

PRODUCING THE GLOBAL HEALTH DOCTOR:
DISCOURSES ON INTERNATIONAL MEDICAL ELECTIVES

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ABSTRACT

The field of global health has grown rapidly over the past two decades. In response, academic institutions have established new educational practices and training opportunities for students. One flourishing area of global health training is in international medical electives (IMEs) in which medical students experience medicine in a different political, cultural, and epidemiological context for a short period of time. Scholarly literature on IMEs has been published and disseminated widely, and various discourses establish the way that IMEs are understood and experienced. However, rather than offering neutral descriptions, discourses actively shape the world in favor of certain viewpoints. When accepted uncritically, dominant discourses can reproduce inequalities by legitimizing certain practices. In the field of global health, dominant discourses have been largely unexamined and unquestioned. Informed by social constructionist and post-structuralist views of language, this study critically examines IME discourses in 60 journal articles published between 2000 and 2011. A method for analyzing discourse influenced by the French philosopher Michel Foucault was used to emphasize the intricate relationship between discourse, knowledge, and power.

The findings reveal that two dominant discourses cohere to produce commonly accepted and appropriate knowledge about IMEs. The discourse of “disease and brokenness” depicts IMEs as situated in faraway lands plagued by “exotic” diseases, and the discourse of “romanticizing poverty” portrays developing countries as trapped in time. These discourses emphasize and privilege certain meanings, while discrediting and silencing others. Moreover, IME discourses constitute uneven power relations and are characterized by a language that relies on dichotomies. In both of the identified discourses, medical students are privileged subjects while inhabitants are marginalized. As a result, inequalities between developed and developing countries are reproduced and the possibilities for forming mutually beneficial relationships during IMEs are constrained.

Recognizing that reality is constituted through language, the findings indicate that prevailing representations are constructed rather than inevitable “truths”. Furthermore, this study suggests that dominant meanings can be resisted, articulates how current “truths” can be destabilized, and proposes a new way of conceptualizing IMEs. By critically reflecting on their work, students, researchers, and practitioners in the field of global health can engage in more socially just practices.

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CHAPTER 1 INTRODUCTION

There is an increasing popularity and interest in global health from North American universities, and as a result formalized global health institutions, programs, departments, and initiatives have multiplied in the past several years (1-3). Growing interest has come not only from academic institutions, but students as well. One rapidly growing trend is participation in International Medical Electives (IMEs), where medical students from pre-clinical, undergraduate, and residency programs go abroad for a short period to experience global health firsthand. IMEs provide medical students with a unique opportunity to understand medicine in a different clinical, epidemiological, cultural, and political context (4). Global health interest groups are also flourishing on many campuses, where students are motivated by a sense of mission and inspired by peers who have already rotated abroad (5). Although global health is still in its infancy, students have arranged and funded their own excursions and have been instrumental in designing global health courses as well as learning objectives (6,7).

Academic institutions have an enormous role in global health initiatives as institutionalized sites for generating knowledge and educating globally minded students (8). Growing global interdependence has compelled universities to initiate processes of internationalization on campuses, while simultaneously attempting to contend with the issues of globalization (9). Situated within broader political, economic, and social forces, the internationalization of higher education can be observed by the number of new programs and practices geared towards international exchanges (10). Institutions from the developed world that send students abroad also have much to gain. Training activities that incorporate core professional values into the undergraduate medical

curriculum help to meet accreditation requirements, strengthen the position of a university to attract future trainees in global health, and heighten the appeal to philanthropists for monetary donations (11,12).

Global health is described, conceptualized, and justified in many different ways. It is therefore critical to consider the way that the language and concepts used in global health are selected and given prominence as well as how they evolve. The predominant knowledge and meanings about global health are formed by various discourses. Importantly, discourses produce meaning that, in turn, shapes and influences practices. Stuart Hall (13) describes how knowledge is created through discourse:

Discourse governs the way that a topic can be meaningfully talked about and reasoned about. It also influences how ideas are put into practice and used to regulate the conduct of others. Just as a discourse rules in certain ways of talking about a topic, defining an acceptable and intelligible way to talk, write or conduct oneself, so also, by definition, it ‘rules out’, limits or restricts other ways of talking, of conducting ourselves in relation to the topic or constructing knowledge about it (p. 44).

Although a variety of different competing discourses are in circulation at any given moment, not all discourses are given equal status or privilege. Certain discourses have a dominant influence on language. Problematically, some discourses are oppressive and marginalize certain group groups in society (14). Dominant discourses privilege certain meanings that become accepted as the “definitive truth” while silencing alternative interpretations (15).

1.1 Purpose of the Study

Within the academic literature, global health is constituted by variety of discourses. Given the multiplicity of meanings, it is necessary to deconstruct global health discourse in order to examine its underlying assumptions, what it excludes, and

how alternative theories might be introduced. In this thesis, I conduct a discourse analysis to examine how meaning about global health – in particular international medical electives (IMEs) – is constructed. Specifically, I analyze how the published academic literature produces a body of knowledge and “truth” about IMEs that has important implications for global health training and practice.

Discourse theory has implications for students, practitioners, and researchers involved with global health work. Dominant discourses sustain and shape recurrent, day-to-day practices. When students, practitioners, and researchers are unaware of how their practices are embedded within and limited by such discourses they are unlikely to envision different alternatives. Urging researchers to be aware of uncritically accepting dominant discourses, Tsang (16) declares that no individuals are ever “totally immune to the influences of the dominant discourses of society” (p. 229).

Examining the discourses around IMEs can provide a starting point for recognizing the plurality of meaning in global health practice and providing resistance to dominant meanings. By recognizing different possibilities, those involved in the field of global health can better reflect on their work and engage in more socially just practices.

1.2 A Critical History of Global Health

The academic field of global health became prominent during the 1990s as the term “global health” captured the attention of students, faculty, media, celebrities, and politicians among others (17,18). Although the term continues to gain popularity, the definition, goals, and activities of global health have often been contentious and controversial (19). Global health has been described as a complex and unwieldy field, permeated by both unclear accountability and exciting opportunity (20). The premise of

global health is based on the idea of a global susceptibility and shared responsibility for health, irrespective of national borders. However, the history of global health is complex and its evolution has not escaped broader political, economic, and social influences. Undeniably, global health is not a neutral domain (21).

Some of the primary concerns and activities of global health have existed for the past several centuries: protecting populations from infectious diseases, reducing premature mortality, forging strategic political alliances, and improving health within and across societies (22). Accordingly, it is important to differentiate global health from other long-established fields such as public health, tropical medicine, and international health. As noted by various historians, these fields are all steeped in historical power differentials to varying degrees.

1.2.1 Public Health

One of the earliest formal definitions of public health appears in the 1920s. Charles Edward Winslow, a distinguished scientist in bacteriology and sanitary science, defined public health as

the science and art of preventing disease, prolonging life, and promoting health and efficiency through organized community effort for the sanitation of the environment, the control of communicable infections, the education of the individual in personal hygiene, the organization of medical and nursing services for the early diagnosis and preventive treatment of disease, and the development of the social machinery to insure everyone a standard of living adequate for the maintenance of health, so organizing these benefits as to enable every citizen to realize his birthright of health and longevity (23)(p. 468).

However, the field of public health has a prolonged existence that dates back to the 14th century. Public health emerged and evolved in relation to larger historical events. Banta (24) describes how the bubonic plague, which devastated much of Europe, compelled different nations to mitigate the spread of disease under the context of

protecting national security and international commerce. A few centuries later, frequent epidemics of cholera and typhoid appeared as squalid living conditions proliferated during the Industrial Revolution. Although such diseases primarily threatened the poor, the masses of working class people were viewed as vital to economic growth (25). Hence, the need to contain epidemics and social unrest became an imperative.

Scholars in sociology, anthropology, and history have also documented public health's long concern with "otherness" (26-29). The tradition of attributing blame to foreigners for disease can be traced back several centuries (30). In various settings, syphilis has been labeled as "French Disease", "Polish Disease", and "Italian Disease" among others (31). British explorers were shocked to discover that the Tahitians referred to syphilis as "British Disease", while in Turkey it was known as "Christian Disease" and in Japan as the "Chinese pleasure disease" (31,32). Reviewing historical documents, Mack (30) professes that in the year 1524 over 200 names existed for syphilis. Portrayals of syphilis have also shifted over time. Once thought to be disease brought back by Columbus's sailors, syphilis was later represented as a disease imported by Africans to Europe during the Middle Ages (30).

Dominant discourses have historically explained syphilis to be the product of inherent inferiority. In the United States, African Americans symbolized a "syphilis soaked race" and were perceived as lacking sexual morality and sensitivity (33-35). Explanations of venereal disease as the product of economic and social conditions were dismissed in favour of explanations of moral failure (34). According to Peiss (33), the high prevalence of venereal diseases among Blacks was seen as both the result and proof of their promiscuity.

Other historians have noted the evidence of racial discourses in public health to justify social control. Underscored by nativist sentiments, quarantine measures had a recognizable racial component (28). For example, one of the most ignoble events in public health history was the incarceration of Mary Mallon, an Irish immigrant to New York City who was linked to several cases of typhoid. Public health officials infamously nicknamed Mallon “Typhoid Mary” and subsequently detained her on a nearby island until her death (27). Characterized as a menace and threat to society, Typhoid Mary set off a wave of anxiety against non-residents. Likewise, during the bubonic plague in San Francisco in the early 1900s, public health officials confined Asians within the Chinatown district under the pretext of preventing outbreaks of the disease (36). Science did not employ neutral language, and the presiding US Surgeon General characterized the plague as a “rice eaters” disease (37). Craddock (37) explains that racial discourses indicated the universal susceptibility of Asians and made it unthinkable that whites could also be potential disease carriers. Using racially charged language, health reformers purported that the plague signified the evidence and consequence of Asian “backwardness” (38). Similar incidents were repeated frequently. In 1924, a plague epidemic that threatened neighborhoods on the eastside of downtown Los Angeles led health officials to invoke racialized discourses to contain Mexican residents and protect L.A.’s reputation (39).

Trinh-Shevrin et al. (29) state that public health has had a long, contentious relationship with minority populations. Immigrants or newcomers have been scrutinized, detained, or segregated on the basis that they were “vermin infested” or “diseased aliens” (28). As a result, many public health interventions have reproduced the same inequalities

that they set out to challenge (29).

1.2.2 Tropical Medicine

The field of tropical medicine most often connotes the area of medical research involving parasitic and vector-borne diseases. Tropical medicine took hold at the end of the 19th century. Noting the potential for new scientific discoveries and the economic significance of disease control, the British Colonial Secretary Joseph Chamberlain at the time urged the British Empire to establish the first schools of tropical medicine (40). The field grew rapidly with the founding of the London and Liverpool Schools of Tropical Medicine in 1899. Beginning with six students in its opening year, the London School of Tropical Medicine had nearly 300 students by its third year (41). Both schools not only offered formal teaching, but also conducted research and carried out medical expeditions. The tropics were thus primarily characterized by “exotic pathologies” discovered in warm climate regions (42). However, the term “tropical” was never meant to be solely a geographical term. For example, the earliest practitioners recognized that tropical diseases were rarely confined to tropical climates. Widely regarded as the “father of tropical medicine,” Patrick Manson (43) wrote in his still widely cited manuscript *Tropical Diseases: A Manual of the Diseases of Warm Climates* that tropical diseases include

certain cosmopolitan diseases... which, properly speaking, do not depend in any very special way, or necessarily, on climatic conditions. They have been practically ousted from Europe and the temperate parts of America by the spread of civilisation, and the improved hygiene that has followed in its train; and are now virtually confined to tropical and sub-tropical countries, where they still survive under those backward social and sanitary conditions which are necessary for their successful propagation, and which are more or less an indirect outcome of tropical climate (p. xvi).

Several critics have found the term “tropical” to be problematic, indicating that

the expression requires further analysis (44). The term “tropical” created a fundamental dichotomy between the West and their colonized territories, and colonizing powers consequently used the term to define difference and unfamiliarity. According to Birn (22), the idea of tropics also invoked discourses that explained the racial inferiority of indigenous peoples, their suitability for work, and their underdevelopment.

Academics have also noted that tropical medicine has never solely been a scientific pursuit but represents the extension of colonial expansion and Western conquest (45). As the British Empire expanded, they encountered diseases that threatened the acquisition of new territories in Africa, the West Indies, and Southeast Asia. Tropical medicine thus became synonymous with colonial medicine (46). Critics suggest that colonizing powers frequently disrupted the ecological balance and exacerbated diseases by carving out new trade routes and redrawing territorial boundaries. For example, Banta (24), describes how the field of tropical medicine emerged to serve the interests of colonial powers who were often “inhibited in their overseas investments and exploitations” (p. 74) due to endemic diseases such as malaria, yellow fever, and schistosomiasis. Indeed, shipping companies with commercial interests in West Africa funded the Liverpool School of Tropical Medicine. Liverpool’s location as a port city provided numerous patients returning from colonial missions with “tropical” diseases. Complementing this assertion, Lyons (47) remarks that the primary origin of tropical medicine was to protect the health of soldiers, traders, and settlers of the colonial power along routes where exploration and conquest took place. On the other hand, when attention was given to the health of indigenous populations, the primary purpose was to manage a pool of productive labor (48). For example, the deadly

outbreak of trypanosomiasis – also known as African Sleeping Disease – between 1900 and 1905 in the British protectorate of Uganda, which resulted in 250,000 deaths, spurred the field of tropical medicine (47). Similarly, British rubber plantations in colonial Malaysia and India experienced severe malaria epidemics when massive tracts of forests were cleared, providing new breeding grounds for mosquitoes (40,49). Worried about the enormous economic impact of the disease on their colonies, the British Government invested heavily in sleeping sickness and malarial research.

Post-colonial scholars contend that tropical medicine was a “tool of the empire” that served as a source of power and dominance for the colonizers (45). Challenging the claim that tropical medicine served humanitarian purposes, King (48) defines colonial medicine as a civilizing mission whose sole purpose was to free colonized societies from the grip of irrationality. Others such as Edmond (50) report that popular publications in tropical medicine created the notion “that native bodies were more susceptible to deforming disease, and perhaps inherently debased” (p. 117). Consequently, tropical medicine came to be viewed as the “white man’s burden” to uplift those suffering from tropical diseases and as a “gift of civilization” to the people of the colonies (42,51).

As the 20th century progressed, scientists made key discoveries about parasites such as helminths and protozoa. Tropical medicine became dominated by the study of parasitology. Researchers argued that understanding the life cycles of intermediate hosts and vectors would stop the transmission of infectious transmissions (52). Hence, they strongly supported methods such as applying chemical agents to kill parasites causing malaria and trypanosomiasis. Technical approaches to disease prevention came to dominate the field of tropical medicine. British colonial officers heavily favored these

targeted methods in 1900s, but so did WHO officials during malaria eradication campaigns in the 1960s. Consequently, disease control approaches influenced the field of international health as it emerged.

1.2.3 International Health

The newer field of international health is perhaps the closest relative to global health, with some scholars preferring to maintain this term as a more accurate reflection of current activities in the field (22). International health maintains a strict geographic focus and is primarily concerned with health issues of the developing world. Birn (22) describes one popular conception of international health as

the diffusion of ideas, practices, and technologies, principally from developed to developing countries. This understanding includes...development work that ranges from infrastructure-building to disease campaigns, programs focused on household and health behavior, nanotechnology, and the distribution of bed nets to prevent malaria, among a myriad of other approaches (p. 10).

A high geopolitical influence is present in international health (20). In the period following World War II, numerous sovereign and nation states came together to promote intergovernmental cooperation and multilateralism (53). Permanent bodies such as the World Health Organization, the World Bank, and the International Monetary Fund subsequently shaped international health. The central activities of international health organizations were characterized by disease surveillance and notification, information exchange, and sanitary regulation. During the mid to later parts of the 20th century, immunization campaigns, family planning, and vector control took precedence.

Many new actors to international health have arrived within recent decades, including public-private partnerships and an abundance of NGOs. Two prominent public-private partnerships are the Global Fund to Fight AIDS, Tuberculosis, and Malaria

and The Global Alliance for Vaccines and Immunisation (54,55). The primary stakeholders of these organizations are donor governments who provide development aid as well as private industries. One major concern is the discordance that exists between donors and recipients. Issues that are prioritized do not always reflect the highest burden of disease (56). In addition, programs may not match the need of the community, fragment existing services, undermine existing systems, and fail to address basic health infrastructure (57). For example, de-worming campaigns in areas with unsafe drinking water are often ineffective (58). Described as “vertical programs,” disease-specific projects are criticized for their narrow approach and for ignoring broader social, and political structures (59).

There has been a growing concern with industrialized countries leading efforts in international health. Aware of the ever-present power dynamics in international health, Birn (22) calls attention to the “continued economic and political domination of industrialized power over developing countries” (p. 6). According to Perlman (60), the influence of Western governments and aid agencies reside in their ability to invoke development discourses. Portraying modernization as a necessary and desirable process, development discourses proclaim economic growth as a universal goal (61). Hence, indicators such as Gross Domestic Product (GDP) and Gross National Product (GNP) as well as the integration of economies into the global market are increasingly used to measure progress in international health (60).

