

# Health and Disease in Context: A Community-Based Social Medicine Curriculum

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## Abstract

Despite the increasing attention paid to the role of social forces in determining health, most physicians finish their training ill-prepared to address these issues. The authors describe their efforts to fill that training gap for internal medicine residents at Oregon Health and Science University through a community-based social medicine curriculum, designed in 2006 in conjunction with community partners at Central City Concern (CCC), an organization addressing homelessness, poverty, and addiction in downtown Portland, Oregon. The challenge was to develop a curriculum that would (1) fit within the

scheduling constraints of an established categorical internal medicine residency program, (2) give all internal medicine residents a chance to better understand how social forces affect health, and (3) help show how they, as health professionals, might intervene to improve health and health care. The authors maintain that by developing this curriculum with community partners—who took the lead in deciding what residents should learn about their community and how they should learn it—the residency program is providing a relatively brief but extremely rich opportunity for residents to engage the

personal, social, and health-related issues experienced by clients served by CCC.

The authors first provide a brief overview of the curriculum and describe how the principles and practices of community-based participatory research were used in its development. They then discuss the challenges involved in teaching medical residents about social determinants of health, how their academic-community partnership approaches those challenges, and the recently established methods of evaluating the curriculum.

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**T**he social conditions in which people live and work can be a critically important cause of ill health in both industrialized and developing countries.<sup>1–4</sup> Thus, even as medical technologies advance rapidly enough to save lives that just decades ago would have been lost, disparities in health and health care driven by differences in income, class, culture, and employment continue to widen.<sup>5</sup> The magnitude of these disparities has led the World Health Organization and the National Institutes of Health to convene task forces, organize

conferences, and offer funding to individuals and organizations that are committed to understanding and addressing the social forces, or *social determinants*, that impede the attainment of good health.

Despite the increasing attention paid to the role of social forces in determining good or ill health, most physicians finish their training ill-prepared to address these issues. Studies suggest that most practicing physicians in the United States do not understand the full extent or nature of health disparities in their country, and that neither practicing physicians nor trainees have an adequate understanding of the U.S. health care system and its challenges.<sup>6–9</sup> Physicians also report feeling ill-equipped to care for and communicate effectively with individuals of different cultures and backgrounds,<sup>10,11</sup> and studies further suggest that most medical trainees become increasingly cynical and less concerned about social context as their training progresses.<sup>12–14</sup>

In this article, we describe an attempt to help fill that gap in training for medical residents at Oregon Health and Science University (OHSU) through a community-based social medicine curriculum that we—members of the

internal medicine residency faculty at OHSU, and staff at Central City Concern (CCC)—designed. CCC is an organization addressing homelessness, poverty, and addiction in downtown Portland, Oregon. The challenge was to develop a curriculum that would fit within the scheduling constraints of an established categorical internal medicine residency program and that would give all internal medicine residents, regardless of their ultimate career aims and interests, a chance to better understand how social forces affect health, and how they, as health professionals, might intervene to improve health and health care. Our goals were (1) to use our academic-community partnership to develop a curriculum that is context driven and service oriented, (2) to improve residents' understanding of the social determinants of health by allowing them to learn about the causes of health and disease in a specific population (homeless and addicted individuals), and (3) to achieve the first two goals while remaining limited enough in scope to fit into a preexisting residency curriculum.

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should learn it, we have been able to provide all OHSU internal medicine residents a relatively brief, but extremely rich, opportunity to engage the personal, social, and health-related issues experienced by clients served by CCC. To illustrate this, we first provide a brief overview of the curriculum. We then describe how we used the principles and practices of community-based participatory research (CBPR) to do so. Finally, we end with a discussion of the challenges regarding teaching medical residents about the social determinants of health, and we offer an explanation of how an academic–community partnership can help overcome those challenges.

## The Curriculum

### Curricular elements

The OHSU/CCC Social Medicine Curriculum was launched in July 2006 and is divided into two parts: Phase I and Phase II. As part of their ambulatory medicine training, all internal medicine residents have a four-week general ambulatory block in their intern year and a four-week ambulatory block focusing on chronic illness management in their second or third year. The social medicine curriculum occurs one day a week during each of these blocks, allowing residents to

experience the curriculum twice during their residency. Residents rotate through Phase I of the curriculum as interns and Phase II as residents.

