Production of the Global Health Doctor: Discourses on International Medical Electives

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ABSTRACT   This article attempts to interrupt dominant narratives in the literature about international service-learning (ISL) in the field of medicine by critically deconstructing discourse related to a common model used to teach global health in undergraduate medical education: the international medical elective (IME). Based on a study conducted in 2012, the results have not been previously published. Using a Foucauldian discourse analysis, the study interrogated the underlying assumptions behind the nature of "service" being rendered by conveying the imagery, language, and consequences of the dominant discourses used in journal articles indexed on MEDLINE between 2000 and 2011. The analysis revealed an IMEs literature steeped in problematic discursive (re)productions of colonial constructs and imagined geographies, primarily through two dominant discourses designated as "disease and brokenness" and "romanticizing poverty." These discourses both justify and reinforce privileged subject positions for students engaged in these ISL experiences, while inadequately considering structures and systems that perpetuate marginalization and health inequities. Such discourses often marginalize or essentialize people of so-called "host" countries, while silencing subaltern perspectives, resistance struggles, knowledges, and epistemologies. Challenging current ISL practices in medicine requires educators to actively work towards decolonialization, in part by recognizing the ability of discourses to produce meaning and subjects.

KEYWORDS   international service-learning; international medical electives; global health; discourse; medical education

"Dissonance is the word that best describes my current view of international service-learning."
                                          -Doerr, 2011, p. 71

"Next to money and guns, the third largest North American export is the U.S idealist, who turns up in every theater of the world: the teacher, the volunteer, the missionary, the community organizer, the economic developer, and the vacationing do-gooders… I am here to suggest that you voluntarily renounce exercising the power which being an American gives you. I am here to entreat you to freely, consciously and humbly give up the legal right you have to impose your benevolence on Mexico. I am here to challenge you to recognize your inability, your powerlessness and your incapacity to do the "good" which you intended to do… Come to look, come to climb our mountains, to enjoy our flowers. Come to study. But do not come to help…"
                                          -Illich, 1968

In his now classic 1968 speech to a group of students embarking on a volunteer summer in Mexico with the Peace Corp, critical educator and priest Ivan Illich (1968) suggests that students do away with their pretense. "*To hell with good intentions*," he proclaims. It was a scathing indictment of the first modern era of international volunteer do-gooders, and arguably as relevant today as ever. Like volunteerism, the premise that underlies much of international service-learning (ISL) is that of good intention, of doing good, of benevolent service. This paper questions that assumption, interrogating the nature of the "service" being rendered in an era in which the West seems resolved to "quest for innocence in a post-colonial world" (Mahrouse, 2010).

International service-learning is in some senses an institutionalized form of the international volunteerism that became commonplace in North America in the 1960s. What has evolved since then is that ISL increasingly takes place in the current academic contexts of community engagement, service-learning, and internationalization. Definitions of ISL frequently suggest it as an ideal form of inter-cultural, international immersion, study, and community service that is fomented and organized through and by partners in more than one country (Bringle, Hatcher, & Jones, 2011). Like community service-learning, ISL is ideally a "structured learning experience that combines community service with explicit learning objectives, preparation and reflection" (Seifer, 1998, p. 274). Promisingly, perhaps, ISL as a form of service-learning is increasingly formalized, documented, and theorized (Bringle et al., 2011). Possibly excepting the relatively small sub-field of critical service-learning (Porfilio & Hickman, 2011), however, it is rarely subject to critique as honest and as raw as that of Illich. Critical approaches to ISL are even more rare in the health sciences where forms of ISL are flourishing.

This article attempts to interrupt the dominant narrative about ISL in the field of medicine by critically deconstructing the most common international service-learning model used to teach global health (GH) in undergraduate medical education—the international medical elective (IME). It does so by unpacking the discourses that pervade the new and rapidly growing field of global health as portrayed in the literature on IMEs. The article is largely based on a study conducted as a Master's thesis in 2012 (by JC), with complementary analyses based on three decades of academic and practical work in global health, including teaching study abroad courses (by LH). To orient the reader, we begin with a brief critical introduction to the field of global health and to IMEs, following which we describe and discuss the approach, methods, and findings from the empirical study. We end with a critical reflection on current approaches and the possibility of de- or non-colonizing practices.

