Global opportunities abound

More and more students, faculty members and clinicians in communication sciences and disorders are getting engaged in work in less developed regions of the world (Hallowell, 2012). The benefits are numerous. We learn by doing, develop CVs, become rejuvenated, gain experience, make friends, and have great adventures. Our faculty’s productivity and visibility expand. Our partner institutions and host communities gain resources and access to expertise and services. Most of us see our global work as a form of activism and we hope that our work in underserved regions helps address health disparities.

The insufficiency of good intentions

- No matter what our motivations, it is important for us to acknowledge that our sense of contribution and beneficence is inherently intertwined with our own self-interest (Pinto & Upshur, 2009). As Roesel (2011) aptly states, “The severe disparities between those living in the poorest parts of the world and those in the wealthiest create a moral responsibility to assist and the ethical hazard of doing so.”

- “First do no harm” – or nonmalevolence – is one of the four medical ethics principles outlined in many health-related areas, along with autonomy, beneficence, and justice. These principles are laudable and make sense in Western cultures, but involve challenges and differences of interpretation when considered elsewhere. Overall, our primary focus should be on respect for human rights and human dignity (Fins, 2008). A key tenet of global ethics, then, is that good intentions are not good enough, especially in cases where the risk of doing “harm” may not be proportionate to the good to be achieved.

What are the potential ethical hazards?

Power imbalances

- Global health work typically entails power imbalances. Those with less power are more vulnerable to exploitation; this may affect treatment decisions, informed consent, and who gains from research and service projects (Jha et al., 2002).

- Students, even without clinical training or credentials, may be perceived as competent because of accompanying an expert, being in a clinical role, or even just because they come from the developed world (Maina-Ahlberg, Nordberg, & Tomson, 1997).

- Students working in other countries may be permitted to do things they would never be allowed to do at home. Examples in medicine include premedical student assisting in surgery or childbirth. What are parallel experiences that CSD student may have?

- Codes of ethics are considered of paramount in our professions, yet do not typically adequately address ethical concerns related to delivery of humanitarian services outside of our clinical health-related areas, including and licensing bodies. As we expand our programs, they are not being held to the same level of scrutiny as our work within our own countries. For example, we may be engaged in interactions that do not entail privacy and confidentiality standards that are in place in our home country.

- We may need to use resources that are already scant from a host facility. For example, we may need others by requiring escorts, translation, housing, etc. In doing so we may cause decreased productivity of the agencies and facilities we are visiting.

Cultural ignorance

- We and our students may make recommendations or judgments about what we know from our own cultural experiences without fully appreciating local cultures and contexts.

- It is not appropriate to assume that ethics training related to work within the cultures we know is applicable to cultures with which we are not so familiar (Pinto & Upshur, 2009)

Historical colonial legacies and cultural stereotypes

- Schimmelpepenn (2012) writes about Whites in Shining Armor: “Americans and other outsiders are uniquely positioned to bring change to a community, as if we are savors coming to deliver them from poverty.”

- If our news stories feature the great work of white westerners and not locals, who are really the backbone of sustainable good, then we are perpetuating the notion that is takes a foreigner to make good things happen. Razack (2002) has coined this “benevolent imperialism.” Inequitable partnerships actually place our non-Western partners at a disadvantage.

Not ensuring sustainability

- Underserved groups need lasting improvements, not just good feelings shared with visitors. We should work toward truly mutual collaboration with host professionals as partners in all aspects of shared goals, and decreasing reliance on Western partners.

Over-reliance on technology and expertise that will not be available when we leave.

Failing to recognize the local expertise in the content areas we represent (Dickson & Dickson, 2005)

Ignoring risks to students

A call for a focus on ethics in global education in CSD

- Medicine and public health, the rapid development of global health curricula and experiences has not been paralleled by concerted planning and reflections about ethics (Hanson, Harms, & Plamondon, 2011; Pinto & Upshur, 2009). Perhaps we can change that course for CSD. We have an opportunity to constructively address these issues for CSD students. More and better student preparation can reduce the risk of doing harm and also enhance student’s experience and foster improved relationships between cultures. “Ideas of global health educators should be “critical reflection, appropriate pedagogy, and intentionality” (Hanson, Harms, & Plamondon, 2011, p. 172) rather than just increasing the number of experiences abroad for ourselves and our students.

Action strategies for ethics in global CSD work

Evaluate our motivations.

- Are we motivated by pity as we see how others are not empowered? This in itself is disempowering.

- Do we recognize that we are addressing our own needs, too? There is a growing need in North American institutions for students to engage in global projects. Our need is pressing, not necessarily the needs of the people we’re serving. “Why should some of the poorest regions of the world shoulder the burden of training some of the most privileged people in the world?” (Roesel, 2011)?

Recognize that paternalistic, neocolonial relationships can be perpetuated.

- For any given project or experience, are we really helping build capacity, cooperation, and solidarity? Are we perpetuating neocolonial stereotypes (Mukherjee & Samanta, 2005)?

Ensure preparation of our students.

- Ensure direct interaction reflection about racism, post-colonialism, power differentials, cultural identity, cultural differences, and differences in world views prior to travels abroad (EIESL Project, 2012)

- Provide substantial opportunities for in-country and post-service reflection and evaluation.

- Consider with our students how, when engaging with any vulnerable population, we should act and achieve the objective of improving health and communication (Crump & Sugarman, 2008).

- When reporting on our own experiences, address these concerns clearly and openly. Share stories of how we are handling these issues, and share data about related student and faculty development.

Recommendations for shared efforts through CAPCSD and related professional organizations

- Develop and share best practices for use with partner institutions abroad, helping ensure that we protect the most vulnerable people.

- Consider how global health should be addressed within our professional codes of ethics.

- Develop and share guidelines and parameters for trainees and supervisors. What can we all do to prevent harm? What training and supervision should all students participating in international experiences receive? What are solid criteria for judging our global service and education programs? How can we make best use of rich resources already available across disciplines in this area?

- Play a much more active role in interdisciplinary global health ethics projects, and develop a stronger presence in this and other areas in related professional organizations, such as the Global Health Education Consortium.

See the accompanying handout for references. Contact Brooke Hallowell via email at hallowel@ohio.edu.