other people would not get treatment. Some of the families had to walk seven hours to the hospital. So it means 14 hours back and forth so you lose 14 hours. You don't do anything else, you don't take care of the kids. So it is a strain for the family. For sure I was not made aware of everything that happened and all the sacrifice that they make, all the choice, all the ethical decisions that people made (P1.10.2).

The role of community and family in decision-making was striking for many of the participants. They often felt great sympathy for families who had to make treatment decisions on the basis of what was good for the whole family and not just the individual who was sick. Clinicians had to consider the role of the extended family in treatment decision-making and adapt themselves to a cultural reality different from the individual-focused value that is more prevalent in Canadian society.

4.5 Seeing yourself in a mirror: ethics and identity for the humanitarian worker

One of the impacts of the ethical issues faced by the participants was to raise questions of identity and self-concept. For Participant 7 it was important that in the face of various pressures the team was "very clear of who we are... We didn't let other people define us, how we were going to work" (P7.9.3). Another participant, as she began to question whether there was a shadow side to humanitarian action, felt that she was looking in a

mirror and "saying OK, what do I do with all this?" (P4.7.1). The ethical dimension of humanitarian and development work was a recurring source of reflection and self-evaluation for the participants. Issues of identity related to being a health professional, a moral person and a humanitarian worker.

4.5.1 Professional identity

The professional identity of health care workers is generally very strong. Clinicians often have a detailed conception of what it is to be a nurse, an occupational therapist, a social worker or a doctor. This professional identity affects how clinicians respond to ethical dilemmas. Professional identities are often closely related to a professional morality and the participant's perception of being consistent with the framework of a professional morality was very important. Participant 7 expressed that having a strong sense of professional identity allowed clinicians to navigate ethical issues cross-culturally.

> They have their culture and their way of thinking. You are not going to understand it all. You are not going to be an expert in... their culture, and so on. You have to be clear of your own. You have to be clear of your own professional identity, what you do, how you do it. Be clear of your own ethics and not compromise that (P7.7.4).

Professional identity and morality have a strong impact on Canadian health workers engaged in humanitiarian and development projects in underdeveloped countries. As this participant notes, ethical reasoning becomes more difficult when health workers fail to maintain their professional identity. However health professionals will also have

difficulties if they fail to evaluate how their interpretation of professional morality ought to be contextualized in the local setting.

Working in the context of humanitarian relief may challenge the notion of what it is to be a professional. This change occurs on a number of different levels. Two of the most common issues relate to health workers being asked to perform duties that are beyond the scope of their professional field of practice and when they are restricted from doing what they feel is consistent with their professional identity due to the mandate or philosophy of the NGO that they serve.

4.5.1.1 Roles beyond training

A particularly distressing experience for a health worker occurs when they are asked to perform a role for which they have not been trained or which falls outside the usual responsibilities of their profession. The pressure to take part in these new activities may come from different sources including at the request of a colleague, the NGO, the patients themselves, or due to a lack of personnel and resources.

Because overstepping one's professional field of practice is a serious legal and moral transgression in Canada, clinicians may be even more uncomfortable when they are in such a situation internationally. The effect can be quite pronounced and may have a lasting impact on the person involved. "You don't stop and you don't think about it. Also because you work six days a week you don't have much time to just reflect and when you come back you just realize it is just not normal to have to take decisions like

this when you don't have the training for it" (P1.6.1). The circumstances in which participants felt they were forced into roles that were not their own were varied. They ranged from being responsible for burying the bodies of children who died in the clinic, to clinicians performing clinical duties that they had never been trained for and improvising procedures because of a lack of proper equipment.

The response of the participants to these issues differed. Participant 1, a nurse, refused to perform activities that were the responsibility of a doctor: "Sometimes I was asked to do stuff that doctors do and the child died because I didn't do it. I felt that I wasn't a doctor. I felt that I couldn't do it, but it was the only thing to do and the child ended up dying. But I didn't want the child to die because I didn't do it right either" (P1.6.2). Another nurse, Participant 3, chose to participate in activities that exceeded her training and experience:

> I was having a doctor with me who was confronted with those things. She was like "I never did that" but we had to do it. Like an open fracture with no electricity in the health center. Just a little generator, with me holding the light like this and her holding the arm and *pllllleeee* and just doing a cast. One day I helped the doctor taking a bullet out, I never did that before. I never gave anesthesia before and the doctor is like "give that" and I'm like "OK" and *shhhhpt*. So at least if we know the person is going to die or be handicapped for life better to do something and not fully succeed than not do anything at all. Better than looking at someone with a big infection or with an open fracture for life. You know, just forget the life in Montreal in a little hospital that the doctor

tells you to do this and you don't have the right to think. It is totally different. You are just doing your best with what you have and in Zaire we didn't have so much (P3.4.2).

This participant and her physician colleague also began performing symphysiotomies despite lacking experience with the procedure and not having adequate surgical equipment. They decided that if a pregnant woman was not going to be able to deliver the baby it was better to attempt a surgical intervention rather than just to palliate the mother without being able to offer any further assistance. For the participants who considered performing activities exceeding their professional training or experience there was often a great deal of moral uncertainty associated with having to make such a decision. Frequently the angst associated with these situations had a long-lasting effect and several of the participants expressed that they still felt uncomfortable several years later with having had to make such decisions.

4.5.1.2 Conflict with vision of NGO

Many humanitarian projects operate in the field with a great degree of independence and members of the health care team are able to exercise discretion in making day to day operational decisions. However, NGOs have specific mandates and the interpretation of these roles may be a source of contention between the health worker in the field and the national or international staff (Slim, 1997). Some of these parameters may also result from the relationship between the NGOs and their donors. Decisions to end projects, to evacuate, or to allocate resources to certain groups, all caused difficulty for the participants. For Participant 3 the need to fight for her conception of what should be

done on the project was tightly linked with who she was, her identity. She felt she had to "fight for what I am and what I want to do" (P3.12.1) with decision-makers higher up in the organization. Eventually this type of conflict led her to withdraw from humanitarian work.

