How Do Professions Globalize? Lessons from the Global South in US Medical Education

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This article explores the professional construction of the space of Global Health. I argue that the growth of Global Health as a field of practice does not merely indicate an intensification of North-South intervention. It is also a professional project of reimporting lessons from the South to countries in the North. I focus on the emerging didactic regime for Global Health in US medical education and the deterritorialized "global" lessons that students are taught in poor countries. By rescaling these lessons to precarious settings at home, the space of Global Health is reterritorialized as a Global Medical South stretching into the United States, reinforcing the perception that health is not a right but a privilege. The analysis is based on a content analysis of university websites and didactic handbooks and a sample of sixty-four articles evaluating the education effects of study abroad experiences. It reveals an emerging canon of Global Health virtues and the construction of domestic scales for Global Health practices, which are based on ethnic and socioeconomic categories. This analysis of professional projects as spatial projects sheds new light on the geography of Global Health and of professional globalization more generally.

Global Health[1] has become a vibrant field of transnational practice involving a broad array of institutions (Leon 2015)-and offering manifold professional opportunities. As stated in the magazine *Science* in 2007, "[t]he international effort to address the health crisis in the developing world is providing a wealth of career opportunities" (Gewin 2007, 348). The report advises students to seek "in-the field experience" in order to become competitive for Global Health jobs and thus highlights the importance of experiential learning and volunteering abroad (Gewin 2007, 349).

Recognizing this need and the growing student demand for study abroad schemes, more and more universities offer Global Health study programs involving structured international experiences, especially in the field of medicine. Today, about 29 percent of US medical students undertake learning experiences abroad, usually in low-income countries—as compared to 6 percent in 1984 (Moran et al. 2015, 1). Through these experiences, often called Global Health Electives (GHEs), learning and *doing* Global Health are inextricably linked. Students (and residents) are enacting their role as representatives of the dominant, "global" core of medicine, administering treatments under conditions of scarcity, and learning about the skills required to work in Global Health programs (Brada 2011).[2] The

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[1] I use capital letters to indicate that Global Health is a self-reflective field of practice that the actors involved are aware of and orient their efforts toward (see Sending 2015 and below, section 1).

[2] Experiential learning and study-abroad programs can take place during medical school or residency. For ease of exposition, I use the term "student" to refer to both categories.

roles into which these students are socialized epitomize the contemporary purpose, and political geography, of Global Health.

This article explores the construction of "global" expertise through experiential learning in Global Health. Focusing on a major center of the current Global Health discourse, US higher education, I examine how North-South relationships are (re-)negotiated as "lessons from the South" are made applicable to domestic health-care settings. Based on a content analysis of university websites, educational guide-lines, and an exhaustive sample of sixty-four articles evaluating the effects of study abroad schemes, I argue that Global Health is not a one-directional practice of North-South knowledge imposition. It also involves the reimport of insights gained at training sites abroad. Skills, attitudes, and practices developed in and for the Global South are redeployed to address health problems in the Global North, especially in Northern healthcare peripheries. These skills include, for example, cultural sensitivity toward foreigners, awareness of the social determinants of health, and the ability to provide care with limited resources. By reconstructing this emerging canon of transterritorial Global Health virtues[3] and their transnational deployment, I aim to shed new light on the political geography of Global Health and its transnational scale of intervention: neglected areas in low- as well as high-income countries.

Thus far, critical analyses of GHEs have focused on their neo-imperial dimensions. Several in-depth ethnographies highlight the one-sided mobility of students from the North to the South (Wendland 2012), their assumed role as superior physicians even before they have completed their training (Sullivan 2018), and the hegemonic status of Anglo-Saxon biomedicine (Brada 2011). These critiques resonate with the broader conception of Global Health as a classic case of North-South intervention (Packard 2016). Global Health is widely understood as health work that has an "international [read: low-income country] dimension" (Janes and Corbett 2009, 168) and that is performed by experts in the North intruding in local lives in the Global South (Biehl and Petryna 2013). These experts and institutions from Euro-America impose their own priorities on people in the South, priorities that are often dictated by health security concerns (Calain 2007; Weir and Mykhalovskiy 2010; Rushton 2011) or the research interests (Crane 2013) of the North. These asymmetries contribute to the impression that Global Health is "an instrument for a new era of scientific, programmatic, and policy imperialism" (Horton 2014, 1705). However, the domestic side of this global endeavor has gone broadly unnoticed.

My analysis of the emerging Global Health curriculum and its enactment through GHEs addresses this neglect and sheds light on the postnational scale of Global Health intervention.

I reconstruct how lessons from the South are deterritorialized from low-income country settings and reinterpreted as mobile skills and attitudes that can improve healthcare in the United States. Students of Global Health are taught a humanitarian ethics of pro-poor career choices, cultural sensitivity, and the ability to provide low-tech and low-cost care in resource-poor settings abroad *and* at home. Additionally, the growing number of so-called domestic GHEs illustrates how Global Health virtues are reterritorialized and directed to specific zones inside the United States. At US universities, experiential learning schemes with migrant, native, or poor communities are made part of Global Health curricula and thus designate domestic healthcare peripheries as parts of a Global Medical South, a space of "global" health intervention including marginalized zones in both poor and rich countries.

Thus, in the field of Global Health, the term "global" does not mean dominant (Fourcade 2006) or universal (Bartelson 2010), referring to some integrated

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[3] I use the term "virtue" to refer to both the attitudes and competences that are valued positively among Global Health professionals. This usage is in line with the philosophical definition of virtues as "a character trait which is seen as leading to good conduct and is supportive of the norms, rules and principles of a given social sphere" (Gaskarth 2011, 435).

cosmopolitan space. Nor is it simply a specific institutional configuration where intergovernmental organizations act alongside private authorities such as business and civil society (Brown, Cueto, and Fee 2006), or an empire of surveillance steered from the Global North (Weir and Mykhalovskiy 2010). Rather, the space of the "global" in US Global Health is the space of the "poor" and "exotic," who are in need of special treatment. This geographic imaginary is highly ambivalent. Even though the reterritorialization of Global Health is based on a social justice agenda seeking to challenge domestic alongside international inequalities, it also risks stabilizing these very inequalities. By designating certain domestic spaces as being "not like us" but part of the Global Medical South, Global Health reifies a medical system that considers healthcare not as a right but as a privilege, a system that leaves the plight of the uninsured and underinsured to the goodwill of domestic humanitarians.

