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WOMEN'S HEALTH CARE PHYSICIANS

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Committee on Ethics

This Committee Opinion was developed by the American College of Obstetricians and Gynecologists' Committee on Ethics in collaboration with committee member Ginny L. Ryan, MD, MA.

Ethical Considerations for Performing Gynecologic Surgery in Low-Resource Settings Abroad

ABSTRACT: Global surgical care programs present obstetrician–gynecologists with important opportunities to address disparities in women's health and health care worldwide. However, these programs also present a unique set of practical and ethical challenges. Obstetrician–gynecologists are encouraged to participate in surgical care efforts abroad while taking the necessary steps to ensure that their patients can make informed decisions and receive benefit from and are not harmed by their surgical care. In this document, the Committee on Ethics highlights some of the ethical issues that may arise when providing surgical care in low-resource settings to help guide obstetrician–gynecologists in providing the best care possible. This document has been updated to broaden its focus beyond the example of obstetric fistulae, to address issues pertinent to medical trainees, and to include new information to guide physicians' return home from participation in global surgical care programs. Although clinical research has an important role in the surgical care of patients in global settings, a complete discussion of the conduct of ethical research in global settings is beyond the scope of this document.

Recommendations

On the basis of the considerations and principles outlined in this Committee Opinion, the American College of Obstetricians and Gynecologists (ACOG) makes the following recommendations:

- Obstetrician–gynecologists are encouraged to participate in global surgical care efforts to provide essential services to patients in low-resource settings who would not otherwise have access to safe and adequate surgical care.
- Obstetrician–gynecologists who are considering participating in global surgical care should familiarize themselves with the extreme social and environmental conditions often found in low-resource settings and the common ethical questions and challenges that arise to help avoid inadvertent harm to the patients and the communities they are serving.
- Laws and regulations in some countries may restrict some medical practices or limit the manner in which care is provided. Obstetrician–gynecologists should seek advice from a qualified legal expert to become familiar with relevant laws that may affect their practice abroad and ensure that they are able to provide care consistent with their ethical obligations.
- Obstetrician–gynecologists should be aware of the potential limitations of the local medical and surgical resources before traveling abroad. The ability to adapt to unfamiliar instrument sets or be flexible regarding surgical techniques is extremely important. Choices about if or how to use local medical and surgical resources always should be guided by an obligation to patient safety and well-being.
- Obstetrician–gynecologists should carefully consider their surgical competence and training before traveling abroad, and they should be prepared to provide care at the level for which they are qualified and to opt out of procedures for which they do not have adequate experience.

- Ethical principles valued in one society may be understood differently in another. Despite cultural differences and the challenges they present, respect for individuals is a universal principle applicable to the global population, and informed consent should be obtained before surgical intervention is undertaken.
- Although most obstetrician–gynecologists participate in only short-term global surgical programs, before returning home they have an ethical obligation to make reasonable efforts to arrange for postoperative continuity of care that is within the limits of the local environment.
- When medical care cannot be provided safely, and the members of the surgical team believe that the chance of harm outweighs the potential benefit with the currently available resources, the obstetrician–gynecologist should be prepared to postpone or cancel surgery or to formulate alternative management approaches on a case-by-case basis.
- Delivery of surgical care in low-resource settings abroad should be partnered with capacity building efforts that contribute to the long-term well-being of the patients and communities being served. Such capacity building may entail ongoing partnerships between global health organizations, local health departments, and local communities to support community education, obtain medical supplies, connect to available health care services, and train personnel so that local community members can take an active role in maintaining and improving the health of the population and preventing disease.

Introduction

Global health disparities are increasingly and appropriately attracting the attention of obstetrician–gynecologists who are motivated to use their skills to prevent illness and improve health in low-resource settings. Global surgical care programs can provide essential services to patients who would not otherwise have access to safe and adequate surgical care because of inequities in resources, services, and personnel or geographic, political, financial, or cultural barriers, or a combination of these. As such, obstetrician–gynecologists are encouraged to participate in surgical care efforts abroad while taking the necessary steps to ensure that their patients can make informed decisions and receive benefit from and are not harmed by their surgical care. This is in line with the ACOG-endorsed International Federation of Gynecology and Obstetrics' (FIGO) resolutions regarding the rights of women and obstetrician–gynecologists' responsibility to promote and protect women's health in their individual and professional encounters (1, 2).

