Chapter 12
Mindfulness, Compassion, and the Foundations of Global Health Ethics

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Introduction

Mindfulness is generally considered a characteristic or quality of individual persons. Its focus is primarily inward, directed toward one's thoughts, emotions, and bodily sensations, as well as toward one's immediate environment. Yet the accelerating pace of globalization compels us to consider mindfulness in a broader context. What is the role of mindfulness for the increasing number of people who work at the global level, who actively seek to improve health and quality of life for entire populations, for people they will never meet, from whom they are separated by great geographic, cultural, and economic distances? How can mindfulness help to guide them through the ethical minefields inherent in such a complex undertaking? Indeed, what *kind* of mindfulness is required? How does globalization affect our fundamental understanding of what mindfulness is and what determines ethical action?

I approach these questions not as a trained ethicist or expert in mindfulness-based interventions, but as one who has worked in the field of global health for almost 30 years. At times during this period, a lack of mindfulness limited the effectiveness of my work. I lacked equanimity, was emotionally reactive, and was unaware of much that was happening—not only within myself, but also among my international colleagues and within the agencies for which we worked. I did not understand the huge gaps in power, opportunity, and privilege that separated us,

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much less the extent to which aspects of my work depended on those gaps. My awareness of the ethical dimensions of global health emerged gradually.

As a global health practitioner, during the past 5 years I have explored the themes of ethics, compassion, and mindfulness with colleagues from around the world, in the corners of meetings, over meals, and while traveling together. I have been impressed by their willingness to reflect deeply on these themes—and also how infrequently these themes are discussed in the professional literature, conferences, and training programs of global health professionals.

The field of global health ethics is still in its infancy. Rooted in bioethics, global health ethics also concerns itself with the forces of globalization, which fuel both the need and opportunity for global health, as well as with the massive imbalances of power, wealth, and opportunity that separate us as humans. Global health is but one of many fields that have arisen or matured during the past 2 decades, catalyzed by an awareness of our profound interconnectedness and of the impact of globalization on the human condition. What does contemporary mindfulness offer these fields? And how might intentional engagement with these fields inform contemporary mindfulness? Using global health as an example, I explore the essential role of mindfulness in fostering ethical decision-making and in nurturing compassionate, effective action at the global level. I also explore how mindfulness and compassion might contribute to the emerging field of global health ethics.

Mindfulness

The ongoing debate about what constitutes mindfulness reveals a rich tapestry of deeply held perspectives (Monteiro, Musten, & Compson, 2015; Compson & Monteiro, 2016; Mikulas, 2015; Purser, 2015; Baer, 2015). Mindfulness in traditional Buddhism, which evolved over hundreds of years, differs in certain respects from contemporary secular notions of mindfulness and from concepts of mindfulness in other religious and spiritual traditions. Further, the term "everyday mindfulness" is sometimes used to differentiate it from "mindfulness while meditating" (Thompson & Waltz, 2007). Scientific investigation, through the disciplines of psychology and neuroscience, has helped to refine our understanding of mindfulness, while also raising many more questions about its phenomenology, biology, and the robustness of our conceptual frameworks (Baer, 2015; Lutz, Jha, Dunne, & Saron, 2015).

I will refrain from offering yet another definition of mindfulness and will generally use the term in its contemporary sense as offered by Kabat-Zinn (1994, p. 4)—"paying attention in a particular way: on purpose, in the present moment, and non-judgmentally." Both for contemporary ethics and traditional Buddhism, the adverb "non-judgmentally" requires some unpacking, as ethical discernment involves value judgments regarding what is wholesome, ethically responsible, and conducive to right living.

Mindfulness and Ethics

Christian Krägeloh (2016, p. 100) argues that "the purpose of Buddhist mindfulness training is to transform one's deluded ways of thinking into habitual mental states that are associated with wholesome behaviors and that avoid unwholesome ones." Mindfulness practices were traditionally taught in a nuanced monastic context of spiritual and ethical formation (Thupten Jinpa, 2015). Currently offered in secular contexts, there are concerns about extracting the practices from their traditional context and stripping them of explicit ethical and religious content to render them accessible to persons in contemporary western societies with various religious beliefs and backgrounds. However, mindfulness-based interventions such as mindfulness-based stress reduction (MBSR, Kabat-Zinn, 1990) and mindfulness-based cognitive therapy (MBCT, Segal, Williams, & Teasdale, 2002) have provided therapeutic benefit for people with a broad range of clinical and medical conditions (Kabat-Zinn, 2003).

Proponents argue that the impressive benefits of these therapies and training programs, which are now realized by tens of thousands of people, outweigh potential downsides of adapting them for secular societies that value "liberal neutrality" in the public sphere. According to this position, mindfulness-based interventions should avoid being limited by "strong ethical commitments" since they can be beneficial or applicable even "in contexts of controversial moral value" (Schmidt, 2016, p. 1), such as military settings. In other words, contemporary mindfulness-based interventions should not be too strongly linked to a particular view of morality.

Others have questioned the wisdom of extracting meditation and mindfulness practices from their traditional spiritual and ethical foundations. Doing so, they argue, detaches mindfulness practice from a commitment to "right mindfulness" and threatens to reduce it to mere technique, subject to misappropriation (Monteiro et al., 2015; Stanley, 2013).

Several lines of thought and evidence suggest that mindfulness, broadly considered, can enhance ethical motivation, behavior, and decision-making. Shapiro, Jazaieri, and Goldin (2012) recently explored four ways in which contemplative practice, and mindfulness in particular, can improve moral and ethical reasoning. First, mindfulness fosters the ability to shift from a personal, subjective perspective to one that is more objective (Orzech, Shapiro, Warren Brown, & McKay, 2009). Such a shift, known as "reperceiving," is especially important for ethical decision-making when the self feels threatened or when identity is at stake. Second, through the process of reperceiving, mindfulness allows practitioners to more readily consider the perspective of others. This opens them to the possibility of empathy and compassion (Kristeller & Johnson, 2005).

Third, mindfulness can help clarify values. We are often not fully conscious of the values that guide our decisions (Ruedy & Schweitzer, 2010). Mindfulness can reveal subconscious motivations, help us discern whether these motivations reflect our core values, and increase our resolve to embrace values that are wholesome and life-giving (Shapiro et al., 2012). Fourth, nonjudgmental awareness, which is a hall-

mark of mindfulness meditation, promotes emotion regulation (Chambers, Gullone, & Allen, 2009; Goldin & Gross, 2010). Emotions are a crucial, and often unappreciated, determinant of ethical decision-making (Narvaez, 2014). Substantial research has demonstrated that mindfulness training increases the capacity for healthy, adaptive emotional regulation and lessens the tendency to engage in maladaptive patterns, such as rumination, rigidity, and impulsiveness (Shapiro et al., 2012; Jain et al., 2007; Baer, 2009).

