TEACHING SOCIAL MEDICINE

Shaking off our lassitude:* Creating a global health service-learning program founded in social medicine

Francis X. Coughlin, MD

Abstract

This paper describes the creation and implementation of a global health service-learning elective based on the ideals of social medicine. The elective was supported by the Brown Alpert Medical School and Rhode Island Hospital. It was designed for fourth-year medical students and internal medicine residents during the winter of 2012, based in Santiago, Dominican Republic. The aim of the course was to create a structured global health elective with principles based in social medicine and social justice. Following a service-learning paradigm, one half of the course was a clinical experience, centered in a large, urban teaching hospital, a primary care clinic, and a rural health promotion program. The other half of the course was a structured compilation of assigned readings, lectures, films, field visits, and reflection sessions that placed the clinical experiences into a national and international context. The course analyzed systemic causes of poverty as well as the role of structural violence in creating poor health. Finally, using Rudolf Virchow's call for physicians to be the "natural attorneys of the poor" as a foundation, we explored the role of the physician-advocate in terms of social justice and solidarity with the poor.

Francis X. Coughlin, MD, Department of Emergency Medicine, Bellevue Hospital Center, New York, NY 10016. Email: fxcoughlin@gmail.com

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* From Claribel Alegría's "Nocturnal Visits", as quoted in Paul Farmer's *Pathologies of Power*

Introduction

As our world continues to become more and more interconnected, we – as national and global citizens – are called to think in more globalized manners. Medicine and the education of physicians is no exception. It is estimated that approximately a quarter of medical students have participated or will participate in international rotations during their time in medical school and that almost all medical schools provide some manner in which to engage in global health.[1] Across all specialties, the demand for global health training has increased dramatically in the last decade.[2] Responding to such demand, global health is in the beginning stages of becoming institutionalized in current medical education.

While it is inspiring to see the number of international experiences available for current and future physicians, there have been significant critiques as to the effectiveness of experiences that are separated from a formal curriculum in global health.[3,4] Current and future physicians are trained to think beyond symptomatology to understand the root causes of biological disease. Unfortunately, an increasingly myopic focus on biophysical processes and clinical knowledge detracts from a comprehensive discourse on the effects of inequality, poverty, and injustice in creating poor health, especially in global health education.[5,6] While there are some global health programs that attempt to create such a broad discourse,† the majority of global health experiences create a

† Most notably, "Beyond the Biologic Basis of Disease: The Social and Economic Causation of Illness" and the new "Nicaragua Social Medicine" course offered by the University of Washington.

disconnect between suffering and the root causes of inequality by failing to analyze the role of "structural violence"[‡] in creating the poor health that these educational experiences attempt to alleviate. In global health, where inequality in health and systemic injustice are the result of complex international systems, such a disconnect does not allow for a critical social analysis which is necessary for true social transformation.[7] As Paul Farmer writes in *Pathologies of Power:*

> *Human rights violations are not accidents; they are not random in distribution or effect. Rights violations are, rather, symptoms of deeper pathologies of power and are linked intimately to the social conditions that so often determine who will suffer abuse and who will be shielded from harm. If assaults on dignity are anything but random in distribution or course, whose interests are served by the suggestion that they are haphazard?*[8]

The 2012 "Brown University Service-Learning Social Medicine Global Health Elective" was a month-long global health elective that worked to analyze these "pathologies of power." It was based in Santiago, Dominican Republic and included four internal medicine residents from Rhode Island Hospital and three fourth-year Brown University medical students. The purpose of this global health elective was to provide a clinical experience in a resource-limited setting and an understanding of the social, economic, and political factors that have created such settings and continue to perpetuate inequality. Following a service-learning model, clinical time in resource-limited settings was used as a backdrop on which to place a structured analysis of poor health, connections between poverty and poor health, causes of poverty, paradigms of health care, and the development of the physician-advocate.

Course objectives

1. To create a structured, month long, global health service-learning program for medical students and residents.
2. To begin to understand the national and international factors which affect populations and perpetuate poor health.
3. To begin to define the role of the physician in combating social injustice and in applying social medicine.
4. To promote solidarity between members of all nations, races, professions, and socioeconomic classes.