Regardless of the origin of the program (academic, private, or religious), obstetrician–gynecologists may be presented with a clinical and cultural environment that is very different than that to which they are accustomed. It is important for obstetrician–gynecologists to familiarize themselves with the commonly encountered ethical challenges inherent in these efforts before participating in global surgical care programs. In this document, the Committee on Ethics highlights some of the ethical issues that may arise when providing surgical care in low-resource settings to help guide obstetrician–gynecologists in providing the best care possible. This document has been updated to broaden its focus beyond the example of obstetric fistulae, to address issues pertinent to medical trainees, and to include new information to guide physicians' return home from participation in global surgical care programs. This document does not address specific local customs and host country laws or regulations that may be pertinent to the practice of obstetrics and gynecology in international settings. Although clinical research has an important role in the surgical care of patients in global settings, a complete discussion of the conduct of ethical research in global settings is beyond the scope of this document.

Background

There is growing recognition of unjust global disparities in the health and health care of women. At the same time, the global health landscape has shifted to include surgery as a necessary component of global health care. For example, according to the *Lancet* Commission on Global Surgery, surgical conditions comprise one third of the world's disease burden, and approximately 5 billion people worldwide lack access to safe, affordable surgical and anesthesia care (3). The World Bank has acknowledged that "surgery is an indivisible, indispensable part of health care and of progress towards universal health coverage" (4), and global surgical care programs have been shown to be a cost-effective component of health care systems in low-resource countries (5). Pregnant women are significantly affected by a lack of available and affordable surgical care. Approximately 951 million women in low-resource settings across the world lack access to emergency obstetric care (6). Most of the 287,000 maternal deaths worldwide each year occur in low-resource settings and could be avoided by appropriate surgical intervention (6). Addressing inequities in such settings is a moral and economic imperative (7, 8).

As such, obstetrician–gynecologists are encouraged to participate in global surgical care efforts to provide essential services to patients in low-resource settings who would not otherwise have access to safe and adequate surgical care. With the growth of global surgical care programs, however, it has become evident that even the best-intentioned efforts can create ethical challenges for obstetrician–gynecologists that are not encountered in high-resource countries (9). Obstetrician–gynecologists who are considering participating in global surgical care

should familiarize themselves with the extreme social and environmental conditions often found in low-resource settings and the common ethical questions and challenges that arise to help avoid inadvertent harm to the patients and the communities they are serving.

Ethical Issues and Considerations

When providing care in international locations, obstetrician–gynecologists should be guided by the same universal ethical principles they use in their daily practices at home. For example, it may be tempting to document care being provided with photography or to share patient information for educational purposes. However, respect for individuals necessitates that such invasions of privacy require informed consent, just as in the United States. Obstetrician–gynecologists also will encounter unique challenges when striving to provide ethically appropriate care in low-resource settings. Some of the most commonly encountered issues pertain to patient vulnerability, informed consent, availability of medical and social resources, surgical competence and training, continuity of care, and sustainability efforts. In addition, language barriers and a lack of cultural competency may present challenges for physicians traveling to unfamiliar parts of the world. Obstetrician–gynecologists in the global arena should make every effort to adhere to the highest standards of clinical practice possible while recognizing that, given local resources, this may not be feasible in all cases.

Caring for Women in Settings of Chronic Deprivation

Obstetrician–gynecologists from the United States who participate in global surgical care programs may be unaccustomed to the extreme poor conditions found in low-resource regions around the world and may be unfamiliar with how these conditions amplify the effects of chronic illness, injury, and trauma. These exceptionally poor conditions may be due to a combination of deprivations such as malnutrition, poverty, social injustice, and gender discrimination as well as cultural practices and political influences. These factors may be exacerbated by trauma that is due to civil war, natural disasters, and related internal or external displacement. The lack of local medical resources further compounds the effect of these extreme conditions on the health and well-being of the local community.

