Abstracts from the Social Medicine session at the 2006 annual meeting of the American Association of Medical Colleges, Seattle October 2007

Social Medicine for the 21st Century

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Introduction: Social Medicine was born in Europe in the 19th century, grew internationally during the 20th century, and faces new opportunities and new challenges during the 21st century.

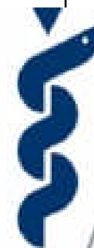
Definition and Principles: Social Medicine includes the *study* of the relationships between society, health, disease, and medicine; the *practice* of community-oriented medicine based on understanding of these relationships; the *training* of health workers for community-oriented and culturally-relevant medical practice; and *advocacy* for systems and structures to promote socially-responsible medical practice and the conditions needed for good health. Commonly-accepted principles of Social Medicine include: 1) Attainment of the highest possible level of health and access to the highest possible level of medical care are fundamental human rights; 2) Medicine is a social science as well as a biological science; 3) All health care has social and psychological dimensions; 4) Optimal health care requires collaboration among medical and non-medical disciplines and with the patients and communities served.

Social Medicine in the 21st Century: Economic globalization, environmental degradation, and the growing gaps between rich and poor have enormous ramifications for health. Social Medicine, with a rich historical and practical experience, is well placed both to understand these social changes and offer creative local, national, regional and global solutions to the problems created by them. Among these are:

1. Strengthening community-oriented primary care practice models where they exist and developing them in communities in developed and developing countries in which they are not available;

2. Generating and disseminating new knowledge in the fields of community and social medicine, including examination of the implications for health of diminished support for social welfare, widespread globalization, increasing militarization, environmental despoilment, lack of democratic governance, and other forms of social injustice;

3. Spreading knowledge of Social Medicine and its principles and providing inspiration for social change, including activism for conditions that will permit the attainment of the highest possible level of health and of universal access to primary medical care for all people of the world.



Centers committed to the principles and practice of Social Medicine in the United States and in other countries may make important contributions to the work. Our department is eager to collaborate with these centers and to help create alliances beyond traditional academic and national boundaries.

Using the Internet to promote social medicine

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Background: Social Medicine has articulated a vision of the physician as the "natural advocate of the poor." As medical schools become increasingly dependent on the funding of pharmaceutical industries, it is a challenge to promote this vision. This paper will discuss ways in which the Internet has been used by medical school faculty and students to advance social medicine.

Use of the web: In 1999 students at the Albert Einstein College of Medicine initiated a website to publicize their self-organized course in medical activism. In 2003 this initiative was expanded to a public website – www.socialmedicine.org - by faculty members. The goal of this Social Medicine Portal was to introduce students to the scope and depth of social medicine and the efforts of health activists around the world. Within a year this site had become the top Google search for the term "Social Medicine." Subsequently, an on-line, peer-reviewed academic journal Social Medicine (www.socialmedicine.info and www.medicinasocial.info) was launched with the Latin American Social Medicine Association (ALAMES) and other international collaborators.

Advantages: An internet forum offers several unique educational advantages. It allows the globalization of social medicine as a discipline drawing on international resources and reaching students throughout the world. Presentations and papers can be uploaded from the sites making a virtual curriculum available to users. A mentorship program can link interested students to mentors in specialty fields. A listserve can promote not only a broad discussion, but serve as an organizing tool. Users can easily offer feedback on the sites. The bilingual nature of the journal serves to decrease the linguistic barriers between North and South America. The journal uses open-access (i.e. free) journal software. This highlights the fact that Internet activities can be accomplished economically.

Challenges: Educational efforts on the web present a set of challenges that are not entirely different from more traditional academics. Specifically there are questions of editorial governance, organization, publicity, copyright, financing and evaluation. Our journal has used the Creative Copyright System that allows for free attributed, non-commercial use of materials. As a journal interested in attracting authors from countries traditionally not represented in the medical academic press, we are working to make peer review into more of a mentoring process.

Conclusion: The Internet offers an opportunity to use the technology of globalization to articulate the 21st Century vision of a physician who is the natural advocate of the poor. It is one way of maintaining the idealism and social commitment of medical students.

Literature and Social Medicine

Martin Donohoe, MD, FACP

This session will focus on literature as an educational vehicle to stimulate social activism among medical students. It aims to encourage educators to incorporate short literary selections into their teaching in the classroom and the clinic and on the wards.