Course overview

Brown University and Rhode Island Hospital have had an eight-year relationship with the Internal Medicine residency at the Hospital José María Cabral y Báez, facilitating a clinically-based observational experience in the Dominican Republic for residents and medical students. It is directed by faculty at Rhode Island Hospital as well as an in-country coordinator, historically a fourth-year medical student from the U.S. In addition to U.S. participants completing their international health elective in Santiago, Dominican residents and faculty travel to Rhode Island Hospital annually for one month to engage in a similar clinical exchange. A month-long time period for both exchanges was chosen secondary to scheduling issues, considering medical student and resident schedules. The 2012 course followed a similar organizational structure compared to previous years, with the full-time coordinator (the author) spending five months prior to the elective engaged in organizational logistics. Participants

[‡] Defined as the following: "Structural violence is one way of describing social arrangements that put individuals and populations in harm's way… The arrangements are structural because they are embedded in the political and economic organization of our social world; they are violent because they cause injury to people … neither culture nor pure individual will is at fault; rather, historically given (and often economically driven) processes and forces conspire to constrain individual agency. Structural violence is visited upon all those whose social status denies them access to the fruits of scientific and social progress." Sources: Farmer PE, Nizeye B, Stulac S, Keshavjee S. Structural violence and clinical medicine. *PLoS Medicine*. 2006;3(10):e449; Farmer P. *Infections and inequalities: the modern plagues.* Berkeley: University of California Press; 2001; Farmer P, Bourgois P, ScheperHughes N, Fassin D, Green L, Heggenhougen H, et al. An anthropology of structural violence. *Current Anthropology.* 2004;45(3):305-25.

signed up for the elective based on its history as a clinically-based elective and were informed of the shift to a social medicine-based course two months prior to the elective. The 2012 course was structured around a service-learning paradigm[4], which is defined by the Liaison Committee on Medical Education as, "a structured learning experience that combines community service with preparation and reflection. Medical students engaged in service-learning provide community service in response to community-identified concerns and learn about the context in which service is provided, the connection between their service and their academic coursework, and their roles as citizens and professionals."[9]

The full-time coordinator created the course based on previous experience working with service-learning programs in the U.S., with significant guidance from the facilitators of a social medicine-based course in Uganda and other colleagues with experience in service-learning. All course logistics, including schedules, readings, and lectures, were centralized on a website. The course was split into two areas of focus, with clinical time during the mornings and a social medicine course during the afternoons. All participants were at least proficient in Spanish, although this was not a requirement of the elective. Translators were not used in any setting. Spanish was used in all clinical settings, with the exception of "Brown Rounds" (see below). The social medicine part of the elective was in English.

The formal clinical time was strictly observational and was spent at Hospital José María Cabral y Báez and Clínica Santa Lucía. The Cabral y Báez is a public teaching hospital that serves as a tertiary referral center for the entire northern third of the country. Our main areas of focus within the hospital were the internal medicine floors, ICU, emergency department, and outpatient clinics. Elective members were split into two-person teams and rotated through each of the above areas, with generally one week spent in a primary care clinic and three weeks spent in the hospital. The focus on tertiary care was a remnant of previous elective objectives and was kept to continue the relationship between residency programs, to allow participants to experience complex clinical cases, and to participate in Dominican-based resident education. While in the hospital, elective members attended the morning resident sign-out and lectures and joined the residents for morning rounds. Elective members would then choose a patient of clinical interest that they had rounded on to read their chart and interview the patient. The two-person teams were assigned to present the patient to the rest of the elective members during "Brown Rounds," which occurred bi-weekly. Attempts were made to place medical students with residents to provide a means of teaching within small groups. Each group presented a focused history and physical, results of diagnostic tests, treatment plans, as well as the clinical reasoning of the Dominican medical team. Clinical understanding was augmented by a Brown University faculty member as well as a problem-based learning case syllabus, which had a focus on tuberculosis, malaria, leptospirosis, leprosy, and organophosphate poisoning. Finally, the patient was interviewed as a team and physical exam findings, barriers to care, and effects of the disease on the patient were discussed.

