BEST PRACTICES FOR SHORT-TERM HEALTHCARE MISSIONS	
Question: How should short term healthcare mission teams handle the issue of malpratice?	
Participants in discussion	Background (perspective)
Peter Yorgin, MD Initiator and primary author	Team leader and participant Academic physician at Loma Linda University, Harvest Christian Fellowship, Riverside, CA
Grace Tazelaar, MS	Director of Nursing Missions, Nurses Christian Fellowship
Why is this important? Poor or shoddy healthcare practice can adversely affect the spread of the Gospel message	

CONSENSUS STATEMENTS

1. Obtain copies of licenses and confirmation of malpractice from all healthcare professionals on the team.
2. Obtain malpractice insurance for short-term mission trip.
    a. Obtain coverage through one's workplace
    b. Purchase coverage
3. Obtain appropriate licensing for the country in which you will work.
    a. For some countries, you may work under a physician's license.
4. Attempt to resolve shared liability issues in advance.
5. Obtain permission/consent for any treatment (even medications) and procedures.
6. Provide an optimal level of care contextualized to the location where one is serving
7. Do not allow lay personnel to perform procedures under your license.
8. Do not perform work outside of your skill level and do not encourage others to do so either.

Biblical concepts involved

Do unto others as you would have them do unto you

> **Luke 6:31**
> Do to **others** as you would have them do to you.

Malpractice in short term missions

Malpractice is defined as:

1. A the failure to perform service as specified in the contract/consent
    a. If there is a complete failure to perform the procedure/work it is considered **nonfeasance**
    b. If there is only partial performance of the procedure/work, it is considered **misfeasance**

   c. If injury results from the procedure/work, even in an attempt to harm, it is considered **malfeasance**
2. The failure to follow generally accepted standard professional practices.
3. The failure to provide care.
   As provided by the practitioner or their assistants

When engaging in short term healthcare missions, we all would like to think that the litigious society in which we live has been left far behind, on the shores of the country from which we came. However, there is an increasing trend of malpractice suits in the developing world and healthcare professionals involved in short term missions are not entirely immune to malpractice suits.

Specific malpractice issues

The basis for the healthcare professional – patient contract

There is a contractual relationship between the physician and the patient. The contract indicates that the healthcare professsional should properly perform the procedure which was agreed upon. For example it would be inappropriate to for a dentist to say that he/she will remove The contract obligates the physician to use reasonable care and skill. Depending on the country, there may also be an expectation of achieving a specific result.

Informed consent is critical

The patient has an expectation of freedom from harm. To this end, self determination should be respected by healthcare professionals. The consent protects the patient from medical paternalism. Healthcare professionals who undertake treatment or an operation without prior consent are at risk for being charged with battery.

Contextualized performance

The performance of the healthcare professional is expected to fall within the context of community standards. Nobody would expect the same resources or outcomes in a remote developing country setting relative to an academic hospital setting in the developed world. Healthcare professionals are at risk of malpractice “when their conduct falls below the standard of protection for others against unreasonable risk of harm”. The healthcare professional can fail to take reasonable care of the patient, or is careless, or causes an injury.

Liability for the work of others empowered by the healthcare professional

Healthcare professionals can be held liable for actions taken by the acts of an employee. The healthcare professional is responsible for giving appropriate instructions and is responsible for providing oversight for their work. Therefore, if a healthcare professional trains a lay-person to provide medical care any problems associated with that care are as if the healthcare professional provided the care by himself/herself.

Shared liability issues

If a healthcare professional provides care in a facility, the healthcare facility may be responsible for any malpractice claims.

Confidentiality issues

There is responsibility for the healthcare professional to keep confidential the patient' s information.

Limiting team risk

Individual professional licenses and malpractice

Increasingly, mission partners need key information regarding the team members with which they will be working. Often professional licenses and confirmation of malpractice insurance in their home countries are requested months in advance to provide to governmental officials who will be approving the team activities. Team leaders can spend a significant amount of time obtaining and submitting such information.