At a theoretical level, the article responds to the call to work toward an international political sociology of medicine (Howell 2012). I do so by combining insights from the sociology of transnational professions (Kauppi and Madsen 2014; Sending 2015; Seabrooke and Henriksen 2017) with a political geography approach to transnational scales of governance (Brenner 2004). I suggest that professionals, through their transnational practices, construct Global Health as a postnational scale of governance that does not coincide with the national scale. The political geography concepts of deterritorialization and reterritorialization help articulate how Global Health professionals make lessons from the South diffusible to specific sites in industrialized countries. The result is a Global Medical South as the space of Global Health, which stretches from low- and middle-income countries to marginalized zones in the United States.

The article is divided into five sections. Section 1 presents the article's core arguments against the backdrop of the literature on GHEs and Global Health and professional globalization more generally. It introduces the idea of a deterritorialized Medical South and its construction through lessons from the South. Section 2 presents the results of a content analysis of GHE evaluations and the emerging canon of deterritorialized Global Health virtues. Section 3 reconstructs the reterritorialization of Global Health through domestic learning experiences inside the United States. Section 4 discusses the ambivalent political implications of this postnational professional project. Section 5 is the conclusion, which summarizes the argument and its implications for further research in Global Health and international political sociology (IPS).

The Political Geography of Global Health Electives

Global Health has become a dynamic field of transnational practice, which, in spite of—or precisely because of—its fuzzy boundaries, creates a "nexus" between actors with diverse backgrounds and agendas (Biehl and Petryna 2013, 10). Its rise has been accompanied by ongoing definitional struggles about the mission and meaning of "Global Health" (Koplan et al. 2009; Lee and Kamradt-Scott 2014). Controversies revolve around precise delineations of the term from more established concepts such as "international" or "public" health, the field's guiding principles, or the nature of the field's "globality." For example, should "equity" be an integral part of the definition or not (Koplan et al. 2009; Bozorgmehr 2010)? Does its globality refer to the worldwide reach of the field's activities (Dilger and Mattes 2018) or rather to the worldwide occurrence of health challenges such as pandemics or tobacco production and consumption (Koplan et al. 2009)? Is Global Health a concern of merely medicine and public health, or does it require nonmedical expertise in disciplines such as law (Gostin 2014, xvi), political science (Kickbusch 2015), or anthropology (Biehl and Petryna 2013)?

These questions are intensely debated as Global Health is evolving and consolidating as a professional field. Indeed, Global Health has become a domain of professional opportunity (Gewin 2007), attracting a growing number of students, especially in the United States (Luong 2009). Universities respond to, and further reinforce, this demand, by offering specific Global Health courses and degrees, opening new inter-disciplinary Global Health centers, and establishing and deepening ties with universities and teaching hospitals in the Global South. Whereas "international" topics were rather marginal in US medical curricula between the 1950s and the 1990s (Bruno and Imperato 2015), by 2014, about 250 North American universities offered some Global Health education, and the number of "comprehensive" programs (programs including several schools, combining research and teaching, and partnering with at least one institution in the Global South) rose from six in 2001 to more than seventy-eight in 2011 (Merson 2014, 1677). Altogether, it is estimated that by 2010, forty-seven (37.5 percent) of 128 US and Canadian medical schools had some Global Health component in their curricula (Francis et al. 2012, 1296), and among US medical specialty residency programs, about one-fifth offered Global Health activities in 2011 (Kerry et al. 2013).

The universities promote and align their efforts through new interuniversity initiatives, most importantly the Consortium of Universities for Global Health (CUGH). Involving the "who's who" in US higher education, health, and development, the CUGH promotes research and education partnerships between Northern American universities and partner institutions in the Global South, with the aim of generating a new generation of Global Health leaders. Reflecting its diversity, this quest for professionalization thus spans many more fields than medicine, and it includes various educational formats and courses. Nevertheless, one practice in particular has become an epitome and a bone of contention in the making of Global Health professionals: the practice of study abroad programs, often referred to as GHEs, which are mainly practiced by medical (and to some extent nursing) students and residents (see fn. 4) as a means to gain first-hand practical and learning experience in low- and middle-income countries.[4] They are considered to be the main "gateway" of Global Health education irrespective of medical specialization (Rowson et al. 2012, 2). Their duration can vary between two weeks (the more common case) and two years (rather the exception), and they may involve both clinical and research activities. These activities are facilitated by voluntary placement organizations and a growing network of interuniversity partnerships, as their availability has become a strategic asset in the competition for students (Evert et al. 2008).

These "service learning" experiences are as much about learning as about doing Global Health. Students get the opportunity to see and treat diverse conditions prevalent in poor countries, conditions which they would not be exposed to at home (Brada 2011; Sullivan 2018). Yet, as I explain in the following subsection, they also "do" Global Health by acting out the kind of North–South mobility patterns and power asymmetries that are typical of the Global Health field at large. Their analysis thus provides critical insights into the political geography of Global Health.

