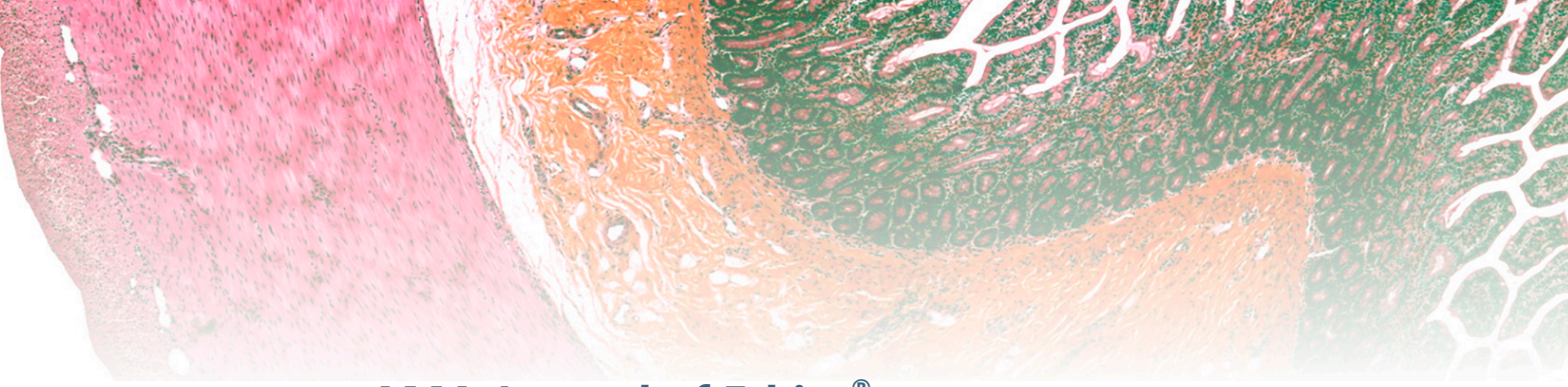

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LETTER TO THE EDITOR

Response to "Ethics and Linguistics of 'Domestic Global Health' Experience"

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In "Ethics and Linguistics of 'Domestic Global Health' Experience," Em Rabelais and Esmeralda Rosales raise concerns about the colonial and paternalistic roots of "medical mission" work (within the United States or internationally) and the use of the term *domestic global health*. In "How Should Academic Medical Centers Administer Students' 'Domestic Global Health' Experiences," I review parallels between community health experiences internationally and experiences serving the underserved within the United States, often with migrant populations or in student-run clinics. I use the term *domestic global health* to highlight these parallels, as has been done in the literature elsewhere.[1,2,3] As a primary care physician within a large urban safety-net system with a focus on immigrant children and families, I agree with the authors of this response that engagement with local underserved areas within the United States is respectable and valuable without need for reference to service elsewhere. I also agree that we, as faculty at academic medical centers (AMCs), have an obligation to understand the roots of and our role in these issues, as discussed in the paper. Ultimately, we have an obligation to critically assess how our communities can be supported by AMCs, in partnership with the communities themselves.

However, there is limited literature on the ethics of AMCs serving the underserved domestically and how AMCs approach teaching students to serve this population.[4,5,6] As the authors describe, this lack of literature is highly concerning and likely reflects 2 key issues: the first is the structural roots of discrimination and disenfranchisement in our communities and country; and the second is the historical popularity of global health as a field among trainees. Clearly, we must work out ethical guidelines for how AMCs approach sustainable community engagement and partnership. Furthermore, AMCs must consider their own roles in addressing systemic inequalities and inequities.

The authors raise concerns about the development of the literature on the ethics of global health engagement, beginning with the term *global health*. I agree with the Rabelais and Rosales that experiences serving the underserved domestically would be better described using a term other than *domestic global health* to eliminate concerns about "othering." Ethically and clinically, these experiences are ultimately community health experiences, regardless of if they are domestic or global. The critical appraisal of the content of and training for this engagement, including training with experts in relevant humanities and social sciences content, is clearly key for AMCs.

However, if we agree that ethical structures for community engagement domestically or globally should be rooted in our communities, there are parallels with global health, many of which are cited in this same September 2019 issue of this journal. The authors themselves highlight shared themes, including colonialism, paternalism, and racism. These parallels exist regardless of the terminology used and represent critical issues in the history of academic medicine in which AMCs must consider their role. Looking to these curricula is less about their shared "exoticism" and more about the recognition of the shared history of structural violence that AMCs have an obligation to address in designing programs and curricula.

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