Global Health and the International Medical Elective

The term "global health" easily conjures ideas such as Ebola, AIDS, SARS, or images of starving kids in Africa, together with North American development missions or Bill Gates-style philanthropy. Such conjecture is not far-fetched, but with a first glance at the academic literature, it would seem that much care is being taken to distance the academic field of global health from these notions. The GH literature claims it as a "new" field arising as: an outgrowth of critique of the paternalism of international health and the colonialist impulse of tropical

medicine (Crane, 2010; Eaton, Redmond, & Bax, 2011; Koplan et al., 2009); a new expression of the inherently international aspects of public health (Nixon, 2006); a strategic response to the security threats posed by new and emerging diseases in low and middle income countries (Garrett, 2007; Macfarlane, Jacobs, & Kaaya, 2008; Merson & Chapman, 2009); or a result of the World Bank incursion into the international health field in the 1990s, and subsequent shifts at the World Health Organization (WHO) (Brown, Cueto, & Fee, 2006; Thompson, Huntington, Hunt, Pinsky, & Brodie, 2003). A widely-shared view is that GH is "an area for study, research, and practice that places a priority on improving health and achieving equity in health for all people worldwide" (Koplan et al., 2009, p. 1995), requiring attention that is supra-national, inter-disciplinary, multi-level, and partnership-based (Canadian Academy of Health Sciences, 2011; Koplan et al., 2009; Marmot et al., 2008). Yet educators, researchers, and practitioners continue to struggle over what, if anything, legitimately makes it a distinct field or practice (Birn, Pillay, Holtz, & Basch, 2009; Brada, 2011; King, 2002; Macfarlane et al., 2008), and, increasingly, critical scholars of global health and global health education see the field less neutrally than any common definition would suggest. Rather, critical scholars point to the reality that global health initiatives originate largely from the Global North and privilege Western epistemologies.[1] They question the "hidden curriculum" in global health education (Anderson, Philpott, & Raza, 2014) and they point out the irony that as a science, global health "both generates and relies upon inequalities, even as it strives to end them" (Crane, 2013, p. 15). Increasingly, critics argue "that taking global health on its own terms obscures the powerful forces by which it becomes intelligible" (Brada, 2011, p. 285) and that it is the "moral maps and medical imaginaries" (Wendland, 2012, p. 108) of global health that are leading a virtual tsunami of interest in the field, shifting priorities of both students and medical schools.

The Consortium of Universities for Global Health (CUGH) reports that GH educational programs in North American universities in fact quadrupled between the years 2003 and 2009, with 61 medical education programs offering international electives and 11 with specified GH tracks as of 2005 (Kerry et al., 2011). The emergence of global health as an academic pursuit has given rise to expanded course offerings, new competencies for students, and novel educational practices (Cole et al., 2011; Hagopian et al., 2008; Redwood-Campbell et al., 2011), with the most popular form of global health training in North America being a form of service-learning known as the international medical elective or international medical experience (IME).

Characterized by short-term immersions of about four to eight weeks in lower- and middle-income countries (LMICs), IMEs are posed as providing medical students with a unique service-learning opportunity to "experience global health firsthand" and to understand

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[1] We must make a note here on terminology. There is no ideal way to categorize countries of the world. Terms such as First, Second, and Third World, or Developed, Developing, and Under-developed countries, permeate the literature. All reflect the discourse of the era in which they were created, and all can conjure unhelpful stereotypical notions. More recently, progressive scholars have begun using the "Global North/South" and/or categorizations based on per capita income levels (LMICs and High Income or HIC) as less politicized choices. We use those, reverting to other terms only when quoting the literature. Importantly, no term is perfect, and all tend to ignore the historic forces that both created and perpetuate global inequities.

medicine in clinical and cultural contexts "far from their own" (Grudzen & Legome, 2007). Most often, IMEs involve a clinical component but may also include elements of community or public health and occasionally research. Demand for IME programs continues to grow rapidly, with over 30% of undergraduate medical students participating in overseas electives by 2010 (Association of American Medical Colleges, 2010), compared to only 6% in 1984 (Jeffrey, Dumont, Kim, & Kuo, 2011; Khan et al., 2013; Thompson et al., 2003).

Largely based on non-standardized students' and administrators' assessments (Hanson, Harms, & Plamondon, 2010), the published literature on IMEs claims that they produce in students improved clinical and language skills, development of compassion and humility, appreciation for primary care and public health, improved cultural competence, and inclination towards working in underserved communities (Crump & Sugarman, 2008; Dharamsi et al., 2010; Dowell & Merrylees, 2009; Smith & Weaver, 2006). Yet they are simultaneously fraught with ethical problems including inadequate supervision, providing clinical care beyond competency levels, exercising double standards, and exhausting local resources that are already constrained, affecting health systems, local trainees, and patients (Crump & Sugarman, 2010; DeCamp, 2011; T. Green, Green, Scandlyn, & Kestler, 2009; Shah & Wu, 2008). Ironically, like the field of global health in which they reside, some authors have suggested that IMEs can both reify and reproduce the very health and social inequities they seek to address, with evident neo-colonialist impulse (Hanson et al., 2010).