For example, there are an estimated 6,000 new cases of obstetric fistulae identified each year in sub-Saharan Africa and South Asia (the highest-prevalence regions in the world) where more than one million women are estimated to have a fistula (10). Obstetric fistulae result from a complex interplay of social and cultural factors, including traditions such as childhood marriage (which leads to childbearing before maturation of the pelvis), poverty, lack of education, inadequate nutrition, and lack of or limited access to adequate and timely obstetric care (11–15). Many women who develop fistulae live in societies in which they are unable to exercise basic human and reproductive rights and in which personal decisions about sexuality and childbearing are customarily made for them by their families and communities through the practice of child marriage (12). Moreover, girls and women who develop fistulae are marginalized from their families and communities, which results in additional discrimination, poverty, illness, and isolation (16).

The unparalleled medical and social needs of women with fistulae require a unique type of health care. International efforts have continued to increase the organization and mobilization of medical equipment and personnel to low-resource regions of the world where fistulae are prevalent. Such health care efforts, which should include psychosocial support, surgical or alternative nonsurgical management, and postoperative care and follow-up, represent a promising example of the broad and multidisciplinary global health approach that will optimize long-term outcomes for women with obstetric fistulae (17).

Informed Consent

The process of informed consent is a vital component in the practice of ethical health care across countries and cultures. Just as in the United States, informed consent should precede surgical intervention in low-resource settings abroad. Informed consent is achieved through a conversation in which a patient and an obstetrician–gynecologist discuss the indications for a proposed therapy, its risks and benefits, the risks and benefits of declining the intervention, and any feasible and alternative interventions given available resources. This conversation helps a patient make an informed decision about accepting or declining therapy in a manner that reflects her own values and circumstances (18). Every effort should be made to document the conversation and the patient's agreement with the planned surgical therapy. A copy of these documents should ideally remain with the patient to facilitate her future care, and another copy (or the original) should be maintained with the care team.

Obstetrician–gynecologists and other health care providers should be prepared for challenges, such as language differences and limited literacy, that may arise in seeking consent in low-resource areas abroad. Leaders of international health care teams should work with local community members to establish a decision-making process that is culturally sensitive and promotes informed and voluntary choice. The informed consent conversation should present information tailored to the education level of the patient, take place in the native language of the patient, and use a medical professional fluent in the language of the local community or a qualified on-site medical interpreter. The interpreter should be sufficiently skilled to provide an accurate and culturally sensitive translation of the medical information.

Ineffective communication can have a negative effect on the quality of health care provided to the patient (19–21), and this can affect the community's trust in the visiting surgical team. Ethical principles valued in one society may be understood differently in another (22–24). Despite cultural differences and the challenges they present, respect for individuals is a universal principle applicable to the global population, and informed consent should be obtained before surgical intervention is undertaken (25, 26). Some cultures place less value on individual autonomy and more value on the role of the family or community in medical decision making. For this reason, obstetrician–gynecologists should incorporate culturally appropriate modes of decision making, which may include consulting family members, community leaders, or religious leaders, or a combination of these, in the informed consent process. Nevertheless, the final decision on whether to consent to a surgical intervention should remain with the patient herself.

One example of a surgical intervention for which clear patient communication and an awareness of local laws and community beliefs are paramount is surgical tubal sterilization. This routine but permanent procedure provides an important contraceptive option for women worldwide, especially for communities with high rates of undesired pregnancy and limited access to other forms of effective contraception because of family planning policies, socioeconomic factors, or gender roles (27). However, obstetrician–gynecologists should be aware of the sociocultural, religious, and political climate of their host community, as well as any pertinent laws, and how these factors affect the acceptability of sterilization. Patient and community education efforts and careful informed consent processes should be in place before offering surgical tubal sterilization as an option to an individual woman or broadly in a community.

Providing Quality Health Care With Limited Medical and Surgical Resources

Obstetrician–gynecologists should be aware of the potential limitations of the local medical and surgical resources before traveling abroad. Although up-to-date technology might be ideal, surgeons should be prepared to use older but adequate equipment, if necessary. Surgeons should anticipate a lack of imaging and automated instruments and prepare themselves to use instruments that have a different design and nomenclature than those to which they are accustomed. The ability to adapt to unfamiliar instrument sets or be flexible regarding surgical techniques is extremely important. Choices about if or how to use local medical and surgical resources always should be guided by an obligation to patient safety and well-being.

