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ORIGINAL RESEARCH

Where We Fall Down: Tensions in Teaching Social Medicine and Global Health

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Abstract

BACKGROUND As global health interest has risen, so too has the relevance of education on the social determinants of health and health equity. Social medicine offers a particularly salient framework for educating on the social determinants of health, health disparities, and health equity. SocMed and EqualHealth, 2 unique but related organizations, offer annual global health courses in Uganda, Haiti, and the United States, which train students to understand and respond to the social determinants of health through praxis, self-reflection and self-awareness, and building collaborative partnerships across difference.

OBJECTIVES The aim of this paper is to describe an innovative pedagogical approach to teaching social medicine *and* global health. We draw on the notion of praxis, which illuminates the value of iterative reflection and action, to critically examine our points of weakness as educators in order to derive lessons with broad applicability for those engaged in global health work.

METHODS The data for this paper were collected through an autoethnography of teaching 10 global health social medicine courses in Uganda and Haiti since 2010. It draws on revealing descriptions from participant observation, student feedback collected in anonymous course evaluations, and ongoing relationships with alumni.

FINDINGS Critical analysis reveals 3 significant and complicated tensions raised by our courses. The first point of weakness pertains to issues of course ownership by North American outsiders. The second tension emerges from explicit acknowledgment of social and economic inequities among our students and faculty. Finally, there are ongoing challenges of sustaining positive momentum toward social change after transformative course experiences.

CONCLUSIONS Although successful in generating transformative learning experiences, these courses expose significant fracture points worth interrogating as educators, activists, and global health practitioners. Ultimately, we have identified a need for building equitable partnerships and intentional community, embracing discomfort, and moving beyond reflection to praxis in global health education.

KEY WORDS health professional education, social medicine, praxis, Uganda, Haiti

INTRODUCTION

As interest in global health and health equity has increased dramatically,[1,2] health professions' educators have attempted to identify global health competencies and to develop training models focused on the social determinants of health.[3-6] In pursuit of these competencies, attention has also been directed

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toward ethical considerations in training and educational experiences in global health.[7-11] Those concerned with the ethics of global health education argue for training programs that minimize the risk for harm to patients and communities and support the development of the 4 values of humility, introspection, solidarity, and social justice.[9]

As North American global health educators striving to build ethical, authentic partnerships that incorporate the values of humility, introspection, solidarity, and social justice with our educator colleagues in the Global South, we are drawn to the call for "global solidarity" as a fundamental framework for global health endeavors.[12] In this sense, "global solidarity" means reciprocal relationships built on mutual respect while acknowledging the inequitable distribution of power and resources across the globe. As teachers of social medicine courses offered in Uganda and Haiti, we believe striving for solidarity promotes honest appreciation of one another, acknowledges the interconnectedness of the world, and invites discomfort with the historically unequal power dynamics of global health. In our estimation, solidarity is fundamental to efforts to put health equity and social justice at the center of medical curricula.[13,14]

Yet, striving for solidarity in global health education, although indispensable, is most certainly not straightforward. In this paper, we describe our pedagogical approach to social medicine, followed by a presentation of 3 significant and complicated tensions we experience as global health educators. Literature on global health education often showcases the successes of various models and pedagogies and describes how global health can achieve the educational goals of American institutions and trainees.[11,15,16] Although proud of the courses we have implemented, there are significant fracture points worth interrogating. Building our curriculum on the notion of praxis,[17] which at the core stresses the value of reflecting on social problems and failings, it is pertinent and appropriate to institute a practice of reflecting on our points of weakness as educators in an authentic and nonlinear pursuit of meaningful social change. Just as we promote the development of humility and self-awareness among our learners, we strive to hold ourselves equally accountable to such standards.