4.5.2 Identifying as a moral person

The participants conceived of themselves as moral individuals and attempted to operate in ways that were consistent with their understanding of morally appropriate behavior. To be an ethical or moral person was described by Participant 7 as: "in French we say *le savoir, le savoir faire et le savoir être* ... what is the knowledge you need to know, what is the knowledge you need, kind of theoretical. How do you apply it? The *savoir faire*: what kind of person uses this knowledge? Which is kind of ethics. The *savoir être*: How do you present yourself. Who are you?" (P7.2.5). In this conception being a moral person is associated with having appropriate knowledge, performing right actions and the manner and attitude with which actions are performed.

A particular challenge to the participants' conception of being a moral person was responding to societies that placed a different value on honesty. When faced with a culture where truth telling was conceived differently it was important for the participant to be consistent with her own conception that telling the truth was a requirement of an ethical professional. One participant expressed that "as a professional your truth, you say the truth. As a Nepali: 'whatever works, whatever you want to hear I will tell you even if it is not the truth'" (P5.13.3). Several participants experienced different conceptions of

honesty in certain cultural contexts, and even a different notion of what constitutes truth. The participants found it very disconcerting when they felt unable to trust that patients and local staff were telling them the truth.

Another frequent concern with being a moral person was how one related to corruption. Corruption was sometimes a source of great frustration for health workers particularly when those who were corrupt were those with influence and wealth. Participant 4 was understanding when local people were taking supplies from a project as a means of survival: "There was a lot of money that was going into the project and that was basically going into the pockets of the people. Which is I found OK to a certain point – corruption is survival. It is very easy to judge that but I would do the same in the situation" (P4.3.2). It was more difficult when participants felt that they had to participate in bribery themselves to be able to run the projects. Participant 7 felt he had "compromised" (P7.7.2) himself because he had insisted that the team, including local support staff, would not pay bribes, but then realized that his local staff paid the bribes from their own pockets because there was no other way to ensure that supplies would be delivered. In the end he let them include the bribery money with their petrol bills. He recognized that he had created a dilemma and felt that the lesser wrong was to allow the staff to use project money to pay the border guards rather than absorbing the financial loss themselves.

Participant 8, the Executive Director of an NGO, described the effect of corruption on some of her medical staff who were giving training sessions for physicians in the

Balkans: "The corruption issue is what dogged them because their expectations were on going to Europe. In their minds they were going to Europe and then they were hit with this incredibly archaic, corrupt system emerging from years of war and a lot of people suffering from the effects of war" (P8.6.2). Corruption represented an important challenge and several of the participants reported having to compromise because, though they felt it was wrong to participate in corruption, there was no other way to proceed with caring for patients.

The professionals had great concern when the corruption was the profiteering of those in power, and especially when they felt that they were involved in the process in some way. Participant 8, as director of an NGO, was involved in a new program to introduce the use of anti-retroviral drugs in association with local health authorities and she relates that

> the Minister had closed the public lab and opened his own lab and then had brought an Indian drug firm in to manufacture the anti-retrovirals but then stored them in a hot, damp factory and then was going to release the ARVs with orchestrated picture taking but no one had been trained on the guidelines. We offered to train the doctors on the guidelines. The Canadian doctors were frantic saying, 'we've got to get these guys trained'. ... and so the guys, the doctors, we trained on the essentials so they wouldn't kill the people with TB or something like that. That was a huge ethical dilemma because we knew it was a disaster waiting to happen. What if the early days of ARV were actually killing people because they weren't delivering the drugs in the proper way? (P8.13.3).

Because the participant and her colleagues were associated with this project they felt

acutely implicated in the way that corruption and incompetence would put patients at risk. The participant saw this as an important ethical issue.

Participants experienced corruption on many levels. This ranged from bribery of border guards to ensure that equipment would be delivered, to high government officials preventing projects from proceeding unless they received direct benefit from the project. Many of the participants found that issues of corruption presented important dilemmas that were not easily resolved.

4.5.3 Identifying as a humanitarian worker

The biggest identity concern for many of the health workers interviewed seemed to be with how they conceived of being a humanitarian worker and how they fit into the larger humanitarian enterprise. Many of the health professionals, while extremely committed to helping those in need, had important reservations about aspects of humanitarian relief as they saw it practiced in the field.

For some individuals it was the vestiges of colonialism that they found problematic. One of the main reasons Participant 4 chose not to renew her contract was her discomfort between the country's colonial past and the role the NGOs were presently playing in that community. In her understanding, the origins of colonialism were also humanitarian: the desire to do good by bringing civilization. She expressed her sense of uncertainty relating to humanitarianism by saying: "I have all these questions and I don't have answers" (P4.7.1). She found that the local population had good cause for associating the

humanitarian workers with their relatively recent colonial history. "'Who are you? You are in your big truck, white truck. The Belgians were here not even twenty years ago and you are in the same houses. I don't even know what you are doing here.' They thought we were just colonists like any other Belgian" (P4.7.1). Participant 10 noted that the community associated their presence with colonialism. "I think the white people they represent the Portuguese. They represent colonialism." (P10.8.2). These associations with colonialism were disconcerting for several participants, both in the way they conceived of the value of humanitarian action and in their perception of how local populations viewed the humanitarian workers.

