Medical Education for What?: Neoliberal Fascism Versus Social Justice

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Abstract

In her 2018 book, *What the Eyes Don't See*, Dr. Mona Hanna-Attisha wrote that it is the duty of doctors to speak out against injustice. In fact, no other physician or institution in Flint had done the research and spoken out, as a whistleblower, against the poisoning of Flint's children by Michigan government. Why had Dr. Hannah-Attisha? Unfortunately, in the absence of a medical education system that teaches *community-oriented primary health care* in the tradition of the 1978 Alma Ata Declaration, there is little reward in doing so. This article focuses on three movements that are challenging medical education orthodoxy: 1) primary health care 2) the medical humanities and 3) "Study Up your Town" medicine. How can we create a radical health pedagogy – one that draws the links between several pandemics raging across the planet: capitalist collapse, climate disruption, Covid-19, racism, and an emergent neoliberal fascism – to enable doctors, health professionals and citizens to see them as *all of one piece*? Medical educators must employ critical pedagogy to create legions of "constructive troublemakers" who challenge the social-structural obstacles that are driving millions to premature death. We have reached the "end times." A new "planet medicine" is finally emerging.

Keywords Medical education · Medical humanities · Primary care · Anthropology · Critical ethnography · Whistleblowing · Environmental justice · Critical pedagogy · Planet medicine

Medicine is a social science and politics is nothing else but medicine on a large scale.
Rudolf Virchow, MD, anthropologist (1821-1902) (Ashton 2006)

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“Stay in your lane”

When Dr. Mona Hanna-Attisha blew the whistle on Michigan’s Governor Snyder, she went home, dropped to her couch, and sobbed. Her husband was unable to console her. “I couldn’t imagine feeling good again ever,” she said (2018, 263). Earlier that day, on September 14, 2015, Dr. Hanna-Attisha, a pediatrician at Hurley Medical Center in Flint, provided definitive evidence that the Snyder administration was poisoning over eight thousand children from the Flint River. Their blood levels of lead (a potent neurotoxin) had risen over two hundred percent from drinking the tap water. After the press conference, she was immediately criticized by the Snyder administration, who called her research “unfortunate” and said she was responsible for creating “near hysteria” (260).

Dr. Hanna-Attisha was feeling especially vulnerable because her employer, Michigan State University, dramatically distanced itself from her in the days leading up to the press conference. She had received an “unsettling call” from MSU’s Dean Aron Sousa, saying that “Nobody from the university will be attending” the September 14 press conference. Dr. Sousa said that, “the university supports you as a member of the faculty. ... but it cannot support your research” (251). As Dr. Hanna-Attisha writes in her 2018 book, *What the Eyes Don’t See*, her internal response was, “What? I found this strange hair splitting – supporting me but not my study – confusing and disturbing. I worried I was being thrown under the bus already.” She told Sousa that this was her job as a pediatrician and told him it was also the medical school’s job: “Our mission as a community-based land grant medical school is to ‘Serve the People’” (263).

To make matters worse, her mentor and close confidant, Dean Sienko MD, the Associate Dean of Public Health at MSU, told her that she “was stepping out of [her] lane and into a role that would threaten people,” and that he would not be attending the September 14th press conference either (252). Sienko was a Major General in the Army Reserves and had served in Iraq. According to Hanna-Attisha, “he thought in military terms with everything.” To the relief of many, two weeks after Dr. Mona Hanna-Attisha’s press conference, the Governor relented and announced that he was stopping the use of Flint water and switching back to the much safer Lake Huron water from Detroit. Dr. Hanna-Attisha’s enormous gamble had paid off.

In *What the Eyes Don’t See*, written after she was recognized as a national hero, Dr. Hanna-Attisha wrote that it is the duty of doctors to speak out against injustice. In fact, no other physician or institution in Flint (including the University of Michigan which has a Flint campus) had done the research and publically spoken out. Why had Dr. Mona? Whistleblowing is not the norm for physicians, academics, or middle-class professionals. Unfortunately, in the absence of a medical education system that actively teaches *community-oriented primary health care* in the tradition of the 1978 Alma Ata Declaration (Nutting 1990) and the World Health Organization, there is little reward in doing so. Coincidentally, a significant historical contingency sheds light on Dr. Mona’s difficulties. Between 1992 and 1998, I was the chief evaluator for a \$6 million Kellogg Foundation grant to Michigan State University who would challenge biomedicine to alter the medical curriculum to create community-oriented primary care practitioners. The grant was intended to educate physicians to do precisely what Dr. Mona Hannah-Attisha, alumnae of Michigan State University, had done. I discuss the “Community/University Health Partnerships” (C/UHP) project below (McKenna 1998).

This article focuses on three movements that are challenging medical education orthodoxy: 1) primary health care 2) the medical humanities and 3) “Study Up your Town” medicine, a movement both old (public health, medical social sciences, renegade physicians, and

muckraking journalism) and new, as it is now being reinvented as a medical practice by Dr. Mona Hanna-Attisha and a great many others outside of biomedicine. My work as a critical ethnographer of MSU's C/UHP in 1992–98, propelled my future work as a critical medical anthropologist in Greater Lansing and other Michigan company towns for over thirty years, including Dow Chemical's Midland, Michigan (McKenna 2009) and GM's Flint (McKenna 2018). During this time, I have been involved in all three movements and know the issues from the inside, as an anthropologist, medical education evaluator, government public health professional, health and environmental journalist, Indian Health consultant, Executive Director of an environmental activist group, and whistleblower (McKenna 2010a, 2010b).