Phase I of the curriculum consists of a seminar series that provides residents with a cognitive framework and introductory fund of knowledge. This didactic series includes sessions on the continuum of care philosophy that underpins CCC's services, health policy and the health care safety net, motivational interviewing, complementary and alternative medicine (CAM), addiction medicine, and an integrated approach to the management of chronic pain. Guided by faculty from CCC as well as faculty from OHSU, Phase I also attempts to deepen residents' understanding of the causes and consequences of homelessness and addiction through clinical experiences in traditional biomedical care settings and also through exposure to alternative health care, homeless outreach, and chemical dependency services such as drug and alcohol detoxification and outpatient treatment (see Table 1).

In Phase II of the curriculum, residents choose one of three pathways that allow them to tailor their experiences to their interests: an addiction pathway, a primary care pathway, and a community

outreach pathway. In this phase, residents spend two days per week in experiential learning. Residents who choose the addiction pathway participate in weekly meetings of an outpatient drug-and-alcohol recovery group at the CCC and provide clinical care to recovering addicts at the inpatient detoxification center. Residents who choose the community outreach pathway divide their time between providing posthospitalization services for low-income and homeless patients, and traveling with case managers providing outreach to the chronically homeless through CCC's Community Engagement Program. Residents who choose the primary care pathway provide primary care at the CCC primary care clinic and urgent care to patients in alcohol and drug recovery at CCC's Hooper Detoxification Center.

### Evaluation

Beginning in academic year 2007–2008, the residency program received IRB approval to use both qualitative and quantitative methods to evaluate the impact of the curriculum on residents' attitudes, knowledge, and behaviors. For quantitative evaluation, we are using a mix of evaluation tools, some adopted from a previously validated survey<sup>15</sup> and others that we, the authors, developed

**Table 1**  
**Phase I of the Social Medicine Curriculum at Oregon Health & Science University, 2007\***

Curriculum week	Didactic session†	Experiential learning session‡
Week one	Orientation to Central City Concern and the Social Medicine Curriculum <ul style="list-style-type: none"> <li>• Overview of curriculum</li> <li>• "Virtual tour" of CCC using a PowerPoint presentation</li> </ul> Organization of Healthcare and the Safety Net System	Orientation to Central City Concern and the Social Medicine Curriculum <ul style="list-style-type: none"> <li>• "Physical tour" of CCC: (1) Hooper Detoxification Center; (2) CCC health services, (3) outpatient alcohol and drug recovery services, and (4) housing</li> <li>• Old Town Clinic primary care</li> </ul>
Week two	Motivational interviewing	Hooper Detoxification Center
Week three	Complementary Medicine for the Internist Addiction Medicine An Integrated Approach to Management of Chronic Pain	Drug and Alcohol Recovery Process Group; Acupuncture Group
Week four	Wrap-up: <ul style="list-style-type: none"> <li>• Reflection piece</li> <li>• Ideas for future projects</li> </ul>	Community engagement program CHIERS Van/Sobering Station (can be done at any time during the four-week curriculum)

\* This curriculum, established as part of the school's training for internal medicine residents in 2006, was designed in conjunction with community partners at Central City Concern (CCC), an organization addressing homelessness, poverty, and addiction in downtown Portland, Oregon.

† The didactic sessions are from three to three and a half hours long.

‡ The order of the experiential learning sessions may vary depending on number of residents per rotation. Each session is three hours long.

internally. These tools have been combined to create one scale, which is administered before beginning the curriculum, again at the end of the first time through the curriculum, then at the end of each participant's residency, and then two years after graduation. Each resident's experience of the curriculum is measured qualitatively through taped wrap-up sessions and anonymous "reflection pieces" written by the resident at the end of the rotation.

Though we have not formally analyzed our data yet, resident feedback during the taped wrap-up sessions, and feedback from the reflection pieces, suggest that the curriculum may be changing the way that residents think about caring for homeless and addicted patients. In fact, it may be changing the way residents think about caring for patients in general. As one resident noted in a wrap-up session, "I need to be more mindful in my approach. . . . Today I didn't talk as loudly as I usually do. I try to give them time to talk. I try to meet people where they are. It's a hard thing to do, and it works. I need to do it with all my patients." Others remarked that they now see persons with addictions and the homeless more as individuals, as people, than they did before the rotation. As one resident put it, "I feel less judgmental." Still others were struck by the social conditions they observed while working with the outreach teams: "Now I truly understand what we are sending patients back to when we discharge them," and "I think that this has changed my view as a physician and how much I have to think about their disposition once they leave the hospital, what resources they'll have available to them one they are outside of our care."

