The Ethical Conundrum of International Health Electives in Medical Education

Robert Huish, Ph.D.
Assistant Professor, International Development Studies
Dalhousie University

ABSTRACT: This paper discusses the ethical challenges of global health education programs and, specifically, International Health Electives (IHEs). The growing popularity of IHEs in medical school has ballooned in recent years largely from students who genuinely want to serve in resource-poor areas of the global South, and also from those students who wish to use the field experience to build a superior CV. Medical schools have responded to the demand, but ethical considerations have not kept pace. In fact, the practice of many of these programs has brought about complex ethical concerns of individual hubris of Northern medical students, and of structural dependency from resource-poor to resource-flush settings. In light of these two concerns, IHEs largely require restructuring. This paper proposes that program changes need to focus on the very ethical issues that the current programs perpetuate. While many IHEs do offer some pre-departure training on ethics, pre-departure training can be trivial if it focuses largely on the behaviour of individuals working in resource poor settings. I propose that a complete reorientation of moral ethics pedagogy and a fresh introduction of social theory training are needed so that the IHE experience is aimed at overcoming current global health inequities at the structural level.

Introduction: Dave's Question

In 2010, a Canadian medical school stood to lose its accreditation from both the American Federation of Medical Colleges and the Canadian Federation of Medical Colleges. The administration held a series of town hall meetings to discuss curriculum changes necessary for achieving accreditation. I attended several of these town halls. On a Friday afternoon, an auditorium was filled with administrators, physicians, nurses, medical school instructors, social scientists, residents, and medical students. The program consisted of some inspirational keynote addresses, but it was mostly designed by the administrators to hear ideas about the curriculum from students and practitioners. At one point, the discussion focused on global health, which within medical institutions is largely understood as programs and rotations for health workers and students to travel abroad.[1]

---

[1] By no means is this the only understanding of global health. While medical practitioners often associate the term with programs designed for international travel and aid work, the concept should be recognized as a

The administration wanted to bolster the role of global health in the curriculum since, as of 2010, two out of every three North American medical graduates will have completed a global health elective. Often these programs, labelled International Health Electives (IHEs), run two to four weeks between April and September and afford Northern medical students the chance to visit and often practice in resource poor settings in the global South. As the conversation unfolded, more and more heads nodded up and down to acknowledge the competitive importance for the medical school to offer such programs. Then, a veteran student of such a program, let's call him Dave, took to the microphone in front of the 250 people in attendance.

Dave told us that he had visited a clinic in Tanzania the year before as part of a global health rotation. He described the scene of the peri-urban hospital as an overwhelming workspace where patients were lined up, nurses were overworked, medicines were outdated, and doctors were too few. Swamped primary care centres are the norm in East Africa. Some hospitals have the maternity wing and the morgue purposefully close together, as all too often a visit to the former results in a trip to the latter. The clinic could hardly handle the demand of incoming patients, let alone meet their primary care needs once admitted. Dave said that there is an ethical problem with this. "This clinic can barely function, and now it has to act as a teaching centre for wealthy and privileged medical students from Canada." This is a current ethical debate that many global health programs are addressing. But then Dave touched on a bigger ethical conundrum. He said something along these lines:

> In the middle of the bustle two guys brought in a woman severely dehydrated. She wasn't even conscious. I was in the ward wearing my white coat. The local nurses, overwhelmed, turned to me figuring that I had the appropriate knowledge and skills and they said, "fix her up with a saline drip." I found the saline and the needle, but when I got to the woman I didn't know what to do. Here is someone dying in front of me from something as basic as dehydration, and I have no idea how to properly insert the needle into her collapsed veins. There I was in Tanzania, where this happens all the time, and I had never learned how to act in this situation. The nurse had to quit attending to someone else, come over and complete the job that I couldn't do, which took her away from someone else's needs. I was no help to anyone in that moment.

Then Dave asked a question to the administrators.

> Right now, if you said that I would have a surprise exam in three days on any of the body's systems, I'll be able to get over 98% on it. I can do that because my medical education has made me very good at absorbing and memorizing information to pass exams on short notice in order to get high grades. Why is it that you have trained us in this way so we can pass any test, but we have absolutely no idea how to help a dying person in the most basic of circumstances?

Dave did not get a straight answer that afternoon. There was continued talk about maintaining best practices and a problem-based curriculum. But in this paper I would like to pick up the conversation that he started. Specifically, I seek to critically explore the end goal of IHEs. Are

broader discipline involving the social and environmental determinants of health that lead to systemic global health inequities. See the Global Health Watch reports published in conjunction with People's Health Movement, 2006 2009 and 2011, Medact, and Global Equity Gauge Alliance.

these programs ultimately designed to afford Northern medical students a unique experience? And what are the implications of such experiences to doctors-in-training in relation to expectations of their performance as medical "experts"? Or, can there be space within these programs to better meet the health care needs of individuals in marginalized communities? Dave's story suggests that local partner needs may come in dead last. It also suggests that there may be a problem between the perceived role of the medical student and their actual capabilities within these programs. Is the intention to cater to the needs of affluent Northerners? Or is it really about achieving the long-term needs of Southern patients? This is problematic in reinforcing consumption and adventure travel patterns that reinforce the equity gap between the haves and the have-nots.

