Medical Education Under Siege Critical Pedagogy, Primary Care, and the Making of "Slave Doctors"

by Brian McKenna

> *"If the structure does not permit dialogue the structure must be changed."*
> Paulo Freire

Introduction

I begin by sharing an excerpt from a stunning speech by Leon Eisenberg, MD, in which he spoke truth to power before approximately 300 medical students, educators, and administrators at Michigan State University (McKenna, 1998).

Here is Eisenberg:

"Like the ancient Greeks there will soon be two types of doctors, slave doctors and free doctors. Which will it be for you?"

Slave doctors are those who dutifully marched to the orders of bean counters and bureaucrats, practicing "cookbook medicine" and seeing 40 patients a day, Eisenberg said. Free doctors placed people's humanity front and center. He explained that they fully understood the dictum that "medicine is a social science, politics by other means, and politics nothing but medicine on a grand scale," a phrase uttered by the 19th century socialist Dr. Rudolph Virchow.

Eisenberg cited Virchow as one of his medical heroes, and echoing him, delivered a lecture that accused the medical profession of fostering a "hidden curriculum" that socialized students to keep quiet in the face of unethical behavior. The audience, and I, sat frozen.

"Four out of five medical students witness unethical practices among their peers, but most find themselves afraid to challenge behavior which they privately deplored," he told us. Eisenberg described biomedical education as a system of "cultural indoctrination" in which "the first year student is reluctant [to speak out], against injustice while the third year student does not even hear [about] it."

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He said that this socialization experience helps to create conservative medical providers. "Courage and morality," he said, "atrophy with misuse."

I recorded Eisenberg's words in the final months of my critical ethnography (1992-1998) of medical education at MSU (McKenna, 1998, 2010). It was the first time in five years of research that I'd heard anyone in my fieldwork mention Virchow's name, a name I knew very well. So rare and unexpected were the truths he spoke that day that they deserve close scrutiny. In fact, my anthropological study of medical education, presented below, corroborates the essence of his statements, and more. As I was to discover, sustained critical dialogue about social problems and the politics of medicine is seldom permitted in medical "education" curricula.

Why is this so, and how can it best be addressed?

This article offers some answers. It is structured in four parts. First I address questions regarding the social etiologies of illness and disease. Second, I present background about a $6 million Kellogg Foundation project that attempted to reform medical education in Michigan. Third, I review some highlights from that Michigan project and its aftermath (1992 to 2011). Finally, I present an analysis and conclusion.

Why Are We Sick?

Virchow's famous aphorism bears repeating: "Medicine is a social science, politics by other means. And politics is nothing but medicine on a grand scale." Today that's truer than ever. But it's not taught in medical school.

In medical school, it's the opposite. It might be said that in medical education, "Medicine is a pathophysiological science, biochemistry by other means, and biochemistry is nothing but poor lifestyle choice (and bad genes) on a grand scale."

If only that were the case. In fact, the major etiologies of illness and disease disseminate from on high. When looking for causes of cancer, for example, one must first investigate the dominant culture before reflecting on one's individual lifestyle. As epidemiologist Devra Davis argued in *The Secret History of the War on Cancer* (Davis, 2007), it was through corporate suppression, government inaction, and medical ineffectiveness, that ten million cancers over the last thirty years were entirely preventable. I was an editor of that book and wrote journalistically about it (McKenna, 2007). Davis informs us how aspartame, medical x-rays, and cell phones (see Davis, 2010), among hundreds of other agents, are cancer contributors. But medical education focuses on the diseased body, not the body politic (Smith-Nonini, 2010).

Medical politics contribute to massive misinformation about my own cancer, melanoma. It is not well known that sunscreen is a cause of melanoma since it generally does not protect well against UVA rays. That means it gives people a false sense of security in the sun. Yet medical doctors continue to advise sunscreen

as a first defense and few say anything about hats, clothes, or shady structures in pediatric visits (McKenna, 2008). In 1999, after the FDA began making motions to require truth in labeling, sunscreen manufacturers responded with an intensive lobbying effort via their trade group, the Cosmetics, Toiletries, and Fragrance Association. Leading the lobbying charge, which won the day, was John Roberts, who today sits as the Chief Justice of the U.S. Supreme Court.

Critical medical anthropologists call the dominant medical system "biomedicine," a scholarly conception that accounts for the narrow microbiological orientation of this field (Baer, Singer & Susser, 2003, Rhodes, 1990). Despite having the most expensive health care system in the world, the United States continues to rank last when compared to six other industrialized countries — Australia, Canada, Germany, the Netherlands, New Zealand, and the United Kingdom — on measures such as quality, access to care, equity, efficiency, and the ability to lead long, healthy, productive lives, according to a 2010 Commonwealth Fund report (Squires, 2010).

