Bioethical Inquiry (2015) 12:5–10
DOI 10.1007/s11673-015-9626-8

EDITORIAL

Defining "Global Health Ethics"

Offering a Research Agenda for More Bioethics and Multidisciplinary Contributions—From the Global South and Beyond the Health Sciences—to Enrich Global Health and Global Health Ethics Initiatives

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Received: 24 January 2015 / Accepted: 1 February 2015 / Published online: 21 March 2015

Some claim that "global health is public health" (Fried et al. 2010) but most regard global health as a new field, rapidly emerging mostly at North American academic institutions (Macfarlane et al. 2008). The term was first incorporated into University of California, San Francisco's Institute for Global Health in 1999 (Macfarlane et al. 2008, 389) and UCSF also inaugurated the first North American master of science in global health in 2009. Global health is commonly acknowledged to have historical precedents in tropical medicine and international health. All three fields are regarded as having some overlapping and some distinctive features (Macfarlane et al. 2008; Koplan et al. 2009; Pinto et al. 2013). One overlapping feature of all three is retaining traces of European and/or North American conquest, imperialism, and colonialism that create a legacy of ongoing ethical challenges for global health (Pinto et al. 2013; Crane 2010). One touted distinctive feature of global health is its emphasis on entering into "'true' *partnership* with poor countries"[1] (Crane 2010, 81, *emphasis added*) to distinguish it from its predecessor fields of international health and tropical medicine—which are seen as operating in a more top-down manner and as "embodying outdated and paternalistic modes of relating between wealthy and poor nations,"—thereby "[positioning] it [global health] morally by allying it with an ethic of equity that earlier incarnations [lacked]" (Crane 2010, 81, 85). While laudable, this ideal also poses significant ethical challenges in practice (Koplan et al. 2009; Crane 2010, 2011; Murphy et al. 2013; Sanchez and Lopez 2013). For example,

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[1] Indeed, for high-income country institutions, "[having] at least one long-term partnership with a low- or middle-income country (LMIC) institution" is one of three requirements for full membership in the Consortium of Universities for Global Health (CUGH), whereas for an LMIC member, "international partnerships are not required … but … encouraged" (Consortium of Universities for Global Health 2014). At the very least, this raises awkward questions from global South members such as, "How do *our* students learn global health? By coming North? By staying home? [and] What do you do, look for an even poorer country to work in? … This puts residents of these countries in the paradoxical condition of needing to remain anchored in place in order to participate in 'global health' … [so] global health is a Northern concept [and] for the academic institution in the South, everyday public health, medical and nursing education and practices constitute 'global health'" (Nelson Sewankambo cited in Crane 2010, 86, *emphasis original*).

> … the very poverty and inequality that they [Northern universities] aspire to remedy is also what makes their global health programs both possible and popular. In other words, in the world of academic global health, inequality is a valuable opportunity [...] The legacy of colonial-era power relations is an uncomfortable topic in global health, and one which the field seeks to avoid reproducing through the invocation of an ethic of "partnership." However, … the espousal of partnership—while a noble aspiration—runs the risk of obfuscating both the enduring and novel forms of inequality that shape the transnational relations of global health. This includes the dependence of Northern global health programs on easy access to the bodies of under-treated patients in the global South, and the difficulty in envisioning how Southern clinicians and researchers might participate in global health (Crane 2010, 93).

In this special issue of the *Journal of Bioethical Inquiry*, we focus on global health, defined most influentially to date by "a panel of multidisciplinary and international colleagues … for the Consortium of Universities for Global Health (CUGH) Executive Board" (see www.cugh.org/about/background) as:

> … an area for study, research, and practice that places a priority on improving health and achieving equity for all people worldwide … [emphasizing] transnational health issues, determinants, and solutions; [involving] many disciplines within and beyond the health sciences and [promoting] interdisciplinary collaboration; and [synthesizing] population-based prevention with individual-level clinical care (Koplan et al. 2009, 1995).

