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Ye Kyung Song
yesong@utmb.edu

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The Medical Student Manifesto

Ye Kyung Song¹

Under neoliberal education systems, medical students are unable to critically engage and develop a critical consciousness because they are forced to master standardized test-taking skills and memorize medical minutiae. As insider-outsiders, medical humanists and bioethicists can shed light on the culture and power dynamics inherent in medical education. Furthermore, the medical humanities could teach medical students to critically reflect on their own human values, and to become ethical and humanistic physicians in the face of the hierarchical culture of biomedicine and neoliberal university administrations. Medical educators, through critical pedagogy, can liberate the medical student and create the potential for changing the culture of medicine as a whole.

Introduction

Medical professionals need a change in the culture of medical education and pedagogy. As a sixth-year MD-PhD student, I have had more time than most of my peers to observe and reflect upon the injustices experienced by medical students during their education. This opportunity has been most fortunate. Many of my classmates continued on to residency and they recount to me horror stories of how they continue to be overworked, underappreciated, and to an extent, oppressed. Like residents, medical students are caught in a bind similar to those experienced by collegiate student-athletes: expected to work

¹ Ye Kyung Song (B.Sc., University of Houston) is a 6th year MD-PhD student at the Institute for the Medical Humanities, University of Texas Medical Branch. Her research focuses on bringing critical pedagogy to clinical ethics education with careful attention to issues of race, class, gender, and disability. The author may be contacted at yesong@utmb.edu.

for long hours and maintain a demanding schedule, while still expected to excel in their academic pursuits. Much of medical education leaves those who suffer through the process feeling uncared for, with concerns about their and their patients' well-being largely unheard. There is a dire need for critical thinking and consciousness raising in medical education: many of the issues that I have heard raised by medical students have to do with larger societal, structural issues. They complain of their patients coming in "too late," without paying enough attention to observe that their patient is uninsured and has very little access to healthcare. They complain of "belligerent patients," without considering the possibility that a patient is advocating loudly for themselves because they don't feel heard in a fifteen-minute encounter. Rather than having students put their heads down and keep working, medical educators need to radically change medical education so that students have a voice and can speak against and address the injustices against the patient they see in the clinic. In the following pages, this manifesto describes how such an oppressive pedagogy came to be, why it flourishes still, and why a call to action from this point forward is necessary.

A History

The Society for Health and Human Values (SHHV), formed in the 1960s and 1970s, was a facet of the larger movement towards bioethics due to a growing concern with the ethical use of technology. It was formed during a countercultural time when all authority figures and power structures were being questioned. It first began with a small group of theologians and expanded to incorporate others in the humanities, and later, physicians and other health professionals. The American Society for Bioethics and Humanities (ASBH) resulted from a coalition of SHHV and other ethics-related groups. Tracing the political origins of the medical humanities and the predecessor organizations to the Committee on Medical Education and Theology and the Society for Health and Human Values (SHHV) reveals a clear mission: addressing the fundamental problems of medical education—depersonalization, the centrality of molecular biology, and the teaching of mechanistic medicine—by committing to reform it through various actions, one

of which was formally educating medical students on human values.² The SHHV aimed to “identify explicitly the human values that are lacking or inadequately represented in the study and practice of medicine and to begin to remedy the deficit Following testing and diagnosis, a dose of the humanities would be prescribed to remedy the deficits of the collective patient, [the medical students],”³ who they found lacking in human values and contributing to a mechanistic medicine informed by Cartesian mind-body dualism.

For its eighteenth annual meeting, ASBH asked important questions about the aim of the medical humanities and bioethics and encouraged reflection upon why these two fields came to emerge. As insider-outsiders, medical humanists and bioethicists can shed light on the culture and power dynamics inherent in medical education. The medical humanities should empower medical students to reflect on their human values in order to become more ethical and humanistic physicians in the face of biomedicine’s hierarchical culture and neoliberal university administrations. Medical students are one of the most disempowered groups in the hierarchy of healthcare providers, and often find themselves focused on one goal: scoring well on their exams. A dialogical education process is an instrument that the medical humanities can use to free the colonized—the medical students—through the use of cooperation, unity, organization, and cultural synthesis. Just as the medical humanists fought against the forces of medicalization, depersonalization, and technology in the 1960s and 1970s, the medical humanists must now stand up against neoliberalism. Neoliberalism, the post-19780s capitalist system which advocates free, unrestrained markets and values an ethic of individualism and individual choice, has reconstituted our universities as corporations that compete with each other for resources and status in a market limited by government resources. Education becomes commodified as improving markers of quality—Step 1 scores, research funding—become the main goal of

² Fox, “Who We Are,” 329-331.