One way that biomedicine addresses this contradiction is to argue that "primary care" is the answer (Starfield, 1992). However, the term is extremely ideological. The practice it depicts, within biomedicine, is usually "first contact," episodic care by a physician. This modality reproduces the conservative orientation towards passive "patient" reception, the marginalization of citizen voice and the clinical denial of the social origins to illness and disease. This last point is extremely important. It means that at the precise "teachable moment" when citizens have just secured relief from their immediate suffering by the doctor and are open for critical dialogue about its causes, their consciousness is displaced back onto their bodies by the "teacher/doctor" who refuses to convert private pain into a public issue (either in the clinical encounter or in his after-clinic work). Blame goes to a semi-fictitious "lifestyle choice," not to a pernicious neoliberal order (Bauman, 2010).

In fact, the primary causes of *preventable* illness, injury, and disease — capitalist social relations — need to become the "primary cares" of medicine. As David Sanders, MD, argued, the fundamental causes of ill health are out of the control of [the biomedical profession], and "indeed, any open recognition of the real causes would call into question the very system that allows [medical professionals] to own and market their commodity" (Sanders, 1985:117).

Many factors influence health and disease etiologies. There is a wealth of evidence that biological, environmental, psychological, political, economic, sociocultural, and other factors interact at any one time in either disturbing or enhancing health (McKeown, 1976; Antonovsky, 1994). This is known as the biopsychosocial concept (Engel, 1977), and was conceived in 1978 by the World Health Organization (WHO) (Coriel and Mull, 1990). It was one of the main principles behind the Primary Health Care Declaration of Alma Ata, which promoted "Health Care for All by 2000." A related concept is the precautionary principle (better safe than sorry) (McKenna, 2004), which serves as a basis for the environ-

mental movement. These two mighty ideas are marginalized in medical education (McKenna, 1998). Marginalized as well is the wealth of recent evidence that indicts social inequality as a primary source of unnecessary morbidity and mortality (Cockerham, 2007).

Medical students are trapped in a rigid system of structured denial in their formal education (Schwenk, 2003; Singer, 2009; Waitzkin, 2005). By the time of the reclusive patient visit, the immense social power of a physician as a potential critical public intellectual has long ago been neutered by a prolonged socialization process stretching from "pre-med" to "MCAT" to "med school" to "graduate medical education," (GME) during which time she has been taught to refuse social science in deference to the natural sciences of biochemistry and pathophysiology. In the drama of medicine, the doctor helps perform the hard work of a neoliberal culture by reproducing the conditions for "wage slavery" of the worker/citizen (Braverman, 1974), who is pacified to be "patient" and not "active" (McKnight, 1995).

The field of critical medical anthropology (CMA) makes these points (Baer, Singer & Susser, 2003; McKenna, 1998, 2008, 2010; Singer, 2009). Like critical pedagogy, CMA fosters "problem posing" education, which seeks radical solutions to widespread suffering and oppression. CMA studies a wide array of cultural issues from ethnomedicine and political ecology, to alternative medicine and political economy. It explores the health implications of exploitation as identified by Marx in his illumination of the labor theory of value (Braverman, 1974).

This article argues that "primary care" and "medical education" must be dramatically transformed along the lines established by Rudolf Virchow, critical social science, and Paulo Freire. However, as this case study illustrates, the structure of medical education largely precludes critical inquiry, and those who challenge it must be prepared for the consequences.

For the past two decades, since arriving in Mid-Michigan from Philadelphia in 1991, I've "studied up" the culture, resources, and power dimensions of medicine, education, and the environment. As a critical ethnographer, I assess forms of hegemony and counterhegemony in Greater Lansing, home to the state capital, site of General Motors' largest production facilities, and the locale of Michigan State University, the state's largest higher education institution. During this period, I've worked as an applied anthropologist, researcher, and teacher in seven key areas: medical education (1992-1998), governmental public health (1998-2001), medical/ environmental anthropology education (2000 – present), Executive Director of the environmental nonprofit Localmotion (2002-2003), environmental journalism (2001- present), media journalism (2002-2003), and melanoma prevention research (2004-present). I also serve as a judge for the American Anthropology Association's annual Virchow awards.

This article focuses on my work as an educational evaluator for a $47.5 million effort, underwritten by the W. K. Kellogg Foundation, called Community Partnerships in Health Professions Education (CP/HPE). It took place in seven

states (Massachusetts, West Virginia, Georgia, Texas, Tennessee, Hawaii, and Michigan), and each of the seven projects received about $6 million. Our site project in Michigan was called the *Community/University Health Partnerships* (C/UHP). It was based at MSU and three associated communities in Saginaw, Houghton Lake/Alpena/Roscommon, and Muskegon.

On paper, the project was quite radical. The mission was to create community-oriented primary care professionals who courageously challenged biomedicine's orientation towards specialization, curative care, professional rivalry, and hospital-based medical education. Remarkably, local communities were to be empowered to shape and create the medical curriculum.

