http://somatosphere.net/?p=14165

Defining “Social Justice” at the Academic Medical Center

2018-01-31 09:22:15

By Marco A. Ramos

I am delighted to contribute to this series on the *Critical Histories and Activist Futures: Science, Medicine, and Racial Violence* Conference. As captured by the submissions published here over the last few months, the content of the conference sparked productive conversations about history, health, and justice that are still ongoing here at Yale. But rather than focusing on the papers presented at the conference, I want to take this opportunity to discuss the organization of the conference itself. Because over the course of the last year, I’ve learned that an academic medical center’s values with respect to big ideas like justice don’t emerge in the content of conferences and colloquia. Once a conference has been organized for the public, its possible content – what you are allowed to discuss, say, and question – has already been defined and delimited in closed-door, private committees involving students, faculty, deans, and grant administrators. It is in the dry agenda of committee planning sessions, I found, where an institutions’ values are laid bare, where administrators express brazenly and without apology what is in and out of bounds, what is “fundable,” what we can “get away with,” as well as what is too political, inflammatory, and subversive for open discussion in the university.

By opening the closed doors of these committee meetings, I hope to show that there are many different “justices” floating around the academic medical center today. We don’t all mean the same thing when we say “justice,” and these various, sometimes conflicting visions are by no means treated equally. Some visions of justice are celebrated, funded, and encouraged. Others are derided, excluded, and labeled too “subversive” or “counter-productive.” And which vision of justice we advance has a lot to say about our own positionality – about our racial, ethnic, gendered, sexual, and professional selves. As Nientara Anderson discussed in her earlier piece in this series, justice means something different to the Ivy League, legacy-admitted white student advocating on behalf of vulnerable populations from a position of privilege versus the activist woman of color, fighting to change a medical school and a profession founded and structured around her exclusion.

This is all to say that “justice” itself is not a transcendental value that

floats above the messy politics, fraught histories, and interpersonal dynamics of academic institutions. Justice is a concept whose meaning can and has shifted over time and place, and whose contours today reflect our particular moment in history and the lived experiences of the people around us. We should treat justice, then, not only as an urgent, ethical imperative that drives our actions, but also as a shifting social category that demands thoughtful critique – especially given its ever-increasing cachet in academic medicine over the last five years. With all the conferences, research centers, and faculty positions springing up around social justice, we need to know where this important concept comes from before rushing to act in its name. What visions of justice animate the academic medical center today? Which are excluded? Whose voices and interests are served by competing visions of justice? And who gets to determine what this important concept means in the first place?

Below, I catalogue some of the struggles over the meaning of justice at my academic medical center. Administrative planning committees, I argue, were sites where different groups sought to advance one particular vision of justice over another by mobilizing the markers of authority (professional, personal, epithelial) available to them. In the first two sections, I discuss the rise of “social justice” as a framing concept at Yale School of Medicine (YSM). I start with my early disillusionment with cultural competency committees and then move to more recent student mobilization and demands for diversity and inclusion at YSM. I conclude with a reflection on how the humanities can help us critically examine the limits of our implicit understandings of justice, as well as expand our imagination about what health justice could be in the future.

I. Committees for Cultural Sensitivity

Discussions around race at YSM have shifted significantly during my long (almost nine years now!) training in the MD/PhD program in the history of science and medicine. Only five years ago, the community of people interested in race and medicine at YSM was isolated and disempowered. As a Latino student who commented on racial disparities in class, I was quickly ushered by YSM faculty onto committees for “cultural competency” and “diversity.” These committees were a frequent source of frustration for students and faculty of color who were forced to sanitize issues of racial oppression and justice into the ham-strung language of multi-culturalism to appease mostly white administrators. Any serious engagement with the exclusion of people of color at our institution – there were no black men in our class of over one hundred students – or the health disparities that marked our local community was off the table. Instead, committees focused on teaching students how to deliver Western

medicine in a culturally sensitive manner. I found this model of “cultural sensitivity” to be out of touch with even my earliest clinical experiences. The most pressing issue for undocumented Latinx patients in the nearby community of Fair Haven, for example, was not that we didn’t ask whether they saw a *curandero* or whether they were taking “folk remedies” (favorite stereotypes of Mexicans in cultural competency initiatives). It was that they had hardly any access to care at all. The primary concern for these patients wasn’t cultural sensitivity – it was survival.