I begin by presenting a glimpse of the current state of IHEs and what I refer to as the two *obvious* ethical dilemmas: a) how students act in severely resource poor clinical settings and b) cultural sensitivity to local workers and patients. These are not necessarily sophisticated ethical conundrums, yet the majority of writing on ethics in global health focuses on these problems. I then discuss two complex ethical challenges that arise from the current normative practices of global health electives. The first is that, without proper ethical mentorship, "medical hubris" is likely to be nurtured within medical students (Horrobin, 1980). Medical education has long been criticised for developing "the hidden curriculum," whereby students develop bedside manner not from textbooks, but from modelling the actions, manners, and opinions of esteemed mentors (Hafferty, 1998). IHEs can feed hubris through poor mentorship and the expectation that the medical student's knowledge, as novice as it may be, is ultimately a force of good for the poor. However, the saviour attitude by medical students may do more to put marginalized patients at risk, and to encourage poor clinics to rely on foreign skills rather than building capacity for experienced residents and clinicians. The second ethical challenge is that IHEs can create dependence of resource poor clinics on the medical students who rotate in with dollars and supplies but without capacity for long-term sustainability. Such dependence can create feedback cycles of resentment and cross-cultural breakdowns between local partners and programs in the global North, and ultimately reinforce notions of hubris in the North by assuming that the Southern program may not have what it takes to keep up with the pace of medical progress. I finish the paper by suggesting that while there may be no immediate solutions to the ethical problems of IHEs at the structural level, the programs should not necessarily be abandoned. Rather, there should be a conscious effort to focus the curriculum around the complex ethical conundrums themselves, beyond individual behaviour in the clinic, so that students, mentors, and communities become active agents in finding solutions. This paper suggests that a deeper inclusion of development studies literature and ethical edification, beginning with some of the work by Emanuel Lévinas (1995), would help to improve IHEs towards a state of mutual cooperation between the desires of health practitioners in the North and the needs of marginalized clinics in the South.

Global health curricula have made important efforts to provide ethical training for medical students, often in the form of peripheral pre-departure training. But seminars, presentations, and handouts on the obvious ethical challenges do not go far enough. What is needed is a deeper commitment to include the complex ethical challenges that both problematize the place of medical students in resource-poor clinics and create structural dependency of Southern health systems on Northern aid. These structural issues need to be addressed as part of the experiential curriculum rather than as a pre-departure training session that is separate from the main experience. The question is: how can IHEs offer students international experience in a way that works to address structural inequities and complex ethical challenges?

The State of International Health Electives

At a time when there has never been more time, money, and resources dedicated to global health, the inequities have never been worse. Life expectancy in Japan is almost twice that of Afghanistan (World Health Organization [WHO], 2009). There is 1 physician for every 222 people in Italy, but not even 1 physician for every 50,000 people in Malawi (WHO, 2009). In countries like Sierra Leone, Central African Republic, and Afghanistan, one mother dies in childbirth for every 50 – 60 live births (WHO, 2009). But in 2006, not a single woman died from childbirth in Iceland (WHO, 2006). Health statistics like these abound, and they signal an urgent demand for increased resources for quality care on a global scale. The nature of these problems goes beyond increasing aid (Moyo, 2009; People's Health Movement, et al., 2005). Reorganization of the normative behaviour of medical systems, practitioners, and health system governance is needed to find better routes to health equity (Pogge, 2002). It would seem that health practitioners should be at the forefront of this movement, and IHEs could be fitting forums to facilitate innovative solutions to the enormous problem of global health inequity. In some cases, practitioners do bear witness and speak out against inequitable structures that systematically deny health care to the poor and marginalized (Farmer, 1999, 2004a; Furin et al., 2006). Unfortunately, many IHEs do not wrestle with the structures of inequity. Occasionally, programs peripherally recognize the role of international financial organizations, globalization, and neoliberal austerity measures in limiting care (Shaffer & Brenner, 2007). But, in other cases, the programs themselves play a role in weakening the capacity of resource-poor health systems by deferring scarce resources away from local patients and students and towards the immediate pedagogical demands of Northern students. In their current practice, it is unlikely that IHEs will do much to undo "historically-rooted global health inequities" (Hanson, Harms, & Plamondon 2011, p. 171).

IHEs, sometimes offhandedly referred to as "medical tourism", have grown enormously in popularity in the last decade.[2] The Association of Faculties of Medicine of Canada found that over 30% of medical school graduates have international experience through a North American IHE (Anderson & Bocking, 2008). Students are often expected to pay thousands of dollars above their regular tuition fees in order to participate in such electives.   Some schools have taken to fundraising drives to support these electives (Chin-Quee et al., 2011). This does not include the numerous international volunteer opportunities with health-focused NGOs. Hanson et al. (2011) argue that the popularity of global health electives is a response to student demand for international experience. As a result, the pressure to meet immediate demand may overlook critical ethical reflection (Shah & Parmar, 2011). Shah & Parmar also note that the underlying motivation to participate in a medical elective is often tied to personal reasons far removed from bridging health inequities between the global North and the global South. These include:

> …altruism, self-serving rationale (e.g. language development, curiosity, adventure, meeting population health needs of Highly Indebted Countries (HICs), and the allure of the opportunity for medical practice outside the scope medical students would experience in their own settings. (Hanson et al., 2011, p. 176)

---

[2] A note of caution with the term "medical tourism." Popularly the term is understood as the process of patients in one country travelling abroad to seek medical care in another. However, within medical schools the term "medical tourism" is used colloquially to refer to the internships and rotations to the global South. For more on the internal divisions and approaches to IHEs, including the use of terminology see Parsi, Kayhan & List (2008).

For some, the experience can be little more than adventure tourism. When attending a "debriefing session" for students returning from an IHE, I noted that several of them included safari slides saying that having the chance to see the Serengeti was an important driver. "I just always wanted to go to Africa," one student said.

While the growing interest in IHEs could be a welcomed opportunity to engage in global health inequity, the manner in which programs generally operate brings about serious ethical challenges in experiential learning's deep impacts on the quality and resilience of health care systems abroad (Shah & Parmar, 2011). Bauer & Saunders (2009) show that the interest to participate in global health electives includes post-graduate residents and faculty. McKinley at al. (2008) advocate that IHEs can increase the likelihood of students seeking careers in primary care or service for the poor. However, the relationship between IHEs and community-oriented service may have more to do with the student's broader interests of wanting to serve, rather than it being a direct outcome of the IHE program. As Battat et al. (2010) suggest, there is a growing sense that physicians need to have knowledge of global health issues, but no set guidelines exist to suggest what should count as global health education. From a review of 32 programs, Battat et al. found that global health education competencies often involved an understanding of "the global burden of disease, travel medicine, healthcare disparities between countries, immigrant health, primary care within diverse cultural settings and skills to better interface with different populations, cultures and healthcare systems" (Battat et al., 2010, p. 1472). However, no competencies or methods were identified as universal, as some programs were more structured around in-class didactic teaching about health system structuring, while others weighed heavy on experiential clinical practice. In Germany, Bozorgmehr and others found that basic practical preparation, let alone ethical preparation for medical students traveling abroad was "appallingly low" (Bozorgmehr et al., 2010).