There were a number of other ethical concerns raised about how the humanitarian workers interacted with local communities. Participant 7 had great concerns because field staff were sleeping with clients. In another situation the expatriate community had a five-course feast flown in from Kenya for a New Year's celebration in the Congo and the meal was served by Congolese who were hired for the occasion. Many of those present were working in nutritional camps. The participants viewed such activities as hypocritical and unethical. They were also concerned that such behaviour would influence how local populations viewed the humanitarian community as a whole.

Other large scale effects on the local population were also noted. Since projects were often very large, the impact when the projects were closed or moved was enormous. There was a great deal of dependence created. "When we decided to pull out of the project in Congo we were, it was so big, we were running the local economy of

Kisangani. There were about 1500 kids that were followed. All the food everyday. We were also feeding the people that were coming with them, we were feeding the staff. We were running the local economy. Pulling out was such a big political thing and they were so upset after us because they were saying the situation will come again" (P4.4.3). Participant 3 noted that the presence of the humanitarian projects and the "taxes" that they paid to the warring factions might potentiate civil war by "feeding the rebellion" (P3.10.1). The presence of humanitarian projects can have a significant negative impact on the population (Pfeiffer, 2003) that participants found to be disconcerting. Some participants also expressed concern that the humanitarian community does not adequately discuss or consider these issues.

What seemed to cause the greatest concern for the participants was the way in which humanitarianism was marketed and funded. Organizations are dependent on funding and they need to keep their donors satisfied and raise the profile of their projects to ensure that support will be available.

> Sometimes you are more willing to go and invest in a project that is what I call 'sexy and fashionable'. Because there is a famine, because there are strong images, you will get the support of the public. You will get funds, and you will be able to go on with what I call the 'humanitarian business' and sometimes I do have a problem with that. In South Sudan... the situation of famine was ending and we were getting so much problem of primary health care but we weren't doing anything for this because it is more on the midterm and longterm. But there was no bloody clinic that was functional, so basically we find a trap reason to stay

in South Sudan, because crisis is chronic in South Sudan, just to be there for the next crisis to be the first one to put our flag (P4.9.4).

In another example of the "humanitarian business" Participant 9 related how one of the leaders of her organization encouraged her to participate in a new project because "there was a lot of money to be made there" (P9.11.4). Several participants had to confront their own notions of humanitarianism. Health workers with overly idealistic views of humanitarianism can become disillusioned as they begin to understand the nature of how humanitarian projects and organizations secure funding. Humanitarian workers are generally motivated by a desire to help those in need. One participant noted that "I think we have to do our possible to save lives... I think that is the main reason we are there" (P3.3.2). The reality of needing to court donors and secure funding can create great discomfort for front line health workers.

Keeping donors satisfied may also impact treatment decisions on the field. "When you work with the World Bank, and when you work with big donations, you don't want your statistics to show that 37% or 40% of patients are dying because then it looks like you are not doing the right things or choosing the right patients" (P1.4.2). The participant described how the need to justify project success in terms of statistics affected the decisions of clinicians on an everyday basis. She felt that donor issues discouraged the acceptance of sicker patients into the center. Participant 7 was concerned that the primary objective of certain NGOs was more to please their donors than to serve the population.

We hear stories about other organisations who would do things that we wouldn't

do ourselves. We wouldn't do that. They wouldn't put the same emphasis on ethics in training their own staff. As long as the work got done they wouldn't ask any questions... They would do what they have to do and sometimes I thought they weren't concerned about the service or making people's lives better but because they had a contract with their donor to do that. They wanted to say to their donor that they had done that" (P7.4.3).

The influence of donor requirements can become problematic when organizations and individuals lose sight of their primary obligation of caring for a population in need. Organizations should be held accountable for practices that sacrifice the quality of services to satisfy requirements of their donors which may not be situationally relevant.

The participants struggled in different ways with the impact of ethical issues on their professional identities, their conception of themselves as moral individuals, and their participation in the humanitarian enterprise. These concerns were very significant for those interviewed and lingering doubts related to these questions led several of the participants to end their involvement in humanitarian work.

4. 6 Trust and distrust: the humanitarian worker and the local community

Many of the participants related experiences where they felt conflicted because the local population or local staff seemed either to be too trusting of them, or when active distrust of the humanitarian workers was present. Participant 9 was concerned by the level of trust that she was shown by the local people to the detriment of accepting local health workers.

> In West Africa it was not that uncommon that someone arrived for the delivery and they asked for the white girl. Even though I had much less experience than the midwife who was African. It is interesting in one way but it is something I don't encourage; 'Well, she is much better than me'. It was the same thing in Afghanistan because they heard that a white midwife was there. They were calling me midwife and I am like 'no, I am a nurse'. Sometimes they were calling me doctor. 'No, I am a nurse. He is a doctor, he is an Afghan doctor, and he is good enough. He will look at you.' I much prefer to do this, to create a good feeling with their own people in their own community because we are leaving (P9.2.2).

Such scenarios in which patients elevate international workers over the local staff have the potential to undermine the trust that locals place in their own national workers. This may have a lasting and detrimental impact on the relationship between the local popuation and their own health workers that would continue long aftter the NGO leaves.

There were other situations in which distrust of the humanitarian workers was an impediment to the cohesiveness of the team, and sometimes to the provision of care to patients. The reason for the distrust varied considerably. In some instances it related to associations with colonialism or to personal grievances, but in many cases the origin of this distrust was not known to the clinician. Participant 10 described how a local physician was "opposed to seeing any white person working there. He really made everything difficult for us" (P10.7.2). Participant 2 noted that there was a constant level of tension between the local staff and the humanitarian workers. "I think you know in

some ways ... there was always a fair bit of tension, ya tension. I don't think there is anything else you can call it, between the workers who were there and the ex-pats, a certain level of distrust" (P2.4.2). This distrust was manifested in different ways but would always be close to the surface. "It didn't take much for a trust that seemed to have been established to be broken." (P2.4.4). The distrust hampered work relations and impeded open communication amongst the professionals and ultimately affected patient care.