Brown and colleagues (17) attribute the evolution of the WHO and World Bank to the influence of the post-World War II reconstruction era, the rapid decolonization of African nations, and the Cold War. Moreover, during these periods international

agencies and organizations struggled to remain neutral. Although the WHO is composed of numerous member states, a minority of wealthy donor nations, and increasingly, private foundations, drives its direction. Similarly, using its unprecedented ability to mobilize financial resources, the World Bank enshrined economic growth as an undisputed priority and influenced many health and development initiatives (53). Many critics charge the World Bank as well as the International Monetary Fund (IMF) for imposing structural adjustment programs on developing countries' loan conditions (62). Deemed to promote economic development, structural adjustments such as the privatization of state enterprises and the removal of tariffs on imports have had devastating effects on the Global South. As a result, in many developing countries, spending on education and health care has reduced drastically (63,64). For example, Pfeiffer (57) recounts how Mozambique's IMF loan required the devaluing national currency, promoting neoliberal economic reform, and slashing government services. Private NGOs and donor organizations are increasingly dictating international health activities in lieu of the public sector and state services.

The prevailing wisdom behind many international health initiatives is still guided by technical disease control approaches and closely tied to economic growth, privatization, trade liberalization, and public sector contraction (57,65-67). Furthermore, in a rapidly globalizing economy the WHO and World Bank are continually subjected to strong Western development and neoliberal discourses. The dominant view on development ultimately creates tension between social and economic; population-based and disease-specific; as well as efficiency and equity approaches to improving international health.

1.3 Global Health in the 21st Century

By the end of the 20th century, the process of globalization was taking on a new magnitude. Globalization ushered in an era of accelerated knowledge flows, the exchange of ideas, and increased economic, political, and social interdependence (9,68). While globalization promised many benefits for the field of global health such as the diffusion of technology, ideas, and values it also brought along threats such as diminished social safety nets, disease pandemics, and the deterioration of the environment (17). The challenge of global health governance has also proliferated. As the world becomes more interconnected, global health is emerging as a key concern at global summits such as the World Economic Forum and G8 meetings (65). In addition, a new wave of actors who were not traditionally part of international health and public health has arrived. On the one hand, private philanthropies endowed with a budget devoted to health and development as large as the WHO, such as the Bill & Melinda Gates Foundation, are highly involved in shaping health outcomes (65). On the other hand, grassroots movements and solidarity groups, such as the People's Health Movement founded in 2000 in Bangladesh, are undertaking research, advocacy, and political action in the field (22).

A growing number of medical students, health practitioners, and academic institutions are also beginning to recognize the growing importance of globalization and the need to understand health in a global context. Among researchers and academic circles, the term “global health” is slowly beginning to replace the term “international health” and is emerging as the more authoritative term (17). Contradictory efforts to define the field suggest an emerging discipline struggling, on the one hand, to embrace

globalization's call for competitive advantage among academic institutions, while on the other hand, projecting distance between the aforementioned issues with tropical medicine and international health. Global health commonly embodies the idea that health issues transcend national boundaries and demands for global solutions (18,66,69,70). The definition of global health offered by the Consortium of Universities for Global Health (18) is widely accepted among academics and researchers:

Global health is an area for study, research, and practice that places a priority on improving health and achieving equity in health for all people worldwide. Global health emphasizes transnational health issues, determinants, and solutions; involves many disciplines within and beyond the health sciences and promotes interdisciplinary collaboration; and is a synthesis of population-based prevention with individual-level clinical care (p. 1995).

More closely connected and integrated than before, numerous individuals from a wide range of disciplines and backgrounds, including students, participate in global health.

In order to respond to a more globalized world, academic institutions in North America have undertaken a process known as internationalization. Among other things, the process creates pressure to reform curricula towards the creation of increased global training and opportunities for North American students across all disciplines, including the health sciences (71). On an internationalized campus, global health activities may reflect a primary concern with "increasing the global advantage of academic institutions through strengthened competitive position" (71)(p. 72), but they can also involve more social justice oriented activities. The recognition of increasing health disparities is therefore also an impetus for global health activities.

Currently, scholars and practitioners continue to struggle over the nature of global health research and practice, what constitutes global health, what work it entails, and

what makes it a distinct field (9,18,69,70). MacFarlane (9) indicates that while debates rage, many common definitions of global health are still narrow in scope: “One common assumption is that working in global health means going from a developed country to work in a developing country” (p. 393).

Global health research and practice has been criticized, and scholars and practitioners have expressed concern over the way forward for the field (66,72,73). Trostle (74), for example, likens global health research and the appropriation of raw data from the Global South as a form of scientific colonialism and safari research. Others such as Benetar and Fleischer (75) have compared global health research to “parachuting” into low-income countries and experimenting on poor, highly vulnerable populations.

The dominance by North American actors in global health raises several issues. For example, Birn (22) argues that the “one-way diffusionist model of assistance from high-to-low income nations” (p. 695) is simplistic and obscures the fact that more health professionals from developing countries work in developed nations than vice versa. Another issue concerns the bias that stems from the overwhelming majority of publications originating from North American and European countries (76). The underrepresentation of developing countries not only hinders building research capacity in the Global South, but is also an ethical concern (77).

There are also more equity-oriented and transformative approaches to global health practice and research. A social transformative approach, for example, recognizes the detrimental impact of globalization and the increased marginalization of significant groups of people around the world (71). In such a conceptualization, global health

therefore ought to involve more than creating international placements or utilizing global examples in academic settings, and instead should seek to foment personal transformation and commitment to social justice (71). Common among equity approaches are efforts to counter older colonial practices and developmental aid approaches. Subsequently, the term global health embodies new values and ideals.

Global health continues to evolve as a relatively new academic field. Both novel educational practices and extended opportunities in older practices are emerging for the new generation of global health students in search of opportunities and experiences with a global perspective. One flourishing area of global health training is in international medical electives (IMEs), which is the focus of this thesis.

1.4 Growth of International Medical Electives

To fulfill the demand and interest in global health, many universities have expanded course offerings in global health; developed new curricula, competencies, and educational frameworks; and established IMEs that students can take as early as their pre-clinical years (78-81). Medical schools have been hard-pressed to keep up with the demand. In a survey at one large medical school, 61% of medical students stated that they didn't know much about global health, yet one third had considered a career in global health (82). More surprisingly, however, 22.5% had worked in an international setting without ever having received any formal training in the area (82). Participation in IMEs has grown rapidly in the past two decades, with over 30% of medical students participating in overseas electives each year compared to only 6% in 1984 (1,83-85). The opportunities offered by medical schools are varied and have been conceptualized under different names such as internships, preceptorships, clinical rotations, and other forms of

on-the-job training (86). Some IME programs are forged through formal institutional partnerships where students are placed in various clinical, research and community settings, among others. However, on other occasions, students discover a local clinic or project on their own and provide their academic institutions with the program details, patient demographics, and contacts of potential physician mentors.

A survey conducted in 2007 found that all 17 Canadian medical schools offer some form of IMEs, with 44% of them organized without any faculty support or supervision (87). Without faculty guidance and clear objectives, fewer criteria are given for site selection, and students have less accountability for their actions. Medical students inevitably have very different IME experiences. Most IMEs, however, are characterized by short-term expeditions of about four to eight weeks (88-90). The most popular destinations are in developing countries where 69% of IMEs occur, with sub-Saharan Africa being the most frequented destination (91). Growing disparities and the increased burden of disease also make the selection of developing countries significant since a common thread of many global health initiatives is to reduce disparities and alleviate diseases that extend beyond borders (9).

It is important to consider that IMEs do not only involve crossing international borders, but socio-cultural ones as well. Moreover, the same characteristics that draw students to global health – such as working with marginalized and oppressed populations confronted with poverty, gender inequality, and political violence – create a power imbalance and a situation ripe for exploitation (92). The growing number of medical students participating in electives is not inconsequential, and with the dominant flow of medical students travelling from the Global North to the Global South, a critical analysis

is required to understand the full effect of these practices.

1.4.1 Benefits of IMEs

The majority of the literature on IMEs discusses small program or project evaluations that have found numerous positive learning outcomes for medical students (1,4,85,93,94). For example, students report an improvement in clinical skills such as medical history-taking and physical examinations; development of compassion and humility; better appreciation for primary care and public health; and more inclination towards working in underserved communities (95). However, most studies on IMEs have been difficult to compare. Poor study designs lack control groups; have a selection bias of participants; and use self-reported outcome measures from unvalidated questionnaires (1). There has also been a tendency in the literature for publication bias for reporting favorable outcomes (93).

Efforts to define the meaning, purpose, and scope of IMEs have not typically included the perspective of the Global South. As a result, there are very few publications that elicit host institutions and communities' understandings of IMEs. Most evaluations only measure benefits for sending institutions from the Global North, lack theoretical depth and focus on one-sided success indicators (96). Admittedly, the benefits to host institutions are also difficult to quantify and are mostly related to anticipated future benefits for patients and communities. This has led some critics to question whether short-term experiences afford students enough time or cultural context to meaningfully contribute to their hosts (97).

1.4.2 Ethical Challenges of IMEs

Currently, a small amount of critical research is beginning to emerge from the

field of medical anthropology; however, most of the critiques concerning IMEs are written from pragmatic viewpoints. The literature reports that global health work and IMEs are saddled with ethical challenges at all levels; from unequal institutional arrangements to providing clinical care (12,92,96,98-101). Ethics for global health training and exchanges are relatively less developed compared to ethics for international scientific research (92,100). Medical students and global health trainees may not encounter the same ethical issues in developing countries that they face in their home environment (98). In addition, ethical issues may also not be addressed in the same manner. Consequently, medical students are more likely to encounter ethical dilemmas that they are unprepared for and unable to respond to (102). Some documented ethical challenges that undergraduate medical students have encountered include working with limited supervision, working beyond their level of competence, lacking preparation or clear educational objectives, and misunderstanding health paradigms specific to cultures (92,96,99-101). The short-term nature of these electives can also disrupt continuity of care to patients and exhaust already limited local resources (100). Host organizations may end up devoting a significant amount of time to coordinating accommodation, transportation, and translation rather than providing essential services to patients (99).

Working in resource-poor settings provides environments where medicine is practiced with more liberties than in North America. Some students brag about performing procedures in a foreign country that they would not have been able to carry out at home or treating a large number of complex cases with little supervision (100). Success measures guided by a “body count mentality” that impels trainees to see as many patients and perform as many procedures as possible have also been criticized for

providing low quality of care (103). IMEs that are poorly arranged can therefore create potentially exploitative situations where medical students practice on the poor (104).

Several authors have also criticized IMEs as having misguided intentions, where well-meaning students can feel good about providing care without ultimately being responsible for their actions (105-108). In some surgical placements, by leaving before adequate follow-up care is provided, trainees leave the entire responsibility of postoperative monitoring on the host (98). Others caution that short-term electives may be a “form of medical tourism wrapped in a veneer of altruism with no sustainable benefits for receiving communities” (109)(p. 4). Examining the perspectives of local healthcare providers and health authorities, one study from Guatemala found that short-term medical missions fostered dependence on foreign medical aid and potentially undermined the livelihood of local medical providers (110).

Many difficulties exist in resolving ethical issues around IMEs. Currently, few ethical frameworks guide global health work and many existing ethical principles are drawn from Western biomedicine, which may not be applicable in the context of IMEs in developing countries (92). Ethicists point out that concepts such as autonomy in Western medical ethics are highly individualistic and may not be appropriate for all cultural contexts (8). Applying ethical principles in new settings is also equally problematic. For example, Decamp (99) observes that disagreements may arise over what counts as beneficence and how to weigh benefits over risks. Students and trainees may also not be able to abide by the principle of respect for persons when they do not have a firm understanding of local customs and the social structure (99). Likewise, the perception that some help is better than no help at all is problematic and adds further complexity to

an already ethically fraught situation.

Imposing Western values on non-Western cultures has also been charged as a form of ethical imperialism by various academics (111,112). At times, initiatives are couched under a “politics of virtue” that moralize and glorify global health, culminating in an “us versus them” mentality that accentuates cultural differences (96). Furthermore, some critics have denounced the use of double standards that allow students and trainees from the Global North to act as healthcare professionals in the Global South, even though they are not permitted by law to perform the identical procedure in their own country (113).

1.4.3 North-South Relationships

In different fields such as political science, international relations, development studies, and global health, the term Global South has been used to refer to less economically developed countries, while the term Global North applies to those that are wealthy, democratic, and technologically innovative (114-117). To better grasp the term Global South, the legacy of colonialism must be taken into consideration. According to Thomas-Slayter (118), many developing countries of the Global South share a common experience of exploitation or subjugation from more powerful states of the Global North. The historic relationship between Southern and Northern countries continues today in the form of exploitative debt and finance, phantom aid, and unfair trade that further compounds the historic effect of colonial rule (119). The terms Global South and Global North are therefore used to highlight and signify the ongoing power inequalities between developed and developing countries (120).

Global health and many international initiatives largely originate from Northern

countries and are steeped in a particular set of views that are rarely questioned (72,73). It is important to note that these particular epistemological views and knowledge claims restrict and narrow definitions of the field (121). Moreover, the Global North has a dominant influence on how agendas are set, issues are framed, problems identified, and solutions proposed (72).

Despite professing to form mutually beneficial relationships and partnerships, few researchers have critically questioned who wields decision-making power and who drives the global health agenda (122). As such, there is a danger that IMEs are being pushed through without local perspectives and that partnerships are not being formed on an equal footing. Conscious of the multiple and conflicting goals between various actors, Grusky (121) warns that global health initiatives can recreate historical misunderstandings and reproduce disparities that characterize North-South relations. Some authors have also questioned whether modern global initiatives are another type of domination by the Global North over the Global South given that they are “largely advocated and funded by those in the modern, metropolitan West, who have the resources and influence to drive them through” (112)(p. 267).

Frequently, debates around global health have taken place without adequate participation from developing countries whose views have largely been ignored or underrepresented (123). This has created a unidirectional flow of knowledge and marginalized local forms of knowledge. Razack (124) expresses that privilege and dominance are largely invisible and unexamined, and criticizes the dominance of Eurocentric theories and Western frameworks as forms of benevolent imperialism. Currently, little attention has been given to how dominance is produced in global health

research and training programs.

1.5 Dominant Discourses in the Academic Literature

Discourses establish the way that an issue or topic is understood and experienced (14,125,126). By representing the world in certain ways, discourses produce particular versions of events that become defined as “truth” and knowledge. Dominant discourses are often so widely circulated and familiar that they appear normal. For example, discourses of femininity and masculinity view women as essentially caring and nurturing and men as essentially independent and driven (127). Given that discourses have a significant influence on what constitutes acceptable forms of knowledge, they are necessarily partial. Instead of offering neutral descriptions, discourses actively shape the world in favor of certain viewpoints. Brookfield (128) suggests that dominant discourses employ “a particular language and a distinctive worldview in which some things are regarded as inherently more important or true than others” (p. 136).

Prevailing discourses have implications for what people can think and say. Equally important, discourses shape and limit the types of permissible practices people can engage in (126,129). Feminist scholars have provided compelling scholarship in deconstructing dominant discourses. In dominant discourses of sexuality for example, men’s sexual desires are viewed as natural, primitive urges and women are often viewed as inciting and precipitating a man’s arousal (127). Women are expected to be seductive and flattered by a man’s advances, yet chastised for partaking in potentially dangerous activities such as going out alone (125). According to feminist scholars, discourses on sexual relationships favor men’s interests over women and explain differences in power and choice (127).

The authority and influence of dominant discourses reside in the power to appeal to commonsense thinking. Commonsense ideas represent themselves as obvious and are taken as a given. Weedon (14) elucidates why commonsense thinking is often difficult to challenge:

All common sense relies on a naïve view of language as transparent and true...its power comes from its claims to be natural, obvious, and therefore true. It looks to 'human nature' to guarantee its version of reality. It is the medium through which already fixed 'truths' about the world, society and individuals are expressed (p.77).

Discourse therefore represents much more than a set of linguistic or representational practices, but normalizes certain behaviours by defining what is natural and acceptable (130). Conversely, knowledge or representations that are seen as unnatural are deemed immoral and wrong. Alternative ways of thinking are rendered implausible, unthinkable, and seen as not having "commonsense" (131).

Declaring certain interpretations to be universal and self-evident, discourses proclaim the existence of a natural order to guarantee their truth (132). Hall (133) explains that during the era of slavery, racial differences were construed as "natural" differences and thus permanent and fixed. Arguing that the "true nature" of Black slaves was to live under servitude, slave owners naturalized racial differences to justify slavery as normal, acceptable, and right. Similarly, reducing women to a female essence governed by biological destiny maintains the gendered division of labour (126). Appeals to natural explanations therefore justify inequitable arrangements and sustain uneven relations of power.