It is worth noting that the "multidisciplinary" CUGH panel offering this most-cited definition of "global health" includes six medical doctors and one PhD epidemiologist working in public health. It is also fair to say that its stated ideal of multidisciplinary and interdisciplinary collaboration, although embraced and expounded uniformly by these and other global health founders (Macfarlane et al. 2008), remains mostly undefined and unrealized, with disciplines "beyond the health sciences" in particular significantly underrepresented in most global health education, research, and service. This raises yet another ethical issue for the field: " … as 'global health' rises in scientific prominence and as a funding priority, the ability to define the field—and thus what lies outside it—becomes a powerful exercise in inclusion and exclusion" thus " … defining the boundaries of what does and does not count as ['global health'] … [according] legitimacy to certain kinds of knowledge and practice while excluding others" (Crane 2010, 85).

We also focus on global health ethics, an associated field currently in its infancy (Upshur et al. 2013) which is of importance for the *Journal of Bioethical Inquiry* as an international and multidisciplinary *bioethics* journal. This is the first special issue of a bioethics journal to focus explicitly on "Global Health and Global Health Ethics." Our primary goal in doing so is to invite specific engagement and stimulate global discussion and collaborations involving bioethicists—who have been curiously uninvolved, and indeed almost absent—in existing global health and global health ethics research, education, and service. Given the North American origins of global health, the current lack of bioethics engagement raises the possibility that ongoing parochialism, myopia, and even "inadequate moral imagination" (Benatar 2005, 1209)—already highlighted by social scientists and some bioethicists—continue to affect, for example, United States bioethics (Fox 1990; Myser 2003; Fox and Swazey 2008; Myser 2007), global bioethics (Myser 2011), and nascent global health ethics (Benatar 2014). A secondary goal for this special issue on "Global Health and Global Health Ethics" is to engage relevant disciplines from our wide multidisciplinary readership within and beyond the health sciences. It is precisely bioethics' "uncommonly broad" multidisciplinary "intellectual base," "contours," and "reach"—"atop [its] strong foundation in moral philosophy"—that is offered as one justification for why and how bioethics is well-positioned to "contribute by utilizing its unique intellectual breadth" to "drive meaningful dialogue on reducing global inequities" (Diamond 2014, ¶2, ¶5, ¶6–¶7).

Drawing on the minimal existing global health ethics literature to venture a brief definition:

> Global health ethics is a "field of applied ethics," inquiry, and practice offering critical exploration, including self-reflection; "interprofessional, transdisciplinary and transcultural" dialogue, rigorous analysis, and normative guidance "[attempting] to capture what is relevant to decision-making" (Upshur et al. 2013, 22) regarding the *distinctive* context, challenges, dilemmas, and constraints of

global health education (Crump et al. 2010; Barnard et al. 2011; Evert et al. 2011; Sharma and Anderson 2013; Dwyer 2011; Cole et al. 2013); research (Hussain and Upshur 2013); service (Kiromera et al. 2013); and North–South partnerships (Koplan et al. 2009; Crane 2010, 2011; Murphy et al. 2013; Sanchez and Lopez 2013)—aiming to reduce global and local health inequities affecting marginalized populations between and within countries. It draws on "multiple domains of applied ethics [including] social ethics, professional ethics, clinical ethics, business ethics, organizational ethics, decision ethics" (Sussman et al. 2014, 13–14), [individual level] classical bioethics ... [and collective level] ... public health ethics ... as a grounding for global health ethics (Upshur et al. 2013). It also offers evolving and expanded *distinctive* rationales (Pinto and Upshur 2009; Hunter and Dawson 2011; Pinto et al. 2013; Upshur et al. 2013); as well as *distinctive* core values (Benatar et al. 2011; Upshur et al. 2013); concepts (Sussman et al. 2014); principles (Pinto and Upshur 2009; Sussman et al. 2014; Evert et al. 2011); codes of conduct (Sussman et al. 2014); and "frameworks for transformational approaches … for global health reform" (Benatar et al. 2011, 136–138)—aiming to advance "more equitable health outcomes" (Upshur et al. 2013, 32).

No doubt the current definition of global health ethics, as well as its claims of various "necessary" forms of "applied ethics" grounding—and associated claims of "adapted" or "distinctive" global health ethics rationales and "core" values, concepts, principles, codes of conduct, and frameworks—will generate discussion and controversy. Given that the existing global health ethics literature originates in the majority from North American medical doctors, the question of *whose* global health ethics experiences, perspectives, worldviews, and agendas it currently represents and advances—and how and why—invites scrutiny.