Provide services for which one is qualified

Healthcare missions, with rare exceptions, do not provide the healthcare professional with the opportunity to work outside of one's competency. Remote settings or those where equipment is lacking is not conducive to attempting that new technique.

Do not train lay people to provide more complex healthcare procedures

The literature is replete with studies which demonstrate that a lay person can be taught a number of basic healthcare procedures including cardiopulmonary resuscitation (CPR)[1-3], automatic external defibrillation[3-5], and carotid pulse determination[6], There are also studies which show that lay people can be taught complex medical care (for hemophilia)[7] and bone marrow transplant recipients[8] when provided with detailed instructions or simulation training, respectively. Studies have also shown that retention of information decreases over time[1,3,9]. Automatic external defibrillation, carotid pulse determination and CPR all are used in emergency situations when a person is no longer breathing and/or has a cardiac arrest. The potential negative implications of limited-skill care are far outweighed by the potential good of saving a life. It could be assumed that a lay person could perform patient weight, height, respirations and pulse if appropriately taught.

More complex procedures (i.e.: blood pressures), if ever to be performed by a lay person, should be clearly written and demonstrated. An additional period of observation should be documented.

Lay persons on a short term healthcare missions team should not be trained to perform procedures that dentists, physicians or nurses perform due to the liability issues. However, training indigenous lay people, midwives, village doctors can be beneficial.

Example: A dentist from Southeast Christian Church trained a Waodoni in basic dentistry. As a result the Waodoni Christians are able to serve their people and present the gospel throughout the year, not just when a foreign dentist comes to visit them. Missionaries and indigenous healthcare personnel have been trained to do emergency C-sections and have saved many mothers.

So much of malpractice is dependent on current law, the location and medical need, and the skill needed. When I (Grace Tazelaar) was in nursing school in the late 1960's , nurses were not legally allowed to give IV medications. Nurses educated in the 1930's were not allowed to take blood pressures!

Issues related to healthcare professionals with expired licenses

Occasionally healthcare professionals who have retired and have not maintained a license or malpractice insurance express a desire to participate on a short-term healthcare missions team. The lack of a healthcare professional license and malpractice creates problems for a team leader. First, is the individual truly competent to provide medical care or education in their home country? If yes, would they be reasonably competent in a cross-cultural setting?

The duration of time between practice and the time when the skill is to be used again is certainly a factor. An individual who ceased practicing/maintenance of a license 5 or more years ago is likely to be a poor candidate for participation as a healthcare provider on a missions team. If a physician were to desire to resume practice after a 2-5 year absence, there would likely be a need for proctoring by colleagues for a period of time (up to 6-12 months) to determine if their standard of care is acceptable. Conducting proctoring for such an individual on a short term healthcare missions trip is not practical. The loss of malpractice insurance creates a problem of liability for the team leader and for the church.

It is important to consider whether or not we would want such a healthcare professional to provide care for us. Except in rare situations where absolutely no access to healthcare is possible, it is unreasonable to think that a healthcare professional's skills are adequate for international missions when they are not adequate in providing care at home.

For the retired healthcare professional this represents a wonderful opportunity to exhibit grace by giving up healthcare – but accepting God's invitation to join Him in relationship and His work. Therefore, the lack of a healthcare role for a retired healthcare professional should not exclude such an individual for participation on a team. Indeed, they can play a number of roles including leaders, administrators, mentors and supporters.

Issues related to disabilities which limit one's ability to provide care

Some healthcare professionals may have disabilities which limit their ability to provide clinical care. While the desire to provide service in God's Kingdom is strong, team leaders must be willing to truthfully assess the match between goer and task. For example, it is not appropriate to suggest that a deaf person with bilateral hearing aids perform auscultory blood pressures. Disabled

healthcare professionals who have difficulty performing routine tasks in their own environment will likely experience greater difficulty in cross-cultural settings. Careful matching of task with person should be undertaken to avoid significant malpractice risk. This is not to say that there is no role for the disabled. Quite to the contrary – a deaf nurse played a critical role in providing hearing aids and cochelear implants for deaf children in China. Often the disability, in God's hands, can become a real asset in indentifying with the poor, hurting and disabled.