³ *Ibid.*, 334.

our universities. Henry A. Giroux claims that “critical learning has been replaced with mastering test-taking, memorizing facts, and learning how not to question knowledge or authority. Pedagogies that unsettle common sense, make power accountable, and connect classroom knowledge to larger civic issues have become dangerous at all levels of schooling.”⁴ In medical schools, instructors are highly incentivized to teach to the Step 1 exam, prioritizing the rote memorization of basic and clinical science over allowing medical students to self-actualize as humanistic, caring physicians.

It seems as if the medical humanities have been marginalized within the wider field, and there are a multitude of driving forces at play. The medical humanists and bioethicists are interfacing even less with medical schools and students than before, a sentiment echoed by many at the recent ASBH meeting. For example, at my institution, what was once a six-week course in humanities, professionalism, and ethics, consisting primarily of weekly small group discussion comprised of eight students, has been minimized to a once-per-every-eight-weeks meeting of students in a group discussion nearly four times the size. Unfortunately, the humanities and ethics are seen as extraneous and distracting by first and second year medical students, whose one true purpose, as they see it, is to prepare diligently for their USMLE Step 1 exam. Anecdotally, many of my classmates have bemoaned the need to study ethics and medical humanities at all—because, as they stated, they already knew how to be ethical, but they didn’t know the science of medicine yet.

Indeed, under neoliberal university administrations, students are encouraged to think only about Step 1, as the average Step 1 score of a medical school is becoming all important. By way of example, during orientation week, my Dean of Student Affairs and Admissions gave a presentation entitled “USMILE”—a play on the acronym, USMLE (US Medical Licensing Examination), stressing the importance

⁴ Giroux, *Neoliberalism's War*, 6.

of starting to study for Step 1 from that moment until students sat for the exam two years later. She showed us charts and diagrams from the National Resident Matching Programs “Charting the Match” which documents the necessary Step 1 scores and number of publications one should have in order to match into a residency program in the specialty of choice. She stressed the importance of this exam in determining what specialties’ doors would be open and what doors would close. Having no tools to contextualize those percentages and numbers on the first day, newly minted medical students are successfully inculcated with anxiety and uncertainty by the administration and Step 1 panic/mania persists for the first two years. This leaves very little room for self-reflection, as the demands of the curriculum and standardized test preparation take precedence over almost everything else. The third year of medical school leaves little time for self-reflection as well; between being in clinic and studying for the USMLE Step 2—the second of three licensing exams—I personally found myself with very little time or energy to think, much less care, about anything else.

What sort of pedagogy is prevalent in medical schools and what are the forces in power that allow this pedagogy to flourish? Medicine, perhaps because it is a field rife with uncertainties, holds fast to the Cartesian philosophy best characterized as “*theory-centered, not practical-minded*,”⁵ and is the last bastion of the positivists. Epistemologically, medicine loves quantitative evidence in order to prove theories and back assertions. In my experience, when physicians talk to medical students about ethics in small group sessions, they readily cling to the principles of autonomy, beneficence, nonmaleficence, and justice, weighing those principles against each other. Medical students don’t have time to critically think and reflect on their personal values that would help with solving ethical issues. Instead, the current pedagogy promotes a reductionistic, formulaic principalism—one that is easy and readily offers solutions to complex

⁵ Toulmin, *Cosmopolis*, 34.

problems. Ethical dilemmas are reduced to the weighing of competing principles in an attempt to determine an objective moral truth, rather than attending to how the patient and physician experience interactions with each other. Many other rich bioethics approaches, such as virtue ethics, feminist ethics, and narrative ethics, are completely ignored, perhaps because they complicate the picture and muddy the waters. Current medical pedagogy oppresses medical students. Some of this is necessary to produce medical professionals in the process of professionalism, but it dehumanizes students and makes it difficult for them to think or advocate for themselves. They're too busy and stressed out to reflect on the values that are important to them, and in my experience, they often find themselves deeply depressed and anxious.

What Can We Do?