I remember one committee where a group of Latinx students and faculty raised the stakes. The administration was revamping the first two years of the medical school curriculum, and our committee was tasked with developing cultural competency goals. We were encouraged to interpret our responsibilities widely and we did. In addition to asking for a Center for Social Medicine, we proposed a graduation requirement that medical students engage with the local community around Yale through research, reading, writing, or clinical practice. We discussed the irony that YSM provided thousands of dollars for students to seek “global health experiences” in faraway nations in Africa, Asia, and Latin America, when so many of those issues – especially access to care – were present in our local community only a mile and a half away.

After six months of hard work, we submitted the proposal and eagerly awaited a response. We heard nothing from the administration – not even a notification that the proposal had been received. It was the bureaucratic equivalent of ghosting. After months and then a year passed, I came to grips with the fact that the committee had been a charade, a performative gesture. I recently tried to piece together exactly what happened to that lost proposal. It’s still not entirely clear, but at some point between our committee and the dean, along the intentionally byzantine channels of the university’s bureaucracy, someone looked at the proposal and stuck it in an unlabeled folder in a filing cabinet. I think it’s important the folder was unlabeled. Because the point of putting it in the filing cabinet was not so that it could be referenced later, or read, or acted upon. Instead, it was marking the proposal for archival rot – a way to take the document out of circulation so that the ideas and visions there would fade away and eventually, be forgotten.

That committee was the one that broke me. As I discussed my aggravation over having worked for nothing, one of my Latino mentors gave me what I have since thought of as the “uncompensated labor talk.”[1] “From now on,” he said, “you need to avoid such committees at all costs.” He told me that convincing YSM administrators who did not share my values to help the Fair Haven community wouldn’t help my career. “Remember,” he concluded, “you need to make sure you get yours – do research, publish, and get your PhD. While you’re sitting on committees that go

nowhere, white students are publishing the research that gets them into residency." That made a lot of sense to me at the time. In the months that followed, I started graduate school in my history program and then left for two years to do field work for my dissertation on mental health activism in Latin America.

II. The Rise of "Social Justice"

How things have changed at YSM since that time! Returning from fieldwork for my dissertation on protest and psychiatry, I was shocked to find my own medical school in a state of protest. The year before I returned, Yale medical students had held a White Coat Die-In to express solidarity with ongoing victims of racial violence across the country. Inspired by the mobilization of undergraduate students in the NextYale movement on campus, Yale medical students had also formed the NextYSM movement, a coalition of medical students of color and partners in solidarity that promote diversity and social justice on campus. I quickly joined their efforts and helped to draft a set of demands to the YSM administration. As conceptualized in the demands, social justice was no longer a niche topic confined to committee reports that no one read. Instead, it was a framework that promised to restructure the medical school from top to bottom – at the level of the diversity of students and faculty, curriculum, the inclusivity of learning spaces (e.g., a bias reporting system), funding for research in community based participatory research, etc. The YSM administration responded and formed a committee composed of NextYSM members who met with the Dean of the Medical School and operated with a wide-ranging mandate to institute sweeping changes across the school.

Given my prior experiences, I was initially skeptical of the translation of a student movement into a university committee. But at the same time, it was clear that the political landscape had shifted from the toothless Cultural Competency meetings of 2012. The administration had just recovered from a sexual harassment scandal covered in the New York Times and was sensitive about its image. The protest of students had threatened to embarrass the school, raising the stakes of the discussion. There was also money and interest pouring in from everywhere on campus to fund any event with "social justice" in the title. Perhaps the true marker of the new capital around justice was that it was becoming trendy among medical students vying for (or "gunning" to use the off-putting jargon of medical school) extra lines on the CV and face-time with influential faculty and administration.

