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The Ethics of Medical Voluntourism:
the Conceptualization and Management of 'Doing Harm' Within the Business

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Spring 2022

SIT Switzerland: "Global Health and Development Policy"

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Abstract

Although medical voluntourism programs are rapidly growing in popularity, deep ethical controversies overly the industry. In particular, understanding how the field of medical voluntourism follows a business model sheds insight on the sources of tension and conflicts of interest that can arise within organizations and the sector as a whole. However, understanding the roles of individual motivations and societal pressures in the development of these ethical controversies is relatively unexplored.

Through an inductive thematic analysis of data gathered from literature review and expert interviews, this project investigates these driving factors behind the rapidly growing business, how these driving factors contribute to ethical controversies, and how harm is often inadvertently done through medical voluntourism. This research project shows that the medical voluntourism business is self-serving and often unequally prioritizes the desires of its participants over the needs of the communities it serves. This project also concludes that the lack of an overarching ethical framework leaves the door open for harm to be done both through individual and social channels. The ethical dilemmas that abound the medical voluntourism business do not fully preclude opportunities for mutually beneficial experiences, but further regulation is warranted.

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Introduction

The concepts of voluntourism and global health experiences are rapidly growing in popularity. Most participants share the goal of volunteering in low-income health settings while traveling and gaining personal experience. However, the foundational combination of volunteering and tourism has prompted an ethical debate among researchers, participants, and organizations.

To understand this debate, it is first important to distinguish between volunteerism and voluntourism. For the purposes of this paper, the following definitions will be applied.

Volunteerism refers to “any activity in which time is given freely to benefit another person, group or organization..., [specifically] activities that are non-obligatory...; undertaken for the benefit of others; unpaid; and undertaken in an organized context” (Whittaker et al., 2015).

Additionally, volunteerism is “a form of helping in which people actively seek out opportunities to assist others in need, make considerable and continuing commitments to provide assistance, and sustain these commitments over extended periods of time, often at considerable personal cost” (Synder, 2001). Regarding the identity of volunteers, there is no strict rule, but they are “often seasoned professionals who are either pursuing a career break or seek to give back by using their skills to help communities” (Cheer, 2019). These definitions have been selected for their broad scope and attention to motivation, timeframe, and level of commitment.

In comparison, voluntourism is shortly the “merger” of volunteering and travel (Cheer, 2019). More specifically, voluntourism has been defined as “short-term volunteer services with high adventure and experience-related content” where “participants from developed countries [embark] on volunteer assignments in less developed countries of the world” (Czarnecki, 2015; Cheer, 2019). Importantly, voluntourism has “a moral dimension” and attempts to satisfy the

“desire to ‘do good’ while travelling” (Benali, 2018; Cheer, 2019). However, the pursuit of personal interests and desires is a distinguishing factor of voluntourism. Thus, the unique “experience that combines tourism and volunteerism through participation in social projects in developing countries... [allows for] reconciliation of altruistic motivations and self-interest” (Benali, 2018). Finally, an additional distinguishing factor of voluntourism is the large sums of money participants pay to partake in this form of volunteering (Cheer, 2019). Regarding the identity of voluntourists, they are often students or relatively unskilled volunteers, though this is certainly not always the case. As above, these definitions have been selected for their broad scope and consideration of motivation and timeframe.

The description of voluntourism given above applies to medical voluntourism, with programmes generally of “short duration, usually between 1-4 weeks” and participants ranging from “qualified health professionals... [to] undergraduate or health professions students, or medical residents (McCall & Iltis, 2014; McLennan, 2014; Sullivan, 2018). The principle of medical voluntourism is to “travel to another country to provide medical services... usually [to] poor or rural populations” (McLennan, 2014). Participants and programs are often of Global North origin, while the targeted communities are usually in the Global South (Godkhindi, 2020). Medical voluntourists may “set up health education workshops, complete observational work or even basic clinical tasks” as part of these programs (Wallace, 2012). Throughout the literature, medical voluntourism experiences are described using a variety of terms, including ‘clinical tourism,’ ‘international clinical volunteerism,’ ‘global health experiences,’ and ‘medical service trips’ among others (Wendland, 2012; Sullivan, 2018; Shah & Wu, 2008; Godkhindi, 2020). For the purposes of this paper, ‘medical voluntourism’ and ‘global health experiences’ will be used interchangeably.

To consider ethical debates of this industry, it is important to clarify what is meant by ethics and the principle of “do no harm”. Ethics is broadly “the study of the nature of morals and the specific moral choices to be made” (Varkey, 2021). Ethics are an essential component of the field of medicine, including the widely known Hippocratic oath, which states “do no harm” (Murray, 2016). Also known as the principle of nonmaleficence, “do no harm” describes “the obligation of a physician not to harm the patient” (Varkey, 2021). However, within the field of medical voluntourism, it is important to consider a definition of “harm” beyond a patient’s physical and mental condition. Philosopher John Stuart Mill considered ‘harm’ to be something that is “injurious or [sets] back important interests of particular people, interests in which they have rights” (Brink, 2021). This definition, in combination with the traditional medical oath to “do no harm,” guides this research project. Importantly, it considers the potential to do harm beyond an individual patient’s health. It also considers the possibility of inflicting harm by setting back local development efforts and entrenching global inequality. These are all interests of local communities in which they have rights, namely the rights to development and equality.