### Community Partnership in Curriculum Development

The tradeoff to ensuring that all residents in an established program experience a new curriculum is that the curriculum must then necessarily be molded to fit within the time allotted. Given those constraints, we were acutely aware of the possibility of creating what Delese Wear<sup>16</sup> has termed a "safari-like" curriculum, in which students become "tourists" among the poor, never leaving their own comfort zones and never fully engaging in the lives of those they encounter. To address that concern, we drew on principles

and practices of CBPR to develop a curriculum that our community partner felt would be meaningful and that would address context-specific health concerns of the homeless community served by CCC.

The philosophy underlying CBPR is that programs, research or otherwise, that aim to understand and improve the health of a population, particularly a disadvantaged population, must (1) draw on local knowledge and resources and (2) provide community members with the capacity to engage in the process and products of research.<sup>17</sup> Fortunately, OHSU has an ideal partner in CCC, an organization staffed largely by formerly homeless and/or individuals in recovery, and deeply committed to addressing the needs and concerns of the homeless community of Portland, Oregon. Staff at CCC were able to provide leadership in developing curricular elements that would allow residents to engage more fully in the lives of the population served by CCC.

Beginning in February 2006, faculty and staff from CCC and OHSU held a series of meetings to develop the Social Medicine Curriculum. From an educational standpoint, a primary concern for OHSU faculty was that residents gain a greater understanding of the social determinants of health while also acquiring skills that would allow them to provide optimal care to a vulnerable population. From a clinical and service-oriented standpoint, clinicians and administrators at CCC were primarily interested in ensuring that the curriculum enhance services to their population and that residents would be adequately prepared to deal with complex needs of CCC's often quite fragile patient population.

Specifically, CCC staff were concerned about (1) the potential for discontinuity of care and difficulties with physician/client trust if clients saw different resident physicians each month, (2) OHSU physicians' potential inability to accept the patients' values and behaviors, even as they work to alter some of those behaviors, (3) OHSU providers stereotyping the CCC clients rather than getting to know them as individuals with unique life stories, and (4) lack of understanding of and even contempt for CAM, which plays a significant role in the primary care and recovery services

provided by CCC. Each of these concerns was addressed in the curriculum design until CCC staff felt satisfied with the outcome (see Tables 2 and 3).

Fortunately, and not surprisingly, once CCC staff articulated the knowledge and skills that they felt residents needed to optimally care for CCC clients, it became clear that those were precisely the types of knowledge and skills that would move residents toward a greater ability to understand and address the social determinants of health affecting the CCC population. CCC staff continually moved didactic elements away from abstraction and toward the very specific, grounded knowledge and experiences they wished residents to have.

For instance, where OHSU faculty suggested a seminar addressing cultural competence and communication, CCC staff were much more concerned that residents understand *individual* life stories and personal trajectories. They were less concerned that residents understand the "culture of homelessness" and more concerned that they receive training in how to "meet clients where they are" and that they have multiple opportunities to hear individual stories and struggles. Thus, we replaced a seminar called Culture and Health with a seminar called Motivational Interviewing, which taught that skill. Similarly, CCC staff were less concerned that residents be optimally efficient when they saw patients in clinic, and more concerned that their clients continue to receive continuity of care and that they not be rushed through the clinical encounter. Thus, CCC staff repeatedly reminded OHSU faculty that although teaching about the social forces that affect health is an enormous topic in the abstract, those forces affect individuals in very concrete, obvious, and teachable ways.

### Discussion

According to the World Health Organization's Commission on Social Determinants of Health, social determinants of health are any "social conditions that can affect people's health." These determinants include, but are not limited to, poverty, lack of or unstable employment, housing instability, stress, addiction, inadequate education and illiteracy, poor health care, and social isolation.<sup>18</sup> Stonington and Holmes<sup>5</sup> take the definition of social