The standards for global health training and competencies are far from standardized, which suggests global health is valued less than other subjects in medical education. Medical curricula is rigorously developed and standardized by licensing bodies, medical schools, and experts at multiple levels. It seems unorthodox that international medical rotations are largely unregulated and are not standardized. While the competencies that come out of IHE programs may be left up to debate, a universal focus on ethics is much needed (Pinto & Upshur, 2009). In 2008, only 6 of 18 Canadian medical schools had mandatory pre-departure training for IHEs. The rest had either student-run sessions or nothing at all (Canadian Federation of Medical Students, 2009). The Association of Faculties of Medicine of Canada (AFMC) has since released a "Global Health Essential Core Competencies" guideline for all IHE programs to follow (AFMC Resource Group, 2010). They advocate, "all medical graduates should understand the major factors that influence the health of individuals and populations worldwide." This involves building knowledge in the global burden of disease, social and economic determinants of health, travel and migration health issues, globalization of health and health care, health care as a human right, and health care in low-resource settings (AFMC Resource Group, 2010).

All of these issues are essential topics of study for social science and policy experts. In reviewing the current guidelines and expectations by the AFMC, it is clear that the goal is for global health students to build understanding about what problems exist more so than understanding why such problems exist, and certainly there are expectations to seek solutions to these structured problems. Finding solutions or innovative policy responses to entrenched health

care inequity could not emerge from a three week clinical rotation and a few accompanying seminars. International development students and post-graduates dedicate years of scholarship to understanding the socially complex nature of inequity. Moreover, there is a risk that, with a shallow appreciation of structured inequity, IHEs may reduce the ability for students to measure inequities in the North as worthy of moral attention. If students witness the severely strained conditions in Malawi, then practitioners may be less willing to advocate for equity issues that patients face on the frontlines of service provisions in the North because the system is comparatively ahead of the poor nation.

If global health is to encompass processes of globalization and socio-economic determinants of health, then practitioners must be afforded both a broader program of study to address themes of inequity, and a greater depth of exploration in social justice, and human rights. Global health practitioners deserve a specialized stream that closely mirrors the curriculum of International Development Studies programs. If the goal is to have practitioners act as agents of change for global health inequity, then it may be worth considering the importance of having medical students enter the program with an entire undergraduate degree in International Development Studies, Geography, Political Economy, Sociology, or Anthropology. Biomedical specialties in medicine require four years of preparation in biosciences and mathematics. If global health inequity is to be treated on the same moral standard as other medical specializations, then programs should expect students to bear the same level of deep understanding to the discipline.

Addressing the complex ethical issues of structured inequity in global health requires ethical reflection on the part of practitioners and mentors. If global health is to work towards the relief of unnecessary inequity and suffering, then there must be adequate space designated for reflection on moral ethics of inequity. Caldicott (2011) suggests that moral ethics lie in the contextual situation rather than just within an individual's behaviour. She implies that:

> What constitutes moral behaviour in medical practice, however, is more than simply knowing how to make a 'good' decision. Moral behaviour can be conceptualized as the result of four independent components or capacities that develop across the life span: moral sensitivity; reasoning and judgment; motivation and commitment, and implementation. (Caldicott, 2011, p. 658)

How, then, without extensive education in social justice, dependency theory, international development practice, practices of local and global health funding, and the impacts of neoliberal globalization, can students or practitioners position their moral sensitivity against the broader dimensions of inequity? IHEs do not, in their current state, afford deeper education into underlying social determinants so that practitioners could readily negotiate the broad dimensions of situations in resource poor settings. They may do well to explain what inequity looks like, and what resources are missing, and what challenges there are within a clinical setting, but they fall short of explaining how any of these scenarios comes about, let alone how to make much-needed structural changes. Caldicott tacitly acknowledges this as she explains that the moral choices that students make in IHEs often come down to how they behave within the structures of the clinic. A student who cannot help a patient, either due to a lack of knowledge or resources, now has to make a difficult moral decision on how to act. For students in this situation, who are without any immediate means to enact structural changes that will relieve suffering, their best choice is simply to bear witness (Caldicott, 2011, p. 660).

But, bearing witness may not be enough to contribute to action on systemic inequity. Students are by no means unaware of the broad range of ethical challenges that face IHEs. Elit et al. (2011) interviewed a series of returnees to elicit what they perceived to be the major ethical challenges faced in the field. They found five broad issues:

      i.   Uncertainty about how best to help;

      ii.   Perceptions of Western medical students as different;

      iii.   Moving beyond one's scope of practice;

      iv.   Navigating different cultures of medicine;

      v.   Unilateral capacity building.

The first four themes mostly relate to the normative ethics of an individual within the context. Point (v), however, speaks to broader structural issues that involved improved capacity building both within the North and within the South. As Elit and others suggest, it would be enormously beneficial for students to receive in-depth ethical training on these issues well before departure.