Producing the Global Health Doctor: The study

"'Global health' and the 'resource-limited settings' in which it takes place are not born … they must be made."
                                                                        -Brada, 2011, p. 286

The scholarly literature plays a vital role in constructing and propagating global health ideas and practices to academics, students, and health professionals, providing fertile ground for the study of global health discourses. Weedon (1987) defines discourses as "competing ways of giving meaning to the world and of organizing social institutions and processes" (p. 34) but argues that not all discourses are awarded equal importance or status. The authority and influence of dominant discourses arise from the way they employ "a particular language and a distinctive worldview in which some things are regarded as inherently more important or true than others" (Brookfield, 2005, p. 136) and by being widely circulated and normalized.

Various authors have suggested how global health discourses induce individuals to conduct themselves and adhere to certain practices. In her fieldwork in Nepal, medical anthropologist Pigg (2013), for example, highlights the power of global health and development workers to deploy discourses that morally define which practices constitute "just sitting around" versus "doing something." Hall (2006) traces the way Western medicine has traditionally been contrasted to the "primitive" practices of the Indian medicine man and notes that discourses in global health often rely on a dichotomy between "civilized, rational, scientifically developed peoples and the atavism of peoples by whom Western science gauges its progress" (p. 285). King (2002) suggests that these practices are well-embedded, noting that throughout the

history of global public health, discourses have been used to "identify villains and heroes, ascribe blame for failures, and credit for triumphs" (p. 767). Brada (2011) meanwhile warns that notions of morality and expertise affect how trainees orient themselves to others, and questions what power-relations are constituted as a result.

With growing numbers of students engaging in global health service-learning, particularly through IMEs, we felt it crucial to become more attuned to the discursive mechanisms by which the global health doctor is being produced and reproduced in North American medical schools. Our study of the published literature on IMEs arose from the belief that deconstructing the discourses therein might contribute to that attunement, and give way to the production of alternative meanings and practices.

Theoretical and methodological approach

Situating our analysis broadly in the traditions of critical, feminist, and post-colonial theory, this study questions whose interests are represented in the prevailing organization of GH education and interrogates how dominant discourses about those arrangements account for and reproduce the status quo (Brookfield, 2005; Hinchey, 2010), privileging some people's voices and experiences while marginalizing others (Hesse-Biber & Leavy, 2005). The study thus included an exploration of how the "Other" gets constructed and portrayed.[2] Reflecting on the effects for colonized peoples of historic exclusions, continuations, and ruptures, we posed a project that recognizes how vestiges of past colonial encounters are frequently, if invisibly, reproduced in the present (Gandhi, 1998; Said, 1979). Thus, an important post-colonial aim of our inquiry was to expose dominant discourses about IMEs, paying attention to ways that the discourses can marginalize, victimize, essentialize, or disempower people of so-called "host" countries, and ways the discourses might silence or misrepresent subaltern perspectives, resistance struggles, knowledges and epistemologies (Spivak, 1998).

In discourse analysis, language plays an important role in constructing meaning and is not presumed to be able to objectively describe reality (Gergen, 2009; Mills, 1997; Weedon, 1987). Rather, as Foucault (1972) states, discourses are "practices that systematically form the objects of which they speak" (p. 49), producing subjects who personify particular characteristics and attributes (Weedon, 1987). Within a particular discourse, individuals occupy subject positions that offer particular ways of being and relating to others. Discourses give meaning to these positions by informing individuals about how to act, normalizing certain practices while denying alternative ways of being and knowing. Individuals are further constituted by being subject to and governed by certain norms and forms of knowledge. For Foucault, discourses are historically variable ways of specifying knowledge; the notion of "truth" is thus problematic and should be challenged.

The Foucauldian discourse analysis (Willig, 2008) we utilize in the study is well suited for understanding how a particular version of events—in this case, the literature's portrayal

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[2] "The Other" is a term that has been widely used in post-colonial studies to emphasize the invented differences between Western and non-Western subjects that enabled the colonial production and reinforcement of positions of subordination and domination (Said, 1979).

of IMEs in the Global South—is elevated to the status of "truth." It is also appropriate given its concern with how subjects are constituted and what the consequences are for those positions within discourses. Finally, Foucault's ideas on power as a dynamic process permit an examination of how a different conceptualization of international service-learning in medicine might be possible to construct. The adapted version of Foucauldian discourse analysis used for the study follows (Willig, 2008).