Clínica Santa Lucia is a publicly funded primary care center located on the outskirts of Santiago, in the neighborhood of Cienfuegos. This site was added to the social medicine course to significantly augment the clinical experience outside of a tertiary setting. The clinic is located in an extremely low-income area of the city, with much of the income derived from selling materials collected from the city landfill, which borders the clinic. A team of two elective members rotated in the clinic, with teams switching every week. They observed the two *médicos generales*[§] see a wide variety of patients and clinical problems involving pediatrics, internal medicine, and obstetrics/gynecology. In addition, members accompanied local health promoters who made house visits during the week to patients who were unable to attend the clinic.

The third aspect of the clinical course involved working with a group of health promoters in the rural towns of Los Marranitos, Los Dajaos, and Manobao, located 2.5 hours outside of Santiago, in the mountains of Jarabacoa. We worked with Café

[§] These are generalist doctors who have completed medical school but not a residency.

Altagracia, a Vermont-based organic coffee farm and two local health organizations of health promoters, Fundación de Salud y Bienestar (FUSABI) and Sociedad Comunitaria de Salud de Los Dajaos (SOCOSADA*)*. The local health infrastructure in the small mountain towns was essentially inaccessible for much of the population either due to distance, cost, or lack of available resources. For the most part, the health infrastructure included a small group of locally trained health promoters, a series of primary care clinics, and a local community hospital in the town of Jarabacoa. The two local organizations named above had worked with Peace Corps volunteers in 2007 to train a group of health promoters to provide basic health care to the residents of their towns. Based on discussions with local leaders, it was felt that elective members could effectively provide a review course for the promoters, since they had not received any training since their initial course. We planned a *Día de Salud* ("Day of Health") where elective members were split into small groups and given two topics to prepare, based on needs assessments conducted by local health leaders. Topics were selected by local health organizers and included nutrition, hygiene, assessing blood pressure, common respiratory ailments, basic infant care, diarrhea, diabetes, basic first aid, and domestic violence. Elective members prepared their presentations based on a Dominican educational book created by the 2007 Peace Corps volunteers for the health promoters. Members worked in small groups with the health promoters to assess knowledge, review basic principles, and discuss ways to promote community health. To gain a more complete view of health care in the rural countryside, we were given a tour of the local hospital. In addition, we were able to speak with a group of natural medicine practitioners, following the health beliefs of the Seventh-day Adventists, who work and live in the surrounding villages.

The social medicine aspect of the course provided a context in which to better understand the Dominican clinical and cultural realities experienced by group members from the U.S. All members were asked to read Paul Farmer's *Pathologies of Power: Health, Human Rights, and the New War on the Poor* prior to arriving to the Dominican Republic. This book was chosen as an introduction to social medicine and to initiate discussion on themes central to the course. It was also suggested to read *Why the Cocks Fight: Dominicans, Haitians, and the Struggle for Hispaniola* by Michele Wucker, as an introduction to the history and current situation in Hispaniola. The social medicine component was a compilation of readings, lectures, discussions, movies, field visits, and group reflection sessions, generally apportioned into week-long increments. The learning material was divided into the following parts:

Part I: Introduction to social medicine and the Dominican Republic

The first part of the course dealt with defining social medicine and understanding it as the conceptualization of how myriad of social causes affect health and how they can create disease in today's globalized climate. A historical background reading of social medicine was assigned. (See Appendix) A lecture gave a further elaboration on the history of social medicine with a focus on key figures and concepts. An introduction to "liberation theology" and "liberation medicine" was given as well as a discussion on the role of the physician in social medicine, following the "observe, judge, act" model used in liberation theology, as highlighted in *Pathologies of Power.*

In place of a specific lecture on the compelling history of the Dominican Republic, elective members were strongly encouraged to pre-read about Dominican history, especially the dictatorship of Rafael Trujillo, contemporary Dominican history, and Dominican-Haitian relations. In addition, we visited the Centro León cultural museum in Santiago, which offered an overview of Dominican history. Furthermore, members participated in a walking tour of Santiago, which included historical sites as well as an elaboration on Dominican history, facilitated by the coordinator. A separate focus of the tour was to highlight the abundant evidence in Santiago of drastic socio-economic inequalities. These inequalities provided a context for further discussion later in the course about structural causes of poverty

and the connection between affluence and poverty. A lecture offered a structured look at the Dominican health care system, health statistics, and barriers to implementation.