The ability to provide in depth training for deep ethical issues at the structural level remains limited. Crump & Sugarman's (2010) study suggests that only very limited data exists about the guidelines of IHEs, and that broader development of ethical guidelines is needed at the institutional level. The Canadian Federation of Medical Students suggests five criteria to be included in any pre-departure training:

      i.   Personal Health: Canadian medical schools should ensure that medical students participating in electives in low-resource settings are adequately prepared to maintain their personal health.

      ii.   Travel Safety: Canadian medical schools should ensure that students participating in electives in low-resource settings are adequately prepared for safe and responsible travel practices.

      iii.   Cultural Competency: Canadian medical schools should ensure that students understand that cultural competency and gender sensitivity are pivotal in creating an environment of professionalism and respect while participating in electives in low-resource locations.

      iv.   Language Competencies: Canadian medical schools should ensure that students communicate their language abilities to elective supervisors and build specific medical communication skills to facilitate meaningful and respectful interactions.

      v.   Ethical Considerations: Canadian medical schools should ensure that students are aware of the ethical dimensions of studying and working in low-resource environments and follow recognized standards of professional and ethical behaviour while on any elective. (CFMS, 2009)

Evidently these criteria have more to do about discussing the normative behaviour of individuals rather than getting into the complex ethical issues at the structural level. Criteria (i) through (iv) are all about the medical student's needs in the field and largely remain in the realm of obvious, albeit practical, ethics of individual behaviour. Language training rarely factors into pre-departure training. This is certainly important for addressing issues of practical travel needs. Indeed it would be a dangerous mistake to let students assume that their knowledge and experience in Northern health care systems will immediately transfer to positive benefits in the South. Point (v) is a direct attempt to deal with ethics, but it remains limited to practices in the clinic rather than ethical issues at a broader structural level. This is also reflected in the pre-departure material provided by the Global Health Education Consortium and the British Medical Journal. In some learning modules the complex ethical issues are mentioned, but mostly in the form of brief presentations or short seminars rather than through deep philosophical exploration. In the training modules, globalization is portrayed as a general economic phenomenon that has created inequities, but it is not attributed to critical dialogues that attribute these inequities to power-relations working to systematically favour the affluent.

Global health pre-departure learning modules are becoming increasingly standardized for IHEs. Pre-departure is now more structured thanks to input from the Global Health Education Consortium, and The Working Group on Ethics Guidelines for Global Health Training (WEIGHT) (Crump & Sugarman, 2010). While this is a positive step forward, the modules remain largely focused on obvious issues of cultural sensitivity, travel practicalities, and behaviour in a foreign clinic. Global health practitioners and scholars should not be content with this level or approach to global health education. Often the advice given in pre-departure sessions remains peripheral from the actual international experience. Pre-departure training offers reminders and guides on how one should behave rather than actually exploring the ethical challenges in a way that exposes structures of power, hierarchy, and inequity. Because current programs and learning modules are almost entirely focused on the ethics of the student's needs and behaviour, two complex ethical challenges remain at large: Hubris and Dependency.

The First Complex Ethical Challenge: Hubris

The hidden curriculum, the unofficial education of physician norms, ethics and behaviour, has been a concern of study for quite some time (Hafferty, 1998). Considered an informal culture of allopathic medical education, the hidden curriculum extends well beyond poor bedside manner to actually encouraging students towards specializations and positions that are especially lucrative, while tacitly demeaning specialization in family practice, rural service, or care for the poor and marginalized (Borgstrom, Cohn, & Barclay, 2010; Ross, Williams, Doran, & Lypson, 2010). Some have suggested that the hidden curriculum can be overcome through improved mentorship and secondary reflection activities (Gaufberg et al., 2010).

Even though Somers et al. (2011) see a global health elective as an enabler for students to choose rural service, the role of the hidden curriculum in global health electives remains a concern. As mentioned earlier in the paper, the demand for global health electives is increasing and for as many career-driven reasons as altruistic ones (Shah & Parmar, 2011). In some cases, residency programs insist that students have had health experience abroad, which is ironic considering how many residency programs exclude foreign-trained students who have enormous international experience (Desbiens & Vidaillet, 2010). The result is that global health programs are in demand

by those students who want the best possible CV in order to get into highly-competitive elite residency positions that will likely lead to lucrative urban-centric practice. While IHEs are seen as enablers for a hot CV, there still exist students who truly want to offer service in under-served areas. The difference is that the students seeking IHEs for altruistic reasons likely embrace such intentions before the program. Likewise, an elite-residency seeking student would consider an IHE useful for his or her purposes. In either case, it is unlikely that the program itself creates a massive shift in the student's predisposed desire to practice.

Hidden-curriculum hubris of elite-seeking medical practice creates two ethical dilemmas for students on international electives. First, if students have chosen the international elective in order to improve their chances for elite residency and then for a desired lucrative specialty in a wealthy area, they will not be as well positioned to tie their career ambitions to the long-term needs of the poor. Some may feel that the experience in a marginalized clinic is too detached from their career goals, and they may be less likely to understand how the challenges of resource deficiency abroad would fit into their chosen career path. One resident who returned from an IHE to Africa said, "Sure it was interesting, but the clinic did not even have a working X-ray. How does that teach me anything when I start working in Vancouver or Toronto? The conditions are too detached from one another."

The second problem emerges when there is a lack of pre-departure mentorship and insight to the nature of structural deficiencies in the field. Many students who engage in international development work, not just in medicine, experience the "I can save the world" mentality. There are grand images held by North American medical students that they can save poor and disenfranchised Africans with little more than their novice medical knowledge. There are expectations that their knowledge, the medicines, and equipment that they are bringing with them will have undoubtedly deep impacts for individuals and communities at large. In fact, outdated medicines, used technology, and temporary rotations in a clinic undercut long-term capacity building efforts, and may do little to trickle out into broader socio-economic development processes at the community level. Medicines can be in short supply, equipment breaks and costs a fortune to repair, and the constant cycling of international health workers to local clinics ensures that local health workers dedicate hours to training and orienting new arrivals rather than building local capacity for local needs. Likely, the "I can save the world" syndrome will be quickly stripped after a few days of clinical work in a resource-poor setting, as Dave's story shows. But then comes the personal moral test of validating one's experience in the field when not all was saved. Self-reflection may revolve around justifying good intentions in a position that affords little agency for change. Towards the end of rotations, both the altruistic and elite-driven students may be left distraught by the state of low-resource settings, and will begin to question why they could not do more. This sentiment can build to the resentment of the local partners for not being well organized or fully resourced in order to keep up with demands. Students may not interpret the lack of resources as a consequence of broader structural processes. Without space for ethical reflection it is likely that returning students would focus on contesting or justifying the experience rather than seeking more complex moral analysis as to what the program, the clinic, local health governors, and the international community could do to overcome obvious and unnecessary inequity.

