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MEDICAL EDUCATION

How Should Academic Medical Centers Administer Students' "Domestic Global Health" Experiences?

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Abstract

Academic medical centers (AMCs) promote educational benefits to students of immersive global health experiences (GHE), both abroad and locally in low-resource settings. Within the United States, these opportunities are called *domestic* GHEs and often take place in student-run indigent care clinics (SRCs) that serve vulnerable populations. Domestic GHEs offer perspectives on the health care system that are similar to those of GHEs. In both, AMCs must balance benefits to students and patients against the potential risks of inadequate supervision and mentorship. This article reviews the roles of AMCs in preparing students for domestic GHEs with a focus on SRCs.

"Domestic Global Health"

Academic medical centers (AMCs) promote educational benefits to students of immersive global health experiences (GHE), both abroad and locally in low-resource settings.[1,2,3,4] GHE participants are more likely to pursue careers in primary care and other areas of medicine that focus on the needs of vulnerable patients.[5] GHEs are also highly valued by trainees.[6,7] Within the United States, these opportunities—which are called *domestic* GHEs—often take place in student-run indigent care clinics (SRCs), serve immigrant and other vulnerable populations, and are staffed by attending physicians who supervise medical trainees, including preclinical students who tend to be responsible for clinic management and organization. SRCs are popular because they offer students opportunities to gain early clinical experience with serving patients from diverse backgrounds[8] and to be exposed to systems-based perspectives on social status, public benefits eligibility, and health care financing that influence individuals' and populations' health status in the United States.[9] However, AMCs must balance benefits to students and patients against potential risks of inadequate supervision and mentorship. This article first describes SRCs and relevant guidelines for GHEs. The article then explores AMCs' roles in preparing students for domestic GHEs with a focus on ethical questions arising in SRC care settings.

Care Standards in SRCs

Similar to global health care delivery settings, SRCs generally aim to address gaps in health service delivery and focus on patients facing barriers to access. SRCs provide limited access to medications, diagnostic testing, and interventions but are often available after hours, typically in rented or donated spaces.[10] SRCs serve patients from ethnically diverse backgrounds with both chronic and acute illnesses. A nationwide survey of 59 SRCs found that 31% of patients were Hispanic and 31% were black/African American, with 36% of visits being for acute care and 33% for chronic disease management.[10] Additionally, SRCs and other free clinics frequently serve populations with limited English proficiency.[10,11] These patients can be ineligible for health care coverage based on immigration status.

Students staffing SRCs face ethical questions that are also raised in resource-limited settings abroad: What should I do when available resources limit my capacity to deliver standard of care to patients? When, if ever, is it ethically acceptable to offer less than standard of care to a patient? Should I—and how should I—communicate standard of care differences to patients in SRCs?

In contrast to formalized predeparture, on the ground, and postdeparture training and mentorship offered to students in GHEs, students in SRCs may lack formal guidance.[12,13] As GHEs have become more common, ethical questions, particularly about students practicing unsupervised or beyond their capabilities, have been formally addressed.[14] In 2010, leaders in global health education initiated the Working Group on Ethics Guidelines for Global Health Training (WEIGHT) to help address graduate medical education development.[15] The WEIGHT guidelines emphasize that well-structured programs should be planned collaboratively (between host and sponsoring institutions) and that students and trainees are responsible for communicating transparently with mentors and patients about their levels of training and experience.[15] These guidelines have been used by AMCs in development of curricula,[16,17] including dedicated global health tracks with simulation programs and web-based modules that review clinical, cultural, and ethics content.[18,19,20]

Curricular Guidelines for Domestic GHEs

A challenge for AMCs is applying lessons learned in international experiences to domestic experiences, particularly longitudinal ones, with vulnerable populations. Building on lessons from global health training, teaching should include preexperience orientation, ongoing mentorship, and postexperience debriefing. Table 1 offers guidelines for domestic GHEs.