The primary objective of this research project is to investigate the medical sector of the voluntourist industry within the broader themes of public health and development. Specifically, this project seeks to understand the impacts of medical voluntourism on public health, as well as the industry’s origins and continued contributions toward global development. The project is guided by the following research question: How do individual motivations and societal pressures experienced by short-term voluntourist health workers contribute to the development of an ethically controversial voluntourist business? To deepen the research, the following sub-question is also considered: How is ‘doing harm’ conceptualized and managed within this business? Main

themes that are relevant to this research project include the growing interest in global health, ethics and ethical frameworks, the concept of ‘doing harm,’ and voluntourism as a business.

This project contributes to a growing body of literature questioning global health experiences and the broader voluntourism industry. It approaches the ethical debate from a new perspective, considering the combined effect of individual motivations and societal drivers on the growth and repercussions of the medical voluntourism industry. The underlying consideration of “Do No Harm” provides a unique insight to the field of study.

Methods

A primarily qualitative method was selected to evaluate this research subject since the research question is exploratory in nature. It seeks to understand, rather than quantify, the impacts of driving factors of the voluntourism industry and how the cultivation of a business is ethically controversial. The research method incorporates both primary research, in the form of interviews, and secondary research, in the form of literature review.

Sources for literature review and analysis were gathered mostly from online databases and library collections. A search of academic journals also yielded important sources about voluntourism trips and ethical considerations. The university libraries of Lausanne and Zurich were also visited to evaluate book sources. One of the most effective methods of gathering additional sources was searching the bibliographies of collected articles; this identified other relevant publications that did not present in the original searches.

Three interviews were conducted, including two formal interviews and one informal interview. Formal interviews were conducted with Dr. Amira Benali and Dr. Noelle Sullivan. Both are well-qualified experts in their field, having conducted extensive field research on the subject of voluntourism. Dr. Benali conducted research in Nepal, while Dr. Sullivan has

specialized in Tanzania. The main selection criteria for these interviewees were qualification, level of experience, relevant research publications, and accessibility. Dr. Benali's has extensively researched the "poverty business," so she offered a valuable perspective in response to the project's research question. Dr. Sullivan has extensively researched structural drivers of voluntourism, so she provided essential insight as well.

An informal interview was conducted with a coordinator at MEDLIFE, a non-profit organization that works with low-income communities to improve medicine, education, and development and provides service-learning trip opportunities to volunteers. This MEDLIFE coordinator is a tourism professional with over 8 years of industry experience. The main selection criteria for this interviewee was experience, involvement with an organization that provides medical service learning trips, and accessibility. This interview mainly served a purpose of general information gathering and discussion.

A majority of selected documents are articles from academic journals. A few others are chapters from books. This process was guided by an assessment of relevance to the guiding research question and quality of source. In particular, it was important to consider peer-reviewed sources, given the complexity of ethical considerations and certain controversies that face the subject. There exists an abundance of blog posts and newspaper or magazine articles which deal with voluntourism; however, these generally dealt with personal experiences or general opinions on the industry, which were not as critically relevant for this project. Thus, the overwhelming majority of selected documents are formal and academic in nature.

This method was selected to collect a balance of data. The goal of this project is to understand and to analyze, not to create a blanket judgement, so it was important to gather a variety of sources and perspectives. A balance of primary and secondary data was intended to

combine gathered information and trends from the literature with opinions and first-hand experience of experts and key players.

An inductive frame with thematic analysis was chosen for this project. The guiding research question specified a few overlying themes, namely ethical dilemmas facing the voluntourist industry, individual motivations of voluntourists, societal pressures that encourage voluntourism, voluntourism as a business, and the concept of doing harm. Information and perspectives from the literature, as well as from personal interviews, were grouped according to relevant theme. These themes were then analyzed to consider trends, debates, and conclusions.

Important ethical considerations for this project included informed consent, voluntary participation, and anonymity. Interviewees were verbally consented before the interviews, and both formal interview subjects gave approval to be quoted and/or referenced within this project. The informal interview subject preferred to remain anonymous.

A few main difficulties and limitations that presented over the course of this research project were short time frame and small interviewee sample. This included an inability to talk to past volunteers, prospective volunteers, and host communities to get the opinions of these groups. Additionally, the project timeline didn't allow for an interview with the founder of MEDLIFE, which would have provided an interesting perspective on program design, ethical considerations, and the voluntourism industry. Thus, this perspective is unfortunately absent in this review.

Literature Review

The historical origins of voluntourism date back to the 1950s, when international volunteering took root with organizations like the Peace Corps, the Voluntary Service Overseas, and Volunteers International (Baron, 2021). Since then, the concept of international volunteering

has grown massively, including an expansion into the realm of tourism. This expansion coincides with increasing global mobility and a growing social emphasis on “social responsibility” (McCall & Iltis, 2014; Snyder, 2011). In fact, since the end of the Cold War and the fall of communism, there have been shifts in politics and ideologies to focus more on individual actions and individual identity. This has been driven by a “crisis of meaning” and focus on ethical consumption, and accordingly, individual volunteering has popularized as a solution to social problems (Lasker, 2016).

