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Institutionalising global health: a call for ethical reflection

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ABSTRACT

We describe a global health course and pedagogy that highlights the moral ambiguity and many ethical compromises that have emerged as the discipline has increasingly become institutionalised. We encourage students to reflect on how the oft-declared aspiration for global health equity still remains seriously contested as a normative and political matter, especially in settings like the USA. We further encourage students to reflect on how authentic concern for social justice, health equity and human rights are consistently undermined by unconscious and/or intentional fealty to standard operating procedures within hierarchical structures and systems. Lastly, we encourage students to openly question and critique the dominant socioeconomic and institutional paradigms that influence practitioner ways of thinking about global health. Our aim is to provide a learning space for students to at least imagine, if not demand, more daring modes of engagement. We also encourage our colleagues in the global health education community to be forthright that the process of institutionalising global health reliably favours our own interests more than those we claim to be most concerned about. If the ideal of global health is to build a bridge to human solidarity, we see substantial risk that current popularised approaches might never yield a structural tipping point.

Summary box

- Global health ethics remains poorly delineated in academic discourse, particularly in professional medical education settings.
- Students of global health need to wrestle with multiple layers of moral ambiguity and disharmony stemming from the field's increasing institutionalisation.
- Teachers of global health should be forthright about the many ethical compromises embedded in the field's established ways of doing business, and encourage attitudes of critical reflection, moral imagination and courage in their students to challenge problematic paradigms for engagement.
- Despite widely shared sentiments embracing health care 'equity' within a broad global health community, the conceptual basis for action in global health remains seriously contested.
- Despite widely shared sentiments embracing healthcare 'equity' within a broad global health community, the loosely organised enterprise consistently prioritises the agendas and interests of resource-rich individuals, institutions and nations.
- The current infrastructure for doing global health work frequently fails to live up to the idealised rhetoric often associated with it, and this reality risks reducing the practising community's sense of responsibility and legitimates narrow, technical terms of engagement.

INTRODUCTION

As global health continues to mature as a distinctive enterprise, so have questions about its aims, scope, and increasingly, ethically acceptable modes of engagement.[1–3] In recent years, as the lustre that often accompanies idealistic social movements recedes, participants in and observers of the global health cause have grown more willing to draw attention to the project's deficiencies and contradictions.[1 4–9] Our interest in this essay is to describe how we have approached a foundational pedagogical question faced in developing a course examining ethics and global health within an academic medical setting: namely, what should we emphasise?

From the outset, we intentionally steered away from narrowly tailored, frontline concerns found in many introductory curricula: resource-scarcity–driven micro-dilemmas, issues of cultural competency and professionalism working within impoverished, unfamiliar communities, and "dos and don'ts" for visiting students and trainees in global clinical settings.[10 11] These topics may be worthy of discussion and have the benefit of being immediately relatable for certain kinds of students. However, early in our endeavour, we sensed an important opportunity for sustained moral reflection about the nature of the global health enterprise itself. We echo Hunter and Dawson that the question: "what is global health ethics?" remains poorly delineated in academic discourse, particularly in professional medical education settings.[12]

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COURSE DESCRIPTION

We have had the benefit of developing a course for students in the Global Health Delivery (GHD) and Bioethics Master's programmes at Harvard Medical School. This has afforded us a great degree of pedagogical liberty, especially when compared with the limited curricular space typically made available in other forms of health professional education (eg, M.D. and M.P.H. programmes, postgraduate residency tracks).[13–15] Our GHD programme attracts professionals working within the healthcare sector from across the globe, most often from low-income countries. The Bioethics programme most often attracts students and professionals from within the USA and Europe from a variety of backgrounds (medicine, law, philosophy). The course is mandatory for enrollees in the GHD programme, whereas it is elective in the Bioethics programme.

