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Medical Student Activism: Political x Institutional x Personal

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By Robert Rock and Nientara Anderson

Robert Rock and Nientara Anderson are medical students involved in a broad range of activism efforts at the Yale School of Medicine, including the US Health Justice initiatives (co-founded by Robert Rock) and the History, Health, and Humanities Reading Group (co-led by Nientara Anderson). Robert and Nientara also co-teach a session within the main curriculum for Yale medical students titled “Making the Invisible Visible: Art, Identity, and Hierarchies of Power.” Critical historic perspectives and humanities scholarship are central to much of their work. At the “Critical Histories, Activist Futures” conference, they joined fellow student activists Jenny Tsai (Alpert School of Medicine at Brown University), Amanda Joyce Hall (Yale University), and Viet Trinh (Yale University), to speak on the lunchtime panel “Deploying Scholarship as Activism,” about student activism, medical practice, and the humanities.

Part I: Robert Rock

I am the descendant of a people who stood up to the full force of the Western imperialist project and asserted “liberty or death.” To this day, Haiti is still suffering the consequences of this proud stance. As a first-generation Haitian-American, a Black man in the United States, this history is not abstract for me. That same pride is what motivated my grand-aunt to choose a slow death to uterine cancer rather than submit to the callous treatment of a paternalistic, Western health system that refused to see her as anything other than a disease or a problem to be solved. I was motivated to pursue medicine after witnessing the impersonal violence that robs health and vitality from colonized communities struggling to exist in the shadow of empire. My scholarship is accountable to these communities and the people that raised me.

A reader would not be foolish to assume that the communities I refer to are in distant countries, but they would still be wrong. The impersonal, structural violence that sealed my conviction is domestic and hyper-local. I grew up in a working-class community of color in Southeast Queens, New York and came of age traversing the city’s socioeconomic strata to attend

private schools my family could not afford. As a medical student, these formative experiences motivate me toward critical self-reflection in a way that acknowledges my privilege and weaponizes it in the service of promoting equity. The core of my work toward this aim has been the *United States Health Justice (USHJ) Course*, a semester-long elective course for medical, nursing, and physician's associate students focusing on the structural determinants of domestic health inequity, social medicine, and means of intervention for clinicians. A classmate and I created the course in an effort to provide students with training not provided in our main curriculum.

The USHJ course explores how health professionals can arm themselves to address the health disparities that manifest as a result of societal marginalization and structural inequity. When translated into the language of medical education, this means acquiring the knowledge, attitudes, and skills necessary to be agents of change wherever one decides to practice. However, I've come to realize that in addition to learning new skills, identifying what must be unlearned in medical education is crucial to preventing the perpetuation of the systems of oppression we hope to remedy.

I have come to recognize that a key function of the university is controlling the transfer of power between generations. It is evident in who is given access to these institutions and priority within them. This sentiment is present in the original Hippocratic oath, which swears "… to impart precept, oral instruction, and all other instruction to my own sons, the sons of my teacher, and to indentured pupils who have taken the physician's oath, but to nobody else." When looking at medicine today, I see no difference. Graduate and professional schools may be geographically proximate, but speak languages that are intentionally obscure both to each other and the outside community. Traditionally, the social and economic capital required to access the university made it effectively off-limits to the working class and poor.

With this in mind, I see USHJ as a means to combatting the consolidation of power across generations, to challenge how society's resources are allocated, and to question whom the recorded history serves. To be sure, pursuing this path within an institution that profits off the status quo has been rife with challenges and threats of failure. However, student efforts must be understood within the context of a legacy of struggle, spanning generations, against white, Western, colonial power structures. My access to academia, to medicine, and to a cannon of texts that refute what I have been trained to accept as fact is the product of generations of sacrifice. For this reason, I do not consider any episode of activism as failure. Every day that we survive to sustain one another and forward the cause within institutions never intended for us is a kind of victory.

However, we as health professional students cannot act alone. Forming coalitions that are interdisciplinary and intersectional is a necessary component of our mission, as is relearning to value the languages academia has trained us to forget. To that end, the US Health Justice Collaborative (USHJC) was created as a distinct entity from the USHJ course, in order to build bridges between the health professional schools and a broader movement. Whether young or old, student or teacher, clinician or researcher, university member or not, all are welcomed to participate. The Collaborative is an affinity group dedicated to building community, radical education, and informed action all in the service of promoting justice in our society.

