

**LETTER TO THE EDITOR**

**Response to “How Should Academic Medical Centers Administer Students’ ‘Domestic Global Health’ Experiences?” Ethics and Linguistics of “Domestic Global Health” Experience**

Em Rabelais, PhD, MBE, MS, MA, RN and Esmeralda Rosales, MD

Sural Shah’s “How Should Academic Medical Centers Administer Students’ ‘Domestic Global Health’ Experiences?” in this journal’s September 2019 issue draws parallels between global health experience and *domestic* global health experience. For—presumably—urban, student-run clinics, Shah presents guidelines and a sample curriculum using lessons learned from international global health experiences. We, the authors, care tremendously about the/our communities that live in the shadows of urban academic medical centers (AMCs) and therefore have a stake in how these/our communities are framed, discussed, and (mis)treated. Language choices are ethical choices. Our concerns, in the context of urban AMCs, are based on the linguistic and ethical problems of *global health* and *domestic global health* when referring to care for local, underresourced, marginalized, and oppressed communities.

Medical and other health professions students commonly seek **global health experiences** (GHEs). Which students seek these, and what are their motivations? Foremost, (primarily) white people from colonial powers are motivated by *white saviorism*: the self-serving assumption that they should be “saving” or taking care of the poor in Africa and other colonized locations.<sup>1,2,3</sup> White saviorism is a prominent feature of medical mission trips, domestic or international,<sup>4</sup> and has roots in **colonialism**.<sup>1,3</sup> GHEs are expensive and promoted as travel opportunities to international, exoticized locations in order to promote students’ understanding of culture or *Others’* cultures, given white people’s unstated denial of white culture(s). Understanding *the Other* (whiteness in action) derives from anthropology, and an early, well-known satire of otherizing is seen in Miner’s 1956 “Body Ritual Among the Nacirema,”<sup>5</sup> which shows just how dangerous the colonial gaze’s framing is. The colonial/white savior gaze is not dissimilar to contemporary medical voluntourism,<sup>6,7</sup> which deemphasizes sustainability and capacity building. Even if these missteps are avoided, how does understanding *the Other* in the global context prepare students to understand *the Other* in the United States?<sup>8</sup> If it is to understand culture or difference, then we’ve already failed our students by reinforcing the idea that *the Other* in the global context is a respectable *Other*, while the domestic *Other* lacks this respectability in terms of culture and difference.

What is it about local urban engagement that isn't as palatable as GHEs? Why is the exoticism of global health terminology needed to make the urban United States respectable? The answers' racism is consistent with colonialist white saviorism: *urban* becomes code for *black*, or at least *not white*. (Notably, urban bioethics focuses on density, diversity, and disparity,<sup>9,10,11</sup> and thereby promotes community-engaged approaches to care and research in order to foster trust.<sup>12,13,14</sup>) The health professions' collective histories of racism, class stigma, othering, knowledge valuation, and individualism exist today as oppressions expressed through **structures and policy** that are supported by whiteness and white supremacy.<sup>15,16,17,18,19</sup> When do any health professions students—or, more importantly, faculty—learn our histories and our contributing roles?

In AMCs, principlism is the predominant ethical framework, yet without acknowledging its history—namely, who it was made by and for—we clinicians are left thinking that principlism consists of our best approach to difficult situations. Principlism's enshrinement by a white moral philosopher and a white Christian theologian (Beauchamp and Childress) excludes literal centuries of contributions from black, indigenous, and other people of color (BIPOC) on what is considered (un)ethical or (im)moral in any medical context.<sup>20,21,22,23,24</sup> The primacy of *autonomy* embraces this country's white founding on individualism and dissociates any limitations, and thus *agency*, in "making a choice." Thus framed for ("domestic") GHEs, principlism shows its paternalism, imperialism, and colonialism.

We agree with Shah in the benefits of ethics training, although we have more questions: Does the ethics training include critical humanities and social science content taught by faculty comfortable with discussing and prepared to discuss critiques of traditional, normative (health) ethics? Do all involved have or gain competency in the structures impacting the community, be it domestic or abroad? Does this ethics training include—before, during, and after provision of care—ethics *about the ethics* of students giving care? How is the primacy of autonomy handled when, unethically, patients are not told that their care is incomplete or potentially inappropriate? Does the discussion go beyond "this is better than nothing"? Most importantly, are the ethics training and program structure created in conjunction with the community, such that the domestic GHEs' *intentions* can be actualized? If an AMC has an ongoing relationship with a community partner, is there mutually beneficial engagement, which is more than students practicing giving care and communities receiving (incomplete) care? Mutually respectful relationships are a core feature of community-engaged work. To be successful and in order to earn trust they require serious investment, on the community partner's terms, from the AMC partner with histories of power.

All patients at our AMCs, recent immigrants or not, are living within the structures and oppressions of whiteness and colonialism in the United States. The problems with domestic GHEs are not with the students or communities but the faculty. We who are faculty—and are not representative of our urban AMC neighbors—perpetuate the oppressions of whiteness through linguistic and ethical choices that devalue people living in the United States as an exoticized *Other* rather than accepting them, and many urban AMCs' BIPOC neighbors, as humans with valid needs and bodies. If our students are to benefit from student-run clinics, so must the communities. Finally, we suggest that Shah's approach to ethics and curricular administration for (domestic) GHEs needs reversal: we in the United States must work out the ethics around AMCs' student-run

clinics and sustainable community engagement *before* assuming we might have appropriately and equitably designed<sup>25</sup> approaches for use globally.<sup>14</sup>

