Medicine for all?, contemporary recommendations for action- Using the example of "medical voluntourism" in countries of the global South

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1. what is the problem / the void?

The travelling of white, privileged medical students from countries of the Global North to countries of the Global South to gain practical experience raises a variety of ethical questions. This practice, often referred to as "medical tourism" or "medical voluntourism", is at the centre of a debate about privilege, ethical behaviour and the potential impact of so-called "white saviorism" in medicine.

One central aspect concerns the question of professional competence. It is often the case that students from countries in the Global North have a lower level of training compared to local professionals. Transferring responsibility to inexperienced students can not only be ineffective, but also potentially dangerous. There is a risk that inadequate knowledge and lack of practical experience can lead to misdiagnosis and inappropriate medical interventions. In an environment where accurate and skilled medical care is crucial, such inadequacies could have serious consequences for patient health. The ethical implications of this approach are extremely complex and come with the risk of exploiting the local population for the students' individual learning goals, without adequate reciprocation or consideration for the needs of the community. This imbalance in the exchange dynamic can lead to indigenous communities being seen as a means to an end in order to further their own professional ambitions. This is at odds with an ethical approach based on respect and reciprocity. The lack of appropriate reciprocity or consideration of local needs can cause breaches of trust. This loss of trust in medicine as a whole is not only relevant on an individual level, but can also affect the collective perception of medical aid and cooperation. Such a loss of trust can lead to a generalised mistrust of medical actors, which in turn can affect the ability to implement effective health interventions on the ground.

Another serious concern is the concept of "white saviourism". This refers to the paternalistic behaviour where white people, often unintentionally, take on the role of saviour and see themselves as superior to the people in the host country. This can undermine the dignity of local communities and reinforce an unequal power relationship.

Paternalistic behaviour has a serious impact on local experts and reinforces unequal power relations. Paternalism in this context means that students from Global North countries take on an overly patronising role based on the assumption that their origin automatically gives them superior knowledge and better solutions. A direct consequence of this paternalistic approach is the devaluation of local expertise. By assuming the role of saviour and assuming that their methods and knowledge are superior, medical students often underestimate or even ignore the expertise of local healthcare providers. This leads to a disregard for the years of experience and context-specific knowledge that local professionals possess. The perceived superiority of students can lead to local experts not being adequately involved in decision-making processes, ultimately leading to a lack of respect and recognition for their skills.

During the COVID-19 pandemic, a seeming contradiction emerged among privileged medical students who otherwise enjoyed medical voluntourism. The travel restrictions and safety measures meant that mobility in the healthcare sector was restricted. In this context, the priority for medical voluntourism seemed to recede for some privileged students. This raises questions about the

importance and motivation for such activities, especially when personal convenience or safety concerns come into play.

For patients in regions where medical voluntourism takes place, the experience can be ambivalent. Often these patients have little to no choice in the medical care they are offered. The arrival of volunteers from wealthier countries may initially appear as a sign of hope for better healthcare, but the reality can often be far from that. These patients often find themselves in a vulnerable position as they are exposed to interventions that are often uncoordinated and insufficiently scrutinised. Patients rely on the medical judgement of volunteers, without always realising that they may not have the same level of expertise and experience as local professionals.

The situation is further exacerbated when medical interventions are not only inadequate but also potentially harmful. In such cases, where patients have no alternative and are in an environment where medical resources are limited, inappropriate practices can lead to serious health complications, which in some tragic cases can even lead to death.

For these indigenous patients, medical voluntourism often reflects a form of structural injustice, where their health and well-being serve as a means to the volunteers' learning goals without adequate consideration for the needs and safety of the community.

2 What needs to change?

Far-reaching changes and adjustments are needed to minimise the negative impact of medical voluntourism on local patients. One key requirement is the introduction of strict ethical guidelines and standards for medical volunteering. These guidelines should ensure that volunteers have appropriate qualifications and experience and that their practices are in line with local health standards. Verification and accreditation of volunteer programmes by independent organisations can be one way of ensuring that participants meet the highest ethical and professional standards.

Transparency and communication are cornerstones of respectful and ethical medical volunteering. Local patients should not only be informed, but also empowered to actively participate in their own healthcare process. They have the irrefutable right to be fully informed about the qualifications and intentions of the volunteers involved. This should not be seen as a mere formality, but as a crucial step in ensuring that locals are actively involved in their healthcare and have confidence in the medical care they receive.

In this context, it is particularly important to emphasise that indigenous patients have the freedom and right to say "no" if they have concerns or doubts about a proposed medical intervention. Their consent and assent should be voluntary and informed. This requires not only an improvement in communication between volunteers, patients and local healthcare providers, but also the provision of clear and understandable information in the local language or otherwise accessible to those concerned. Involving patients in the decision-making process and recognising their autonomy are fundamental to ensuring that medical interventions are carried out on an informed and respectful basis. These changes are essential to restore the balance between volunteers and local patients and to ensure that healthcare primarily fulfils the needs and wishes of the latter.

Finally, long-term training and strengthening of local healthcare systems should be prioritised. Promoting educational programmes for local healthcare providers and providing sustainable resources will help to reduce dependence on external sources of aid and strengthen the local healthcare infrastructure.

Overall, effective change requires a fundamental realignment of priorities, prioritising the needs of communities and viewing medical volunteering as a tool to support local health efforts rather than an independent initiative.

3 How can change happen?

The transformation of medical voluntourism requires a comprehensive reorientation towards ethically responsible and sustainable practices. A key component is the introduction of strict ethical guidelines and standards for medical volunteering. These standards should ensure that volunteers have the appropriate qualifications and experience to work effectively and safely in host communities. Organisations organising such programmes should be regularly audited for compliance with these guidelines.

To address the shortcomings in existing guidelines, medical schools, for example, can develop clear ethical guidelines and standards. State examination offices can create a clear framework to ensure that medical voluntourism is viewed critically. This could include an evaluation and possible adaptation of experiences abroad to ensure that activities are ethical and patient safety is prioritised. By implementing these structural solutions, faculties and state examination offices could help to ensure improved structure and control over medical voluntourism.

The fact that medical students are not allowed to perform certain practices in their home countries and can circumvent this restriction in other countries, such as performing caesarean sections or cataract surgery without sufficient anatomical knowledge and technical experience, is problematic and could lead to incorrect treatments. Local teams should be able to select new healthcare professionals based on their experience and the skills they would bring to the local team. The emphasis should be on volunteers providing their skills to strengthen local capacity. Medical students who do not have the required skills and have not yet gained practical experience should not be admitted. This requirement reflects the concept of medical justice and avoids potential double standards in international medical activities. Increased co-operation with local health experts is therefore crucial. Involving and engaging communities and their professionals in the entire process, from planning to implementation, is essential. Local professionals should not only be seen as recipients, but as equal partners in the design and implementation of health initiatives. This requires a shift from a paternalistic model to a partnership approach centred on local needs.

A long-term commitment to strengthening local health systems is essential. This can be achieved through educational programmes that emphasise training and development of local healthcare providers. Such sustainable development is crucial to reduce dependence on external sources of aid and to ensure a long-term positive impact on health care in communities.

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