Both courses are taught seminar style for 2 hours per week, over a 12-week period. We assign 2 to 4 hours of preassigned weekly readings that describe and/or analyse common underpinnings and understandings of global health as both an ideal and a series of activities that have become institutionalised. The readings are drawn from a variety of disciplines, including anthropology, sociology, economics, political science, philosophy and psychology. Because the majority of our students have been working professionals, we prepare no PowerPoint slides or lecture notes to present to students. Rather, we see our task as opening and holding a space for difficult conversations. We facilitate each class with an aim to foster engaged, reflective, and respectful debate and discussion. We have reliably found that within two to three classes, students with remarkably diverse backgrounds and lived experiences grow comfortable with us and one another, and are eager to have their ideas tested and challenged. We attempt to cultivate in our students an attitude of respectful, courtroom-style cross-examination of both the means and ends of global health. A key challenge in achieving this openness is convincing the students that we are not going to interrupt the discussion to provide the "right" answers.

What has emerged over this multi-year, iterative exercise is a normatively focused curriculum following in the provocative tradition of critical studies: one that ethically dissects what is now a rather loosely bound industry of global health projects.[4 5 8] Over the course of a semester, we ask students to wrestle with complicated layers of conceptual and practical moral incongruity in multiple, dis-coordinated practices of global health. We find it important for our learners to recognise that "too often, discourse appears to point in one direction, while reality runs rapidly in quite another."[9] We prime them to reject claims of ethical immunity that might reflexively be granted to global health practitioners or institutions just because their activities pledge allegiance to the salutary aims of equity.[16]

Themes addressed in the course

Our course seeks to expose learners to numerous forms of normative dissonance created by almost two decades of increasingly institutionalised practices in global health. We invite others who self-identify as global health educators to reflect on our thematic approach described herein and consider whether any part of it might prove meaningful to their pedagogy, regardless of where or who they teach. A major aim of our course is to demonstrate to students how the process of institutionalisation reduces the global health community's ethical sense of responsibility and quickly limits our terms of engagement to that which we are very specifically expert.[1 5 7 8]

> Theme One: Despite widely shared sentiments expressing a desire for healthcare "equity" within the broader global health community, the conceptual basis for action in global health remains seriously contested.

Morally substantial claims, particularly those grounded in normatively complex concepts like justice, motivate much idealism within the global health movement. Many who are drawn to the field take it as gospel that it is unfair for poor people to bear health risks and/or die prematurely through no fault of their own.[1 13 17] Far from their own doing, these poor outcomes are due to luck of their born circumstances, and often, due to a long history of colonial and capitalist extraction which now manifests as socially constructed resource scarcity.[17 18] What is to be done to meet the demands of justice (reparative or otherwise), however, is hardly settled in the philosophical literature, let alone in domestic and international law.[12] Thoughtful and respected public intellectuals here have long disagreed about both what we "owe" one another and why.[19–21]

This debate spills over into the public sphere, where at least in the USA, citizens remain at odds with one another about whether and how much access to healthcare should be politically guaranteed.[22] Our experience suggests that learners are done a disservice if these genuine disagreements are bypassed in favour of either an untested assumption that the justice question is settled or a bow to pragmatism. The former perpetuates a moral echo chamber within global health circles, while the latter emphasises that most difficult decisions can be settled through versions of a cost–benefit analysis.[4]

It also can be tempting to trumpet human rights as the basis for normative claims in global health.[23] Hailing the Universal Declaration of Human Rights (UNDHR) is therefore a common analytical move for practitioners and students alike.[24] While acknowledging the declaration's symbolic value, we invite our learners to reflect on the fact that the UNDHR makes little difference in the lived daily experience of the vast majority of the world's most vulnerable populations, who continue to endure mind-boggling economic and social deprivations that contribute to their poor health outcomes.[5 21 23] In settings like the USA, a lively political debate continues about the proper understanding, content and scope

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of essential human rights.[25] Because of this, we urge students to disabuse themselves of simplistic reliance on easy slogans like "health is human right." Even if we grant that normative progress has been made through international enshrinement of UNDHR, there is consensus that achieving anything close to health equity will require exponentially more attention to thorny issues of implementation and enforcement.[23 26] Our course is designed in part to prompt students to consider whether they need to be on the front line of global health advocacy—which is primarily political and legal—or whether they can be comfortable participating exclusively as technical health specialists.[27]