Methods

To understand the different ways that IMEs are constructed in the literature, we examined academic journal articles published between the years 2000 and 2011, a time frame corresponding to the period in which IMEs gained popularity and grew rapidly. We searched MEDLINE with a combination of these MeSH subject headings: "Undergraduate Medical Education," "Internationality," "International Cooperation," "International Educational Exchange," "World Health," "Developing Countries," "Travel Medicine," and "Tropical medicine." The search results were limited to articles published in English. A total of 293 articles were produced. We reviewed the abstracts of each article and only included articles that met the following criteria: 1) the participants were undergraduate medical students; 2) the direction of travel was from High Income Countries (HICs) to LMICs; and 3) the duration of the elective was short-term. The final dataset for this study consists of 60 articles.

Our analysis consisted of a number of iterative readings, noted observations, and coding informed by the kinds of concerns Foucault raises. First, the literature was coded in terms of varied and general ways that the text represented IMEs and their concomitant practices and activities. After identifying several possible discourses, we sought to understand how the varying discourses were structured and organized to legitimate certain practices. We noticed 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; and the activities that take place during IMEs. We also examined how medical students and hosts were positioned within dominant discourses by considering the relationships and power relations between them. In the end, it was the common elements in the literature—portrayals of hosts, motivations, activities, and relationships—that revealed dominant patterns and discourses.

Findings

In this section, we present and explore the implication of two of the principal dominant discourses identified. The first discourse portrays IMEs as a risky undertaking in places that are sick, chaotic, and in dire need of help. We name this the discourse of "disease and brokenness." The second dominant discourse constructs an idealized and romanticized version of trainees working in faraway settings; this is the discourse of "romanticizing poverty." In each section, we demonstrate how each discourse is constructed and how subjects are positioned within them by highlighting quotes from the IMEs literature. Due to space constraints, we only list a portion of the references.

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—that all is broken. Implicitly and explicitly, the writing conveys inherent risks in such settings. The first dominant discourse is constructed from four main ideas: 1) Illness and Death; 2) Despair; 3) Foreignness; and 4) Material Depravity. In discussing these key components, we demonstrate how the discourse foregrounds certain versions of events over others.

The first aspect of the discourse introduces the idea that IME experiences are situated in faraway lands replete with strange diseases and death, a recurring image of the Global South characterized by "a greater variety of acute and serious illnesses" (Mutchnick, Moyer, & Stern, 2003, p. S4) where "health care providers . . . find a unique opportunity to learn about exotic diseases" (Schechtman & Levin, 2006, p. 326). Epidemics and outbreaks have a totalizing presence, allowing medical students to direct their gaze towards a "wider range of illnesses . . . and clinical experiences" (McKinley, Williams, Norcini, & Anderson, 2008, p. S53) and fixate upon "new diseases" (Eckhert, 2006, S38). Diseases are spoken of as "staples" (Sears, 2007, p. 351), as an essence of the host environment where affliction is thus viewed as natural and presenting "unmistakable" (Taylor, 2001, p. 373) patterns. More importantly, host settings are constructed as fundamentally different, symbolized by illnesses that "have not yet appeared in the Western Hemisphere" (Dubin, 2000, p. 732) or are "rarely encountered in the student's home country" (Drain et al., 2007, p. 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" (Dubin, 2000, p. 732) further portray host countries as inherently threatening to the West.

The technique of foregrounding images of despair and immeasurable suffering also strengthens the notion of disease and brokenness. IME programs are depicted as set in the "world's poorest places" (Gupta & Farmer, 2005), among the "most oppressed and impoverished" (Rybak, 2007, p. 357), and in "situations of almost universal need" (Dodard, Vulcain & Fournier, 2000, p. 398). The sheer magnitude of the situation is exemplified by poignant illustrations of the "billions living in poverty" (Shah & Wu, 2008, p. 377). Despair seems to engulf the Global South, where the "neediest" people and patients (Schechtman & Levin, 2006, p. 332; Sears, 2007, p. 351) and the "poorest of the poor" (Panosian & Coates, 2006, p. 1771) live amidst "extreme poverty" (Pinto & Upshur, 2009, p. 2) and "deplorable situations" (Gupta & Farmer, 2005). The chaos that assails host countries is constructed as inescapable, dominating the "desperately poor" (Elit et al., 2011, p. 706) and the "throngs of patients" (Jesus, 2010, p. 19) who wait long hours for help: "Hundreds of families lined up each morning to receive treatment for ailments including parasitic infections [and] tropical diseases" (S. Green, Comer, Elliott, & Neubrander, 2011, p. 304). One is further drawn into the plight as students retell harrowing experiences of places where "disease was rampant" (Sears, 2007, p. 351), "the number of ill and dying exceeded local resources" (Elit et al., 2011, p. 708), and "patients with obvious diseases could not be treated" (Jesus, 2010, p. 19). In the "most impoverished places" (Parsi & List, 2008, p. 268) where so many are "truly in need" (Ramsey, Haq, Gjerde, & Rothenberg, 2004, p. 415), a grim future that is "grave and far-

reaching" (Greenberg & Mazar, 2002, p. 1651) awaits. Differences between LMICs and HICs are portrayed as inevitable, with little effort to engage in a critical analysis about the inequities: "So I was just kind of lost . . . and again going to the point of, okay in Canada this would never fly" (Elit et al., 2011, p. 708).