Participant 10 described the resistance that existed to her because she was a member of an international organization. "So how do you work in this situation? They don't want to see you. They don't trust you. They don't want to discuss things with you. The whole nursing staff was certainly against me. In the emergency room if I was to show the nurse in charge there to hear a murmur, to see the liver, something, he would just put my stethoscope down and walk away. It was difficult" (P10.7.2). This same doctor experienced that this distrust impeded improvements in clinical care.

> They do things the way it was done before. For instance they give Aspirin intravenous. Aspirin is not used anymore in children and even though it was clear in the manual, and they even give it intravenously. And even if I would say 'another medication like this, Tylenol or acetaminophen', the nurses would send the parents to go to the market to get some other stuff (P10.8.2).

In this setting distrust led to a tense atmosphere where local staff would actively undermine the interventions of the international team.

Sometimes the effects of distrust were particularly tragic.

> In Zambia the refugees were coming from a rural area and it was the first time that they were coming in contact with any kind of humanitarian aid. Therefore everything that we were using in the feeding center, drugs, pills, they had never been treated by that. They didn't have any money going into town for that. So people were very suspicious about that. So people were basically dying in their tents outside because people wouldn't bring them to the clinic, they wouldn't trust anybody. Also we had nurses and all the local staff working with us were Zambian and the refugees were Angolan. So they didn't really trust the Zambians (P4.6.2).

In this project the participant eventually succeeded in overcoming the suspicion and distrust of the refugees by meeting and discussing with the community leaders and negotiating an agreement on how to initiate treatment. The participant succeeded in overcoming some of the distrust by engaging the community and bringing them into the decision-making and planning process. There were further difficulties experienced in the project but the communication and trust that was established aided in responding to these issues.

On occasion the issues appeared less drastic but the impact on the relationship between locals and the international workers was still important. In one project there was a lack of form-fitting latex gloves. Because of this limitation latex gloves were only made available to the midwives, as they were routinely exposed to blood. The other staff had to use flimsier plastic gloves. One of the repercussions of this situation was that the local

nurses working at the clinic became increasingly distrustful of the expatriate workers saying "you are just trying to expose us to these things [diseases], you don't care about us" (P2.5.1). It seemed to the participant that the nurses held the expatriate workers personally responsible for the lack of supplies. This situation is emblematic of a sub-issue in regards to resource allocation and distrust. Several participants noted that the locals perceived the international workers as "though we just had an endless supply of money, each one of us" (P2.5.1). This perception that the international workers were individually withholding resources fostered further distrust. Participants felt that they were stuck in a situation where it was impossible for local people to have a realistic portrait of their own situation. This difference of expectations between local staff and expatriates sometimes led to discord and hostility.

4.7 Summary

The participants in this study described a variety of ethical issues that they experienced as part of their work as clinicians in humanitarian relief and development projects. Several of the participants also expressed that they felt ill-prepared and poorly supported to respond to these issues. The impact of these experiences was significant for those involved and elicited a variety of responses including anger, helplessness, frustration, sadness and self-doubt.

The central themes that emerged from the data were a tension between respecting local customs and imposing one's own values, questions of how to respond when basic care was not possible, the impact of differing conceptions of health and illness, questions of

identity for the participants, and the presence of trust and distrust dynamics between the participants and the local population. Each of these themes represents an important element in the phenomenon of how the participants experienced ethical issues in their international work.

Chapter 5: Discussion

5.1 Introduction

Health professionals involved in humanitarian and development work are faced with important ethical dilemmas associated with the provision of clinical care to affected populations. The ten professionals interviewed as part of this research project described a variety of important, challenging ethical issues that arose as a result of their work. Analysis of the interviews revealed five central themes that were expressed by the various participants. These themes include tension between respecting local practices and imposing values, differing conceptions of health and illness, how to respond when basic care is impossible, questions of identity for humanitarian workers, and issues of trust and distrust between aid workers and the local population.

In this chapter I will consider limitations to the research that was conducted and the implications of this research project for humanitarian practice. I will also suggest recommendations for international strategies, and for policy development for NGOs, to develop structures to support and equip clinical staff for the ethical dimension of their work. Finally, I will describe avenues for further research.

5.2 Limitations of the research

The original focus of this research project was to consider how clinical ethics was experienced by health care workers who were involved in humanitarian and development projects. However, throughout the interviews the participants consistently identified both

dilemmas of clinical ethics as well as ethical issues that were broader than the clinical setting. Since the concerns of the participants in regards to ethics were more extensive than exclusively clinical issues and encompassed issues of humanitarian intervention, as well as issues arising from living and working cross-culturally, the focus of the study was broadened to include this wider set of issues. It should be noted that several of the participants identified these larger issues of humanitarian action as having a direct and important impact on care delivery. They considered issues of how humanitarian work is funded, managed and marketed as having an impact on patient care.

The purposefulness of the study sample was limited by the recruitment of more women than men, and more nurses than other professionals. The prevalence of female nurses in the sample might skew the results towards being more representative of this group than the multidisciplinary cohort that was intended. However, it should be recognized that nurses constitute one of the largest groups of humanitarian health workers and so the imbalance of the multidisciplinary cohort may be more representative of expatriate health workers than it first appears (Robbins, 1999).