As students sense the boldness of the moral claims at the heart of global health, we also ask them to consider whether those claims might simply be too demanding.[28] We ask them to examine the narrow range of intrinsic psychological traits that plausibly make up our cognitive moral architecture, and to reflect on circumstances that can activate instincts to prioritise loyalty and authority over fairness and harm.[29] Together, we consider how stress on our own sense of safety (eg, a pandemic) predictably pushes us back down to the base of Maslow's pyramid and sends us retreating into survivalist mode.[29 30] We offer to our students that it may not be enough to rail against powerful and impersonal neoliberal and corporate interests.[4 6 7] Rather, each one of us would first do well to ask and answer disquieting questions of ourselves.

Such an intrapersonal exploration allows our students to consider whether the fashionable, cosmopolitan and humanitarian concerns for the world's "worst off" are actually privileges afforded mostly to those who live in relative security. Many students are wary to accept the fragility of our capacity for generosity towards others, but we use the course as a deliberate opportunity to mindfully dwell on this reality. That the moral basis for global health action plausibly remains both a psychological contest within any individual and a matter of deep conceptual debate between groups may help to explain why strident demand for radical structural reforms have failed to date. We encourage students to see that very few of us can live our lives to a moral maximum, and that we have no choice but to work within the "grain of our nature."[28] This reality does not make us hypocrites.

Still, we might do better to think long and hard about how much we are truly willing to give up before retreating to a "strictly circumscribed warmth."[31] Many of us desperately want to agree with Singer's humanitarian insight: "if it is within our power to prevent something very bad happening, without thereby sacrificing anything of comparable moral significance, we ought to do it."[32] Yet, the fact is for many global health participants residing in settings like the USA, we continue to sacrifice very little; we are left tongue tied when confronted with Cohen's cutting challenge: "if you're an egalitarian, why are you so rich?"[33]

Our students come to recognise that for the global health project to succeed, we may need far more robust communal, political and legal nudges to consistently bring out the most pro-social version of ourselves. But if so, they ask why advocating for major social rearrangements that represent a clear break from the current, settled pattern of our personal and professional lives are not prioritised in formalised global health discourse, especially within academic settings? We agree. At a minimum, serious students of global health deserve a meaningful and unrushed chance to deliberate over these challenges. The goal of such deliberations in our course is not to make students feel bad about themselves; as instructors, we invite them to this critical introspection by first frankly admitting our own doubts and psychological vulnerabilities.

> Theme Two: Despite widely shared sentiments embracing healthcare "equity" within the broader global health community—the enterprise consistently prioritises the agendas and interests of resource-rich individuals, institutions and nations.

The missionary-like movement towards what is now called global health in the USA has, in part, been inspired by the celebrity of a few outlier morally minded activists.[34 35] Today, however, it is clear that actions emanating from resource-rich settings are mediated through deeply entrenched institutions with an array of competing priorities and interests. Academic medical centres claim an interest in pursuing health equity, but are mostly held accountable for other declared purposes.[36] In academia, perhaps the most frequently cited definition of global health reflects this: "global health is an area for study, research, and practice that places a priority on improving health and achieving equity in health for all people worldwide."[37] While this definition is descriptively accurate, it is normatively equivocal. Harkening back to Singer, we instruct our students to ask: how should this equity ambition be reconciled against competing institutionalised priorities? For example, should a professional incentive to contribute to the evidence base edge out the urgency to deliver on health equity? Put more bluntly, how can we morally justify using money to conduct research on a population under study, instead of using it to feed and provide them antibiotics?

From a critical studies perspective, we suggest that the following description of global health, offered by Benatar and Upshur, is a more honest starting point for students:

Global health work as a field of activity is a social institution that is integrated into and influenced by the structure of other social institutions in particular contexts. Those who work on global health issues tend to view the topic through a lens that has been moulded by their social experience. Global health work is thus a human activity that takes time and money, and so is guided by and directed by those forces that have control over money and time.… the dominant social and economic forces in society determine to a large extent what global health is about and how it is pursued.[38]

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This definition sheds sentimentality in favour of sociological reality: regardless of any idealist roots, global health is now an income-generating and profile-enhancing industry for actors and institutions mostly from high-income settings. Many self-identified global health professionals' careers and livelihoods are built on tacit acceptance and maintenance of the structural status quo, and current schemes for allocating economic resources.