Given the sudden interest and support, it felt like the perfect time to make

demands, push for change, and yes, host some conferences. The *Critical Histories and Activist Futures* conference in February 2017, which inspired this series, and a later conference I helped organize called *Rebellious Psychiatry* in May of this year capitalized on this environment.

Initially, what struck me in planning these conferences was the sense of urgency, enthusiasm, and action that the word "justice" inspired. This urgency, I realized, depended largely of the fact that "justice" itself was rarely defined in planning meetings. Instead, justice was positioned as a framing ethical value or principle, an unqualified good that everyone shared precisely because they didn't have to state *what it was*. But as the planning for these conferences progressed, tensions began to emerge between conflicting implicit visions of justice. I started to think about justice in these meetings as an example of what political theorist Ernesto Laclau has called a "master signifier."[2] Laclau writes that the master signifier is a sign that lacks a coherent meaning, that doesn't correspond to some "real" meaning out there in the world. Instead, it functions as an "empty" space, a battleground on which various groups compete for the right to define its meaning – often in ways that reflect their own positions and interests. These committees, then, were sites where we struggled for the right to define "justice" by mobilizing available markers of authority (professional, personal, epithelial) in our defense. The power of justice – the sense in which it is a "master" – lay precisely in its emptiness, which oriented the energies of various factions around it in an effort to fill it.

Here, I want to sketch two of the competing visions that emerged in these conference committees. The first developed through the organization of the *Critical Histories and Activist Futures: Science, Medicine, and Racial Violence* Conference that inspired this series. There, students of color and allies in solidarity advanced a sense of justice that Anderson in her piece for this series has called "auto-critical," reflexive, or activist. The idea for the conference was to reflect on how medicine reproduces and reinforces structures of violence (critical histories) that can help generate new paths of health activism going forward (activist futures). Such a space, we believed, would allow humanities scholars, clinicians, and community activists to explore how critical humanistic approaches to medicine – in the fields of history, anthropology, sociology, and critical race theory – can inform health activist work today. This is similar to what Jonathan Metzl, writing on psychiatry in the wake of Ferguson for *Somatosphere*, has called a "new politics of…medicine," in which practitioners "recognize [how] the very health systems of which they are a part can contribute to disparity and inequality."

In the Critical Histories Conference, then, we advanced a notion of justice that demanded that medical practitioners see their own profession as problematic, a field in need of critique and reform. This vision of justice on

our campus has developed primarily among students who claim identities historically marginalized by academic medical institutions. Our insider-outsider position as medical students whose bodies have traditionally been excluded from medical training – along the lines of race, gender, nationality, sexuality, ability, documentation status, etc. – produces a sense of alienation that can have a number of effects. On the one hand, it can result in the "burnout" I described above in my work on cultural competency committees. In that context, I understood my institutions' rejection of the Latinx community with which I identified as a personal rejection of me as a Latino medical student at this institution. But in the right environment, this alienation can also serve as a productive resource for more subversive and disruptive work in the university. Conferences like Critical Histories, I thought, could provide the intellectual tools and historical background both to understand how and why medical institutions have alienated the groups with which we identify and what we can do about it.

The "auto-critical" approach to justice that animated the Critical Histories conference was largely the vision of justice I brought with me to the next conference I organized only a few months later – *Rebellious Psychiatry: Where Mental Health Meets Social Justice*. While similarly oriented toward justice, "RebPsych" was also a different kind of conference. Instead of being organized by an interdisciplinary group of graduate students of color and allies in solidarity, it was organized by health professional students and faculty, many of whom had not participated in campus protests.