Non-medical literature has long been employed in medical education as a vehicle for vicarious experience and a catalyst for discussion of the social, cultural, economic, occupational and environmental contributors to health and wellness. Reading about the experiences of those who suffer the consequences of poverty, homelessness, racism, violence, substance abuse and stigmatization can help practitioners and students to identify more closely with their patients, whose complex lives they glimpse only briefly in the clinic and on the wards.

In this session, I will:

- Provide brief background information on famous physician-activist authors, such as John Keats, Rudolph Virchow, Anton Chekhov, and William Carlos Williams.
- Summarize relevant short stories and poems from these and other writers (e.g., Leo Tostoy, George Orwell, Pearl Buck, Doris Lessing, Shusaku Endo, Ernest J Gaines and others).
- Offer suggestions for incorporating literary pieces into medical education. Resources, including sample syllabi, will be available for those interested.
- List barriers to the inclusion of literature in medical school curricula, and ways in which these barriers might be overcome.

Title: Building Capacity to Serve Communities: The Social Medicine Orientation Month Experience

Alice Fornari, EdD, RD and Matthew Anderson, MD, MS, DFSM/RPSM AECOM/ Montefiore Medical Center, Bronx, NY

Introduction/Background Department of Family and Social Medicine

The Residency Program in Social Medicine was founded in 1970 on the principle that health is a state of physical, social, economic, psychological, and political well-being. We believe health care is a right. There is a social component in the origin and course of disease; therefore, to promote health, we support grass-roots community action and progressive change in

public policy and social structure.

The Residency Program in Social Medicine (RPSM) is unique in that it combines residents from three primary care specialties: Family Practice, Pediatrics and Internal Medicine. Residents work and learn together in clinical seminars and social medicine courses. Each discipline brings special strengths to these conjoint learning experiences.

Social Medicine Curriculum Few residency programs offer as much training in social medicine and community health. The curriculum includes activities during each year. The RPSM orientation month allows interns in all three tracks (Internal Medicine, Pediatrics, Family Medicine) to come together and introduces the social medicine component of their residency training. Additional core rotations include Medical Spanish, Epidemiology and Community Assessment – all PGY 2, and Understanding Health Care Systems (PGY 3), and a longitudinal social medicine project culminating in a oral presentation in the PGY 3 year is required. These experiences will support graduating physicians who will practice in medically underserved communities.

RPSM Orientation Month The **goal** is to early on introduce residents to the philosophy, theoretical framework and practice of Social Medicine (SM) in the Bronx. The month's activities are structured around three themes: community, patient care and self-care. The **objectives** are**:**

Community: Expose residents to a number of tools (both conceptual and practical) to utilize to identify and understand health problems of a community.

Patient Care: Assist residents to demonstrate sensitivity and responsiveness to diverse patient values and experiences

Self-Care: Assist residents to develop some self-care skills as they travel through an often hostile health-care system.

These objectives are integrated into a model representative of Community Oriented Primary Care (COPC). All activities include didactic presentations with readings, community outreach, workshops and a longitudinal community based group project. This community project begins by identifying a clinically-relevant problem to all three residency tracks. For the past two years this problem has been obesity and diabetes. Clinically, the orientation month focuses on the social practice of medicine and employs a multimodal and multidisciplinary approach to "learning by doing."

Issues (educational): Orienting interns to their communities of practice and patient lives outside of the clinical environment Engaging interns in both the intellectual and practical components of a Social Medicine curriculum, during a block rotation: Orientation MonthDeliver didactic and workshop sessions designed to include reflective dialogue, information and ideas and some form of experiential learning to assure critical thinking among the residents. Enhancing knowledge, developing COPC skills and teaching advocacy, which results in advocacy-based efforts supportive of patients and the community, post orientation month
Using adult learning theory to involve learners in the curriculum development, as well as utilizing learners' prior experiences to inform their ongoing development as a RPSM resident

Montefiore's Residency Program in Social Medicine: A brief history of thirty-five years of interdisciplinary training in primary care and social medicine

Victoria Gorski, MD, Hal Strelnick, MD, Eliana Korin, Dipl.Psic., Janet Townsend, Philip Ozuah, MD, PhD, Debbie Swiderski, MD