More specifically, in this article, I ask three overarching questions: 1) “How can we create a medical education system that produces thousands of Dr. Mona Hanna-Attishas – an education in which Dr. Mona's actions become the norm, rather than the exception?” 2) How can we rethink medical education and create a radical health pedagogy – one that links several pandemics raging across the planet: capitalist collapse, climate disruption, Covid-19, racism, and an emergent neoliberal fascism – to enable doctors, health professionals and citizens to see them as *all of one piece*? This is an end times, multi-pandemic pedagogy that activates the fierce urgency of now for professionals and citizens alike. We may only have ten years to alter the tide. 3) What are the chief obstacles for achieving the first two goals? First, I turn to obstacle number one.

Neoliberal fascism in the end times – like the 1930s, only worse

In 1939, the renowned sociologist Robert Lynd, writing against Hitler and the rising tide of fascism across the globe, wrote a book that is as relevant today as the moment he penned it, *Knowledge for What? The Place of Social Science in American Culture* (Lynd 1939). In it, he argues that, “the role of the social sciences is to be troublesome, to disconcert the habitual arrangements by which we manage to live along and to demonstrate the possibility of change in more adequate directions.. .. Like that of a *skilled surgeon*, [social scientists need to] get us into immediate trouble in order to prevent our present troubles from becoming even more dangerous. In a culture in which power is normally held by the few and used offensively and defensively to bolster their instant advantage within the status quo, the role of such a constructive troublemaker is scarcely inviting...” (181). Dr. Mona Hannah-Attisha is such, a “skilled surgeon,” a pediatrician who simply told the truth in order to protect her children. She is a medical doctor who used social science and medicine in order to “prevent [Flint's] present troubles from becoming more dangerous,” and she is a “constructive troublemaker” in the end times. As such, she is a model radical pedagogue.

We have entered the “end times” of our world. Scientists call it the Anthropocene – a new geological age, beginning with the industrial revolution, in which human activity has become the dominant force on the climate and the environment. Climate change threatens to make two-thirds of our planet uninhabitable by 2100. When combined with related threats, some see a “perfect storm” of annihilation on the horizon. The threat of nuclear war at its highest in history (the Doomsday clock has moved to one hundred seconds before Midnight, the closest to catastrophe since 1953); multiple plagues ravage our bodies, like H1N1, SARS, Ebola and Covid-19, erupting every eight to ten years with unremitting regularity as capital expands into new ecosystems. Hundreds of millions of preventable illnesses, diseases and deaths define our planet. All of this is exacerbated by the rise of authoritarian and neo-fascist governments across

the world, including the United States. All of these plagues fold into one another: one cannot discuss one of them without a holistic framework that combines politics, economics, ideology, medicine and education.

It is very significant that Dr. Hanna-Attisha employed the term, “capitalism,” in her bestseller, which ranks as one of the New York Times one hundred best books of 2018. “While charges have been brought against some of the individuals who were culpable, the real villains are harder to see,” she writes. “Because the real villains live underneath the behavior, and drive it. The real villains are the ongoing effects of racism, inequality, greed, anti-intellectualism, and even laissez-faire neoliberal capitalism. These are powerful forces most of us don’t notice, and don’t want to” (13–14).

An increasing number of theorists are calling Flint something far worse. Sheldon Wolin was among the first theorists in recent times to offer a name as well as a penetrating description of our era in his 2008 classic, *Democracy Incorporated: Managed Democracy and the Specter of Inverted Totalitarianism*. Far from being exhausted by its twentieth century versions, “would be totalitarianism now have available technologies of control, intimidation and mass manipulation far surpassing those of that earlier time,” Wolin writes (McKenna 2018, 53). “Unlike classic totalitarianism with its strong central control and rigid citizen mobilization, our times represent the political coming of age of corporate power and the political demobilization of the citizenry. With the constant downsizing, privatization, outsourcing and the dismantling of the welfare state, the resulting state of insecurity makes the public feel so helpless that it is less likely to become politically active,” Wolin explained (53). In Flint, the historical conditions determined new forms of control. Michigan’s Governor removed all powers from Flint’s mayor and city council and appointed an “emergency manager” to make most of the city’s decisions, including the use of the polluted Flint River for drinking, in order to save five million dollars. Flint became Wolin’s “Managed Democracy,” (Wolin 2008) and the Emergency Manager performed the job of “Manager of Democracy.” The crisis title was a useful veneer to present Michigan government with official, neutral-sounding authority to overrule democratic processes and exclude citizens from decision-making power that would have prevented a catastrophe. It offered legitimization for the collapse of local democracy (McKenna 2018).

Like Wolin, social theorist Henry Giroux argues for a new concept, “neoliberal fascism.” He defines it as a form of extreme capitalism that views democracy itself as the enemy. Neoliberalism is on steroids, having greatly accelerated its path of destruction since its 1970s emergence. It is now upending virtually everything in its path: the commons like public schools and universities; federal lands for oil and gas fracking; public institutions like the Post Office, and most importantly at this moment, public health, leaving millions sick, fearful and dead. Giroux agrees with much of Wolin, but notes that Wolin, now deceased, “had nothing to say about the growing culture of cruelty, the rise of white supremacy, and the extreme mobilization of the conditions that make fascism tolerable again” (McKenna 2018, 54).