In October 2010, I attended a small debriefing session by a group of students returning from sub-Saharan Africa who gave short presentations on their experiences. One student acknowledged the severity of resource shortfalls that involved reusing needles and sanitizing disposable gloves.

The students acknowledged the challenges, and gave pre-departure students advice on what to bring for their own personal medical kits. They recommended including Tylenol and Imodium, scissors, and scrubs. By the end of their presentation, after showing safari slides and photos with local children, one student said, "Sure there are ethical problems here with rich students coming into poor places, but in the end we were present, we did all that we could, and if we weren't there that would have been one less person present to help." In this case, the moral message from this presentation was focused at individual students to say that the situation is bad, but out of my hands. My intentions for going are noble and therefore justified.

The response in the global health literature to the problem of overlooking the root causes of structural deficiencies, let alone for taking action to challenge them, is improved mentorship (Shah et al., 2011). Certainly this would be an important step; however, without careful planning to approach the ethical challenges through deep and reflective study, ethics training will likely remain focused on the obvious ethical conundrums of individual ethical behaviour in the clinic. Of the schools that currently offer pre-departure training, the sessions vary between 30 minutes and 30 hours. The Global Health Program of the Canadian Federation of Medical Students sees the value of global health training in order for medical students "to grow as global citizens at the local, national and international levels" (2009, p. 29). Students at the University of Michigan developed a pre-departure handbook aimed at encouraging global citizenship through cultural competency, a desire to increase global awareness, and participation in activities aimed at alleviating disease and poverty (Bush et al., 2010). The guidelines from the Global Health Unit of the American Federation of Medical Colleges outline that global health education is usually rewarding, but there is the risk that students are placed in potentially harmful situations and medical schools could be liable (Anderson & Bocking, 2008). In all of these standardized pre-departure guides, the emphasis remains on the medical students themselves so that they can act as global citizens. Little is mentioned in these programs about seeking positive transformative action at the community level in resource-poor settings.

The Global Health Education Consortium (GHEC) reviewed several introductory textbooks for global health in an attempt to help normalize national-level curriculum. The tendency among reviewers was to support the texts that covered medical and disease-related topics over the textbooks that discussed social science themes related to International Development Studies and Political Economy (Nathanson & Hall, 2010). GHEC provides numerous online learning modules for pre-departure training. Topics are quite broad and they do make an effort to address the complex ethical challenges. Categories of free on-line presentations include (numbers indicate quantity):

- Global Health: Priorities, Problems, Programs, Policies (12)
- Health Systems, Services, Resources, Programs (22)
- Infectious, Parasitic, and Communicable Diseases (19)
- Methods, Tools, Skills, and Related (2)
- Módulos en Español (12)
- Non-Communicable Disease, Injuries, and Related (16)
- Priority and Vulnerable Populations (7)
- Working and Visiting Low Resource Countries (6)
  (GHEC, 2011)

Many of these modules are extensive and very informative. With 83 separate modules, it would be difficult for a student or a practitioner to navigate and retain all of their information in a short time span. "Global Health: Priorities, Problems, Programs, Policies" contains enough material for a full semester course. Of the many modules that could be explored, likely pre-departure students will focus on "Working and Visiting Low Resource Countries". There they will find modules by Wayne Hall and others that discuss topics that have such learning outcomes as:

> Self-understanding of tolerance levels; new skills knowledge and language; academic credit; satisfaction that you can perform in exotic settings; finding direction for future learning; developing and experience level for further opportunities (GHEC, 2011)

The modules discuss even more basic, albeit patronizing, issues such as how to arrive at the airport and make connections, and even advice to "use seatbelts if available" when travelling on the road. The majority of this section on working in resource-poor settings is about the student's own enjoyment and safety, rather than discussion of the broader socio-economic structures that shape those settings. Regrettably, a lot of the information is simple travel advice that could be gleaned out of any travel guide.

It seems unfortunate that among the many materials available, so precious little space is dedicated to global health mentorship and pre-departure training that the modules aimed most specifically at first time travellers offer pedestrian travel advice and little deep ethical training. It is even more unfortunate considering that Dharamsi et al. (2010) suggest that social justice-oriented approaches to service learning with critical reflection provide potentially viable pedagogical approaches for learning the health advocate role. Their study shows preliminary evidence that IHEs, with the appropriate reflection and study, could lead to heightened health advocacy for social justice. To squander this learning space on technical advice and individual needs is in many ways a lost opportunity for more ethical global health education.

The Second Complex Ethical Challenge: Creating Dependency

In the GHEC learning modules, Kevin Chan (2010) provides an overview of global health and development. Chan's excellent presentation focuses on the association of trade regulation to public health cuts. Certainly the topics brought up in Chan's presentation are valuable for any would-be advocate of global health equity. Still, explaining what causes inequity may not necessarily explain what creates long-term dependency. Aid, especially health aid, is assumed to provide relief to suffering. But the nature of aid matters enormously in creating or relieving patterns of dependency. Many models of aid are dependent upon a steady stream of input from the global North to carefully plotted areas in the global South and can be costly, limited in its impact, and at times intermittent.[3] If aid is structured closer to the auspices of solidarity and multi-lateral capacity building, then there is potential for the creation of local autonomy and self-reliance over the long term. While it is

---

[3] Narrow-scope interventions that promote disease-specific interventions are highly problematic in this regard. Initiatives aimed at HIV treatment may bring in millions of dollars worth of medicine to a region, but in doing so overlook broader elements of care that are needed for therapy, pain management, and rehabilitation. Such projects may also recruit local health workers into the disease-specific program by drawing them out of primary care services. Rarely do such interventions manage to support broader primary care or holistic care initiatives, and this ultimately weakens primary care quality at the local level. Please see Global Health Watch 2 (2009).

important to understand the origins of inequity, as Chan points out, it is equally important to understand the ethical implications of the response that come from the North.