Alongside this emphasis on individual action, there has been an increase in a desire to personally help. In many Western nations, the past few decades have been prosperous (Cheer, 2019). In response, there has been “a tidal wave sweeping the country... [of people] responding to their visceral impulse. [They think] ‘there is so much need, and I want to be part of the solution.’ Not any further than that” (Lasker, 2016). This gut reaction response, without true consideration and reflection of purpose and usefulness, has been shown to be problematic. For example, as part of an ethnographic study of voluntourism in Nepal, a voluntourist explained his decision to participate saying, “‘I’m just going to go myself. Why not, like, go and do something?’” (Benali, 2018). However, this assumed ability to help “reflects a development narrative based on a highly anchored assumption of the supremacy of the West over the ‘rest’” (Benali, 2018).

The popularization of voluntourism is both a contributing factor to, and result of, the growing societal expectation of morality and philanthropy in the global North. It seems that volunteering and “humanitarianism and development have never been as fashionable and sexy as today” (Benali, 2018). In fact, “volunteer tourism is becoming a part of the western lifestyle under the fashion of moral consumption and global citizenship” (Benali, 2018). Important factors

to consider in this trend include the influence of social media and popular communications, as well as the participation of famous celebrities in volunteer and development efforts. All of these components contribute to a societal pressure and expectation which associates voluntourism with achievement of moral citizenship and approval.

Similar trends are seen specifically with medically focused voluntourism trips, often termed global health experiences. Over the past few decades, there has been a steep rise in interest in global health among medical and pre-medical students, as well as physicians. Again, there is an association between international volunteering and achievement of a societal standard of morality. The idea that “it is our moral duty as global citizens to alleviate the suffering of others and address the rights to health” has been pushed to the forefront with a particular emphasis of travelling to lower-income countries to do so (Asgary & Junck, 2013).

In response to this growing demand, universities, medical schools, and volunteer organizations have increasingly developed opportunities for global health experiences (Melby et al., 2016; Sullivan, 2018). These short-term trips are, in essence, voluntourist trips, catering to the desires of students and physicians to travel, learn, help, and have a global experience (Kittle & McCarthy, 2015). Based on the presumed educational and moral benefits for volunteers, these global health experiences are commonly referenced on medical school applications and are increasingly included as part of health care profession training (DeCamp, 2011; Sullivan, 2016). In fact, in 2000, just over a third of medical students in the U.S. and Canada had participated in a short-term global health experience, which represented a three-fold increase over 20 years (Wendland, 2012). By 2010, that number had increased to two-thirds of medical students (Sullivan, 2016).

This rapid growth in the industry prompts a few questions, particularly regarding its intentions and priorities. It is clear that medical voluntourism claims moral and altruistic goals. However, it is important to also consider the economic side of the industry. Medical voluntourism opportunities are not free; in fact, participants often pay upwards of US\$1000 for a one- or two-week trip (Cheer, 2019). This pay-to-participate format reflects a business model that guides the industry. As such, medical voluntourism is “situated between the corporate vision of private organizations based on profit maximization and the philosophy of NGOs founded on community development” (Benali, 2018). Furthermore, the existence of both for-profit and non-profit organizations drives the business. In particular, for-profit voluntourism organizations are motivated to recruit more volunteers in order to profit off of their participation fees. In turn, this forces non-profit voluntourism organizations to adopt elements of this business model to effectively compete for volunteers (Reel, 2016).

These business characteristics shed light on the needs and priorities of voluntourism organizations aside from assisting local communities. The potentially conflicting nature of these priorities is at the root of the ethical controversy. For example, the literature discusses voluntourism as an “ethical business: it helps the poor while it helps itself” (McGloin & Georgeou, 2015). It also questions the “voluntourism paradigm,” where “while voluntourism ‘gives,’ it is also taking, as the experiences of the authentic ‘other’ and of ‘doing development’ are acts of consumption” (McGloin & Georgeou, 2015). This competition between ‘giving’ and ‘taking’ is a point of tension within the priorities of medical voluntourism organizations.

Although voluntourism organizations advertise the opportunity to help communities and ‘give back,’ they also strongly advertise opportunities for volunteers to benefit personally. In fact, to effectively recruit volunteers, organizations often focus on volunteer benefits and

satisfaction, which can lead to exclusion or neglect of local priorities (Benali, 2018; Lasker, 2016). These volunteer benefits can include new global experiences, resume/CV enhancers, and personal transformation (Bauer, 2017; Bjerneld, 2009; McGloin & Georgeou, 2015; Occhipinti, 2016; Sykes, 2014; Willot et al., 2019). However, there is a third potential beneficiary—the sponsoring organization itself (Lasker, 2016). For-profit voluntourism organizations aim to profit from the programs they run, and all voluntourism organizations benefit from volunteers participating in terms of their own continued existence and longevity (Clark, 2020). In this way, organizations may inflate the importance of attracting prospective voluntourists in relation to considering how to best benefit the populations they serve.

In the case of medically oriented voluntourism, there are additional considerations for both local communities and volunteers. For example, one goal of global health experiences is to provide valuable learning opportunities for participants, especially students. However, this must be weighed alongside impacts on local communities, such as quality and continuity of care (Hamideh, 2017; Matlick, 2018; Willot et al., 2019). Research has shown that short-term global health experiences can support education and lay foundations for “globally engaged health care workers,” but if they focus only on the volunteer experience, these programs can “constrain the broader aim of international development, elimination of health disparities, and public health, particularly if the experiences are not associated with a capacity-building agenda” (Melby et al., 2016). This again presents the potential conflict of interest between volunteer and community benefits, and it introduces the possibility of doing harm through voluntourism.