A variety of alternative discourses and ways of speaking about or representing a topic are always available. Alternative and counter discourses make an effort to contest

dominant interpretations. However, not all discourses are given equal importance and alternative meanings are typically excluded from influence. Dominant discourses privilege some people with more entitlement and authority while marginalizing others (134). Michel Foucault (135) describes marginalized discourses as a form of subjugated knowledge that has been buried and disguised. Foucault (135) contends that the voice of those on the margins of society, like psychiatric patients and delinquents are often discredited and disqualified in comparison to the formal knowledge of psychiatry and criminology. His aim is to investigate how certain truths have had destructive effects, and introduce subjugated knowledges as legitimate ways of knowing.

In global health, some authors have argued that the prevailing meanings rely on a dichotomy between “civilized, rational, scientifically developed peoples and the atavism of peoples by whom Western science gauges its progress” (136)(p. 285). For example, Hall argues that the progress of Western medicine has traditionally been contrasted to the “primitive” practices of the Indian medicine man (136). However, the dominant discourses guiding current global health practices have been largely unexamined and unquestioned. Nonetheless, discourses in post-colonial studies and international development have been widely studied and may offer insight for global health researchers.

1.5.1 Orientalism

The term post-colonialism is frequently used to describe the enduring legacy of colonialism in former colonies. Post-colonial studies examine the effects of the relationship between the colonizers and the colonized in order to better understand the present (137). One of the most important contributors to post-colonial studies is Edward

Said, whose major texts are devoted to understanding the historic relationship between Western and non-Western societies. In *Orientalism*, Said (138) describes how the West produced discourses about the Orient by “making statements about it, authorizing views of it, describing it, teaching it, settling it, [and] ruling over it” (p. 3). According to Said, Orientalist discourses were customary in the writing of European scholars, poets, philosophers, historians, travel writers, and others. Said further proposes that the hegemony of European ideas gave Orientalist discourses their strength and durability. Orientalism gave rise to a proliferation of objects: academic manuscripts, museum displays, and artwork.

Said refers to the Orient as Europe’s complementary opposite. For example, everything about the Orient “offended sexual propriety...[and] exuded dangerous sex” (138)(p. 167). Discourses on the Orient also constructed the Other – a subject who represented the unfamiliar and the strange. The British and French explorers depicted themselves as superior in relation to inferior Egyptians. Knowledge possessed by Egyptians, Arabs, and Indians, who were perceived as deficient in reason and logic, thus constituted a subjugated knowledge. Marginalized subjects of the Orient included the oversexed, degenerate Arabs, harems, and dancing girls (138).

Orientalist discourses are neither neutral nor objective. The Orient is set apart from and defined in opposition to the West (139). Images of the Other are portrayed as fixed and unchanging. By representing itself in contrasting terms, the West justified colonizing missions and conquests in the Orient. Knowledge about the Orient allowed the West to “to dominate it [and] to have authority over it” (138)(p. 32).

1.5.2 Development Discourses

The discourses used in development studies also offer many insights into global health. Rist (140) illustrates that dominant discourses of development proclaim industrial progress and scientific advancement to be universal truths. Development discourses are compelling because they are described in evolutionary terms and as a natural process following a predestined path (61). Conversely, the term underdevelopment signifies backwardness (141). In deconstructing the prevailing view of development, Tucker (61) demonstrates that Western discourses discredited and excluded other forms of knowledge:

[Development and modernity] were rooted in an evolutionary myth...which reduced history to a series of formal stages honed from the particular experience of European societies and then elevated to the status of universals. This schema became a destiny and a norm by which other societies were judged and moulded (p. 7).

These discourses construct science and technology as unassailable and economic growth as the final arbiter of progress (142). Societies that deviate from the norm are judged as traditional or primitive and in need of liberation from ignorance and superstition.

Portrayed as a destiny and couched in teleological terms, development has been used to “legitimize slavery, genocide, colonialism, and all forms of human exploitation” (61)(p. 5).

Global health discourses similarly operate from positions of power, which results in a language that is neither neutral nor reflective of all experiences. Harding (143) observes that the subjugated knowledges of people in the Global South are often not given the same importance as Western science. In a similar vein, throughout the history of the global health, discourses have been used to “identify villains and heroes, ascribe blame for failures, and credit for triumphs” (48)(p. 767). The effect is that certain

“truths” are normalized, while others are silenced. Problematically, dominant discourses are used to explain, justify, and promote global health work and students’ engagement in global health, with a particularly salient example of that being reflected in IMEs.

1.6 The Social Construction of Global Health through IMEs

Language is central to how meaning is derived. In the social sciences there has been a shift in thinking from the traditional view that language can directly describe reality to one in which language constitutes reality (13,14,125,126,144-147). Meaning does not inhere in people, objects, or events, but is socially constructed by humans. Language allows experience to be meaningfully constituted and represented.

Taking a closer look at a few examples can illuminate the idea that meaning is socially constructed. Numerous social scientists argue that gender is socially constructed rather than an outcome of biological sexual difference (14,126,148). Judith Butler (148) explicates that prevailing constructions of gender effectively compel our belief in their necessity and naturalness. According to Butler, discourse constitutes what forms of femininity and masculinity are appropriate, teaching individuals how to “do gender”. Individuals understand the world through language, learning that blue is for boys and pink is for girls from a young age (149,150). Other differences such as choice of clothing are also given gendered meanings (151,152). Challenging the male-female binary thus demonstrates how gender is constructed through language and not a natural difference.

Subjects who personify particular characteristics and attributes are also constructed by discourse (13). Individuals come into existence, occupying subject positions that establish expectations and relationship patterns. Subject positions allow individuals to make sense of the world within a particular discourse. Individuals are

subjected to the norms and particular forms of knowledge (13). In gendered discourses, men are constructed as assertive, independent, and expected to be preoccupied with work, achievement, and success (153). On the other hand, women are constructed as selfless, emotional, and submissive and are expected to act “ladylike” (154).

There are several implications for understanding meaning and reality to be social constructed. Knowledge and “truth” are historically, culturally, and socially contingent. Meaning is not fixed. As such, I argue that the rise of IMEs should not be uncritically accepted as a natural progression of global health knowledge or medical education. Global health students, researchers, and practitioners are also the product of discourses. They do not possess a true essence that defines them. Moreover, the language contained within dominant texts such as the academic literature does not directly reflect the true reality of IME experiences, but privileges certain interpretations over many other possible realities.

Realizing the impossibility of discovering the true nature of reality, Witkin (155) suggests that meaning can be better understood by focusing on the constructive effects of language and what alternative meanings might be possible. Similarly, Wetherell (15) declares that we should be “interested in studying the process of construction itself, how ‘truths’ emerge...and the consequences of these” (p. 16). When unexamined and uncritically accepted, dominant discourses can reproduce inequalities by legitimizing certain practices. Prevailing meanings and interpretations are privileged, taken for granted, and reified (156). Discourse and power are inseparable, since certain ways of representing the world or events privilege some groups in society while subordinating or excluding others (157). Power is thus not merely the capacity to dominate, but the ability

to label, define, and produce knowledge about others.

By demonstrating IMEs to be socially constructed rather than an experience that reflects the true nature of global health, dominant meanings can be transformed and modified. Moreover, what it means to be a global health student, researcher, and practitioner can be renegotiated.

1.7 Dominant Discourses of IMEs

Within the field of global health, a particular form of educational programming – international medical electives (IMEs) – is burgeoning. Scholarly literature on IMEs has been published and disseminated widely, and I postulate that this literature accomplishes an important role in introducing IMEs to other academics, students, and the health professionals. However, few studies have examined the dominant discourses around IME experiences and their related subject positions.

The dominant discourse around IMEs can have various implications for different parties engaged in various IME practices, and it is critical to be attentive to how discourses reinforce knowledge through practices, which may be harmful, unjust, and inequitable in some cases. Yet on the other hand, alternative discourses can be helpful, just, and equitable. Given that meaning is never fixed, but always contestable, it is also equally important to create an opening for these alternative discourses in order to avoid reinstating unequal power relations.

To begin understanding how prevailing knowledge in global health – specifically IMEs – is constructed and maintained, an examination of the discourses underlying these initiatives is necessary. The published literature on IMEs provides an apt way to critically study this discourse. Within academic circles, scholarly literature is given

authority and prominence. Given that meaning making is concentrated among scholars from the Global North, the knowledge and “truths” put forward are partial. I have selected articles from the academic literature because such publications are associated with institutions in the West that have the resources to work or conduct research in global health and dominate the production of scientific knowledge (158).

The way that IMEs are constructed and represented has implications for students, host and sending institutions, and more broadly, the field of global health. Although the literature is by no means homogenous and representative of all published documents on IMEs, I believe that it provides a starting point for researching a relatively new phenomenon in global health.

1.8 Research Questions and Objectives

The purpose of my thesis is to identify and critically examine the dominant discourses of IMEs in the published academic literature. There are a variety of competing discourses that influence how IMEs are spoken about and combine to produce meaning about IMEs.

In this thesis, I offer a new lens to understand how dominant meanings about IMEs are conveyed through the academic literature. I specifically draw on discourse theory to look at the current “truths” about IMEs. My objective is to demonstrate how IMEs are socially constructed through language. I contend that the literature privileges certain representations about IMEs that become naturalized and normalized. Moreover, I take a critical perspective in order to disrupt privileged meanings and challenge the subject positions produced by IME discourses. My thesis addresses the following research questions:

1. How are IMEs in developing countries constructed and given meaning?
2. What subject positions are produced by the dominant discourses on IMEs?

While deconstructing the academic literature, I discuss the strategies and techniques employed by the dominant discourses to give legitimacy to specific claims over others. Although discourses attempt to establish “truth” around IMEs, I destabilize dominant meanings by revealing inherent tensions and contradictions. I also reveal silences and omissions from the text.

In the chapters to follow, I first outline theoretical perspectives on discourse, language, and reality. These perspectives will subsequently guide my research and also allow me to re-conceptualize IMEs in new ways. My work is guided by Michel Foucault, who was a politically active French philosopher concerned with marginalization, power, and exclusion. Hence, I utilize a research method based on Foucault’s theory of discourse, which has been adapted by other social scientists. Throughout the thesis, I reinforce the notion that privileged forms of knowledge can result in dominance and reiterate the need to be more critically aware of the assumptions guiding global health and IMEs.

I present my results on IME discourses, arguing that dominant representations enable certain ways of knowing and being. Finally, in unsettling privileged meanings, I assess the implications of IME discourses for global health training, practice, and research. I also explore how prevailing discourses can be resisted and propose a way for global health students, researchers, and practitioners to introduce alternative meanings.

CHAPTER 2 THEORETICAL PERSPECTIVES

Theory plays a crucial role in this thesis by challenging commonsense understandings about IMEs and drawing attention to the role of language in constituting reality. Brookfield (128) professes that “theory helps us name or rename aspects of our experience that elude or puzzle us...by offering unfamiliar interpretations of familiar events” (p. 5). Theory therefore also offers the possibility of transformation.

In this chapter, I propose that social constructionism and post-structuralism provide useful frameworks for problematizing the dominant meanings of IMEs and opening up possibilities for change. I will also describe how these two theoretical perspectives are considered critical approaches in research as well as acknowledge my own assumptions and roles as a researcher.

2.1 Social Constructionism

The postmodern movement has introduced many new theoretical perspectives to the social sciences (159). Social constructionism is an approach to conceptualizing reality and how knowledge is acquired. Arguing against the notion of an objective reality, social constructionism drastically alters previous ways of understanding the world. According to social constructionists, the true nature of the world cannot be revealed (125,144,147,160-162). Similarly, an individual’s internal state such as his or her thoughts, attitudes, or intentions can never be directly accessed.

Gergen (147) postulates that postmodernism and social constructionism are reactions to modernism, which was founded during the Enlightenment era. Modernists postulate that individuals can directly understand how the world is organized through

direct observation (145). Assuming that an independent reality exists, modernists seek to discover the “truth” about nature and describe it in absolute terms (162). Accordingly, they propose that knowledge and truth are immutable and untainted by human values (159). Grand theories and metanarratives are used to explain the true nature of the world with an overarching principle. For example, Marx theorized that underlying economic structures determined all societal relations, and Freud proposed that underlying psychic structures revealed humans’ natural need for pleasure (125). Likewise, the study of biology and psychology has attempted to reveal human nature, proposing that individuals have innate, immutable cores that determine their personality (160-162). The common thread among all grand theories is the use of essentialism. Essentialism is the belief that members of one group or entity have unvarying qualities and an unchanging history. In essentialist approaches, people possess fixed and innate attributes simply by virtue of group membership whether by race, class, gender, or sexual orientation, etc. (163). All social phenomena and relations are thus reduced to an underlying essence that supersedes every other influence (164).

Many postmodern scholars take a critical approach to science and are skeptical of essentialist accounts of human nature. Contending that traditional science is neither neutral nor objective, feminist scholars problematize biological explanations of gender differences as reductionist (14). For example, feminists argue that essentialist explanations that present gender inequalities as natural and inevitable privilege masculine assumptions (126). In psychology, critical psychologists are similarly challenging the way traditional psychology pathologizes individuals by locating all problems as emanating from one’s essence (125).

Postmodernists also dispute the notion that the world contains finite and knowable facts. According to postmodernists, human knowledge does not progress linearly and new forms of knowledge are not any closer to the truth (147). Truth is always contingent. Arguing that individuals can never directly perceive the true nature of the world and its reality, postmodern researchers – particularly social constructionists – propose that humans construct rather than discover knowledge.

In social constructionism, multiple versions of reality exist and no knowledge is objective and unbiased. Scientific knowledge represents only one version of the real world. In fact, no knowledge can be neutral since any method of inquiry only presents partial versions of reality (159). The same phenomenon, event, or experience can be understood in multiple ways and produce strikingly divergent understandings. Wetherell (15), for example, delineates how one set of behaviours might be interpreted as schizophrenia or witchcraft. Similarly, individuals do not have any core essences or pre-determined nature that determines their being. Hence, personality does not originate from within individuals, but is a social construction that gives meaning to different experiences. Knowledge about the world and humans is therefore historically and culturally specific, situation-dependent, and conditional. Meaning can never be fixed.

Language is a central aspect in social constructionism. Most importantly, reality and meaning are constructed through language. Burr (125) details how the introduction of a mental-physical dichotomy through language produces a unique understanding of the world. Using language to make sense of events, humans can subsequently interpret phenomena such as pain as physical or mental experiences, or both. Additionally, social constructionism proposes that all “differences” are constructed and acquire meaning only

through language (13). For example, there is nothing intrinsic in colours, clothing, postures, and expectations that define them as masculine or feminine (153). Rather, meaning is relational and relies on constructed differences. Within feminist discourses, Mills (126) explains that women's health issues, such as menstruation, are represented as pathological in relation to male norms. Similarly in development discourses, traditional practices are constructed as inferior or backwards when compared to Western standards and norms (61,141).

Recognizing the multiplicity of meaning, social constructionists argue that language cannot be the bearer of truth (13). Language does not simply reflect reality, but constitutes it and gives it meaning. However, if there are numerous ways for interpreting the world, then language and meaning are unstable. Words and passages signify different meanings in different contexts and also change over time. Given that language is contestable, post-structuralist theory provides a further perspective on how meaning is constructed.

2.1.1 Post-Structuralism

Post-structuralism rejects the notion that language is transparent and argues that language itself is arbitrary. Post-structuralism is therefore a reaction to previous structuralist views of language, which assume that the meanings of words and concepts are stable (13,125). According to structuralists, all languages operate as signs (13). Each sign consists of two elements: the "signifier" and the "signified". The signifier denotes a word or image, and the signified refers to its corresponding concept. For example the word "school" is a signifier that conjures up the concept of "an institution for teaching and learning" (165). Hence, structuralists assume that all languages have an underlying

structure that describe reality and are fixed by signs. In comparison, post-structuralists reject the notion that language can ever represent the world in a straightforward manner. Furthermore, post-structuralists reject the idea of language having an underlying structure since this notion presupposes an existing, fixed reality.

According to post-structuralists, words change meaning over time. Hall (133) explains that words such as “Black” signified darkness, evil, danger and sin in many Western societies for centuries until the 1960s when the adage “Black is Beautiful” signified new connotations. Similarly, in 1530 the diagnostic label “syphilis” served as a euphemism (32). Syphilis was the name of the protagonist – a shepherd boy who suffered from the disease – in a poem written by the Italian physician and poet Girolamo Fracastoro (166). However, the label syphilis no longer has any euphemistic meaning but conjures up negative associations. Many doctors now avoid the term with their patients, preferring to use labels such as treponemal disease. The same pattern is seen with “leprosy”. Leprosy not only refers to a biological disease, but also carries social meanings as evidenced by the idiom to be treated like a leper (167). The term Hansen’s disease has largely replaced “leprosy”; however, this term only appeared in 1873 to commemorate the Norwegian microbiologist Gerhard Hansen (168). Clearly, these examples demonstrate the fluidity and arbitrariness of language as argued by post-structuralists. Language cannot be fixed.

Post-structuralists therefore view language as a potential source of conflict where meaning is contested and negotiated (14). Language can serve as a site of struggle and a form of resistance. The post-structuralist view of language attempts to unfix meaning and open up space for the production of new truths; it offers the possibility for changing

dominant meanings. Given that language is unstable, terms such as “Third World” and “developing country” and even “global health” can be contested.