Medical schools and residency programmes partner with sister institutions in Africa and Asia where *our* trainees go to learn about global health.[1 3 8 13] Researchers obtain grants to *study* poor people in destitute settings and publish studies that secure their promotion.[8 39] Philanthropists and social entrepreneurs develop and *test* the utility of high-tech, low-cost innovations in poor communities, and engage in the double speak of "doing well and doing good."[4 40] Private doctors and hospitals fund-raise to sponsor short-term mission trips to poor countries, and once back home, communally celebrate their achievements which also serve as marketing materials.[41 42] Many, if not most, of these discrete projects are legitimated under a big tent definition for what counts as global health work. We encourage our students to consider if and how broad forms of social legitimation might placate our collective sense of moral outrage, and also discourage our willingness to engage in politically disruptive activism.[27]

We press our students to question whether these many sanctioned activities earnestly live up to the goal of prioritising health equity, or instead, prioritise the relatively well off's institutional and individual interests.[5 8] To the extent that they represent the latter, we challenge students to consider how these arrangements are ethically justified. How far can a consequentialist framework focused on doing "a bit of good" take us?[43] As a class, we ask and try to answer a series of questions for any publicly proclaimed global health activity (figure 1). Systematically working through these questions makes clear to our students that the human objects of global health's "study, research, and practice" paradigm—most often, poor people who lack access to care, or healthcare workers in poorly resourced health systems—have the least power and ability to set and influence agendas, let alone sustainably benefit from any activities carried out in their name.[5]

Theme Three: How to navigate working in global health with moral imagination and courage—is it possible to push back on a flawed system while working within it?

Recognising the many ways in which the current infrastructure for doing global health fails to live up to the rhetoric of global health rightly dampens idealism. Some of our students come to a sobering moment and ask us whether continued participation in the project can even be defended. This is particularly true when they recognise that it is not only so-called "beltway bandits" who fail to live up to the ideals of global health, but also well-intentioned, sincere participants like ourselves.

We believe that continued participation can be defended, but fostering a culture of internal critique must be invited and also genuinely embraced by the entire global health community, especially those who sit in positions of influence and power. Students express reasonable concern that criticising the global health project as they enter into it will be seen as a form of heresy. Emphasising the enterprise's deficiencies can pose a risk for those who need to maintain their credibility within the community.[6 7] Look, for example, to the bedrock funding and promotion pathway for an academic pursuing global health; as it is in all other university-based disciplines, those who play by, rather than object to, prevailing institutional norms tend to be rewarded.[1 44]

We remind our students of one Albert Hirschman's insights more than 50 years ago: when considered alongside the option to exit, using one's voice to criticise an institution can be a sign of loyalty rather than disloyalty to the project.[45] Encouragingly, more academics are voicing critical concern about ethically dubious paradigms on which global health practice has been established.[8 15 38] Nevertheless, our students' concerns highlight a substantial tension as they contemplate on-going or future work in this field. Agreeing to join or remain part of a flawed global health project typically requires one to work from the inside out, and risk being complicit in the kinds of ethical dilemmas most of us wish to avoid. How much complicity can each of us tolerate before we decide to

1) Whose idea was this? What made this idea worthy of pursuing?
2) On what basis, if any, do funders have a legitimate claim to be included in the design or execution of a project?
3) Who has the most power in a collaboration or partnership, and why?
4) How is expertise identified in a collaboration or partnership?
5) If this is a collaboration or partnership, which group receives most of the funding and why?
6) If this is research, is the scientific merit so great as to outweigh the value of spending the money on direct services of some kind?
7) What conflicts of interest influence the project?
8) What economic background conditions are assumed and why?
9) Could the "equity" goals of this project be better achieved by different means?