There were two reflection sessions during the first part of the course. The first reflection was a general conversation about themes concerning social justice addressed in *Pathologies of Power.* Specifically, a focus was placed on a discussion of the causes of poverty, how poverty is presented in the mainstream U.S. consciousness, and how the causes of poor health are discussed in global terms, using the above cited Paul Farmer quote concerning rights violations as a starting point. In the same reflection, we discussed first impressions of the city, as seen during the walking tour, and of the public hospital. Reflection was facilitated with a focus on the contradictions of extreme poverty abutting abundant wealth, how such realities affect our ability to practice health care, and then what our role as physicians should be in understanding social structures that facilitate such inequality. The second reflection session was an attempt to build cohesion within the group through the telling of life stories.

Part 2: Social determinants of health and poverty

Much of the literature on social medicine distinguishes between socio-economic factors adversely affecting health and the perpetuation of disease through poverty.[10-12] Poverty is seen as a common cause of poor health, affecting a number of complex factors including access to health care, environmental risk factors, economic stress, and unhealthy employment. While there are innumerous causes of poverty, the course focused on an analysis of the global economic structure, environmental degradation, and the role of gender inequality in perpetuating poverty.

To provide a general overview of poverty and health, we began by watching the documentary entitled *End of Poverty,* followed by a reflection session discussing the main themes of the movie. This movie was chosen because of its focus on the long-standing effects of colonialism on the Global South, its explanation of inequality as a major cause of poverty, and an introduction to "structural violence." There was a lecture on the history of globalization, including the role of mercantilism, imperialism, and neo-liberalism,[**] current economic institutions such as the World Trade Organization, and the effects of structural adjustment programs on resource allocation. To better understand contemporary Dominican realities, we studied the role of US military interventions, the debt crisis during the 1980's, role of International Monetary Fund policies in the country, and the effects of growing neo-liberal policies in relation to healthcare expenditure.[13-15]

We began our discussion of environmental degradation and health by analyzing the causes of environmental degradation, including poverty, deforestation, global warming, consumerism, and war. Environmental degradation was chosen because of its universal nature and the environment's very central role in sustaining health. We discussed impacts of global warming on vulnerable populations, adverse effects of untested chemicals and pesticides, pollution, overconsumption, and environmental devastation associated with the military-industrial complex. To highlight some environmental effects of consumerism, we took a tour of the Santiago city landfill, which is within walking distance of the Santa Lucia primary care clinic. A member of the local *recicladores*[††] association spoke to us about the health effects of working in the landfill as well as their attempts to have their rights as workers recognized by the government.

The landfill visit was chosen as an attempt to create a structured "consciousness-raising" experience. As can be imagined, the community surrounding the landfill, from which the residents extract their livelihoods, is a scene of oppressive poverty, to say nothing of conditions for the *recicladores* work-

[**] Neoliberalism was defined as an economic and political theory that promotes the liberalization of markets, reduction of public expenditures for social services, deregulation, and privatization of public enterprises.

[††] A *reciclador* is someone who collects items such as plastics, metals, and bottles from the landfill and sells them back to manufacturers. For more information and photos about the situation of *recicladores* in Cienfuegos, please read Isabelle Carbonell's amazing photo essay and website about her upcoming film about Cienguegos (http://www.somosbuzos.com/index.php).

ing in the landfill. "Consciousness-raising" is a term attributed to feminists in the 1970's, who used small group discussions to highlight gender discrimination and create a "shared" experience between participants. It is defined as, "a personal, face-to-face interaction which appears to create new psychological orientations for those involved in the process…the personal face-to-face interaction technique is selected because it is consistent with the radical revolutionary's belief that shared experience should generate political theory and action."[16]

The field visit was structured in such away as to avoid the often dubbed "disaster porn"[‡‡] conceptualization of extreme poverty. Attendance was voluntary and a post-visit reflection session focused on personal observations, description of personal feelings, connections between social oppression and working in the landfill, and connections between U.S. consumerism and poor health internationally.