Beyond the North–South Intervention Perspective

GHEs have attracted critical scholarly attention, especially by medical anthropologists studying Global Health projects in low-income countries. Several ethnographies of the implementation of GHEs at different African partner institutions have pointed out that this educational practice "raises the spectre of a new form of

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[4] As indicated above, Global Health is not merely a medical field, and it is not taught at medical faculties only. The focus on GHEs as a core medical practice is justified due to their prominence and symbolic importance in Global Health practices as well as critical social science research. Additionally, by showing how GHEs are used to make medicine more "social," this analysis further contributes, albeit indirectly, to debates about how "medical" Global Health is or should be.

colonialism: extending uses of sites in the Global South to study their disease burdens to satisfy the needs of science (particularly, these days, the AIDS industry) to find new subjects and explore new problems" (Janes and Corbett 2009, 176). These studies emphasize that it is mostly researchers, businesses, and visiting students from the North that benefit from these exchanges, not the host institutions and their professionals or patients (Crane 2013). Additionally, they have exposed the neocolonial hierarchies enacted in encounters between Euro-American students and the faculty and patients at teaching hospitals in Africa (Wendland 2012). Arrogant and disrespectful behavior occurs where (usually white) students who have not even started or completed their training disregard the guidance of local faculty. This may even involve "egregious ethics violations" through irresponsible and unauthorized medical interventions (Sullivan 2018).

These critical analyses of GHEs reflect the broader critical scholarship on Global Health in the fields of political science (e.g., Rushton 2011), sociology (e.g., Weir and Mykhalovskiy 2010), anthropology (Biehl and Petryna 2013), and history (Packard 2016). This literature stresses that Global Health is a one-directional practice of North–South intervention. In this "imperial" endeavor, priorities are set in the North (Horton 2014), whereas the actual needs and also the expertise of the "partners" in the South are widely disregarded (Rushton 2011; Crane 2013). The visitors from the North behave like imperialists because they claim to (or are told to) represent an "unmarked" space of "global" medicine—a standard against which African realities and forms of knowledge can only be a deviation (Brada 2011, 296).

The view of GHEs as North–South interventions also resonates with broader sociological debates about professional globalization. The burgeoning scholarship on transnational professionals highlights that expert knowledge and postnational struggles for legitimate expertise are critical determinants of global governance and its underlying discourses (Kauppi and Madsen 2014; Sending 2015; Seabrooke and Henriksen 2017). Similar to the Global Health literature, this literature tends toward one-sided representations of North and South, where institutions in Euro-America generate valid professional knowledge that is then diffused through transnational networks (Chwieroth 2010; Sending 2015, 97). In this imaginary of transnational professionals, the "global" sphere of knowledge production is factually an Anglocentric world of Western elites who impose their ideas on dependent countries (Boussebaa 2017). Thus, professional globalization is theorized as a North–South "export" of expertise (Dezalay and Garth 2002), where peripheral countries are the "local" targets of "global" professional projects originating in the United States or Europe (Fourcade 2006).

The one-directional North–South intervention perspective thus informs the literatures on GHEs and on Global Health and transnational professional dynamics more generally. While this perspective exposes important asymmetries in the current world order, it also comes with an important blind spot: it disregards the ways in which global projects target people in the Global North as well and the ways in which knowledge exports *for* the Global South are intertwined with reimports of medical lessons *from* the Global South. To capture these domestic dynamics, we need to understand the intertwined dynamics of reimport and scale-making that are part of professional globalization under conditions of North–South inequality. In the following subsection, I combine insights about professional reimports with the geography of scale-making in an effort to capture the reconfiguration of the Global Medical South.

Reimports and Scale-Making through Lessons from the South

Dezalay and Garth (2011) have recently reminded IPS scholars that we need to pay more attention to the domestic feedback effects of professional exports. They highlight that legal and economic professionals from hegemonic countries often

act as "double agents," pursuing professional projects both at home and abroad (Dezalay and Garth 2011, 277). By demonstrating the success of their knowledge in laboratories abroad, professionals can also attain dominance in domestic struggles over legitimate expertise (Dezalay and Garth 2011, 278; see also Hönke and Müller 2016). For example, the "Chicago Boys'" economic reforms in Chile were actively interpreted as evidence of the general validity of monetarism (Dezalay and Garth 2011, 279).

In order to bring their expertise back home, the reimporters need to make their knowledge mobile and diffusible across contexts. For Dezalay and Garth (2011, 141), this is achieved through claims to universality: success abroad enables professionals to master knowledge of the "internationally legitimate state" and thus claim that the professional knowledge is applicable *anywhere*. Thus, universalistic claims, for example of neoclassical economics, are prone to make expertise diffusible due to the pretense of applicability across contexts (Fourcade 2006).

However, especially in the case of South–North reimports, the diffusibility of knowledge need not depend on universalistic claims. To the contrary, reimports from the South can also come with specificities that are only, or especially, applicable in certain contexts in the North. Simply put, the art of governing the poor abroad need not be applicable to the domestic rich in order to have a domestic value. It suffices if it helps in governing the domestic poor.

This differentiation is important in order to capture the fact that the reimport of professional knowledge from the South is not just the final step in a process of universal diffusion, a process whereby the world becomes one "global village." Rather, reimports from the South are facilitated by the construction of a general, postnational Global South that is not coextensive with world society but can be encountered in diverse national contexts. This general South is a world marked by higher insecurity, more poverty, or more precarious socioeconomic conditions than the lifeworlds of the transnational professionals and is thus a space where specific skills are required. It can be the global "aidland" in need of development expertise (Mosse 2013), the "peaceland" asking for specific security and mediation expertise (Autesserre 2014), or the world of humanitarian crises requiring emergency medicine (Debrix 1998).

In that vein, I suggest theorizing Global Health as a professional project of constructing a generalized Medical South. This generalized Medical South is not coextensive with the territorial confines of classic "tropical" medicine but a postnational space of poverty and exclusion that places particular demands on health professionals:[5] it requires the ability to work under conditions of scarcity and to tackle the root causes of poor health and the readiness to make humanitarian sacrifices in order to help the poor. Accordingly, in this construction process, GHEs are not merely practices of imperial North–South imposition of universal medical models. They are also endeavors of developing and teaching a set of "periphery skills" and attitudes that can best be learned in underserved settings. I reconstruct these lessons from the South as the emerging canon of Global Health virtues.