Philosopher Hannah Arendt cautioned that “the protean elements of fascism [from the 1930s and 40s] always run the risk of crystalizing into new forms” (Giroux 2018, 53). In characterizing our present moment as such a “new form,” we see that there will always be continuities and ruptures with the past. Theory is fundamental to allow us to uncover, in Dr. Hanna-Attisha’s words, “what the eyes don’t see.” You cannot act on a phenomenon properly if you cannot properly “see” it.

The eyes can clearly see that medical professionals are rendered unable to perform their jobs effectively under neoliberal fascism. Medical science was useless in preventing the Covid-19 pandemic, just as it was unable to prevent the Flint catastrophe. The culture of

neoliberalism created the context in which authoritarians made the key decisions: Governor Rick Snyder in Michigan (still uncharged) and President Trump (impeached but not convicted). As a result, tens of thousands needlessly perish. What lurks behind these empirical realities? It is important to look to the past for reminders, reclamations and recoveries of who and what we are and what is being lost.

In the 1930s, history produced Dr. Norman Bethune, a world-renowned “constructive troublemaker” from Canada who responded to the urgent call for help to fight fascism in pre- World War II, traveling overseas, first in Spain for the Republicans and later in China with Mao’s Eighth Route Army (where he died). Using his extraordinary surgical skills, the independent communist strongly advocated for universal health care in Canada, which was very influential in forming Canada’s single-payer National Health Service decades later. Bethune was a model physician who studied up, down and sideways, stepping out of his lane, to “serve the people” (Chandra 2020). Today he is revered throughout China and in Canada as well. China extols him as its most famous Canadian with two colleges and a hospital named after him, and Canada has named a hospital after him as well. Generally unknown in the U.S., he is one of the most important anti-fascist physicians in history. Crises present excellent opportunities for action, and the crisis of that time spawned a movement that resulted in Canada’s single payer today, saving countless lives, especially during the Covid-19 crisis. To date there are approximately twenty thousand out of a million physicians (about 2 %) involved in Physicians for a National Health Program, which advocates for a single payer approach in the U.S. (PNHP 2020).

Stick to pathology - study down

Still, for some medical educators these histories and social issues are irrelevant for medical education. In a very influential Wall Street Journal editorial, “Take Two Aspirin and Call me by My Pronouns,” Dr. Stanley Goldfarb, the former Dean of Curriculum at the University of Pennsylvania, argues that social justice is “an ideology” that is related to health care only tangentially. He is worried that, “curricula will increasingly focus on climate change, social inequities, gun violence, bias and other progressive causes only tangentially related to treating illness” (2019).

Concurring with Goldfarb is medical educator L. Maximilian Buja, a pathologist at The University of Texas Health Science Center. He argues in “Medical Education: All that Glitters is not Gold” (Buja 2019) that reformers are attempting to replace biomedicine “with a broader biopsychosocial model of health” which has resulted in “the dilution of core scientific principles” and the loss of a firm understanding of the pathophysiology of disease. He wants a “deep grounding in biomedical science,” and is of the view that a “good medical education resembles evolution in that it advances by ensuring the advancement of the fittest” in medicine (2019).

There was pushback to these views. A group called the “Beyond Flexner Alliance,” responded to Goldfarb: “COVID-19 is laying bare society’s underlying structural inequities that increase the risk of exposure, infection, and death for minority and disadvantaged communities across the US... .The attitude that physicians should focus solely on clinical care aims to disempower the profession and frankly, is dangerous” (Beyond Flexner 2020).

Dr. Susan Prescott agrees. In a 2018 article, “From Authoritarianism to Advocacy: Lifestyle-Driven Socially Transmitted Conditions Require a Transformation in Medical

Training and Practice,” she points out that “physicians are the most trusted members of western society” (5), and their educational role is very influential, yet they act as a “border wall” against a broad vision of global health as put forward by the WHO (1). She argues that the “life-style” non-communicable diseases (NCDs) – such as diabetes, cancer, heart disease, stroke, mental illness, stress – have overtaken infectious diseases and that they are primarily caused by social conditions and class position. Prescott argues that physicians are not properly educated to address these illnesses, concerns and diseases that constitute about 80% of presenting complaints.

Regarding Goldfarb’s complaint against climate change education, Prescott cites three recent studies that report that as many as 47% of physicians are at odds with scientific consensus by answering that climate change is either (a) not happening; (b) it is mostly a natural phenomenon; or (c) that human activity is no more of a factor than natural processes (Prescott and Logan 2018, 8). In nutritional science, the lack of a good medical education is equally as concerning. In just one example, medical school graduates in pediatrics were found to be extremely deficient in basic knowledge in an eighteen-question test where physicians’ percentage of correct answers (52%) was “only marginally different in patient groups who completed the same test” (Prescott and Logan 2018, 7).

Moreover, Prescott cites a great number of studies reporting that “authoritarianism, a social dominance orientation and Machiavellianism” are rampant in medical education and getting worse the longer students are in medical school. These traits “are not found in most students,” she says, but “remaining silent on this topic. . . is unacceptable” (4). Furthermore, “patients are rarely involved in decision making dialogue,” in primary care, she reports. In one study “physicians rarely discussed patient preferences, risks and benefits; specifically, 81% of clinical decisions did not elicit patient preferences, 85% did not discuss alternatives and 91% did not discuss pros/cons” (7). The same is true for “community participation” in medical education, which is endorsed throughout the world.