Addressing a first gap and caveat, authors from the global South object that the "existing … global health [literature]—its evolving definitions, scope and, *very importantly the values and competencies required for ethical practice*—reveals a *troubling imbalance*: there is little contribution from Southern authors *based in the South*" (Sanchez and Lopez 2013, 129, *emphasis added*). Additional international authors acknowledge that,

> … little is known about the benefits and unintended consequences of global health training experience to host institutions and host trainees and, if a component of service is anticipated, whether benefit is realized and at what cost … The principal limitation is the lack of available systematic data collected within the context of existing global health training programs reflecting the ... challenges experienced by partners (Crump et al. 2010, 1181).

Other North American authors acknowledge that,

> [w]hile it can be objected that global health ethics is yet another example of domination from the North, we contend that there has been increasing evidence of perspectives from low- and middle-income countries taking similar critical stances. [Noting] Much more needs to be done to advance a global dialogue (Upshur et al. 2013, 32).

Addressing a second gap and caveat, it has already been noted that bioethicists and other relevant multidisciplinary contributors—especially those from beyond the health sciences—have been inadequately represented in global health, and this also extends to global health ethics to date. One new publication makes a crucial contribution to global health—that can be extrapolated to global health ethics—by making an initial effort to define and outline in more specific detail what "interdisciplinary contributions"—especially involving the "critical yet often underrepresented perspective of global health from academic and professional disciplines … *perceived by clinicians* as 'non-medical'" (Pascoe et al. 2014, 263, *emphasis added*)[2] can offer. It does so,

> … to provide perspectives … from disciplines not always encompassed in "global health," … demonstrating the importance of preventive, infrastructural, and social science-related research and interventions as essential … [as] a call for greater inter-sectorial and collaborative work … [and] to showcase experiences, reflections, lessons learned, and successes and failures of working in the field of "global health" … [acknowledging] the challenges for true inter-disciplinary global health scholarship (Pascoe et al. 2014, 263–264).

[2] Emphasis mine, revealing *whose* perceptions and worldviews are operational including or excluding, or at least benignly neglecting to consult, *other* relevant academic disciplines.

Disciplines included—with each featuring in depth case studies—are: anthropology and medical anthropology; design and architecture; engineering; gender studies; geography; law; nutrition and food security; public health; and social work. This list can and should be expanded to include many additional relevant disciplines.[3]

The current Ebola epidemic in West Africa offers another intriguing window revealing important global South and multidisciplinary contributions beyond the health sciences to global health and global health ethics on the ground. It is worth noting that very few of these involve *academic* "professionals," but their essential contributions resoundingly demonstrate why we need to look with appropriate humility even deeper into global South communities for possible insights, lessons, and collaborators. For example: Liberian and Guinean musicians respectively contribute global health prevention education in two new Ebola songs (Poole 2014; Fakoly et al. 2014)[4]; a South African bioethicist contributes global health ethics guidance regarding Ebola experimental treatments (Moodley 2014); Liberian workers contribute improved architecture, design, and materials for Ebola clinics alongside a German engineer (Han 2015); a Sierra Leone businessman, and Liberian and Guinean remote forest region village chiefs and elders, contribute their local organizational, cultural, political, and government knowledge and skills to address traditional religious beliefs and fetishes/rumors/mistrust, and enable more effective Ebola surveillance, prevention, and treatment in their respective countries (Frankel 2014; Epstein 2014; Nossiter 2014); Sierra Leone radio show hosts contribute new "vox pops" global health education "to tackle [Ebola] rumours and misinformation" (Sangarie 2014); Ebola survivors across Liberia, Sierra Leone, and Guinea contribute their local cultural and language knowledge to counter stigma, build community trust, and improve Ebola care through community-based global health advocacy and education (Stein et al. 2014); and a Liberian academic and activist contributes cultural studies/critical race theory analyses to problematize "the myth of the white savior complex," refocusing attention on local not foreign Ebola interventions (Pailey 2014, 3; see also Seay and Dionne 2014).