Drawing on the political geography of globalization, we can therefore understand the construction of the "professional jurisdiction" (Abbott 1988) of Global Health as the making of a postnational *scale* of intervention: the Global Medical South. As suggested by Brenner (2004), globalization is a process whereby new (urban, rural, regional, etc.) "scales" of governance emerge that cut across established national confines. These scales are constructed as actors orient their activities and resources to specific spatial "organizer[s] . . . of collective social action" (Smith 1995, 61). This collective scaling hinges on concomitant practices of "deterritorialization," whereby preexisting—for example, national—scales are transcended through new organizing concepts and practices, and "reterritorialization," whereby new, postnational

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[5] On the colonial origins of tropical medicine see, for example, Anderson (2006) and Worboys (1976).

scales of governance are collectively constructed ([Brenner 2004](), 33–37). Evidently, transnational scales of intervention are not constructed on a blank slate. They inscribe themselves in and reshape spaces marked by historical forces such as class and race ([De Genova 1998]()) and provide only temporary and constantly contested "scalar fixes" ([Brenner 2004](), 10). The following sections explore how professional reimports engage in such scale-making in US Global Health. GHEs abroad serve to construct deterritorialized lessons (section 2), and the emerging practice of domestic GHEs reterritorialize the "global" jurisdiction of Global Health inside the United States (section 3).

Lessons from the South

What do US students learn through GHEs in poor countries? This question is at the center of a rapidly growing literature produced by the practitioners of Global Health education ([Drain et al. 2009](); [Merson 2014]()). The educators seek to professionalize international student mobility, given that student demand has long outpaced university supply and that many students used to go on self-organized trips ([Moran et al. 2015](), 2). Meanwhile, the makers of the GHE curriculum invest considerable resources in monitoring and designing these study abroad experiences and, as part of this endeavor, evaluate the effects of existing study abroad schemes. In myriad articles published in specialized medical and public health journals, educators report their experience with designing GHEs and the effect they have on students' professional development. Rather than merely stating lofty goals and ideals attached to "global experiences," many authors invest considerably in gathering data on measurable educational effects. We will see in this section that these educational effects are almost exclusively framed in deterritorialized terms: as skills and attitudes that may be more easily acquired in the South but are equally applicable in the North. These skills and attitudes form an emerging canon of mobile Global Health virtues ranging from pro-poor career priorities to specific clinical capabilities. These virtues shall bring lessons from the South to bear on American medical practice.

My reconstruction of this canon is based on a content analysis of sixty-four articles that evaluate GHEs' educational effects. This exhaustive sample was retrieved through a database search in the PubMed database of the US National Library of Medicine of the National Institutes of Health, which initially yielded 3,845 hits.[6] From these, I selected all articles reporting primary or secondary empirical data (and thus not only stating lofty ideals), in order to focus on those publications that invested significant time and effort in assessing the educational effects of GHEs. Most of the retrieved articles were published in the present decade, indicating a considerable intensification of the debate in recent years. Against only one article that appeared before 2000 (in 1995) and eight articles published between 2000 and 2009, fifty-five articles (about 86 percent) were published between 2010 and 2016.

All these articles report some positive effect of GHEs on students' competencies— their theoretical knowledge and practical competencies—and on their careers, in favor of public health priorities rather than private gains. They identify these effects on the basis of diverse methodologies. Some present single program evaluations; some analyze geographic data on physicians' careers; some are based on test scores of students returning from GHEs; and some merely draw on self-reported lessons or preferences. Thus, many of the articles in the sample have (and often acknowledge their) methodological limitations. Problems such as self-selection (students opting for GHEs could be those who already display the desired skills or attitudes), sampling problems (low response rates to surveys, lack of control groups), or

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[6]The search string and sampling criteria are specified in appendix 1.
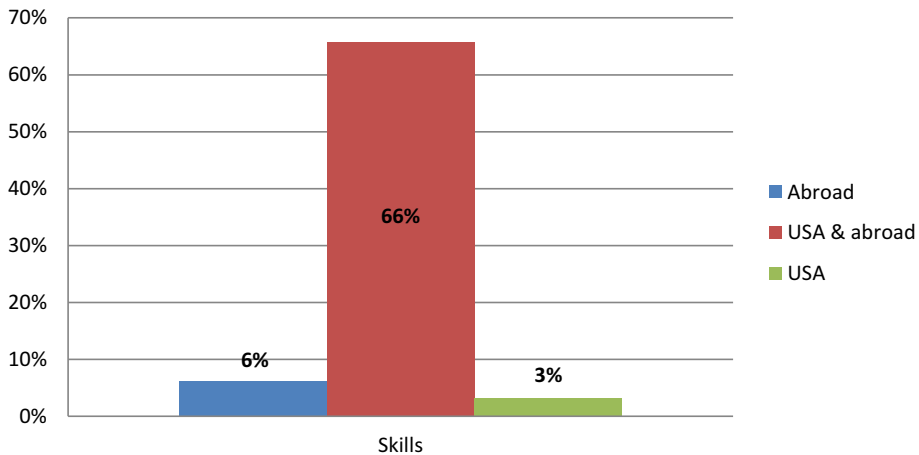
Figure 1. Territorial focus of GHE educational effects on students' skills. (Full color version available online)

concerns about reliability (as when drawing on student self-reporting) do not allow for definitive causal conclusions.

Despite these limitations of the *answers* the articles provide, their analyses do reflect trends regarding the main *questions* educators care about. They help us understand which educational benefits educators deem relevant in the first place. Together with handbooks and educational guidelines, GHE evaluations therefore reveal the emerging professional norms of Global Health. They are a central part of the prescriptive how-to literature that articulates and further shapes the "spirit" of Global Health.[7]

In fact, an analysis of the articles' main evaluative categories yields a considerable convergence around central themes and virtues considered "global" at US universities. Given that the articles focus on reporting positive effects, the categories thus distilled allow us to identify the normative core of US Global Health education.[8]

*Skills from the Laboratories Abroad*

In many ways, the Global Health teaching sites abroad are unlike US healthcare settings. Technological equipment is much more basic, patients have a different cultural background, and many of the prevalent diseases may be hardly encountered among US patients. Nevertheless, Global Health didactics is not primarily dedicated to teaching students how to practice in these foreign settings. Rather, it highlights a set of more generic and mobile skills that can be acquired in low-income countries and then reimported to the United States.