Together, these considerations argue for mindfulness training as a component of educational programs intended to foster ethical decision-making. Yet, with the exception of some clinical settings (Rushton, Kaszniak, & Halifax, 2013; Rushton et al., 2013; Vinson & Wang, 2015; Guillemin & Gillam, 2015), mindfulness and contemplative practice are addressed infrequently in the fields of applied ethics, including bioethics. Little attention is given to how mindfulness should be cultivated, manifested, or brought into ethical deliberation. In part, this may be because the fields of applied ethics assume a certain level of, and capacity for, mindfulness. Such an assumption may not be justified.

Mindfulness and Compassion

Broadly speaking, compassion requires a certain stability of mind. It requires cognitive awareness of suffering, as well as the ability to recognize suffering as suffering. The cognitive basis for compassion involves perspective-taking, insight, and memory (Halifax, 2012). Mindfulness meditation can increase the capacity for taking on perspectives of other people (Shapiro, Schwartz, & Bonner, 1998; Lueke & Gibson, 2015; Baer, 2009).

Compassion also requires emotional attunement or empathy. Empirical studies have shown that mindfulness training increases empathy in medical and health professional students (Shapiro et al., 1998, Shapiro & Izett, 2008; McConville, McAleer, & Hahne, 2016). Upon continued exposure to intense suffering, empathic overload can lead to personal distress, burnout, and so-called "compassion fatigue." Equanimity and emotion regulation are critical to maintaining affective balance and emotional resiliency in such settings (Halifax, 2012; Rushton, Kaszniak, et al., 2013; Ruston et al., 2013; Rushton, 2016; Kearney, Weininger, Vachon, Harrison, & Mount, 2009; Singer & Klimecki, 2014).

Finally, compassion is action-oriented. His Holiness the Dalai Lama notes that compassion "is not just an idle wish to see sentient beings free from suffering, but an immediate need to intervene and actively engage, to try to help" (Dalai Lama, 2002, p. 225). But this is not action borne of a compulsive need to "fix" the situation or alleviate one's own personal distress. Rather, compassionate action requires clarity of intention, awareness of one's own biases, blind spots, and conflicts of interest, and respect for the potential of unintended consequences. It requires wisdom and insight into the causes of suffering. Compassion asks, "What will serve?" It emerges when "the mind is in a state of readiness to meet the world in response to suffering"

(Halifax, 2012, p. 6). Mindfulness practice can help cultivate compassionate responses to suffering (Leiberg, Klimecki, & Singer, 2011; Rosenberg et al., 2015).

To briefly summarize, mindfulness is strongly associated with—and indeed may be essential for—both ethical decision-making and compassion. This does not mean that mindfulness necessarily results in ethical behavior or compassionate action; it is not, in and of itself, sufficient. A host of other co-factors, including our upbringing, culture, physiology, and perhaps even epigenetic factors, play an important role in human moral development (Narvaez, 2014). Nonetheless, the fundamental importance of mindfulness for ethical decision-making and compassion remains unappreciated and overlooked.

Globalization and Ethical Action

We now move to the challenge of ethical action at the global level and the role of mindfulness in guiding such action. The aspiration to achieve a positive or wholesome impact at the global level brings us face to face with the ancient philosophical paradox of "the one and the many." The shift in focus from local to global is accompanied by a transition from the concrete to the abstract, from the individual to the population or system, and from care or compassion to justice. In this transition, the tenor of ethical discourse tends to move from the interpersonal and relational to the legal and transactional.

In our age of globalization, the question of moral status lies at the heart of the ethical endeavor: who or what do we regard as worthy of ethical consideration, and to what extent? Who—or what institution—has the right to confer moral status on individuals or groups of people? In the words of Mother Theresa, how large are we willing to "draw the circle of family" (Reifenberg, 2013, p. 194–195), especially when those within our own group protest that their claims or interests are being ignored or eroded? The process of globalization has so dramatically increased our interdependence—economically, culturally, and politically—that the unintended consequences of apparent ethical action in one setting can inflict injustice or cause suffering for entire populations elsewhere.

Ethical action at the global level requires an uncommon and deep awareness of *both* the "one global" and the "many locals," as well as the interplay between and among them. We turn now to the field of global health to illustrate how these tensions play out and how they might be resolved.

Global Health

Global health is the term given to a rapidly growing, multidisciplinary field that emerged in the 1990s and has its origins in public health, international health, and tropical medicine. It was shaped by a series of global infectious disease pandemics,

such as HIV/AIDS; concern for the environment; the forces of globalization; increased funding from private foundations; and the emergence of public–private partnerships to address specific health issues (Brown, Cueto, & Fee, 2006). The purview of global health is broad, including both clinical care and public health, addressing the social as well as biological determinants of health, and involving a wide range of academic disciplines (Koplan et al., 2009).

Given its extraordinary breadth, a precise definition of global health is elusive, even among its practitioners (Beaglehole & Bonita, 2010). A framework definition proposed by Koplan et al. (2009) considers global health to be a notion, an objective, and a discipline.

Global Health as a Notion

Global health is rooted in a deep awareness of the interconnectedness of all things, a recognition that, in the words of Archbishop Desmond Tutu, "My humanity is caught up, is inextricably bound up, in yours" (Tutu, 1999, p. 35). As recent outbreaks such as those caused by Ebola and Zika virus have demonstrated, human disease is no respecter of international borders. Therefore, the notion of global health is not limited or defined by geography. Rather, it is a worldview in which our interconnection and mutual dependency are accepted as given. Global health practitioners work to improve the health of populations, of people they may never meet, separated by vast geographic distances as well as economic, cultural, and political divides. Dr. Bill Foege, former director of the US Centers for Disease Control and Prevention (CDC), referred to this worldview when he said, "Everything is local and everything is global. Global health is not 'over there'—it's right here" (Bill Foege, personal communication, Task Force for Global Health in Decatur, Georgia, April 26, 2012). Global health transcends barriers of time and space, rendering nonessential our usual dichotomies of local and global, here and there, individuals and populations, us and them. As we shall see, effective global health leadership requires mindfulness that can hold the tension and paradox of these dichotomies while guiding ethical action in a global world.