Sender

Before

Senders should have an oversight function as it relates to malpractice. Before sending at short term healthcare team internationally, it is important that the senders have made sure that the team leaders have properly dealt with the issue of malpractice. The church/parachurch/sending organization may wish to have a check-list to make sure that the leaders have addressed the malpractice issue. The church can also determine its policy regarding healthcare professionals who do not have licenses.

The church/parachurch/sending organization should determine their liability, before sending a team, should a malpractice event occur. Reviewing this possibility with the church insurer is prudent. Church/parachurch/sending organizations should plan on contingency plans in the event of a problem. A form should be developed and given to team leaders to help facilitate reporting the information.

One of the main reasons not to provide this oversight function is the lack of knowledge regarding international medical legal issues. Healthcare mission conferences can look towards providing this information to church leaders/pastors/elders and decons.

During

Should an adverse or malpractice event occur, the team leader should immediately contact the sending organization to let them know what has happened. Conveying basic facts will be very helpful – who, what, when, where, how, etc. The goal should not be to assign blame for the incident. Determining the truth of the situation, determining the best means by which the adverse event can be managed and extending forgiveness to the person involved in the malpractice are key roles for the team leader.

The team leader, host country partner and the sending organization can discuss means of reparation to "make things right" for the patient and their family. The scope of options is so large as to preclude an extensive discussion in this format. In general, options might include a letter of formal apology, assisting in making arrangements to provide the appropriate health care to rectify the problem, or arranging appropriate remuneration. Given the severity of the event it

may be appropriate for the church to work with the appropriate embassies and denominational offices.

After

Assuming that the team did not experienced any problems, church leaders often assume that the risk to the church was minimal. This is probably not the case.

Example: An American Ear, Nose and Throat surgeon is preparing to perform a cochlear implant when the he notices that the patients blood oxygen levels are dropping rapidly. Low blood oxygen levels can lead to a cardiac arrest and even death. The two anesthesiologists ran out of the room to find help leaving the American physician alone with the patient. He quickly removed the breathing tube (which was in the wrong place) and used a bag and mask to resuscitate the patient. The patient quickly recovered and successfully underwent surgery.

It may be best for church leaders to have a frank discussion regarding concerns or incidents after an event. These discussions could shed more light on the risks that the church is taking with a short-term healthcare missions team.

Goers

Before

Team leaders for short term healthcare mission trips have the responsibility to make sure that team members have submitted copies of their professional licenses. Oftentimes copies of these licenses will need to be submitted to the international partner and governmental officials.

With the guidance from their church, the team leader needs to set policy regarding licensing and malpractice prior to launching a healthcare missions program – and certainly prior to interviewing potential team members. Most churches and team leaders will likely determine that healthcare professionals without active licenses should be excluded from serving as clinical healthcare practitioners on the team (other options remain, however).

One of the most challenging areas for a team leader is that of proper utilization of sub-specialists and managers. Some sub-specialists and managers are so far removed from general practice that they may pose a risk to patients when used in a general clinical setting. For example, should a neonatologist be providing care for geriatric patients in a rural village in China? Options for managing these situations should include:

1. Proctoring of their practice by a physician or nurse suited for general clinical care.
2. Selecting venues which are more appropriate to the team's skill mix. For example, providing a continuing medical education conference for neonatologists or teaching village doctors the basics of resuscitation for babies.

3. Some sub-specialists can obtain relevant experience including proctoring a general internal medicine resident clinic.
4. Only recruit generalists and be prepared to have smaller numbers/capacity.

