Practising beyond one's scope while working abroad

Large numbers of health-care professionals and trainees from high-income countries travel to low-income and middle-income countries as participants in short-term experiences in global health (STEGHs), which last from a week to several months. STEGHs encompass various types of clinical and non-clinical professional activity and raise many ethical issues, the management of which is key to successful programmes.[1–6]

A particular ethical concern arises when participants are asked to practise outside their scope of training. Although health professionals and trainees might exceed their scope of training in their day-to-day work at home, low familiarity with clinical, cultural, and health-care system contexts, as well as emergencies, perceived deficiency of available resources, or time constraints, could make practising outside scope more likely in STEGHs. Despite ethical practice guidelines recommending against practising outside scope,[3,7–9] anecdotal evidence indicates that it continues.

Few data exist regarding how often, or under what circumstances, individuals are practising outside scope. To address this gap, we did a web-based survey of health professionals and trainees across disciplines and professions (ie, physicians, nurses, nurse practitioners, and physician assistants, as well as those pursuing such certifications) from high-income countries who had worked or volunteered in the setting of low-income and middle-income countries in the past 5 years.

Given the absence of an accepted definition or validated survey of practising outside scope, a 39-item survey instrument was created and piloted for content and face validity at three institutions (appendix). Survey items reflected the idea that practising outside scope, and its consequences, can be viewed as subjective experiences shared across health professions relative to their specific competencies, and among both licensed professionals and trainees. Study participants were recruited through email-based snowball sampling within health professional networks. We analysed quantitative data using univariate and bivariate methods. We coded responses to open-ended survey items using an emergent thematic style of qualitative content analysis.

There were 223 respondents from across a large variety of university-based and non-university-based global health programmes; 99 (44%) of these reported a university affiliation. 109 (49%) of all respondents reported being asked to perform outside of their scope of training in the preceding 5 years during a STEGH, most of whom (67 [61%]) reported actually practising outside scope. Many individuals were asked to consider practising outside scope multiple times. Trainees were nearly twice as likely as fully licensed professionals to practise outside their scope, although licensed professionals were more likely to believe that doing so could be appropriate in some situations. There was no association between either location of STEGH or type of health professional (eg, physician, nurse, etc) and the frequency of practising outside scope.

Survey respondents reported a broad range of procedures done under these circumstances, from non-emergency interventions to highly specialised interventions or emergency interventions. The most frequently reported procedures constituting practice outside scope were basic ultrasound, fracture management, wound care and suturing of lacerations, endotracheal intubation, vaginal delivery, and neonatal resuscitation. Common reasons respondents identified to explain practising outside scope included a mismatch with host expectations, a suboptimal amount of supervision, inadequate preparation to decline requests, a perceived absence of alternative options, and emergency situations. Qualitative analysis showed a variety of negative and positive emotional responses among those who practised outside their scope. Although the survey could not distinguish the effect of practising outside scope itself from the overall context of a STEGH, most respondents expressed lasting moral distress over practising outside scope.

The persistent ethical dilemma of practising outside scope could be symptomatic of the structural problems of many global health activities.[5] Best practice recommendations propose that practising outside scope is typically appropriate only in particular types of emergency situations.[1,8] However, what constitutes an emergency is both an uncertain area and a crucial distinction for STEGH participants working in unfamiliar, resource-constrained settings. Participants in our study described practising outside scope in situations that varied widely in the severity of the health crisis and the skill of the clinician, showing that this distinction is far from clear. STEGH participants might be less likely to know what constitutes a true emergency in the local context, which care options are locally available, and how to effectively communicate with patients and families in times of crisis. In addition, the frequency of visitors being asked to act outside of their scope shows that host staff, patients, and clinical peers might misunderstand visiting professionals' scope of practice and credentials. Power imbalances at institutional and individual levels could further hinder open communication about these contextual and practice differences.[10]

Based on our findings and best practice guidelines, we believe the following recommendations deserve careful consideration and further exploration in STEGHs. First, organisations that send health-care professionals and trainees from

See Online for appendix

high-income countries to these settings should ensure that expectations of the host organisation are aligned with the individual participant's skills and provide predeparture training that includes effective communication around practising outside scope. These organisations should regularly ask returning STEGH participants about their experiences with practising outside scope to improve policies, guidelines, and training programmes. Second, health professionals and trainees who participate in STEGHs should be aware that requests to practise beyond their scope are likely to occur and be prepared to respond to them. Third, host organisations and institutions who receive STEGH participants should ensure that all visiting clinical professionals and trainees receive the necessary permissions from local or national licensure and credentialing bodies before giving patient care and include costs of administrative and supervisory support in partnership agreements.

The rise of global health as a defined field of study, research, and practice over the past decade creates an urgent need to ensure that all global health professional activities, particularly those that involve patients, adhere to the highest standards of care and expertise. We must, therefore, monitor our programme outcomes, both desirable and undesirable, and make necessary programmatic and policy changes to achieve these goals.

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