While initial meetings were enthusiastic and productive, when it came time to write the Call for Papers, it was clear that there was a large divide in the room. One camp (to which Anderson and I belonged) wanted to organize the conference around the reflexive sense of justice outlined above, with plenty of space for critical reflection on the violence of psychiatric practice in the past and present. However, the other camp advanced a second sense of justice. In their vision – which we might call extroverted, service-oriented or advocacy-driven – medicine itself was not the problem. Medicine was an unqualified good. The problem was simply a question of health disparities and access. We had to get medicine "out there" by expanding access to care for vulnerable populations, including but not limited to incarcerated people, undocumented immigrants, refugees, and other communities marginalized culturally and socially in our society.

Initially, I didn't see any reason why there shouldn't be ample space in a conference for both these visions. Community-based participatory research is a great example of how these two forms of justice can work in tandem. Research in the past has excluded the participation of vulnerable subjects. So, in addition to prioritizing underserved communities in our projects (expanded-access justice) we also need to critically think about

how we are doing research to involve these communities (auto-critical justice). This, however, is not what happened. Instead, the debate quickly became polarized, with our side pushing for critique and the other side calling for attention to mental health disparities. Name-calling ensued. One side was uncritical and not reflexive; the other was “navel-gazing,” overly political, and insufficiently attentive (“callous” even) to the urgent need to deliver mental health care to those who really need it. The advocacy side came away with the unqualified win and in the end, the conference was largely about health disparities.

The victory of the expanded-access approach to justice on our committee was not incidental. These forms of justice are not equal within the academic medical center. The battleground of the master signifier is by no means “fair.” Anderson argues that privileging advocacy over activism reflects institutional interests. Regarding the medical student who advocates for justice-as-expanded-access, she writes, “This position …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.” Because this required expertise is certified by academic medical centers (through all their mandatory points of passage, including exams, evaluations, tuition, etc.), this form of advocacy both reflects and reinforces the legitimacy of the institution to which the advocate belongs. It advances the academic medical centers’ understanding of itself as a healing force in the world.

On the flip side, the auto-critical approach to justice calls into question the medical institution’s commitment to be a force for good. And advancing this approach, as I found on this committee, can cause those who see their careers as oriented towards access- and advocacy-based forms of justice to respond defensively. “This conference,” one committee member stated, “is supposed to attract those who want to do *good* through psychiatry, not those who have ‘*weaponized’* it as you claim.” Our auto-critical approach to health justice called into question the “good” that clinicians saw themselves doing in their work. And on our end, their rejection of our auto-critical vision of justice triggered the sense of alienation that structures our relationship with the university we inhabit – it “deepened,” as Anderson notes, “the fracture between [our] elected professional identity as medical students and [our] other, non-elective, internalized, epithelialized, personal identities.” If this form of justice is not palatable even at a conference organized around the concept of *rebellion,* we wondered, is there anywhere at this academic medical center where we belong?

III. Health Justice and the Humanities

Reflecting on this experience, I've realized that I – and others around me – were initially intoxicated by the speed and urgency attached to justice projects over the last year. While this urgency had the benefit of institutional resources for important initiatives – from the development of new faculty positions for scholars of color to a lecture series on race, science, and social justice – there were also drawbacks. Everyone spoke as if the meaning of justice was self-evident, a universal "good" that we should all rally around. The enthusiasm and fervor for this big idea covered up and obscured the rifts and tensions between competing visions of justice at my academic medical center.

Rather than diving head first into initiatives for justice, then, I think we need to *slow down* our work on justice. We should pause and reflect on what we mean when we use this term before we rush to act on its behalf. History can play an invaluable role here. For one, the history of medicine offers a cautionary tale. Recent critical work on international humanitarianism and global health, for example, provides instructive examples of well-intentioned physicians rushing forward under the banner of justice who end up inflicting harm on the communities they intend to serve.[3]