Other necessary resources include adequate medications and effective methods to clean and sterilize equipment. At a minimum, appropriate anesthetics, antibiotics, and pain medications should be available. Surgical, nursing, and anesthesia staff from traveling teams must work together with local professionals and partners to ensure that all necessary equipment and personnel are available for safe and effective care (28). The visiting team should bring these resources and other necessary supplies if they are not available in the local community, including opioids because they may be particularly difficult to procure locally and their transport across borders may be restricted. Patients also should have access to clean, potable water and to adequate nutrition to support healing while under the care of the visiting health care team.

Despite the best preparatory efforts, the circumstances of some health care settings abroad may not be evident until the international medical program is under way. When medical care cannot be provided safely, and the members of the surgical team believe that the chance of harm outweighs the potential benefit with the currently available resources, the obstetrician–gynecologist should be prepared to postpone or cancel surgery or to formulate alternative management approaches on a case-by-case basis. For example, if trained personnel and resources are not available to place a urinary catheter for possible postoperative urinary retention after incontinence surgery, this issue may be better treated with a pessary.

The effort to reduce the global burden of cervical cancer using "see-and-treat" protocols stands out as an example of how the provision of health care in low-resource settings abroad can take place in a way that is different but effective (29); these efforts also provide a valuable opportunity to build capacity for domestic cancer screening programs by training local obstetrician–gynecologists or other health care providers in this method.

Surgical Competence and Training

Obstetrician–gynecologists who practice in high-resource settings may not have experience with the specific type or severity of medical or surgical conditions found in low-resource settings, and they may be unfamiliar with the surgical equipment available in low-resource settings. Therefore, specialized education and training are often needed before participating in global surgical care programs. Obstetrician–gynecologists should engage with organizations that are willing and able to provide predeployment training that may involve technical education and immersion in the country's language and culture. Academic institutions that have global health programs should take advantage of the experience and resources developed by academic partners nationwide to educate their traveling physicians and physician-trainees before deployment on how to provide safe and culturally sensitive surgical care. An example of such a resource is the Association of Professors of Gynecology and Obstetrics' *Clinical Care in Low Resource Settings* curriculum (30).

There should be adequate communication between the local health care providers and the visiting team before

travel so that the trip is responsive to local needs (3, 31). Visiting obstetrician–gynecologists should understand local customs and laws as well as their organization's policies related to menstruation, contraception, pregnancy, fertility, abortion, and sexual behavior, for example. Laws and regulations in some countries may restrict some medical practices or limit the manner in which care is provided. Obstetrician–gynecologists should seek advice from a qualified legal expert to become familiar with relevant laws that may affect their practice abroad and ensure that they are able to provide care consistent with their ethical obligations. Simulations also may be helpful to prepare physicians, and especially trainees, for unexpected and potentially distressing emotional responses to global health experiences by presenting challenging situations and allowing debriefing (32).

Obstetrician–gynecologists may be asked to provide procedures abroad that are outside the scope of their daily practice at home; for example, they may be asked to perform a cesarean delivery when they have not taken part in this procedure in many years. Obstetrician–gynecologists should carefully consider their surgical competence and training before traveling abroad, and they should be prepared to provide care at the level for which they are qualified and to opt out of procedures for which they do not have adequate experience. Practitioners should not undertake complex or unfamiliar surgery without adequate mentorship, training, and experience because they risk patient injury, worsened disability, or death. And there is the attendant risk that the community will lose trust in the organization that provided the surgical services.

The patient's safety should be the utmost priority and should take precedence over the value of any particularly unusual case, or the volume of cases, for a trainee. Trainees from the United States may view work experiences in low-resource settings as an opportunity to increase their case numbers, especially in procedures not commonly performed at their home institutions. This practice, which has been called "surgical colonialism," may be unsafe for patients and unfair to local trainees from the community (3). If a surgeon does not have adequate experience and training for the type of services needed, an experienced mentor should take on the role of primary surgeon, and all surgical trainees (such as residents or fellows in obstetrics and gynecology) should be adequately supervised. If available, in-country experts provide a critical resource for mentorship and training, and the traveling surgeon should undergo on-site training as an assistant before taking on primary surgeon responsibilities.