5.3 Implications for humanitarian workers

This qualitative research study has a number of important implications for humanitarian action and for humanitarian workers. The results of the study highlight the importance, diversity and prevalence of ethical dilemmas that are faced by health workers during their international missions. As was experienced by the participants of the study these ethical issues can have a significant impact on international health workers and result in

important distress and anxiety (Bjerneld et al, 2004). It appears from the literature, and from the apparent lack of focus on this area by NGOs, that this situation has been under-recognized or acknowledged to date.

The results of this research may help to focus the attention of NGOs on the need to better support and equip their staff in analyzing and responding to ethical issues that they experience in their work. Slim (1997) asserts that "Much poor morale in relief agencies is directly linked to a sense of moral confusion" and encourages organizations to engage in improved ethical analysis and discussion. Many of the study participants stated that NGOs should be more proactive in supporting front line health workers and equipping them for the analysis of ethically complex issues. Several of the participants expressed significant frustration and disappointment at being poorly supported in this regard.

5.4 Organizational strategies to address ethics

The interview participants described their experience of ethical issues that were manifest during their involvement in humanitarian and development work. They also contributed many practical suggestions concerning how aid organizations might better support and equip health workers to analyze and resolve ethically complex issues. Participants had suggestions relating to a number of different aspects of humanitarian work. In particular, they provided insights into staff selection, preparation, support and debriefing.

Wilson (1997) asserts that NGOs are morally obligated to provide adequate training, support and debriefing to their staff. "Relief institutions have special ethical obligations

to their staff during humanitarian emergencies... Adequate preparation and training beforehand, and effective counseling and support during and after operations are strongly advised." NGOs should be encouraged to incorporate organizational strategies to address ethical issues. People in Aid, the Sphere Project and other international initiatives to develop standards and accountability in humanitarian action may be useful structures to move these issues forward. The willingness of NGOs to incorporate these strategies is essential if humanitarian aid organizations are to be better able to support their health care staff in responding to ethical dilemmas in the field.

5.4.1 Selection of staff

NGOs must be especially careful when recruiting staff that the professionals they hire are able to cope with the instability, variability and challenges inherent in humanitarian work. Recruitment should not just consider professional qualifications but also personal attributes relating to adaptability and resourcefulness. As Bjerneld et al (2004) note "NGOs must spend adequate time on recruiting, assure that only persons with adequate professional experience are sent out, and screen out those who are personally ill suited for the work". NGOs should also strive to be realistic in describing the job situation to potential staff and give them as clear a picture as possible of the requirements of the position. Candidates who have unduly glamorized or idealistic perceptions of humanitarian work should be encouraged to discuss the realities of this type of work with experienced field staff before they accept a position with an NGO.

5.4.2 Training

Once staff have been hired adequate training should be provided. Bjerneld et al (2004) report that many NGOs invest sparingly or not at all in staff training. Training, however, can have important benefits for preparing staff for international work. Training should consider issues such as cross-cultural living, language learning and an introduction to the culture of the country/population. The training should also include discussion of the types of ethical issues that will be faced by health care workers. Incorporating an ethics component to the training curriculum will assist humanitarian health workers in responding to ethically complex issues that they will experience in the field.

Of the participants in this study several had no official training prior to departure. These health workers were left to their own initiatives to prepare for their international projects. Of those who had more significant preparation none could recall any discussion of clinical ethics. The one participant who identified an ethical component to her training had taken a preparatory course for project managers. She described the ethics component of this training to consist of a discussion of how managers should respond if staff were misusing project assets or were frequenting prostitutes. Most of the participants reported having spent time reading about the country and its people prior to departing for their field missions.

Training and study are important means for preparing health workers for international aid work. This is especially important because few health workers have training in development studies or anthropology. The preparation offered to clinicians will be most

effective if different methods are combined. NGOs should consider using both formal training courses and guided individual study to promote the best opportunity for learning.

Preparatory Courses

Preparatory training should include sessions on learning about the cultural group amongst whom the health professionals will be working. An awareness of, and openness to, the local culture is essential for effective cross-cultural health care. The investment that organizations and individuals make in the process of cultural learning will have an important benefit once professionals are in the field. Health professionals who begin their cultural learning prior to departure will be better prepared to begin their clinical duties upon arrival as they will be more knowledgeable about the cultural values and concerns that are present in the community. This knowledge will assist health workers in responding to ethical dilemmas that arise in the clinic, hospital, feeding center or refugee camp where they will work. The content of the training should be designed for the specific responsibilities of the professionals. For instance, health workers who will be involved in triage and decision-making regarding the allocation of scarce resources should have the opportunity to consider and discuss these issues. The training sessions should also include review and discussion of any code of ethics or code of conduct developed by the organization.

A specific method of training that may be particularly useful is case studies that are clinically and culturally relevant for the type of work and the cultural milieu of the mission. Case studies will allow clinicians to develop analytic skills and refine moral

reasoning in regards to complex ethical issues. Case studies should be derived from the clinical practice of others in the organization. These sessions should be facilitated by individuals who have both field experience and a similar professional background to the group members. The health workers should have an opportunity to reflect on these cases and discuss them with their colleagues.

Individual Study

NGOs should provide staff with resources to study prior to departure. These materials will be even more effective if the health workers have an opportunity to discuss what they read with others in the organization. This type of directed individual study could encompass many different subjects. As in the preparatory courses, it will be valuable to incorporate material on cultural and language learning, culture shock, stress management and ethics. Individuals should be given some freedom in selecting the material that they feel is most pertinent and interesting to them amongst the various resources provided.

A particular element of self directed study that should be encouraged is for departing health workers to consider their own cultural values and ethical understandings. Several of the study participants noted that with greater awareness of their own moral assumptions they gained a better perspective from which to evaluate the ethical issues that were at stake and their own reactions to these issues. This is consistent with the observation of Ells and Caniano (2002) "when relating to anyone from another culture, one must seek to understand one's own culture, the other's culture and the interaction between the two." Many departing health workers may not have a clear sense of their

own professional and moral convictions. Individual study and reflection can assist them to clarify these issues prior to being deployed in the field.