As summarized in figure 1, the evaluation of skills acquired through GHEs does not focus on skills specific to careers abroad. Most authors refer to GHE-based skills in delocalized, generic terms. Only 6 percent of the articles exclusively focus on "abroad-only" competencies; for example, by highlighting that students acquire a better understanding of a foreign healthcare system or of a rare tropical disease. By contrast, 66 percent refer to skills in generic terms, and 3 percent even focus

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[7] Clearly, the focus on the perspective of the educators gives less voice to the students and their meaning-making. An analysis of student journals and travel reports might yield different or additional categories. Nevertheless, this article's focus on the sanctioned agenda underlying GHEs, and thus on the prescriptive how-to discourse about them, does provide critical insight into the professional norms governing this field of practice (on this analytical strategy see also Boltanski and Chiapello 2007).

[8] See appendix 1 for the coding rules and detailed results.
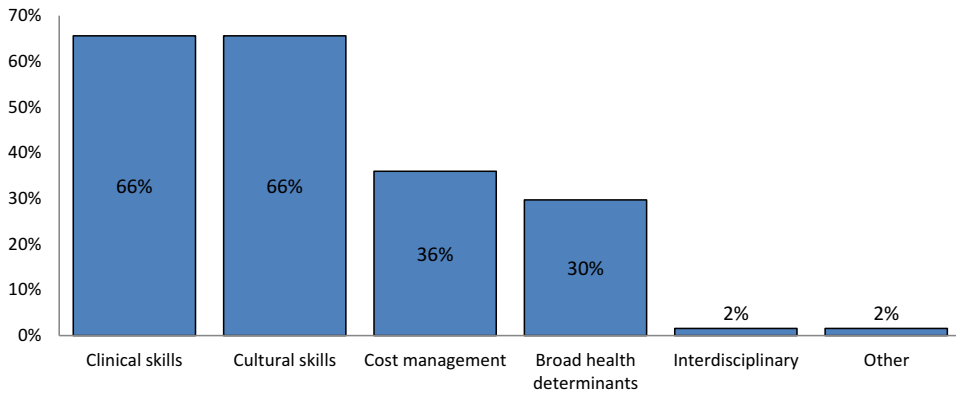
Figure 2. Postulated GHE educational effects on specific skills

exclusively on skills that are only applicable to US contexts, for instance, by assessing the impact of GHEs on "residents' knowledge of immigrant health" (Zink and Solberg 2014, 174).

What are those portable skills that are better learned in low-income countries than in US settings? A closer look at the educational literature reveals that these are mainly skills of coping with resource scarcity and cultural difference. As shown in figure 2, the two central categories debated in this literature are cultural and clinical skills (mentioned in 66 percent of the articles). *Cultural skills* revolve around the management of difference in medical practice. In the United States, such skills are defined as (nonminority, nonindigenous) healthcare providers' awareness of, and ability to engage with, the cultural differences of the populations they serve (Hester 2015, 321). In that vein, encounters with foreign colleagues and patients in Africa, Asia, or Latin America help students overcome emotional barriers to engaging with others. Students also learn to understand the cultural context—be it religious, family, or broader social—that guides their patients' lives and health-seeking behavior. This lesson is interpreted as an important competence for dealing with difference at home as well. For example, a review of psychiatric GHEs at New York University states that participants got better at "understanding and treating other ethnic groups" (Belkin et al. 2011, 402). It is also indicated that the ethnic "others" here are nonwhite patients, for instance, with a distinct "immigration experience and culturally shaped mental health syndromes" (Belkin et al. 2011, 403). Through the deterritorialized concept of cultural skills, the normative whiteness that informs the performance of GHEs abroad (Sullivan 2018) travels back home, and lessons from the South become capabilities to deal with domestic difference and "multicultural populations" (Campbell et al. 2011, 127). They are thus specifically targeted at minorities.

A second central category refers to the enhancement of *clinical skills*: practical competencies in physical examination, oral history taking, and medical treatment. This benefit is attributed to two main factors. First, during GHEs, students have the chance to see and treat more diverse conditions than they would have the opportunity (or even the permission) to see and treat at home (see section 1). They have the chance to practice. Second, at the partner institutions in low-income countries, students often have to manage without the technical equipment that they would be able to use at home, especially laboratory services and imaging technology. This low-tech, resource-scarce environment, so the interpretation goes, empowers them to rely on classic medical skills and trust their own clinical judgment. For example, it is claimed that students returning from GHEs tend to "report a greater ability to recognize disease presentations, more comprehensive physical examination skills, with less reliance on expensive imaging" (Drain et al. 2007, 226).
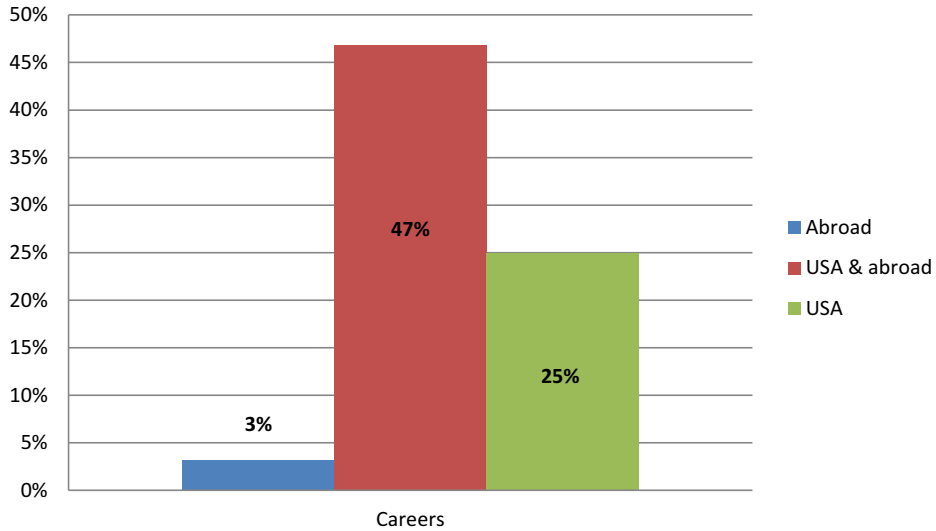
Figure 3. Territorial focus of postulated GHE effects on students' careers. (Full color version available online)