Lastly, we examined gender inequality as a cause of poverty. Gender inequality was chosen for its universal nature as well as to represent the growing body of literature supporting the "feminization of poverty" [§§], in which females overwhelming bear the burden of daily poverty and comprise the majority of the world's poor.[17] To begin, we formally defined and discussed the global feminization of poverty, along with an analysis of the causes of such socioeconomic discrepancies. Through videos, we also examined the plight of women around the world, from sex workers in Cambodia to teenage girls in Africa. A focus was made on causes of gender inequality, its role in perpetuating poverty and poor health, gender-based violence, and how women are most affected by environmental degradation. Our reflection session concentrated on the pervasiveness of gender discrimination, highlighting experiences in our medical system, as well as the role of feminist thought in re-formulating the concept of gender equality.[***]

Part 3: Paradigms of Global Health Interventions

The third aspect of the course dealt with the ideological ways in which people have attempted to confront poverty. As discussed by Paul Farmer in *Pathologies of Power*, we examined three main paradigms that have been used to address poor health: *charity, development,* and *social justice.*[†††] [8,18] Charity is perhaps the most known paradigm, with a strong presence in medical relief. Our discussion centered on a critique of the resurgence of charity as being an unjust answer to poverty as it obscures the injustices that created the need for charity. Secondly, we investigated the paradigm of development, specifically through the lens of the United Nations Millennium Development Goals[‡‡‡]. Our conversations were directed by a critique of development's ability to address the historical causes of underdevelopment as well as the paradox of using policies of globalized capitalism to alleviate the results of the injustices it itself causes.[19-21][§§§]

Lastly, we addressed the paradigm of social justice, which not only focuses on the alleviation of suffering, but also the eradication of the causes of such suffering. The lectures and readings highlighted the need to have a politicized understanding of health (i.e., understanding of global economic struc-

‡‡ Usually used to describe mass media presentations of disasters, focusing on the desperation of affected peoples without any subsequent contextual background or historical explanation of poverty. For a more nuanced description, I recommend David Sirota's "Our Addiction to Disaster Porn" (http://www.creators.com/opinion/david-sirota/our-addiction-to-disaster-porn.html).

§§ Used to describe the overrepresentation of women and children among the poor in the U.S. See Ref. 17.

*** For a more detailed discussion, please see Barbara Ehrenreich's "What Abu Ghraib Taught Me," available at: http://www.alternet.org/story/18740/what_abu_ghraib_taught_me.

††† Social justice can be defined as an understanding of the role of structural violence in creating injustice and "working with the poor themselves as they struggle to change their situations." Farmer, Ref. 8.

‡‡‡ For more information and details on the specific UN goals, please see official UN Millennium Development Goals site.

§§§ For a more detailed description of how development projects, when not coupled with a historical perspective, do not alleviate poverty and can in fact worsen poverty, please read "The Anti-Politics Machine: 'Development' and Bureaucratic Power in Lesotho" by James Ferguson. Available at: http://www.colorado.edu/geography/class_homepages/geog_3682_f08/Articles/Ferguson - The Anti Politics Machine.pdf

tures as discussed previously) in order to adequately address poverty and inequality. We analyzed the "right to health"[****] as described in the United Nations Declaration of Human Rights (1948). This analysis included a discussion on a definition of a right to health, what rights global citizens can demand, and how a right to health can influence a global health intervention. To add to the discussion, we visited a large private hospital in Santiago, Hospital Metropolitano de Santiago (HOMS), in order to examine the drastic contrast in the level of care for Santiago's more affluent patients compared to the level of care for patients in the publicly funded Cabral y Báez Hospital.

The reflection sessions in relation to paradigms of health care centered on an analysis of structural violence as it relates to health. First, we read the story of Acephie and the effects of the Peligre Dam on her and her family, as told in *Pathologies of Power.*[8] We then questioned a response to her HIV in terms of charity (offering treatment), development (building health infrastructure, using market-based approaches), and social justice (treating her HIV through the lens that poverty, which was caused by displacement because of a market-based development project, is ultimately the cause of her illness) using Farmer's analysis as a background. In a similar vein, our reflection on a "right to health" and our HOMS visit was centered on the morality of a medical system in which the majority of the population cannot access the level of services seen at the private hospital. This analysis was augmented by personal reflections on the difference between facilities at HOMS, the Cabral y Báez, and Santa Lucia, as well as international differences in healthcare facilities.