Table 1. Guidelines for Domestic Global Health Experiences

Phase	Guidelines
Preexperience	• Review expectations and responsibilities of clinic leadership, faculty, trainees, and academic medical centers. • Review the supervision model and expectations for appropriate supervision standards. • Review standards of professionalism and cultural humility. • Establish language capabilities and supports. • Review the curriculum—including clinical, ethical, and social considerations—that is specific to the population served. • Review safety concerns.
During the experience	• Provide effective supervision and regular mentorship by designated faculty for clinical care and with regard to ethical issues. • Establish a forum for feedback and dialogue regarding ethical concerns and moral distress. • Identify opportunities for advocacy.
Postexperience	• Collect and evaluate data from trainees, faculty, and the community on the experience, its impact, and challenges encountered. • Provide formal feedback to trainees on clinical performance, cultural humility, and professionalism. • Debrief with trainees regarding ethical concerns and moral distress. • Provide ongoing mentorship to trainees interested in pursuing a career with vulnerable populations domestically.

Table 2 presents a sample curriculum with an ethics component for students taking care of patients who are immigrants.

Table 2. Sample Curriculum for a Domestic Global Health Experience in Immigrant Health

Topic	Content Areas
Clinical	• Utilize evidence-based resources and guidelines for the clinical evaluation of immigrant patients. • Recognize the role of trauma, acculturation, and postmigration stressors in the lives of immigrants. • Provide trauma-informed care when appropriate. • Recognize caregiver burnout and apply strategies to address secondary trauma.

Access	• Direct immigrant patients to health care coverage and services for which they are eligible based upon their immigration status.
Community-based partnership	• Identify strategies to meaningfully partner with community-based organizations serving immigrant communities to improve immigrant health, including those involved in the provision of legal services, mental health care, social services, community building, and education.
Culturally and linguistically appropriate care	• Identify and apply resources to enhance communication with patients with limited English proficiency, including using interpreter services, and gain comfort providing linguistically and culturally appropriate care that takes into account health literacy and familiarity with the health system.
Policy and advocacy	• Demonstrate knowledge of the impact of US immigration and health policy, both current and historical, on the health care needs of immigrant populations. • Identify strategies for advocating for immigrants and health policy reforms.
Social determinants of health	• Apply a strategy to screen for social determinants of health. • Recognize common legal issues facing immigrants based on their immigration status. • Understand how to effectively and responsibly partner with legal organizations on immigration-related issues, including by forming medical-legal partnerships.
Ethics	• Establish a forum for trainees to provide feedback and engage in dialogue on ethical concerns and moral distress. • Develop and apply an ethical framework for common challenges faced in the care of low-income immigrant patients.

Surveys of medical education programs have shown that topics related to domestic GHEs are often included in global health curricula.[21,22,23,24] Given that participants in GHEs are more likely to care for patients who are immigrants,[23] this approach seems reasonable. However, given the popularity of domestic GHEs such as SRCs and the prevalence of vulnerable populations in the United States, many trainees will care for patients in these populations without having participated in a global health track. AMCs

should, therefore, consider introducing all trainees to instruction in caring domestically for vulnerable populations.

Ethics and Cultural Humility

As in GHEs, the concept of cultural humility and Beauchamp and Childress' ethical principles can help trainees respond to ethical questions. Cultural humility encourages openness and—in contrast to cultural competency, which focuses on education about "typical" cultural practices—emphasizes approaching each individual patient as having a unique identity. Practicing cultural humility requires lifelong commitment to self-reflection and patient-centered dialogue to identify each individual patient's values and priorities.[25]

Beauchamp and Childress' 4 well-known principles include nonmaleficence (avoidance of practices that are unjustifiably or unnecessarily harmful), beneficence (the obligation to work in the best interest of a patient), respect for autonomy (expressing respect for a person's self-determination, including by disclosing information needed for a person to make a decision), and justice (typically understood as requiring fair resource allocation).[26] Cultural humility, however, can also be understood in terms of justice, as it requires transparency and cultivating awareness of historical, social, and cultural situatedness of systemic inequality.[25] Cultural humility and the 4 fundamental principles of bioethics are useful guides in discussing common ethical challenges in domestic GHEs, such as resource allocation and advocacy, transparency and partnership, the hidden curriculum, and systemic inequities.