We are building bridges among the isolated, those made to believe they are alone in their interests and told that what they bring to the academy is of no value relative to what they stand to gain. I believe the foundation of the oppressors' power is their ability to convince the oppressed of their powerlessness. Our ultimate goal is to refute this narrative of power and unify the minority majority under the shared interest of creating a more just system.

Part II: Nientara Anderson

Since arriving at medical school in the Fall of 2015, I've noticed that there are (broadly speaking) two main kinds of medical student activism, each of which is received very differently by the administration and faculty of the medical-educational institution otherwise known as the academic medical center.

The first kind of medical student activism concerns itself primarily with the question of access. It posits that the main "problem" in health justice is a lack of access to sufficient healthcare resources. This activism is premised on the idea that the main purpose, the very soul of medicine, is alleviating suffering. Thus, according to this model of health professional student activism, the "answer" is simply, and always, *more medicine*.

The other paradigm of medical student activism is preoccupied with building critiques of medicine itself. In this vein of student activism, the "solution" is emphatically *not* more medicine. In fact, this model posits that medicine itself can be a form of institutional violence. In doing so, this activist framework implicates medicine in the very suffering that medicine claims to assuage. Therefore, the "solution" in this model is to reform medicine and repopulate its ranks, to make restitution for medicine's crimes, perhaps even to reject medicine in its current biotechnological manifestation.

Crucially, these two forms of medical student activism are often received very differently by the administration and faculty of academic medical institutions. The first form of activism, the expansionary/access model, is often met with applause and institutional endorsement. The institution is proud to claim this form of activism, and so plays up its visibility by willingly affiliating the institutional brand with these efforts. In this mode of activism, access is reframed as a perfect and complete substitute for justice – access and justice are seen as perfectly overlapping circles rather than a Venn diagram, a total conceptual eclipse rather than a partial one. And this form of justice, primarily concerned with increasing access to medicine, is not perceived as threatening to the institution. In fact, by promoting and expanding the reach of the institution's healthcare "wares," this access-based notion of justice consolidates power within the institution and shores up its claim to expertise. And so, the institution supports and celebrates it. The exertions performed within this genre of student activism are seen as of-a-piece with the institution's core values and mission, and so they are often characterized as "advocacy" – a selfless, "constructive," and optimistic (if paternalistic) mode of activism.

The second, auto-critical form of medical student activism, on the other hand, is instantly cast by the institution as subversive and seditious. It is frequently met with institutional censure and apprehension. The institution may even seek to disown the actions of its own medical students involved in such activism, or at least to forbid the appearance of its brand, its symbols, its name, or even its institutional garb, in conjunction with these efforts. This form of activism, while not rejecting the importance of access, insists that equality is NOT equity, that distributive justice is no substitute for reparative justice. By adopting this position, this mode of activism undermines the institutionally-endorsed premise that medicine is, in and of itself, an unmitigated good. Indeed, it questions the very notion of medicine qua medicine and destabilizes the institutional claim to absolute expertise on the subjects of health and suffering. In doing so, this activism democratizes and distributes power away from the institution. So the institutional response, at best, is focused on co-optation of these efforts. At worst, the institution disowns and disavows this form of medical student activism, and casts these efforts as distracting and detracting from the institution's core educational and caregiving missions. This form of student activism is often referred to as "political" protest – a self-interested, "divisive," and pessimistic form of activism. Examples of this include NextYSM (a medical student group at Yale that formed in solidarity with the undergraduate organization NextYale in order to protest for greater racial justice and inclusion on the medical campus), WhiteCoats4BlackLives, and medical students visibly participating in local BlackLivesMatter events.