Social Medicine in Global Health. Social medicine education is part of a tradition with European and Latin American roots that calls for health care professionals to undergo training in the "social origins of illness and the need for social change to improve health conditions."[18] Rudolf Virchow, a key historical figure in social medicine, posited that "medicine is a social science."[19] Virchow was convinced that social inequality was a root cause of ill health and that medicine therefore had to be a social science to best address it.[20] With a focus on identifying and affecting the root social determinants of health and working "upstream"[21] to address them, social medicine demands a continuous orientation toward social justice and requires an understanding of and efforts toward social change, specifically through social movements and health activism.[13,22] In parallel with the growing interest in global health, social medicine has experienced a resurgent interest, although this has not been consistently appreciated.[23-29]

METHODS

Our analyses are based on an autoethnography of 6 years of social medicine courses delivered by 2 unique but related organizations: SocMed and EqualHealth. The data are composed of participant observation descriptions, student feedback collected in anonymous course evaluations, and fieldnotes from ongoing relationships with alumni of our courses. There are a total of 245 students who have participated in our courses (166 from the Uganda SocMed course offered in 2010, 2011, 2012, 2013, 2015, and 2016 and 79 from the Haiti EqualHealth course taught in 2013, 2014, 2015, and 2016). Anonymous student feedback was collected at the conclusion of every course through paper and more recently electronic surveys. In addition, anonymous qualitative student feedback was gathered each week concurrent with course delivery, which contributed to the participant observation data. One hundred percent of the students in both the Uganda and Haiti courses provided feedback.

SocMed is a social justice, nonprofit organization working to expand the conversation on and engagement with the social determinants of health through education and movement building. Founded in 2011 by a small group of U.S. and Ugandan colleagues, the organization developed out of a social medicine course first offered for medical students in Gulu, Uganda, in January 2010 aiming to broaden student conceptualizations of disease beyond solely biology.

EqualHealth is a nonprofit organization founded in 2010 by health professionals motivated by a desire to partner with Haitian health professionals

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toward a long-term engagement in rebuilding the nursing and medical education system after the 2010 earthquake that devastated Haiti. EqualHealth, which aims to inspire, empower, and support the development of leaders among Haiti's next generation of health professionals, fosters the growth and development of an equitable and opportunity-filled Haitian health professional education system that equips Haitians to provide high-quality care to all.

Considering the deep parallels in the gaps in health professional education in Uganda and Haiti, a partnership emerged between SocMed and EqualHealth in 2012 to expand social medicine education in Haiti through the development of a similar SocMed annual course. Both organizations define social medicine as an approach that integrates:

1. Understanding and applying the social determinants of health, social epidemiology, and social science approaches to patient care;
2. An advocacy and equity agenda that treats health as a human right;
3. Both interdisciplinary and multisectoral efforts across the health system;
4. Deep understanding of local and global contexts and ensuring that the local context informs and leads the global movement, and vice versa; and
5. The voices and votes of patient, families, and communities.

A number of influences prompted initial development of the Uganda and Haiti courses. First, growing alarm and discomfort with medicine's myopic and dishonest "act of seeing, the gaze," in Foucault's words, on the physical body, sparked the development of a curriculum that attempted to incorporate the social world and craft more balanced understandings of disease and health as biosocial phenomena.[30] Second, unease with the often unstructured and unsupervised nature of many global health experiences,[31,32] alongside recognition of an untapped potential to create shared classrooms composed of international and local students, also drove course creation. Third, these courses arose as a concrete response to personal ambiguity around the tension between our reality as foreigners with considerable power and privilege living outside our communities of origin and our steadfast belief in striving for social justice, health equity, and health as a human right. Fourth, health professional education around the world provides little exposure to impoverished settings, and thus graduates emerge afraid of and unprepared to work in the settings with greatest need. Finally, the few social medicine courses that did exist when SocMed and EqualHealth began teaching were primarily focused on the theory and history of the field and were delivered within the confines of a university classroom situated in the Global North, leaving little curricular time devoted to taking action toward equity and skill building.