Medical programs that offer IHEs need to address how they position themselves in addressing global health inequity. While the optics of continuous IHE programs for resource poor countries may appear beneficial by simply bringing knowledge and resources to the resource poor, there may be devastating consequences. Sending medical students, professors, medicine, and equipment to resource-poor settings can give the appearance of aid and concern for the poor. But, because IHEs are primarily learning environments organized for the benefit of the Northern medical students, many clinics become organized around the needs and capabilities of the IHE programs. Clinics will rely on IHEs for donated medicines, second-hand equipment and monetary donations. The risk is that donations can be intermittent, and they may not always meet immediate demands. Without contingency plans to ensure quality and access, local health workers are placed in a situation where they must decide how the allocation of services is carried out, by either dedicating mentorship time to IHE students or by dedicating time to patient care. This places local health workers in a difficult position of having to either provide care for those in need, or dedicate resources to the needs of students.

The bigger challenge is having a steady stream of medical students and professors/mentors come to the clinic. If clinics and hospitals in resource-poor settings come to rely on Northern educational rotations through their clinic, then there is less space for training locals as long-term health workers and less support for that space. If funds and resources go towards training health workers from the North, local public health authorities can lean on their presence to offset the need to train and hire locals, even though the knowledge of Northern medical students may be far below the skill set of local health workers. This is part and parcel of a general misrepresentation that in resource-poor clinics the Northern workers bear expertise that supersedes local allopathic medical knowledge. Finally, the presence of foreign workers and partnerships can be seen as potential allies for locals to seek migration to the North, which would exacerbate the already devastating "migration pipeline" (Aluwihare, 2005; Astor et al., 2005; Marchal & Kegels, 2003; Ray, Lowell, & Spencer, 2006).

Medical programs that offer IHEs need to address this dependency imbalance. More often than not, rotations in low-resource countries take place in areas with perilous doctor to patient ratios and high levels of basic and preventable disease. As much as these sites are being used for Northern medical students' capacity building, Northern medical programs need to negotiate assistance to marginalized clinics to bolster sustainable capacity. IHEs should take on the responsibility for assisting resource-poor clinics in building capacity through programs aimed specifically at training local health workers alongside, or in lieu of Northern students. The moral precedent should be one of cooperation so that resource-poor communities can increase capacity to better manage and bolster their quality of care.

A Potential Solution: Make Ethics the Curriculum

Despite the pervasiveness of the two complex ethical challenges on top of the obvious challenges, there are some efforts to take on a deeper exploration of ethics that get to the structural organization of inequity. Programs that offer reflections on ethics are taking a positive first step (Leppa & Terry, 2004).   But programs that are specifically designed to address structural

deficiencies would be better suited to adhere to local needs. Projects by Partners in Health largely reflect an ethos to overcome health inequity at a structural level by training locals and building infrastructure and educational capacity at the local level. The programs also make a dedicated effort to speak out against unnecessary suffering caused by poor and discriminatory health regulations at the national and international levels (Farmer, 2004b; Farmer & Garrett, 2007; Furin et al., 2006). Addressing the origins of inequities at structural levels is what matters the most for working towards global health equity (Shankar, 2010). A similar program operates in Jamkhed, Maharashtra, India. The goal of the project is to bring Northern students to a rural part of India to learn about the structural deficiencies. Northern students spend time in lectures and studying health policy in India rather than solely practicing in the clinic.

Projects like the Partners in Health clinics in Haiti and Rwanda are good examples of ethical global health cooperation; other medical institutions would do well to embrace the ethical focus of these programs in putting the needs and capacity of locals ahead of experiential interests of Northern students. This paper has pointed out many of the ethical troubles associated with IHEs. A simple solution to overcoming the ethical problems of IHEs would be to shut them down. But this is a ham-fisted solution that ignores a genuine concern of students and practitioners to contribute to health needs in resource-poor settings. I suggest that IHEs and global health education require reorganization so that ethics are not just served up as peripheral pre-departure pamphlets, but so that the programs themselves are structured to focus entirely on the complex ethical questions of hubris and dependency within current global health practice.

Programs would begin by illuminating the complex ethical problems, and would engage in International Development Studies, Political Economy, Geography, Anthropology and History literatures. Topics would certainly include dependency theory, colonialism, neo-colonialism, neoliberal globalization, cultural racism, and hegemony. Curricula would also require a focus on moral ethics, perhaps beginning with the work of Emanuel Lévinas, in order to discuss the real importance of making the effort to travel, meet, and engage with people face to face (Lévinas, Arno, & Collège international de philosophie 1995; Lévinas & Šerpytyte, 2009; Saint-Cheron & Lévinas, 2010). Lévinas wrote about the complexity of making contact with another person, regardless of cross-cultural settings, and how as individuals we could never really "know" each other, but through face-to-face contact we could learn to "respect" one another. It is an important understanding of human relations that explores philosophy, not necessarily to find absolute reason, but to be knowledgeable about the meanings of emotions, morals, and norms between people. This line of study could be an incredibly important process to overcoming hubris and moving more towards building relationships of solidarity between people, regardless of the setting being a medical one let alone resource-poor to resource-flush encounter. From developing an understanding of each other it is possible to move discussions and outcome desires more towards values of equity, solidarity, and social justice that aim to overcome processes of colonialism and hegemony.

But ethics training alone will not alleviate immediate suffering. If there is an ethical relationship to work with, then, if notions of cooperation and solidarity can come forth, there is room to develop clinical education sensitive to local needs and resources. Health workers in resource-poor settings require a specific set of skills to carry out appropriate diagnosis, prognosis, and treatment. If a patient requires an X-ray, a broken machine or the high cost of a service does not relieve the attending physician of his or her responsibility. The physician must find solutions

for the patient's needs. Curricula like this exist. David Werner, Carol Thuman, and Jane Maxwell's (1992) book, *Where There is No Doctor*, sets out to train even semi-literate peasants in the basics of health. Curricula in Cuban medical schools are set up to train persons from marginalized countries for service in poor regions; classes there specifically address questions of how to negotiate resource-poor structures (Huish, 2009).

