COMMENT

# Ethical issues in fellowship training across the global divide

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For doctors from developing countries, clinical fellowship training in the developed world (ie. 'the West') is considered a golden opportunity, both for their own improvement as well as to help their fellow country people. This article briefly examines the potential downsides of this training from an ethical and practical perspective.

At its best the quality of Indian medical and surgical care is competitive with any in the world but this level of care is usually available only to the wealthy. For most of India's huge population there are large obstacles to affordable, good quality health care. There is a shortage or mal-distribution of high-technology equipment and highly trained personnel like nurses and doctors, so that the level of health care accessible to the average Indian is inferior to that available to the citizens of a country like Canada. One way to improve the quality of care is to improve the skills of Indian doctors. An excellent and popular way to do this is for them to spend a year or two in fellowship training abroad.

Clinical fellowships are done by doctors immediately or soon after they complete a residency. It is a very beneficial experience, especially if they wish to sub-specialise or acquire a technique that their peers may not have expertise in. Without such training, patients in the region may not have access to certain treatments, as the expertise is not taught locally. It may not be available anywhere in the region or country. Fellowships are becoming accredited by licensing bodies and are more rigorously regulated and monitored by educational authorities than previously, when they were less formal learning experiences (1).

I work in a neurosurgery unit in a large teaching hospital of the University of Toronto. Our hospital has all the latest technology and medical and nursing expertise. Furthermore, the Canadian health care system is totally socialised so all citizens get whatever medical care they need at essentially no cost, except for non-essential care such as cosmetic surgery. Every day surgical patients at my hospital get a magnetic resonance imaging study the morning of surgery; have access to advanced computerised surgical navigation systems to help with the efficacy of the surgery; have access to an intensive care unit bed; have access to excellent nursing and other staff; and have access to clean and comfortable physical facilities.

My primary interest is in brain tumours. Another neuro-oncologist and I run a surgical neuro-oncology fellowship every year. We also both happen to have an interest in, and commitment to, advancing surgery in the developing world. Almost every year we purposely select, from our list of applicants, a candidate from the developing world. This year's fellow is from Kolkata; the one starting July 2005 is from the Philippines, and we have already committed a slot in July 2006 to an Indonesian. We feel good about providing what we feel is a superb cutting-edge training experience for young neurosurgeons who have less access to resources and clinical expertise than we do. Ultimately, it will enable better health care for their patients who are less fortunate than ours. Having a fellow from a place like India is also an incredibly rich and positive experience for the supervisor and the other trainees who can learn a great deal from colleagues from distant places and different cultures, in both medical and social arenas (1).

But are there downsides of this positive educational experience? It would be hard to imagine that exposing a surgical fellow from Kolkata to cutting-edge management of brain tumours could have any negative consequences. But what if we train this fellow in methods, and with technologies, which are uncommon and extremely expensive and/or personnel-intensive, and therefore unavailable back home? These will be techniques he can therefore not translate into care for his patients. An example would be removing a brain tumour inside a large-bore magnet with real time magnetic resonance imaging to guide the resection (2). Then he has wasted his time, and one could argue we have wasted a valuable salary which is generously provided by our hospital, and thus the taxpayers of this province and country.

But some techniques he will learn in the course of his fellowship will be readily translatable with a minimum of extra equipment and/or personnel. An example would be becoming comfortable with outpatient brain tumour surgery, which is the biopsy or removal of a brain tumour as an outpatient procedure (3). This procedure is safe and effective and also saves a healthcare system money, which might be particularly appropriate in the developing world setting. Furthermore, irrespective of the possible tangible results, one hopes that exposure to cutting-edge care will stimulate the fellow to be the best he can be, and perhaps even lobby back home for better equipment and personnel. These outcomes would be hard to measure.

Another potential downside of fellows from the developing world training in the West is that they become so enamoured with the relative wealth and facility of the healthcare system – and of course the personal lifestyle possibilities – that they

decide it would be too difficult to return home. This would compound the already existing 'brain drain' of doctors from countries like India (4). In a bid to remain in the west at any cost, some fellows will even repeat their entire residency training to obtain the requisite qualifications. I have personal experience with two such individuals in the last decade – one was from the Philippines and one from Russia and both were very good surgeons, good doctors, and fine people. Again, the resources the home country spent to train these physicians would have essentially been wasted by the taxpayers of that country.

A personal downside for the fellow is the potential abuse by fellowship supervisors. Some fellows are self-funded and some are funded by hospitals, grants, and other agencies. Either way fellows are usually 'free workers' and some supervisors treat them as workhorses and warm bodies to ease their workload. Teaching responsibilities and similar duties are sometimes passed on to fellows to liberate the supervisor's time for more pleasurable or profitable pursuits. Another adversarial situation for fellows is the potential – and sometimes real – conflict with residents within the training programme as residents and fellows compete for cases and clinical experience. It is ultimately the responsibility of the supervisor to fulfil teaching obligations to both fellows and residents so that all parties obtain a satisfactory learning experience and are treated fairly and with respect (1).

In summary, precious resources of money and time are allocated to training a clinical fellow in a specialised area of medicine. If this time is not well spent – if it does not have a positive impact on the patients the doctor will ultimately treat – one could argue that these precious resources have been wasted. Perhaps prospective fellows and fellowship supervisors should discuss in detail ahead of time what useful training the fellows can hope to acquire. Perhaps this should be assessed in light of what will be practical for the fellows when they return to their home countries. Perhaps even a third-party supervisory committee should be instituted, with no vested interest in the fellows or their supervisors. Finally fellows obviously have responsibilities to their supervisors and supervisors have an even greater responsibility to train their fellows, and to not abuse them.

Fellowships can be rich, rewarding, and even life-changing experiences for doctors and, more importantly, for their future patients. This experience may be richer for all parties when a fellow comes from the developing world to train in the developed world. But expectations of outcomes by both the fellow and supervisor should be clearly considered and articulated up-front.

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