These two forms of medical student activism are further differentiated by

the positional stances and identity claims made by the medical students who participate in each. In the first, the expansion-of-access model of medical student "advocacy," the student "advocate" is positioned as an intercessionary acting *on behalf* of the patient – the medical student is aligned with, but separate from, the person for whom they are advocating. This position of separateness, of distinction from the object of the student's advocacy, relies on the student wholly claiming the identity of a medical student, because it is this identity that gives her the expertise required to perform her advocacy. And since one cannot be a medical student without an institutional affiliation with an academic medical center, medical students involved in this form of advocacy derive a large portion of their legitimacy as "advocates" from their institutional affiliation. Thus, in the advocacy model, all of the student's non-medical and non-institutional identities become secondary to her identity as a medical student affiliated with a particular medical institution.

In the second, auto-critical/protest model of medical student activism, however, the medical student is not positioned as separate from the patient or the non-medical "other." Instead, the medical student activist is positioned within the ranks of the "outsiders" critiquing medicine. And so, affiliation with the broader consciousnesses/communities that represent these other, non-medical student identities becomes relatively more important than the institutional affiliation upon which their status as a medical student depends. In this form of activism, it is often the student's other, *non-medical identities* such as race, gender, nationality, sexuality, documentation status, etc. that legitimize their activism and give them the "expertise" required to formulate their critiques of medicine as well as their proposed reforms. As a result, students affiliated with this form of activism may be more likely to belong to groups of people that have been institutionally marginalized by, excluded from, or historically harmed by medicine. Thus, the medical educational institution's hostility and resistance towards these efforts compounds whatever sense of alienation such students may already feel – deepening the fracture between their elected professional identity as medical students and their other, non-elective, internalized, epithelialized, personal identities.

The point here is not to simply criticize the access-expansion/advocacy model of medical student activism. Equitable access to medical services is an important issue, and initiatives such as medical student patient navigator programs, student clinics, and advocacy to expand existing medical services undoubtedly have concrete positive effects for patients. The goal here is to explore the differences between the access-expansion/advocacy model vs. the auto-critical/protest model of medical student activism as a way of understanding why academic medical institutions respond so differently to each. And from there, to ask other questions. For instance, how does this divergent institutional

reaction affect the different groups of students affiliated with each form of activism in ways that re-inscribe historic injustice and reify existing hierarchies of power? What institutional interests are served by counterposing “advocacy” and “political protest” by medical students? Why is one form of activism considered “political” while the other is not? What societal or soi-disant moral hierarchies are upheld by medical educational enforcement of the distinction between these two forms of medical student activism? What theoretical “givens” in the Western intellectual, academic, and medical tradition provided the conceptual justification for embracing one particular form of medical student activism while fearing and resisting another? And, perhaps most importantly, how can we deconstruct this false dichotomy between these two visions of justice and see them as complementary, rather than oppositional? How could the autocritical/protest model of activism be seen as enriching and informing the access expansion/advocacy model of activism (and indeed, the medical educational institution itself) rather than threatening it?

These are the questions that humanities scholarship can (and must) help us answer – by bringing historical, sociological, theoretical, and phenomenological analyses to bear on these issues. And the urgency of answering these questions lies in the very real personal, professional, and psychological consequences for the medical students who elect to participate in the first versus second form of activism. The mode of activism a medical student chooses and the institutional response she receives as a result of this choice, may affect everything from publication opportunities, to professional recommendations, to feelings of belonging in the social landscape of medical school, to a psychological sense of safety in the learning environment, and even the ability to reconcile her individual identity with her professional identity as a medical provider. And these personal consequences for individual medical students will have broader effects on what types of doctors will shape healthcare, which in turn will affect the structural and individual experiences of healthcare for patients. It is this interdigitation of the political, the institutional, and the personal that keeps us accountable for our scholarship and our activism, reminding us that institutional responses are necessarily political, and that the political is always personal.

Robert Rock is a fourth-year medical student at the Yale School of Medicine (YSM). He is also the co-founder of the US Health Justice elective course and co-creator of the Making the Invisible Visible art tour, which has been incorporated into the mandatory curriculum at the Yale School of Medicine.

Nientara Anderson is a third year medical student at the Yale School of Medicine (YSM), and a masters candidate in the History of Science and

Medicine at Yale. She is a founding member of NextYSM, a co-leader of the History, Health, and Humanities (HHH) reading group, and founding member of the organizing committee for RebPysch, an annual conference on psychiatry and social justice.

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