Global Health as an Objective

In practical terms, global health is also a goal. The World Health Organization defines health as "a state of complete physical, mental, and social wellbeing, and not merely the absence of disease or infirmity," and affirms that health is a fundamental human right (World Health Organization, 2006, p. 1). In its pursuit of this goal, criticized for its unattainability (Larson, 1996), global health prioritizes its efforts on behalf of those who are most vulnerable and impoverished, and for whom

access to health care is most remote. Thus, the principle of health equity is central to global health (Koplan et al., 2009).

Global Health as an Academic Discipline

Global health is also a rapidly growing field of scholarship and practice, highly popular among students of medicine, nursing, and public health (Landrigan et al., 2011; Macfarlane, Jacobs, & Kaaya, 2008; Battat et al., 2010; Kerry et al., 2013), as well as undergraduates (Hill, Ainsworth, & Partap, 2012). This interest reflects a strong desire among many people to make a difference at a global level, as well as their concern for health disparities (Merson, 2014).

Global Health as a System

The structure of global health is complex, redundant, and somewhat chaotic. It involves a broad range of government agencies and national ministries, both civilian and military; multilateral institutions such as the World Health Organization, UNICEF, and the World Bank; and a host of private sector organizations, including foundations, for-profit corporations, religious institutions, and thousands of non-governmental organizations. These organizations often join together in public–private partnerships or alliances to advance certain health agendas (McCoy, Chand, & Sridhar, 2009; Frenk & Moon, 2013).

Global Health as Compassion

I have made the assertion elsewhere (Addiss, 2015) that global health also is a manifestation and expression of compassion. Global health agencies mobilize vast human and financial resources to relieve human suffering (McCoy et al., 2009). Further, global health seeks to alleviate disease-related suffering of *all* people. In this sense, it embodies the message of universal compassion espoused by spiritual teachers through the ages. Because global health is founded upon an awareness of the deep interconnectedness of all beings, it is radical in its inclusivity. Moral status belongs to all. To realize its vision of health equity, global health emphasizes a "preferential option for the poor." Paul Farmer notes that this is appropriate, since "diseases themselves make a preferential option for the poor" (Farmer, 2013, p. 36).

The universalism of global health places it in tension with the human tendency to reserve compassion for those who are close to us, or who seem worthy of it (Goetz, Keltner, & Simon-Thomas, 2010). In this sense, global health challenges the views of care ethicists, such as Noddings (1984), who argue that the scope of one's

responsibility for caring is limited, and that it should be strongest toward close-others, with whom one is in relationship.

Challenges to the Ethic of Compassion in Global Health

The aspirational principles that global health uses to describe itself are not always realized in practice. Global health priorities are often driven by foreign policy, partisan politics, and institutional agendas (Gow, 2002). Practitioners may experience the tension of dual loyalties, divided between the agencies that employ them and the people whose health they seek to improve—and from whom they may be separated geographically and culturally. Those who work in large institutions may find that the work itself is organizational and bureaucratic—even mechanical—in nature. In such settings, global health work becomes abstract and disconnected from the people who are seen as its "recipients." Physician Abhay Bang reminds us that, "global health decisions without compassion become bureaucratic, they become impersonal, they become insensitive. Global health operations without compassion may become autocratic" (Task Force for Global Health, 2011).

Nurturing and maintaining "compassion at a distance" is a challenge for many global health professionals (Addiss, 2015). Awareness of suffering, required both for empathy and compassion, often comes not from a direct human encounter, but from statistics and numbers. Bill Foege highlighted this fundamental challenge in a speech to his CDC colleagues. "If we are to maintain the reputation this institution now enjoys, it will be because in everything we do, behind everything we say, as the basis for every program decision we make—we will be willing to see faces" (Foege, 1984). For many, this was a startling message: what CDC needed was not updated laboratories or improved facilities, but compassion—the willingness of its employees, collectively, to see the faces of suffering.

At times, global health workers are called on to serve in acute situations of overwhelming suffering. The 2014–2015 Ebola outbreak in West Africa was a recent dramatic example. In such settings, empathic arousal can be intense; health and relief workers may be flooded with feelings of inadequacy, fear, helplessness, and anger. Considerable emotional resiliency is required to avoid personal distress and to respond consistently with compassion (Rushton, 2016).

Fear and its political manipulation are among the most serious threats to global health. When the World Trade Center in New York City was attacked on September 11, 2001, the nation was immediately gripped by fear. CDC's top priorities became bioterrorism defense and "homeland security." The ethos within the organization shifted overnight, from public health to civil defense (Altman, 2002). While both public health and civil defense are necessary for national interests, they differ in their fundamental world views.

The power of fear—especially when exploited by politicians and the media—to create chaos, override sensible public health measures, and stifle compassion was demonstrated again during the outbreak of Ebola in West Africa. Anticipating the

possibility of patients with Ebola arriving in the United States, Thomas Frieden, Director of the CDC, called on the compassionate impulse of the US public, saying, "I hope that our understandable fear of the unfamiliar does not trump our compassion when ill Americans return to the US for care" (Henry & Stobbe, 2014). His statement highlighted both the power of fear to undermine the compassionate impulse as well as the power of compassion to overcome fear.

Mindfulness and Global Health

The question I now wish to address is not whether mindfulness can enhance ethical discernment, decision-making, and action in global health. It seems difficult, if not impossible, to live out the aspirational values of global health without mindfulness. The landscape and challenges are too complex, the stakes too high. Rather, the relevant question is: What *kind* of mindfulness is needed? Mindfulness of *what*? I suggest that ethical global health practice requires the application of mindfulness in four dimensions or domains. It requires mindfulness of one's own interior landscape and "movements"; global health's core values; the interconnectedness and interdependence of all life; and the external factors (e.g., cultural, economic, historical) that contribute to human health and health inequity. In addition, mindfulness can help overcome dichotomous thinking, which Julio Frenk calls "the greatest threat to global health" (Rosenberg, Utzinger, & Addiss, 2016). We explore these dimensions briefly in this section.

First, global health is extraordinarily complex, requiring collaborations that bridge vast disparities of wealth, privilege, and power, not to mention differences in geography, language, and culture. Without a high degree of self-awareness of one's biases, motivations, limitations, and potential conflicts of interest, it is all too easy for practitioners from "donor" organizations or countries to violate basic principles of solidarity and to impose their own priorities or those of the organizations for which they work. We are often strikingly unaware of the ethical and interpersonal boundaries that we violate. Based on conversations with hundreds of global health leaders, practitioners, and students, I suggest that we also are susceptible to the subtle trap of "compulsion to save the world" (Addiss, 2015). The shadow side of the desire to "make a difference" is over-identification with the righteousness of one's cause and the tendency to cling to specific outcomes, which can lead to defensiveness, over-work, exhaustion, and burnout. Mindfulness is essential to allow space for insight and self-awareness, foster emotional balance, and depersonalize criticism.