Each team member should have malpractice coverage that specifically covers their actions in the host country. In some cases, malpractice coverage by the employer may provide sufficient coverage. At Loma Linda University, employees are granted international malpractice coverage if a form is submitted which indicates the location where one serves, partner, team members, etc (see form attached). Unfortunately, most employers do not provide international malpractice insurance for their healthcare professionals.

Brotherhood International (http://) provides insurance coverage for missionaries. They have an option to add malpractice insurance for $50 (April 2008). If a healthcare professional does not have host country malpractice insurance, and is planning on providing clinical care, it would be wise to purchase it. The team leader should be responsible for making sure that malpractice insurance has been purchased and is in place prior to going.

It is possible that not every healthcare professional will need malpractice insurance. For example, nurses who conduct physical assessment (i.e. blood pressure, glucose monitoring) or respiratory therapists who teach other respiratory therapists, or physicians who conduct a survey may have a malpractice risk that is so low as to not warrant purchasing the insurance.

Team leaders also have the responsibility for educating the team before they leave regarding best practices. Specifically the following points need to be made:

1. Only provide care within the scope of one's practice and ability. This short term healthcare mission trip is not the chance to try some new procedure
2. Educate the group regarding the health problems that are likely to be seen.
3. Educate the group as to the resources near where they will be practicing (i.e. closest hospital, dentist, clinic, village doctor, etc)
4. Plan on seeing fewer patients
5. If one has concerns about what is being done – say so. Develop a non-punative culture for people who have concerns.

During

We cannot decide whether an adverse event occurs – all that we can decide is that we handle the situation that is honoring to God. Prayer becomes an indispensable part of this process. Should an adverse event occur, notify your host country partner and *together* attempt to calmly obtain all of the information regarding the event. If necessary, interview the people involved separately to obtain the most truthful description of what happened. Remember that emotions

will likely be running high and anyone involved will have the tendency to want to frame the situation in a light most favorable to themselves. People may be tempted to lie about what happened in an effort to avoid blame or preserve ego.

Depending on the severity of the problem, the team leader should be empowered to either 1) deal directly with the problem (in cases where the harm to the patient is minimal-moderate) or 2) Obtain the advice and resources of the sending church/parachurch/sending institution (severe, or if the death of a patient has occurred. It is important to remember that the severity of the adverse effect may not necessarily correlate with the "intensity" of a procedure/treatment. For example, death can rarely occur with a medication reaction.

After determining what happened, encourage the healthcare professional who is responsible for the adverse event to speak directly to the family, explain clearly what happened, and how one intends to handle the resulting problem. It is important to meet with the patient/family as soon as possible and to not hide any aspect of the adverse event. There are two general types of adverse events. It is critical to distinguish between the two before starting to talk with the patient/family. The first is an adverse effect where responsibility does not lie with the healthcare professional. We all are familiar with situations where everything was done properly but there are still adverse effects. This is not malpractice.

Example: A minor surgery was performed to remove an abscessed tooth After the prophylactic antibiotic dose was given, the patient developed a severe rash. The patient had no known medication allergies prior to the procedure.

The adverse event is unfortunate, but is beyond one's control. In this situation one may even say that the event was something that could happen because we live in a world where bad things happen even when you do everything right. Sometimes a patient even dies despite excellent care. In these situations it is important to explain the situation not in terms of guilt but in terms of an event of nature – something beyond our control. There should not be any need for reparation.

The second type of adverse effect occurred because the healthcare professional failed to provide care or even did something harmful.

Example: Orthopedic surgeons, training local doctors, are performing surgery on children with disabilities. During surgery, a major nerve was inadvertently damaged when performing a knee replacement.

Clearly the adverse effect was the responsibility of the surgeons – even if it was an accident and the surgeons were good-intentioned. In these situations we need to accept responsibility and ask for forgiveness. Every effort should be made to resolve the issue to the satisfaction of the patient and family.

