reprioritize, which means at minimum any support should include improved career mentorship and guidance. The establishment of formal training programs leading to defined employment might also help rationalize the existing "start-up" environment. Formally trained specialists would resemble the differences between public health physicians and physicians interested in public health; the former are vocationally trained, the latter are clinicians with side projects. Should global health work continue to solely exist "on the side," then much like early clinician–researchers chasing their first grant, interested practitioners will ante up hoping to "make it" into an expatriate career—perhaps against their better judgment.

Disclosures: None reported.

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2 Krisberg K. Global community: Medical schools meet students' desire for international learning experiences. AAMC Reporter. September 2015. https://www.aamc.org/newsroom/reporter/september2015/442220/global-community.html. Accessed October 20, 2015.

To the Editor: We commend Drs. Palazuelos and Dhillon[1] for articulating challenges associated with building academic global health careers. We offer an intergenerational response from two physicians (mother and daughter) both engaged in academic global health.

Dr. Haq completed medical school in 1983, when there was little interest or mentorship in global health. Her first international assignment, training village health workers in Uganda in 1986, was transformative for her and her family. Dr. Haq earned a living, repaid student loans, and spent the majority of her professional time working in Wisconsin as an academic clinician–educator in rural and urban health professional shortage areas and laid the foundation for hundreds of students to pursue international experiences annually. She provided international health services pro bono for 15 years and carved out time to pursue these activities, officially considered "vacation," through less than full-time employment and periodic leaves of absence from domestic duties through negotiated support from colleagues. She paid substantial "global health tax" through loss of income. The family survived and thrived through the "wild cards" of logistical challenges, political turmoil, and unanticipated family crises.

Dr. Lukolyo is completing a combined residency in pediatrics and child global health at Baylor College of Medicine and has over 10 years of global public health experience. Despite this background, including a one-year clinical placement abroad during residency, academic global health career pathways for graduating residents are not well defined. Dr. Lukolyo's global health interest was undoubtedly influenced by her mother's career which exposed her from childhood to diverse cultures, social inequities, and health disparities. Since her mother's efforts to carve an academic global health pathway three decades ago, national interest in global health has swelled but medical education debt has also increased.

Global health-oriented medical trainees, who are in the "pipeline" for global health careers, will benefit from opportunities to sustain their interest during residency, career guidance, and strategies to repay their medical education debts. In addition to the "wild cards" mentioned by Drs. Palazuelos and Dhillon, female physicians face the additional "wild card" of reproductive health, as pregnancy and delivery in many low-resource settings confer additional risks. Despite the challenges conceptualized by the authors as "global health tax" and "wild cards," we have reaped a bountiful "global health bonus." This "bonus" comes through opportunities to engage in work that is urgently needed, deeply meaningful, and life enriching not only for the physician but potentially for his or her entire family and communities served.

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1 Palazuelos D, Dhillon R. Addressing the "global health tax" and "wild cards": Practical challenges to building academic careers in global health. Acad Med. 2015;91:30–35.

In Reply to Lukolyo and Haq and to Loh: We wrote this Perspective piece as one facet of a much larger conversation: What will it take to sustain effective health delivery across the world?

If "expat" global health MDs are trailblazers, then their efforts must lead to a new field. Dr. Haq is a hero who forged out against the "better judgment" of many, took sizable risks, and reaped incredible personal life rewards. We are delighted that Dr. Lukolyo is following in her footsteps and understand that the gendered challenges presented are very real. Dr. Loh describes the "global health tax" as an "ante," which is an important framing of the risks each individual must weigh, but we are increasingly of the opinion that the future of global health must not be decided on an individual basis. Instead, global health should be a movement of people and institutions who use the field's unique perspective to launch new systems and solutions.

The history of medicine is rich with stories of innovations that were championed by individuals who struggled to gain acceptance: vaccinations, surgical sterile technique and hand washing, organ transplantation, etc. Once the innovations—but not always the individuals—were seen as genius instead of aberrant, they became some of medicine's proudest achievements. Many even launched entire fields of practice. For an innovation to become a field, numerous investments are needed; these may include the establishment of clear and sustained funding sources, the definition of clear objectives and best practices, and even the formation of multidisciplinary teams that can tackle different facets of the larger problem, to name only a few.

Globalization offers *some* of us incredible opportunities for trade and travel, but