According to Kathryn Hunter, the medical humanities and bioethics should direct medical students to “a model of non-scientific rationality that may point to the rational validity of much that is not scientific in the practice of medicine; an understanding of texts and of how to read them; our own interpretation of medicine’s ordinary medical activity as itself interpretative; and above all, the understanding that medicine is not a science.”⁶ In the medical humanities and bioethics, interpretation is key in teaching medical students to tolerate the messy exigencies and particulars of medicine and clinical practice. Ronald Carson, former president of the SHHV, observes that “moral wisdom resides now as always in practices; however, medical practice today is under siege, pushed by social change and pulled by cultural forces, with the result that the moral wisdom in the practice is obscured. The work of the medical humanists . . . is to discern that wisdom, draw it out, focus it, illuminate it, and extend it so that medical and other healthcare practitioners can reconnect with their moral purposes.”⁷

⁶ Hunter, “*What We Do*”, 377

⁷ Carson, “Focusing on the Human Scene,” 57-58.

By pursuing a dialogical process, the medical humanities and bioethics can teach medical students to ask and answer for themselves the key questions: “What does it mean to be human? And how do we promote human flourishing? . . . we understand that all answers to these questions will be fallible, revisable, dialogic, and incomplete.”⁸ Taking the time to critically reflect upon these important questions and then critique their reality in practice will help medical students be better able to tolerate the inevitable uncertainty they will face in practice, and thus, medical schools will produce critically engaged and compassionate physicians.

As stated previously, many students bemoan the need to take medical humanities and ethics courses, and administrations have also cut down the amount of face-time the medical humanities and bioethics professors get with medical students. In addition, not much has changed regarding the culture of medicine since the advent of the medical humanities and bioethics in the 1960s. We still have the same concerns: that the practice of medicine remains cold, impersonal, and mechanistic. The caring, patient-centered physician is considered to be a rarity, even now. If we go back to the original aim of the Medical Humanities as articulated by the SHHV and compare that with an examination of current medical school pedagogies, *the banking model* of education as understood by Paulo Freire becomes evident. In the current banking model pedagogy, the student is an empty vessel to be filled with knowledge and imbued with humanistic values and ethics, as if medical students have none of their own. Teachers lecture to medical students, hoping to fill them with external and generally accepted knowledge and wisdom in order to give them some humaneness when their sense of humanity already exists—untapped and silenced. Freire argues, “scientific revolutionary humanism cannot, in the name of revolution, treat the oppressed as

⁸ Ibid., 167.

objects to be analyzed and (based on that analysis) presented with prescriptions for behavior.”⁹ There’s an irony in lecturing to medical students as we try and teach them that lecturing to their patients is bad.

However, we should aim towards cultivating a garden of knowledge, viewing students as flowers that, when nourished, grow on their own. As Cole and Lagay write, the medical humanities, in the humanist tradition “[teach] effective verbal communication, [enhance] individual development, and [promote] civic responsibility,”¹⁰ true to its origins of “preparing free men to participate in democracy.”¹¹ The time for a pedagogical shift in medical education—and medical humanities and bioethics education—is now. The medical humanities and bioethics only survived initially due to the partnership of advocates in medicine. Collaboration with medical students is a necessity in the identification of issues that matter to them, the next generation of medical professionals. What concerns do they have about being a medical student, or about the practice of medicine? What concerns do they have about greater society? What about their patients?

The medical humanities should challenge students to think critically about the world they live in, the communities they will serve, and the medicine they will practice. In teaching medical students to be critical thinkers, we must teach responsibly. We must encourage medical students to self-reflect; as educators, “I cannot think for others or without others. Nor can others think for me. Even if the people’s thinking is superstitious or naïve, it is only as they rethink their assumptions in action that they can change. Producing and acting upon their own ideas—not consuming those of others—must constitute that process.”¹² Empowering medical students with the critical tools of self-reflection and interpretation will allow them to

⁹ Freire, *Pedagogy of the Oppressed*, 133.

¹⁰ Cole and Lagay, “How the Medical Humanities Can Help,” 159.