Constructing an image of foreignness further reinforces the idea of brokenness, of chaos. Captivated by the difference, medical students construct the host environments of LMICs as "unfamiliar" and "foreign." The exoticness of the "Third World" is enthralling, forcing outsiders to adapt to "alien cultures" (Imperato, 2004, p. 353) in a place that is strange and has unfamiliar rules. Vivid accounts reveal traumatic tales of medical students who "committed suicide after return" (Tyagi, Corbett, & Welfare, 2006) or who were "severely beaten up . . . as punishment for carrying so little cash" (Goldsmid, Bettiol, & Sharples, 2003, p. 163). Yet, rather than diminishing IMEs, the frequency of such reports seem to imbue them with an aura of exoticism and "allure" (Chin-Quee, White, Leeds, MacLeod, & Master, 2011, p. 742). Medical students are depicted as pursuing experiences that "might as well have been in another world" (Sears, 2007, p. 351), witnessing out of the ordinary fatalities and "watching someone die for the first time" (Vora, Chang, Pandya, Hasham, & Lazarus, 2010). Because the countries can be both foreign and dangerous, IMEs become a "foray into developing countries" (Parsi & List, 2008, p. 268) or an "international venture" (Jesus, 2010, p. 19) where students should be emboldened to "fight" (Drain et al., 2007, p. 226) against unknown hazards. Emphasis on the "inherent risks, uncertainties, [and] unexpected crises" within the Global South further sensationalizes "the unpredictable nature of international experiences" (Steiner, Carlough, Dent, Peña, & Morgan, 2010, p. 1563). The idea of foreignness effectively constructs IME experiences as imbued with mystery and intrigue, but also full of danger and threats.

Finally, the overwhelming material depravity of the Global South features prominently in the discourse of disease and brokenness. The broken landscape and poverty-stricken conditions of the "Third World" (Imperato, 2004) are portrayed as sickening: "The scope of poverty and the consequences of inadequate health care may overwhelm students unfamiliar with conditions in developing countries" (Reisch, 2011, p. 95). Descriptions of depleted facilities in a "war-torn setting in Uganda, and a mobile, railroad-based hospital in India" (Panosian & Coates, 2006, p. 1772) as well as poor clinics only capable of conducting "primitive ultrasound[s]" (Mukundan, Vydareny, Vassallo, Irving, & Ogaoga, 2003, p. 796) reinforce the impossibly destitute situation to be encountered. Speaking about host settings as devoid of modernity constructs a singular image of IMEs taking place in an undifferentiated space of brokenness.

The Dangerous Irrational Other and the Caring Medical Student. Within the discourse of "disease and brokenness," subjects from the West and host countries interact with and respond to one another in prescribed ways, with host countries populated with irrational beings who are either passive or dangerous, while the Western students are logically positioned as dynamic and intelligent—and even as saviours. An orientation of the medical student for the ensuing danger reinforces this:

> 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. (Einterz, 2008, p. 1462)

Student reflections on the health workers and professionals they encounter largely relay the image of less rational and less educated peers. This inferior, non-Western Other comes in "late, irregularly, or not at all" (Ly, 2007, p. 356) and even fails to practice "universal precautions" (Imperato, 2004, p. 363). Any ability for the Other to provide care is subsumed by an apparent lack of reason: "I didn't feel like I had any choice in the matter because he [the surgeon] literally walked away" (Petrosoniak, McCarthy, & Varpio, 2010, p. 685). Incapable of practicing medicine effectively, the Other purportedly has a "lack of knowledge about medical education" (Radstone, 2005, p. 109). Moreover, the Other is faulted for being "hesitant to address concerns" (Provenzano et al., 2010, p. 212), or worse still, their "culture" (Crump & Sugarman, 2008, p. 1457) is to blame for their ineffectiveness when working with trainees. Portrayed as irrational and ignorant, the Other appears "insulted" (Vora et al., 2010) over trivial matters. Alternatively, they are seen as aloof and uncaring, walking away from a patient with uncontrollable seizures and leaving one student to "attend to him each time he seized" (Elit et al., 2011, p. 706).