After

After the team returns home, the team leader should contact their partner to receive follow-up information regarding the patients who were treated. Team leaders will also need to seek out church leaders to review the trip in detail, including concerns regarding potential risk. If the team has not experienced any problems, then a careful assessment of the potential lessons learned should be shared with other team leaders. My personal (Peter Yorgin, MD) suspicion is that each clinical care team has a number of potential risks – everything from mis-diagnosis, to inappropriate dosing of medications, or failure to check for medication allergies or other remedies and medications that are already being used.

In the event that a team has experienced a significant adverse event, the church should have a frank and open discussion of the event, its root causes, how it could have been avoided and how the problem was handled. The church has the responsibly for determining whether the malpractice event was due to nonfeasance, misfeasance or malfeasance. The primary issue at hand is whether the malpractice event represented an "unfortunate act of nature" or poor judgment, failure to provide care or reckless behavior. Leaders are uncommon, even rare. The attitude of the church should be that of a "coach", not punitive so as to restore the great majority of leaders/team members who experience a malpractice event. However, should a team member or leader demonstrate a persistent pattern of poor judgement, failure to provide care or reckless behavior then counseling against further service in short-term healthcare missions would be best.

Recipient

Before

Oftentimes in poor cultures, remote from large cities, there is the perceptions that visiting healthcare professionals from other countries provide the best care and treatment.

During

Should some adverse effect occur related to the treatment received there are different levels of patient understanding of the causative nature of the problem. Sometimes this reflects a personal bias/approach. We all know of families who are very understanding and forgiving, while other families are very suspicious and prone to blaming.

Therapeutic relationship	Problem caused by Nature	Problem cause by healthcare professional
Happy, accepting, cooperative,	Understanding	Forgiveness
Suspicious, blaming, angry	Wants to sue	Wants to sue

Healthcare professionals have the responsibility to determine whether the relationship is therapeutic. A non-therapeutic relationship at the beginning can signal trouble. Given the additional risks taken in cross-cultural medicine, it may be most appropriate to refer these patients to more appropriate venues.

After

Should an adverse event occur, the patient and family will likely experience the five stages of grieving and loss, initially described by Kubler Ross[10].

1. Denial
2. Anger
3. Bargaining
4. Depression
5. Acceptance

Disbelief is a common first response to an adverse event – both from the patient and from the physician. There may even be a desire to avoid the situation – to deny it by not facing it. This happens for both healthcare practitioners and families. Anger is often next, but is very difficult to work through for some families and healthcare professionals. If one has a proclivity to avoid confrontation, this stage can be very difficult. A Matthew 18 approach, where one confronts the brother who did something wrong, should be encouraged.

Example: A 71 year old man had a haital hernia repair by his surgeon. Two CT scans had been obtained prior to the surgery. Both showed the haital hernia but also showed a slow growing benign kidney cancer. The doctor never told the patient about the kidney cancer – the patient's wife found out about it after reading the radiology report. The 71 year old man never confronted his doctor but called everyone he knew to tell the story and explained how angry he was.

By not confronting the anger, no forgiveness can ever achieved. Interestingly, the anger and lack of trust can still persist even when forgiveness has been exteneded. It is often during the anger phase that families seek restitution. However, the poor's lack of confidence in the impartiality of the justice system and lack of money for legal counsel, limits the number of these cases.

Bargaining typically occurs with God, and sometimes the healthcare professionals. Generally, the patient accepts something uncomfortable or even something good ("going to church for the rest of my live") in exchange for healing.

Depression is a common response to a loss caused by malpractice. Simply praying, sitting and grieving the loss with the patient/family is the best approach (Think of Job). Statements like, "I know how you feel" or quoting "We know that in all things God works for the good of those who love him, who have been called

according to his purpose. (Romans 8:28) are not helpful. Bible study[11,12], journal writing[13], and counseling to work through the emotional depression and trauma can be helpful[14,15]. Situational depression may benefit by anti-depressant medications[16].

Finally, patients and their families accept the impact of the malpractice event. In poor communities, there may be greater acceptance that an adverse event was God's will.