As a result, SocMed and EqualHealth have designed and implemented annual 3- to 4-week courses in Uganda, Haiti, and the United States for medical, nursing, and other health profession students. In all courses, half the students are from the country in which the course is taught and half are not. The courses use an interdisciplinary approach and strive to promote biosocial understandings of community disease and health through unconventional and at times uncomfortable pedagogies, including community visits, film, group work, theater of the oppressed, and small- and large-group discussion. The teaching philosophy draws on "the 3 Ps":

- **Praxis:** Taking inspiration from the Brazilian educator Paolo Freire,[17] we use a constant interplay between reflection and action. Teachers are not present to deposit knowledge but rather to facilitate the cocreation of knowledge with participants.
- **Personal:** Critical self-awareness of ourselves enhances our ability to undo harmful social structures. We believe it is important to study social and health problems not just as esoteric dimensions "out there" but as our personal realities.
- **Partnership:** We work to advance equity collaboratively across difference; we aim to break down the barrier of donor/recipient and move toward mutuality, reciprocity, and peer-to-peer relationships.

We aim for students to gain a core body of social medicine knowledge salient to the global and local context of the course, to develop a set of skills necessary to practice social medicine, and to deepen their humility, integrity, self-awareness, and sense of social justice. We also seek to inspire interest in and commitment to working in underserved communities. One hundred percent of students in the Uganda-based course report that the course has enabled them to think more critically about the underlying causes of health problems and how they might be solved. In Haiti, 95% of students report that the course has significantly affected the way they will practice clinically in the future.

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Where We Fall Down: Three Failures in Teaching Social Medicine. ***#1: The dominance of North American ownership.*** The first major area of tension we have wrestled with pertains to course ownership. The core course directors are North Americans with extensive experience working abroad in Haiti and Uganda. The development and implementation of both social medicine courses have been guided by our identities as activist-scholars[33] and our authentic commitment to health equity and social justice.

In creating both curriculum and pedagogy, we have used resources—readings, pedagogical tools, and social theories—primarily derived from literature produced by authors from the Global North and elite North American universities. Although all along we have collaborated with, engaged in dialogue with, and incorporated colleagues from Uganda, Haiti, and other parts of the Global South, ultimate decision making rests with us, privileged North Americans with advanced degrees. We have drawn on our resources and contacts to implement these courses and have at times invited into the classroom a disproportionate number of faculty from the Global North because we struggled to find local experts who we felt could provide the historical detail concisely and engagingly.

We collect and take very seriously student feedback, but we also attest honestly that ultimately we find ourselves—outsiders in communities in Uganda and Haiti—determining what is essential to fit in the course curriculum, how course resources (such as scholarships, honorariums, and transportation) are distributed, and which students will be accepted for admission and which will not. We decide which course speakers to invite back, which field visits to carry out, and how to handle stress, exhaustion, conflict, and feelings of guilt and shame that arise among the students during the course. We manage the course budgets and decide how resources will be used. Although others are brought into the recruitment and enrollment process, fundamentally we have the power to decide who is the best fit for our course and who is not. When the style or approach of professors from the Global South are dyssynchronous with our pedagogical vision or depart from the model we want our students to follow, we have the choice to remove them from the course.

Although we have collaborated with colleagues, friends, and practitioners from Haiti and Uganda and have regular involvement with former Haitian and Ugandan students and staff playing coordinating and teaching roles, we recognize genuine failure in building a senior faculty leadership team that truly reflects the student body. We believe that course "ownership" still lying exclusively with North American doctors is problematic. It deprives our students of an embodied example of partnership in social medicine and results in most major decisions pertaining to the courses still being made by outsiders from the Global North. We are keen to work on avoiding imposition or colonization[34] of our colleagues and students in the Global South, particularly considering the fact that the majority of the world's social medicine practitioners practice in the Global South but without the same academic visibility.

#2: Inequities amongst our students. A second tension we grapple with each year grows out of the diverse demographic of our students and the underlying disparities that exist within our classroom. Disparate socioeconomic statuses, home environments, and educational experiences become evident during the intensive course. These differences are inherent to having students from many countries, especially countries spanning such diverse economic backgrounds. Although there are certainly gifts to teaching and learning in such a diverse classroom, namely that sharing and reflecting on divergent social experiences among the students can be tremendously effective in grappling with concepts of oppression and privilege, tensions also emerge as a result of these disparities.