Figure 1 Questions students are asked about discrete, publicly identified global health projects.

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become an actor working from the outside in? On the other hand, is working from the outside in even possible if one loses (what feels like) necessary institutional standing to "study, research, and practice"? Our students understandably feel trapped.

Whether our students plan to work from the inside or outside, exit or never enter, a key goal of the course is helping them to develop a moral imagination for how global health might be pursued differently than it currently is. The risk for all of us is that our conventional work environments dull our imagination and blunt our courage over time. The expectations and routines of an academic medical institution, for instance, can easily convince a newly minted global health practitioner that conformity is the only way to get things done. After a few years, the idea that "success" looks like a Gates-sponsored Grand Challenges grant becomes quite natural to accept, as part of a larger, fully institutionalised global health narrative. Without dedicated nurturing, the courage it takes to demand substantially different approaches might be extinguished and also dismissed as both unrealistic and irresponsible.

So how can we maintain our moral imagination and courage? Admittedly, we cannot adequately answer this question. Both imagination and courage require a normative line of sight beyond what appear to be solidifying global health disciplinary boundaries: "following an ideal performs some of the functions of immortality, not in time but through possibility, enlarging our lives so that they are not wholly contained in the actual world."[46] Imagination requires a reference point from which to propose alternative ways of working and courage requires a willingness to be ex-communicated for an action. In our course, we aim to first name these capacities and acknowledge it in the few role models that have appeared to exemplify such boldness.[35 47] We underscore Emerson's insight that the ancestor of every action is a thought—or, for our purposes, a moral argument.

IMPLICATIONS FOR GLOBAL HEALTH PEDAGOGY

The philosopher Robert Nozick noted: "if time after time, an ideal gets institutionalized and operates in the world in a certain way, then *that* is what it comes to in the world. It is not allowed then to simply disclaim responsibility for what repeatedly occurs under its banner."[46] US-based academic medical educators who earnestly strive to push forward a progressive global health agenda are confronted with an inescapable and frustrating dilemma. It is uncontroversial to assert that America's is not a health system that ought to be replicated elsewhere if health *equity* is truly the primary goal, and yet ours is the default norm-shaper of most efforts to educate global health students.[48] Paradoxically, many of the US educational institutions and hospitals that serve as training grounds for students thrive in large part because of the stability secured through deliberate adherence to the structural status quo.[49 50]

We are clear-eyed about the fact that there may not be much of an appetite for the kind of individual and institutional reflection we develop in our course. We recognise that macro-level structural barriers to achieving global health equity do not easily lend themselves to technical fixes contemplated by implementation science.[51] We recognise that plenty of motivated, compassionate practitioners are impatient to immediately do something useful with their skills. They try earnestly to avoid allowing the perfect be the enemy of the good. Part of our goal is to open up cognitive space for all of us to pause and ask harder questions about how we ought to define, rather than how we are defining, good *enough*.

We argue that academics involved in the discipline should be more cautious in trumpeting our lofty aspirations and more conscientious in recognising areas of moral and ethical inconsistency. In order to retain integrity, we need to be transparent with one another and our students about how authentic concern for social justice, health equity and human rights are consistently undermined by fealty to the structural status quo. Furthermore, if we do not push ourselves and our students to openly question and critique the dominant socioeconomic and institutional paradigms that influence our ways of thinking, we will find it increasingly difficult to either imagine or demand better modes of engagement. Passive acceptance of that which is convenient comes at a normative cost.

We also appreciate that incremental fixes often win out in the name of pragmatism, but we encourage colleagues to be forthright that these also reliably favour our own interests more than those we claim to be most concerned about. Coaxing and nudging the existent structures and systems for doing global health work may be all that we can expect of ourselves, but if so, less celebration of our scattershot, piecemeal accomplishments, and instead, greater moral humility is needed. The compromises we are making are disturbingly unbalanced, and there is little reason to believe the scales will shift without a substantive course correction by people like us.[8 27] Modesty about the limits of our commitment might go a long way to educating our students about the reality of global health work, and more importantly, shoring up our long-term ethical credibility with the human objects of our attention.