The past also provides a resource for thinking more critically and imaginatively about justice today. This theme was recently taken up by an experimental, interdisciplinary working group at Yale called History, Humanities, and Health (HHH). HHH brings scholars from anthropology, history, and critical race theory together with health professionals at the Medical School. Over the last six months, our group has looked to the past to uncover the historical origins of the forms of justice that do (and perhaps more important, do not) circulate in our medical economy. What happened, for example, to the vision of health justice deployed by groups like the Black Panthers and Young Lords in the 1970s?[4] Why (and how) was their more expansive and politicized approach to justice repressed by our profession and the state? How is the Panthers' sense of racial justice the same and different from more recent and celebrated activist movements in our field, like Protect Our Patients? And how do these histories help us make sense of our own institution's response to the activism of students of color at Yale today? These questions have helped us articulate the limits of our implicit understandings of justice, as well as think more expansively and imaginatively about what health justice *could* be in the future. Could we imagine an academic medical center where the reflexive critique of the violence perpetuated by the medical profession is considered not counter-productive or subversive, but an essential component of our professional responsibility as physicians? Exploring the boundaries of justice and imagining new horizons is critical not only for ourselves as emerging practitioners, but also for our future patients. Because our imagination with respect to health justice constrains and

delimits the field of medical action, intervention, and activism that is possible in its name.

Marco A. Ramos *is a medical student with a doctoral degree in the History of Science and Medicine from Yale University. His dissertation, entitled* Making Disappearance Visible: Psychoanalysis, Trauma, and Human Rights in Cold War Argentina*, argues that state violence and political repression during the late Cold War shifted the very meaning of health justice from revolution to human rights, in ways that favored authoritarianism and the spread of capitalism in the region. His dissertation was supported by grants from the National Science Foundation, the National Institutes of Health, the Social Sciences Research Council, and the Yale MacMillan Center. Dr. Ramos won the Shryock Medal Award from the American Association for the History of Medicine for an essay based on the dissertation. His research has been published in clinical and historical journals, including* Journal of the American Medical Association*,* The Lancet Psychiatry*,* Bulletin of the History of Medicine*,* American Journal of Psychiatry: Resident's Edition*, and an upcoming chapter in the edited volume* Cold War Medicine in Latin America *published by Duke University Press. Dr. Ramos is currently applying to residency programs in psychiatry.*

*"*Critical Histories, Activist Futures*" is a series edited by Tess Lanzarotta and Sarah M. Pickman.*

Notes

[1] See the earlier piece in this series "Working for the Race" for a discussion of the labor demanded of minority scholars in the field of history.

[2] For example, see "Identity and Hegemony: The Role of Universality in the Constitution of Political Logics" in Judith Butler, Ernesto Laclau, and Slavoj Zizek (2000) *Contingency, Hegemony, Universality: Contemporary Dialogues on the Left*, Verso: London, 70-71.

[3] See, for example, Lisa Stevenson's recent work on the way that medical care might be experienced as violent, or murderous, in colonial contexts in *Life beside itself: Imagining care in the Canadian Arctic*. University of California Press, 2014. Or Didier Fassin on international humanitarianism in *Humanitarian reason: a moral history of the present*. University of California Press, 2011.

[4] Alondra Nelson, *Body and soul: The Black Panther Party and the fight against medical discrimination*. University of Minnesota Press, 2011.

AMA citation
Ramos M. Defining “Social Justice” at the Academic Medical Center. *Somatosphere*. 2018. Available at: http://somatosphere.net/?p=14165. Accessed January 31, 2018.

APA citation
Ramos, Marco A.. (2018). *Defining “Social Justice” at the Academic Medical Center*. Retrieved January 31, 2018, from Somatosphere Web site: http://somatosphere.net/?p=14165

Chicago citation
Ramos, Marco A.. 2018. Defining “Social Justice” at the Academic Medical Center. Somatosphere. http://somatosphere.net/?p=14165 (accessed January 31, 2018).

Harvard citation
Ramos, M 2018, *Defining “Social Justice” at the Academic Medical Center*, Somatosphere. Retrieved January 31, 2018, from <http://somatosphere.net/?p=14165>

MLA citation
Ramos, Marco A.. "Defining “Social Justice” at the Academic Medical Center." 31 Jan. 2018. Somatosphere. Accessed 31 Jan. 2018.<http://somatosphere.net/?p=14165>