Differences in student backgrounds manifest in many aspects of our courses. It is noted in simple routines around waking up and going to sleep, as well as organizational and study habits, which stem from different educational systems and learning environments. For example, when completing group projects, students' work styles and experiences are markedly different, sometimes resulting in dominance of international students as a result of their familiarity with group work in an educational setting. Further, the Haitian education system uses a traditional lecture format, often not accompanied by audiovisual display such as PowerPoint slides. When Haitian professors lecture without slides, American students struggle to stay engaged and provide critical feedback around a lack of interactive learning. By contrast, the Haitian students rate those class sessions more favorably. In both courses, we have wrestled with the iterative improvement of the course based on student feedback for such situations where ratings of classes correlate to students' country of origin.

Additionally, disparities are inadvertently exposed by the course design. For example, we elicit feedback from the students throughout the Haiti course, and in an attempt to streamline the process, we converted the feedback form to an electronic format. This eased evaluation for students with electronic devices but increased the likelihood of incomplete feedback from students without easy access to such technology.

Tension around inequities among our students has surfaced most intensely through course content on oppression and privilege. We conduct a privilege walk, an exercise derived from Peggy McIntosh's scholarship on white privilege,[35] in which facilitators read a series of statements about life experiences related to privilege or oppression that prompt students to step forward or backward depending on their personal lives. The privilege walk reveals inequalities in the classroom that students may not have been aware of before participating in the educational exercise and lays bare the existence and operation of privilege and oppression in our students' lives and in society.

Although we deeply value this activity as facilitators, feedback suggests that it is genuinely painful for many students, particularly those who have less privilege and feel overwhelmed by their newly found consciousness of the harsh inequity of societies and their relative social positions. In the debrief after the privilege walk, many students avoid making eye contact and are physically overwhelmed with sadness and tears. A visceral sense of heaviness besets a classroom that less than an hour before was animated by multicultural interaction and joy. Despite our efforts to frame the exercise as one that illuminates how social structures affect our own lives, some students have asked us with tears in their eyes, "I just don't see the point. Why did you have us do this?" Students, particularly those with less privilege, seem to note a sense of being classified as inferior. They demonstrate an urge to resist an identity as someone with little or less social power. One student in the Uganda course noted in her evaluation, "privilege walk not applicable. Intentions??? Was it showing off? or simply showing others that they are under others' feet? Things were never the same afterward."

Despite this obvious discomfort after the privilege walk, our own collective educational philosophy is that we must confront challenging topics in a struggle for social justice. It is critical for people from divergent backgrounds to acknowledge the disparate social locations they occupy in order to have honest conversations and authentically build partnerships to address inequity in society. Yet, as educators, we must also recognize how some of our students, particularly resource-poor students from sub-Saharan African countries and Haiti who have intimately experienced trauma, violence, and extreme poverty, may prefer to forget what has hurt them and instead focus on opportunities for future upward social mobility. The discomforting question we remain with then is: Are we doing something positive by giving voice to the "elephant in the room"[36]—that is, white privilege and power inequities—which some, who have been trampled on by the world, would rather not bring to light so publicly?

#3: Demoralized students. Finally, the third major friction point in our social medicine teaching is the sense of demoralization and discouragement that many students experience, not immediately but several months after course completion. Students often leave our social medicine courses on an emotional high. They feel educated, armed with new information and analysis outlining an alternative explanation of health inequity, and ready to take positive action for social change. However, many of these same students soon face significant barriers in their personal and professional lives that can quickly erode this newfound aspiration.

Professionally, students return to study and eventually work endless hours in broken health systems with limited resources for the most vulnerable patients; they are sometimes in repressive contexts that do not allow space for open critique of the health clinic or system, the government, or the structural forces that create inequity. Such realities can exist whether working at a community health center in rural Uganda or an urban clinic or hospital in the United States. The deeply entrenched biomedical gaze focused on objective analysis of the body leaves little latitude for practicing social medicine.[37] Health care systems focus on clinic- and hospital-based care delivery without robust community linkages through community health workers, home visits, and partnerships with community organizations. Short, productivity-pressured clinic visits with patients preclude the use of narrative medicine. Rigid bureaucracies and regressive leaders limit dialogue and activism on racism and prejudice's impact on health and extinguish the energy necessary to change it. Engagement in social change activities may be considered unprofessional, is rarely incorporated into any practicing health professional's job description, is often associated with lower

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compensation or no compensation at all (relies on volunteerism), and can represent a serious transgression from the apolitical, objective ideals of biomedicine. This could be particularly risky in certain contexts or governments. Finally, students struggle in the return to institutions that lack a critical mass of colleagues and educators familiar with the tenets of social medicine.