2.1.2 Relativism versus Realism

The notion that no absolute truths exist and that discourses constitute reality has several implications for social constructionism. Acknowledging that multiple interpretations of reality exist can be problematic for those who must justify selecting a particular set of interpretations (144). Social constructionism has been criticized for being relativist, which is problematic for researchers working against oppressive discourses. For example, if multiple versions of reality exist, then oppression is only one of many different ways of interpreting the world. Furthermore, if objects of knowledge and different subjects are brought into being through discourse, then uncertainty arises over whether any pre-existing reality exists. Accordingly, some extreme versions of social constructionism have been accused of maintaining that nothing exists outside of discourse (169). The criticism of being relativist is important in analyzing global health discourses. In global health, poverty, political violence, and shorter life expectancies have real material effects. However, the moment researchers begin to ascribe meaning by explaining these realities, they are engaging in social construction.

There are several considerations for resolving the issue of relativism and taking political stances towards marginalizing discourses. Crotty (159) reminds researchers using a social constructionist perspective that the search for an absolute truth must be abandoned:

There is no true or valid interpretation. There are useful interpretations, to be sure, and these stand over against interpretations that appear to serve no purpose. There are liberating forms of interpretation too; they contrast with interpretations that prove oppressive. There are even interpretations that may be judged fulfilling and rewarding – in contradistinction to interpretations that impoverish human existence and stunt human growth. ‘Useful’, ‘liberating’, ‘fulfilling’, ‘rewarding’ interpretations, yes. ‘True’ or ‘valid’ interpretations, no (p. 48).

Moreover, having multiple versions of reality does not mean that there are no criteria for selecting one interpretation over another. Wood and Kroger (170) contend that all interpretations are consequential: “Relativism does not equal a lack of political commitment; the failure to take a stand is to take a stand” (p. 16).

Social constructionism also does not deny the presence of a material world that exists independently of language and discourse. Although a real world exists, the meaning of objects only comes into being through discourse. Individuals experience material and social effects in their daily lives, but their interpretation of reality is constituted by discourse (13). Social constructionists therefore actively engage with reality and construct meaning. For example, despite the existence of quantifiable biological differences between men and women, Weedon (14) argues that a variety of meanings can be produced under different discourses. Medical discourses and feminist discourses thus differ radically in the degree to which biological essences are used to explain gender differences.

The attempt to balance realist and relativist positions is described as critical realism (171). Critical realism acknowledges that a material dimension exists that is not reducible to discourse, and that context and direct experiences may also explain why people draw upon certain discourses.

Finally, the issue of relativism can also be addressed by using critical theory.

Dominant meanings can be questioned and problematized. In the next section, I discuss why social constructionism and post-structuralism represent critical approaches in social science research.

2.2 Critical Theory

Critical theory calls attention to how specific representations can marginalize and oppress certain groups. According to critical theorists, all texts are political because they legitimate and normalize a particular set of meanings (172). An important function of critical theory is to draw attention to how dominant groups maintain their power by constructing certain understandings of the world to be universally true (128). Critical theory examines the underlying assumptions behind prevailing representations and asks how things might have been otherwise (173). Given that certain meanings are favoured while others are silenced and devalued, Hall (174) refers to all discourses as engaging in the “politics of signification” (p. 116).

Critical theorists dispel the notion that “the world is made up of facts independent of the observer” (175)(p. 202). The human ability to construct meaning suggests that discourses do not simply reflect the world in an objective manner. Noticing the ability for traditional scientific disciplines to be oppressive, Hesse-Biber and Leavy (176) state that the “assumptions within positivism...have maintained radically unequal power relations” (p. 31).

As an alternative theoretical perspective, the field of critical theory is utilized by various disciplines to problematize the ways in which certain discourses privilege some groups over others. For example, in deconstructing patriarchal discourses, feminism introduces “new theoretical perspectives from which the dominant can be criticized and

new possibilities envisaged” (14)(p. 6). Critical theory questions the naturalness of any representation and recognizes the capability of norms to set limits on the range of acceptable ideas (177). Recognizing the validity of multiple realities contests commonsense assumptions and destabilizes dominant systems of meaning. Universal truths are rejected and representations that portray themselves as self-evident or natural are challenged.

I have chosen to apply critical theory to this research to expose how certain representations in global health are socially constructed and to examine how power relations are constituted. Foucault (178) posits that to critique dominant viewpoints, we must “question over and over again what is postulated as self-evident, to disturb people’s mental habits...to dissipate what is familiar and accepted” (p. 265).

My concern for social justice also transpires from the capacity for discourses to produce marginalized subject positions. Foucault (178) suggests that a commitment to social change requires alternative and subjugated knowledges to be heard. A critical deconstruction of the text can open up space for resistance. Critical theory therefore provides a new way for theorizing and understanding global health. As a result, new possibilities that are more liberating can be envisioned. Moreover, bringing about new meanings involves praxis and working democratically with others (173). In global health, a critical approach might thus begin by asking what knowledge and practices have been excluded and what groups have been marginalized.

Challenging dominant discourses within the field of global health requires recognizing that our understanding of global health is historically produced and thus changeable. Hall (174) proposes that an “oppositional” or “negotiated” reading should be

employed to contest representations that are seen as natural, normal, or desirable. Critical researchers (179) suggest that reading against the grain involves consciously reflecting on and rethinking given commonsense assumptions. Consequently, in my analysis I take a social constructionist and post-structuralist approach to avoid reproducing dominant meanings in the literature and work towards introducing new discourses instead.

2.3 Role of the Researcher

The study of discourse is not a neutral process. There are no universal truths, and the struggle over meaning involves reconstituting power relationships. The notion of neutrality and objectivity associated with traditional, positivistic approaches is neither possible nor desirable in discourse research. In analyzing discourses, any interpretation reflects the observations and partial understanding of the researcher. Therefore it is necessary to account for the researcher's identity in influencing the interpretation and analysis of the data (180).

As a researcher, I inherently bring my own worldviews to the analysis of IME discourses. I am influenced by my social and political positions, which are reflected in my research interests as well as in the research questions I ask. My research is also guided by certain theoretical perspectives and methodologies, which reflect particular views about reality and knowledge. Hall (13) writes,

The receiver of messages and meanings is not a passive screen on which the original meaning is accurately and transparently projected. The taking of meaning is as much a signifying practice as the putting into meaning (p. 10).

Hall (13) considers the reader to be equally important to the writer in the production of meaning. The reader's knowledge and worldviews influence his or her interpretation of the text. Given the emphasis on the reader's capability to produce meaning, it is crucial

to understand how my own worldview is brought to bear on this research.

Becoming a reflexive researcher requires becoming aware of all the potential influences that may affect one's research and being able to step back to take a critical look at one's position (181). Researchers cannot separate their interpretations from their knowledge, experiences, and linguistic resources, all of which are embedded in everyday discourses. Reflexive researchers therefore need to be self-aware, examining their own assumptions and recognizing their own role in the production of knowledge.

Reflexivity begins by locating one's position within the research project and providing other readers with a description or account of one's own experiences in relation to the research topic. According to Finlay (182), careful, in-depth self-evaluation demonstrates a level of integrity in research.

The focus for this thesis topic and choice of theoretical lens arise from my personal experiences and my time as a graduate student in community health and epidemiology. I come from a middle-class, urban family. My educational background is grounded in modernist perspectives of reality and knowledge. The way I understand global health is therefore highly influenced by Western worldviews. However, as a graduate student immersed in qualitative research, I am beginning to develop a discomfort with current approaches to health and development. I am also recognizing the limitations of conventional scientific methods and the idea that knowledge is impartial.

In meeting many new students from countries from all over the world, I am constantly introduced to different literature and forewarned about the danger of having a single story. Novels such as *Things Fall Apart* (183) have taught me about the detrimental effect of colonization, but more importantly have shown me the capacity of

subjugated forms of knowledge in producing liberating interpretations. Spending four weeks in Nicaragua as part of an experiential learning course has also led me to question my assumptions about global health and my role as a future researcher and practitioner. For example, while experiencing rural life and witnessing marginality firsthand, I experienced unease about global health work and the role of practitioners from the Global North. I continually felt a dissonance between what I heard from inhabitants of developing countries and the dominant discourses about science, technology, and economic development as universally desirable goals. These challenging experiences and frustrations have led me to question the underlying assumptions around global health work and to problematize the prevailing meanings behind global health discourses. My experiences and background undoubtedly contribute to my selection of theoretical perspectives and critical approaches.

As a student in global health, I am particularly interested in how discourses and dominant meanings about IMEs are produced. In this thesis, I therefore chose social constructionist and post-structuralist theories to understand IME experiences. These theories are particularly useful because they allow commonsense notions about global health and IMEs to be interrogated. Moreover, these theories suggest that rather than looking at particular IME programs or individuals, broader discourses should be examined instead. In the next chapter, I present one version of discourse analysis influenced by Michel Foucault and outline the methods I use in deconstructing the dominant discourses on IMEs.

CHAPTER 3 METHODOLOGY

A qualitative approach is the most applicable methodology for examining the construction and representation of IMEs in the published literature. One defining characteristic of all qualitative research is its interpretive quality. Merriam (184) describes this as striving to understand “the meaning people have constructed about their world and their experiences “ (p. 5), and seeking for depth of understanding.

Adopting a social constructionist perspective as well as a critical approach, I take the stance that knowledge is not derived from objective, unbiased observations of the world. All meaning and knowledge are bound up with power relations. Accordingly, I do not attempt to discover the true nature of IME experiences, but instead identify how IMEs are constructed and come into being through language. I also apply the same approach towards analyzing the available subject positions for medical students and inhabitants of the Global South. Subject positions are not natural categories and distinctions, but are produced by discourses that are partial. Based on my assumption that language is central in constituting meaning and reality, I use discourse analysis as my primary research method.

3.1 Discourse Analysis

Discourse analysis is a broad methodology that examines a large variety of data across a range of disciplines and areas of study. Sources of data typically include transcripts of structured interviews, recordings of natural conversations, or extracts from a structured collection of texts (172). Other unique forms of data include diaries, memos, and newspaper articles. Historical archives and records can also be analyzed to

demonstrate abrupt changes in knowledge or systems of thought held by society.

Discourse analysis is not limited to spoken and written language. Hall (13) suggests that language should be understood in a broad manner:

The writing system or the spoken system are obviously languages, but so are visual images...when they are used to express meaning. And so are other things which aren't linguistic' in any ordinary sense: the 'language' of facial expressions or of gesture, for example, or the 'language' of fashion, of clothes, or of traffic lights...Any sound, word, image, or object which...is capable of carrying and expressing meaning is from this point of view, a 'language' (p. 18).

For discourse analysts, language is the site where meaning is constructed, maintained, and resisted. Discourse analysis can therefore serve as a critique instead of reproducing dominant viewpoints, which according to Wood and Kroger (170), is repetitive and reifies literal content.

There are several varieties of discourse analysis including conversation analysis, discursive psychology, critical discourse analysis, and Foucauldian discourse analysis among others (170,171,185-189). These forms differ in their methods as well as in their research objectives. For example, conversational analysis focuses on the interactional process of communication and how speakers manage "turn-taking" in everyday talk (189). On the other hand, Foucauldian discourse analysis, which was highly influenced by Michel Foucault and other post-structuralist theorists, is attentive to how discourses produce a particular set of truths and knowledge claims. Foucault (190) remarks that he is not interested in uncovering the "truth" about a topic, but instead seeks to understand the following:

...the mechanisms and instances which enable one to distinguish true from false statements, the way in which each is sanctioned; the techniques and procedures which are valorised for obtaining truth: the status of those who are charged with saying what counts as true (p. 46).

Foucault wants to examine how discourses constitute various aspects of society and how certain subjects are produced. He is also concerned with how different subject positions created uneven relations of power. In considering the relationship between discourse and power, a Foucauldian discourse analytic approach is the most apt.

The methodology behind a Foucauldian discourse analysis involves theorizing the relationship between discourse, power, and knowledge. In the following section, I draw on some of Foucault's key writings to describe how he conceived discourse and how it is connected to power and knowledge. I then outline the steps, procedures, and methods that I used in analyzing IME discourses.

3.2 Foucault's Contribution to Discourse Theory

The French historian and philosopher Michel Foucault is an instrumental figure whose work played a key role in shaping discourse theory. Foucault argues convincingly that "truth" is historically contingent. The majority of his work is devoted to meticulously tracing the key moments and shifts in history when discourses underwent radical changes (191-195). For example, Foucault believes that experiences such as homosexuality, madness, and delinquency do not have any essential meaning, but are the result of discursive constructions. He maintains that history contains breaks and ruptures; thus, the present cannot merely be understood as a steady progression of knowledge.

Foucault (178) explicitly states:

History serves to show how that which is has not always been; i.e., that the things which seem most evident to us are always formed...during the course of a precarious and fragile history. (p. 37)

Illustrating that history is non-linear and highly discontinuous, Foucault challenges the notion of inevitable or immutable truths.

3.2.1 The Role of Discourse in Constituting Reality

Foucault believes that it is impossible to discover or reveal the true nature of the world. Instead, he argues that discourses construct a particular version of reality that constitutes commonly accepted knowledge. Meaning is not inherent in any situation. Foucault thus goes to great lengths to describe how discourse brings objects, subjects, and events into meaningful existence. According to Foucault, discourses are “practices that systematically form the objects of which they speak” (194)(p. 49). Furthermore, Foucault challenges the notion that truth can ever be fixed and asserts that discourses are historically variable ways of specifying knowledge and truth.

Two of Foucault’s key works provide insight into how discourses constitute reality. In *The History of Sexuality: Volume 1*, Foucault (192) demonstrates that discourses during the Victorian era established new “truths” about human sexuality. According to Foucault, sexuality does not have any true nature. Rather, discourses construct meaning about sexuality. Looking across different times and places, Foucault notes that homosexual practices and a multitude of other sexual behaviours have been present throughout history. He declares that the present meanings, which assign values and positions within a sexual hierarchy, only emerged through discourse.

Discourses of sexuality included representations that constructed what was natural and normal against what was abnormal and deviant, which did not exist previously. In studying Foucault’s work, Cossman et al. (196) remarks that the discourse of sexuality systematically marked and identified sexual practices, which were then mapped like a geographical terrain. Additionally, these discourses produced objects of knowledge and subjects who embody particular characteristics. Homosexuality became an object of knowledge and something to be studied. A new type of subject also emerged – the

homosexual – who was excluded outside the definitions of normal, healthy beings. Consequently, discourses of sexuality do not merely describe sexuality, but constitute its reality.

Foucault is also interested in how madness emerged as a phenomenon (193,194). He proposes that madness is not a universal experience and does not have any essential nature. In his book *The Archaeology of Knowledge*, Foucault (194) describes the formation of madness through discourse:

...mental illness was constituted by all that was said in all the statements that named it, divided it up, described it, explained it, traced its developments, indicated its various correlations, judged it, and possibly gave it speech by articulating, in its name, discourses that were to be taken as its own (p. 35).

With meticulous detail, Foucault traces how concepts about madness have evolved. At certain times, madness was venerated and at other times conceived of as an idle or sinful act. The later emergence of psychiatry constituted madness as an object to be treated and produced a subject – the mad person – who was ostracized and confined from society.

The important point Foucault attempts to make in both of these applications is that specific moments in history give rise to new discourses. Foucault argues that dominant meanings only appear natural and normal because they function as a “regime of truth.”

3.2.2 Regimes of Truth

At any given moment, certain versions of events or interpretations become prevailing ways of understanding the world. Although a number of different and competing discourses circulate, dominant discourses have a privileged influence. Alternative discourses attempt to contest dominant meanings. Each of these different

discourses constructs knowledge differently by focusing on different aspects of reality, attributing or denying value to certain representations, and producing claims that are conflicting. As a whole, these different discourses operate within a “regime of truth”, where certain meanings have more authority and are given greater credence (135). Once different discourses come together to effectively produce a version of events that is taken as true it becomes defined as knowledge. Foucault (135) describes why some discourses become accepted as customary and natural at certain moments in history:

Truth is a thing of this world; it is produced only by virtue of multiple forms of constraint. And it induces regular effects of power. Each society has its regime of truth, its ‘general politics’ of truth: that is, the types of discourse which it accepts and makes function as true (p. 131).

Every truth claim is therefore made within a regime of truth, which it relies on to gain its status. Additionally, each regime has a procedure for producing, regulating, distributing, and circulating accepted forms of knowledge. Hence, Foucault (197) does not evaluate the veracity of different accounts, but seeks to understand how regimes of truth and its ensemble of rules came to be:

I want to try to discover how this choice of truth, inside which we are caught but which we ceaselessly renew, was made – but also how it was repeated, renewed and displaced (p. 70).

Recognizing that “regimes of truth” have a regulatory and governing capacity, Foucault further examines how power is distributed among various actors and theorizes a relationship between discourses, knowledge, and power.