Such a curriculum could develop field placements and programs that aim to address two questions:

      i.   How can health care be practiced in an equitable, sustainable, and empowering manner so that patients are not just free of disease, but so they can enjoy total fulfillment of health and human capabilities?

     ii.   How can medical students and professionals cross borders to create mutual solidarity and understanding that addresses the ethical, resource, and capacity challenges of each system?

It would be naïve to assume that such in-depth analysis could be adequately covered in a pre-departure seminar format. This level of study would require an entire undergraduate or pre-medical school certification. If students are to become practitioners of global health, and if it is possible to value advocacy for social justice and equity as a moral good, then global health practitioners need to possess skill sets that:

      i.   are appropriate for relieving suffering in resource-poor settings,

     ii.   maintain moral values to pursue health equity at the local and the international level.

If global health is to be taken seriously as a medical discipline, then valuable and necessary training in structural inequities and global health ethics is required. If other specializations require years of training in the specific details of organic chemistry and calculus, then by all rights a topic as ethically complex as global health requires similar grounding in social theory, philosophy, and ethics. In doing so, it may be possible to realize new avenues of global health practice that grow closer to notions of cooperation and solidarity and farther from hubris and dependency.

Concluding Thoughts

For too long social sciences and biomedical sciences have stood off against each other. Often pure sciences dismiss social science contributions as irrelevant. If ever there was a crucially important moment for ethics, social theory, and biomedicine to unite, this is it. Global health inequity is ultimately a socially constructed, anthropocentric phenomenon. Medical interventions can do wonders to relieve suffering and to improve the quality of life, but without the understanding of and the passion to seek change, medicine will continue to treat the symptoms of suffering rather than work towards overcoming global health inequity.

I see current global health education programs falling short of deep ethical exploration that could lead towards a better understanding of global health equity. Medical programs need to reposition the nature of these programs so that the experience is not entirely focused on the student,

and so that the experience specifically addresses global health ethics of inequity. Pre-departure training and peripheral preparation may provide some pedestrian ethics, but in order to properly address the ethical conundrums at a systems level, medical programs need to embrace social theory deep into their core. Doing so will allow for greater advocacy by practitioners for health regulation that leads closer to global health equity. And, of course, it would satisfy Dave's request, as noted in the introduction of this paper, to have a medical education that is appropriate for those who genuinely want to serve the poor.

References

Aluwihare, A.P.R. (2005). Physician migration: donor country impact. *Journal of Continuing Education in the Health Professions*, *25*, 15 - 21.

Anderson, K., & Bocking, N. (2008). Preparing medical students for electives in low-resources settings: A template for national guidelines for pre-departure training. Retrieved from http://www.cfms.org/pictures/file/Global%20Health/Pre-Departure%20Guidelines%20Final.pdf

Association of Faculties of Medicine of Canada Resource Group. (2010). Global health core competencies. Retrieved from http://globalhealtheducation.org/resources_OLD/Documents/Primarily%20For%20Faculty/Basic%20Core_Competencies_Final%202010.pdf

Astor, A., Akhtar, T., Matallana, M.A., Muthuswamy, V., Olowu, F.A., Tallo, V., & Lie, R.K. (2005). Physician migration: Views from professionals in Colombia, Nigeria, India, Pakistan, and the Philippines. *Social Science & Medicine*, *61*(12), 2492 - 2500.

Battat, R., Seidman, G., Chadi, N., Chanda, M. Y., Nehme, J., Hulme, J.,…Brewer, T.F. (2010). Global health competencies and approaches in medical education: a literature review. *BMC Medical Education*, *10*.

Bauer, T. A., & Sanders, J. (2009). Needs assessment of Wisconsin primary care residents and faculty regarding interest in global health training. *BMC Medical Education*, *9*.

Borgstrom, E., Cohn, S., & Barclay, S. (2010). Medical professionalism: Conflicting values for tomorrow's doctors. *Journal of General Internal Medicine*, *25*(12), 1330-1336.

Bozorgmehr, K., Schubert, K., Menzel-Severing, J., & Tinnemann, P. (2010). Global health education: A cross-sectional study among German medical students to identify needs, deficits and potential benefits (Part 1 of 2: Mobility patterns & educational needs and demands). *BMC Medical Education*, *10*.

Bush, K., Glen, C. , Maslowsky, J., Mitsak, A., Parikh, S., & Rheingans, C. (2010). *Student handbook for global engagement*. Ann Arbor: University of Michigan.

Caldicott, C. (2011). Ethics lie in the situation and in the response. *Medical Education*, *45*(7), 658-660.

Canadian Federation of Medical Students. (2009). *CFMS Annual Review*. Toronto.

Chan, K. (2010). Global health and development: The basics. Retrieved from http://globalhealtheducation.org/Modules/Pages/20_Global_Health_And_Development_The_Basics.aspx

Chin-Quee, A., White, L., Leeds, I., MacLeod, J., & Master, V. A. (2011). Medical student surgery elective in rural Haiti: A novel approach to satisfying clerkship requirements while providing surgical care to an underserved population. *World Journal of Surgery*, *35*(4), 739-744.

Crump, J. A., & Sugarman, J. (2010). Ethics and best practice guidelines for training experiences in global health. *American Journal of Tropical Medicine and Hygiene*, *83*(6), 1178-1182.

Desbiens, N. A., & Vidaillet, H.J. (2010). Discrimination against international medical graduates in the United States residency program selection process. *BMC Medical Education*, *10*.

Dharamsi, S., Richards, M., Louie, D., Murray, D., Berland, A., Whitfield, M. & Scott, I. (2010). Enhancing medical students' conceptions of the CanMEDS Health Advocate Role through international service-learning and critical reflection: A phenomenological study. *Medical Teacher*, *32*(12), 977-982.