My job was formative evaluation (Stufflebeam & Shinkfield, 1985), designed to help the project "succeed." It soon became apparent in my evaluation that the community interests dramatically diverged from the medical schools. The community wanted something dialectically different than the medical schools. Through participant observation, semi-structured interviews, and surveys, I discovered that local citizens involved with the project desired health care for all, poverty reduction, more jobs, economic development, alternative medicine reimbursement, mental health services, better nutrition, team approaches to health care, preventive care (e.g. prevention of chain saw accidents), and environmental health improvement (e.g. addressing a dioxin hot spot). All of this is called "social medicine" in the tradition of Virchow, and yet citizens did not have a language for it.

One might think that such a spectacular project would have had quite an impact on the medical schools (there were two medical schools at MSU, an allopathic and an osteopathic). But today if you ask around the campus, it's as though the $6 million C/UHP never existed!

In fact, when a tenured medical economist, a "cluster evaluator" within the Kellogg project employed by Michigan State University, dared to tell some truths about the failures of this project, he suffered greatly, as I detail below (Hogan, 2001, 2003; McKenna, 2010). His public punishments greatly delayed the publication of this article.

My work over two decades integrates three theoretical problematics: 1) critical pedagogy (McKenna, 2008, 1998, 1986); 2) critical medical anthropology (McKenna 2010, 1998); and 3) public pedagogy, including journalism (McKenna, 2003, 2009, 2010, and forthcoming 2011). Synthesized, these problematics amount to a new practice I call "critical social medicine" (McKenna, 2009; McKenna, 2010), discussed below. As such, this article is a form of critical pedagogical resistance against the hegemony of biomedicine.

This work provides strong support for Sheldon Wolin's assertion that the United States is on the verge of becoming an "inverted totalitarian" culture (Wolin, 2008). 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 down-

sizing, 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.

Critical pedagogue Henry Giroux concurs, arguing that the United States has become "proto-fascist" (Giroux, 2007), and that we are subject to "the terror of neoliberalism," (Giroux, 2007) and, as a result, must "take back higher education" and become public intellectuals ourselves.

A great many of the culture's brightest young people, desperate for secure futures while wanting to do good, are turning to medicine. What is going on in that "black box" of medical schooling?

The Challenge of Primary Care to Medical Education Historically Situating the Project

Medical education has not changed much since Abraham Flexner's report to the Rockefeller Foundation in 1910. Flexner's work resulted in the growth of so-called scientific medicine in the model of Johns Hopkins University. Since then, there have arisen many movements to challenge its dominance. One, the 1978 Alma Ata movement can be viewed as "a rejuvenation of the concerns of social theorists of the last Century (Virchow et al.) that were undermined both by political forces and by the bacteriological emphasis of the late nineteenth and early twentieth centuries (Heggenhougen, 1993:214)."

In 1961, Dr. Kerr White initiated a form of medicine in this tradition. White adopted a population-based, ecological perspective on primary care practice. He argued that it was the social responsibility of medical education to reorient itself to the actual and perceived health needs of a given population. White called for "the full range of cultural and social diversity" in the academy. He included the disciplines of epidemiology, economics, demography, statistics, cultural anthropology, sociology, and social psychology (White, 1991:970).

But 30 years later, in 1991, White concluded that medical educators had essentially failed in this mission (White, 1991), with physicians "providing little insight into the nature of needed changes" (White, 1991:968). "Too often," White said, "[medical academics] are mired in unhelpful rhetoric, unbecoming hubris, and reliance on an outmoded biomedical paradigm that ignores social, environmental, and psychological influences on health and health care."

It was at this point in 1992 that I joined Michigan's C/UHP as a medical education evaluator. As indicated above, a radical proposition guided the initiative. Incredibly, the medical schools had agreed, as a condition of the grant, that local citizens were to be empowered to shape the medical curriculum to address their own community needs.

From an international perspective, the demand for community participation in health was not new. Like the critical pedagogy movement, the origins of the 20th century's primary health care movement were primarily in the second and

third worlds. By the 1950s, government administrators across the world came to the conclusion that the hospital approach to health care had largely failed (Coreil and Mull, 1990). By the late 1970s, Mull (1990:30) reports that “health leaders were ready for an entirely new approach, and were galvanized by the social justice ethic implicit in the drive for ‘Health for all by the Year 2000.’” As a result, in 1978, an international assembly of representatives from over 130 WHO member countries and 60 international agencies met in the Soviet Union to codify this new understanding in a document called the Alma Ata Declaration, named after the location of the conference. The Alma Ata Declaration was approved unanimously. Among its eight essential planks were education concerning prevailing health problems and the measures of preventing and controlling them, provision of adequate food supply and proper nutrition, and community participation in health. The authors of the Declaration drew inspiration from China, Cuba, Tanzania, and the Kerala State in India in order to indicate that high levels of health and social development could be accomplished by a strong political commitment to policies based not on economic growth, but on equity (Asthana, 1994:182). The Alma Ata document said that community participation was an important index of “political will” because the program challenged governments to involve common citizens in assessing their locally felt health needs, defining problems, setting priorities, and helping to implement and evaluate the success of health programs (Coreil and Mull, 1990; Asthana, 1994).