On the personal level, many students have serious financial constraints (families living in poverty and/or the burden of higher education loans) making it practically difficult to consider any job that requires a financial sacrifice, which is often true of jobs dedicated to serving vulnerable populations. The exhausting priorities of medical school, exams, residency, and other career considerations such as prestige and pressures from family often take over once the course ends, leaving little time to keep the practice of social medicine at the forefront.

Such realities are a recipe for demoralization. Two years after participation in the 2011 SocMed Uganda course, a U.S. medical resident posted the following to her class's Facebook group:

> "I'm muddling through peds internship, working with other residents I like, with the urban inner-city patient population I am interested in, with good attendings etc. BUT there is literally no time for any "social medicine" stuff at all and I'm finding it extremely frustrating. I have been repeatedly told by seniors and attendings that unfortunately with the high patient volume there is not time to do any social history or worry about anything that will not affect the patient "in the next 3 hours." Instead, if I have any hint of any social issue, I'm supposed to call social work (as if they have lots of time and resources themselves) and let them handle everything. I do realize that residency doesn't last forever, but without being permitted to even spend 5 secs on some of the things that matter most to me–And definitely to the families I work with, it's getting hard to stay motivated to keep suffering through this 80-hr-a-week × 3 yrs situation… Anybody else feeling or felt something similar? If so, how did you get through??"

Such sentiments reflect what many U.S. alumni wrestle with as they return to medical school and residency.

Ugandan and Haitian alumni often struggle with placement at community health centers where regular staff disappear for the duration of their rotations; patients receive "free" care but are expected to buy any medications, intravenous supplies, and equipment needed; and they are expected to see more than 100 patients per day, leaving little time to adequately address the glaring underlying social medicine issues of poverty, sexism, and militarization. A fourth-year medical student in Gulu, Uganda, reflected on the detrimental impact of her community health rotation, which she completed immediately after the 2010 SocMed course:

> "For me, I love community based health care as in I really want to get to the grassroot. And that has always been my passion…but then after my time in the village, you sometimes find that the problem is not with the health worker, but the problem is with the top management of the health system cause if there are not supplies, then your presence there means nothing. It will not change anything. So, I was looking at a lot of frustration for those people who are working in that setting, working with community based, there is a lot of frustration. Yeah. Yeah, basically frustration…so, it just makes me have second thoughts about community based healthcare. It's my passion but how do I achieve it, how do I achieve that?"

These examples illustrate the grave danger that exists if aspirational teaching is not paired with building community and a supportive network. Without this, we risk further contributing to the already troubling degradation of empathy, hope, and generosity that medical training precipitates.[38,39] Our previous inattentiveness to this dynamic has taught us that teaching social medicine also means equipping students with the skills they need to set appropriate expectations for themselves after the course, to effectively build a community that encourages them to consistently practice social medicine, and to focus their efforts on action as change agents despite bureaucratic systems. For example, alumni of the Haiti course have started a social medicine alumni organization, which now boasts more than 40 members and has de facto become a community of support and action, deepening their collective strength for structural change in addition to promoting the centrality of social medicine.

In recent years, we have placed increasing emphasis on self-care, compassion, empathy, and resilience in our curricula as a preventive antidote to the heightened potential for demoralization and burnout after a social medicine course and during a career focused on social justice. This has taken the form of dedicated sessions focused on self-awareness early on in the course, which has allowed students to be more self-aware from the beginning. We have also integrated reflective sessions on compassion and empathy at the end of the course, while also introducing a panel of social medicine

practitioners who share their personal experiences of burnout and the successful strategies that they have used to prevent and manage it. Our hope is that these sessions will not only prepare students for the predictable frustrations that lie ahead in careers focused on social justice, but will also offer them tools to manage and overcome hardship such that they may persevere practicing social medicine throughout their careers.