The fact is, every voluntourist that participates in a trip influences the community they visit, for better for worse. However, they also inevitably contribute to the perpetuation and proliferation of the voluntourist business, the impacts of which are also controversial, albeit on a

larger scale. These questions and unresolved issues provide the foundation for the current research project, which seeks to understand the interrelations between these various factors and question the inevitable conflicts of interest which plague a business aimed at aid and development.

Analysis

Medical Voluntourism as a Business

To understand how individual motivations and societal pressures drive the business of medical voluntourism, it is first essential to understand the conceptualization of medical voluntourism as a business. In essence, the medical voluntourism industry follows a business model based on the good intention and motivation of young people to travel and to help” (A. Benali, personal communication, April 21, 2022). Medical voluntourism organizations “remake the needs of postcolonial health facilities into a market, attracting mobile foreigners with aspirations to ‘do’ global health” (Sullivan, 2018). This market becomes profitable due to the large amounts of money participants are willing to pay to take part. Accordingly, it can be said that medical voluntourism is “the embodiment of a most commoditized form of altruism” (Sullivan, 2018).

Good Service or Good Business

As is true with other businesses, marketing is an essential component of medical voluntourism. Without effective marketing, sponsoring organizations would not have a volunteer base with which to operate. Importantly, medical voluntourism organizations get to self-advertise, pitching their programs in ways that seem responsible and cater to their audience (N. Sullivan, personal communication, April 29, 2022). Some ways to attract participants include promotional videos, statistics to show impact, and attractive framing of price schemes (Benali,

2018). Another popular marketing strategy is sharing testimonials of past volunteers. By “celebrating opportunities to have a transformative experience, to be more ‘hands-on’ ... [and] to have a real impact while learning important professional skills,” these narratives allure prospective volunteers (Wendland et al., 2016). This strategy can be particularly effective with medical and pre-medical students, who are eager to learn and develop skills. It may even convince these individuals that they will miss out on opportunities or fall behind if they do not participate.

All of these strategies ensure that the medical voluntourism business grows its customer base. However, it also needs to maintain market demand for its services. Although medical voluntourism intends to promote development, the business’ very survival and prosperity relies on the continued existence of communities and health systems to help. In fact, voluntourism organizations “rely on and perpetuate the very inequalities they purport to address through volunteers [because] doing so is good business” (Sullivan, 2018). In this way, the voluntourism industry is self-serving. However, this leads to an inherent tension between the economic needs of sponsoring organizations and the goal of sustainable, local development which relies less and less on foreign volunteers (Berry, 2014). It is seemingly impossible for the medical voluntourism industry to simultaneously continue growing and effectively benefit the local communities it serves. This presents a huge conflict of interest for organizations and the industry as a whole.

Local Harm and Dependency

In many ways, these programs can thus do harm. On the sector level, the medical voluntourism industry can harm local economies and increase dependency. Namely, whereas local health workers would be compensated, voluntourists do things for free (Benali, 2018; Clark, 2020). This can lead to preferential selection of voluntourists over skilled locals when

filling positions, which decreases employment opportunities for these local professionals (Cheer, 2020). In the long-term, this can contribute to a devaluing of local knowledge and expertise in favor of the *assumed* skill of Western voluntourists (Sullivan, 2018).

Furthermore, the availability of free treatment and services from voluntourist groups may encourage patients to wait and avoid seeking care from their local healthcare system (Bauer, 2017; McLennan, 2014; Shah & Wu, 2008). Beyond the obvious health risks this phenomenon poses to patients, it is also detrimental to the overall local healthcare system. First, it counteracts local healthcare investment and discourages local initiatives, as the “input of foreign capital takes pressure off the local government to invest in its health care” (Bauer, 2017; Green et al., 2009; Godkhindi, 2020; Melby et al., 2016). Further, it can decrease demand, and therefore wages, for local health providers. Over time, this can lower morale and push local professionals to leave in search of positions abroad, which exacerbates local struggles and encourages a perceived need for assistance from voluntourism organizations (Bauer, 2017). This then contributes to cultivation of dependency, which again reinforces the voluntourism business and “ends up creating a grotesque market that capitalizes on [local] concerns” (Anderson S et al., 2017; Hamideh, 2017; McCall & Iltis, 2014; Snyder et al., 2011).

This cyclic chain of events sheds insight into the underlying strategy of the voluntourism business. Namely, it reveals how the industry can appear to promote aid and development in communities while simultaneously ensuring its own survival. This distinction lies at the heart of the ethical controversy facing the medical voluntourism business.

Lack of Ethical Framework

The main ethical controversy of medical voluntourism is that, in the midst of conflicts of interest and competing priorities, there is no enforced ethical framework to guide and regulate

the industry. This is in stark contrast to the field of humanitarianism, which is strictly and officially guided by the principles of humanity, impartiality, independence, and neutrality (Gordon & Donini, 2016). Additionally, it is in contrast to the field of medicine, which is strictly and officially guided by the principles of beneficence, nonmaleficence, autonomy, and justice (Varkey, 2021). Considering the similarities and relations between the field of medicine, humanitarian action, and medical voluntourism, the lack of a guiding ethical framework within the last begs a serious question.