Institutional forgetting – Dr. Mona Hannah-Attisha, and me, at Michigan State University

In 1992, I joined the six million dollar Community/University Health Partnerships project at Michigan State University as an evaluator/medical anthropologist. It was part of a national \$47.5 million effort, sponsored by the W.K. Kellogg Foundation, to evaluate seven U.S. states. The main goal was to create community-oriented primary care professionals by challenging biomedicine’s orientation towards specialization, curative care, professional rivalry, and hospital-based medical education. Citizens were “empowered” to alter the curriculum to address their own needs. Their interests diverged from the medical schools. The community was interested in poverty reduction, health care for all, economic development, interdisciplinary education, preventive care, environmental health and biopsychosocial medicine (McKenna, 2010a, b).

There have arisen many movements to challenge biomedicine’s dominance (McKenna 2011). One, the 1978 Alma Ata movement, can be viewed as “a rejuvenation of the concerns of social theorists of the last century that were undermined both by political forces and by the bacteriological emphasis of the late nineteenth and early twentieth centuries” (Heggenhougen 1993, 214). Assembling in Alma Ata more than one hundred thirty World Health Organization countries unanimously endorsed the revolutionary “Heath Care for all by 2000” declaration.

Barbara Starfield (1992), a medical doctor affiliated with Johns Hopkins University, took the movement as a point of departure in her advocacy of a revolutionary approach to health praxis. Starfield identified two movements or two sets of processes/interests which are embedded in the ambiguous term “primary care” (Starfield 2010). They are primary medical care (PMC) which is directed towards a conventional biomedical orientation (cure, episodic care, passive patient reception, and physician dominance) and primary health care (PHC) which is oriented towards intersectoral collaboration, interdisciplinarity, community participation, and social justice. Starfield conceived of a social change model in which PMC strives to become PHC. She asserted that, “this view requires that a health care system be organized to stress social justice and equality, self-responsibility, international solidarity, and acceptance of a broad concept of health” (1992, 5).

The C/UHP announced it would implement a version of Starfield’s primary health care approach. However, the medical schools actively resisted the Kellogg Foundation challenge by using stall and delay tactics from the start, arguing that accreditation standards prevented them from being interdisciplinary or listening to citizens. There were five different C/UHP directors in the first two years as the project struggled to forge an “ad hoc community curriculum.” One director indicated in a public meeting that he thought the community’s efforts were inadvisable, even though that was the purpose of the grant. “But medical students see themselves as poor in basic knowledge,” he protested, “They don’t like epidemiology and statistics. Students want new knowledge. They are consumed by it. They feel almost paranoid by anything that takes them away from it. It is sort of losing ground. What about disguising these objectives in clinical experiences?” (McKenna 2010a, 9). The idea to disguise the central purpose of the initiative outraged the three community directors (all hired from outside the medical schools – most were social workers). One exclaimed to me, “We saw that the universities would not implement one zillionth of a change. They were satisfied with just didactic education; we wanted multi-professional clinical education as well. I said that if you’re going to spend \$6 million dollars, it’s not enough to change just 2 percent of the curriculum” (McKenna 2010a, 9).

“We’ve had all this before, in the first two years of medical education,” one student told me. “The community is not my client,” another angrily charged. “The client is my client. That’s public health, not us; that’s social work, not us. The Kellogg Foundation project is a waste of my time. We’ve been told that the money’s been sopped up by administrators and deans. Don’t waste our time with this, give us scribe notes” (McKenna 2010a 9). The students had received no orientation by their college and were under a number of misconceptions about the project. Community directors reiterated that students were required to participate in the program, as the grant indicated. Twenty-one allopathic medical students signed a petition to protest their “forced” participation in the C/UHP program. They viewed the program as an “add on” that would interfere with their “real education.” The College of Human Medicine conceded to student demands, permitting them leave the program if they so desired. Eleven chose to do so (McKenna 2010a, 9).

However, there was progress in some of the communities. There was a two-hour seminar, organized by community leaders in Muskegon, called “Poverty and Health.” One of the speakers was an elderly African American osteopathic physician, James Church (pseudonym), who spoke favorably of a country that he had recently visited that had a strong health policy: Cuba. After his talk, Church opened a box at the podium and hurriedly distributed scores of pamphlets by a group called the National Organization for an American Revolution. It was titled, “A New Outlook on You, on Me, On Health” (Boggs 2008). They were highly critical of capitalism and the fifty-five page pamphlet read: “The present system is based upon

maintaining the monopoly of the medical profession in health care” (McKenna 1998, 218). Students devoured them. Many told me that they had been long looking for curricula like this. I wrote an article in the C/UHP newsletter, but it was never followed-up by C/UHP medical school management and was quickly forgotten (McKenna 2010a).

Something remarkable happened towards the end of the C/UHP grant. When Dr. Andrew Hogan, a high level CP/HPE participant, a medical evaluator with tenure, attempted to disclose his findings about failures of the CP/HPE project in 1998, he was charged with “unacceptable research practices” by MSU. Hogan had found that the \$47.5 million project (of all seven national sites) was not cost effective as had been publically asserted. Specifically he found that the nearly \$107 million spent (in Kellogg Foundation and matching dollars) “had been expended to influence fewer than 3,000 students and there was no evidence of significantly increased choice of a primary care specialty” (Hogan 2001, 1). As a result of the disclosure of his research findings, Dr. Hogan was charged with misconduct and spent thousands of dollars in court to defend himself. He later wrote about this publicly in the local newspaper, the *Lansing State Journal* in an article titled, “MSU Suppresses Unflattering Views of Research Efforts,” underlining the point that “whistleblowers are almost the only source of research misconduct. The public has no way to assure the integrity of the research it sponsors and no way to protect those who blow the whistle on research misconduct” (Hogan 2003).