Comments:

Brian Piecuch (4/22/2008)

I live in Peru, and I think that many people in developing countries have been aware for some time of the litigious nature of US culture. However, most of the time the only ones who would dream of taking a doctor to court would be middle class and upper class citizens. Because most medical missions focus on serving the needy, we rarely face legal issues, even when things go wrong. I see three reasons for this:

1. The poor truly are grateful for the care we provided them and who no one else will. This is related to point two.
2. There is greater acceptance that what happened was God's will.
3. The poor have no faith in their justice systems. In countries where decisions are purchased, the poor believe they don't have the resources to win against "rich" N. Americans.

Where we as people serving the Lord through medical missions have to be careful in all of this discussion is to not lose our sense of justice (if/when there was a mistake made) and mercy (when the needy find themselves even needier). Bad things can and do happen to our patients. What is our responsibility to help a husband, wife and/or family in need when someone in our care dies or is left permanently disabled in a country where there is no social "safety net"?

References

1. Wright, S., Norton, C. & Kesten, K. Retention of infant CPR instruction by parents. *Pediatr Nurs* **15**, 37-41, 44 (1989).
2. Bilger, M.C., Giesen, B.C., Wollan, P.C. & White, R.D. Improved retention of the EMS activation component (EMSAC) in adult CPR education. *Resuscitation* **35**, 219-24 (1997).
3. Cummins, R.O., Schubach, J.A., Litwin, P.E. & Hearne, T.R. Training lay persons to use automatic external defibrillators: success of initial training and one-year retention of skills. *Am J Emerg Med* **7**, 143-9 (1989).
4. Moore, J.E. et al. Lay person use of automatic external defibrillation. *Ann Emerg Med* **16**, 669-72 (1987).
5. Walters, G., Glucksman, E. & Evans, T.R. Training St John Ambulance volunteers to use an automated external defibrillator. *Resuscitation* **27**, 39-45 (1994).
6. Bahr, J., Klingler, H., Panzer, W., Rode, H. & Kettler, D. Skills of lay people in checking the carotid pulse. *Resuscitation* **35**, 23-6 (1997).
7. Vidler, V. Teaching parents advanced clinical skills. *Haemophilia* **5**, 349-53 (1999).
8. Heermann, J.A., Eilers, J.G. & Carney, P.A. Use of modified OSCEs to verify technical skill performance and competency of lay caregivers. *J Cancer Educ* **16**, 93-8 (2001).
9. Berden, H.J. et al. Resuscitation skills of lay public after recent training. *Ann Emerg Med* **23**, 1003-8 (1994).
10. Kübler-Ross, E. & Kessler, D. *On grief and grieving : finding the meaning of grief through the five stages of loss*, xviii, 235 p. (Scribner, New York, 2005).
11. Koenig, H.G. Religion and remission of depression in medical inpatients with heart failure/pulmonary disease. *J Nerv Ment Dis* **195**, 389-95 (2007).
12. Tatsumura, Y., Maskarinec, G., Shumay, D.M. & Kakai, H. Religious and spiritual resources, CAM, and conventional treatment in the lives of cancer patients. *Altern Ther Health Med* **9**, 64-71 (2003).
13. Smith, C.E., Holcroft, C., Rebeck, S.L., Thompson, N.C. & Werkowitch, M. Journal writing as a complementary therapy for reactive depression: a rehabilitation teaching program. *Rehabil Nurs* **25**, 170-6 (2000).
14. McCullough, J.P. Psychotherapy for dysthymia. A naturalistic study of ten patients. *J Nerv Ment Dis* **179**, 734-40 (1991).
15. McCullough, J.P., Jr. Treatment for chronic depression using Cognitive Behavioral Analysis System of Psychotherapy (CBASP). *J Clin Psychol* **59**, 833-46 (2003).
16. Joffe, R.T., Levitt, A.J., Bagby, R.M. & Regan, J.J. Clinical features of situational and nonsituational major depression. *Psychopathology* **26**, 138-44 (1993).