Second, as already noted, global health's universal values and its concern with the health of *all* peoples sometimes puts it at odds with the values of nation-states and secular societies. Students entering the field should understand that global health can be perceived as a radical enterprise and they should be well-grounded in its core values. These include solidarity, social justice, equity, respect for all human life, interdependence, humility, introspection, and compassion (Pinto & Upshur,

2009, 2013). Benatar et al. (2003, p. 129; 2014) argue that global health practitioners must cultivate "a global state of mind" and embrace the cosmopolitan virtues of tolerance, curiosity, humility, and generosity. Global health practitioners must be fully mindful of these values, especially during times of crisis and when facing ethical dilemmas.

Third, being rooted in these values is not merely an intellectual exercise. Zen teachers, such as Bernie Glassman, emphasize the importance of a deep *experience* of interconnection (Glassman, 1998). Many successful global health leaders can point to a personal encounter—often an experience with a single patient or individual—that transformed their awareness and set them on a path that eventually became a career (Addiss, 2016a). Such an experience of interconnectedness is accompanied by an invitation to live one's life in accordance with this realization—to participate in it fully. These experiences often provide a renewable source of inspiration for those who dedicate their lives to global health. They also serve as the source of the values that guide the field itself.

Experiences of interconnectedness are inconceivable without mindfulness. Although they may arise unexpectedly, they are conditioned by receptivity and a "particular way" of paying attention to self, others, and one's surroundings, i.e., "in the present moment and non-judgmentally" (Kabat-Zinn, 1994, p. 4). The challenge for those who have been in the field for many years is staying connected to the evocative power of these experiences. Without this, the work of global health, particularly in large government agencies, can become mechanical and dry, and the "faces" fade from view, replaced by "numbers." Mindfulness and contemplative practice can help us remember the experience of interconnection and reignite our imagination. Mindfulness is a pathway to the spiritual "wells" (Gutierrez, 2003) from which we must drink to sustain our spirits and realize the promise of global health.

Fourth, mindfulness of and respect for the complexities, nuances, and particularities of each situation are crucially important. One of the strengths of global health is its focus and insistence on effective action. Good intentions are not enough. Ideally, interventions are based on evidence and guided by people whose lives are affected by them. The fields of international health and development have not always lived up to these principles. "Solutions" from "donor" countries and organizations have often been imposed on "recipients" without regard to historical realities or local priorities, beliefs, or practices (Gow, 2002; Farley, 1991; Caufield, 1997). In a recent example, the understandably high priority given by western medical teams to infection control and cremation during the early stages of the Ebola epidemic did not give adequate consideration to local religious beliefs or traditional burial practices. The epidemic did not begin to subside until the World Health Organization issued guidelines that took these factors into account (Blevins, 2015).

Another example of relative disregard for historical, cultural, and local particularities is the proliferation of short-term missions (Forsythe, 2011) and "voluntourism," which has become big business (Kushner, 2016; Forsythe, 2011). Ostensibly fueled by "compassion," these activities are often characterized by a lack of awareness and mindfulness (Kushner, 2016; Linhart, 2006). They have been criticized as

ineffective, misguided, arrogant, and actually harmful. True solidarity and accompaniment must be informed by knowledge of the cultural, political, economic, and historical factors that influence health inequities, and by an awareness of one's own complicity in the systems that underlie the inequities that one is trying to "fix." The Catholic Health Association of the United States (2016) has developed excellent materials that invite those considering short-term global health work into an honest appraisal of motives and a process of mindful reflection regarding what will best serve. Ethical principles and best practices also have been proposed for short-term medical missions (Decamp, 2011; Wall, 2011) and international student training experiences (Crump & Sugarman, 2010).

Of the four domains in which mindfulness is needed for ethical global health practice—one's interior landscape; global health's core values; the profound interconnectedness of life; and the cultural, economic, and historical factors that contribute to health inequity—only the fourth is adequately addressed in schools of public health. However, it is approached as a body of knowledge to be mastered, a set of professional skills to be developed, rather than as a path of mindfulness or of ethical inquiry. As a result, this knowledge is not necessarily or explicitly brought to bear on ethical decision-making.

Leaping Clear of the One and the Many

The primary science that guides and supports interventions in global health is epidemiology, the study of patterns of disease and health across populations. Traditionally, epidemiology tends to view the world in dichotomous categories—healthy or sick, dead or alive, case or control. Epidemiologists seek to understand the causes of—or risk factors for—disease in order to develop effective interventions (Gordis, 2009). Epidemiology has proved to be an extraordinarily powerful tool, and its analytic approach influences the way global health professionals think. In the lived experience of global health, however, the dichotomous distinctions of here vs. there, local vs. global, individuals vs. populations, and us vs. them become blurred. For ethical global health practice, a particularly challenging and pervasive dichotomy is the paradox of "the one and the many," the whole and its parts, or in Bill Foege's words, the "numbers and faces." Effective action at the global level can only be accomplished through attending to the "numbers" through programs and initiatives that operate at scale. But the compassion that motivates and sustains that action is often found in an experience of a particular "face" at the individual level. Both are needed. Foege and Rosenberg (1999, p. 86) wrote, "Successful public health leadership in the next millennium will require…the ability to see the whole and its parts *simultaneously*. Public health leaders…need to scan and to focus and to see relationships. And they need to do these *all at the same time*" (emphasis added).

The paradox of "the one and the many" has been the object of serious reflection at least since the early Greek philosophers (Anderson, 1953; Johnston, 2004). It

finds resonance in the Buddhist doctrine of no-self. The whole is qualitatively other than its parts. The self is comprised of non-self elements. And, in the words of Roshi Joan Halifax (2012, p. 229), even "compassion is composed of noncompassion elements." Compassion is enactive, an "emergent process that arises out of the interaction of a number of noncompassion processes" (Halifax, 2012). The paradox of the "one and the many" is also a central concern of public health ethics. A classic challenge in public health is how to weigh the overall good to the whole (i.e., society) provided by interventions against the unintended harm that they cause to a few individuals (Childress et al., 2002; Barrett et al., 2016). The benefit to society is a scant source of solace to the individual who has been harmed. The logic of the whole does not necessarily apply to each of the parts.