[****] Article 25 of the UN Declaration of Human Rights states, "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control. Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection." This declaration is often used as the reference for a "right to health."

Part 4: Social justice interventions and the development of the physician advocate

The fourth part of the elective was structured to give members a brief understanding of existing interventions that are based in the social justice model, including international organizations such as Partners in Health and Médecins Sans Frontières as well as local Dominican organizations such as Health Horizons International and FUSABI. The main emphasis was to analyze the ability of groups to implement a social justice paradigm in the framework of limited resources and the need for sustainability, as well as conflicts with existing power structures.

In addition, a strong focus was placed on the resurgence of the historical role of the physician as an advocate. Our discussion centered on an attempt to increase the awareness of physicians and to see their role as patient advocates in a social sense and their role as citizens in a global way. We summarily examined physician advocacy groups such as The People's Health Movement, Physicians for Social Responsibility, Doctors for Global Health, Médecins Sans Frontières, and most recently the Occupy Healthcare Movement.

Impact

The impact of the elective was initially assessed through pre- and post-elective surveys. Online surveys were given to members the month prior to the elective as well as immediately following the conclusion of the elective. The post-elective survey included post-elective opinion questions. The two surveys were otherwise identical (see Appendix 1). An elective feedback form was also sent out, which asked participants to critique specific aspects and logistics of the course, including clinical time, field visits, lectures, and reflection sessions.

Overall, there was a general increase in comfort level with defining terms in the second set of questions, but there was not a significant difference in the other questions. Perhaps a more substantial way to measure the impact of the elective is in the direct commentary from elective members, elicited in their post-elective survey. When asked, "Has this elective altered your view of the world? If so, in what way?" some of the responses were:

It has reinvigorated a passion to serve the destitute sick.

This elective has strengthened, substantiated, and re-invigorated my worldview in ways that I am extremely grateful for. The tenets of social medicine are central to my motivation for becoming a physician but have sometimes seemed far away during the myopic journey of medical school.

Another question asked was, "What questions has this [elective] raised for you?" The following were some of the responses:

How can we address the root causes of poor health on a practical level?

Primarily, it makes me ask myself the best way that I can be part of the global struggle to end income inequality and how that will relate to my ability to provide medical care.

What is the most effective way for physicians to engage in policy making? How can I effectively make conscious consumer choices?

Finally, participants were asked, "Has this elective changed your future medical plans in any way? If so, how?" The following are a summary of responses:

I think it will make me want to continue working with patients in a global context.

It has raised my level of awareness, but likely has not changed my career path.

It has reinforced my conviction to work with the underserved.

In the elective feedback form, when asked about overall opinions of the course, one participant noted, "It was not what I was expected going in, however it exposed me to some new ideas about healthcare and poverty." Of note, one participant began an educational project with the health promoters in Jarabacoa a few months after the elective completion, with details still pending. Ultimately, as with most educational tools and experiences, the overall and lasting impact of the elective may not ever be assessed, but will be seen in the day-to-day interactions and decisions of these passionate participants.

Evaluation of course

As stated above, the course had very broad and ambitious objectives. As with any course, there were logistical limitations that need to be addressed in future social medicine courses. Primarily, the 2012 elective was the first time social medicine had been added to the curriculum of the course.[††††] It was added based on personal interest and experience of the full-time in-country coordinator. However the course was constrained by structural characteristics inherited from previous years. These included having the majority of clinical time in a tertiary center and facilitating professional interests (i.e., participants were given opportunities to work in specialty clinics, based on their personal desire). While a tertiary care center offers a wide array of complex cases, it does not adequately represent the actual health of a population. In the author's opinion, it was an important aspect of the course and should be kept to some degree, but future courses may wish to focus on primary care as a way to connect with communities and have a more complete understanding of social factors that impact health.