DISCUSSION

As a result of honest attentiveness to our failings and classroom tensions, we have learned a set of lessons with applicability for all those teaching global health and social medicine.

Lesson #1: Build equitable partnerships. Partnerships that are built on dialogue, vulnerability, and honest self-awareness create space to recast the persistent donor-recipient dichotomies engrained in global health. In our 10 collective years of teaching social medicine courses, authentic partnership guided by open dialogue is what has allowed us to move beyond superficial relationships, explore uncomfortable tensions, and begin to model equity. It is vitally important to recruit instructors and decision makers from a diverse range of social locations, which can only be built on long-term commitment and relationships. Such recruitment also requires paying people fairly for their contributions. Implementing courses in countries with acute shortages of health workers, such as Uganda and Haiti, means that building local leadership requires deliberate action to support their course efforts paired with mindfulness about minimizing disruption to the critical clinical care and public health services they provide. We have successfully integrated course alumni through teaching assistant positions, internship and fellowship positions, and participation in the recruitment, interviews, and orientation of future cohorts. Although these intentional practices have begun the process of shifting ownership and decision-making power, we recognize that sustaining equitable partnerships requires constant attention.

Lesson #2: Embrace discomfort. Discomfort is the transformative ingredient in our courses. As learners and facilitators, we cannot escape our personal implication in injustice and inequity and must acknowledge our role in sustaining inequity. We work to intentionally structure courses to create permissive spaces for diverse, sometimes conflicting, perspectives. We recognize power and privilege through explicit acknowledgment in our lectures and interactions with students. While promoting difficult, at times, emotional conversations, it is imperative to ensure that uncomfortable spaces never become unsafe spaces. Responsibly highlighting inequity in the classroom requires persistent attention to the impact of such awareness on students and facilitators. Promoting and sustaining growth and personal transformation is a process and not an event. Finally, we must humbly recognize that despite the personal transformation that results from our courses, societal transformation often lags far behind and requires robust efforts for social change outside the classroom.

Lesson #3: Link reflection with action through praxis. Reflection alone breeds inaction and paralysis. Although indispensable to building self-awareness and minimizing unintended consequences, reflection must be paired with action even in educational settings. Action counters demoralization by giving learners a deepened sense of agency as they confront health challenges in their own communities. To do so, such action must intentionally invite untraditional sources of wisdom. Historically, academic elites in the Global North describe successful models of global health interventions extensively in academic journals, grant applications, and classroom settings while ignoring solutions readily available in the Global South. Our courses create opportunities to venture outside of traditional academic frameworks, investigate local solutions, and act together toward changing the inequities we witness. The courses also model praxis, through establishment of regular opportunities to both receive and act on real-time evaluation in order to create a dynamic curriculum capable of adjusting to critique. Creating an active, flexible classroom teaches learners to similarly adopt such practices as they engage health challenges in their own communities.

Lesson #4: Build intentional community. To further counter demoralization, it is critical to build community networks that sustain morale and promote accountability. We have worked to support class connection and cohesion after the course conclusion through social media, joint publication, and reunions. Former students have independently built alumni associations to promote unity, engage in continual education, and provide support for each other. Learners must also be given tools in constructive dialogue so that they can effectively transmit course lessons and work to change the narrative on health equity in their own communities.

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Establishing strong community bonds among alumni and with their home communities promotes the resilience necessary to work for health equity over the long term.

CONCLUSION

After a collective 10 years of teaching social medicine, we have syllabi, readings, teaching teams, community visits, films, and pedagogies that are impactful and transformative. We routinely hear from alumni that participation in our courses was "the most transformative experience of my health professional training," and we are experiencing exponential increases in interest in our courses and opportunities. However, our journey in teaching and practicing global health and social medicine has just begun. The failures, tensions, and lessons shared here are our starting point as we work to teach and practice social medicine, ultimately in pursuit of global health equity.

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