Zen masters, too, have contemplated how to hold the tension between the one and the many. Typically, they adopt a non-dual approach. In the thirteenth century, Eihei Dōgen wrote, "the buddha way, is, basically, leaping clear of the many and the one" (Dōgen, 1985, p. 69). Dōgen might suggest to us in our age of globalization that the awakened way, the compassionate way, requires us to leap clear of these dichotomies, to see the faces in the numbers, and to embrace both our deep interconnectedness and our diversity.

More recently, Roshi Bernie Glassman commented on Dōgen's experience and elaborated on his teaching: "The one way to be truly universal is to be very particular, moment by moment, detail by detail. If you are merely 'universal,' you lose the feel of life, you become abstract, facile…But if the emphasis on everyday detail is too rigid, our existence loses the religious power of the universal. To walk with one foot in each world—that was Dōgen's way, and Dōgen's life. In a single sentence, he talked from both points of view, the absolute and the relative, the universal and the particular. He was not only living in both, he was switching so fast between the two that he was in neither! He was entirely free! And this is wonderful, just as it should be!" (Matthiessen, 1985, p. 190).

Glassman's description of Dōgen's ability to live both in the absolute and the relative, the universal and the particular, is reminiscent of the qualities that Foege and Rosenberg (1999, p. 86) maintain are needed for global health leadership, "the ability see the whole and its parts simultaneously…to scan and to focus and to see relationships...to do these all at the same time." How *can* global health practitioners be fully aware of the faces and the numbers, reconcile the local and the global, and stay motivated by a profound sense of humanity's vast interconnectedness while being fully attentive to seemingly endless, minute technical details—all at the same time? Training in mindfulness and contemplative awareness, required to "leap clear of the many and the one," is offered in retreat centers and monasteries of many of the world's religious traditions. It is not often included in the curricula of schools of public health, medicine, or nursing. I believe it should be.

Toward a Global Health Ethics

Having considered the characteristics of global health, explored four domains in which mindfulness can contribute to ethical global health practice, and touched on the challenge of "the one and the many," we turn our attention now to the emerging field of global health ethics. We will begin with a brief description of bioethics and public health ethics, arguing that they provide a necessary but insufficient basis for global health ethics. In particular, we will consider how compassion and the ethics of care might contribute to a mature framework for global health ethics.

Bioethics

As noted earlier, global health ethics is still in its infancy. It is rooted in the field of bioethics, which developed during the 1970s to address ethical issues arising from advances in technology and its medical applications, particularly at the beginning and end of life (Callahan, 2012). The need for bioethics was also highlighted by widely publicized ethical abuses in medical research, particularly the notorious US Public Health Service study on the effects of untreated syphilis among African-American men in Tuskegee, Alabama (Jones, 1981).

Within the field of bioethics, the dominant conceptual framework is known as Principlism, based on the four principles: beneficence, nonmaleficence, justice, and autonomy (Beauchamp & Childress, 2012). The application of these principles to ethical decision-making is often described as a measured, rational process that balances the competing principles, leading to an ethical decision and a clear course of action. In practice, achieving such balance can be difficult. Individuals and societies assign different weights to each of the principles (Page, 2012). The priority assigned to individual autonomy, in particular, has been criticized as inappropriate for some non-western cultures (O'Neill, 2002). Further, preliminary evidence suggests that the degree to which specific principles are valued does not necessarily predict how decisions are made when one is faced with an ethical dilemma (Page, 2012).

Public Health Ethics

In contrast to clinical medicine and nursing, which are focused on individual patients, public health is broader in scope, concerned with the health of populations. Although the four principles are often used to frame and consider ethical challenges in public health, the principle of individual autonomy is tempered by the relational and social dimensions of human interdependence. Similarly, in public health, the principle of justice extends beyond simple distributive justice (e.g., equitable access to health services) to issues such as the social determinants of health (Commission

on Social Determinants of Health, 2008) and the responsibilities of the state (O'Neill, 2002).

Once the effectiveness of a particular public health intervention has been demonstrated (the principle of beneficence) and its associated risks are shown to be at least as acceptable as the alternatives (nonmaleficence), attention must be given to the degree to which the intervention would infringe on individual autonomy, whether the benefits and burdens would be distributed equitably (justice), and the degree to which its implementation has been justified to the public with honesty, transparency, and trust (Childress et al., 2002). This leads to several observations.

First, even an intervention with a scientifically acceptable risk–benefit ratio may be considered unethical if it is implemented without respect and concern for the autonomy of those who might benefit from it. Ethics is concerned not only with scientific evidence regarding benefits and risks of a particular intervention (the *what*), but also with *how* it is implemented. For example, surgical sterilization is a safe and effective method of reducing fertility, but is unethical when applied in a coercive manner.

Second, many public health measures, especially when they are compulsory, as with vaccination and seat belts in automobiles, infringe to some degree on individual autonomy; this does not necessarily make them unethical (O'Neill, 2002). Third, ongoing epidemiologic monitoring and evaluation of public health interventions is not only good public health practice; it is an ethical mandate. For example, during the first few years of the onchocerciasis (river blindness) control program in sub-Saharan Africa, its ethical profile was beyond question. Community-directed treatment with the drug ivermectin provided massive relief from suffering, was associated with few adverse reactions, advanced social justice (Bailey, Merritt, & Tediosi, 2015), and established decision-making (autonomy) at the community level (Homeida et al., 2002). The risk–benefit balance shifted radically, though, when monitoring systems established to detect serious adverse events identified cases of neurologic complications, some of which were fatal. These cases occurred in areas that happened to be co-endemic for another parasitic worm, *Loa loa* or African eyeworm. Epidemiologic and laboratory investigation revealed that persons with high-intensity *Loa loa* infection (i.e., more than 8000 organisms per mL of blood) were at risk of serious neurologic complications due to the exquisite sensitivity of that parasite to ivermectin (Twum-Danso, 2003a, 2003b). In areas endemic for *Loa loa*, the river blindness program was halted until safeguards could be put into place to avoid these complications (Addiss, Rheingans, Twum-Danso, & Richards, 2003).

And finally, public health ethics continues to wrestle with the challenge of the "one and the many." Simple utilitarianism ("the greatest benefit for the largest number") does not adequately take into account the one who is harmed or does not benefit. A communitarian approach, in which all voices are invited into the decision-making process, is preferable. However, the communitarian approach assumes a state, government, or community that is both representative of the population and responsive to the needs of its minorities and marginalized persons. This assumption is not always justified.