Related to this emphasis on clinical capacities built in faraway resource-poor settings, a third of the articles stress the domestic economic benefits arising from these skills through physicians' growing cost awareness. Clinical self-reliance goes hand in hand with a more skeptical attitude toward costly diagnostics and interventions. This cost sensitivity is measured, for example, via students' more critical attitude toward life-prolonging intensity care and, generally, a more conservative use of expensive medical technology. An example from the field of orthopedics underlines the expected domestic pay-off:

> Residents who participated in the international orthopaedic elective were also more likely to believe that sophisticated imaging modalities are often overutilized in the United States. Given the current health-care budget crisis and dire need to curb health-care costs, reducing the unnecessary use of imaging tests may help to accomplish this goal. (Disston et al. 2009)

A final major skill effect refers to *social awareness*. Thirty percent of the articles claim that GHEs enhance students' understanding of the broader, nonbiological determinants of health. Their exposure to severe poverty and inequality raises their awareness that social, political, and economic conditions have a major impact on health. This "social and public health awareness" is considered part of the (usually deficient) non-biomedical skillset of physicians and enables them to take into account structural and epidemiological factors underlying health and health-seeking behavior (Tupesis et al. 2012, 4). Again, educators expect that this public health lesson is learned much more effectively outside of the domestic comfort zone of highly resourced university hospitals.

Global Health Electives as Career Changers

The virtues acquired through GHEs are not confined to skills and competencies but also pertain to career choices. Seventy-five percent of the sampled articles report that GHEs alter students' careers or career preferences.

As in the case of skills, these career effects are barely specified for careers abroad (see figure 3). They are understood in deterritorialized, generic terms as an

inclination to opt for pro-poor career pathways abroad *or* at home. The evaluations measure whether experiences in the South "encourage practicing medicine among underserved and multicultural populations" (Drain et al. 2009, 320), make students opt for general medicine rather than (more lucrative) careers as specialists, or induce them to become a public health professional or researcher. All these choices have in common that they are normally costly in monetary terms, since pro-poor career choices tend to mean less income. They also tend to come with less comfortable working conditions; for example, when family physicians serve in low-resource areas or work long and flexible hours.

Given that many students are heavily indebted after finishing medical school and thus have many incentives to opt for a well-paid specialty, their humanitarian ethos thus becomes a valuable resource for American medicine. The idealism of medical internationalism can be deterritorialized from its international setting and help address domestic health workforce problems:

> Students' idealism and desire to work with underserved populations decline as they progress from preclinical training through clerkships and residency. With an increasingly diverse population and increasing health disparities, academic health centers need to incorporate changes in their curricula to train socially responsible and idealistic physicians. International electives can provide valuable learning experiences to help achieve these goals. (Smith and Weaver 2006, S32)

Taken together, these skill and career effects point to an emerging canon of Global Health virtues that are deterritorialized from the overseas learning laboratories and reterritorialized for the American context. These virtues combine the humanitarian ethos of caring for poor ethnic others with economic considerations of cost effectiveness. Clearly, this didactic agenda is directly related to US struggles for health reform and the dual challenge of drastic health inequities and the ongoing cost explosion (Callahan 2018). The Global Health agenda inscribes itself in these struggles by tapping lessons from the South for addressing urgent healthcare challenges in the United States. Problems encountered in poor countries, such as lack of resources and cultural difference, thus become learning resources for improving US medical practice. The practical competencies and ethical attitudes of US physicians benefit from the global humanitarian horizon provided by GHEs.

This domestic utilization of GHEs highlights the professional reimport of lessons from the South to the domestic context. However, it also cuts across established North–South dichotomies, because lessons from the South are not evenly reimported at a national scale. Complicating simple accounts of the North and the South, and the direction of aid, in Global Health, the focus on poverty and cultural difference already indicates a specific focus on domestic peripheries. This selectivity becomes even more obvious when looking at the practice of GHEs at home, as we will see in the following section.

The Global South at Home

The previous section has shown that GHEs are not merely an instrument for US students to learn how to help the poor abroad. GHEs are also a means to reimport lessons from the South for improving medicine at home. This reimport is based on a deterritorialized understanding of Global Health practices—as practices that target the poor and the marginalized anywhere and not just in low-income countries. As generic and deterritorialized, Global Health virtues can travel back to the United States. However, this reimport is not a universal reimport that evenly applies lessons from the South across the United States. It is a spatially selective reimport and it targets "global" domestic spaces—spaces that are deemed global not because they are central or universal, but because they are specific, precarious, and marginal. These are the spaces that educators designate for Global Health experiences that

students can access in their own country—an "opportunity" especially for those who cannot afford to go abroad:

> Although on the international level the global health movement focuses on low- and middle-income countries, in general it is concerned with underserved and underprivileged people no matter where they live. Local populations in any country or community struggle with issues of health disparity, providing residency programs with local opportunities to expose resident physicians to global health concerns. Opportunities abound: homeless shelters, refugee or immigrant health clinics, travel clinics, and tuberculosis and HIV clinics, to name a few. (Evert et al. 2008, 19–20)

The so-identified opportunities are indeed being integrated with the US Global Health curriculum. A sizeable share of US Global Health programs offer some kind of domestic GHE. Of the forty-two US universities that rank among the global top in the *Times Higher Education* World University Rankings and offer Global Health programs, twenty advertise some domestic training experience as part of the program (see appendix 2). These experiences, called "internship," "service learning," or "field experience," are recognized as the practical assignment of a Global Health study program, just like GHEs abroad. Educators thereby create equivalence between the domestic training sites and the targets of health aid in the South.