One year later, in a spectacular reinforcement of Hogan’s charges, Michigan State University’s Intellectual Integrity Officer and Assistant Vice President for Research Ethics and Standards, Dr. David Wright, publicly resigned specifically citing MSU’s College of Human Medicine whose “proposals. .. a large portion of the faculty view as secretive in development, ill-considered and highly objectionable” (Wright 2004). He charged that MSU was a university awash in secrecy and as a result, “an institution in persistent decline,” and “in serious difficulty.” (Wright 2004, 7).

Towards the end of the C/UHP project in 1997, I made an astounding library find. In 1990, Dean Andrew Hunt, then seventy-four and retired from MSU, wrote a scathing critique of his profession. In the frank text, titled, “Medical Education, Accreditation and the Nation’s Health, Reflections of an Atypical Dean,” he recounted the social forces that resulted in “a compromise of principle” at MSU. Biopsychosocial explanations were often treated as “temporary hypotheses. .. until the ‘real’ explanation comes along” (Hunt 1990, 51). “Without consideration of humanistic and ethical considerations, [medicine] can be brutal and inhumane” (149). Hunt’s anger led him to suggest that an anti-trust suit might be the appropriate response. “While not ‘illegal’ in the usual sense of the word, under the Sherman Act there is apparently an element of illegality. It seems conceivable that significant changes in medical school accreditation policies could emerge as a result of legal pressures” (137). For his earlier efforts to transform medicine, I was surprised to discover that Hunt had lost his Deanship job in the 1970s, being forced out (McKenna 2012).

Dr. Mona Hanna-Attisha attended MSU’s College of Human Medicine between 1998 and 2002, after the conclusion of the C/UHP project (1992-1998). It is probable that Dr. Hanna-Attisha was never taught anything about MSU’s “radical” C/UHP program, which administrators had undermined from the beginning. She probably knows nothing about Dean Hunt’s “Sherman Anti-Trust Act” text (though it is in the library), nor about Andy Hogan’s courageous whistleblowing against MSU. In addition, she probably has not read anything critical about the history of the C/UHP. This historical knowledge would have validated and greatly supported Dr. Mona Hanna-Attisha’s work. The suppression of this history is dangerous. As

Camus said, “Memory is the enemy of totalitarianism.” History is a weapon, and because it is too threatening to power it is often suppressed.

As it goes for primary health care, so it goes for the medical humanities. Prescott notes that, “for decades the medical humanities have called for expansion into curricula. .. however while individual courses are added, the medical curriculum is stubbornly resistant to needed changes” (Prescott and Logan 2018, 6). Therefore, just as Barbara Starfield’s vision of primary health care endures, despite severe suppression, so do the medical humanities.

“Thinking otherwise” with the medical humanities – against pedagogies of violence in medical school

In 2017, two medical humanists wrote a self-described “radical” book, titled, *Rejuvenating Medical Education, Seeking Help from Homer* (Marshall and Bleakley 2017). In it, they describe medical education as a horror show for many. Robert Marshall and Alan Bleakley, with over forty years of teaching between them, describe “rageaholics” throwing scalpels, widespread degradation rituals (called pimping), bullying, mobbing and sexual abuse. Some of the chapters are: Abuse, Error, Anger, Bone-Tired, Bullying, Whistleblowing, Lost in Translation, and Putting it Bluntly.

The medical humanities are a derivative from bioethics and for years have made important inroads in making medical education more democratic and humane. They intend to make students more empathic, compassionate, and caring (to counteract the competitive patriarchal values dominating medical school), and they equip students with better listening skills, improved interpersonal relations and seek to re-awaken their moral imaginations.

Bleakley and Marshall argued that one way these problems can be addressed is through an exegetical reading and reflective dialogue with Homer’s two texts, the *Iliad* (covering Achilles and the Greek-Trojan war), and the *Odyssey* (in which Odysseus travels for twenty years, visiting many lands). Homer is replete with similar abusive incidents that occur in medical school, and it is the authors hope that the classics (which used to be a standard part of medical education) offer some models for how to treat these in medical practice. In addition to the disturbing chapters named above, they include very insightful chapters titled Compassion, Lyricism, Sing-Muse, and Resilience, qualities that are also evident in Homer’s tales. The authors seek to abolish the “doctor as hero,” motif, an expectation in which physicians feel s/he must do everything. Another aim is to demonstrate effective ways to act as social change agents. Building on decades of teaching medical students, they primarily educate students to “think otherwise.”

