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Are Patients' and Communities' Poverty Exploited to Give Health Professions Students Learning Experiences?

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Abstract

In clinical settings, exploitation of patients who live in poverty can be exacerbated when health professions students' educational goals are overemphasized relative to patients' and communities' needs. Continuity of care relies on health system infrastructure and its capacity to keep patients engaged. Achieving just health care delivery in domestic and international settings requires balancing students', patients', and communities' interests. This article examines how students' interests in learning should be considered relative to patients' and communities' interests in receiving quality care.

Who Is Served?

Poverty is often misunderstood as simply an economic standard, such as an income level below which a person or family is defined as impoverished. From a health care perspective, this standard overlooks another barrier to accessing care: culture. In wealthy (and thus generally more educated) communities, a physician can generally assume that patients will appear on time for appointments, that advice will be understood and followed, and that access to tests, prescriptions, and follow-up care is readily available. But such assumptions are problematic in impoverished areas. Although opportunities for students to gain clinical experience by participating in care delivery in impoverished areas can be rewarding and eye opening,[1] there are also concerns about patient exploitation,[2] especially in regions where populations not only face cultural barriers but also do not have adequate access to health care or rely on clinics with student caregivers.

We argue that though accreditation standards have been established, health needs of patients living in poverty raise social justice and practical questions about which students should be aware. First, students should be informed about their patients' social, cultural, and environmental realities and not just their clinical symptoms. Second, to address patients' clinical vulnerabilities and ensure the adequacy of their own education, students need clinically qualified and socially adept mentors who can guide them in offering effective care that is within their scope of practice and level of training. We suggest that achieving just health care delivery in impoverished settings, both domestic and international, requires a team-based approach to facilitate continuity of care.

Existing Standards

The Liaison Committee on Medical Education (LCME) is the United States Department of Education-recognized accrediting body for programs leading to the MD degree in the United States.[3] One LCME standard relevant to delivering care in impoverished settings is that students cannot work independently.[4] Each patient must be seen by a licensed physician who accompanies a student who sees the patient. This requirement is intended to protect both student and patient and to help ensure that clinical care offered by students is not exploitative, even given the limits of a student's skill level. However, it could still be possible to exploit patients by giving students responsibility beyond what their training and experience warrants, in contravention of LCME standards. Although LCME standards also address cultural competence,[4] medical education needs to explicitly link cultural competence to global health in the curriculum and to take an interdisciplinary approach to these topics.[5]

Standard Care

Clinicians are obliged to deliver standard of care, typically defined as the level and type of care a reasonably competent and skilled health care professional with a similar background and in the same community would provide under similar circumstances.[6] This standard requires comparison of apples to apples, so care given to uninsured patients in a free clinic should be compared to care offered in clinics delivering similar care and not to care offered in, say, a major academic medical center. Likewise, care offered in another region of the world should be fairly compared.

Domestic context. Limited resources mean that care standards are not the same in free clinics and in academic medical centers; at times, care considered substandard in one health service delivery context is reasonable in another. For example, the Emergency Medical Treatment and Labor Act (EMTALA) is a legal requirement for hospital emergency departments to stabilize patients, but this minimum obligation does not apply to outpatient settings.[7] When patients who do not have health insurance are discharged, they might misunderstand discharge instructions, have trouble accessing prescribed medications or recommended foods, or have trouble accessing or attending follow-up appointments for outpatient care.[8] These obstacles mean that inpatient or emergency care might have only temporary value. In global situations, similar obstacles can be exacerbated by a lack of health service infrastructure. Tension between inpatient and outpatient care standards, particularly in impoverished communities, reveals how poor people can play important roles in educating students and trainees about the effects of scarcity and poverty on health status and health outcomes.

Global context. The American College of Physicians (ACP) offers guidance about how to protect both students and patients, locally and globally.[9] But, in our view, the ACP's emphasis on mitigating power imbalances and on respectful partnerships treats cultural

differences mainly as a challenge to students' preparation for international immersion experiences and not as influencing their responses to a patient's health status or their understanding of a health problem or what to do about it. We further suggest that the ACP's emphasis on distributive justice[9] is too limited. Both continuity of care for the individual and for the population is needed, and these obligations should be embodied in how we structure the education of students.

Team-Based Immersion Care

Given that cultural and economic factors affect access to and utilization of health care in impoverished regions of the world, students should learn to offer continuity of care in team-based approaches to health care service delivery. Educating students in ethics and health justice requires helping them recognize complex interconnections among clinical, social, cultural, and ecological health determinants. A team-based approach to navigating these interconnections is intended not just to oversee students' performance and progress but to respond with care to the needs and vulnerabilities of patients in resource-poor settings.

By *team*, we mean individuals who work together to improve health outcomes in individual patients and entire communities. Because teams should be able to respond to the needs of a patient with a specific disease, coordinate follow-up care, and facilitate access to needed interventions, they might include certified interpreters, social workers, pharmacists, nurses, and physicians, for example. Practicing medicine well in resource-poor settings requires technical skill, clinical knowledge, and well-developed capacities for listening and empathy. Getting to know patients in a longitudinal relationship and as members of a community provides clinically and ethically relevant insight that can help trainees respond more fully to concerns raised in a specific encounter.[10] Such immersion experiences can motivate more complete care of patients and more informed career choices of students and can help balance learners' and patients' interests.

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