Table 2

## Seminars of the Social Medicine Curriculum at Oregon Health &amp; Science University, 2007\*

Original Seminar Title	Modified Seminar Title	Change	Rationale
Orientation to CCC, to health care for the homeless, and to the rotation	Orientation to CCC, to the continuum of care, and to the rotation	Changed from discussing "health care for the homeless" to discussing a continuum of care to end homelessness	Reflecting the CCC philosophy that individuals require a network of care, which includes but is not limited to health care, to end homelessness and addiction
Organization of health care in the United States and Oregon: Introduction to Community-Based Participatory Research (CBPR)	Organization of health care in the United States and Oregon, with an emphasis on health systems gaps and the effect of cuts to the Oregon Health Plan	Added content that specifically addressed the health systems obstacles faced by the poor and underinsured, deleted intro to CBPR	The population served by CCC has generally fallen through the gaps in the health system; therefore, those gaps should be emphasized and explored. CBPR was deleted because of a lack of interest from CCC staff
Culture and Health	Motivational interviewing (MI)	Removed a session devoted to culture as a whole and replaced it with an MI session devoted to assessing concerns on an individual and particular level	Staff at CCC were emphatic that all OHSU residents receive training that would help them meet clients "where they are" and without preconceptions; culture and communication are considered less important
Health Disparities in the United States	Complementary medicine, addiction medicine, and an integrated approach to chronic pain management	Removed entirely the original session and replaced it with the modified, didactic one	Staff felt that it was crucial for physicians in training to understand the CCC model of integrated primary care and addiction services for its clients, using both allopathic and naturopathic methods; health disparities was eliminated because of overlap with Session Two and time constraints
Wrap-up session to discuss what went right, what went wrong, what was learned, and what should be changed	Wrap-up session to discuss what went right, what went wrong, what was learned, and what should be changed	No change	No change needed

\* These seminars are part of a curriculum that was established as a component of the school's training for internal medicine residents in 2006 and designed in conjunction with community partners at Central City Concern (CCC), an organization addressing homelessness, poverty, and addiction in downtown Portland, Oregon.

determinants one step further, suggesting that the social determinants of health are not limited only to large-scale social forces such as poverty and unemployment, but that "finer-grained" forces such as cross-cultural miscommunication and power differentials in provider-client interactions also influence health and health disparities. Thus, according to these authors, addressing the social determinants of health means addressing not only the already-too-large issues of global and local socioeconomic inequalities but also the less imposing, but still vast, issues of culture and communication.

Unfortunately, it may be precisely because the range of issues covered by the term *social determinants of health* is so

immense that providers, students, and even many educators hesitate when asked to think about and address the social context of health and health care. There is simply no way that a provider (or social worker or nurse or case manager or educator) can address each of the social forces that deleteriously affect an individual's health, and, to our knowledge, there are no standard pedagogical approaches for teaching medical residents about the social determinants of health.

However, review of the social science, educational, and health science literature on teaching, on cultural competence, and on community-based care suggests that there are effective, powerful models for teaching about the social context of

disease. For instance, scholars and educators generally agree that to begin to understand the complex and interrelated social factors that lead to disease and to health disparities among the poor and disenfranchised, students must be exposed to the specific historical, socioeconomic, and geographic contexts within which disparities arise.<sup>16,19,20</sup> Some have linked this exposure to experiences in service learning in which learners begin to comprehend the impact of social forces on health through direct experience in service and through reflection on those experiences, and many undergraduate and graduate medical education programs have successfully modeled service learning in their curricula.<sup>15,21-25</sup>

Table 3

**Experiential Learning Sessions of the Social Medicine Curriculum at Oregon Health & Science University, 2007\***

Experiential Learning—Original	Experiential Learning—Modified	Change	Comments
Old Town Clinic one or two afternoons a week	Old Town Clinic—one afternoon a week; residents to see two or three patients per session; the same preceptor at CCC each week to personally meet and speak with the patient each visit	Reduced resident time in primary care clinic and increased the time available to see each individual patient; increased preceptor involvement and continuity	Additional opportunities for experiences outside of primary care reduced the time available in clinic; time per patient was increased so that residents could talk with clients for as long as they needed/wanted to; increased preceptor involvement for increased continuity of care
Portland Alternative Health Center (PAHC)—shadowing a naturopath practitioner	Alcohol and drug treatment groups and acupuncture	Change from shadowing a naturopathic practitioner to participating in a treatment group, followed by a group acupuncture session	This provided residents a greater opportunity to understand the process of recovery, to share stories and experiences with individuals in recovery, and to experience acupuncture first hand
CHIERS (Central City Concern Hooper Inebriate Emergency Response Service) van ride-along and observation at the sobering station	CHIERS van ride-along and observation at the sobering station	No change	No change needed
Hooper Detoxification Center—one half-day observing intake and assessment at the subacute detoxification center	Hooper Detoxification Center—one half-day beginning at 7:30 am observing intake and assessment at the subacute detoxification center	Faculty asked residents to arrive at the detoxification center before the doors opened, to have a chance to talk with individuals in line for assessment	Again, this reinforced the importance of individuals' life histories and individual trajectories
None	Community engagement program—ride along with case managers as they provide outreach, and sometimes nursing care, to dually diagnosed addicts	Added this program	Provides a model of effective outreach to those who seem hardest to reach