Conversely, the student subjects from the West are constructed as the exact opposite of the Other—as intelligent and dynamic actors. Unlike the Other, the discerning medical student is portrayed as "the most qualified person" (Radstone, 2005, p. 109), being able to make quick decisions and possessing "unique resources" (Chin-Quee et al., 2011, p. 740). Medical students embody the role of leaders who have "passionate commitment" (Edwards, Piachaud, Rowson, & Miranda, 2004, p. 689) and are seen as "good will ambassadors" (Imperato, 2004, p. 372). They are distinguished by their "sense of mission" (Panosian & Coates, 2006, p. 1773), "visions of Great Deeds" (Coulehan, 2006, p. 814), and "altruistic ideals" (Ramsey et al., 2004, p. 412).

These differences are then used to justify and portray the subjects from the West as the protectors and guardians. The West is bestowed with a "special power" (Gupta & Farmer, 2005) to protect the health of people globally. An ensuing relationship develops where the West is positioned as a saviour who provides the extra "manpower" (Dowell & Merrylees, 2009, p. 124) to "help those in need" (Vora et al., 2010). Embodying the role of saviours, medical students are seen as answering a "calling" (Panosian & Coates, 2006, p. 1771) and endowed with the responsibility of "giving voice to those who are stifled by social burdens that seem impossible to overcome" (Dharamsi et al., 2010, p. 979). 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" (Parsi & List, 2008, p. 268).

In highlighting the subject positions offered to students within this discourse, we draw attention to the power of students to constitute themselves as heroes or saviours and their ability to represent themselves as morally upright. However, we also bring into question the type of relationships that are enacted.

Discourse of "romanticizing poverty"

The second dominant discourse that we identified constructs a romantic notion of medical students working in under-resourced environments. In the literature, we encountered two specific and distinct ways in which poverty is romanticized. First, destitute and impoverished environments are represented as an opportunity to develop basic clinical skills and overcome challenges. Second, the host countries are constituted as static societies that are timeless and unchanging, where inhabitants live contently in beautiful simplicity.

The discourse of romanticizing poverty begins by constructing impoverished settings of host countries as rich learning environments and as natural settings for medical students to rediscover the roots of medicine. In this discourse, the destitution and material depravity of the Global South are no longer dreaded, but serve as propitious sites for medical students to discover the "attributes that make for becoming better clinicians" (Drain et al., 2007, p. 228). The under-resourced settings are constructed as an opportunity "for on-the-spot problem solving"—a kind of "medical outward-bound" (Dodard, Vulcain, & Fournier, 2000, p. 400). New responsibilities engender challenges, which students now embrace as an "adventure[]" (Einterz, 2008, p. 1461) as they set out on "exciting international medical opportunities" (Panosian & Coates, 2006, p. 1772) that will ultimately be "beneficial to their careers" (Morris et al., 2006, p. 119). Venturing to the Global South signifies a return to the days of their "forefathers" (Eckhert, 2006, p. S39) with a nostalgic yearning for pre-modern times: "Technology is not required to provide good, caring health care" (Haq et al., 2000, p. 569). Trainees represent poverty as a way to "appreciate medicine in its simple form" (Smith & Weaver, 2006, p. S35) and improve their "abilities to use their own diagnostic skills" (Dubin, 2000, p. 732), glorifying 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" (Schechtman & Levin, 2006, p. 326). Practicing medicine in "primitive" settings is also signified as a "return . . . to our foundation" (Eckhert, 2006, p. S39) and conceived of as a means to rediscover the "art of medicine" (Mutchnick et al., 2003, p. S3). There is an "allure" (Chin-Quee et al., 2011, p. 742) to such practice and a challenge for students to "become more sophisticated" (Parsi & List, 2008, p. 268) without the benefit of "the newest and most sophisticated technology" (Jotkowitz, Rosen, Warshawsky, & Karplus, 2006, p. 355). Compared to Western environments defined by "routine" (Chin-Quee et al., 2011, p. 743), learning medicine in the poor Global South is spoken of as inspiring and exhilarating. Within this discourse, experiencing poverty up-close is presented and constructed as a gratifying personal experience.

The notion that the Global South is a timeless, unchanging place is the second strategy that the literature employs to romanticize poverty. In a "primitive" environment where "[t]hings move slowly" (Schechtman & Levin, 2006, p. 327), an enduring image of 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" (Coulehan, 2006, p. 814). 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" (Vora et al., 2010). Trapped in time, the inhabitants of such places are depicted as being happy and content with their simple way of life: "I think it looks poor here, but then I think if you lived here, you wouldn't feel so poor" (S. Green et al., 2011, p. 306). Medical students "marvel at how much capacity there [is] among people who [have] very little" (Dharamsi et al., 2010, p. 980) and are fascinated by the noble and heroic ability of the poor to bear hardship. Stunned by images of stark poverty, students idealize the poor's capacity to "endure without complaint" (Holmes, Zayas, & Koyfman, 2012, p. 931) and to be appreciative of any form of care. The literature thus celebrates the redemptive aspect of poverty and idolizes those who have the ability to endure long suffering: "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" (S. Green et al., 2011, p. 307). Simplicity is the essence of the poor. 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" (Einterz, 2008, p. 1461).