Dr. Trisha Greenlaugh MD, wrote the Foreward. She is one of the top primary care researchers in the world, and in framing the book, she writes that that the world has fallen prey to STEMM ideology (Science, Technology, Engineering, Mathematics and Medicine), which privileges *reductionism* (over critical thought), *abstraction* (not real world experience) and *standardization* (a single, correct a moral imagination). Greenlaugh’s summation is uncannily similar to Zygmunt Bauman’s magisterial work, *Modernity and the Holocaust*, in which he warned that one of the ways that higher education supported the Reich was through instrumental rationality and the extreme focus on positivist science (not history, humanities or the critical/interpretive sciences): “The facts of the Holocaust are capable of telling us about the hidden capacities of present day life” (2000, 223). In other words, modernity will probably generate many Holocausts to come. While giving a nod to Arendt’s “banality of evil,” thesis,

he argues that “the banality of reason,” is of equal importance. This occurred in Nazi higher education: “German universities, like their counterparts in other modern countries, carefully cultivated the ideal of science as an emphatically value free activity; they bestowed upon their wards the right and the duty to serve in the ‘interests of knowledge’ and to brush aside other interests in which the welfare of scientific pursuits might clash. Once one remembers this, he said, the keen cooperation [of doctors] in Nazi tasks loses much of its shocking power” (2000, 126). Alessandra Colaïanni notes that more than 7% of all German physicians became members of the Nazi SS, even though it was voluntary, participating in torture, murder and genocide. She adds, “It is a disturbing legacy seldom discussed in medical school, and unrecognized in contemporary medicine” (2012, 435).

The medical humanities are committed to resisting undemocratic, paternalistic and fascistic authority structures. In his 2019 Routledge *Handbook of Medical Humanities*, an edited compendium with forty-four leading medical humanists, Bleakley focuses on fascism in the very first paragraph of the 440-page collection. He writes that there is no better account of resistance than Peter Weiss’s (2005) novel *The Aesthetics of Resistance*, “in which a group of young socialists growing up in pre-WWII Nazi Germany are part of an underground resistance movement. They meet in galleries and museums to study art, honing their humanitarian beliefs through discussions about relationships between aesthetics and the politics of resistance” (1). Fascism has now returned.

In *Rejuvenating Medical Education* (Bleakley 2019), Bleakley and Marshall tell the stories of Homer, as a guidepost for medical education. As Greenhalgh writes, “We learn the skills of reflection, and how to deliberately and imaginatively place ourselves in the position of others through stories ... Through stories, we learn that the world is not fair; that men and women are not born equal in terms of their material circumstances or the character traits they can bring to bear on these circumstances; that hopes and dreams and traditions are important; and that all choices have moral significance and unintended consequences (xiv).” Importantly the book devotes an entire chapter to whistleblowing, a central theme of this article.

In Greek times, Marshall and Bleakley note, whistleblowing was called *parrhesia* or truth telling, where frank speaking out against injustice was encouraged despite the consequences. They remind us how dangerous this act is. Citing Foucault, Marshall and Bleakley inform us that “In the Chinese legend, the mandarin who knows he must contradict the emperor orders carpenters to build him a coffin and take it with him to court” (182).

In the *Iliad*, the seer Calchas decides that he must address King Agamemnon with *parrhesia*, or “fearless speech,” because he knows the origins of a plague and that knowledge will highly enrage Agamemnon. He does something important. He asks Achilles, a very powerful rival of the King, to swear he will help him. Achilles agrees. The reaction of the King is fury. Agamemnon was so “angry, his heart filled with a black passion and his eyes flashing with flame.” If Achilles were not there, Calchas would likely have been murdered.

A key informant, an anthropologist who has worked in top tier medical education for over thirty-five years told me, in a piece worth quoting at length:

Do you really believe that there is any hope for whistle-blowers and renegades inside the hospitals, clinics, private practices and the like, when they are burdened by debt and fighting for their professional lives? Like Diogenes, I am searching for a physician honest enough to speak up about the systems they are enmeshed within, and see nobody in this pandemic environment actually being a whistleblower. Those that have spoken out in places like New York have been sidelined or fired, even amid a pandemic. Have I

heard any of them once speak out against injustice since I was an Assistant Professor of Medicine in 1984. No. What I heard them speak out about, right up through the first months of the pandemic is how much money they were losing as a result of the procedures they could not perform because the hospitals were turned over to Covid cases. Can a conservative profession like medicine be a change agent, with a practice environment regulated as it is under neoliberal austerity? What about the rigidity of the young people who go into medicine, who are fully enmeshed in a STEM universe, where they are regimented for a decade and one-half (high school through residency) of rigorous, heartless pedagogy? (Anonymous #2 2020)

Reinforcing this view is a general surgeon from the Midwest who wrote anonymously (“I’m not going to sign this document. .. I still need my job for a few years”) in the *Scandinavian Journal of Surgery*, an article titled, “We Continue to Drift into a Totalitarian Medical System: A View from a County Boy” (2018). He wrote that:

“The role of whistle-blowers in today’s hospitals can be compared to that of *suicide bombers*. If you wish to report any malpractice or on any misconduct in your hospital, be it malpractice or corruption, you do not have a chance to survive. These days most hospitals will ask you to sign a “non-disclosure” form: you agree not to disclose or discuss anything about anything pertaining to the hospital outside its walls. Any query, any issue has to be brought to the management. In most cases it will be ignored.” (Anonymous #1 2018, 4)

These testimonies make one better appreciate the courage of Dr. Mona Harris-Attisha. She literally was risking her job, her mental health and her family’s security. One reason that Dr. Hanna-Attisha survived is that she instinctively did some of what Homer recommended. She went to her more powerful mentor, Dean Sienko, to shield her. He discouraged her but still stood by her, no matter how reluctantly. Another is because she assembled a scientific team, checking and rechecking her findings “over a hundred times.” Clearly, her community-oriented primary care was not something encouraged by Michigan State University, Hurley Hospital or the government.