5.4.3 Developing a culture of ethics

NGOs should endeavour to foster an organizational culture that is responsive to ethics. Several participants felt that the organizations for whom they worked did not prioritize ethics and underestimated the impact of ethical issues on their staff. This is an extremely problematic situation that should be addressed. Ethics should be a natural element of the discourse, planning and functioning of health-related NGOs (Slim, 1997). Several methods by which this can take place include mentoring, developing ethics expertise and encouraging increased ethics dialogue with local stakeholders.

Mentoring

A particularly valuable practice in the organization of health care teams is the establishment of mentoring relationships between more experienced clinicians and new staff. NGOs should ensure that clinicians have the opportunity to discuss issues that arise in the course of their clinical work. Mentoring will facilitate those with less experience learning from the perspective and field knowledge of more seasoned colleagues.

A difficult situation exists when individual workers are involved in isolated projects. In this study one of the participants was the only expatriate worker in the region where she lived. In such situations it is particularly important to have contact with a mentor or peer, perhaps by email or phone. Another study participant expressed that discussions in the

field with experienced colleagues were more valuable than preparation prior to departure because it was impossible to predict in advance the specifics of the local milieu.

Ethics expertise

Organizations should be deliberate in cultivating expertise related to ethics (Slim, 1997). NGOs may choose to identify an experienced person in their national or international offices who could be a resource person for field staff when they are faced with complex ethical dilemmas that they are unable to resolve independently. Ideally the person selected would be an experienced health professional who has an appreciation for the diverse ethical issues that can arise in the field. There are certain limitations to this type of arrangement. Because of the isolation of some field projects there may be difficulties with phone or email contact. Also delays in contacting an outside person may be too long to assist in time-sensitive situations on the field. Another concern is the need to cultivate field expertise and local accountability in ethical decision-making. Thus consultation with the ethics expert should be reserved for particularly difficult or chronically unresolved issues.

If an ethics expert is identified in an organization this person should be involved in the pre-departure training of new staff. They would be particularly well placed to discuss ethical issues and to review case studies. This will also sensitize the workers to the availability of this service and give them a direct contact with the ethics resource person.

Some NGOs may also decide that it will be useful to have a clinical ethics committee as is present in many health care institutions. This committee would meet on a regular basis and could function to review past cases, field policies and recurrent or chronic issues relating to ethics in the field. This committee would then make recommendations that could assist both field staff and administrators. Such a committee could contribute to the development of "the moral mind of [the] organization" by which the "vague moral unease which pervades most relief agencies today could be sharpened by the prick of conscience" (Slim, 1997).

Dialogue and discussion

A further emphasis should be placed on discussing resource allocation, care decision-making and other ethically laden issues with local health professionals and community leaders (Pfeiffer, 2003) . The study participants related situations when discussion and dialogue between the health care team and local stakeholders led to more effective interventions, decreased distrust and increased cohesiveness between local and expatriate care providers. This dialogue also increases the cultural knowledge and awareness of the international workers involved.

5.4.4 Debriefing

The psychological impact of humanitarian work on health care professionals can be significant (Robbins, 1999). Humanitarian workers are frequently exposed to physical risk, overwork and are witness to human suffering on a profound and disturbing scale

(Wilson, 1997). Presently it is common practice for returning health workers to receive a debriefing after they finish their international mission.

Debriefing can play an important role in assisting the transition back to life in their home country. It can also help identify individuals who are suffering from stress related disorders (Robbins, 1999). Debriefing is a useful tool that should continue to be evaluated and utilized to advantage. Those involved in debriefing health workers should be aware of the potential impact of clinical ethics that may be manifest for health professionals in contrast to other types of aid workers.

5.5 International strategies to address ethics

There are few international guidelines that attempt to delineate codes that might direct health workers in clinical health care ethics. The World Medical Association is one organization that has published an international code of ethics and several guidelines for physicians (WMA revised 1994, WMA revised 1983, WMA 1994). The creation of guidelines is a challenging and contentious endeavour. Without consensus for a "global bioethics" it will remain difficult to achieve international acceptance of any code of clinical ethics unless the guidelines are left sufficiently vague. Also, for a global code to be effective in assisting humanitarian workers it would need to be responsive to local contexts and applicable in ways that were meaningful in a variety of cultural and clinical settings. For these reasons the creation of global codes for clinical ethics in humanitarian work will be difficult and risk being unhelpfully vague or unresponsive to local realities.

What may be more realistic and appropriate are standards of practice oriented towards humanitarian organizations and relating to the support and training of staff for the analysis of ethical issues. These standards could be put forward under the rubric of organizations that oversee accountability and best practices in humanitarian work. The Sphere Project and the People in Aid initiatives, or other similar organizations, may be appropriate vehicles for integrating standards that NGOs provide training and support to their staff in regards to ethics. The philosophy of People in Aid may be particularly relevant in this regard as they state that aid organizations should be accountable not only to donors and recipients of aid but also to their staff (People in Aid, 2003). Donors may also have a role in encouraging NGOs to participate in such initiatives. Michael and Zvi (2002) note that an accreditation process might be instituted for NGOs to improve accountability. Accreditation could assist in ensuring that NGOs meet standards that are accepted in the humanitarian community as good practice. An element of this accreditation could indeed be to consider how NGOs address clinical ethics.