The proposed presentation will provide a brief history of the origins of Montefiore's Residency Program in Social Medicine (RPSM), rooted in the social movements of the late 60s and early 70s and in the Community Health Center movement. It will also trace the program's success over time in maintaining focus on its mission and on its capacity to produce clinicians committed to primary care of underserved populations and leaders in social medicine education, research and policy.
We will describe the RPSM's unique interdisciplinary training of primary care internists, primary care pediatricians and family physicians with emphases on integration of the behavioral sciences and a focus on population health. We will discuss its special curricular features and their evolution in response to social and cultural changes and to new medical and public health knowledge and issues. In addition, we will describe how the program has served as the foundation for the growth of the Albert Einstein College of Medicine's Department of Family and Social Medicine and it associated fellowship, community partnership and research programs.

We will discuss the over 500 graduates of the program who have come to the Bronx from all corners of the U.S. and many corners of the globe. We will review their racial and ethnic backgrounds and describe the special features of the program that have allowed for its strong retention and recruitment of racial and ethnic minorities. We will also describe the variety of career trajectories the graduates have taken.

In closing we will present the program as it is operating today, the challenges it faces and strategies being adopted to overcome those challenges and position it for future growth and success.

Social Medicine at the University of Illinois College of Medicine at Rockford

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The Department of Family and Community Medicine (DFCM) at the University of Illinois College of Medicine at Rockford (UIC-R) sees social medicine as a way for an academic department to work with community institutions to expand and/or improve care for underserved populations. Over the past six years, we have entered into formal relationships with multiple community organizations to accomplish this, including:

Working at three different local county health departments to provide on-site prenatal, well child, and family planning services to low-income populations and large numbers of Hispanic patients.

Serving as medical consultant for the largest county health department in the region.

Partnering with a local school district to start the first school-based health center in the area and providing the primary care for the program and becoming medical director for a subsequently developed school-linked health center.

Providing primary care to adolescents in an inpatient substance abuse program. Bidding on a contract to assume responsibility for the healthcare services at the county jail (inmate population 600) and juvenile detention center (population 40), and then successfully implementing a program that includes nursing, primary care, mental health, dental, and pharmacy. Responding to an urgent request from a local substance abuse agency to assume the Medical Directorship of the methadone maintenance program, the only one in northwest Illinois.

There are multiple benefits to the community organizations and our department from these efforts. For the community groups, these include access to reliable high quality care, opportunities to expose students and residents to their programs and to care for various types of vulnerable populations, reasonable costs and, in some areas, considerable savings, and the potential to leverage the relationship with a University into other program expansion (i.e. jail program into mental health at the juvenile detention center, prenatal clinic into well child clinic).

Benefits to the DFCM and UIC-R include opportunities to provide community service, positive financial benefits, additional educational opportunities for medical students, family medicine residents, and MPH students in non-traditional settings and with non-traditional populations, a positive public image, expansion of options for faculty to work in new and interesting areas, and opportunities to develop new programs (i.e. methadone maintenance program, alternatives to incarceration).

Humanities Education in Medicine: Meeting Institutional Needs Through Educational Mission

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BACKGROUND: Southern Illinois University School of Medicine (SIUSOM), from its founding in 1970, recognized the importance of the social sciences and humanities in the education of physicians. The Department of Medical Humanities has operated continuously since the inception of the school, and provides extensive curricular content to medical students. Its mission is to "contribute insights from the humanities to the teaching, research, and service endeavors of the School of Medicine."

EDUCATIONAL ACTIVITIES: The Department of Medical Humanities at SIUSOM includes faculty with expertise in health law, health policy, public health, spirituality, counseling and communication skills, and biomedical ethics. The department is home to formal Programs in Health Law and Policy, Psychosocial Care, Medical Ethics, and Medicine in Society. Five core faculty, one emeritus professor of law and medicine and an extensive group of adjunct faculty, deliver required and elective coursework during all four years of the undergraduate curriculum. Course content is delivered using many interactive and case-based teaching modalities:

- First year offerings include a half-day seminar for medical and law students entitled "Professional Responsibility Day," in which small faculty-facilitated groups discuss and debate cases focusing on ethical and legal issues that arise at the interface of law and medicine. Additionally, several seminars are presented that address public and population health topics..
- Second year students work with Medical Humanities faculty as part of the Population Health and Prevention curriculum, with particular emphasis on health care policy and finance mechanisms in clinically relevant contex-

tual problems. Additionally, departmental faculty present seminars related to adolescent medicine and patient safety in the Professional Attitudes and Conduct portion of the curriculum.