The Childlike Other and Triumphant Medical Student. The representation of the Global South as unchanging and static has consequences for how its inhabitants are subjectively positioned. Living in a timeless present and removed from modernity, they are no longer positioned as a threat or irrational, but as a childlike being or as someone inscrutable and "shrouded in mystery" (Coulehan, 2006, p. 816). Portrayed as simple, the Other is described in a shallow and superficial way: " . . . women with colorful headscarves, crossed arms, and dozens of shoeless children" (Coulehan, 2006, p. 817). The suffering Other relies simply on "prayers" (Dodard, Vulcain, & Fournier, 2000, p. 399) and "hope" (Rybak, 2007, p. 357). The Other is the recipient of "kindness, gentleness, curiosity, and smile[s]" (Haq et al., 2000, p. 569) who 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" (Vora et al., 2010). Not surprisingly, medical students glowingly describe how they learned to "gather a history and physical despite significant cultural/language barriers" (Smith & Weaver, 2006, p. S35), or are astonished that they can get by with "pantomime, facial expression, and personality . . . [and] really get a lot across that way" (S. Green et al., 2011, p. 306). They "even communicate with patients and other medical professionals through smiles and different expressions and gestures" (Vora et al., 2010). Mesmerized by the Other's innocence and juvenile nature, students describe their encounters with inhabitants with frankness and simplicity:

> 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. (Rybak, 2007, p. 357)

The depiction of a childlike essence, apparent innocence, and delight at meeting the Western medical student subordinates and romanticizes the Other as happy and content. The people thus constructed, without depth or complexity, are contrasted with the sophisticated medical students coming of age. Leaving the familiar environment of the West, medical students are seen as undergoing life-changing experiences that are "exciting and character-building" (Edwards et al., 2004, p. 688). Answering a "calling" (Panosian & Coates, 2006, p. 1771), brave and daring medical students set out to "explore parts of the world that interest them" (Dowell & Merrylees, 2009, p. 122). Obstacles encountered during IMEs are seen as contributing to their "sense of mastery and confidence" (Dubin, 2000, p. 732).

This subject position of adventurous medical student coming of age also has connotations of status and power. It suggests a notion of superiority and authority insofar as students can "finesse the expectations that people have" and seamlessly "see one, do one, teach one" (Elit et al., 2011, p. 708, 707) with regards to new procedures. As they undergo "great personal and professional development" (Dowell & Merrylees, 2009, p. 122), students "realize their self-potential" (Murdoch-Eaton & Green, 2011, p. 645) and "restore [their] idealism" (McKinley et al., 2008, S55). The indomitable nature of medical students is signified by their ability to "triumph[ ] over adversity" (Dodard, Vulcain, & Fournier, 2000, p. 400) while "surviving and adapting" (Vora et al., 2010). Undeterred by the challenges of adapting to a new environment, medical students are defined by the essence of their "adventurous spirit" (Schechtman & Levin, 2006, p. 327). Accounts of brief "clinical stints" (Panosian & Coates, 2006, p. 1772) in places beset by poverty convey students' newfound ability to "exercise clinical judgment and independent decision making" (Chin-Quee et al., 2011, p. 742). Finally, the completion of an IME marks the transition from an ordinary medical student to a self-assured, triumphant or heroic medical student.

Discussion

According to post-colonial theorist Edward Said (1979), the common Western practice of characterizing non-Western countries as "foreign" produces imagined geographies. Though not associated with any geographical space naturally, such places come into being through the imposition of a limited vocabulary and imagery—through the production of a discourse. For Said (1979), the Orient for example, becomes produced and characterized as "a place of romance, exotic beings, haunting memories and landscapes, [and] remarkable experiences" (p. 1). According to Said (1979), imagined geographies legitimate a particular and essentialist vocabulary about non-Western countries:

> 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)

The presence of a foreign imagined Orient in turn strengthens the conventional image the West holds of itself, positioning it to produce and re-produce colonial subjects. Such subjects are posed as backward and irrational, in need of Western help in order to modernize. The interrogation of mechanisms by which colonialism continues to function and reproduce itself—in this case through the educational system—requires deconstruction of these dominant discourses and the practices they produce. Only in so doing might we enable a search of more liberating alternatives (Gandhi, 1998; Said, 1979).