3.2.3 Power and Knowledge

Foucault’s conception of discourse provides a basis for understanding power and knowledge. Discourses convey knowledge around acceptable or normal social practices. Discourses legitimize certain ways of being and acting, which may then be used to

regulate, monitor, and govern the conduct of others while invalidating and marginalizing alternative practices. Therefore, power and knowledge cannot be separated from each other. According to Foucault (195), power and knowledge are joined together in discourse. Foucault continues to elaborate on the intricate relationship between power and knowledge:

Power and knowledge directly imply one another. There is no power relation without the correlative constitution of a field of knowledge, nor any knowledge that does not presuppose and constitute at the same time power relations (p. 27).

Power is constituted through discourses. Discourses on madness legitimized the practice of isolating mad persons with lepers during the early Victorian period, and later on, the practice of imprisoning both sets of subjects in asylums (193). Burr (144) argues that versions of events deemed as “knowledge” allow certain actions to be represented in an acceptable light. Power is therefore exercised by drawing upon discourses, legitimizing what it is possible for one person to do to another.

Although power can be used to discipline and control, Foucault attempts to complicate the idea of power. He rejects the conventional view that sees power as only a repressive force. He also questions the concept of sovereign power, which only operates through threats, violence, or physical punishment. Foucault (195) thus states:

We must cease once and for all to describe the effects of power in negative terms: it ‘excludes’, it ‘represses’, it ‘censors’, it ‘abstracts’, it ‘masks’, it ‘conceals’. In fact, power produces: it produces reality; it produces domains of objects and rituals of truth (p. 194).

Foucault thus places a considerable amount of emphasis on the productive aspect of power. In attempting to suppress certain ways of being, power produces new forms of knowledge, new kinds of subjects, and new types of relationships (198). Efforts to contain madness produced a whole new field of study – psychiatry – as well as hospitals,

asylums, and mental wards to go along with it. These institutions isolated madness into an object of study in order to produce new classifications, categorizations, and labels for various forms of behaviour. Additionally, new subjects were produced and labeled: “sane” and “insane” people (130).

The productive aspect of power was also evident in the attempt to suppress homosexuality. Hall (13) observes that efforts to control sexuality produced an explosion in new discourses, citing evidence of sex talks; television and radio programs; sermons and legislations; novels stories and magazines featuring medical and counseling advice; essays and articles; academic theses and research programs; and even the pornography industry.

Furthermore, in attempting to suppress homosexuality, the discourse of sexuality produced new norms and ideals: “a healthy body”, “a normal family”, “a proper man and woman”, etc. (199). Foucault (135) considers power to be insidious and pervasive precisely because it does not solely rely on force: “Power doesn’t only weigh on us as a force that says no; it also traverses and produces things, it induces pleasure, forms of knowledge, produces discourse” (135)(p. 119). For example, Healy (200) suggests that individuals in today’s society subject their body to dietary, fitness, and appearance regimes because it induces pleasure.

Foucault is also against the idea that power can be possessed or held by any one dominant group. Instead, he pronounces that power resides and operates in every social relation: “Power is not something that is acquired, seized, or shared, something that one holds on to or allows to slip away; power is exercised from innumerable points” (192)(p. 94). Hence, power is not imposed, but is dispersed throughout all relations in both

private and public spheres. Once a set of truths is established, individuals are subjected to normalizing judgments so that power relations are ever present (130). Foucault writes, “Power is everywhere; not because it embraces everything, but because it comes from everywhere” (192)(p. 93).

The definition of power proposed by Foucault is thus quite different from theorists who equate power with ideology. For example, Marxist ideology presumes that power is held by a ruling class to economically exploit workers by keeping them under a state of false consciousness (126). This is problematic, however, because it implies that an underlying truth is merely hidden and waiting to be discovered by individuals. Howarth et al. (201) also contend that the idea of class determinism or economic reductionism proposed by Marxists does not reflect postmodernist views of reality. It is important to note that Foucault does not deny the power of institutions and states; however, his conception of power is radically different. Weedon (14) provides nuance and extra depth to Foucault’s definition of power:

While Foucault takes power relations to be an always-present structural feature of human societies, his theory does not prescribe what forms power will take in any particular society or area of social concern. Unlike Marxism, for example, Foucault does not begin his analyses with the presupposition that the economic mode of production will be the ultimate determining factor and that, in this sense, class relations and class power are primary (p. 114).

Embracing the idea that no single dominant group possesses power, the aim of resistance is transforming social relations rather than overthrowing them (202). If power is an effect of discourse, then different possibilities for action are available (203,204). Marginalized discourses or counter-discourses can be introduced to subvert dominant meanings and dislodge the “regime of truth”. Hunt and Wickham (205) thus redefine the notion that “power is bad” or that it should be purely abolished. Rather they argue that

power legitimates some realities and that knowledge can be either oppressive or creative.

Foucault's ideas provide a useful starting point for studying the discourses that construct IMEs. Given the historic inequities between the Global North and Global South, Foucault's notion of power is also particularly helpful in understanding the relationships between various subjects who participate in IMEs.

3.3 Data Source and Sampling Criteria

For this thesis, I used a subset of published academic journal articles from MEDLINE – the U.S. National Library of Medicine's bibliographic database. I specifically chose MEDLINE because of its capability for using indexed search terms known as Medical Subject Headings (MeSH). This is particularly important given that IMEs have been conceptualized and described differently throughout the literature. The following MeSH terms were subsequently used to search MEDLINE's database: 1) "Education, Medical, Undergraduate" 2) "Internationality" 3) "International Cooperation" 4) "International Educational Exchange" 5) "World Health" 6) "Developing Countries" 7) "Travel Medicine" 8) "Tropical medicine." I also limited my search to articles published in English between the years 2000 and 2011. This time frame corresponds to the period in which IMEs gained popularity and grew rapidly.

A total of 293 articles were produced. I reviewed the abstracts of each article and included them in my data set only if they met the following criteria: 1) Participants were undergraduate medical students 2) Direction of travel was from developed countries to developing countries 3) Duration of the elective was short-term – fewer than 12 weeks.

After the inclusion criteria were applied, a total of 50 articles remained. I chose to augment my search with articles from Google Scholar using a basic keyword search

for “international medical electives” or “international health electives.” Using the same inclusion criteria above, 10 additional articles were produced. My final dataset therefore consists of 60 articles.

3.4 Methods

Various researchers have attempted to analyze discourses with Foucault’s theories (130,206-210). Most adopt a social constructionist position and post-structuralist view of language. For this thesis, I used a set of methods suggested by Carla Willig (171) to analyze discourses using Foucault’s concepts. Willig’s methods are highly accessible and can be applied to analyze a variety of texts. She proposes six stages for conducting the analysis in a systematic manner by posing several questions to the data. In the following section, I outline each stage of Willig’s methods for conducting a discourse analysis. I also provide examples from other authors to demonstrate how each stage of analysis is applied.

Stage 1 (Discursive Constructions):

The first stage of analysis involves identifying the different ways that a topic is represented and constructed. The topic of interest constitutes the object produced by discourses in circulation. Therefore, the first step of analysis primarily involves coding and highlighting all the various ways that a topic is constructed.

Both direct and implied references of the object are noted. Willig (171) asserts that “the fact that a text does not contain a direct reference to the discursive object can tell us a lot about the way in which the object is constructed” (p. 115). For example, a disease can be spoken about without directly naming it, by referring to it as “this awful thing” or “the condition.” Each different representation constructs the object and

provides a certain version of knowledge and perspective. Capturing the variability in language also demonstrates the fragmentary nature and active construction of meaning. Wood and Kroger (170) suggest that the variability of language adds to the breadth of the analysis. Recognizing the plurality of meaning, they propose that discourses analysts should understand variability and to employ it for analytical purposes rather than eliminate it.

Stage 2 (Discourses):

The second stage of analysis locates the discursive object within wider discourses and prevailing ways of thinking about the world. For instance, what different discourses are called upon to build up a particular representation that becomes taken as truth? Although a number of discourses exist, Foucault's concept of "regimes of truth" is a reminder that certain discourses will have a dominant influence.

Willig describes how patients living with illness draw on a variety of discourses. For example, a biomedical discourse might be used to construct the disease as a target for diagnosis and treatment. Psychological discourses might represent the disease as a "somatic manifestation of psychological traits" (171)(p. 116). Likewise, militaristic discourses might portray the disease as an enemy that requires individuals to "fight" against it.

Stage 3 (Action Orientation):

Once discourses have been identified, the third stage examines how one version of events is privileged over another. For instance, how do dominant discourses establish what are acceptable and appropriate ways for portraying a topic? What representations are normalized and naturalized? What techniques and strategies that are employed to

produce a particular “truths” and reinforce essential characteristics? What version of events is promoted by the discourse?

Burr (125) describes how discourses on education founded on meritocracy serve to justify the greater wealth and opportunity afforded to some, while assigning blame to victims of systemic, institutionalized racism, sexism, and all other forms of discrimination when they underachieve. Failure is thus attributed to inherent differences in personalities. On the other hand, discourses representing education as systems of exploitation are less likely to become seen as common-sense truths.

Stage 4 (Positioning):

Discourses constitute individuals as particular kinds of people through subject positions, which involve different rights and obligations. Hence, the fourth stage is concerned with establishing how the discourse constructs subjects who personify “certain ways-of-seeing the world and certain ways-of-being in the world” (171)(p. 113). What statements and paragraphs imply particular types of individual satisfaction and self-fulfillment and deny the validity of others? What types of relationships are formed between different individuals?

Describing subject positions offers particular ways of being and behaving, Weedon (14) writes:

Gendered subject positions are constituted in various ways by images of how one is expected to look and behave, by rules of behavior to which one should conform, reinforced by approval or punishment, through particular definitions of pleasure which are offered as natural and imply ways of being a girl or woman (p. 99).

Additionally, subject positions locate individuals within the moral order. Carabine (206) demonstrates that subject positions offered to men and women within the discourse of

lone motherhood include moral judgments. On the issue of illegitimacy, women are often positioned as predatory and as deliberately getting pregnant to seek profit and personal gain, whereas men are positioned as victims and absolved of any moral, sexual or financial liability.

Stage 5 (Practice):

Establishing the practices that are permissible for various subjects constituted by the dominant discourse is the aim of the fifth stage of analysis. What practices are legitimated and what ways of acting are marginalized based on the current prevailing knowledge? What actions are opened up or closed off? For example, discourses of masculinity invite men to put on a “tough guise” while prohibiting them from showing weakness or emotion (153).

Willig (171) also describes how social practices legitimate and reinforce existing discourses. For example, patriarchal discourses endorsing men as the primary income earner and women as natural caregivers reproduce the traditional institution of family (14). Similarly, discourses on lone motherhood that deny single mothers access to public assistance serve to reinforce the institution of marriage (206) .

Stage 6 (Subjectivity):

Finally, Willig (171) suggests that discourses not only produce knowledge and possibilities for acting, but also an individual’s subjective experience. Accordingly, thoughts and feelings do not originate from within individuals but are constituted by discourse. However, given that I am not concerned with subjectivities in this research, I exclude this step from my analysis.

3.5 Analytic Approach

I began my analysis by first familiarizing myself with the data. Wood and Kroger (170) suggest reading the data at least once, without attempting to analyze it, to prevent meaning from being imposed too quickly. I thus began by reading each article several times and paying close attention to different possible meanings.

During my first initial reading through the text, I took notes of all my impressions and highlighted words, phrases, and segments that triggered any reaction. I also paid equal attention to what I felt was absent from the text, recognizing that silences and omissions were consequential. At this point, I was not able to label or name any dominant discourses, but carefully noted the presence of a few recurring themes. For example, I noticed persistent patterns in the way developing countries were portrayed and how their inhabitants were represented.

In the following weeks, I returned to the data to carefully establish how certain discourses made particular interpretations possible and plausible. This process inevitably involved numerous re-readings of the text. I went through each article again thoroughly, applying Willig's six-stage method. I also paid specific attention to the similarities and contrasts between various meanings and marked down any contradictions in my findings.

As I progressed further, I compared new interpretations and refined them against previously examined meanings. This allowed me to better understand how discourses were structured and organized to achieve various effects. Throughout the analysis, I reminded myself that all representations and portrayals of IMEs are neither neutral nor objective descriptions but constructed by discourses. Negotiating with various representations with the text, I attempted to deconstruct dominant meanings that I found

to be oppressive or unjust. Wood and Kroger (170) suggest that this can be accomplished by adopting a strategy of reversal. For example, one might ask how another writer would construct meaning in a different context, or how would meanings change if a particular word or sentence were left out, substituted, or combined with different ones?

Subsequently, I problematized the way differences were constructed as being natural or inevitable and the way subjects and actors were portrayed as having inherent essences.

My analysis continued in a recursive and iterative pattern, and during this stage, the results and interpretations were always provisional. I was only able to name various discourses after noticing fairly consistent patterns of representation and finding examples from the text to ground my interpretations. Finally, I cannot claim to have identified all possible discourses. Numerous interpretations and ways of reading are always possible. However, I believe that the discourses I identified through this approach contribute to a critical discussion on how IMEs are represented.

In summary, Foucault's concepts of discourse and "regimes of truth" as well his consideration between power and knowledge provide a practical way for critically analyzing the academic literature. I view dominant meanings about IMEs as a "regime of truth", which can ultimately be challenged. Moreover, I perceive Foucault's notion of power to offer a possibility for change in a field that has been historically marked by uneven relations. I present the two dominant discourses I identified in the following chapter and draw attention to how prevailing meanings are constructed through language.

CHAPTER 4

DOMINANT DISCOURSES IDENTIFIED

The discourses on IMEs contained in the academic literature are wide ranging. As a result, there are different ways of speaking about IMEs that build up a particular version of “truth.” My intention in this thesis is not to portray all possible discourses, but rather to illuminate and explore the implication of two dominant discourses I identified in the literature. The first dominant discourse is what I label as the discourse of “disease and brokenness.” The discourse of disease and brokenness surrounding IMEs primarily represents developing countries as sick and chaotic. The second dominant discourse is what I term the discourse of “romanticizing poverty,” which constructs an idealized and romanticized version of working in impoverished settings.

I named these discourses after closely examining the literature and noticing that the text consistently invoked particular portrayals of the following elements: representations of host countries and environments; the rationale of students and institutions for participating in IMEs, the preparation for involvement in IMEs, the activities that take place during IMEs, and the relations between medical students from the Global North and people from the Global South. Equally important, I noticed omissions and silences on relevant issues such as the agency of people in developing countries or the complicity of the West in creating health disparities both historically and within the current globalized context. In examining silences and absences, I asked myself what alternative versions of events were obscured.

I will begin by presenting the discourse of disease and brokenness followed by the discourse of romanticizing poverty. My discussion of each dominant discourse is divided into two parts in order to align with my research questions:

- 1) How are IMEs in developing countries socially constructed and given meaning?
- 2) What subject positions are made available by the dominant discourse?

In addressing the first research question, I discuss techniques and strategies that the text employs to give meaning to each particular discourse. In examining the second research question, I consider how different actors – medical students and people in the developing countries – are constituted and consider the ways in which the discourse differentiates them.

4.1 Discourse of “Disease and Brokenness”

A prevailing construction of IMEs in the literature presents medical students from the West going to a place laden with *disease* and imbued with a sense that nothing works – *brokenness*. Implicitly and explicitly, the writing conveys inherent risks in such settings. I base my analysis and interpretation of disease and brokenness on descriptions of surroundings, environments, activities, and relationships that are both implied and absent. I also analyze the motivations and arguments used by medical students and institutions in the West to justify current IME activities and the rapid expansion of these programs.

The first dominant discourse is made up of four main ideas: 1) Illness and Death 2) Despair 3) Foreignness and 4) Material Depravity. In deconstructing these key elements, I demonstrate how the tone and language within the literature invokes an image of disease and brokenness that relies heavily on negative representations and depictions and promotes certain version of events over others.

4.1.1 Illness and Death

The first aspect of the discourse introduces the idea that IME experiences are

situated in faraway lands ripe with exotic diseases and multiple risks. The assumption behind this view is that developing countries are dangerous and unsafe. A recurring image of the Global South characterized by “a greater variety of acute and serious illnesses” (94) prevails. Ever present is “illness and death...highly prevalent” (12) in developing countries, which are constructed as homogenous entities: “Health care providers who visit and practice medicine in the developing world find a unique opportunity to learn about exotic diseases” (211). Epidemics and outbreaks have a totalizing presence, allowing medical students to direct their gaze towards a “wider range of illnesses...and clinical experiences” (212) and fixate upon “new diseases” (213).

Diseases are spoken of as “staples” and regarded as an essence of the host environment:

We saw an enormous array of pathology, from infectious disease staples like dengue, malaria, leptospirosis, and advanced HIV, to a range of zebras such as relapsing polychondritis, Ludwig’s angina, and neurofibromatosis (214).

Prominence is given to illness and signified by “a range of infectious conditions” (215) that are “often far more extreme” (88). Sickness is “relatively common” (216) and ubiquitous:

Trainees participating in international electives are at risk for exposure to locally endemic diseases such as malaria, dengue fever, traveler’s diarrhea, and sexually transmitted infections as well as nosocomial transmission of blood- or body fluid-borne pathogens such as hepatitis B, hepatitis C, and human immunodeficiency virus (217).