Mainly, it leads to concerns of violation of fundamental ethical principles, such as beneficence and nonmaleficence. Critical in the medical field, these principles draw from the Hippocratic oath of ‘do no harm’. Beneficence actually goes a step further than nonmaleficence, emphasizing benefit to the patient, not just absence of harm (Varkey, 2021). It can be seen that these principles may be difficult to ensure in medical voluntourism trips where the sponsoring organization’s focus may be split, or even favor, the voluntourist’s experience instead of the needs and desires of the community. Ultimately, if there is no standard to hold organizations accountable, when organizational priorities compete with patient best interest, doing harm—even unintentionally—becomes more likely (N. Sullivan, personal communication, April 29, 2022).

Furthermore, the lack of an ethical framework allows for a lowering of ethical standards. For example, “if short-term occasional health services were the best way to get medical care, we’d be doing it in our own countries, and obviously we are not” (Lasker, 2016). Likewise, if a revolving door of often young and inexperienced mobile foreigners were the best providers of care or the best assessors of local needs, we would see them in our own countries. Again, we do not. These arguments are not intended to negate the very real and vast demand for healthcare in underserved communities around the world. However, they *are* intended to call attention to

failures of the current system, which contribute to a flawed and insufficient response to this demand. Additionally, these arguments are intended to highlight ethical blind spots. Left unaddressed, these realities ultimately “suggest that it is acceptable for the quality of medical care provided in the developing world to be lowered,” which is deeply problematic (Wallace, 2012).

Along this line, there is also no industry-wide conceptualization of “doing harm,” nor is there any widely accepted strategy to prevent doing harm. A select few organizations work very hard to maintain good ethics within their programs, but overwhelmingly, programs fail to recognize or acknowledge their long-lasting effects on local economies and global relationships (N. Sullivan, personal communication, April 29, 2022). Medical voluntourism projects assume the West has “the answers to the developmental problems of the developing countries, while failing to acknowledge the place of the West in creating/entrenching such problems” (McLennan, 2014). This lack of acknowledgement especially includes the ways in which the perpetuation of the medical voluntourism industry inherently perpetuates local struggles and dependency. Critically, the lack of consistent consideration and prevention of “doing harm” on the sector level leaves the door open for harm to be done on the individual level, especially given the business’ heavy reliance on individual motivations and societal pressures.

Medical Voluntourism on the Individual Level

The medical voluntourism business would not exist without a steady stream of interested participants. Understanding why these individuals want to participate in medical voluntourism is therefore at the root of understanding the overall industry.

Driving Factors of Medical Voluntourists

Individual motivations for participation in medical voluntourism speak to the overall purpose of the industry, as well as give insight into the rapid growth of the business. Both medical voluntourists and sponsoring organizations tout moral and altruistic intentions; however, these are not the only motivations. Rather, medical voluntourists also seek personal benefits and experience (Anderson et al., 2017). The desire for and growing societal expectation of participation in medical voluntourism trips has caused more and more medical voluntourists to partake in these global health experiences.

Social Capital and Performance

Global health experiences are highly desirable to students and young professionals in part due to the ‘social capital’ they provide. An international clinical experience is viewed as a distinguishing factor on a medical school application or resume (Lasker, 2016; Matlick, 2018; Occhipinti, 2016; Snyder et al., 2011; Sykes, 2018; Willot et al., 2019). It is considered to be a way of demonstrating the applicant’s interest, morality, empathy, and global engagement (Anderson et al., 2009; Benali, 2018; Occhipinti, 2016). In fact, the fields of biomedicine and global health increasingly “expect aspiring students to demonstrate altruism and ‘experience’ prior to acceptance into health professions programmes... [which converts these characteristics] into moral commodities for prospective students to consume” (Sullivan, 2016). In this way, those who can afford to participate in medical voluntourism are awarded with social and academic advantage, and institutions such as undergraduate universities and medical schools—which place value on these experiences—contribute to the business’ growing demand (N. Sullivan, personal communication, April 29, 2022). This trend has subsequently seen participation in a medical voluntourism trip as a “coming-of-age ritual” within higher education and medical education (Bornstein, 2012).

This is compounded by societal pressure to perform and demonstrate one's morality and altruism. There is a strong sense that "society is pushing you to become someone special... [and thus] it is very much rooted in our society to slave about what others think about us" (A. Benali, personal communication, April 21, 2022). Volunteerism is something that looks good to society and is celebrated by society, and this social reward makes participation in medical voluntourism appealing (N. Sullivan, personal communication, April 29, 2022). This is especially true for medical students who aim to present themselves as ideal candidates for medical school, and for medical professionals who aim to uphold the values of morality and compassion they stand for in society. Participation in medical voluntourism is frequently celebrated. Participating in global health experiences can be a demonstration of these values. Furthermore, medical voluntourism trips are presumed to "engender cultural competency, improve work efficiency, increase awareness of health disparities, and stimulate interest in care for underserved populations" (Sullivan, 2018). These skills are particularly emphasized in today's society and field of medicine, so demonstrated pursuit of these skills and experiences can be a way to respond to and satisfy this societal pressure.