Elit, L., Hunt, M., Redwood-Campbell, L. Ranford, J., Adelson, N., & Schwartz, L. (2011). Ethical issues encountered by medical students during international health electives. *Medical Education*, *45*(7), 704-711.

Farmer, P. (1999). *Infections and inequalities: The modern plagues*. Berkeley: University of California Press.

Farmer, P. (2004a). *Pathologies of power: health, human rights, and the new war on the poor: With a new preface by the author*. Berkeley: University of California Press.

Farmer, P. (2004b). *Pathologies of power: Health, human rights, and the new war on the poor*. Berkeley: University of California Press.

Farmer, P., & Garrett, L. (2007). From "marvellous momentum" to health care for all. *Foreign Affairs*, *86*(2), 155-159.

Furin, J., Farmer, P., Wolf, M., Levy, B., Judd, A.,...Katz, J. (2006). A novel training model to address health problems in poor and underserved populations. *Journal Of Health Care For The Poor And Underserved*, *17*(1), 17-24.

Global Health Education Consortium. (2011). The collection of global health learning modules. Retrieved from http://globalhealtheducation.org/Modules/Pages/Forms/Default.aspx

Gaufberg, E. H., Batalden, M., Sands, R., & Bell, S. K. (2010). The hidden curriculum: What can we learn from third-year medical student narrative reflections? *Academic Medicine*, *85*(11), 1709-1716.

Hafferty, F. (1998). Beyond curriculum reform: Confronting medicine's hidden curriculum. *Academic Medicine*, *73*(4), 403-407.

Hanson, L., Harms, S., & Plamondon, K. (2011). Undergraduate international medical electives: Some ethical and pedagogical considerations. *Journal of Studies in International Education*, *15*(2), 171-185.

Horrobin, D. (1980). *Medical hubris: A reply to Ivan Illich*. Ann Arbor: Eden Press.

Huish, R. (2009). How Cuba's Latin American School of Medicine challenges the Ethics of Physician Migration. *Social Science and Medicine*, *69*(3), 301 - 304.

Leppa, C. J., & Terry, L. M. (2004). Reflective practice in nursing ethics education: international collaboration. *Journal of Advanced Nursing*, *48*(2), 195-202.

Lévinas, E, Münster, A., & Collège international de philosophie. (1995). *La Différence comme non-indifférence : éthique et altérité chez Emmanuel Lévinas: le séminaire du Collège international de philosophie*. Paris: Editions Kimé.

Lévinas, E., & Šerpytyte, R. (2009). *A century with Lévinas: On the ruins of totality*. Vilnius: Vilnius University Publishing House.

Marchal, B., & Kegels, G. (2003). Health workforce imbalances in times of globalization: brain drain or professional mobility? *International Journal Of Health Planning And Management*, *18*, S89-S101.

McKinley, D. W., Williams, S. R., Norcini, J. J., & Anderson, M. B. (2008). International exchange programs and US medical schools. *Academic Medicine*, *83*(10), S53-S57.

Moyo, D. (2009). *Dead aid: Why aid is not working and how there is a better way for Africa* (1st American ed.). New York: Farrar, Straus and Giroux.

Nathanson, N., & Hall, T. (2010). A comparison of 5 introductory textbooks in global health. Retrieved from www.med.upenn.edu/globalhealth/.../GHTextbookReviewNov2010.doc

Parsi, K. & List, J. (2008). Preparing medical students for the world: Service learning and global health justice. *Medscape Journal, 10*(11), 268.

People's Health Movement. (2007). *Global health watch 2005 - 2006: an alternative world health report*. London: Zed Books.

People's Health Movement. (2009). *Global health watch 2*. London: Zed Books.

People's Health Movement (2011). *Global health watch 3*. London: Zed Books.

Pinto, A. D., & Upshur, R. E. G. (2009). Global health ethics for students. *Developing World Bioethics*, *9*(1), 1-10.

Pogge, T. W. M. (2002). *World poverty and human rights: cosmopolitan responsibilities and reforms*. Cambridge; Malden, MA: Polity.

Ray, K. M., Lowell, B. L., & Spencer, S. (2006). International health worker mobility: Causes, consequences, and best practices. *Institute for the Study of International Migration*, *44*(2), 181-203.

Ross, P. T., Williams, B. C., Doran, K. M., & Lypson, M. L. (2010). First-year medical students' perceptions of physicians' responsibilities toward the underserved: An analysis of reflective essays. *Journal of the National Medical Association*, *102*(9), 761-765.

Saint-Cheron, M. de, & Lévinas, E. (2010). *Conversations with Emmanuel Lévinas, 1983-1994*. Pittsburgh, Pa.: Duquesne University Press.

Shaffer, E., & Brenner, J. (2007) Globalization and its impact on health. Retrieved From http://www.globalhealtheducation.org

Shah, C., & Parmar, H. D. (2011). International perspectives and initiatives. *Health Information and Libraries Journal*, *28*(1), 77-81.

Shah, S. K., Nodell, B., Montano, S. M., Behrens, C., & Zunt, J. R. (2011). Clinical research and global health: Mentoring the next generation of health care students. *Global Public Health*, *6*(3), 234-246.

Shankar, P. R. (2010). Attracting and retaining doctors in rural Nepal. *Rural and Remote Health*, *10*(3).

Somers, G. T., Jolly, B., & Strasser, R. P. (2011). The SOMERS Index: A simple instrument designed to predict the likelihood of rural career choice. *Australian Journal of Rural Health*, *19*(2), 75-80.

Werner, D., Thuman, C., & Maxwell, J. (1992). *Where there is no doctor: A village health care handbook* (Rev. ed.). Palo Alto, CA: Hesperian Foundation.

World Health Organization. (2009). Country survey results. Retrieved from http://www.who.int

World Health Organization. (2006). Country mortality profile - Iceland. Retrieved from http://www.who.int