CONCLUSION

Our core objective for a course grounded in normative ethics is to agitate our learners, rather than mould them into the next generation of cheerleaders for a decent cause.[52] We believe that cynical abandonment of the global health project is not warranted, but neither is preying on any naive idealism that initially attracts many to the field. As we see it, the risk is that the entire enterprise devolves into a corporate endeavour, which can dangerously shade into a new form of colonialism—regardless of the rhetoric within which we package

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our activities.[4 8 38] There is also substantial risk that the current approach might never yield a structural tipping point or build a permanent normative bridge to the ideal of global solidarity. Students deserve our honesty about these estimations.

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REFERENCES

1. Citrin D, Mehanni S, Acharya B, *et al*. Power, potential, and pitfalls in global health academic partnerships: review and reflections on an approach in Nepal. *Glob Health Action* 2017;10:1367161.
2. Melby MK, Loh LC, Evert J, *et al*. Beyond medical “missions” to impact-driven short-term experiences in global health (STEGHs): ethical principles to optimize community benefit and learner experience. *Acad Med* 2016;91:633–8.
3. Kolars JC, Cahill K, Donkor P, *et al*. Perspective: partnering for medical education in sub-Saharan Africa: seeking the evidence for effective collaborations. *Acad Med* 2012;87:216–20.
4. Adams V, Behague D, Caduff C, *et al*. Re-imagining global health through social medicine. *Glob Public Health* 2019;14:1383–400.
5. Biehl J, Petryna A. *When people come first: critical studies in global health*. Princeton University Press: Princeton NJ, 2013.
6. Kim H, Novakovic U, Muntaner C, *et al*. A critical assessment of the ideological underpinnings of current practice in global health and their historical origins. *Glob Health Action* 2019;12:1651017.
7. Stuckler D, Basu S, McKee M. Global health philanthropy and institutional relationships: how should conflicts of interest be addressed? *PLoS Med* 2011;8:e1001020.
8. Gautier L, Sieleunou I, Kalolo A. Deconstructing the notion of "global health research partnerships" across Northern and African contexts. *BMC Med Ethics* 2018;19:49.
9. Taylor S. 'Global Health': meaning what? *BMJ Glob Health* 2018;3:e000843.
10. Crump JA, Sugarman J, Working Group on Ethics Guidelines for Global Health Training (WEIGHT). Ethics and best practice guidelines for training experiences in global health. *Am J Trop Med Hyg* 2010;83:1178–82.
11. Available: http://ethicsandglobalhealth.org/index.shtml
12. Hunter D, Dawson A. Is there a need for global health ethics? For and against. In: Brock G, Benatar S, eds. *Global health and global health ethics*. Cambridge: Cambridge University Press, 2011.
13. Adams LV, Wagner CM, Nutt CT, *et al*. The future of global health education: training for equity in global health. *BMC Med Educ* 2016;16:296.
14. Farmer PE, Rhatigan JJ. Embracing medical education's global mission. *Acad Med* 2016;91:1592–4.
15. Kasper J, Greene JA, Farmer PE, *et al*. All health is global health, all medicine is social medicine: integrating the social sciences into the preclinical curriculum. *Acad Med* 2016;91:628–32.
16. Fink S. Care differs for American and African with Ebola. *The New York Times* 2015.
17. Farmer P. *Pathologies of power*. Berkeley, CA: University of California Press, 2004.
18. Schrecker T. Interrogating scarcity: how to think about 'resource-scarce settings'. *Health Policy Plan* 2013;28:400–9.
19. Nozick RA. *State, and utopia*. New York, NY: Basic Books, 1974.
20. Rawls J. *A theory of justice*. Cambridge, MA: Harvard University Press, 1971.