- In the third year, students participate in a two-week required clerkship, entitled "The Physician-Patient Relationship.." Plenary and small-group discussion sessions are utilized to teach health law, biomedical ethics, communication skills, and psycho-social aspects of care, including end-of-life care. In addition to this required course, the department presents at least one, and up to three, ‚required seminars integrating medical humanities issues into each of the six major clinical clerkships.

In the fourth year, the department again presents a two-week required clerkship, entitled "Society, Law and Health Care," designed to present a health-care systems approach to the interaction between the medical profession, the legal profession, health care finance and administration, and the physician's responsibility in society. This segment has included a Mock Trial, one of the first developed and delivered in US medical education (1977 - 2005), and currently includes a Mock Video Evidence Deposition in which students observe attorneys deposing a physician about a current and relevant clinical case.

In addition to these activities, the department offers a total of 36 electives to third and fourth year students. Fifty-eight students in this year's graduating class (80% of the class) took one or more of these electives, with a total enrollment of 141 students.

Beyond its commitment to educating medical students, the department jointly sponsors one of only 20 MD/JD dual-degree programs in the United States, in conjunction with colleagues at SIU School of Law in Carbondale, Illinois. Two students per year matriculate in this program, which has now graduated 21 students, making it the most successful MD/JD program in the country. Its graduates augment their medical practice by using their legal expertise in the context of various activities at the local, state and national levels.

SUMMARY: The Department of Medical Humanities has significant longevity, depth and breadth in its educational mission. The department enjoys significant institutional support, including the rare opportunity to deliver over four weeks of required curriculum time for every student who attends SIUSOM. Course content is relevant and timely, and the larger institution finds it to be of significant value in today's world of diminishing health care resources, increasing systematization of the practice of medicine, and the expanding interface between the judicial, legislative and regulatory policy arenas and the practice of medicine. For more than 30 years the department has served SIUSOM by helping it meet its commitment to the teaching of "compassion, respect and integrity" to over 2,000 graduates.

Humanities in Medical Education: Teaching Social Medicine

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Since 1978, the Department of Social Medicine at the University of North Carolina has taught a required course, "Medicine and Society", which meets for 90 minutes each week for first year of medical school. It is taught in small seminar groups. Faculty teach from an extensive and well-developed syllabus. A compilation of syllabus materials, *The Social Medicine Reader*, is now in its second edition (Duke University Press, 2005).

This presentation describes how this course integrates the teaching of medical humanities and medical social sciences, from the perspective of a humanities-trained faculty member who has taught it for 20 years. The course surveys key topics, including: the patient's experience of illness; social factors and their effects on health (family, race and ethnicity, gender, culture, religion, socioeconomic status); the physician-patient relationship; medicalization, labeling, and stigma; chronic illness and disability; the boundaries and limits of medicine; the culture of medicine and medical education; a wide range of basic issues in medical ethics; death and dying; resource allocation; health care financing in the United States; and the problem of providing treatment for those without health insurance.

First-year medical students spend almost all of their time in lecture halls, expected to memorize great quantities of information. The Medicine and Society course stands out by emphasizing critical reflection on the profession of medicine and its relationship to modern society. Teaching students to value complexity and to accept the absence of clear answers poses an ongoing challenge. Effective use of the medical humanities in teaching is essential to meeting this challenge, so that students may become thoughtful and resourceful clinicians.

The Medicine and Society course successfully makes use of the disciplinary rigor of the humanities to promote student learning. It incorporates literary analysis, critical reading of the medical literature, and examination of history and philosophy to address key course questions. *The Social Medicine Reader* includes poetry, fiction, literary nonfiction, and selections from law, anthropology, philosophy, political

science, and history, among others, to help demonstrate to students how medicine shapes and is shaped by the society in which it is practiced. Essential to the effectiveness of medical humanities teaching is its multidisciplinary character. For example, ethical issues are not segregated from their social context, or from the scientific questions with which they are entwined; poetry and fiction are just as valuable in discussion of the end of life as they are in examining the effect of poverty on health status; and data on the cost of health care are important to inform both discussions of the ethics of physician-assisted suicide and of the political feasibility of health care reform.

