International medical volunteers, do they do more harm than good?

This year, I spent 6 weeks in Kisumu in West Kenya as a medical student. I embarked on this trip with the hope to answer the question of whether medically trained volunteers with all good intentions inevitably do harm. By working and speaking with Kenyan healthcare workers and international volunteers I hoped to learn about the positive ways to benefit a Kenyan community within healthcare as well as learn from the previous mistakes of other international volunteers.

My experience as a medical student in Kenya was far more hands-on than my experience has been in the UK. I worked with two doctors whose skills and breadth of knowledge far surpassed the average of their level in the UK. They told me that this confidence, skill, and knowledge came from their hands-on “sink or swim” style of training. Immediately after medical school they were given responsibility of a whole small hospital and within weeks were performing caesarean sections, minor general surgery on their own. This was a morally difficult environment to find myself in, coming from my more hands-off training. The doctors asked me to perform duties, far outside of my UK training such as holding the scalpel and leading a lumpectomy, being involved with the anaesthetic decisions of a surgery and assisting with caesarean sections. It would have been easy to adopt this “sink or swim” attitude in Kenya, say yes to these oppourtunities to further my training and potentially do harm to the patients of Kisumu. I knew that this would be inappropriate and out-side of my capabilities and always suggested that I take a more supernumery role, supporting within my capabilities and not working outside of my UK medical school training.

I spoke with two international medical volunteers, Helen and Tom that have been working in low resource settings within Africa for 10 years. They worked for many years in Sierra Leone, Botswana, Zambia and Malawi. When posed with the question at the heading of this essay, they shared with me some negative examples of medical volunteers working to the detriment of local communities. One story stayed with me. In Sierra Lione, Helen was working in a local clinic in Freetown when she and other local professionals were approached by an NGO from the UK, offering the funding to build a large medical clinic and school. Helen explained to me that every local member of the constructed committee agreed that this would not inevitably benefit the community. This would threaten viability of local clinics and hospitals within the community and possibly put local healthcare workers out of action. Additionally, Helen suggested that local patients were far more likely to access healthcare from doctors and nurses that they know and trust. This change could lead to patients not accessing healthcare due to distrust and misunderstanding. The NGO listened to the advice of the local

Helen’s role within the hospital was to set up and ensure the safe and effective opening of a new neonatal baby unit. I thought that her approach to her job was a brilliant example of useful medical intervention. She is a consultant paediatrician with years of experience with neonates. She therefore has the knowledge and experience for the job. She knew that her role was to open the neonatal unit and ensure that the neonatal staff have the training and experience to continue the work in the unit without her. She, therefore, didn’t take a clinician’s role at all. She passed all clinical work to the Kenyan doctors working in the

hospital. She ensured that the nurses and doctors working in the unit were fully trained and independent to her so that the hospital has no reliance on her after she chooses to leave.

The counter argument to this came within a conversation I had with one of the doctors at the hospital. He told me about how in their opinion, the government of Kenya are corrupt and place very little funding into the healthcare system. Therefore, when doctors become qualified they find it very hard to find a funded job within a hospital. The ideal situation in terms of the neonatal baby unit would be for a Kenyan doctor to ensure the safe start of the unit and to then continue the care. However, the government would not fund a consultant paediatrician in this hospital and the hospital cannot afford fundraise enough to employ a paediatrician and therefore Helen's employment is the next best option.

During the ward rounds, my medical student colleagues and I realised that the doctors and nurses weren't using NEWS charts and were instead writing all the observations individually. We found this to be time consuming and suggested to the doctors that they use NEWS charts. We also suggested that the doctors enlist a nurse or medical colleague to write in the patient's notes during the ward round rather than the doctor writing in the notes after the round as they had been doing in order to save time. We soon realised that though these interventions work brilliantly in the UK, they were obstructive to the Kenyan doctors when they employed our suggestions. The nurses were competent in working with observational reference ranges, NEWS charts became confusing and the doctors preferred to write their own notes, despite the added time. This was a classic example of international medical volunteers, having spent a short amount of time in Kenya, wrongly assuming that our way of functioning would benefit healthcare workers in the Kenyan system.

I have since had time to reflect on my time in Kenya and my future of working in low resource settings. In an ideal world, Kenyan healthcare staff would sufficiently provide medical care to patients in Kenya without the need for foreign aid. However, colonialism and foreign mistreatment of Kenya has left it with corruption and poverty. International medical volunteers are needed and useful when they work with local community sustainability in mind. Helen showed me a classic example of ensuring sustainability of your work by training local staff and empowering Kenyan doctors and nurses. She taught me that knowledgeable locals should be consulted on the direction of funding. That simply building a health centre can be unhelpful and potentially detrimental to a community. I also learned about the danger of working outside your capabilities. That conversations should be had prior to a trip to establish boundaries of work and to manage expectations of duty to ensure that patients aren't put at risk due to lack of training. I have found this trip very informative, and I feel it has started to equip me with a toolkit of knowledge and skills that I must build upon with more learning and conversations before considering using my medical training to aid low resource medical centres.