Take Back Medical Education—The “Primary Care” Shuffle

Brian McKenna

This editorial is based on an ethnographic case study of a six-year (1992–1998), $6 million project at Michigan State University and three surrounding communities. The project was called the Community/University Health Partnerships (C/UHP). Its overarching goal was to transform health profession education to create more community-oriented primary care practitioners. Community participation was a paramount goal in all areas of project life. Underwritten by the W. K. Kellogg Foundation, it was part of a larger $50 million effort in seven U.S. states. The C/UHP challenged biomedicine’s orientation toward curative care, professional rivalry, specialization, and hospital-based medical education. Change was sought in areas such as primary care research, public health, social policy, and biopsychosocial service provision. This editorial highlights significant instances of hegemony and counterhegemony between the medical schools and the communities in the doomed project.

Key Words: community partnerships; critical ethnography; evaluation; medical education; primary care; social medicine

Brian McKenna is an assistant professor of anthropology at the University of Michigan–Dearborn. His research and practice focuses on how to reinvent “social medicine” for the twenty-first century with a special emphasis on three elements: (1) transforming U.S. medical education, (2) integrating medicine with environmental health, and (3) publicly challenging the reconfigured “company town” culture of neoliberalism, which is a basis for continued biomedical hegemony. Recent publications include “Dow Chemical’s Knowledge Factories: Action Anthropology Against Michigan’s Company Town Culture” (Anthropology in Action) and “Melanoma Whitewash: Millions at risk of Injury or Death because of Sunscreen Deceptions” (in Killer Commodities). Correspondence may be directed to him at Department of Behavioral Sciences, University of Michigan–Dearborn, 4901 Evergreen Road, 4025 CASL Building, Dearborn, MI 48128-1491, USA. E-mail: mckennab@umd.umich.edu
It’s easier to move a graveyard than to change medical education.

Michigan State University College of Human Medicine official

“Like the ancient Greeks there will soon be two types of doctors, ‘slave doctors and free doctors.’ Which will it be for you?” Leon Eisenberg, MD, roared to a group of 300 medical students, teachers, and administrators.

Slave doctors are those who dutifully marched to the orders of bean counters and bureaucrats, practicing “cookbook medicine,” seeing 40 patients a day, Eisenberg said. Free doctors placed peoples’ 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 nineteenth century socialist, Dr. Rudolph Virchow.

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. Sitting in the front row, spry and tall at 81 years, was Hunt. He and the crowd listened attentively as Eisenberg cited Virchow as one of his medical heroes, and then, echoing his hero, 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 there 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.” He said that this socialization experience helps to create conservative medical providers. “Courage and morality,” he said, “atrophy with misuse.”

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 John Hopkins University. Since then, many movements to challenge its dominance have arisen. 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 and Connelly 1991:970).

But 30 years later, in 1991, White and Connelly concluded that medical educators had essentially failed in this mission, with physicians “providing little insight into the nature of needed changes” (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.”

Just one year later, in 1992, I became involved as a medical anthropologist in a spectacular $47.5-million effort, underwritten by the W. K. Kellogg Foundation, to continue this work. The project was called Community Partnerships in Health Professions Education (CP/HPE) and took place in seven U.S. states (Massachusetts, West Virginia, Georgia, Texas, Tennessee, Hawaii, Michigan). Each of the seven projects received about $6 million. The overarching goal was to create community-oriented primary care professionals by challenging biomedicine’s orientation toward specialization, curative care, professional rivalry, and hospital-based medical education.

I served as an evaluator with the Michigan-based portion of the project. My job was formative evaluation (Stufflebeam and Shinkfield 1985), designed to help the project “succeed.” Our site project was called the Community/University Health Partnerships (C/UHP). It was based at Michigan State University and three associated communities in Saginaw, Houghton Lake/Alpena/Roscommon, and Muskegon.

A radical proposition guided the initiative. Citizens were to be empowered to shape the medical curriculum to address their own community needs. Their interests diverged from the medical schools. They were interested in poverty reduction, health care for all, economic development, interdisciplinary education, preventive care, environmental health, and biopsychosocial medicine (McKenna and Notman 1998; see also Starfield 1992).

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 to hire independent “regional managers” in the three distant communities to run them (McKenna and Notman 1998).
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 2% of the curriculum.” When the regional managers began acting, all hell broke loose.

Without warning, two years into the project, 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 education.” 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.

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 that he had recently visited that had a strong health policy: Cuba. Church said that though it was experiencing economic trouble, Cuba “has not cut down on their medical care or their educational system.” Health providers there were “more accessible and less elitist” than U.S. medical workers. He lambasted managed care, which he argued had made the U.S. system “more disjointed,” and he advocated Cuba’s governmental programs as a model for the United States. 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 U.S. 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 1996, 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.

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.”

Toward the end of the project C/UHP officials were dramatically brought to task in a very embarrassing incident. On September 24th, 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 arm 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.”

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

I wondered how Hunt would have responded to the depiction of the C/UHP as a bolus?

I soon made an astounding library find. In 1990, Hunt, then 74 years and retired from MSU, wrote a scathing critique of his profession. In the frank text, entitled, Medical Education, Accreditation and the Nation’s Health, Reflections of an Atypical Dean, he recounted the social forces that resulted in “a compromise of principle” at MSU. Biopsychosocial explanations were often treated as “temporary hypotheses . . . until the ‘real’ explanation comes along” (Hunt 1990:51). “Without consideration of humanistic and ethical considerations, [medicine] can be brutal and inhumane” (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).

For his earlier efforts to transform medicine, I was surprised to discover that Hunt grew “anguished,” bearing heavy criticism from traditional medical educators who resisted his reform agenda. Hunt later left the deanship (Lyon 2003).

It was soon discovered that it could be dangerous to call the C/UHP project a failure. When Dr. Andrew Hogan, a high-level CP/HPE participant, 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 publicly 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, *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).

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 Coliseum 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.” (1996)

Today Michigan is a physician “export state” because too many doctors choose to relocate to “states with stronger economies and better climates” (Farquhar 2007). By 2009, 11 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 crises in some of the associated C/UHP communities. 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 (that pays 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 16 years ago. The lessons learned from Hunt and the C/UHP are not much in evidence.

In the end, institutional “power,” not citizen health, was Michigan State University’s “primary care.”

The liberal idea of a university as a democratic public sphere is being eroded through a growing combination of corporate alliances, government contracts, foundation dependencies, pharmaceutical indoctrination, military partnerships, and over-specialized professional mindsets. A powerful social movement to, as Giroux (2007) put it, “take back higher education,” is required.

Medicine is too important to be left to biomedicine. The medical graveyard is knee-deep with corpses. It’s time to uproot it entirely.

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