Examples of course readings and syllabus materials will be provided and discussed, with an eye in particular to eliciting inter-institutional comparisons of pedagogical strategies.

TEACHING SOCIAL MEDICINE - Teaching Residents The Strengths of Social Medicine through a Community Health Center (CHC) based HIV Elective

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Social Medicine embraces the concept of healthcare in a socio-political context. Providing HIV care in the primary care setting illustrates how effective such healthcare delivery is.

The South Bronx Health Center for Children and Families (SBHCCF) is a CHC located in an underserved, poor community of color. Reported rates of HIV/AIDS are 2% and the actual rate is thought to be 3%. People living with HIV and AIDS (PLWHA) have multiple medical and psychosocial problems.

In addition to primary care for 6000 adults and children, and in response to community need, our health center has developed a comprehensive HIV program serving over 100 HIV+ patients and their families.

The CHC based, integrated nature of the program decreases stigma and increases accessibility to HIV care. Care is provided by a multidisciplinary team including:

Family Physician HIV Specialist trained in Social Medicine
Adherence Counselor
Peer Educator
Nutritionist
Social Worker

Internal Medicine and Family Medicine Residents from the Residency Program in Social Medicine (RPSM) at Montefiore are invited to participate in an HIV elective to encourage Primary Care Physicians to become HIV Specialists in practice. The elective includes experience of HIV care in diverse settings such as homeless shelters and primary care sites such as SBHCCF.

OBJECTIVES - at the end of this session participants will understand that in applying the principals of Social Medicine:

Primary Care physicians with additional training in HIV and experience working in CHCs are ideally suited to provide care to HIV patients and to teach residents the strengths of Social Medicine in this setting

HIV Care can be integrated into a busy CHC

A Case Study: The Workings of a Student-run Social Medicine Course

Laureen Ojalvo and Michelle Yu

In 1998 a group of students at the Albert Einstein College of Medicine (AECOM) created an elective designed to spread the practice and principles of social medicine to the AECOM community. Today, in 2006, this elective is titled "Social Medicine Course: Global, National and Local Perspectives." After eight years of successful implementation here, we aim to share its model with other institutions for similar incorporation.

Since its inception, our course has been and will remain entirely student-organized. We feel that this is an essential component of the course. This format creates extensive diversity in the sessions, enabling the course to illustrate the many facets of the practice of social medicine. Additionally, the course affords the opportunity for student organizers of individual sessions to communicate and establish relationships with professional leaders championing the cause of social medicine. This course encourages session organizers to begin to self-identify as a social medicine leaders: an identification that will hopefully continue into their own professional practice. Key to our course's success has been the continued institutional support and faculty mentorship from AECOM and its affiliated hospitals. For example, professionals from the Montefiore Medical Center, which has the oldest hospital-based Department of Social Medicine in the country, have been particularly instrumental to our course. Faculty mentors help the course to maintain continuity as students move on to the wards and graduation and help to ensure fundamentals and historical relevance of the practice of social medicine are not inadvertently missed. While we aim to present the diversity that encompasses social medicine, we recognize the need to balance this with the overarching goals of the practice of social medicine: the right to health and social justice for all. We believe it is critical for our course participants to understand

the solidarity between the issues that the course presents.

There are many issues presented. As suggested by our title, we aim to find a balance between global, national and local perspectives. To illustrate these perspectives, in 2006 session topics included: racial disparities illuminated by Hurricane Katrina, HIV/AIDS in NYC, liberation medicine, immigrant access to reproductive healthcare, and a doctor-patient panel on alternative medicine, among others. Generally, we aim for a total of 14-16 evening sessions over that many weeks in the spring semester. Each year, our course has one or two key student coordinators who work in the fall semester to identify students who would be willing to organize a session. The coordinators work with each session organizer to determine topics and identify potential internal and external faculty presenters. Our course calendar comes together in late November to enable advertising during the AECOM AIDS Week coinciding with Global AIDS Day (December 1). The lectures occur Wednesdays in the early evening and generally last about one hour, 20 minutes of which we encourage using for questions and discussion. This timeframe allows students, faculty, and community members to attend without interrupting workdays or family time. We provide dinner (thanks to generous AECOM support) and generally have between 20 and 60 participants, which we feel directly relates to the extent of advertising for a given session.