Clinical Experience

Medical voluntourism is also appealing to medical and pre-medical students who are "eager to help and to try their hands in the clinical setting" (McCall & Iltis, 2014). They may see the experience as educational, or they may believe that with their Western theoretical background and good will, they can help care for patients in the field (Bjernelid, 2009; Stone & Olson, 2016). A large component of medical tourism is the experience participants gain—experiencing a different culture, experiencing poverty, experiencing a different healthcare system, and experiencing clinical care within that system. However, "amidst all of this

‘experiencing’, most volunteers also hope to find opportunities where they, as individuals, might make a difference in the lives of patients or the quality of healthcare provision” (Sullivan, 2016).

Specifically, many student medical voluntourists may look for opportunities to play a more active role in the clinical setting while participating in a medical service trip. Medical voluntourism programs may specifically appeal to pre-medical students who want to get clinical experience but have faced roadblocks in their home communities, usually due to strict ethical guidelines. Medical students may view global health experiences as an opportunity to test their skills or to see a different healthcare system (N. Sullivan, personal communication, April 29, 2022). Accordingly, students frequently view medical voluntourism programs as valuable learning opportunities.

The appeal of medical voluntourism also applies to qualified health professionals who have an interest in experiencing a different clinical setting. For many medical professionals who participate in global health voluntourism, it is an escape from the bureaucracy and paperwork “back home” and serves as an opportunity to practice “real medicine” (Occhipinti, 2016; Stone & Olson, 2016). Physicians say volunteering abroad “reminds [them] why [they] do what [they] do,” and that they “looked forward to be working as ‘real doctors’ during [these] missions” (Occhipinti, 2016; Bjerneld, 2009). Surveys of physicians who took part in short-term medical missions revealed that escape, adventure and challenges, renewal, and perceived meaningful patient encounters were all motivating factors for their participation (Caldron, 2017). Physician voluntourists may also be intrigued by the possibility of practicing different skills or caring for different patient populations than they do in their every-day jobs.

Repercussions of Medical Voluntourist Actions

Students and professionals who participate in medical voluntourism have likely been influenced by personal motivations, societal pressures, and “good intentions,” as discussed above; however, these driving factors don’t always include considerations of net benefit and harm (Wallace, 2012). For example, the short-term nature of medical voluntourism trips may not be conducive to true reflection on effectiveness or repercussions (Anderson et al., 2021; Benali, 2018). Additionally, medical voluntourists are frequently not informed or aware enough of their limitations and/or how ethical dilemmas may present during a global health experience trip. These realities contribute to the ethical controversy overlaying medical voluntourism, as well as the potential to do harm.

Harm to Patients

The most immediate negative repercussions of medical voluntourism involve harm to patients. In general, this harmdoing is unintentional. However, there is an essential ‘duty of care’ in medicine which depends on patient-provider trust, and which preserves a “patient’s ability to rely on the clinician as a skilled professional who will help the patient make informed choices in the patient’s best interest” (Shah & Wu, 2008). This ‘duty of care’ is the fundamental reason why medical voluntourists “have an obligation to disclose their level of training and to not act beyond their capabilities to maintain this trust” (Shah & Wu, 2008). Particularly in medical voluntourism settings, “where patients might have had no access to medical professionals for long periods of time, visiting medical students can be seen as being no different from qualified medical professionals, which is hazardous in both directions in terms of expectations” (Willot et al., 2019; Kittle & McCarthy, 2015). If medical voluntourists aren’t clear with their qualifications and limitations, this ‘duty of care’ is not upheld, and they risk doing harm.

Unfortunately, motivated by their desire to help and gain clinical experience, medical voluntourists do often violate this ‘duty of care’. For example, student medical voluntourists may find themselves in situations beyond their qualifications and “with ‘exceptional responsibilities’ well beyond their competence” (McCall & Iltis, 2014; Willot et al., 6; Snyder et al., 2011). Notably, these students may find themselves with opportunities to participate and perform tasks that would be prohibited at home (Langowski & Iltis, 2011; Anderson & Wansom, 2009; Stone & Olson, 2016). If these individuals choose to capitalize on these opportunities and act outside their qualification, it can put patients in danger (Asgary & Junck, 2013). Often, peer pressure from other medical voluntourists and a noticeable lack of repercussions can encourage individuals to do so, prioritizing their own interests over the well-being of patients (Green et al., 2009; Hamideh, 2017; N. Sullivan, personal communication, April 29, 2022). Unfortunately, these “ethically problematic clinical situations can... place volunteers in circumstances that are potentially psychologically damaging,” especially if the choices made by those individuals have harmful or fatal consequences (Wallace, 2012; N. Sullivan, personal communication, April 29, 2022).

The format and characteristics of medical voluntourism trips also elevate the risk of doing harm. First, many medical voluntourists are students, who are simply not licensed to practice medicine. Their lack of training, coupled with the unfamiliarity of a new country and new healthcare system, could lead to missteps and unsafe practices (Asgary & Junck, 2013; Hamideh, 2017). Additionally, even licensed practitioners are not licensed to practice medicine anywhere they please, owing to critical differences in environment, healthcare systems, resources, and other factors (N. Sullivan, personal communication, April 29, 2022). For example, some Western practitioners may be dependent on advanced technologies for testing and/or

treatment and struggle without access to these resources, hindering their ability to provide quality care to patients (Asgary & Junck, 2013; McCall & Iltis, 2014; Stone & Olson, 2016).