In spite of what is said of international service-learning being about partnerships and mutuality, with structured experiences intended to lead to such alternative understandings and actions, we found little in the literature on IMEs to support the idea that any service being rendered through them was in fact leading to alternative discourses and practices. Instead, the portrayal of an imagined geography with undifferentiated "Others" in need of Western assistance appears too often to be providing propitious territory for well-meaning educators and students to inadvertently reproduce the kinds of inequitable social relations at the root of ill-health.

Far from being neutral, the IMEs literature frequently uses imagined geographies to depict timeless, symmetrical host settings that are inferior to North American social and physical environments. The power dynamics that underpin global health inequities are largely omitted from discussion; deeper social, economic, or political contexts are mostly missing; stories of local resistance and host community agency are almost entirely absent. There is little debate about the contested colonial history or the imposition of imperial power in the Global South and how those things have determined health in host countries. Instead, we would argue that the IMEs literature reflects mostly the West's image of itself and its power to define and constitute "global health" in a way that confers unique privileges to Western practitioners and medical students. The exercise of those privileges through the production of the global health doctor requires a discursive construction of the "Other" in order to exist.

Our analysis thus reveals that the IMEs literature does not merely describe training opportunities in LMICs, but is a means of producing certain types of global health doctors. Problematically, discourses in the literature largely legitimize existing racialized colonial arrangements and liberal notions of benevolence, asserting what it means to practice global health as a medical student cum practitioner. This is largely achieved by relying on imagined geographies, notions of liberal benevolence and innocence, and pervasive colonial constructs, which post-colonial scholars argue are techniques that have been used repeatedly by the West to assert knowledge over the non-Western world (Gandhi, 1998; Said, 1979; Spivak, 1996).

Conclusion

Using a critical theoretical lens and a Foucauldian discourse analysis, we have reported

on a study in which we examined literature on the form of international service-learning most common to undergraduate global health training in medicine: the IME. We find that the literature relies heavily on two dominant discourses to represent IMEs as set in places that are both poverty-stricken yet idyllic, and where the inhabitants are both dangerous yet childlike. These two dominant discourses construct common "truths" about IMEs, creating commonsense knowledge that is used to explain, justify, and normalize ensuing forms of global health work, starting with students' engagement in IMEs. The production of global health doctors is occurring within existing inequitable social relations that are seldom questioned in this literature. Problematically, such discursive constructions constrain alternatives.

We opened this paper with a quote on a sense of dissonance as a descriptor of international service-learning and with a question regarding the nature of "service" actually being rendered in the form of ISL most common to medicine. Morton and Campbell (2007) suggest that "cognitive dissonance" is the "temporary gap that exists between what we think we already know and a contradictory experience or piece of evidence" (p. 12). If the field of global health is, as posed, primarily a field concerned with inequities, how is it that our current mode of ISL training prepares students to arrest them? Do IMEs, as currently practiced, actually function as a service to host communities? Can "good" come of a practice so imbued with colonial constructs and imaginaries? Is service what is required? Or is it solidarity that is called for? What might de- or non-colonizing medical training involving privileged Western students look like? What language would be employed, what practices awarded status? What would the dominant images look like? How and for what would students be attracted to global health, if it were otherwise conceived? About what kinds of training, what practices, and what settings would we be reading in the literature? Perhaps most importantly, who would be writing those stories?

Writing about resistance, Foucault (1978) explains that 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). We therefore contend that language can be turned into a "site of resistance" (Weedon, 1987) and can serve to destabilize existing discourses. Resisting and challenging dominant discourses and their associated practices through educational interventions in the highly problematic field of global health requires the development of post-colonial thinking and, to the extent possible, de- or non-colonizing practices. Material realities and historic social processes that determine health and lead to social struggle (rather than imagined geographies and colonial constructs) are where such interventions might reside. Perhaps educators need to be more insurgent (Porfilio & Hickman, 2011) and courageously defend the politicization of curricula in global health rather than succumbing to the creation of an a-theoretical and falsely neutral or benevolent field. In practice, that might mean the expansion of GH curricula to include, for example: critical theory; critical reflexivity; community organizing; mobilization for social change, and the learning of humility and solidarity in order to work *with* rather than *for* communities. ISL could be a useful pedagogical tool toward that end, but only "[i]n the hands of insurgent educators . . . [where] service-learning has the potential to blast open a liberating space of

criticality and consciousness" (Renner, 2013, p. 110).

Ultimately, the discourse on global health training can diminish the sense of dissonance only if it disrupts prevailing representations that are historically rooted in colonialist, racist, sexist and other forms of oppressive practice. In recognizing the ability of discourses to produce meaning and subjects, new "truths" about global health and ISL/IME experiences as well as alternative ways of being a global health student, educator, researcher, activist, or practitioner may become possible.

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