The prolonged list creates an element of gravitas. Looming threats exist each time medical students perform “risk-prone procedures on individuals who are potentially infected” (217). Other times, danger is conveyed more explicitly by forewarning of death: “accidents were responsible for six deaths and three serious injuries from just nine

medical schools” (218). In developing countries ravaged and plagued by a plethora of diseases, affliction is viewed as natural and presents “unmistakable” (219) patterns. The Global South is subsequently collapsed into a place of pestilence and contagion:

Students encountered an array of infectious diseases they had learned about but not seen in their traditional medical school setting. One student ‘...saw several diseases...never encountered in US—congenital rubella, xeroderma pigmentosum, very late stages of rheumatic heart disease...’ Another one stated, ‘I learned more about TB and leprosy...I learned and saw greater oncology pathology’ (220).

More importantly, host settings are constructed as fundamentally opposite to their counterparts in the West, symbolized by illnesses that “have not yet appeared in the Western Hemisphere” (221) or “rarely encountered in the student’s home country” (85). Accordingly, to participate in IMEs, medical students must acquire the skills to contend with diseases that increasingly pose a threat to the West through increased travel and immigration (1,7,84,85,87,88,93,94,100,211-215,217-227). Warnings to students headed to the Global South that “infections can spread from the jungle to the urban doorstep in less than a day,” (221) and descriptions of strict measures that must be taken for “hospital employees with recent employment abroad” (225) portray developing countries as inherently threatening to the West. Such statements render host settings as treacherous, pitting developed and developing countries against each other.

4.1.2 Despair

Prevailing constructions of developing countries tend to project an image of despair and highlight immeasurable suffering and innumerable problems (5,12,84,85,88,89,92-95,100,102,104,211,213,214,216,217,219-222,224,226,228-244). A specific choice of vocabulary can be found in medical students’ sensational accounts of the Global South. Upon reading the recollections of students’ IME experiences, a

peculiar set of representations and ideas are constructed. IME experiences are depicted as set in the “world’s poorest places,” (233) among the “most oppressed and impoverished,” (237) and in “situations of almost universal need” (242). Misery and hopelessness are exemplified by poignant illustrations of poverty-stricken places. Passages are framed to emphasize the catastrophe affecting the “billions living in poverty” (100). A sense of despair and neediness engulfs the Global South, where the “neediest patients” (211,214) and the “poorest of the poor” (5) live amidst “extreme poverty” (92) and “deplorable situations” (233). The chaos that assails developing countries is constructed as inescapable, dominating the “desperately poor” (240) and the “throng of patients,” (216) who will wait long hours for help: “Hundreds of families lined up each morning to receive treatment for ailments including parasitic infections [and] tropical diseases” (231).

Progress in these countries appears to be continually drowned out by seemingly intractable and unrelenting epidemics:

It is patients like him—or the thousands of Dominicans who still need antiretroviral medications, or the legions of pregnant women and elderly farmers waiting for appointments at Pequeños Pasitos—who remind us of the work that needs to be done (214).

One is further drawn in to the plight as students retell harrowing experiences of places where “disease was rampant,” (237) “the number of ill and dying exceeded local resources,” (240), and “patients with obvious diseases could not be treated” (216). In the “most impoverished places” (228) where so many are “truly in need,” (232) a grim future that is “grave and far-reaching” (226) awaits.

Differences between developing countries and the West are seen as inevitable, with little effort to engage in a critical analysis about inequities: “So I was just kind of

lost...and again going to the point of okay in Canada this would never fly” (240). The helplessness of developing countries becomes perhaps its quintessential feature and effectively erases the agency of people in the Global South. As such, there is a significant silence surrounding the underlying root causes of disease within the dominant discourse.

4.1.3 Foreignness

The element of foreignness relies heavily on the idea that host countries involve a perilous component with unknown and mysterious hazards. Descriptions tend to favour bizarre and unusual details. Notably, several articles employ the term “exotic” in their writing (12,92,211,221,230,245). The exoticness of the “Third World” (222) is enthralling, forcing outsiders to adapt to “alien cultures” (222). One author declares: “...global health outreach work is conducted in a setting that, to medical students, is strange and has unfamiliar rules...[similar to] trips to exotic locations” (245). Captivated by the difference, medical students construct the host environments of developing countries as “unfamiliar” and “foreign” (11,12,85,87,94,102,104,220-222,224,228,239,242,246-249).

Foreignness signifies the potential for deadly encounters and appeals to the hostile and dark side of the host. Vivid accounts reveal terrifying tales of medical students who “committed suicide after return” (218) or who were “severely beaten up...as punishment for carrying so little cash” (215). Yet such accounts do not diminish IME experiences, but rather imbue it with an aura of exoticism and “allure” (248). Medical students are depicted as pursuing IME experiences at the risk of their own personal wellbeing as they set out to countries that “might as well have been in another world,” (214) witnessing out

of the ordinary fatalities “including exotic ones [such] as hippo and crocodile bites” (219) and experiencing “watching someone die for the first time” (7).

A medical student during an IME in South America recalls being bitten by “an unidentified animal in the forest,” (225) reinforcing the idea that medical students have come to a place marked by mysterious dangers and further sensationalizing “the unpredictable nature of international experiences” (84). Portraying dangerous and unknown elements effectively constructs IMEs as a “foray into developing countries” (228) or an “international venture” (216). The terms “foray” and “venture” invoke ideas of a risky undertaking, drawing on language from a militaristic discourse that emboldens students to “fight” (85,245) against threats. Steiner (84), for instance, expounds on a student-led project in Honduras with remarkable vividness and intensity:

Tensions rose as the exiled president announced plans to reenter the country, the national airports were closed, and the U.S. State Department advised against nonessential travel...Because of the potential continued instability in the capital, the student group was evacuated through Nicaragua.

Some authors take it further. Edwards et al. (89) construct IMEs as being set in a crisis driven country where menacing and irrational men wreak havoc and inflict terror on their own people:

One of the authors of this commentary remembers (fondly) his elective in Uganda, shortly after its liberation from the murderous Obote regime, and just as the HIV epidemic took hold. Negotiating road blocks manned by 13-year-olds brandishing Kalashnikovs seemed exciting and character-building, although we doubt if many medical schools today would support an equivalent experience in, say, the Democratic Republic of Congo or Somalia...[Yet] harms remain, from, for example, infectious disease, assault, accidents, and sexual harassment.

Emphasizing the “inherent risks, uncertainties, [and] unexpected crises” (84) within the Global South, the text inculcates in the reader that medical students are never far away from calamity and will eventually succumb to threats. Consequently, the idea of

foreignness is at once mysterious and intriguing but also dangerous and threatening.

4.1.4 Material Depravity

The destitution of the Global South is another prominent feature of the discourse (5,7,12,84,85,88,89,93,94,100,102,211,213,214,216-219,221,222,225,227,228,231,236,237,241-243,245,249,250). The broken landscape and poverty-stricken conditions of the “Third World” (222) are portrayed as sickening: “The scope of poverty and the consequences of inadequate health care may overwhelm students unfamiliar with conditions in developing countries” (239). Developing countries are spoken about as an abject and utterly destitute place where a “lack of roads to many of the villages limits the mode of travel to hiking, horseback, or canoe” (84) or requires “[trekking] through dense forests” (236). Authors frequently seem struck by the brokenness and the lack of modernity, providing stirring descriptions of decrepitude and deterioration:

In the evenings, we went over our data in our “flat,” the apartment that had been found for us above a Chinese general store near Elderslie. Naked light bulbs. Red Stripe beer. The sweet smoldering tip of a spiral Mosquito Destroyer. And me pecking away at the old typewriter we had purchased at a warehouse in Kingston (230).

Similarly, another author writes:

Student participants slept on the floor of the host community’s local school. Meals were prepared over an open fire by a Honduran cook. Travel from community to community was via a four-wheel drive pickup truck, with students crowding into the seats and beds of the truck. The remoteness of the region and the lack of contact with outside influences, such as television, radio, and Internet in most villages, allowed for a near-total immersion experience (231).

Brokenness and poverty undoubtedly resides in poor developing countries, and descriptions of medical practice tend to invoke a sense of backwardness and primitiveness. Whenever any infrastructure is mentioned, it is typically lacking or

wanting:

A woman suffering from eclampsia was taken in a taxi by her family to the capital because nothing could be done for her in the Rumonge Hospital...No mother-to-child transmission of HIV prevention was in place in the Obstetrics clinic (237).

Further examples include depleted facilities in “war-torn setting in Uganda, and a mobile, railroad-based hospital in India” (5) as well as poor clinics only capable of conducting “primitive ultrasounds” (227). Hospitals that are equipped with functioning equipment and technology are absent, and there is little to no mention of how communities are responding to their own needs. The consequence of speaking about host settings as devoid of any modernity or connection to the outside world constructs a singular image of IMEs taking place in an undifferentiated space of brokenness.

In the literature, I find the discourse of disease and brokenness both prevalent and problematic. The dominant representation presents an imbalanced and distorted view of the Global South with particular consequences, and in the following section I discuss what implications this has on how actors from the West and developing countries interact with and respond to one another.

4.2 Subject Positions: The Dangerous “Other” and the Caring Medical Student

The dominant discourse offers different subject positions that affect how IMEs are experienced. As such, actors have unique positions from which they can speak and act. In examining the portrayal of various actors within the overall context of the text, it is evident that different subject positions exist offering different ways for interpreting IME experiences.

I pay particular attention to the types of relationships between IME students and local workers, patients, and inhabitants of developing countries and the tensions between

them. I find that these two groups are constituted differently based on descriptions of IME activities and accounts of interactions (or lack thereof) between medical students and local residents. In my analysis below, I will refer to individuals in developing countries in the Global South as the “Other” – a term that has been widely used in post-colonial studies to emphasize the differences of non-Western subjects (138).

4.2.1 The Dangerous and Irrational “Other”

The ways in which the texts differentiate between medical students and the Other in their discussion is striking (5,7,84,85,87,89,93,100,211,214,215,217-219,221,222,224-228,230-233,235-238,240,242,243,245,248,249,251). The language describing the Other is frequently judgmental and condescending. Medical students are positioned as being at the mercy of the Other:

‘I’m afraid of being robbed or raped,’ one student admitted to me, explaining why, a few weeks before she was due to leave the United States, she was having second thoughts (243).

The dangerous Other is described as being one’s “nightmare” (219) and fervor over fatal contact is described among “students [who] reported having had sex with a new partner...native to the country where the elective was performed” (225).

Bizarre and erratic portrayals depict the Other as wild and exotic. A notable example involves medical students reveling in the aberrant and strange manners of local children and remarking upon striking visual differences:

For me, the most memorable case of the afternoon was this young boy, about 11 or 12 years old...He was pretty listless and not very responsive, he seemed like he was in a constant daze. The chief complaint was that he kept eating chalk. I was perplexed, what would cause this kid to eat chalk?...It turns out that anemia is associated with pica, the desire to eat unusual things, usually dirt, ice cubes, etc. So that explained his chalk cravings (242).

Health workers and professionals in developing countries are similarly reduced

and collapsed into irrational beings. The inferior, non-Western Other is a “less educated peer,” (245) who comes in “late, irregularly, or not at all,” (236) and even fails to practice “universal precautions” (222). Any ability for the Other to provide care is subsumed by their apparent lack of reason: “I didn’t feel like I had any choice in the matter because he [the surgeon] literally walked away and said, ‘Close’” (238). Incapable of practicing medicine effectively, the Other purportedly has a “lack of knowledge about medical education” (104). Moreover, the Other is faulted for being “hesitant to address concerns,” (101) or worse still, their “culture” (12) is to blame for their ineffectiveness when working with trainees:

Addressing this set of issues explicitly may not be culturally appropriate in some settings in which it might be considered impolite not to accept the request to host foreign trainees or to indicate that the trainee’s presence was anything but helpful.

Portrayed as irrational and ignorant, the Other appears “insulted” (7) over trivial matters. Elsewhere, they are seen as aloof, walking away from a patient with uncontrollable seizures and leaving one student to “attend to him each time he seized” (240). Finally, the Other has “little control over their political or social future” (92) and is constituted by their inability to escape the clutches of disease and brokenness of the Third World.

4.2.2 Caring and Compassionate Medical Students

Subjects from the West are constructed as the mirror image of the Other. The discourse favourably positions medical students and idealizes them as intelligent and dynamic actors. Unlike the inferior Other, the discerning medical student is portrayed as “the most qualified person,” (104) being able to “make snap decisions,” (245) and possessing “unique resources” (248). Medical students embody the role of leaders, who have “passionate commitment” (89) and are “caring,” (11) “quickwitted,” (245) and

“ambassadors of goodwill” (222). They are distinguished by their “sense of mission,” (5) “vision of great deeds,” (230) and “altruistic ideals” (232). As stated frankly by one author, “It’s so simple over there – they need help, we provide help” (219).

The construction of medical students in every way opposite to the Other strengthens the image of the West as inherently superior. More importantly, these differences are used to justify and portray the West as the protector and guardian of developing countries. The West is represented as being bestowed with a “special power” (233) to protect the health of people globally (5,7,85,87,88,93,220,222,224,226,228,232,235-237,239,244,245,248,249,251). Medical students are spoken highly of for their “commitment to improving health care in other countries” (226) and their desire “to treat diseases around the world” (245). An ensuing relationship develops where the West is positioned as a saviour who provides the extra “manpower” (88) to “help those in need” (7). The image of a guardian protecting the feeble Other is unmistakable:

My own reminiscences range from one student who called me urgently to examine a comatose toddler (who in fact was sleeping) to the student who, clutching an infant in one arm and raising the other fist toward a trio of vultures on a hospital roof, shouted, ‘You’re not getting any of them!’ (243)

An unspoken assumption is that the brokenness of developing countries can only be ameliorated by through Western intervention. Embodying the role of saviours, medical students are answering a “calling” (5) and endowed with the responsibility of “giving voice to those who are stifled by social burdens that seem impossible to overcome” (244). Without the benevolence of the enlightened Westerner, the Other is invisible and unable to speak:

In one settlement, women lined up for hours and told students that they wanted to be part of the needs assessment, because it was the first time that they had felt ‘heard and listened to’ in their lives (228).

Consequently, the dominant discourse offers incomplete representations of the Other and positions them as helpless victims. It is significant that the positive and idealized attributes given to medical students are rarely seen in descriptions of physicians, health workers, or inhabitants of developing countries. Little effort is made to elicit the perspective of doctors from the Global South or provide any description of their ability to solve their own problems. The resulting subject positions of the helpless Other and caring medical student are narrow and do little to deepen the context in which practicing medicine in developing countries takes place. The bigger issue at hand, however, is that the dominant discourse misrepresents and dehumanizes people in the Global South.

4.3 Discourse of “Romanticizing Poverty”

The second dominant discourse that I identified in the literature constructs a romantic notion of medical students working in poverty. I define romanticizing poverty from the way the literature idealizes and sentimentalizes primitive environments. I am particularly attentive to the way that medical students describe their decisions to participate in IMEs in developing countries and their interactions with people living in the Global South. In examining how poverty is implicitly and explicitly constructed, I encounter two specific and distinct ways in which poverty is romanticized. First, destitute and impoverished environments are portrayed as an opportunity to develop basic clinical skills and the ability to overcome challenges. Second, developing countries are constituted as static societies that are timeless and unchanging, where its inhabitants live

contently in beautiful simplicity.

4.3.1 Discovering the “Art of Medicine”

An idealized view of poverty is used to rationalize and justify IME programs. The impoverished settings of developing countries are constructed as rich learning environments and seen as a natural and compelling reason for participating in IMEs (1,5,7,12,84,85,88,93-95,211,213,219-221,223-225,228,230,232,243,248,249).

The destitution and material depravity of the Global South are no longer dreaded, but serve as a backdrop for medical students to discover “all [the] attributes that make for becoming better clinicians” (85). Poverty is written about enthusiastically and portrayed as a means to relearn “cost-conscious practice and back-to-basics diagnosis” (5). Under-resourced settings are constructed as an opportunity to improve “clinical skills (i.e. history taking, physical exam and care procedures) in less than ideal conditions” (220) and take up “novel roles and responsibilities” (88). Portraying journeys to poor countries as an opportunity “for on-the-spot problem solving,” students “frequently refer to the trips as medical outward bound” (242). Students, who “desperately want a taste of global medicine” (11) and are “hungry to discuss poverty,” (5) long for the opportunity to “experience global health challenges firsthand” (12,102). New responsibilities engender difficulties and challenges, but for medical students “an adventure is only an inconvenience rightly considered” (219) as they set out on “exciting international medical opportunities” (5) that will ultimately be “beneficial to their careers” (246).

For medical students, venturing to the Global South signifies a return to the days of their “forefathers” (213). A nostalgic yearning for pre-modern times underscores the discourse: “Technology is not required to provide good, caring health care...I learned

wound debridement, skin biopsies, lumbar punctures, spinal blocks” (224). Trainees, who represent poverty as a way to “appreciate medicine in its simple form” (95) and improve their “abilities to use their own diagnostic skills,” (221) glorify the idea of self-reliance:

Tremendous professional growth can develop from being forced to work up to the absolute limits of one’s knowledge and skills. This is particularly true when scarce resources limit diagnostic and treatment options, and leave little or no mechanism for referral to a specialist or a higher level of care. The added patient care time, which results from the lack of a need to practice defensive medicine and the relative absence of paperwork, is another welcome feature of working abroad (211).