Continuity of Care

Preoperative care and postoperative care are essential parts of responsible surgical management. Lack of adequate preoperative and postoperative management places patients at increased risk of surgical complications and suffering that may be worse than the patient's initiating symptoms. Although most obstetrician–gynecologists participate in only short-term global surgical programs, before returning home they have an ethical obligation to make reasonable efforts to arrange for postoperative continuity of care that is within the limits of the local environment. This obligation could be fulfilled by arranging for an equally proficient practitioner to arrive onsite and accept the transfer of care or by transferring care to a local health care provider specifically trained to provide postoperative care for the surgical intervention that was performed. This obligation integrates well with the visiting team's obligation to train physicians and staff in the local community to build capacity for independent surgical infrastructure. Just as they do when practicing in their home country, practitioners have an ethical obligation not to abandon their patients.

Adequate postoperative care for patients also should include short-term and long-term care for health care issues indirectly related to the surgery. For example, an important postoperative consideration after fistula repair is the reentry of patients back into their local communities. Obstetrician–gynecologists involved in fistula repair efforts should be aware of these important preoperative and postoperative quality-of-life issues and work with their organizations to arrange for appropriate care. For many women, this includes addressing the social marginalization that separated them from their families and community networks before undergoing surgical reconstruction.

Capacity Building

Although visiting health care providers and gifted resources are important temporizing strategies to begin to alleviate disparities in global surgical care, they should not be considered a replacement for a long-term investment in local health infrastructure and staff training that would allow low-resource communities to develop their own long-term surgical capacity (31). Delivery of surgical care in low-resource settings abroad should be partnered with capacity building efforts that contribute to the long-term well-being of the patients and communities being served. Such capacity building may entail ongoing partnerships between global health organizations, local health departments, and local communities to support community education, obtain medical supplies, connect to available health care services, and train personnel so that local community members can take an active role in maintaining and improving the health of the population and preventing disease.

Obstetrician–gynecologists who perform surgery abroad should contribute to such capacity building efforts. The temporary nature of many global surgical care efforts means that some obstetrician–gynecologists cannot personally participate in continued efforts to provide care, but there are several other opportunities to contribute to the goal of capacity building. For example, obstetrician–gynecologists should choose to collaborate only with organizations that demonstrate a long-term interest in the

health of the local community, particularly when those organizations have a continuing community presence after the surgical team leaves. Because education is one of the most effective ways to advance capacity building, obstetrician–gynecologists should participate in efforts to educate members of the community and local health care providers. Before departure, traveling obstetrician–gynecologists should help the community identify local resources that can be used for the management of gynecologic surgical care. For example, community leaders can serve as advocates for women's health, and regionally available medical and surgical equipment can be mobilized at a local level to promote sustainability.

Debriefing and Transitioning

Re-entry may be marked by reverse culture shock and a range of emotions, from invigoration to frustration (33), and it is vital for the sponsoring organization to provide opportunities for travelers, and especially traveling trainees, to debrief regarding their experiences and emotional responses during travel and after travel. This will help to support the individual's well-being and maintain the global surgery program at the organization or academic medical center for other physicians. Returning obstetrician–gynecologists also play important roles as educators and advocates for improved global surgical women's health care. By sharing de-identified stories and communicating the burden of surgical disease and health disparities, obstetrician–gynecologists can inspire further efforts and recruit more health care professionals to do this valuable work (3).

Conclusion

Global surgical care programs present obstetrician–gynecologists with important opportunities to address disparities in women's health and health care worldwide. However, these programs also present a unique set of practical and ethical challenges. Although this document has highlighted some of the leading issues that obstetrician–gynecologists should consider before participating in these programs, it cannot address all the issues that may arise. Therefore, obstetrician–gynecologists should always keep the safety and well-being of the patient central when adapting surgical care to the local context and should ensure that community partnership and capacity building are key components of their efforts. For more information, on global medicine, including fellowships, continuing education, organizations, and implementation guides, see ACOG's Global Women's Health webpage (2).

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