Global Health Ethics

Global health ethics, in my view, builds on public health ethics, infusing it with a global perspective that transcends borders of nationality, ethnicity, and identity and with certain fundamental values that, while present in public health, are nevertheless more explicitly articulated in global health. These values include human interconnection and interdependence, solidarity, social justice, and the cosmopolitan virtues of tolerance, curiosity, humility, and generosity (Benatar & Upshur, 2014). The principles of solidarity and accompaniment, in particular, have emerged as core values that distinguish global health. They are expressed in a radical inclusiveness that seeks to reduce, if not eliminate, traditional barriers between "donor" and "recipient" and encourages honest appraisal of motives, structures, and practices that are deeply imbedded within the international health and development communities.

These values provide the foundation for a new global health ethics, and as noted above, reveal the tensions inherent in this emerging field. The tensions arise not only from the partisan motivation and self-interest of agencies, organizations, and nations that fund global health work and establish its agenda (Beaumier, Gomez-Rubio, Hotez, & Weina, 2013; Lancet, 2009; Frenk & Moon, 2013), but also because these institutions, particularly the military, tend to appropriate global health as a tactical "tool" (Daniel & Hicks, 2014). Thus, an inherent tension exists between the universal ideals and values of global health and the more limited strategic objectives of some of its funders. In this context, global health workers not infrequently face the challenge of divided loyalties, caught between their commitment to the populations they seek to serve and advancing the goals of the institutions that employ them or fund their work (Briskman & Zion, 2014; London, 2002; London, Rubenstein, Baldwin-Ragaven, & Van Es, 2006; Singh, 2003). When this divergence reaches a critical threshold, the result is moral distress. Within health care, moral distress has been described primarily in the fields of nursing, palliative medicine, and intensive care (Austin, Saylor, & Finley, 2016; Prentice, Janvier, Gillam, & Davis, 2016; Rushton, Kaszniak, et al., 2013; Ruston et al., 2013; Rushton, 2016). Undoubtedly, it is an under-appreciated problem in global health as well (Sunderland, Harris, Johnstone, Del Fabbro, & Kendall, 2015; Ulrich, 2014).

The radical inclusiveness of global health and its commitment to solidarity argue for an ethical framework that addresses the systemic causes of suffering and health inequity while, at the same time, maintains fidelity to the relational, human, and interpersonal foundations of global health practice. On the one hand, the Principlism of bioethics offers a useful tool to identify and balance competing claims, and the human rights approach provides a powerful framework for achieving just social systems. On the other hand, Bill Foege's plea to "see the faces" speaks of the need for global health ethics to embrace the core value of compassion.

Compassion as the Basis for Global Health Ethics

The idea of compassion as a foundation of ethical conduct is not new. According to Chris Frakes, the "pro-compassion camp" includes Aristotle, Adam Smith, Jean-Jacques Rousseau, David Hume, and Arnold Schopenhauer (Frakes, 2010, p. 82). For example, Schopenhauer (1903, p. 213) declared that, "Boundless compassion for all living beings is the surest and most certain guarantee of pure moral conduct" and Albert Schweitzer (1988, p. 11) wrote, "I can do no other than to have compassion for all that is called life. That is the beginning and the foundation of all ethics."

Other thinkers, including Socrates, the Stoics, Immanuel Kant, and Frederick Nietzsche reject compassion as a valid guide for achieving a just society (Frakes, 2010). As an emotion directed at a particular individual or group, they argue, compassion detracts from the reasoned decision-making demanded by equitable and ethical allocation of limited resources. In other words, empathy and compassion interfere with the utilitarian ideal. Supporting this view are findings from a recent study, which suggest that low levels of empathic concern predict utilitarian moral judgment (Gleichgerrcht & Young, 2013). Therefore, compassion and justice are sometimes regarded as being in tension, if not in conflict. If compassion is to be a cornerstone of global health ethics, we will have to resolve this tension.

I believe it is more correct to regard compassion and justice as expressions of the same impulse. In a globalized world, the notion of neighbor—to whom we typically accord moral status, and, if he or she is suffering, offer compassion—must be extended to the entire human family (Addiss, 2016b). In this regard, as a field, global health is in the vanguard, given its concern for "the attainment by all peoples of the highest possible level of health" (World Health Organization, 2006, p. 1).

The notion that compassion and justice are not only interrelated, but that both are required, is not new. The prophet Micah (6:8) wrote, "What does the Lord require of you, but to do justice, to love kindness, and to walk humbly with your God?" Numerous spiritual teachers and philosophers have commented on the interplay and interdependence of justice and compassion. For example, theologians Paul Knitter and Roger Haight (2015, p. 201) argue that "to be compassionate for all requires that we be concerned for justice." Exploring the ethical implications of Ricoeur's dialectic view of love and justice, Van Stichel asserts that, although they operate at different levels (interpersonal and institutional, respectively) and have different logics ("superabundance" and "equivalence," respectively), love and justice need each other. "Love needs justice to be practically embodied, while justice would become more human when inspired by love" (Van Stichel, 2014, p. 505). Referring to Jesus' parable of the Good Samaritan, Maureen O'Connell (2009, p. 205) writes, "When we turn to face suffering persons, we realize that it is no longer enough for individual travelers to step into the ditch and offer emergency aid to the victims of humanly perpetuated violence. Samaritanism calls for a collective response to whole groups of people." Global health is precisely such a collective response.

Ubuntu

A global health ethics could benefit from dialogue with two ethical frameworks that emphasize the personal and relational and that value interconnectedness and compassion. The first of these is the communitarian worldview of Ubuntu, a term found in several Bantu languages of southern Africa (Chuwa, 2014). Archbishop Desmond Tutu describes Ubuntu as "the essence of being human" since it "speaks of the fact that my humanity is caught up and is inextricably bound up in yours. 'I am human because I belong'" (Chuwa, 2014, p. 31). Ubuntu views human life as profoundly interconnected and relational—indeed, the notion of an individual human is inconceivable outside of the relational context of community.

By conceiving of the individual in this way, and through its experience of the deep interconnectedness of human life—which is also a cornerstone of global health (Koplan et al., 2009)—Ubuntu softens the distinction between "the one and the many." The individual is compelled to care for others, since without others one cannot be fully human. Similarly, Ubuntu's profound sense of interconnectedness demands justice, which is both reconciliatory and communitarian. "There is no conflict between the human need for both care and justice. There is not even a separation between the two. Justice and care are concomitant and concurrent. They are perceived as two sides of the same coin" (Chuwa, 2014, p. 135).