5.6 Recommendations for future research

Further research into this subject is very important. To build on this present research, and to a gain a deeper appreciation for how humanitarian health workers experience ethics, a larger cohort should be studied. There is great diversity amongst the experiences of international aid workers. Humanitarian assistance work is a "complex system in which responsibilities rest with many parties" (Bjerneld, 2004). Thus, a larger sample size might give a better appreciation for the experiences of Canadian health professionals involved in humanitarian and development work. Some of the issues that

arose in the interviews of the participants might also bear study in their own right. These include a further examination of the suggested relationship between imperialism and humanitarian action, how funding issues affect clinical decision-making, and the impact of population-health decision-making on health care professionals trained in a model of care focused on the individual patient.

A typology of aid organizations, and their processes of support and training for staff in regards to ethical issues, should also be undertaken to gain a better sense of what structures are presently in place by NGOs. A study that might also be of benefit would be an analysis of organizations that are particularly effective at addressing ethical issues in clinical care, and gain an understanding of what strategies most contribute to this orientation towards clinical ethics.

5.7 Summary

Canadian health care workers experience important ethical issues as they provide clinical care to affected communities as part of humanitarian and development projects. Many of the participants in this study described important anxiety and uncertainty related to the ethical decision-making that they experienced as international aid workers. To better support health care workers, and to provide more ethically appropriate and just care to individuals and communities, NGOs should consider the emphasis that they place on clinical ethics. A number of different organizational strategies such as appropriate selection of staff, training which includes pre-departure courses and guided individual study, mentoring, the development of ethics expertise and the nurturing of ethics dialogue

with local stakeholders might all be beneficial for NGOs to incorporate in their organizational practices. Though international guidelines may be of less benefit in guiding humanitarian health workers for clinical ethics, international initiatives and accreditation could be utilized to encourage more robust standards of clinical ethics support and training for humanitarian aid organizations.

Chapter 6: Conclusion

Canadian health professionals are increasingly involved in humanitarian relief and development projects in many regions of the world. These projects are initiated in response to situations of famine, war, disaster and underdevelopment. In the course of their clinical duties humanitarian health workers frequently experience important ethical issues. Many of the professionals involved in this work have not received training in international health settings and may struggle to adapt to new cultural and clinical realities. Complex ethical issues may have a substantial impact on clinicians and be a source of significant anxiety, uncertainty and angst.

Given the importance of these ethical issues and their impact on health workers I decided to undertake a study of how Canadian health professionals experience ethics in humanitarian assistance and development work. I employed a qualitative design and the framework of phenomenology to evaluate this question. The study sample consisted of nine health workers with varied professional backgrounds and clinical experience and one executive director of an NGO. The participants each had extensive international experience.

The participants took part in an interview that was audio recorded. First, brief demographic information was collected on the participants relating to their clinical experience in Canada and internationally. The second section of the interview followed an interview guide consisting of seven questions. The third part of the interview was an

informal conversational style that allowed me to further pursue issues that were not sufficiently discussed during the first segment of the interview. The interviews were transcribed and the collected data was analyzed using content analysis. Five distinct themes were identified from the data set.

The first theme related to the tension experienced by health professionals between respecting local customs and imposing outside values. The study participants reported a strong desire to be respectful of local traditions and culture, but not to compromise their own core values. It was not always possible for the interviewees to satisfy both of these concerns and they were faced with difficult ethical choices. Some of the most challenging dilemmas occurred when the participants identified cultural practices that they viewed as unjust. The participants described situations in which status, gender, ethnicity and wealth all affected access to health resources. Several of the participants also related incidents where they felt compelled to contravene local authorities because they strongly disagreed with the authorities' policy decisions.

Second, the interviewees reported being challenged by situations in which basic care could not be provided. Most frequently this occurred because of limited access to resources such as personnel, supplies, equipment or facilities. In these situations health workers had to consider the best way to maximize the resources available. This often resulted in caregivers needing to adopt a population view of health care delivery. This shift was difficult for many participants who were accustomed to focusing on the needs of individual patients. Many of the participants worked alongside local caregivers and an

ethical dilemma was created when local staff provided inappropriate or incompetent care. The participants often found it difficult to respond to such situations. Also, the health care team had to evaluate what standards of care were appropriate in the local setting. Standards of care were a contentious issue because community baseline health and nutrition status were usually quite low, refugee populations were often involved, and limitations of resources affected the care available.

The third theme that emerged from the data was that local understandings of health and illness frequently differed from those of the international workers. Some of the specific differences reported by the participants related to discordant views of death and dying, the relationship between spirituality and health, the use of traditional healers and the involvement of community and extended family in health decision-making. A further element of this theme was how participants responded to cultural rites and customs relating to health. The participants found it perplexing to decide how to respond when important cultural practices had negative impacts on health.

Fourth, the participants' involvement in international aid projects precipitated reflection on subjects of identity. Questions of self-concept were raised related to how the participants understood being a professional, a moral person and a humanitarian worker. Professional identity was challenged when health workers were asked to participate in activities beyond their training or field of practice and when their vision for clinical practice differed from the mandate of the NGO. Many of the participants also had to respond to corruption and differing notions of honesty that challenged their conception of

being a moral person. Finally many participants struggled with how humanitarian action is supported, managed and marketed. The issue of fund-raising caused great concern for several participants. A number of the interviewees also expressed misgivings with the way that humanitarian projects can create dependence and how the presence of NGOs can inadvertently prolongate armed conflict.

The final theme related to issues of trust and distrust between the expatriate workers and either the local health workers or the local population. These trust issues were often very significant and had an important impact on the participants and their ability to provide good care to their patients. In some instances the local population placed exaggerated trust in the international workers to the detriment of relationships with local professionals. In other situations the international workers were faced with active distrust and suspicion by the local health team and community members. Distrust sometimes became an important barrier to the delivery of care.