Modern medicine involving “cutting-edge technology” (220) is deemed as causing a “crisis in the teaching of the physical examination in many Western medical schools” (223). On the other hand, practicing medicine in primitive settings is signified as a “return to our foundation” (213). Compared to the West where participants “often see ‘routine’ lab panels and imaging,” (248) learning medicine in the poor Global South is spoken of as inspiring and exhilarating. There is an “allure” (248) to medical practice in under developed countries, where students seek to “become more sophisticated” (228) without the benefit of “the newest and most sophisticated technology” (223).

IMEs are therefore conceived a means to rediscover the “art of medicine” (94) lost due to the “lack of need in the high tech era” (1). Within this aspect of the discourse, experiencing poverty up-close in developing countries is presented in a straightforward manner and constructed as a gratifying personal experience.

4.3.2 A Timeless, Unchanging Global South

The notion that the Global South is a timeless, unchanging place is another strategy that the literature employs to romanticize poverty (5,7,11,88,89,95,211-213,219-

224,230,231,237,242-245,247,250,251). In a primitive environment where “things move slowly,” (211) an enduring image of developing countries untouched by modernity is constructed. Working in “exotic” and “unfamiliar” settings thus takes on a whole new set of meanings. Medical students construct an image of an enticing, seductive landscape in their descriptions of travelling along “fragrant, winding roads” and reading up on strange diseases during “long sultry evenings” (230). A distinctive and carefree life is envisioned, and an idyllic lifestyle is idealized with unusual candour: “I will never forget my stay in the jungle...you don’t need much to live a very peaceful and happy life” (7).

Poverty is constructed as an opening to see “the human side of medicine” (95) and the opportunity to practice “thoughtful medicine with human touch” (7). Trapped in time, inhabitants of developing countries are depicted as being happy and content with their simple way of life:

Most participants on this trip had never witnessed the kind of poverty found in developing countries. They saw that despite economic conditions, people seemed happy and fulfilled. One student commented: ‘I think it looks poor here, but then I think if you lived here, you wouldn’t feel so poor. They have the support of one another, and maybe they never feel poor until people like us come along and there is a contrast. But within their own community they are all just working hard to get by and they get together and go to church, and sing, and work together and everyone is happy. The children seem very happy’ (231).

Medical students “marvel at how much capacity there [is] among people who [have] very little” (244) and are fascinated by the noble and heroic ability of the poor to bear hardship. Stunned to see “stark poverty and in the midst of it, such generosity,” (250) students revel in their newfound appreciation towards “the limits of the human condition” (219). The poor are further idealized for their capacity to “endure without complaint” (220) and be “appreciative of any care” (219). The literature celebrates the redemptive aspect of poverty and idolizes those who have the ability to endure long suffering:

People told us endless stories about [one doctor's] generosity and loving-kindness. He doesn't even have a bank account, one woman said, because he gives away everything he earns (230).

This is also evident in the following extract:

I often wish my patients could understand how great they have it in the US, instead of complaining about a \$20 copay! Everyone should go to Honduras and see what we saw (231).

Simplicity is defined as an essence of the poor living in the Global South. Hence, poverty ceases to be harmful or dangerous: "The hospital may be low-tech, its clients poor and uneducated and its facilities unpolished, but it is providing a valuable service to the people who use it" (243). Subsequently, a unified image of developing countries as forever primitive emerges:

Finally, to provide medical service abroad successfully, one must accept that it will not be possible to achieve the same level of care that can be reached in the industrialized world...it is reality...Health professionals who have difficulty accepting this unfortunate reality may find themselves frustrated, disillusioned, and depressed while working in the developing world (211).

As a result, the dichotomy between the West as modernized and developing countries as primitive is constructed as a natural and immutable "reality" (211). Equally important, by normalizing poverty, the discourse effectively elides any of the dehumanizing aspects of impoverishment.

4.4 Subject Positions: The Childlike Other and Triumphant Medical Student

The discourse of romanticizing poverty has a significant influence in the way that it constitutes medical students differently from people in developing countries. In highlighting the different subject positions available, I analyze how the relationships between these two groups are established and describe how the discourse legitimizes these relations. Inhabitants of developing countries are once again represented as the

Other, while the medical student is constructed as mature and intelligent. However, unlike in the discourse of disease and brokenness, the Other is no longer positioned as a danger or threat, but is reduced into a childlike being. I deem that although these two constructions appear contradictory, they represent strategies to contain the Other in a marginal position.

4.4.1 The Simple and Childlike Other

The representation of the Global South as unchanging and static has consequences for how the Other is positioned. Living in a timeless present and removed from modernity, the Other is viewed as childlike or as someone inscrutable and “shrouded in mystery” (230). Portrayed as simple, the Other is described in a shallow and superficial way: “...women with colorful headscarves, crossed arms, and dozens of shoeless children” (230). The Other, who only knows of suffering, relies simply on “prayers” (242) and “hope” (237). On other occasions, the childlike Other is uncertain of “what they [are] doing” (240).

Relationships between medical students and the Other are constrained as a result of representing the Other as simple and childlike throughout the literature (7,88,95,104,211,213,215,217-220,222,224,228,230,231,237,238,240,242,243,245,249). The Other is the recipient of “kindness, gentleness, curiosity, and smile[s]” (224) from benevolent Westerners and puts childlike trust in medical students: “Frustrated that I could not speak the language and offer her words of comfort, I simply held her hand and pet her head” (7). Not surprisingly, medical students glowingly describe how they learned to “gather a history and physical despite significant cultural/language barriers” (95). On other occasions, students are astonished that they can get by with “pantomime,

facial expression, and personality...[and] really get a lot across that way,” (231) or “even communicate with patients and other medical professionals through smiles and different expressions and gestures” (7). Mesmerized by the Other’s innocence and juvenile nature, students describe their encounters with inhabitants with frankness and simplicity:

Just as it (the health fair) was about to end, a tremendous monsoon made its presence felt. We all scrambled for the cover of the orphanage. Once again the children succeeded in capturing 100% of my attention; I couldn’t resist... While the Haitian skies were opening above us, we danced and sang with the children... Suddenly, amidst all the celebration, everything went pitch black. We were informed that the power is shut down every night in many parts of Haiti. No matter, the celebration grew bigger (242).

The Other therefore does not speak for himself or herself, but is represented from the West’s perspective. Their subordinate subject position is also notable in portrayals of their powerlessness and lack of agency to change their own circumstances:

I believe the contrast between health care there (Honduras) and here hits me every day. Here (the U.S), I hear whining that I didn’t do enough in some way. There, I remember lines of people waiting in the hot sun without comment (231).

Unable to understand their own situation or circumstance, the Other is spoken about as being “flattered and delighted by the effort” (243) of Western medical students “just being there for [them]” (224). Their childlike essence, apparent innocence, and delight at meeting the Western medical student all fit the characteristics of a subordinate subject position:

When we first arrived in Kigutu, we could feel the excitement of the villagers kilometers before we reached our destination. Children ran to the road and followed our vehicle, laughing, delighted by our waves. As we pulled into the field we were immediately surrounded by hundreds of villagers, eager to show us the pile of bricks and stones they had collected for the foundation of their long awaited health clinic (237).

The romanticized portrayal of the Other as happy and content, however, should not be considered endearing. Although seemingly benign, the childlike Other is nevertheless an

externally defined image. Thus, the literature is highly problematic for not only portraying inhabitants of the Global South without depth or complexity, but also for stripping them of their agency.

4.4.2 The Adventurous Medical Student Coming of Age

In comparison to the people of the Global South, medical students are described enthusiastically and positioned as capable and bright individuals (1,5,7,12,84,85,88,93-95,211,213,219-221,223-225,228,230,232,243,248,249). Leaving the familiar environment of the Western world to encounter “face-to-face contact with real-world problems,” (245) medical students are constructed as individuals coming of age. “Life changing experiences” (11) await medical students who embark on “exciting and character-building” (89) adventures. Answering a “calling,” (5) brave and daring medical students “sacrifice time and money” (247) to “explore parts of the world that interest them” (88) and to fulfill “a desire for cultural exposure” (247).

Obstacles encountered during the “journey to poorer locales” (245) are seen as contributing to the students’ “sense of mastery and confidence” (221). Their maturity and intellect are represented by their capacity to “finesse the expectations that people have” and their sophistication to “see one, do one, [and] teach one” with regards to new operations (240). As they undergo “great personal and professional development,” (88) students “realize their self-potential” (251) and “restore [their] idealism” (212). The indomitable nature of medical students is signified by their ability to “triumph over adversity” (242) while “surviving and adapting” (7). Undeterred by the challenges of adapting to a new environment, medical students are defined by the essence of their “adventurous spirit”:

...most medical work abroad involves Spartan living conditions and new, and sometimes limited, foods. One useful rule of thumb is that people who are not fond of camping may not be happy with the conditions that they find while working overseas. An adventurous spirit and a certain degree of risk tolerance also is essential (211).

Another similar example is seen in the following excerpt:

Everybody was under the impression that we were out of vitamins, but a couple of us searched again and found some folic acid supplements for pregnant women. We looked on the label and noticed that the pill also contained a small but adequate amount of iron. Score! (242)

Accounts of brief “clinical stints” (5) in places of poverty in developing countries convey the ability and capacity of medical students. Exemplified by their ability to “exercise clinical judgment and independent decision making,” (248) medical students are positioned as being able to master both modern clinical practice and its traditional form:

In Liberia, I remember taking care of a child with severe diarrhea and vomiting, and a medical student said, “I don’t know what to do because I don’t know what the electrolytes are.” My response was, “Well, you have this child in front of you and you have to make a decision. So what can you learn, without a backup laboratory, from the history and physical examination to help you manage the patient?” Such an experience in a resource-poor nation can return us to our foundation (213).

Purporting to understand and comprehend medicine in developing countries, medical students presume a dominant role in IME activities:

I saw it many times. I built it up slowly, starting by just observing and doing more and more myself. Until finally, I performed the whole procedure and was more or less in charge of the operation (249).

The completion of an IME marks the transition from an ordinary medical student to a self-assured medical student. For medical students, who are accorded such privileged positions, their coming of age experience is constituted as the “best experience of their medical school” (222) and their “most exciting experience” (234).

4.5 Summary of Results

The two dominant discourses identified in this chapter cohere to produce commonly accepted knowledge and “regime of truth” about IMEs. I argue, however, that these prevailing notions are not neutral reflections of IME experiences, but are social constructions. The discourse of disease and brokenness constitutes IMEs as a foray into foreign lands full of pestilence and destruction. The discourse of romanticizing poverty portrays developing countries as primitive and timeless. Moreover, differences between the West and developing countries are seen as natural and inevitable. The two discourses offer different subject positions for medical students and inhabitants of the Global South. In both cases, medical students occupy privileged subject positions and are viewed favourably while people in developing countries are reduced to the Other.

CHAPTER 5 DISCUSSION

As IMEs have grown in popularity over the past several years, certain portrayals of IMEs have been established as “truth” through dominant academic discourses. The emergence of IME discourses become “knowledge” and guides the work of many global health students, researchers, and practitioners. Dominant discourses construct IMEs and privilege certain representations, appearing as objective and inevitable facts.

My thesis serves to demonstrate that IMEs are socially constructed through language. In my analysis, I find that prevailing representations rely on fundamental dichotomies and preclude “subjugated knowledges”. Inhabitants in developing countries occupy subordinate positions compared to subjects from the West who occupy privileged positions. Differences between the Global North and Global South are presented as universal and fixed. Dominant discourses shape and produce IME experiences as venturing to a place of “disease and brokenness”, but also simultaneously “romanticize poverty”. These prevailing representations have implications for IMEs, excluding certain practices and reaffirming others.

In the following sections, I discuss how dominant meanings about IMEs are naturalized in a way that serves to reproduce and reinforce inequalities between the West and developing countries. I also examine how competing discourses are silenced and what alternative meanings are neglected. Using Edward Said’s (138) idea of “imagined geographies,” I argue that the dominant discourse constructs a distinctive image of the Global North and Global South, which limits the possibilities for forming mutually beneficial relationships.

Additionally, a purposeful examination and critical approach to IME discourses

allows dominant meanings to be resisted. I find that social constructionism and post-structuralism provide an effective way to open up space for new perspectives and alternative meanings. Recognizing that meaning is plural and never fixed, I turn language into a site of struggle and contestation. I rely on Foucault's concept of power to describe how prevailing interpretations can be disrupted and subverted. To conclude, I propose new possibilities for thinking about IMEs and offer global health students, researchers, and practitioners practical ways to transform current discourses.

5.1 Implications for Students, Researchers, and Practitioners in Global Health

The dominant discourses in the academic literature do not merely describe IMEs, but help create them. From a social constructionist perspective, no knowledge is objective. Words and meanings are not neutral, and power and knowledge are inseparable. The dominant discourses of IMEs emphasize and include certain meanings, but more importantly, discredit and silence others. I argue that the discourses of "disease and brokenness" and "romanticizing poverty" are marginalizing not only for what they include, but also for what they exclude.

5.1.1 Absences and Omissions

The two discourses I have identified in the literature focus exclusively on disease and poverty and reduce the Global South into a singular image. Observing that dominant meanings often serve the most powerful groups of society, Foucault (194) stresses the importance in revealing what has been marginalized:

...only one truth appears before our eyes: wealth fertility, and sweet strength in all its insidious universality. In contrast, we are unaware of the prodigious machinery of the will to truth, with its vocation of exclusion (p. 220).

The ability to produce knowledge about IMEs is dominated by subjects from the

Global North. In the academic literature, people in the Global South are excluded in giving meaning to IMEs. Their knowledge and perspectives about health issues or living in poverty are rarely heard. Additionally, there is a remarkable silence on how local people actively shape their own lives and assert their own interests. Their knowledge is thus subjugated and discredited.

There is little consideration and discussion about the global structures and systems that perpetuate poverty. Moreover, prevailing interpretations exclude explanations about the Global North's complicity in producing global inequities. Neither structural transformation of the global economy nor political action is suggested as an important component of IME activities or global health work.

The failure to examine the complex past between developed and developing countries leads to an incomplete understanding of host environments. Relationships between the Global North and Global South are considered natural and apolitical. Hence, little attention is given to the uneven relations of power constituted by the discourse. For example, totalizing statements such as "African hospitality is just legendary" (243) omit the long history of resistance by developing countries against external powers. It is thus significant that only two of the 60 articles examined explicitly mention the colonial history between the West and developing countries (92,222). Similarly, the political and military involvement of Western nations in the Global South is ignored in prevailing representations or considered simply incidental.

A new set of meanings is required to give nuance and complexity to IMEs. By not challenging the current dominant discourses, developing countries in the Global South that host IMEs are portrayed as naturally sick, impoverished, and broken. As a

result, students, researchers, and practitioners involved in global health fail to address the multiple forms of oppression that produce disparities.

5.1.2 Normalizing Strategies

Discourses on IMEs effectively dichotomize developed and developing countries as inherently different. One effective way of normalizing these differences is by *othering*. Othering is the process of constructing differences between dominant and marginalized groups in opposition to each other (252). Norms are established against which to measure “otherness” (253). According to Hill Collins (254), othering creates a hierarchical relationship where dominant groups are represented as normal and marginal groups as abnormal:

One such idea is binary thinking that categorizes people, things, and ideas in terms of their difference from one another... In such thinking, difference is defined in oppositional terms. One part is not simply different from its counterpart; it is inherently opposed to its ‘other’ (p. 70).

Prevailing representations position inhabitants of the Global South as the Other – someone who is strange, foreign, and exotic. I suggest that labels such as “exotic” are never neutral, but are damaging and often serve as blanketing terms that render other people, objects, and places as inherently different. In both discourses, the Other is pathologized while medical students are presented as healthy, capable subjects. The language towards medical students is overwhelmingly positive and has an unmistakable regard for their unique characteristics.

In a similar manner, the West is portrayed as essentially different compared to their “foreign” counterparts and constructed as the polar opposite of developing countries. The binary opposition implicitly presumes that Western countries naturally progress and mature, while developing countries remain inevitably hopeless and

backwards. Differences between developing countries and the West are presented as inevitable and determined by geographical location:

Concepts of culture, racism, doctor-patient interactions, language, specific cultural content, access issues, socioeconomic status, and gender roles [are] components naturally addressed in the developing world (11).

Western ideals constitute the desired norms where all others are judged, measured, and compared to. Subsequently, the Global South is reduced into a set of deficiencies that are “intrinsic to clinical and cultural experiences, [which] contrast markedly with those offered by the domestic environment” (88).

Discourses therefore construct reality and frame the concepts of disease, brokenness, and poverty. These “truths” and meanings appear fixed, becoming commonsense and establishing how IMEs are understood and experienced. Constructing a universal image of a broken continent, one student simply writes, “It encouraged me to go back to Africa” (232). The attributes of developing countries are viewed as enduring and universal:

Students who worked hard, cared deeply and engaged fully during their rotations will realize wistfully, but without regret, that they brought a little of Africa home with them while leaving a part of themselves behind (243).