Dr. Hannah-Attisha is one of the fortunate ones. It usually does not work out that way. Dr. Barbara Johnston has written about the work of being an activist and whistleblower, especially in relation to doing environmental justice work (Johnston 2001). She warns about associated risks. Environmental justice work “requires confronting, challenging and changing power structures.” When someone is involved in this work, says Johnston, “backlash is inevitable.” “When environmental justice work involves advocacy and action – confrontational politics – a number of professional bridges are burned.... Cause-oriented’ anthropology suggests people who make trouble. Troublemakers are celebrated in this discipline when their cause succeeds and justice prevails. However, ‘justice’ is elusive, success is hard to gauge, and action results in unforeseen adverse consequences (2001, 139). Most are targeted and forced to retreat, as we have seen with Dr. Hogan who left MSU or Dr. Bolsin, an anesthetist whistleblower mentioned in Bleakley’s chapter, who was labeled a troublemaker, fired and later moved to Australia.

Fortunately, there are many ways to expose the truth: secretly sourcing the information as an informer to a journalist, confiding to a trusted superior, anonymous communications, through art and fiction. As an environmental activist once told me, “It’s more important that the truth be heard than to tell the truth.” The “truth” can thunder mightily or dazzle gradually (McKenna and Darder 2011). Bleakley and Marshall’s curricular idea is solid. One needs a

safe place to talk about bullying, abuse, medical error and whistleblowing because nearly all medical students will witness ethical improprieties during their careers. The authors provide a curricular place where questions like this can be expressed and it helps future physicians develop a moral compass.

In sum, Bleakley and Marshall's dialogic form of pedagogy about medical abuse, ethics, justice and survival – using Homer's classics – are imaginative and provocative – a very welcome addition to medical education. Pedagogically, Bleakley and Marshall open the door for a much wider dialectical discussion with students on their personal and historical concerns. The book does not do everything, of course. They admit as much, encouraging us to be auto-didactics. We require further discussion, from a thousand sources on issues such as labor history, the inner workings of capitalism, the placebo effect, proletarianization, integrated medicine, complementary and alternative medicine, the history of medicine, political economy, Big Pharma, planet medicine, and an emergent neoliberal fascism. In fact there is no one key book/practice that will do the job of politically educating medical students (or their teachers). In the view of the “critical pedagogy” school, education implies political praxis, which is sometimes risky, in order to test radical knowledge and transform the culture and yourself, just as Dr. Mona Hanna-Attisha did. Transforming medical education will require risky critical practice as detailed in classics like *Pedagogy of the Oppressed* by Paulo Freire (Freire 1970), *Rejuvenating Medical Education*, and *What the Eyes Don't See* as essential resources for medical students to understand, critique, and transform medical education and practice environments.

Thinking otherwise with Dr. Mona Hannah-Attisha – get out of your lane and “study up” your town

Was there something unique about Dr. Mona Hanna-Attisha that might help explain her exceptional courage? A review of her biography makes it appear she was destined to be a whistleblower. Her “radical” education began in her toddler years. Mona was a refugee from Iraq “where a right-wing fascist had risen to power (7). Her father stood up to the fascist, Saddam Hussein, refusing to work on bombs as a civil engineer, and her mother was a chemist and a women's rights pioneer, being one of only two women in her Baghdad university. Dr. Hannah-Attisha's entire extended family were “leftists,” often jailed for their resistance. Finally her family were forced to flee Iraq, first to England and then to Detroit, Michigan where they settled in a tiny house in Royal Oak, Michigan, when she was four. Her mother would constantly read Mona stories of Bagdad and of her great Iraqi heritage. Mona Hannah-Attisha absorbed much of the medical humanities of her culture, including folk tales like Sinbad, Ali Baba and Aladdin. She was proud that Iraq was historically the center of mathematics, astronomy and medicine. It was where *The Canon of Medicine* was written – and taught throughout the world for six hundred years.

In high school, Mona Hannah-Attisha befriended Elin and both became very heavily involved in environmental issues, leading a club that campaigned to elect John Freeman, an environmentalist and lawyer who was fighting to bring down the Madison Heights incinerator, which was causing asthma and COPD. They knocked on doors, distributed literature, and he won, and stopping the incinerator. Later, Mona went to the University of Michigan in Ann Arbor, where she created her own major in “Environmental Health” and befriended Bunyan

Bryant, the world famous founder of environmental racism. Mona Hannah-Attisha had become a leading medical/environmental student.

Yet, when the Flint water crisis happened, Dr. Hanna-Attisha seemingly suffered social amnesia, forgetting her background. When patients asked about the distasteful and colored water, she said that it was safe for drinking: “just boil it.” “I assumed that the state knew what they were doing.” By chance, Elin, her old grade school friend, came for a visit to her home in 2015 and “the urgency on her face was unmistakable.” She asked Mona about the Flint water crisis. Elin had become a water specialist with the EPA and knew almost everything about it, most through a colleague, Dr. Mark Edwards, who exposed the lead water crisis in Washington DC and won a MacArthur Genius Award. Edwards was beginning to research Flint on his own. Apparently, Dr. Hanna-Attisha’s *eyes had learned not to see* in medical school, but Elin put her in touch with Edwards, and she immediately started to study the issues – around the clock. The point: without the contingency of that meeting with an old activist friend, Dr. Mona Hannah-Attisha might never have come forward. That tells you something about the socialization processes in medical education. Dr. Hanna-Attisha made an extraordinary confession in the book and that makes the book even more revelatory about the power of biomedical ideology.