¹¹ *Ibid.*

¹² Freire, *Pedagogy of the Oppressed*, 108.

bear change in the world as they see fit. This will lead to a more humanistic practice of medicine: everyone comes into medical school wanting so badly to positively influence the lives of others, but the humanists and bioethicists cannot do the work *for* them. In a more dialogic model of teaching clinical ethics, medical students would be guided towards identifying *for themselves* the issues they find troubling in clinical encounters. As students, *they* can facilitate the discussion as to what is troubling and what solutions could be taken. Current clinical ethics textbooks indicate a lack of attention to affect: rather than having the student reflect on why, the books tell students that answer B is the right answer regardless of how students feel, because this or that ethical principle takes precedence in the case. From personal experience, having your moral intuition invalidated by textbooks and facilitators that ignore your moral agency is disheartening at the least, and dehumanizing at the worst.

As Giroux notes, “educators will have to focus their work on important social issues that connect what is learned in the classroom to the larger society and the lives of their students.”¹³ We can help medical students speak up against injustices they see. We can help medical students advocate for themselves and withstand the pressures of the neoliberal university so they can practice the kind of medicine that they aspired to when they first applied for medical school. In addition, liberating the medical student liberates the patient and allows for human flourishing for all parties involved in a clinical encounter. Imagine a medical school if Step 1 results were simply reported as pass or fail—how differently would the students act then? Would that not free up more time for self-discovery and flourishing? Moving to pass/fail USMLE Step 1 and Step 2 exams would give students the time to practice self-care; a less oppressive medical school environment would radically change the doctor-patient relationship. Students, instead of wanting to rush home to study more for an exam, would be more willing to sit and listen to their patients in the clinical

¹³ Giroux, *Neoliberalism's War*, 40.

encounter, then help them navigate the mess of paperwork required to obtain additional care. Students, instead of drawing on an empty well of empathy, would have empathy to give. Instead of feeling rushed and uncared for in the clinical encounter, imagine a world where patients walk away feeling as if they have been listened to, have been attended to, and know that the next steps of their care are ensured and accounted for. Imagine a world where these students become attending physicians and continue to give the patients the time and empathy they deserve while teaching their students to do the same. Surely but slowly, the culture of medicine would change. Unfortunately, capitalist structures ensure that pass/fail Step 1 and Step 2 exams would be unlikely: test prep companies (and the National Board of Medical Educators) thrive on the need to score higher than ever before. Many other countries, such as the UK and Australia, require licensure exams, but a quick perusal of student doctor forums reveals that Step 1 is more complex; a more complicated licensure exam does not make a more qualified physician—only one that is more stressed out.

Through critical pedagogy, we can help physicians practice a more humanistic medicine. As Dr. Leon Eisenberg, psychiatrist and medical educator, challenged his audience in a speech to approximately 300 medical students, educators, and administrators at Michigan State University, “Like the ancient Greeks there will soon be two types of doctors, slave doctors and free doctors. Which will it be for you?”¹⁴ Slave doctors, in this case, are ones that mindlessly go through the motions of a patient encounter, checking off boxes in the electronic medical record without getting a sense of the patient as a person. Free doctors have removed themselves from the mire of bureaucracy and are able to practice medicine in a fulfilling way for both themselves and their patients. They *truly care* for their patients. They push back against demands from administrators that require them to meet a patient quota by simply spending more time with each

¹⁴ McKenna, “Medical Education Under Siege,” 95.

patient. Personally, I loved working in a low-income charity-funded clinic because the attending encouraged me to spend as much time with the patients as possible, to counsel on a myriad of issues, and to get to know the patient's wishes, values, and desires. Illuminating larger societal structures will help physicians be the ideal physicians they want to be. As medical students become emancipated and continue in their career to become attending physicians, they can use these insights to change medicine from the inside out, from the bottom up. They will teach their students how they were taught—in a manner that encourages critical inquiry and self-reflection—and the culture of medicine will slowly change. Perhaps in a more emancipated state, free doctors will lobby together to advance political change that benefits patients, such as lobbying together and fighting against policies like the American Health Care Act of 2017, which at this writing threatens the health care access of millions in our country.

As Giroux points out, critical “pedagogy in this instance can be addressed as a moral and political discourse in which students are able to connect learning to social change, scholarship to commitment, and classroom knowledge to public life. Such a pedagogical task suggests that educators speak truth to power, exercise civic courage, and take risk in their role as public intellectuals.”¹⁵ It is a lofty ideal, but a challenge we should nonetheless strive to meet. Perhaps educators should be asking different questions, such as “What can the medical humanities and bioethics do to prevent the commodification of physicians?” or “How can we improve medical pedagogy?” Despite being out of our traditional purview, perhaps it is our job to start that conversation.

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¹⁵ Ibid., 42.

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