Previously this had been a flexible, clinically-based course. Since participants did not sign up for an explicitly social medicine course, some learning experiences were hampered by lack of participation. All clinical aspects were considered mandatory, but the social medicine course was considered voluntary because it was added only after residents had agreed to join the elective. There were varying levels of interest in issues relating to social medicine, most notably seen in regards to background readings and discussion participation. There was a significant discrepancy in levels of understanding on issues relating to social medicine. While a general overview was provided, one lecture was not sufficient to adequately introduce extremely complex topics, such as global economic structures. Much of the curriculum was kept at a general level because of such discrepancies in knowledge. The elective

[††††] It was ultimately decided to return to a clinically-based focus in future rotations.

would have also benefitted by being able to more adequately analyze Dominican specific systems of violence, such as sex-tourism, popular tourism, and Dominican-Haitian relations. It is likely that if all participants had knowingly signed up for a social medicine course, overall participation would have been higher secondary to interest and knowledge level. Also related to the voluntary nature, it would have benefitted the program and group cohesion to have group weekend trips to various sites outside of Santiago. As it was, most participants had previously planned small separate trips, based on feedback from past participants on the flexible nature of the weekend schedules. By increasing group cohesion, individuals might have more adequately engaged in critical self-analysis, which is necessary for a social justice transformation. One consequence of not having a self-selected population was that discussion sessions were often very diverse and engaging, as many people had significantly different views and experiences in relation to privilege, social justice, and global health.

Another significant lack in the course was how it addressed objective number four, building solidarity. Rounding and socializing with the Dominican residents and the existence of a bilateral exchange program were ways the course as a whole attempted to create a relationship between the U.S. and Dominican participants. Work with the health promoters in Jarabacoa and the field visit to the landfill where the primary care clinic was located were attempts to build solidarity with more oppressed populations. An effort was made to measure feelings of solidarity on the post-elective survey form, with some responses noting a general increase or solidification of feelings to work with "destitute" or "underserved" populations. Of note, in the elective feedback form, one participant noted in response to an opinion question concerning work with the health promoters in Jarabacoa that she really "enjoyed meeting those amazing ladies and feeling like I was in solidarity with them and the work they are doing." Most notably, the course would have greatly benefitted from incorporating Dominican medical students, residents, and community members into the development and implementation of the social medicine aspect of the course. This was not done because of concerns over language barriers, lack of coordinating staff, and lack of preparation time. The creation of solidarity was further hampered by housing all US participants in one apartment in a wealthy area of Santiago. These accommodations were inherited from previous course logistics, safety concerns, and lack of significant coordinating staff to facilitate homestays. While it may have decreased group cohesion by not having everyone stay together, it would have significantly augmented the overall experience of the elective to have participants live and work in the most affected communities. The above-mentioned group trips may have been able to more effectively create group cohesion.

The last significant weakness of the course was the evaluation process. With a small sample size, a numerical survey may not produce statistically rigorous results. In addition, attempting to numerically evaluate understandings of complex issues, personal opinions, and feelings of solidarity will invariably not produce useful data. Focus groups, personal interviews, and/or personal reflections would potentially provide a more useful determinate of the success of the elective. Follow-up assessments, perhaps after 6-months or a year, could potentially assess any long-term effects. Finally, the success of the elective would have been increased if emphasis was put on a group project or discussion space upon return to the U.S.

Conclusion

This course was fundamentally built upon two ideals: truth and solidarity. As quoted in the introduction, Paul Farmer implores us to not fall into the trap of thinking that all that is wrong in the world happens as a result of accidents. We must begin to understand that our world is intimately connected and that there are larger "pathologies of power" which determine who benefits and who suffers.[22] This is a truth most medical professionals must learn, for those affected by it know it much more intimately.

As we struggle against massive global issues such as climate change and resource wars, we must wake up to the truth of our interconnectedness. Not

because we wish to help others, but because we must see that our survival is intimately related to the survival of others and that injustice anywhere is an injustice everywhere. As Lila Watson states, "If you have come to help me, you are wasting your time. But if you have come because your liberation is bound up in mine, then let us walk together." May we continue struggling for peace and justice, in solidarity with those who fight for a more just world.

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