Many health leaders drew inspiration from Paulo Freire, arguing that participation was also an educational endeavor, a way of raising political consciousness and of stimulating people to become involved in the wider development process.

However, as numerous commentators subsequently reported, calls for community participation in health and development contained an inherent potential for stimulating radical socio-economic and political transformation among the rural poor. Heggenhougen states that “in any hierarchical and non-egalitarian society PHC efforts . . . will be repressed when they begin to succeed, since success of necessity implies an attack on existing socio-political and economic structures” (Heggenhougen, 1984:217). The Guatemalan government’s response to the Alma Ata community participation program was to murder some of the health workers (Heggenhougen, 1984; Green, 1989).

In the United States, primary care, as a social movement, is dominated by “primary medical care” (PMC) approaches. That is, “primary care” physicians retain a conventional biomedical orientation of cure, episodic care, passive patient reception, and physician dominance. Building on the Alma Ata Declaration, Barbara Starfield distinguished PMC from “primary health care” (PHC) as a critical practice that challenges PMC through its orientation towards prevention, interdisciplinary cooperation, and community participation in health. However, as we’ll see, Starfield’s conception did not adequately address two other competing visions of primary care: “managed care” (usually tied to explicit capitalist prin-

ciples of clinical efficiencies and profits) and "social medicine" (with Virchow and CMA, oriented towards democratic eco-socialism).

As a critical pedagogue and medical anthropologist, I knew in 1992 that these four discourses and practices were not reconcilable. But as a process evaluator, my job was to advocate for the PHC agenda and align myself with social forces that marshaled it. I now turn to some ethnographic highlights of the case study, followed by analysis and conclusion.

Pedagogy of the Suppressed: The Systematic Exclusion of Community Participation in the C/UHP

The C/UHP's emphasis on community participation was quite prominent. In fact, one Kellogg Foundation position paper quoted liberally from theorists such as Peter Bachrach, Steven Lukes, Murray Edelman, and John Gaventa (1980), all radical democrats and critics of capitalism. The specific monograph, entitled "Concept paper: Change in Community on Empowerment," was written in 1992. In the paper, they noted Gaventa's theory of power as "the internalization of values that inhibit consciousness and participation while encouraging powerlessness and dependency" (p. 2). The political theorists had "relevance to the Foundation's Community Partnerships" in that:

> Over time several changes can be expected. Both sides of the partnership [university and community] should increasingly be represented by a variety of individuals who can speak for, obligate, or ensure that resources will be mobilized and actions will be carried out … Increasingly, the degree to which decisions are considered binding and mutually beneficial to both sides are indicators of a growing empowerment and legitimacy of the community partnership concept. This implies an increasing and meaningful involvement of community in decision making relative to health professions education, an arena in which community was previously not a meaningful actor (pp. 3, 4).

The Kellogg writers supported the idea that the project should facilitate a critical educational consciousness raising, as delineated by Gaventa. However, after the release of the paper, it was buried and never referred to again. Then, for the first two years (1992-93), there was no concerted effort by the medical schools to help forge a community. In fact, there were four project directors, each quitting one after the other.

It was at this time that I decided to resurrect John Gaventa as a framework of my own critical ethnography of the project, and to write my dissertation on it. This involved becoming project historian (Guba and Lincoln, 1989), as well as "studying up" at the modes of decision making in the project (Pottier, 1990). I was familiar with Gaventa and his work, "Power and Powerlessness." I had met him in the 1980s at a conference where he publicly presented the work of Paulo Freire.

I later traveled from Philadelphia to Amherst, Massachusetts to meet Freire at a 1986 Critical Pedagogy conference. There I also met Henry Giroux, Stanley Aronowitz, and Peter McLaren, leaders in the nascent school. My Master's thesis in educational anthropology was built upon their work (McKenna, 1986).

Stall and Delay Tactics: Can Doctors Heal Themselves?

One way that the medical schools and university dealt with the Kellogg Foundation challenge was to use stall and delay tactics. They argued that accreditation standards prevented them from being interdisciplinary or listening to citizens. They said that it was too difficult to implement because no one had ever done anything like this before. So slow was C/UHP development that Kellogg was rumored to have privately threatened to withhold money from MSU in September, 1994. The MSU project then hired its fifth project director to get things in order. The medical schools were pressured to establish more community boards and hire independent "regional managers" in the three distant communities.

Medical school resistance was evident early in project life when the first cohort of students were educated separately. In 1992, medical providers in the first community health center to become involved in the project informed evaluators that the students needed training in "chain saw accidents" and domestic violence, and teaching them how to maneuver through the relatively underdeveloped health resources in the area (referral patterns, access to home health care, transportation to and from health care delivery settings, etc.). One community board member suggested students should spend a day with the postman to see how the population lives. Community members' voiced concerns to us included smoking, transportation problems, alcoholism and its effects on children, pre-natal care, geriatric health promotion, the environment's relation to health, and the cost of rural home health care. The number one concern uncovered in a 1992 assessment of a rural community was a combination of "underemployment/unemployment/poverty," followed by substance abuse, the lack of continuity of health care, and the lack of health insurance. Later in the project, a curriculum calling for a cross-college mandatory curriculum meant to train students in "community competence" was created by an ad hoc committee. These requests met with strong resistance from academicians on campus.