Additionally, many practitioners of Western medicine are highly specialized and used to a healthcare system reliant on referrals between providers, which may not be compatible with the low-resource settings or short time frames they encounter in medical voluntourism (Asgary & Junck, 2013). Finally, the process of allocating resources in low-resource settings and maintaining justice may present challenges to both student and professional medical voluntourists (Asgary & Junck, 2013; Murray, 2016; Willot et al., 2019). Ultimately, these challenges are all rooted in inexperience and unfamiliarity.

Furthermore, the short duration of medical voluntourism trips presents an increased risk of doing harm. First, it generally precludes opportunities to truly get to know the local community and healthcare system. This can be dangerous if delivery of care and/or medications is carried out without consideration of language barriers, cultural differences, and potential incompatibilities with local lifestyle (Bauer, 2017; Asgary & Junck, 2013). Additionally, lack of follow-up care provision can be detrimental to both patient well-being and local health workers. Specifically, it hampers continuity of care and can “[burden] already overstrained local health workers” (Doleeb & Khare, 2021; Godkhindi, 2020).

The consequence of such harmdoing is violation of the ethical principles of beneficence, nonmaleficence, and autonomy. Although there is no enforced overarching ethical framework for medical voluntourism, these violations are, by nature, highly problematic. Namely, those ethical principles are essential to delivery of ethical medical care, and neglect of these principles can be harmful. The violations of beneficence and nonmaleficence arise out of poor or unauthorized care of patients as discussed above. The violation of autonomy arises out of power imbalances,

ambiguous levels of voluntourist qualification, and communication barriers (Murray, 2016; Sullivan, 2018; Wallace, 2012). Specifically, since autonomy upholds the rights of patients to make their own informed decisions and “exercise [their] capacity for self-determination,” then lack of honesty, communication, or informed consent can contribute to violations (Clark, 2020; Hamideh, 2017; Varkey, 2021). It is important to remember that “patients, regardless of their finances, ethnicity, gender, or status, have the right to know if their medical provider is a medical student... [and] should always have the choice whether or not to receive care from a student physician” (Shah & Wu, 2008). However, this right is clearly not always protected within medical voluntourism and can leave the door open to further harmdoing.

Creation of Ethical Double Standard

On a deeper level, the actions of medical voluntourists can lead to creation of an ethical double standard. There are two common justifications that medical voluntourists employ which allow for the creation of this double standard: ‘any care is better than no care,’ and ‘good intentions’ (Hamideh, 2017). First, the idea that ‘any care is better than no care’ allows for a lowering of ethical standards regarding the quality of care provided to local patients and communities (Bauer, 2017). This may be seen with donation of expired medications and/or damaged or outdated medical equipment to local healthcare facilities (DeCamp et al., 2018; Melby et al., 2016). The donation of these resources suggests that they are no longer seen as fit for use within the Global North healthcare system but of acceptable quality for the Global South.

Another example of this ethical double standard is the justification of medical voluntourists performing tasks they are unlicensed to perform based on the presumption that local communities will “benefit from *any* medical services” (Murray, 2016; Shah & Wu, 2008). For example, voluntourists may say, “‘if there’s something going on and there’s nobody free to

deal with it, ... I'm practically qualified. I couldn't stand there and not do something'" (Sullivan, 2018). This again suggests that local populations are deserving of a lower quality of care and reinforces the idea that the same degree of ethical standards need not be upheld, which ultimately "disrespects the dignity of patients and discounts their equality as fellow humans" (Asgary & Junck, 2013). Ultimately, this idea that 'anything is better than nothing' centers around the voluntourist, not the recipients of care (N. Sullivan, personal communication, April 29, 2022). This case-by-case alteration of ethical standards perpetuates underlying inequitable relationships and threatens long-term efforts to attain global development and equality.

Ultimately, this leads to the realization that good intentions are not enough. When not coupled with honesty, training, and a commitment to uphold ethical standards, good intentions can still lead to doing harm (Hamideh, 2017; Wallace, 2012). Unfortunately, good intentions are often the beginning *and* the end of a medical voluntourist's experience. Good intentions may motivate individuals to participate in the first place, but this is where many stop. For these medical voluntourists, no further consideration is given to the potential impacts and repercussions of their actions, including the perpetuation of an ethical double standard (N. Sullivan, personal communication, April 29, 2022). For example, they may not understand the healthcare system or community they are visiting, they may not know the outcomes of their programs, and they may not consider their role within the larger scope of local development efforts. Thus, simply having the best of intentions can still lead to medical voluntourists "perpetuating constantly the same narrative, the same discourses" while failing to achieve "sustainable, long-term healthcare that should be the foundation of every global health program" (A. Benali, personal communication, April 21, 2022; Stoltenberg et al., 2012).

Learning Opportunities

All of this to say, the field of medical voluntourism is controversial and flawed, but it is not worthy of total eradication. In the midst of these opportunities to do harm, there are many redeeming opportunities to learn. First, for medical students and professionals alike, medical voluntourism programs can be a great opportunity to directly observe a different healthcare setting and patient population. In fact, “exposure to global health experiences in resource-poor settings arguably creates more competent future doctors, with improved diagnostic capabilities and a better understanding of the nuances of culture” (Sullivan, 2016).