21. Pogge T. *World poverty and human rights: cosmopolitan responsibilities and reforms*. Cambridge: Polity Press, 2008.
22. Gawande A. Is health care a right? *The New Yorker* 2017.
23. Wolff J. The human right to health. In: Brock G, Benatar S, eds. *Global health and global health ethics*. Cambridge: Cambridge University Press, 2011.
24. United Nations. Universal Declaration of Human Rights, 1948. Available: www.un.org/en/documents/udhr/
25. Available: https://www.state.gov/wp-content/uploads/2020/07/Draft-Report-of-the-Commission-on-Unalienable-Rights.pdf
26. Beitz C. *The idea of human rights*. Oxford University Press: Oxford, 2009.
27. Chomsky N. *The responsibility of intellectuals. The New York Review of Books*, 1967. (February 23).
28. Gert B, Gert J. The definition of morality. In Zalta E, ed. *The Stanford Encyclopedia of Philosophy*, 2017. Available: https://plato.stanford.edu/archives/fall2017/entries/morality-definition/>
29. Haidt J. *The righteous mind: why good people are divided by politics and religion*. New York: Pantheon Press, 2012.
30. Maslow AH. A theory of human motivation. *Psychol Rev* 1943;50:370–96.
31. Poverty GJ. Distance and two dimensions of ethics. In: Brock G, Benatar S, eds. *Global health and global health ethics*. Cambridge: Cambridge University Press, 2011.
32. Famine SP. Affluence, and morality. *Philosophy and Public Affairs* 1972;1:229–43.
33. Cohen GA. If you're an egalitarian, how come you're so rich. *J Ethics* 2000;4:1–26.
34. Brandt AM. How AIDS invented global health. *N Engl J Med* 2013;368:2149–52.
35. Kidder T. *Mountains beyond mountains: the quest of Dr. Paul Farmer, a man who would cure the world*. New York: Random House, 2003.
36. Ackerly DC, Udayakumar K, Taber R, *et al*. Perspective: global medicine: opportunities and challenges for academic health science systems. *Acad Med* 2011;86:1093–9.
37. Koplan JP, Bond TC, Merson MH, *et al*. Towards a common definition of global health. *Lancet* 2009;373:1993–5.
38. Benatar S, Upshur R. What is global health? In: Brock G, Benatar S, eds. *Global health and global health ethics*. Cambridge: Cambridge University Press, 2011.
39. Available: https://www.povertyactionlab.org
40. Ganz M, Kay T, Spicer J. Social enterprise is not social change. *Stanford Social Innovation Review* 2018;16:59–60.
41. Green T, Green H, Scandlyn J, *et al*. Perceptions of short-term medical volunteer work: a qualitative study in Guatemala. *Global Health* 2009;5:4.
42. Berry NS. Did we do good? NGOs, conflicts of interest and the evaluation of short-term medical missions in Sololá, Guatemala. *Soc Sci Med* 2014;120:344–51.
43. Sinnott-Armstrong W. Consequentialism. The Stanford Encyclopedia of Philosophy (Summer 2019 Edition). Available: https://plato.stanford.edu/archives/sum2019/entries/consequentialism/
44. Palazuelos D, Dhillon R. Addressing the “global health tax” and “wild cards”: practical challenges to building academic careers in global health. *Acad Med* 2016;91:30–5.
45. Hirschman A. *Exit, voice and loyalty*. Cambridge, MA: Harvard University Press, 1970.
46. Nozick R. *The examined life*. New York: Simon and Schuster, 1989.
47. Available: http://searchforhealth.ngo
48. Case A, Deaton A. America can afford a world-class health system. Why don't we have one? *The New York Times* 2020.
49. Marlowe A. Is Harvard whitewashing a Russian Oligarch's fortune? *The New York Times* 2018.
50. Birn A-E. Philanthrocapitalism, past and present: The Rockefeller Foundation, the Gates Foundation, and the setting(s) of the international/global health agenda. *Hypothesis* 2014;12:e8.
51. Ridde V. Need for more and better implementation science in global health. *BMJ Glob Health* 2016;1:e000115.
52. Panosian C, Coates TJ. The new medical “missionaries”—grooming the next generation of global health workers. *N Engl J Med* 2006;354:1771–3.

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