With the above gaps and caveats being noted, the initial definition of global health ethics offered here can serve as a *future research agenda*: inviting new lenses, theories, and methods going forward: (1) more proactively and centrally featuring global South perspectives (acknowledging that the current socioeconomic, political, and other definitions and distinctions implied by the concepts of "global South" and "global North" require further critical analysis and definition); and (2) more richly engaging bioethics and multidisciplinary contributors underrepresented to date. Neither the first nor second gap highlighted should be left to chance: proactive cross-campus[5] and cross-institutional and cross-national[6] efforts are required.

We offer this special issue of the *Journal of Bioethical Inquiry* on "Global Health and Global Health Ethics: Bridging Crucial Gaps," as an initial effort to stimulate broader discussion and engagement from the context of an international, multidisciplinary *bioethics* journal. Topics covered include: ethics of offshoring nonconsensual pharmaceutical trials in low-income countries; political and ethical challenges of multi-drug resistant tuberculosis; ethics in global governance of an influenza pandemic; ethics of long-term, career

[3] This includes additional disciplines targeted by the *Journal of Bioethical Inquiry* and others I would add such as: Arts, Business, Critical Theory, Medical Humanities, Political Science, Science and Technology Studies, Social Medicine, Sociology, and Veterinary Medicine.

[4] The Gates Foundation is similarly engaging multidisciplinary artists—including global South and global North photographers, painters, bioengineers, designers, writers, filmmakers and musical bands—in its "Art of Saving a Life" campaign "to promote vaccination … [and save lives] especially in poor nations" (Ryzik 2015, ¶4). As another (global North) example, a professor of Ecology, Evolution, and Natural Resources contributes study of human behavior and outbreak management through virtual world games (e.g., *World of Warcraft*) and gamer role-play during an "epidemic" in which "corrupted blood" spreads through virtual characters like an infectious disease (Kitchenman 2014).

[5] For example, as director creating two new MD–MS and MS "Global Health and Global Health Ethics" degree programs at Florida Atlantic University (2011–2014), I proactively engaged *all* relevant disciplines across campus, as well as local and global South nonprofits and field partners, creating specific strategies to catalyze richer interdisciplinary collaborations in our proposed teaching, research, and service.

[6] For another example, a cross-institutional and cross-national empirical research project is underway to elicit and incorporate more *ethically sound* competencies better *reflective of partner goals* in global health education. The project is led by William Cherniak and Jessica Evert and also includes: Geoffrey Anguyo, Barbara Astle, Quentin Eichbaum, Emily Latham, Catherine Myser, Michael Silverman, and Katherine Standish; funded by Child Family Health International. Our March 2015 CUGH poster presentation is titled, "Interprofessional Host Perspectives on Global Health Competencies."

involvement by physicians in global health work; and a multi-year, multi-regional consultation to understand and begin to remedy research partnership ethics inequities affecting some global South (South Asian, Latin American, and Sub-Saharan African) stakeholders. We also include a subsection to compare, contrast, and ideally professionalize evolving approaches to teaching global health and global health ethics in varied contexts. We also feature a global health humanities subsection featuring nine award-winning global health and ethics essays, and finally, two responses to a global health ethics case published in an earlier issue of the journal (Anderson 2014). We offer the Introduction editorial for this special issue at least via "Open Access"—as an ethics and social justice commitment—particularly to invite more global South discussion and collaborations. We thereby hope to begin bridging crucial gaps between bioethics, global health, global health ethics, and additional relevant scholars and practitioners, as well as between the global South and global North.

Acknowledgments First and foremost, I would like to thank our Managing Editor, Bronwen Morrell, for her indefatigable support, and generous and expert advancement of this special issue, from start to finish. She never lagged for even one moment, and was always a delight to work with. I would also like to thank two of our Founding Editors, Ian Kerridge and Paul Komesaroff, for walking the ethics and social justice walk in every context, for extraordinary additional editorial help, and for their friendship. I would also like to thank all of our multidisciplinary Bioethics, Global Health, and Global Health Ethics authors and peer reviewers, without whose passionate and generous contributions this special issue could never have come to fruition. Finally, I thank Renee Fox and Solly Benatar for their sage editorial insights.

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