\* These experiential learning sessions are part of a curriculum that was established as a component of the school's training for internal medicine residents in 2006 and designed in conjunction with community partners at Central City Concern (CCC), an organization addressing homelessness, poverty, and addiction in downtown Portland, Oregon.

Taking these models a step further, medical educator Wear<sup>16</sup> has argued compellingly for the importance not just of exposure to the context in which disparities arise, but for *longitudinal* exposure in which trainees move out of their own comfort zones and into less comfortable contexts in which they must negotiate relationships and roles unfamiliar to them. Without these longitudinal contacts, she argues, curricular experiences are akin to the "safari" experiences alluded to above, "where 'tourists' view the unfortunate inhabitants who need these services. A few hours at a homeless shelter does not address the issue of affordable housing any more than a few hours at a hot meal program addresses how some people find themselves in circumstances without enough money to buy food."

Wear's<sup>16</sup> argument is convincing. It also presents a challenge to established medical education programs and, perhaps, particularly to residency programs, which are struggling to meet the Accreditation Council for Graduate Medical Education's program requirements while also complying with more restricted resident duty hours. A few residency programs, such as the Albert Einstein Residency Program in Social Medicine, are structured entirely around understanding social determinants through longitudinal, community-based health care experiences and, as such, clearly provide the in-depth contextual exposure Wear advocates.

However, understanding the social determinants of health is not the primary aim of the OHSU internal residency program, nor is it the primary goal of

most residency programs, and although programs may wish to address social determinants in a meaningful way, the structural, institutional, and financial barriers to implementing a longitudinal, community-based experience for all residents are significant. Our challenge was to develop a curriculum that would "fit" within the scheduling constraints of a categorical internal medicine residency program and that would give all internal medicine residents, regardless of their ultimate career aims, a chance to engage with ideas, issues, and individual lived experiences that illustrate the social determinants of health. So, just as residents rotate through renal consults and the ICU to be able to understand renal pathology and critical care medicine, regardless of whether they plan to be nephrologists or intensivists, we felt

that it was essential that all residents rotate through CCC to be able to have at least an introductory understanding of the social determinants of health. Following the lead of staff at CCC, we also felt that it was essential that we offer residents multiple opportunities to hear clients' stories and to become personally involved in clients' lives. In this way, we hope that residents' understanding of the social determinants of health moves beyond the theoretical and is instead grounded in very local, very personal involvement in the individual, social, and health-related issues faced by clients at CCC.

### Summing Up

The underlying premise of the OHSU/CCC Social Medicine Curriculum is that to produce a generation of physicians who can apply an ethic of social responsibility and civic engagement to the consideration and alleviation of disease-promoting structural inequalities, clinical training must first provide them with the tools both to understand what those inequalities are and how to address them. To accomplish this, we have attempted to unite and apply experiential learning theory and the principles of CBPR. We have also attempted to integrate the social medicine curriculum into a traditional internal medicine residency program so that all residents will graduate with a better understanding of the nature of health disparities among socially marginalized populations and will have some sense of the possibilities of working with those populations to address community identified needs.

A four-week curriculum will not be sufficient to teach all there is to know about health care for the poor and underinsured, nor to "solve" the health-related problems suffered by a single community. Similarly, a curriculum focused on understanding the forces affecting homeless and addicted individuals will necessarily provide residents only a very limited picture among a very limited population of the role of social forces in determining

health. However, it is a first step. As stated earlier, our initial efforts to evaluate the curriculum indicate that it has indeed deepened residents' understanding of the contexts that will shape the health of some of their future patients. Our hope is that by taking this initial step, we will spur residents to continue to investigate, and perhaps even address, the causes and consequences of health and disease among individuals living on the social and economic margins.

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