This equivalence is based on two (often intersecting) rationales. The first consists of delineating Global Health spaces as ethnospaces inhabited by cultural and/or racial others. For example, universities point out the availability of "diverse populations" in San Diego, the concerns of "migrant and seasonal farmworkers" in Minnesota, or collaborations with Tribal Health projects and Native populations in Washington, Minnesota, or Pennsylvania. As in the case of GHEs abroad, the markers of culture and diversity are used to delineate nonwhite minority populations requiring special cultural sensitivity. This conceptual equivalence is sometimes accompanied by multisited projects that make minority groups at home and foreigners abroad part of one field of practice. An example of this spatial integration is the Lawrence Family Medicine Residency in Lawrence, Massachusetts—a city that is also labeled the "city of immigrants" because about 73 percent of its population is Hispanic or Latino, mostly from the Dominican Republic or Puerto Rico. Students at Lawrence receive Spanish courses at Dartmouth College, and in their first year attend a "trip to the Dominican Republic which functions as an opportunity to see and experience the country of origin of half our patient population—as well as to have a break in the middle of winter in a tropical setting!"[9] These experiences abroad are combined with community service in and around Dartmouth and thus establish a multisited practice for globally minded family doctors who become socially aware and culturally competent by connecting healthcare experience abroad with local practice at home (Evert et al. 2008, 55–56, 69–72). US students can thus learn cultural sensitivity at home as well as at international partner institutions. They just have to reach out to the Global South at home, a quasi-extraterritorial space that is located on US national territory but still part of the Global Health jurisdiction.

The second rationale that serves to mark certain spaces in the United States as amenable to Global Health intervention is based on notions of poverty and lacking access to social services. Many domestic Global Health projects are specified as projects for "underserved," "resource-poor," or "vulnerable" communities. For example, students at Harvard have the option to choose a "resource poor area in the United States" for research assignments, the University of Texas at Austin provides "opportunities available to serve underserved populations," and Pennsylvania State University provides "fourth-year electives focusing on caring for underserved populations in the U.S. and abroad."[10]

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[9] See "Spanish Curriculum: Overview of the Curriculum," Lawrence Family Medicine Residency, accessed April 19, 2017, http://lawrencefmr.org/site/?page_id=15 https://glfhc.org/residency/curriculum/spanish-curriculum/.

[10] Cited from the university websites listed in appendix 2.

The emphasis on the domestic poor is based on a deterritorialization and reterritorialization of the term "resource-poor setting," which is part of established terminology in the US Global Health field (Macfarlane, Jacobs, and Kaaya 2008, 387).[11] This concept refers back to historical debates in tropical medicine about the causes of ill health in the Global South. In the history of tropical medicine, attributing ill health to "[p]overty rather than climate" (de Cock et al. 1995, 860) meant to detach health inequality from the geography of "warm" zones and highlight socioeconomic factors instead. This reinterpretation of the health challenge in the Global South also allows for a postnational reimagination of the location of the Medical South. As pointed out by Behforouz and colleagues, resource-poor settings can be encountered in many places, "including rural Haiti and inner-city Boston," and for this reason require similar responses (Behforouz, Farmer, and Mukherjee 2004, S429).

Clearly, the construction of domestic Global Health in the United States does not occur on a blank slate. Specific health services for the poor, for migrants, and for tribal communities—called, for example, "community" or "social medicine"—have long existed in the United States (Geiger 1984; Holmes 2013). Likewise, the (re)interpretation of domestic health inequity in an international horizon is not without historical precedent; it has been part of medical internationalist projects throughout the twentieth century (Birn and Brown 2013). Still, the expansion and professionalization of Global Health and the systematic integration of domestic spaces within its jurisdiction signal a far more wide-reaching "globalization" of US social medicine than previous episodes of "health internationalism" (Birn and Brown 2013). The following section discusses the ambivalent political implications of Global Health returning home.

The Politics of Inequality between Laboratories Abroad and Global Health at Home

The reimport of lessons from the South to marginalized sites in the United States complicates established visions of North and South in Global Health and in global politics more generally. The domestic agenda of medical exports and the postnational scale of Global Health expertise reveal the systematic linkages between health work abroad and at home, and between geographically remote sites—for example, in rural Malawi and inner-city Boston. As a deterritorialized political project, Global Health is thus evolving into a practice of tackling health inequity abroad and at home.

This social justice agenda, however, cannot escape the fact that Global Health still unfolds in a world of continued North–South asymmetry. The increasingly institutionalized practice of teaching lessons in the South for the treatment of a generalized Medical South inevitably feeds on these inequalities and has to face the risk of essentializing them. The professionalization of GHEs establishes sites of aid abroad as laboratories of compassion and risks normalizing domestic inequality by making it exotic.

Outsourcing Moral Education

It has long been criticized that GHEs hardly benefit the patients and colleagues at the teaching hospitals that partner with US universities. Even if students arrive with the wish to save lives and serve local patients, they are not fully trained, and they place a considerable demand on the space and time of local hospitals and faculty (Brada 2011; Sullivan 2018). The findings of this article suggest, on the one hand,

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[11] This is also mirrored in the fact that out of the sixty-four articles evaluating GHE electives that were discussed in section 3, thirty-five used some variant of the term "resource-poor/constrained/limited" (see appendix 1).

that these learning experiences, even if not benefiting the poor abroad, can still benefit the poor at home, by equipping future doctors with the necessary skills and attitudes to help the domestic underserved. This educational gain is realized by outsourcing the acquirement of skills that in particular benefit the domestic poor to the learning experiences abroad.

Outsourcing doctors' moral education to training sites abroad is appealing for various reasons. Students may be lured more easily into voyages to remote settings, which combine a sense of adventure, some touristic attractions, and a socially meaningful task (Wendland 2012; Anderson, Philpott, and Raza 2014). Additionally, study abroad experience is highly valued at US universities and by future employers and promoted through programs such as the Generation Study Abroad initiative launched in 2014.[12] Finally, and somewhat paradoxically, "community" experiences tend to be more accessible abroad, where students usually do not have to navigate as many bureaucratic obstacles and coordinate with parallel, already existing social projects, as they would in domestic community projects (Rowthorn 2015, 599).