Ethics of Care

The second major school of thought that seems philosophically aligned with the core values of global health is the ethics of care. Articulated during the 1980s by Carol Gilligan and Nel Noddings, care ethics takes as its starting point the lived experience of care and caring, upon which human life is absolutely dependent, rather than *a priori* principles based in modern liberalism, which value autonomy, rationality, and self-interest. In contrast to Principlism, care ethics places higher value on connectedness, emotion, relationship, and personal experience. It emphasizes the contextual nature in which moral decisions and actions occur.

Noddings (1984) describes caring relationships as being comprised of the "one-caring" and the one "cared-for." Because the context of relationship is paramount, one's responsibility for caring is essentially limited to persons with whom one is already in relationship. In this view, partiality is virtuous, since caring, as the basis of ethics, is imbedded in relationship. To neglect the care of those with whom one is in relationship for the care of a distant stranger is to neglect one's primary responsibility as the "one-caring." However, the prospect of encountering a needy stranger creates a sense of "wary anticipation" in the one-caring, since, as Noddings writes (1984, p. 9), "aware of my finiteness, I fear a request I cannot meet without hardship. Indeed, the caring person… dreads the proximate stranger, for she cannot easily reject the claim that he has on her."

For global health, this view of care is problematic on two levels. First, the distinction between the "proximate stranger," for whom the one-caring becomes responsible (albeit with "wary anticipation") through a personal encounter, and the "distant stranger," for whom caring is not required or even appropriate, loses its meaning in the context of global health. In practice, global health rejects this dichotomy. The whole point of global health—as well as its prophetic claim—is that we are all, to one degree or another, "proximate strangers," even neighbors. Further, the collaborative interpersonal relationships that sustain the global health enterprise transform "distant strangers" into friends. Thus, global health not only welcomes the "distant stranger," it goes even further to embrace the "global other." As Noddings cautions, however, such an inclusive stance toward care leaves one vulnerable to being psychologically overwhelmed by the magnitude of suffering and by one's inability to address it. We will return to this point shortly.

The second objection to the partiality of care arises from global health's insistence on impartiality, equity, and social justice. Care ethicists since Noddings have wrestled with how to temper the partiality of care, confined within the private, relational sphere, with the ethical demands for impartiality and justice in the public sphere. For example, Halwani (2003) considers care as one (albeit very important) virtue among others. He highlights the importance of moral reasoning for discerning when, in fact, it is virtuous to prioritize care for the suffering stranger (justice) over the claims of care-in-relationship. In this sense, moral reasoning modulates the primacy of care. Others, especially Tronto (1993) and Robinson (1999), hold fast to the primacy of care, not only within close relationships but also as the basis for justice at the societal and political levels. For example, Robinson (2013, p. 137) defines injustice as "those practices, institutions, structures, and discourses which inhibit or subvert adequate care or which lead to exploitation, neglect or a lack of recognition in the giving and receiving of care." Interestingly, this perspective aligns with the Ubuntu worldview, in which "justice is secondary to, and part of, care" (Chuwa, 2014, p. 32).

In accordance with these broader interpretations of care, one could conceive of global health as extending an ethic of care to the global level. In fact, many global health professionals approach their work through a lens of caregiving. They are deeply motivated by an ethic of care and not infrequently inspired by spiritual or religious values, even if these values are not explicit or overtly expressed (Suri et al., 2013). However, scholarship on global health and global health ethics has little to say about the relational one-on-one aspects of caregiving, focusing instead on population-level themes of justice and equity.

At least in part because global health discourse has been largely devoid of content regarding personal values and because its training programs have not addressed self-awareness, emotional resiliency, or mindfulness, global health workers not infrequently find themselves feeling overwhelmed by the enormity of human suffering and by the inadequacy—even futility—of their efforts to address it (Addiss, 2015). By extending their circle of concern (and care) to all humanity, global health workers open themselves not only to Nodding's "wary anticipation of the distant stranger," but also to the lived experience of having failed to care for

her. A global health ethic that does not support individuals in their relational caregiving, accompaniment, and solidarity—in addition to addressing the field's central issues of social justice, health equity, and human rights—is, in my view, going to be difficult to sustain. If, as some care ethicists argue, justice is a necessary corrective to the partiality of care, and if an essential value of global health is social justice, what can provide the source of motivation, resiliency, and encouragement for individual practitioners to both enjoin the fight against injustice and to care—for the whole world? Here we return to the theme of compassion and explore its relationship both to care and to justice.

Compassion, Care, and Justice

We are guided in this exploration by Chris Frakes (2010), who worked as a counselor in a domestic violence shelter in the United States. The physical and psychological toll of this work eventually forced her to leave the shelter. Her sustained reflections on this experience led her to conclude that "neither care nor justice adequately motivates attention to the suffering of strangers" (Frakes, 2010, p. 79). Rather, for Frakes, compassion, correctly understood, holds this potential. First, she notes that compassion is more restricted in scope than care, since it is limited to attending to the "negative condition" (Blum, 1980) of suffering. In addition, compassion does not require an intimate or long-term relationship with the person suffering, so it "can be directed not only to those known, but also to those unknown to the agent. Thus although compassion may involve partiality, it can move the agent more generally in the direction of impartiality" (Frakes, 2010, p. 82). So far, this view of compassion aligns more closely with the global health experience than does care as described by care ethicists. Indeed, although global health is also concerned with promoting human flourishing and well-being, it remains largely focused on alleviating the "negative condition" of suffering. Further, relationships in global health, both among individuals and organizations, are often short in duration or low in intensity, circumscribed by particular projects or initiatives. And at times, they would be properly described as transactional.

Along with justice, compassion shares a concern for the unjust suffering of the stranger. However, the aim of compassion "is to alleviate suffering generally, whether or not the one or indeed anyone is responsible for the suffering of its intended target. This is an important distinction from justice, which does not seem to lead automatically to the alleviation of suffering in general" (Frakes, 2010, p. 82). Here again, Frake's discrimination between justice and compassion resonates with global health experience. Global health does concern itself with what john a. powell (2003, p. 103) terms "social" or "surplus" suffering, inflicted by our "social arrangements." In this sense it is grounded in, and intimately allied with, the pursuit of structural justice. But global health also concerns itself with what powell terms ontological or existential suffering, the inevitable suffering inherent in living and dying as a human being.