Soon after she was hired, one regional manager said, "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 two percent of the curriculum." When the regional managers began acting, things went down hill fast.

Two years into the project, without warning, 21 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 edu-

cation." In their petition, students quoted lines from their student handbook that apparently gave them the right to refuse participation in any program that would interfere with their education.

"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."

The students had received no orientation by their college and were under a number of misconceptions about the project. Regional managers believed that students were required to participate in the program, as the grant indicated. The allopathic college conceded to student demands, permitting them to leave the program if they so desired. Eleven chose to do so.

Later, as a process evaluator, I carefully informed the regional managers (who had formed an alliance) about the work of Paulo Freire and John McKnight and suggested they find a way to implement them in their work. This was to have telling consequences.

Disguise the Community Curriculum? Ideological Suppression as Normative

Soon afterwards, in an unusual move, the fifth C/UHP project director visited the regional managers as they were forging an "ad hoc community curriculum." He indicated that he thought their efforts were inadvisable. "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?"

The suggestion to "disguise" the community curriculum angered the Regional Managers. Marginalized by the medical schools, frustration was growing. The single working-class representative on a community board charged that MSU followed "the golden rule, those with the gold rule." He said, "MSU came in, hugged the community, went to the Kellogg Foundation and got the money, then took off. Then they looked back and saw the community behind … [After much pressure] MSU went back to the community and formed the regional community board."

Muskegon's Region's Manager planned a two-hour seminar, "Poverty and Health," which nursing students and MSU osteopathic students attended. One of the speakers was an elderly African American osteopathic physician, James Church (pseudonym), who spoke favorably of a country he had recently visited that had a strong health policy: Cuba. Church said that though they were experiencing economic trouble, Cuba "has not cut down on their medical care or their educational system." Health providers there were "more accessible and less elit-

ist" than U.S. medical workers. He advocated Cuba's governmental programs as a model for the U.S.. Church described the Cuban system as a neighborhood-based model that did not segment the population into different plans by class and was thus more accommodating to local people than American medicine.

After his talk, Church opened a box at the podium and hurriedly distributed scores of green and white colored pamphlets by a group called the National Organization for an American Revolution. They were titled, "A New Outlook on You, on Me, On Health" (see Boggs, 2008). They were reprints from 1975. The 55-page pamphlet said that "the present system is based upon maintaining the monopoly of the medical profession in health care." Students gobbled them up. They had been long searching for leadership like this; they were not getting it elsewhere.

A Capital Idea! "Managed Care" Replaces "Primary Care"

Meanwhile, back on campus, within the C/UHP's suite of University offices, I was shocked to find that a new health policy organization made preparations to take over some C/UHP space. At the doorway to project headquarters, the new group's signage was hammered into a position above that of the Partnerships, symbolically supplanting the project's dominance in the office space. The new organization would operate a parallel program with no formal links to the C/UHP. The new sign read, "Institute for Managed Care."

Medical educators, including C/UHP-affiliated doctors and administrators, would go on to attend five splashy managed care seminars to prepare for "the new practice environment." I attended them all. The C/UHP was never mentioned, nor were C/UHP community members invited. The Institute was established from a $1 million grant from a local insurance company. Increasingly in the project the metaphor of "parallel play" became commonplace within the medical schools as they worked on their exclusive curricula.

A Communist Idea? Unmasking Deeper Medical Contradictions

In their continued search for alternative medical curricula, the three regional managers were soon drawn to John McKnight, a biomedical critic and health activist who had authored a widely acclaimed work in 1995, "The Careless Society, Community and its Counterfeits," in which he criticized medicine's "tendency to convert citizens into clients and producers into consumers." McKnight was friendly with two of biomedicine's fiercest critics: Ivan Illich and Robert Mendelson (author of "Confessions of a Medical Heretic," 1979).

McKnight would soon become a touchstone for a countervailing movement in the Saginaw region. They secured him as a consultant in 1997. As an evaluator, I built on this internal font of resistance in the C/UHP by highlighting attention

on McKnight in various internal publications and forums. Ultimately, these developments were marginalized or ignored by C/UHP administrators who, when pressed, said they were constrained by accreditation standards from exploring "creative curricula."

"Creative curricula" was the topic of Eisenberg's 1997 speech (referenced above) before these very same individuals. He suggested that the new Surgeon General issue a warning announcing that "managed care is dangerous to your health," and warned that physicians were being proletarianized [micromanaged and deskilled] by corporate capital.

In the question and answer session that followed his talk, there was a very interesting exchange, which follows.

> A student asked Eisenberg, "Do medical schools have any obligation to train doctors in relation to nurses?"
>
> "If you know how much nurse practitioners do and how they can expand care, clearly yes," he said. "Train them side by side. Why not do it?"
>
> "But won't the increased awareness of the income differential be problematic?" the student continued.
>
> "What are you, a communist?" Eisenberg retorted half-jokingly (for Eisenberg clearly had a socialist orientation). He then added, "side by side is not the same as the same education."