On the other hand, these advantages of GHEs are realized at the cost of turning learning sites abroad into laboratories of compassion, where faraway poverty and sickness become tools for doctors' moral awakening (Wendland 2012). Training sites abroad serve as demonstration sites where others' misery becomes valuable for the development of medical virtues.[13] Thus, in contrast to the laboratories of repression and policing analyzed in postcolonial security studies (Hönke and Müller 2016), and the laboratories of biomedical experimentation studied by critical Global Health scholars (Rottenburg 2009), GHE sites as laboratories of compassion become places that fabricate medical virtues. This practice creates a problematic symbiosis between the Westerners' moral betterment and poverty abroad. It valorizes and capitalizes on North–South inequality at the same time as it seeks to challenge it.

Globalizing Domestic Inequality

Likewise, the expansion of the scale of GHEs to domestic sites comes with an ambivalent politics of domestic inequality. As US Global Health makes underserved areas inside the United States part of its jurisdiction (see section 3), it harnesses the spirit of global solidarity for truly "glocal" projects at home (Rowthorn 2015). This expansion of the Global Health field draws badly needed attention and resources to neglected spaces inside the United States.

The flipside of this endeavor, however, is that domestic Global Health reinforces a perception of underserved communities as different and exotic. Approaching them as part of a "global" world of poverty and cultural difference abroad thus becomes part of ongoing practices of "thirdworlding at home" (Koptiuch 1991)—where certain spaces are perceived as quasi-extraterritorial and not part of US society. Reading domestic inequality in a global horizon can thus reinforce tendencies among citizens and medical practitioners to "normalize inequality" (Holmes 2013), and feed into racialized conceptions of space in the United States (De Genova 1998). Where migrants or other minorities are approached through the imaginary of the "global," the geographic distance to the sick abroad is mapped onto the social distance to the marginal sick at home. This may further cement the perception and fact that for large parts of the US population, access to healthcare is dependent on the goodwill of domestic humanitarians and not an entitlement.

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[12] See "Generation Study Abroad," Institute of International Education, accessed August 1, 2018, https://www.iie.org/Programs/Generation-Study-Abroad.

[13] Crane (2013, 167) makes a similar point about "valuable inequalities," yet with a focus on the biomedical and not the ethical/sociomedical value of research and training in poor countries.

The "global" perspective on domestic inequality is thus not only mobilizing for justice but may contribute to essentializing difference. As studies of "cultural competency" training in US medicine have shown, the risk of these trainings is that they reify difference at the same time as seeking to bridge it (Hester 2015). The project of "Global Health at home" has to navigate a similarly ambivalent terrain and strive to keep challenging inequality while finding means to alleviate its consequences.

Conclusion

Challenging established conceptions of Global Health as a practice of North–South diffusion and domination, this article has analyzed the reimport of lessons from the South to the United States. The focus on the US American center of the Global Health discourse has shown that even this metropolis is not an unmarked, "universal" territory of medical globalization. The United States is itself a target of Global Health, a professional field that marks in particular poor and marginalized Americans whose access to the domestic healthcare system is at best precarious. I have focused on a central site of meaning-making in the United States, namely higher education and thus the construction of a Global Health curriculum. The deterritorializing and reterritorializing moves through which educators make lessons from the South applicable at home reveal the transnational reach of Global Health professional authority. It is a scale of expertise that cuts across established North–South divides and considers peripheries abroad and at home as part of one domain of Global Health. This analysis is based on a cross-fertilization of professional sociology and political geography. It shows how professional claims for expertise refer to a transnational space that need not be coextensive with national territory (Brenner 2004). Thus, the scale of professional jurisdictions should be considered as endogenous to the process of globalization and not as its stable (national-territorial) background.

My focus on the United States thus helps provincialize the Global Health discourse and reveals its local meaning in a seemingly placeless, universal center of globalization. Evidently, this provincialization also implies that observations from the United States cannot be swiftly generalized to other exporting countries of Global Health. Domestic agendas and reimports are shaped by many contextual factors, and in the health service domain, the role of immigrant or indigenous rights, the organization of health systems, and the social background of medical students will all influence how Global Health plays out domestically. Notwithstanding the specificity of the US case, trends in the United States do often set the agenda for developments in other countries. US public health schools attract students from all over the world,[14] and they continue to lead in international rankings where they are followed by universities in the UK, Canada, and Australia.[15] Given that practices developed in the United States circulate widely through transnational networks, they often become references for professional projects in other countries.[16] Future studies of Global Health practices should thus pay more attention to South–North knowledge flows and their implications for health inequality around the globe.

At a more general level, this article underscores the importance of non-elite professional globalization. Not only policy elites but also ordinary medical practitioners are highly mobile, and they integrate professional work abroad and at home. In particular, I have highlighted that this transnationalism starts during medical education. Yet, transnational student mobility is a much more pervasive trend

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[14] In 2012, among the students enrolling in one of the public health programs of the member schools of the US Association of Schools and Programs of Public Health, about 15% were non-US citizens (Kono and Chang 2014).

[15] See, for example, the *US News and World Report* ranking of "Best Global Universities for Social Sciences and Public Health" for 2017, whose top ten comprise seven US-based and three UK-based schools (*US News and World Report* 2017).

[16] See the contributions in Schott and Hornberg (2011), many of which refer to "US standards" or examples of US support for public health institution-building in Germany.

that is not limited to the health professions. Today, higher education institutions seek to prepare students of practically any discipline for transnational careers in an interconnected world (Zamani-Gallaher, Leon, and Lang 2016). Study abroad experiences socialize students into specific political conceptions of the global (see Müller 2011). Additionally, study abroad experiences are also assets that benefit students' future career opportunities. They become "international capital" (Basaran and Olsson 2018). Thus, both the substantive didactics and the stratifying impact of globalized higher education deserve closer scrutiny by scholars interested in globalization, expert power, and social inequality.

Supplementary Information

Supplemental information can be found at *IPS* Online.

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Funder Information

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