Our course is ungraded, un-examined and un-stressful. We aim to build a social medicine conscience within our community, and we have successfully contributed to student activism locally via a student-run free clinic in the South Bronx, nationally via students serving as national officers in medical organizations, and globally via 25% of our fourth-year medical students choosing to do electives abroad. We hope our model stimulates similar social change at other institutions.

Student-Run Free Clinics: Challenges and Opportunities

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Some seven hundred free clinics provide medical care to poor patients in the U.S. The vast majority opened their doors since 1990, reflecting the growing crisis of the uninsured and a recent revival of the freeclinic movement in the U.S. Approximately five percent of these free clinics are run by medical students under the supervision of volunteer attendings physicians. Student-run free clinics provide a valuable service to their communities and a unique educational experience in social medicine to their participants. However, free clinics also present many challenges to the student leaders who coordinate them and to their respective affiliated medical schools and hosting clinical sites. The first student-run free clinic in New York City was founded in 1999 by students from the Albert Einstein College of Medicine (AECOM) in the Bronx. The Einstein Community Health Outreach (ECHO) Free Clinic is located in the nation's poorest Congressional district (NY-16) and serves some 500 patients a year under the supervision of volunteer physicians, many of whom are faculty of the AECOM Department of Family and Social Medicine. The ECHO Free Clinic serves patients under the auspices of the community based, non-profit Institute for Urban Family Health and was a recipient of the AAMC's Caring for Communities grant in 2000. The clinic is JCAHO compliant, operates entirely via electronic medical record, and provides free consultations and laboratory services. The clinic is open weekly and provides on-site social work and health-education services. Specialty care referrals and prescriptions are provided at a reduced cost.
Using ECHO Free Clinic as a case-study, this presentation will address several complex issues faced by free clinics and the institutions with which they are affiliated

- Could the collaboration between the Einstein Department of Social and Family Medicine and the ECHO Free Clinic serve as a model for other Social Medicine departments around the country?
- What are the limitations on the care a student-run free clinic can provide, and is the investment of time and resources by sponsoring institutions worthwhile given those limitations? Might there be scenarios in which the ECHO Free Clinic might potentially serve a patient *better* than a regular health care institution?
- How can institutions best provide malpractice coverage for providers and students participating in the free clinic (will include discussion of the Free Clinics Federal Tort Claims Act Medical Malpractice Program)?
- What specific educational experiences relevant to social medicine and unavailable in the MS3 and MS4 curriculum do students gain by participation in the free clinic?
- To what extent can medical schools recognize, incentivize, or even mandate student participation in free clinics?
- How can educational and health care institutions collaborate with students to provide comprehensive services such as laboratory and radiology to free-clinic patients?
- What are the social and political ramifications of student participation in free

clinics in the current climate of controversy over immigrant rights, the explosion of the obesity and diabetes epidemics, skyrocketing drug costs, and reduced access to reproductive health?

The Diverse Evolution of Social Medicine: From Social-Structural Environmentalism to Behavioral Individualism and Back Again.

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The second edition of *The Social Medicine Reader* edited, as was the first, by faculty from the Department of Social Medicine at the University of North Carolina, Chapel Hill, offers a richly expansive view of an academic discipline that has struggled to find a precise definition for over a century. The intellectual range of *The Reader* includes many characteristic foci of early visions of the discipline, such as the social and economic structure of health care provision, health policy and clinical holism. The three volume edition also reflects the evolving conceptual parameters of the field including concerns with doctor/patient relations in culturally diverse societies. The evolution of social medicine as an academic subject, however, has been internationally diverse and thus a coherent definition of the discipline has remained elusive. Can the history of this evolutional diversity assist in gaining definitional coherence and intellectual purpose for the discipline now to aid it in understanding and responding to the expansion of the biomedical technological complex in post-industrial aging, affluent societies and in a colonially globalized world? This paper briefly examines some of the diverse development of social medicine as an academic discipline and its links to political conceptualizations of the role of medicine in society. It then offers an analysis of possible future paradigmatic directions opening up to the discipline in the Anglo-American context today.