In light of the findings of this study it is obvious that many health care workers feel under-supported or ill-equipped to respond to the complex ethical issues that are present in many international health projects. In such situations ethical issues can cause frustration, disillusionment and angst for the health workers involved. To address this reality NGOs need to take measures to recruit appropriate professionals, better prepare their staff before deployment, offer resources to support them in the field, and adequately debrief them upon their return. Staff should be selected who have both excellent professional qualifications and the personal attributes required to function in extreme

work environments. The aid agency should also offer potential staff a realistic description of the requirements of the position. Training prior to deployment should be mandatory and include both thorough culture and language training, as well as addressing issues of clinical ethics through case studies and other methods. This preparatory training should consist of formal courses and guided individual study. Once professionals have completed a field project they should receive formal debriefing on their return to Canada.

NGOs should also strive to develop an organizational culture that is characterized by openness to ethics analysis and debate. Aid organizations should strive to develop ethics expertise by identifying an ethics resource person or through the formation of a clinical ethics committee. The organization should also structure its field teams so that mentors are available to less experienced staff. Finally, NGOs should encourage dialogue on ethical issues with local stakeholders, including local health workers and community representatives.

The health care workers in this study described a number of different ethical issues that they experienced during their work on humanitarian assistance and development projects. For many of those interviewed the impact of these complex ethical issues was significant and long lasting. NGOs have an obligation to prepare and support their staff in their international work. This includes an obligation to assist staff in responding to ethically complex issues. Organizational strategies to promote ethics training and support are essential and should be encouraged as standard practices for NGOs either through a

process of accreditation or through voluntary initiatives such as People in Aid, the Sphere Project, or an equivalent international organization.

When delivering health care to affected populations in humanitarian relief and development settings clinicians frequently need to evaluate and respond to complex ethical issues. The nature of clinical ethics in these environments is significantly different than what occurs in North American health care. Clinicians require training and support to respond to the reality of these diverse issues. This study can help to orient these interventions to better address the specific types of issues experienced by health professionals in the field.

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Appendix A: Interview Guide

Biographical information

Occupation: Years of experience prior to going overseas:
Country of service: Duration of project:

Research Questions:

1) My first question today is whether you can describe for me the nature of the work in which you were involved internationally?

2) Did you notice differences between your understanding of clinical ethics and that of the individuals with whom you worked?

   - Can you describe this?

3) In the course of this work were you ever faced with ethical dilemmas in clinical decision making?

   - Was there resolution to these particular ethical issues or conflicts?
   - Did the different cultural understandings of those involved have an impact on how these issues were addressed (patients, families, other staff members)?

4) How did you experience these ethical issues? What impact did these dilemmas have on yourself (professionally, personally, emotionally)?

5) What process did you and your colleagues employ to address and resolve this (these) issue(s)?

   - How did this process come about?

6) In your mind what is the most helpful way for people from different cultures to work through ethical issues?

   - Why do you find this approach helpful?

7) Could the organization you were working for have better prepared you for the ethics of your work?

   - How might they better assist future field workers? What training would be useful?

Appendix B

McGill

Faculty of Medicine
3655 Promenade Sir William Osler
Montreal, QC H3G 1Y6

Faculté de médecine
3655, Promenade Sir William Osler
Montréal, QC, H3G 1Y6

Fax/Télécopieur: (514) 398-3595

CERTIFICATION OF ETHICAL ACCEPTABILITY FOR RESEARCH INVOLVING HUMAN SUBJECTS

The Faculty of Medicine Institutional Review Board consisting of:

SERGE GAUTHIER, MD
PAUL BRASSARD, MD
MARIGOLD HYDE, BSc
FRANCES ABOUD, PhD
VICTOR COHEN, MD
PETR KAVAN, MD
HARVEY SIGMAN, MD

has examined the research project **A11-E33-04B** entitled **"The Nature and Impact of Ethical Dilemmas Faced by Canadian-Trained Health Professionals Involved in International Humanitarian and Relief Work"**

as proposed by: Leigh Turner (Applicant) to _____ (Granting Agency, if any)

and consider the experimental procedures to be acceptable on ethical grounds for research involving human subjects.

January 3, 2005 (Date) _____ (Chair, IRB) _____ (Dean of Faculty)

Institutional Review Board Assurance Number: FWA 00004545

Appendix C

The nature and impact of ethical dilemmas faced by Canadian-trained health professionals involved in international humanitarian and relief work.

Informed Consent Form

This study is intended to evaluate the types of ethical issues faced by health care professionals in humanitarian and relief contexts. The effect that these experiences have on clinicians and the processes that they go through to evaluate and address these issues will be explored. The role of Non-Governmental Organizations in preparing and supporting health care workers for the ethics of cross-cultural health care delivery will also be considered.

Each participant will take part in an interview that will last 60 to 90 minutes. These interviews will be recorded on audiocassette and then transcribed. Participants may request to have a typed copy of their interview. If required, follow-up questions may be asked by telephone after the interview. The responses to these questions will also be recorded.

The interview material will only be identified by a code and confidentiality and anonymity will be preserved. Only the researcher will have access to the taped material.

Participants may refuse to answer any question and may withdraw from the study at any time by contacting Matthew Hunt.

The study and consent form have been explained to me and my questions have been answered by Matthew Hunt. I will not immediately benefit from this study. I agree to participate voluntarily in this project.

	Name	Signature	Date
Participant			
Witness			

Researcher:
Matthew Hunt
4076 Grand Blvd
Montreal, Qc.
H4B 2X5
(514) 488-6814
matthew.hunt1@staff.mcgil.ca

Research Supervisor:
Dr. Leigh Turner
Biomedical Ethics Unit
3647 Peel Street
Montreal, Qc,
H3A 1X1
(514) 398-4239