The American Journal of Surgery 221 (2021) 244

Contents lists available at ScienceDirect

The American Journal of Surgery

journal homepage: www.americanjournalofsurgery.com

Invited Commentary

Invited response to: Motivations and impact of international rotations in low- and middle-income countries for orthopaedic surgery residents: Are we on the same page?

To understand medical voluntourism is to understand Western colonial ideology. Formed largely through health challenges of colonialist expansion into tropical areas, global health has come a long way.[1] Many current long-term and large-scale global health efforts are driven by governmental and non-governmental organizations, which have informed the growth in knowledge as to the importance of community-informed practices centered on local barriers to care and economic and political forces.[2] Despite increasing evidence, short-term medical relief and education trips remain commonplace. Those traveling may be well-intentioned, but by skirting culturally-centered care, these trips only serve to perpetuate a colonial past.

Roberts and colleagues[3] highlight the impact of international rotations on U.S.-based orthopedic residents and on their counterparts in host sights throughout the world. The host responses to the survey highlighted positive impacts of these relationships, including transfer of surgical and cultural knowledge and the ability to learn about new practices, which is often the desired outcome for both visitor and host in these trips. However, they too highlight the paternalistic ideologies of residents to conflate their own importance and that of Western procedures in countries where they may not be sustainable. Worse, at times discriminating against local peoples and cultures. Further, one-sided power dynamics are apparent with the lack of invitation to host residents and faculty to visit U.S- based hospitals.

Short-term medical trips, particularly common in the field of surgery, are reminiscent of assimilationist practices imposed on black, indigenous and people of color (BIPOC) throughout Western colonial history.[4] They remain predicated upon the notion that Western practices, education, and ideals based in white paternalism are universal standards to which others should adhere. However, without cultural insight, these ideas often cause more harm than good. While outwardly purporting to serve communities, volunteers and trainees are often serving their own egoistic desire to help an underserved area to the detriment of already marginalized communities. Many trainees use trips to low and middle income countries as an opportunity to perform procedures and provide care outside of their scope of practice. It is hard to separate this from the dehumanization of BIPOC in the United States with settler colonialist policies and practices that formed the foundation on which medical experimentation and eugenics were sanctioned.[4] In allowing, and even encouraging, substandard care we are devaluing those individuals we are purporting to serve. We use them as means to our own ends.

If international surgical trips are to continue, they must be part of a larger sustainable infrastructure. Models based in cultural competency, such as those of the Lancet Commission on Global Surgery and the World Health Organization should be followed. This commission stresses the importance of working with and learning alongside partners in other countries and ensuring that short term support is part of long term programs.[2] To skirt ethical standards of care while working in low to middle income countries is to devalue and dehumanize, perpetuating colonialist biases against BIPOC. A shared power structure can and should be developed with host institutions to foster cultural competency and true learning opportunities for both parties involved. To ensure shared power, Western residents and faculty should undergo implicit bias training to help them understand and prevent acting on biases against BIPOC or other cultures. In working towards a more equitably and just global surgical model, shared power dynamics can serve to decolonize global programs through shared power and education.

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25 September 2020

https://doi.org/10.1016/j.amjsurg.2020.10.035