Finally, Dr. Hanna-Attisha “studied up” at power. Her book provides a detailed guide of how to do it for all physicians. First, she read the backlog of newspapers, which had been producing muckraking reports on the Flint water crisis for nearly a year. Soon she contacted Dr. Mark Edwards and arranged a meeting between him and Dr. Sienko, two powerful overlords of health policy who had years earlier strongly disagreed with one another, publicly, about a lead water crisis in Lansing (Edwards was proved correct). She formed a group, called in her networks, did the research and made sure her science was 100 % correct. She reached across the aisle and tried her best not to alienate anyone, and then she spoke out that fateful September day.

Today, as Pediatric Residency Director, Dr. Mona Hanna-Attisha gives tours throughout Flint to her new residents and makes them study the social causes of disease. She makes them watch “Unnatural Causes,” a seven-hour PBS documentary about racism, capitalism, and the social determinants of health. She is surprised that many of her white medical residents know nothing about the Tuskegee experiments and know little about the history of racism in the United States. She teaches them. Her book has become a field guide on how to become a “constructive troublemaker.” It is not about the money. She quotes Marx favorably in his observations about money: “It transforms fidelity into infidelity, love into hate, hate into love, virtue into vice, vice into virtue, servant into master, master into servant, idiocy into intelligence, and intelligence into idiocy” (253). Moreover, she talks of one of her heroes, Alice Hamilton, “a stubborn badass who devoted her life to improving the lives of workers, the poor, and children” (149). Hamilton studied medicine at the University of Michigan in the 1890s and served with Jane Adams at Chicago’s Hull House. When “she began touring city slums, mineshafts and factories, discovering more than seventy jobs that exposed workers to lead” (149). When things are hard for her in Flint, Hanna-Attisha turns to Hamilton for inspiration.

The tree of knowledge consists of roots, branches, stems and leaves. The root is the origin, the first organ to appear when a seed germinates. It is also called the *radical*, the “primary” source (like the “*primary care*” of the mother or doctor). The stems are byproducts. Medical education focuses on STEMS, not ROOTS. As such, I call Dr. Mona Hanna-Attisha a **ROOT** doctor, more than a **STEM** doctor. In my mnemonic, ROOT stands for **R**adical history (her history of Flint, herself, her family, her patients and capitalism); **O**ntological truth (questioning

the meanings of “health” and “medicine”); **Organizing skills** (assembling effective meetings and engaging with people from all cultural/political persuasions to find allies, while still working with those with whom she disagrees); and **Transformational humanities** (her book is a captivating tension-filled story, full of hard-won lessons, that communicates so well that it transforms readers). Unfortunately, these ROOT skills are not taught (or are marginalized) as an “add on” in medical education, where the pressures on doctors to perform instrumental tasks can be overwhelming and inhumane.

For an excellent elaboration of the forces working on medical doctors, we need only turn to Jeff Schmidt’s *Disciplined Minds, A Critical Look at Salaried Professionals and the Soul-Battering System that Shapes their Lives* (2000). Schmidt describes the socialization process in universities [and medical education] as a process of fostering political and intellectual subordination. The process “ultimately produces obedient thinker – highly educated employees who do their assigned work without questioning its goals. Professional education is a battle for the very identity of the individual” (2). The experience can be brutal. Schmidt argues that professional schools attempt to break individuals into politically subordinate roles to prepare them for employment, undermining independent thinking.

It is not about “staying in your lane.” It is about “getting out of your lane.” You must expect trouble, and must learn how to protect yourself. At its core, education is about thinking: “Thinking otherwise,” as Bleakley and Marshall so well put it, and about trouble. Thinking always leads beyond itself, into new areas of knowledge and action. Most people are not comfortable with thinking because it always leads to questioning authority: the authority of knowledge, of your teachers, your administrators, your managers, and yourself. However, solid research and thinking – and exposing the truth – are radical acts in these dangerous times.

Henry Giroux sums up what the admixture of neoliberal fascism and the plethora of plagues – viral, climate, political and ideological – has done to our culture:

One consequence is that truth, evidence, and science fall prey to the language of mystification and legitimates a tsunami of ignorance and the further collapse of morality and civic courage. What this pandemic reveals in shocking images of long food lines, the stacking of dead bodies, and the state sanctioned language of Social Darwinism and racial cleansing is that war has become an extension of politics and functions as a form of pandemic pedagogy in which critical thought is derailed, dissent suppressed, surveillance normalized, racism intensified, and ignorance is elevated to a virtue. The coronavirus pandemic has made clear the false and dangerous neoliberal notion that all problems are a matter of individual responsibility. (2020)

Philosopher Hannah Arendt’s words resonate with doctors ordered by administrators to keep quiet about abuse, corruption, medical errors and public health catastrophes, endangering themselves and others:

Politically speaking, it is that under conditions of terror most people will comply but some people will not...Humanly speaking, no more is required, and no more can reasonably be asked, for this planet to remain a place fit for human habitation. (Popova 2017)

In transforming medical education, we need to develop the civic courage to speak out as public intellectuals, as Dr. Mona Hanna-Attisha did. Social responsibility must rise to the fore as this planet is fast becoming unfit for human habitation. The first two years of medical education should therefore focus on history, the arts, the social sciences and humanities – including

anthropology, political economy and psychology – *these are the liberation arts* – the ROOT (not the STEM) of the tree of knowledge. It is the end times, after all. We need all the “constructive troublemakers” we can muster.

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