Resources and advocacy. Learning in resource-limited settings may prompt some to conclude that it is ethically acceptable to provide lower quality care with less privacy to patients living in poverty.[8] For example, if a trainee sees patients with poorly controlled diabetes and observes a mentoring physician delaying insulin initiation due to its high cost, that trainee could interpret this behavior as ethically unproblematic, given the totality of the patient's circumstances.[27] Alternatively, a trainee could consider if there are other methods of providing the standard of care, such as referral to other safety net programs. Additionally, situations in which trainees feel they must act in a way that is unjust or counter to their sense of what is ethically permissible cause moral distress.[28] Trainees can advocate for health-system changes that would improve access to care,[29] which might ameliorate their moral distress. To assist in advocacy, the American Academy of Pediatrics publishes information on immigration policies[30] and an advocacy toolkit.[31]

Transparency and partnership. In resource-limited settings, clinicians are often asked to make difficult decisions among treatment options based on price and access. For example, trainees might be tempted not to reveal to patients that they are being given substandard care because standard care costs too much for their setting. Or they might

choose to discuss all treatment options with patients, even those that seem financially untenable, thus allowing patients to be aware of potential harms and ultimately to determine their own care. In global health settings, trainees should be taught to consider both individual patient and community voices in managing and administering SRCs. It is key that domestic community members are involved in decision making to ensure that an SRC meets patients' needs.[16,17]

Hidden curriculum and teaching compassionate care. As in international GHEs,[32] there is concern that some students learn that it is acceptable to practice their skills on those living in poverty.[8,32] Accordingly, some trainees might withhold from patients (or from themselves) that, due to inexperience, they could be practicing in ways that violate the principles of nonmaleficence and respect for patient autonomy.[12] One survey of GHE participants showed that 48% felt it was acceptable to bypass standard of care guidelines in developing countries.[32] These responses suggest that students must cultivate recognition of their own limitations and that some are not adequately prepared to navigate ethical questions about what patients in resource-limited settings deserve from them. Students' lack of awareness and preparation can have important consequences, ethically and clinically, for patients in SRCs.

Clearly, educators can model and teach compassionate care. Educators, for example, should use evidence-based guidelines to teach how to care for patients who are immigrants,[33,34] and teaching in SRCs should model cultural humility in caring for patients with limited English proficiency.[35] Best practices in teaching care management extend beyond teaching clinical medicine, however. For example, for patients who are undocumented immigrants facing the threat of deportation, detention, or family separation, information can be provided on legal partners who can help them seek immigration relief or plan for the care of children in the event of detention.[35,36]

Systemic inequality. SRCs do not address pervasive systemic barriers to health care access for patients they serve.[28] In order to counsel patients with limited resources, trainees must understand the US health system enough to help patients navigate their options. For example, undocumented immigrants are generally excluded from publicly funded health coverage, with key exceptions in specific states and in the case of some emergencies.[37] Recently arrived legal permanent residents are also excluded from federally funded health coverage.[37] Trainees must be aware of patients' coverage options (or lack of them) or how to refer them to others who can provide this information. Trainees should also understand that patients who are able to adjust their immigration status (eg, by obtaining asylum or legal permanent residency) tend to be eligible for more services. Thus, trainees should know how to refer immigrant patients to legal partners who can advise them about eligibility and next steps. Domestic GHE training should also emphasize learners' acquisition of knowledge about safety net options that can address patients' needs, such as public hospitals, federally qualified

health centers, and Emergency Medicaid to cover life-threatening conditions for patients whose immigration status makes them ineligible for traditional Medicaid.[37]

Conclusion

Given students' increasing interest in caring for vulnerable populations (eg, immigrants) domestically, AMCs have the responsibility to provide domestic GHEs, just as they do GHEs. This article has discussed ethical challenges in these settings and how AMCs can prepare students to meet them. In particular, it suggests the importance of ethics education in developing service-learning experiences that improve health care access for patients and support trainees responsibly.

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