Furthermore, there is opportunity for a “beneficial form of cross-cultural engagement and mutual learning” (Sullivan, 2016). The crucial aspect of this proposed ‘*cross-cultural* engagement’ and ‘*mutual* learning’ is the idea of sharing and exchange. Namely, it is important to value the bidirectionality of medical voluntourism and to recognize that “even when [host communities are] poor, even when they have challenges, they always have something to teach us” (A. Benali, personal communication, April 21, 2022). As a matter of fact, there are “many [reported] cases in which students’ travels lead to long-lasting connections... that appear to enrich all concerned” (Wendland, 2012). For these reasons, medical voluntourism still has the capacity to be beneficial.

However, to mitigate potential harmdoing, it is essential to approach these learning opportunities with an aspect of humility. For example, it is normal and respectable for young people to be learners, but “it’s important to recognize that one doesn’t have to be a ‘do-er’ to be a ‘learner’” (N. Sullivan, personal communication, April 29, 2022). This requires medical voluntourists to take a step back and be receptive to what they can learn, not just what they think they can do to help. Additionally, as a society we should address the “powerful flattening [that] occurs when a three-week excursion by someone unskilled and ill-supervised... is celebrated in

the same terms as a multi-year commitment by a fully trained and experienced clinician” (Wendland et al., 2016). Instead, of viewing medical voluntourism as the automatic solution to others’ problems, we should recognize it as a learning opportunity and treat it as such. This would likely help reduce the societal pressure to ‘do’ and to ‘fix,’ not just ‘learn’.

With these reflections in mind, when considering the future of medical voluntourism, it is helpful to separate the concepts of the business and the learning exchange. Although ethical controversies apply to both, the business element only serves the industry, whereas the learning and exchange element serves the participants and the communities. This fundamental distinction is why “we should maybe stop the business, but the volunteering, the cultural exchange itself is very important” (A. Benali, personal communication, April 21, 2022). It directs where reform should be prioritized and where meaningful impact arises from.

Conclusion

Throughout this project, the ways in which medical voluntourism operates as a business have been thoroughly considered, as have the points of tension and conflicts of interest that arise from this fact. By analyzing the ethical controversies and repercussions of medical voluntourism at both the sector and individual level, this project has contextualized these debates within the broader themes of public health and global development, as well as considered the potential to do harm.

A few main conclusions can be drawn from the above analysis. First, a cover of altruism disguises the self-serving nature of the medical voluntourism business. Second, the medical voluntourism industry relies heavily on individual desires and social pressures to attract a steady stream of participants. Third, the lack of an overarching ethical framework leaves the door open for harm to be done both through individual patient encounters and through broader social

phenomena. Fourth, good intentions are simply not enough to ensure that medical voluntourism is ethically sound. And finally, honest and informed medical voluntourism can be beneficial as a bidirectional learning opportunity.

These main conclusions summarize the current state of ethical controversy and debate, as well as provide some guiding foundations for future reform of the medical voluntourism industry. However, it is important to note that criticisms and calls for reform of medical voluntourism are not new. Researchers have been denouncing aspects of the industry for years. Some have even drafted proposals for ethical frameworks and guidelines. However, a lack of demonstrated political and economic will have prevented any meaningful response to these critiques.

As discussed, the main concerns regarding the medical voluntourism industry are the unchecked growth of the business, the potential to do harm, and the lack of accountability to ethical standards, on both the individual and sector levels. Thus, recommendations for medical voluntourism primarily revolve around increased regulations and ethical acknowledgement. Increased regulations—such as limits on participation fees, requirements for financial transparency, and more stringent application policies—could help standardize and control the business element of the industry. For example, slowing down the process and placing additional barriers to participation may reduce the demand from prospective voluntourists, as some may pursue separate opportunities for clinical experience or travel. Additionally, implementing an overarching ethical framework and creating a certification for organizations that uphold those principles may help prospective volunteers identify organizations that are more ethical and truly focused on the communities they serve. Finally, implementing a feedback and assessment system within organizations and the field would allow for medical voluntourists to reflect and hold

organizations accountable. These are just a few potential recommendations that have been scattered through the existing literature. However, the most important element for any of these recommendations to take hold is demonstration of political and economic will, especially from medical voluntourism organizations and participants themselves.

Regarding future research directions, there should certainly be continued critique of the medical voluntourism industry as a business. This can help continue to apply pressure on the industry and call out instances of ethical issues. However, I would argue priority should be given to identification of positive characteristics within medical voluntourism programs and further development of reform efforts. The broader significance of this subject is that there is still substantial need for access to quality healthcare around the world, so programs that intend to address this need should be encouraged; however, it is of utmost importance that these programs do not exacerbate this existing need. To work toward this, the business of medical voluntourism needs to be reined in. Therefore, removing the stronghold that societal pressure and the attractiveness of medical voluntourism programs have on the industry is essential. In conclusion, moving forward with honesty, humility, and a willingly self-critical gaze is the best way to continue evaluating the ethical controversies of medical voluntourism and not doing harm.

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