## References

1. Cole T. The white-savior industrial complex. *Atlantic*. March 21, 2016. <https://www.theatlantic.com/international/archive/2012/03/the-white-savior-industrial-complex/254843/>. Accessed September 21, 2019
2. Nordmeyer K, Bedera N, Teig T. Ending white saviorism in study abroad. *Contexts*. 2016;15(4):78-79.
3. No White Saviors. No white saviors: decolonizing missions and development work. <https://nowhitesaviors.org>. Accessed September 22, 2019.
4. Sullivan N. International clinical volunteering in Tanzania: a postcolonial analysis of a global health business. *Glob Public Health*. 2018;13(3):310-324.
5. Miner H. Body ritual among the Nacirema. *Am Anthropol*. 1956;58(3):503-507.
6. Sullivan HR. Voluntourism. *AMA J Ethics*. 2019;21(9):E815-E822.
7. Bauer I. More harm than good? The questionable ethics of medical volunteering and international student placements. *Trop Dis Travel Med Vaccines*. 2017;3(1):5.
8. Wall A. The context of ethical problems in medical volunteer work. *HEC Forum*. 2011;23(2):79-90.
9. Jonsen AR. Social responsibilities of bioethics. *J Urban Health*. 2001;78(1):21-28.
10. Fleischman AR, Levin BW, Meekin SA. Bioethics in the urban context. *J Urban Health*. 2001;78(1):2-6.
11. Center for Urban Bioethics, Temple University. Educational programs: master of arts in urban bioethics (MAUB). <https://medicine.temple.edu/departments-centers/research-centers/center-bioethics-urban-health-and-policy/educational-programs>. Accessed September 21, 2019.
12. Meurer LN, Young SA, Meurer JR, Johnson SL, Gilbert IA, Diehr S. The Urban and Community Health Pathway: preparing socially responsive physicians through community-engaged learning. *Am J Prev Med*. 2011;41(4):S228-S236.
13. Alicea-Alvarez N, Reeves K, Lucas MS, et al. Impacting health disparities in urban communities: preparing future healthcare providers for "Neighborhood-Engaged Care" through a community engagement course intervention. *J Urban Health*. 2016;93(4):732-743.
14. Jones NL, Burger J, Hall A, Reeves KA. The intersection of urban and global health. *Pediatr Clin North Am*. 2019;66(3):561-573.
15. Anderson C. *White Rage: The Unspoken Truth of Our Racial Divide*. New York, NY: Bloomsbury; 2017.
16. Perron A, Rudge T. *On the Politics of Ignorance in Nursing and Healthcare: Knowing Ignorance*. London, UK: Routledge; 2016.
17. Bowleg L, Del Rio-Gonzalez AM, Holt SL, et al. Intersectional epistemologies of ignorance: how behavioral and social science research shapes what we know, think we know, and don't know about US black men's sexualities. *J Sex Res*. 2017;54(4-5):577-603.
18. Wear D, Zarconi J, Aultman JM, Chyatte MR, Kumagai AK. Remembering Freddie Gray: medical education for social justice. *Acad Med*. 2017;92(3):312-317.
19. Lorde A. *Sister Outsider: Essays and Speeches*. Trumansburg, NY: Crossing Press; 1984.
20. Tuck E, Yang KW. Decolonization is not a metaphor. *Decoloniz Indigeneity Educ Soc*. 2012;1(1):1-40.

21. Washington HA. *Medical Apartheid: The Dark History of Medical Experimentation on Black Americans From Colonial Times to the Present*. New York, NY: Doubleday; 2006.
22. Roberts D. *Fatal Invention: How Science, Politics, and Big Business Re-create Race in the Twenty-First Century*. New York, NY: New Press; 2011.
23. Crenshaw K. Mapping the margins: intersectionality, identity politics, and violence against women of color. *Stanford Law Rev.* 1991;43(6):1241-1299.
24. Taylor KY, ed. *How We Get Free: Black Feminism and the Combahee River Collective*. Chicago, IL: Haymarket Books; 2017.
25. Costanza-Chock S. Design justice: towards an intersectional feminist framework for design theory and practice. In: *Proceedings of the Design Research Society*. Published June 3, 2018.

**Em Rabelais, PhD, MBE, MA, MS, RN** is an academic health ethicist and assistant professor at the University of Illinois at Chicago College of Nursing. Their scholarly focus is on decentering whiteness in bioethics and health ethics and in the biomedical and health professions research, education, and practice. Dr Rabelais' scholarship and teaching establishes an inclusive and distinct ethics that prioritizes critical resistance and identity-focused narrative ethics approaches to purposefully center patient and student narrative voices as the definers of discriminations. In doing so, this ethics requires the initiation of dismantling the transmission of learned, enacted, and centered whiteness in these settings to recreate space, practice, and education as defined by those who are demanding the change.

**Esmeralda Rosales, MD** attended the University of Illinois at Chicago College of Medicine and will be joining Erie/Northwestern McGaw as a family medicine resident in July 2020. As a child, Esmeralda and her family emigrated from Mexico to the United States. Her family quickly learned the hardships that immigrant families face when trying to access basic health care. Inspired by her own family's struggle to afford medical care, she is committed to fighting for equal access to health care for everyone regardless of socioeconomic or immigration status. As a physician, her long-term goal is to become a family medicine physician that is at the forefront of providing treatment, education, and preventative medical services to underserved communities.

#### Citation

*AMA J Ethics.* 2020;22(5):E458-461.

#### DOI

10.1001/amajethics.2020.458.

#### Conflict of Interest Disclosure

The author(s) had no conflicts of interest to disclose.

*The viewpoints expressed in this article are those of the author(s) and do not necessarily reflect the views and policies of the AMA.*

Copyright 2020 American Medical Association. All rights reserved.  
ISSN 2376-6980