Community Health Clerkship: Introduction to Community Access Issues, Cultural Competency, and Health Advocacy

Michele Pugnaire, Mary Zanetti, Michael Godkin, Deborah Katz, Robin Klar, Janet Hale, Linda Cragin, and Suzanne Cashman

Background:
The Community Health Clerkship is a required two-week, community-based experience for all first year medical students at the University of Massachusetts Medical School. The clerkship features on-site placements in community-based agencies, a small group project addressing a population-specific health issue, and a brief lecture-based core curriculum. Two years ago, the clerkship added a three-hour "Walk in my Shoes" (WIMS) simulation session. Developed by Community Catalyst, a consumer health organization, WIMS uses a simulated large group exercise to enable students and clerkship faculty to "experience" barriers to health care access. Participants are introduced to social, cultural, and economic disparities in accessing health care and see how these interact with other social determinants such as housing and employment. In the debriefing discussion associated with the activity, students learn about public policy and the role of advocacy in addressing these issues and barriers.

Method:
During the 2005-2006 academic year, four evaluations were developed and administered to 101 medical students to measure the effectiveness of major components of this Community Health Clerkship. Students completed an overall evaluation at the end of the WIMS session (n=80), at the end of the two-week experience (n=97), as well as a pre- and post- WIMS evaluation (matched n=60).

Results:
Overall results from the overall clerkship evaluation showed that 92% of the students reported having developed sensitivity to the needs of a specific population and 83% developed an appreciation of their role as a community advocate. Regarding the WIMS session, over 90% of the student participants rated "agree" or "strongly agree" when asked if the experience provided an opportunity to reflect on and empathize with the experience of medically underserved people. In addition, over 90% "agreed" or "strongly agreed" that the topic was essential to their medical training. Seventy-nine percent indicated the WIMS session strengthened their intention to address health care access problems.

Based on the matched responses to the pre- and post- tests, changes in knowledge accuracy were associated with the following items: legal immigrants may be ineligible for many public assistance programs [42%]; health care providers are required to provide medical interpretation [33%]; established treatment protocols prevent differences in treatment based on race, culture or ethnicity [19%]; employers are required to allow employees to attend medical appointments on work time [35%] and legal immigrants residing in Massachusetts have the same access to Medicaid as U.S. citizens [31%].

Discussion:
Based on an analysis of pre-post data, students gained knowledge related to immigrant eligibility for health programs, institutional factors related to racial/ethnic disparities, and language discrimination. These outcomes indicate that an exercise such as WIMS could be a useful tool for assessing cultural competency training in a manner consistent with the AAMC's TACCT domains as well as objectives for cultural competence.

Iodide Deficiency Disorder (IDD)

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Iodide deficiency disorder (IDD) is the most common cause of preventable mental retardation and brain damage in the world. Goiter, cretinism, decreased child survival, and impairment of growth and development are common characteristics of iodide deficiency. Fortunately, there is an effective and affordable way to prevent IDD. Providing the regions at risk with iodized salt has already proven successful in decreasing the incidence of IDD. Despite predictions that IDD would be eradicated by now because prevention is so simple and inexpensive, the latest WHO estimate is that at least 1/3 of the world's population (about 2 billion people) are at risk for IDD.

Iodide is an essential component of the thyroid hormones T3 and T4 (triiodothyronine and thyroxine), the only iodide-containing hormones in the body. The thyroid hormones play a key role in the intermediary metabolism of virtually all cells and are of integral importance to the development and maturation of the central nervous system of the fetus and the newborn, as well as skeletal muscle and lungs.

The first essential step in the production of the thyroid hormones is the transport of Iodide into the thyroid. In 1996, our lab cloned the cDNA that encodes the Sodium/Iodide Symporter (NIS), the protein that mediates iodide transport. Since then, we have carried out an extensive analysis of the relationship between the structure of the protein and its function and determined some of the structural requirements for proper NIS function.

Iodized salt and iodized oil supplements are the most common tools for fighting IDD. Adding Potassium iodide or potassium iodate to salt is ideal because it is technologically simple and inexpensive. Also, because everyone needs salt, most people eat it daily. The only way that IDD can be eradicated is through a collaborative effort made by governments to educate people about the dangers of iodide deficiency and to legislate that table salt be supplemented with iodide, for the salt companies to iodize salt, and for people to protect themselves from IDD.