The audience was speckled with numerous C/UHP veterans, including the allopathic dean, curriculum administrators, and affiliated faculty and students, but nobody mentioned the *Community/University Health Partnerships* program that at that very moment (and for the previous six years) was attempting to train doctors and nurse practitioners side by side. I noted also how the word "communist" was bandied about in reference to a training program that mirrored, in intent, the invisible *Community/University Health Partnerships* project.

Eisenberg's address occurred at a ceremony to honor the maverick pediatrician Andrew Hunt, MD, the first Dean of Human Medicine at Michigan State University in the 1960s and 70s. Sitting in the front row, spry and tall at 81, was Hunt. The fact that Hunt was alive to witness this event was a vindication of enormous import, as will become clear.

Recovering the Hidden History: *The Shock of Discovery*

Towards the end of the project, C/UHP officials were dramatically brought to task in a very embarrassing incident. On September 24th, 1998, the Institute for Managed Care organized a conference titled "Partnerships in Health Professions Education." The keynote speaker hailed from Harvard and spoke of the importance of integrating clinical preventive services with "managed care." At one point in his talk, he highlighted what he believed to be the major medical reform commissions and efforts at forging health partnerships within the past 10 to 15 years. He cited

five of them. Amazingly, every major health policy foundation in the country, like Pew and Robert Wood Johnson, was discussed except one: the Kellogg Foundation.

Sitting in the audience was a top administrator from the Kellogg Foundation, who, at the completion of the talk, quickly raised her hand to speak. "I noticed in your discussion of the major medical reform studies, that you did not mention the Kellogg Foundation. Was there any reason for that omission?"

The speaker, caught off guard, said that the Kellogg Foundation did very important work, and that he simply couldn't include everybody. It was just an honest oversight. The Kellogg administrator responded angrily, "The Kellogg Foundation spent nearly $50 million to finance health partnership programs across the country. This university received $6 million for one of them. So, to what extent is the university learning from our expenditures. Could you discuss this?"

Many C/UHP veterans at my table glanced nervously at one another, wondering who would respond. After a long silence, an allopathic administrator slowly rose to speak. She paid homage to the Kellogg Foundation in her remarks and mentioned the "service learning" program in the Saginaw region. But at the end of her statement, she dismissed the C/UHP, saying that the foundation monies were insufficient for the larger purposes. "The world is moving too fast for a 'bolus' approach to curriculum change," she said.

> A "bolus" is a soft mass of chewed food passing rapidly through the digestive tract, I later learned.

Silence! *From Medical Doubletalk to Inverted Totalitarianism*

> *"Any situation in which some men prevent others from engaging in the process of inquiry is one of violence."*
>
> Paulo Freire, *Pedagogy of the Oppressed*, p. 73

I've waited a dozen years to publish this study in an academic journal. A short editorial on it was published in a British journal (McKenna, 2010), but this is the first full exposition of the case study, aside from the dissertation (1998). What was lost by timeliness was gained by insight. As I was originally preparing to publish an earlier version of this article a decade ago, I was taken aback when I discovered that it might be very dangerous to publicly call the C/UHP project a failure. When Dr. Andrew Hogan, a high level CP/HPE participant and a medical evaluator with tenure based at Michigan State University, attempted to tell the truth 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 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 his whistleblowing, Dr. Hogan suffered for years even though he was tenured. 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. Wright specifically cited 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).

My dissertation provided a wealth of evidence to support these claims. Indeed, after hearing Eisenberg's speech in honor of Dean Hunt, I made an astounding library find about Hunt. I discovered that in 1990, Hunt, then 74 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). He also said, "Without consideration of humanistic and ethical considerations, [medicine] can be brutal and inhumane" (Hunt, 1990:149).

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" (Hunt, 1990:137).

Analysis: A Medical Revolution? Social Amnesia Today at the Med Schools

Gaventa argued that the evocation of power has as much to do with preventing decisions as it does with bringing them about. Gaventa would likely view the C/UHP project as illustrative of all three dimensions of power that he uncovered in his portrait of self-interested Appalachian mine owners: 1) people were excluded from decision making power; 2) issues were avoided or suppressed; and, 3) the oppressed's interests went largely unrecognized.

In 1999, the historian Kenneth Ludmerer wrote an accomplished history of U.S. medical education titled "Time to Heal, American Medical Education from the Turn of the Century to the Era of Managed Care" (Ludmerer, 1999). His con-

clusions reinforce my own. Ludmerer charged that in the 1990s, "medical education started to become more tangential to medical practice."