How then does compassion both modulate the partiality of care and equip us to pursue social justice in the public sphere? Here, Frakes (2010, 85) draws upon the Buddhist virtue of equanimity, which "is specifically directed at overcoming dualism and perceiving fundamental equality." For those who are "compassionate by character," equanimity serves to regulate the emotions and fosters a "disposition that does not mire them in anguish over the enormity and intractability of human suffering, but rather motivates them to perform actions aimed at the alleviation of such suffering" (Frakes, 2010, 87). Frakes' emphasis on emotion regulation and emotional resiliency resonates with recent literature on the psychology and neuroscience of compassion (Halifax, 2011, 2012; Goetz et al., 2010; Klimecki, Leiberg, Lamm, & Singer, 2013). Finally, Frakes (2010, p. 87) defines the virtue of compassion as "the habit of choosing with equanimity the action that is the proper response to the suffering of others." Such a definition seems consonant with global health, which is rooted in the principle of equity and guided by scientific evidence to determine and refine the "proper" response to suffering.

Mindfulness and Global Health Ethics

To briefly recapitulate, we have considered the essential role of mindfulness both for ethical discernment and for compassion at the individual level. Using global health as an example, we also have explored how mindfulness might contribute to global endeavors. We touched on a few of the many ethical challenges in global health, including dual loyalties, "compassion at a distance," inadequate resilience, and fear, and considered four domains, or areas of focus, into which mindfulness might be brought to address some of these challenges. We then addressed the nascent character of global health ethics and explored strands from bioethics, public health ethics, Ubuntu, and care ethics that might contribute toward a more mature conceptual framework for global health ethics. Underlying all of this is the inherent tension between the "one and the many," which permeates global health.

Four Domains of Mindfulness in Global Health

We return now to the four domains of mindfulness that, I suggest, have something significant to contribute to ethical decision-making in global health. One might think of these domains as areas or "objects" of focus or attention, analogous to how one directs one's attention during mindfulness meditation, in turn, to the breath, thoughts, and bodily sensations, for example. Admittedly, to speak of mindfulness as being applied to these four domains extends—and some might argue, distorts—what is commonly meant by mindfulness. Regardless, I suggest that mindfulness, broadly defined, can help address some of the critical ethical challenges in global health.

First, mindfulness brings into awareness one's subconsciously held beliefs, attitudes, assumptions, and emotional triggers, which distort moral judgments. In navigating the complex ethical landscape of global health, the lack of such awareness is a real hazard. Further, mindfulness in this sense must be an ongoing practice, since as Narvaez (2014, p. xxvii) reminds us, "On a moment-to-moment basis, an individual's morality is a shifting landscape. We move in and out of different ethics based on the social context, our mood, filters, stress responses, ideals, goals of the moment, and so on… The trick for most wise behavior is to maintain emotional presence-in-the-moment."

Second, ethical decision-making requires that global health professionals be constantly mindful of, and fully grounded in, the universal values of global health, which sometimes run counter to the values and agendas of funders, employers, and government agencies. Third, being rooted in these values is facilitated by a deep personal *experience* of interconnectedness, whereby the "distant stranger" becomes friend and a commitment is forged to remain, in one way or another, in solidarity. Such a transformative experience can both crystalize a decision to enter the field, and, if mindfully recalled on a frequent basis, sustain a career. The importance of this experiential dimension and the power of mindful fidelity to it are documented in stories from global health practitioners by the Center for Compassion and Global Health (www.ccagh.org). Fourth, to be effective and ethical as a global health practitioner, one must be both knowledgeable about, and mindful of, the cultural, economic, and historical particularities of any situation in which one is working.

Mindfulness and Global Health Practice

How would global health—and global health ethics—benefit if mindfulness were cultivated in these four domains or dimensions? I offer a few speculations. First, mindfulness of one's own internal "landscape," as noted above, would undoubtedly benefit the individual global health practitioner, resulting in improved resilience, self-awareness, and awareness of one's biases and assumptions. This, in turn, could protect against ethical missteps. Second, improved self-awareness and more mindful grounding in the values of global health would provide guidance in navigating divided loyalties. Improved mindfulness in these two domains would also serve to facilitate conversation about shared personal values in global health, in effect ending the current "conspiracy of silence" on this issue. This, in turn, would provide crucial support to global health practitioners and institutions when the flames of nationalism and militarism are stoked by fear, as they were in the United States after the 9/11 attacks on the World Trade Center. In my view, the paucity of such conversations within CDC at that time contributed to its rapid transformation from a premier global health agency to one that, at least for a while, was largely concerned with civil defense.

Mindfulness might also help facilitate a conversation within global health about how individuals and institutions should respond when their well-intentioned

interventions result in unexpected harm. The importance of disclosure and apology in cases of unintended injury or wrongdoing is increasingly recognized and practiced in clinical medicine (Wood & Isaac Star, 2007). This is not yet the case in global health. Discerning how these practices might best be brought into global health—where the issues are even more complex—would necessarily begin with mindfulness.

Finally, the underlying challenge of dichotomous thinking, which pervades global health, will never be overcome without mindfulness. As we have seen, a fundamental challenge for the ethics of global health and other global disciplines is the tension between the "one and the many," the faces and numbers. "Think globally, act locally" is an appealing slogan, but in global health, actions and decisions also have global ramifications. An ethic is needed that, in the words of Dōgen, helps global health practitioners leap clear of dichotomy to experience and articulate the "one and the many" in new, integrated ways. In turn, I believe that this would lead to more coherent global health policy and more humane decision-making.

An effort to bring mindfulness training into the global health practice and education would likely be met with challenges similar to those encountered in other public settings, such as schools and hospitals. For global health, mindfulness training would need to be evidence-based, as well as compelling to a largely secular workforce. One of the critiques of bringing mindfulness-based interventions into the secular public sphere is that the practices are stripped from their ethical foundations and taught in a value-neutral context—or some would argue, in an ethical void. This would not be the case for global health. The problem for global health is not that these values do not exist, but that they are inadequately articulated and shared. An intentional welcoming of mindfulness practice could help the field of global health elucidate and express the strong values that it already has. It could also stretch our understanding of mindfulness beyond the individual sense in which it is usually understood to the global level.

This chapter is intended as a prolegomenon, an exploratory foray into new territory. The core values of global health, as described by the leaders of the field, correspond well to those of the spiritual traditions where mindfulness training practices developed. Central to both is compassion. With its explicit core values of compassion, justice, and interconnection, global health could serve as a vehicle for bringing mindfulness into the global arena. In turn, an embrace of mindfulness could significantly influence the emerging field of global health ethics and enable global health to reach its full potential.

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