Prevailing IME discourses therefore present differences between the Global North and Global South as natural, disguising the social construction of disease, brokenness, and poverty. As long as negative representations of the Other exist, practices that exclude local knowledge will appear normal. The practice of “othering” therefore normalizes certain portrayals of the Global South, without questioning domination and subordination or examining issues of power and privilege. Worse still, the lived experience of people in the host settings will continue to be negated and denied.

5.1.3 Concealing the Reproduction of Inequalities

I contend that understanding differences between the developed and developing countries as natural serves to conceal the reproduction of inequalities. For example, the silence on issues of health care and poverty by individuals in the Global South is perceived as acquiescence. The accepted implication is that all individuals in the Global South are resigned to their fate, while the poor in the Global North are considered ungrateful.

I argue that the current discourses prescribe compliance with existing arrangements. More importantly, I contend that inequalities are reproduced when no active stance is taken towards introducing more equitable practices. In a setting where the level of work often outpaces the number of health workers, students relish the chance “to take a more active part” (234) and learn “novel skills that they would not normally have learned in North America” (7). Living in poverty is confining. However, students who romanticize poverty are likely to cherish it rather view it than restricting. As a result, no direct action against the causes or structures of poverty is taken.

Romanticizing poverty also allows the West to appear democratic, while concealing the uneven relation of power they have with non-Western countries. By portraying current Western medical practice as “excess and waste” (213) and as needing to place “less emphasis on the use of high tech instruments or interventions,” (93) the West can be represented as seemingly egalitarian, thereby maintaining their privilege. Differences in choice are disguised. While medical students choose to experience medicine in a different context and decrease their “reliance on technology,” (232) they remain oblivious to the same systems that result in their own longer life expectancy. For privileged medical students from the West, IMEs become an experience that is

independent of their behavior or complicity.

Additionally, emphasizing the opportunity to learn back-to-basics medicine in poor-resource settings IMEs discourages an in-depth examination of poverty. Without situating IME experiences within deeper social, economic, or political contexts, differences between the Global North and Global South are taken as given. An effect of such practices is the reproduction of inequalities, which the field of global health sets out to challenge.

5.2 Imagined Geographies

In the West, there is a long practice of characterizing non-Western countries as “foreign” that, according to Edward Said, produces imagined geographies (138). Said argues that meanings are not associated with any geographical space naturally, but rely heavily on the production of knowledge. Importantly, the distinction between a familiar space and an unfamiliar space is entirely arbitrary and socially constructed. As such, I propose that the practice of producing knowledge mediated through the eyes of Western students is neither neutral nor objective.

Said convincingly describes how discourses shape the encounter between the West and the Orient. He notes that certain phenomena are brought into being as a result of imposing a “limited vocabulary and imagery” (138)(p. 60). For example, the “Orient” represents more than a geographic entity adjacent to Europe. In Western writing, the Orient has come to be known as “a place of romance, exotic beings, haunting memories and landscapes, [and] remarkable experiences” (138)(p. 1). Said affirms that the presence of the Orient helps to strengthen definitions of the West. He refutes the notion that there is a “real” Orient, proposing instead that preeminent images of the Orient are

constructions. According to Said (138), imagined geographies legitimize a particular vocabulary about the Orient and present itself as universal:

They are all declarative and self-evident; the tense they employ is the timeless eternal; they convey an impression of repetition and strength; they are always symmetrical to, and yet diametrically inferior to, a European equivalent, which is sometimes specified, sometimes not (p. 72).

My findings suggest that the IME discourses constitute developing countries and their inhabitants as an imagined geography. These imagined geographies influence possible actions and offer different possibilities for IME practices. Positioned as vulnerable to the strange, mysterious Other, medical students are required to vigilantly prepare for entering a setting constituted by disease and brokenness (1,11,12,84,87-89,93,100,102,211,215,217,219-221,223,225,226,231,234,237,240,243,249). The imagined geography of the Global South brings a particular world into being:

Students role-play scenes they might experience on arrival. For example, a student arriving at the airport and going through customs is approached by a young man who offers to carry her suitcase. Though he appears and may be genuinely helpful, it is also possible that his real intention is to steal the suitcase, to lure her into his car or perhaps to embarrass her into paying him an exorbitant fee for his baggage-handling service (243).

As a result, imagined geographies mark out and construct a boundary between the Global North and the Global South. Developing countries do not merely represent spatial locations, but are named and categorized as safe or unsafe. Writers from the West position themselves as “specialists at the central location,” who create and produce knowledge about “remote locations in the developing world” (227). New objects of knowledge are produced, including “central databases to track...emergency and evacuation planning” (84) and travel advisories (221,222). Students also construct revealing accounts, declaring that they “taught people about the country,” (238) upon

returning home and telling “fascinating stories of medical practice they observed and the people they met” (250). Portrayed as “a source of delight and even maybe inspiration,” (243) student accounts become privileged forms of knowledge.

A preoccupation with maintaining a safe distance with the Other is also evident. For example, IMEs are increasingly justified as a means for preparing students to treat imported diseases among “poor and ethnic minorities” or immigrants (1,7,12,85,87,89,92-94,100,102,211,213,220,222-224,228,233,237). Framing immigrants through imagined geographies as the diseased Other is thus one way that power is exercised.

Prevailing knowledge about IMEs is not objective and poses the possibility of reducing and essentializing entire geographic regions. According to Said (138), the knowledge produced about the colonized Other always privileges the West. Said also notes the impossibility of writing objectively about the Orient and the Other:

For if it is true that no production of knowledge in the human sciences can ever ignore or disclaim its author's involvement as a human subject in his own circumstances, then it must also be true that for a European or American studying the Orient there can be no disclaiming the main circumstances of his actuality: that he comes up against the Orient as a European or American first, as an individual second (138)(p. 11).

I thus argue that imagined geographies confer on the West a form of legitimacy and silence other forms of knowledge. Producing knowledge about the Global South and its inhabitants is not an objective practice, and the academic literature on global health cannot claim to be neutral. Consequently, there is a possibility for misrepresenting people in the Global South and creating potential misunderstandings.

5.3 Resistance

Dominant discourses can be challenged and resisted. Norms can be exposed as a privileged interpretation rather than commonsense knowledge (255). Meanings are never fixed, but are constantly being negotiated and changed. Foucault (192) suggests that dominant discourses are not all-powerful or deterministic and proposes that where there is power, there is also resistance:

We must not imagine a world of discourse divided between accepted discourse and excluded discourse, or between the dominant discourse and the dominated one; but as a multiplicity of discursive elements that can come into play in various strategies...Discourses are not once and for all subservient to power or raised up against it, any more than silences are. We must make allowance for the complex and unstable process whereby discourse can be both an instrument and an effect of power, but also a hindrance, a stumbling-block, a point of resistance and a starting point for an opposing strategy (p. 100).

Prevailing representations are therefore contestable because alternative versions of events can be constructed. Recognizing what knowledge is legitimized, whose interests are marginalized or excluded, and how power is exercised creates resistance. Given that reality is constituted by discourse, differences that are assumed to be natural should be conceived of as social constructions instead. For example, understanding developed and developing countries to be a socially construction disrupts commonsense notions that differences between these settings are natural. Similarly, recognizing that medical students and inhabitants of the Global South do not have fixed essences challenges established subject positions. Resistance is thus formed by making the social construction of meaning visible and questioning the inevitability of truth claims.

5.3.1 Destabilizing the Two Dominant Discourses

Challenging dominant representations can be also be achieved by exposing the

gaps and contradictions in discourses (14,254,256-259). Discourses contain ambiguities and openings and are thus open to revision. Searching for ways to subvert prevailing meanings, Appleby et al. (259) assert that change comes about through “slips in the fault lines of broad discursive configurations” (p. 223). Contradictions call into question the idea that prevailing “truths” express fixed meanings or that language is reflective of reality.

In my findings, I propose that the two discourses present conflicting and contradictory images. For example, the same settings that are constituted as sick and chaotic in the discourse of “disease and brokenness” are glossed over in the discourse of “romanticizing poverty”. In the former representation, individuals in developing countries are presented as dangerous and threatening, and in the latter as simple and childlike.

The paradoxical meanings and implications of these two discourses are best revealed in their strategic use. Both discourses rely on the element of characterizing the Global South as strange, foreign, and exotic. The discourse of “disease and brokenness” constructs developing countries as diametrically opposite to Western countries. Reducing developing countries into strange, foreign places beset by “exotic” disease allows the West to maintain its superiority and signify its power.

However, at the same time, the strangeness and foreignness of developing countries allows it to be characterized as “exotic” and alluring. Unrecognizable to Westerners, the childlike Other has an uncanny ability to bear hardship. Living contently in poverty comes to signify the expected type of relationship between the Global South and the Global North in a world with growing inequalities. The romanticized version of

poverty thus places the medical student in picturesque setting, removing the fear of the Other and willfully denying the need to critically analyze issues of poverty and uneven power relations.

Although these two prevailing ways of constructing developing countries and their inhabitants are fraught with contradictions, I deem that they are mutually reinforcing and strategically used to position the West in a favorable light. Taken together, these two prevailing images are two sides of the same coin that keeps the Other in a subordinate position.

Prevailing discourses of IMEs therefore serve to control the Other. They are reductive and essentialist. However, when contradictions are highlighted, the oppressive meanings within the discourses become increasingly visible. Images and representations of the Other are thus never authentic, but constructed to serve different purposes. Drawing attention to the ambivalence and discontinuities in dominant representations undermines and destabilizes current “truths”.

5.3.2 Agency

Individuals have agency to resist dominant representations and take up alternative subject positions. Within a social constructionist framework, the idea of agency has a unique meaning. Acknowledging that subjects are constituted through discourse, social constructionists affirm that individuals do not entirely have free will. However, they also refute the notion that individuals are entirely determined by discourse, given that individuals are capable of critically reflecting upon existing representations as well as negotiating and transforming current meanings (14,125,144,148). Judith Butler (148) views the binary of free will and determinism as a simplistic notion, declaring:

“Construction is not opposed to agency; it is the necessary scene of agency, the very terms in which agency is articulated and becomes culturally intelligible” (p. 187).

By rejecting the notion that individuals are passive recipients of knowledge, people are seen as capable of choosing among various discourses. Arguing that language constructs rather than reflects reality, social constructionists and post-structuralists turn language into a site of resistance. Foucault (192) reveals why dominant discourses can always be dislodged by new ones: “Discourse transmits and produces power; it reinforces it but also undermines and exposes it, renders it fragile and makes it possible to thwart it” (p. 101).

Discourses are neither absolute nor are they overpowering since knowledge is provisional and unstable. Given that no dominant group possesses power entirely, all individuals can exercise power and agency by introducing new discourses. Emphasizing the possibility for individuals to introduce new forms of knowledge, Butler (260) writes, “The resignification of speech requires opening new contexts, speaking in ways that have never yet been legitimated, and hence producing legitimation in new and future forms” (p. 41).

Redefining and reconstructing the potential subject positions offered to medical students and inhabitants of the Global South opens up new possibilities for all those involved in IMEs. Similarly, the meaning behind IME experiences can be transformed by introducing new discourses that are less totalizing and by valuing diversity and plurality instead. Recognizing that language offers numerous meanings and constructions, I envision a new definition for IMEs below and suggest how global health students, researchers, and practitioners can practice more justly.

5.4 Visions of a Post-Colonial Global Health

I propose that more liberating discourses about IMEs can be created. Instead of accepting the dominant meanings offered by the discourses of “disease and brokenness” and “romanticizing poverty,” I suggest that IMEs should be guided by a discourse of humility. I define humility as having respect for people in the Global South and recognizing their capacity and talents. In this counter discourse, medical students are no longer positioned as experts providing assistance to the helpless Other. Medical students are invited to view their knowledge as limited and be prepared to change previously held assumptions. Moreover, individuals in developing countries are given the opportunity to decide their own future and solve their own problems. They are valued and regarded as complex individuals who are versatile and creative. The range of subject positions is thus increased for medical students and individuals from the Global South. Consequently, both groups have more opportunities to participate in IMEs without totalizing descriptions.

Humility requires open-mindedness and a space for dialogue, negotiation, and learning. Developing critically reflexive practices deepens the context of IME experiences. Global health students, researchers, and practitioners can begin by being explicit about issues of domination and challenging discourses that reproduce inequalities. Moreover, uneven power relations between the Global North and Global South should be discussable and viewed as revisable.

Students, researchers, and practitioners need to acknowledge their participation in producing knowledge and their own sphere of influence within global health. According to Peggy McIntosh (261), privilege remains invisible when unexamined. Comparing

privilege to an “invisible knapsack”, McIntosh asserts dominant groups in society have special provisions that are taken for granted. For example, she writes:

My schooling gave me no training in seeing myself as an oppressor, as an unfairly advantaged person, or as a participant in a damaged culture. I was taught to see myself as an individual whose moral state depended on her individual moral will (p. 72).

Thus, privilege is similar to a carrying a weightless knapsack without being aware of the many benefits that exist within. Individuals with privilege perceive their advantage in society as normal, failing to recognize that current social arrangements are oppressive to others. In addition, privilege also closes down creative possibilities and alternative meanings. Gayatri Spivak (262) explains that new knowledge and new ways of seeing the world can only be acquired by “unlearning one’s privilege”:

Our privileges, whatever they may be in terms of race, class, nationality, gender, and the like, may have prevented us from gaining a certain kind of Other knowledge: not simply information that we have not yet received, but the knowledge that we are not equipped to understand by reason of our social positions. To unlearn our privilege means, on the one hand, to do our homework, to work hard at gaining some knowledge of the others who occupy those spaces most closed to our privileged view. On the other hand, it means attempting to speak to those others in such a way that they might take us seriously and, most important of all, be able to answer back (p. 4).

Acknowledging our privilege, we can explore ways for creating space for alternative meanings and recognize when marginalized perspectives and “subjugated knowledges” have been excluded. As a privileged researcher living in the Global North, I also involve myself in the critique of IME discourses.

A new vision of global health must be combined with resistance. Every challenge to prevailing discourses reduces its dominance and opens up new ways of being.

Ultimately, I contend that a discourse of humility reduces essentialist thinking that polarizes the Global North and Global South, creating a new environment for all subjects

involved in global health that is more inclusive and liberating.

5.5 Conclusion

Discourses on IMEs influence how global health programs and exchanges are practiced and meaningfully represented. As a consequence, IME experiences are predominantly understood through the lens of disease and brokenness and the romanticizing of poverty remains largely unquestioned. These representations are taken as “truth” and regarded as natural, favoring some groups while marginalizing others. In this thesis, I thus argue that dominant representations are socially constructed and position medical students and individuals from the Global South in a constrained manner. However, I maintain that uneven power relationships can be changed by resisting and contesting dominant discourses.

Understanding truth, reality, and knowledge to be constructed by discourse allows us to challenge the inevitability of dominant meanings. Language can be turned into a site of contestation, where new meanings are forged. Although my research critiques the academic literature, I contend that no texts are neutral. I hope I have provided a starting point for other researchers to engage in analyzing discourses on global health. As such, I propose that researchers problematize other texts on global health and also examine the implications of accepting certain meanings over others.

I understand the difficulty in writing about global health without being subsumed by existing discourses. Undeniably, there are stark health disparities and material differences between the West and developing countries. Discourses on global health can therefore be both productive and problematic, and care must be taken when producing new knowledge. As critical scholars, we can broaden and deepen the way we represent

global health and IME experiences by including multiple perspectives. Valuing the plurality of knowledge in research, Gergen (147) notes “the existence of the single voice is simultaneously the end of conversation, dialogue, negotiation” (p. 233).

This thesis suggests that social constructionist and post-structuralist approaches to reality and knowledge offers a way forward for global health students, researchers, and practitioners. We have the ability to construct new meanings and new ways of thinking. The struggle over meaning is not merely a matter of interpretation. We can resist against dominant representations and subsequently transform uneven relations of power. We can make prior absences visible as well as demonstrate how certain “truths” are constructed and how meanings and language are all susceptible to change. Explicitly naming the assumptions guiding our practice will also allow us to negotiate new knowledge. I arrive at these conclusions as I near the end of my masters’ studies. Through the mentorship of my supervisor Dr. Lori Hanson – a global health researcher and dedicate social justice advocate – I have learned to challenge my own assumptions and ways of thinking about global health. Our conversations together have led me to recognize that our involvement in global health is never entirely innocent. My time as a graduate student, coursework, and experiential learning experience in Nicaragua have also allowed me to notice the privilege that makes it possible for academics and students from the Global North to practice global health. We must therefore always seek to deepen the history, context, and discourses that guide our work in order to unsettle existing power relations and ultimately eliminate them.

Finally, we all have the responsibility to read texts critically. Although we are never free from the influence of dominant discourses, we can develop reflexivity and

choose to either reaffirm or challenge prevailing meanings. Understanding that meaning is never fixed, we must continually engage in the process of criticism. In doing so, we can move beyond current “truths” and towards alternative ways of being.

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