"What was notable," he said, "was the absence of leadership of the nation's medical faculty in the debate over quality." Ludmerer asserted that "in the closing years of the twentieth century, as the public became more and more anxious about the quality of care under managed care, little was heard from medical school leaders on the subject. As Jerome P. Kassirer, editor-in-chief of the New England Journal of Medicine, observed, "the air was filled with a 'strained silence' on the issue" (Ludmerer, 1999:386). Ludmerer concluded his work with these stern words: "Rather than challenge the more questionable medical practices of HMOs, most academic health centers reacted to managed care as a fait accompli and worked mainly to position their institutions to survive within the new marketplace, even adopting high physician 'productivity' requirements for their own faculty so they could better compete for managed care contracts. Academic medicine continued to speak of its unique altruistic and social mission. However, its actions suggested the primacy of self-interest" (Ludmerer, 1999:386).

In other words, power (institutional self-reproduction and appeasement to higher powers) was, and continues to be, medical education's "primary care."

> Gaventa noted, "Freire's notions provide useful insights into the relationships of power and participation … in situations of oppression the powerful try to prevent any real participation of the powerless, for non-participation serves to preclude 'conscientization'" (Gaventa, 1980:209).

That describes my project, the C/UHP, which is evidently a project of oppression. The medical schools succeeded in preventing any real community participation in the C/UHP even while claiming tremendous victory in doing so.

Today, Michigan is a physician "export state" because too many doctors choose to relocate to "states with stronger economies and better climates." By 2011, thirteen years after the C/UHP was laid to rest, Michigan State medical schools had failed, as per the $6 million C/UHP mission, to avert a primary care delivery crisis in some of the associated C/UHP communities (like Alpena County, still a Health Professions Shortage Area). In response, the colleges (osteopathic and allopathic) are increasing their class sizes and asking the state for much more public money in the form of Medicaid and Medicare reimbursements (which pay for education), as well as student loan repayment incentives for those willing to serve in physician shortage areas, like the ones targeted by the C/UHP 19 years ago. The lessons learned from Hunt and the C/UHP are not much in evidence

In the end times of the C/UHP, I consulted my key informant, a physician who chose the pseudonym Hephaestus, the Greek god of fire and metalworking. On the medical faculty for 25 years by 1996, Hephaestus orally relayed the following: "The only way to reform medicine is by revolution and if there is a catastrophic economic collapse … Medicine is not concerned with the truth, but with its own aggrandizement. Our civilization is no better than Rwanda [where hundreds of thousands died in ethnic violence]. Civilization is the thinnest of

veneers … The provision of medical care is a socially acceptable but unconscious payoff for the depersonalization processes associated with an industrialized social structure. You have to mollify the mob somehow. The Roman Colosseum is fun and games. It's Circus Maximus. Keep the mob in its place. As Nietzsche said, 'Insanity in individuals is rare, in nations, epochs and eras it is the rule.'"

Incredibly, I soon found myself in the same situation as Dr. Hogan. In September, 2001, I became a whistleblower myself. As Coordinator and lead researcher for the Ingham County Environmental Health and Improvement Project (1998-2001), after painstakingly uncovering a great deal of environmental hazards in Greater Lansing's air, water, land, and food, the government suppressed the first 130 page study (McKenna, 2001, 2010). The Kellogg Foundation was also a funder of the Health Department at the time. Subsequently, we had the work released by a national whistleblower group named Public Employees for Environmental Responsibility (PEER). The medical schools were silent on the issue even though it drew much media attention. I won the environmental achievement award from The Ecology Center for this work. Unexpectedly, I was invited to become the weekly "Health and Environment" journalist for Lansing's City Pulse (2001-2002), where I went on to write 44 columns on a wide array of social medicine topics that were largely ignored by the medical schools. In some cases, the medical schools and MSU were responsible for supporting corporate pollution and I reported on that locally (McKenna, 2002; McKenna 2010b).

Summary and Conclusion

> *"The two most fundamental determinants of health are the relationship of people to the earth on which they stand and to the community to which they move."*
>
> Carroll Berhorst, M.D.1922-1990

Today's medical diagnosis is bleak. The sequelae of trauma from neoliberal capitalist policies leave millions of people in the U.S. sick, injured, or dead, needlessly. Gross inequality, social isolation, and alienation are endemic. It is not Virchow's revolutionary movement, but an authoritarian movement that dominates our age.

The question we must ask ourselves, as the principle funders of medical education and graduate medical education through our fees and tax dollars, is why do we, as citizens, permit this to be so in a democracy? Why do we permit the very conservative Liaison Committee on Medical Education (LCME), the hierarchical culture of biomedicine and neoliberal university administrations, to have hegemony over a form of education that severely and unnecessarily harms us through its restrictive ideologies, piecemeal practices, and close alliances with corporate capital?

In 2002, a key informant, who happened to be a local politician, exclaimed to me in the midst of a conflict between Lansing and General Motors, "Don't you know, Brian, this is a company town?" I wrote about his remarks and the GM pollution (in which MSU and the Ingham County Health Department sided with General Motors, and in which the medical schools were silent) in several columns as a critical public pedagogue and local journalist (McKenna, 2002a, 2002b). This conception has led me to diagnose Greater Lansing as a new-style company town, the subject of a larger, ongoing work. As I demonstrated above, biomedicine and medical education are central pillars of this ruling power, greatly contributing to the ideological spell of a "company town" culture. This is true across the country. The lion's share of doctors refrain from civic engagement against hierarchy, corporate control, and the knowledge factories of higher education, and therefore educators, social scientists, and journalists must rise to the occasion. They need to seek out progressive health professionals and together expose the culture/resource/power dynamics of their hometowns for the public. Physicians, public health professionals, and local governments, by and large, will not do so, especially in the towns where they live (Balshem, 1993; McKenna, 2002c).

Medical education refuses Berhorst's mission. As a child of neoliberalism, it nurtures cults of professionalism (Bledstein, 1976) and creates "disciplined minds" of conformity (Schmidt, 2000). In his important book, "*Hippocrates' Shadow: Secrets from the House of Medicine*," physician David Newman (2008) offers a "beginner's list" of how biomedicine deceives. As an insider, he testifies that:

> … our knowledge is far more limited than most believe; we advocate and utilize interventions we know don't work; we disagree on seemingly fundamental issues of science; at system levels we care nothing about communication; we choose technology over touch; we openly defy established evidence; we deny and decry a placebo effect while we tacitly accept and enlist it… (Newman 2008:195).

Anthropologist Daniel Moerman (2002) has written extensively about the placebo effect (what he calls the meaning response) and argues that it is a powerful healing modality that should be a fundamental part of medical education ("placebo" means "I shall please"). But it is not. He argues that biomedicine's neglect of emotion, ritual, and culture mean that medical education is "as much of a hindrance as a help" (Moerman, 2002:13). Critical pedagogue Antonia Darder concurs, writing tellingly about the "pedagogy of love" that must also be a centerpiece of critical education. These two ideas are linked in their focus on loving people and "patients." Darder's book, titled *Reinventing Paulo Freire* (Darder, 2002), is apropos for this mission. In reinventing medicine, we must reinvent Freire and Virchow in our efforts to become public pedagogues (see McKenna and Darder, forthcoming, 2011).

Independent scholars and pedagogues can rarely afford the time or energy to conduct holistic social medicine analyses of their own towns and cities. Such a wide-angle "history and physical" (H&P) of the community is a crucial first step in creating the critical primary care for the 21st century. Several important social medicine groups are working hard on this front. A group of physicians with the Montefiore Department of Family and Social Medicine has created an essential website called The Social Medicine Portal (2011), which has an up-to-the-minute assembly of news, readings, and events in this field. The Portal is also affiliated with the Latin American Social Medicine Association (see website below). Also, Dr. Timothy Holtz has assembled an exhaustive reading list on social medicine from his work at Emory (Holtz, 2007). The People's Health Movement is another valuable resource (see: http://www.phmovement.org/en).

In reinventing social medicine, it is necessary to reclaim the fact that Virchow was not only a physician, but also an anthropologist who took enormous risks as a public intellectual. Virchow was viewed as a threat after "writing up about the people's health" (McKenna, 2010) in a government report. He attributed the 1848 typhus epidemic in Upper Selesia to malnutrition, poverty, and the machinations of the upper classes. He published his own weekly journal, *Die Medicinische Reform*, from July 1848 to June 1849. He argued that "at a time when the overthrow of our old political institutions is not yet completed … medicine cannot alone remain untouched; it too can no longer postpone a radical reform in the field" (Rosen, 1974:62). In March of 1849, he was suspended from an academic position as Prosector at Charite Hospital. He so angered Bismark that it is rumored that in 1865 Bismark challenged him to a duel.

Social medicine advocates today sometimes seem to forget that Virchow was a border crosser who entered the world of muckraking reporter and government whistleblower. These are essential aspects of critical social medicine.

In summary, medicine is too important to be left to biomedicine. A critical pedagogy of medical education must entail the rediscovery of the historical conflicts over the meanings, limits, and possibilities of medical science (Grossinger, 1980; Baer et al., 2003). We must show the public how biomedicine and its defenders are obstacles to "primary care" and to "community participation" in health. We must publically challenge the hierarchical pedagogies of the medical-industrial-pharmaceutical complex and eliminate its hegemony over the assembly line rituals from Pre-Med, to MCAT, to LCME, and drug-industry sponsored GME. Social scientists need to teach health professionals how to become adept at strategies of resistance in order to challenge hierarchy and injustice at every turn (Pereira and Almeida, 2005). In short, medical education must be premised on a "critical social medicine" that converts private sufferings into public issues, is cross-cultural in its understandings of disease etiology, and is serious about building a medical infrastructure that challenges the neoliberal culture of capitalism.

Medicine is, potentially, a revolutionary force to transform the culture towards freedom, equality, and democracy.

But medical educators rarely dialogue about these issues in good faith, as this article demonstrates.

As Freire said, "Only dialogue, which requires critical thinking, is also capable of generating critical thinking. Without dialogue there is no communication, and without communication, there can be no true education" (Freire, 1970:81).

This article is a contribution to that dialogue.

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