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A Case for Critical Pedagogy in Medical Education

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"[…] our work is not merely to share information but to share in the intellectual and spiritual growth of our students" (hooks, *Teaching to Transgress* 13).

Abstract: *In 1978, the Declaration of Alma-Ata defined health as "complete physical, mental, and social well-being." Almost half a century later, medical education is still largely based on what Paulo Freire described as a "banking" model, where the students are mere containers to be filled with information in order to achieve some degree of success in their future careers. However, since education is never politically and ideologically neutral, this approach reinforces the deepening social inequalities in healthcare. In contrast, Freire's critical pedagogy proposes that education should focus on developing democracy and ending oppression. This paper deals with why and how to introduce critical pedagogy in medical education, arguing for a complete return to the Alma-Ata definition and for an adaptation of the classroom tools provided by critical pedagogy to the current social context.*

Keywords: *critical pedagogy, medical education, Medical English, critical thinking, social accountability*

In September 1978, the International Conference on Primary Health Care, which brought together government representatives and supranational bodies such as the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF) at Alma-Ata (now Almaty), then capital of the Kazakh Soviet Republic, focused on health as a "fundamental human right and worldwide social goal" (*Primary Health Care* 16). With these principles in mind, the participants recognized that health depends on and contributes to the social and economic domains, and thus notoriously defined health as "a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity" (*Primary Health Care* 2). The Declaration of Alma-Ata constitutes a landmark in the development of a certain view on medicine, medical practice, and medical education in that it addressed social and economic inequalities, promoted a medical worldview that was focused on communities and not on individuals, and involved and demanded consistent efforts from all sectors of society towards accomplishing its goals (*Primary Health Care* 4). The Conference and the resulting Declaration

immediately triggered hot debates among medical professionals, especially in the pages of *The Lancet*, after the publication of the Declaration. Some praised it for being enthusiastic, egalitarian, and achievable (Passmore 1008; Dukes 1256; Redmond 218), other dismissed the definition of health as “an illusion” (Passmore 1008; Robertson 1144), “too idealistic and an unattainable goal” (Fendall 1308). In spite of all the criticism, the Declaration of Alma-Ata has arguably been the most important and influential official document to establish health as a basic human right.

However, the Declaration’s ideas regarding health, medicine, and socio-economic contexts that seem so awkward today were by no means new in 1978. Around the middle of the nineteenth century, a young medical doctor, Rudolf Virchow, was investigating a typhus epidemic that had broken out in Eastern Germany. Virchow soon came to realize that the cause of the epidemic was strongly linked to the socio-economic condition of the locals: malnutrition, poor housing, lack of access to medical care, etc. (Lange 149) In other words, Virchow had discovered the social determinants of health, or rather re-discovered them, since explanations regarding the environment and its link to health can be seen as far back as the Hippocratic texts. As a result of his observations, Virchow began to advocate for what is today known as “social medicine,” an approach that looks at the relation between illness and the broader socio-economic conditions of living, going as far as to famously assert that “medicine is a social science and politics nothing but medicine on a grand scale” (Lange 150). In more detail, Virchow presented a few interventions to reform German health care, for instance, to consider the health of the people a social concern, and, since the social and economic conditions have a decisive impact on health, to address these conditions in order to improve them (Eisenberg 526); in short, Virchow’s proposed medical reform was a reform of society that is strikingly similar to the stated goals of the Declaration of Alma-Ata.

The Virchowian tradition (including the Declaration of Alma-Ata) has remained, in spite of various criticisms, a beacon of global healthcare. Of course, its goals have not yet been met, a fact that sparked the need for a renewal of Alma-Ata in 2018 with the Declaration of Astana. At the Global Conference of Primary Health Care, the WHO and UNICEF, hosted by the government of Kazakhstan, issued a statement to reaffirm that health is a fundamental human right. However, the underpinnings of Alma-Ata and Astana could not be more different. While the Declaration of Alma-Ata acknowledged that health is strongly connected to social, political, and

economic contexts, the Declaration of Astana takes an explicitly neoliberal turn, stating that "we will support people in acquiring the knowledge, skills and resources needed to maintain their health or the health of those for whom they care […]" (WHO 10). Thus, Astana places the emphasis and, at the same time, the responsibility for one's health onto the individual – gone is the broader social problematization of 1978. Now, Astana implies the narrow-minded paternalistic view that individuals should educate themselves in health matters, even if it does mention dangers posed by poverty, bacterial resistance to drugs, the health impacts of climate change, and so on (WHO 5), which are obviously factors and determinants beyond the control of specific individuals. Astana also subtly reverses the Alma-Ata relationship between health and socioeconomic development, turning the former into an instrument for the latter by asserting that health is important for development (WHO 5), and not the other way around.

In this context, it is clear that the Virchowian tradition of social medicine is waning. At the same time, throughout the years since the Declaration of Alma-Ata, there have been voices that reasserted the need to revive Virchowian social medicine. As early as 1984, Leon Eisenberg of Harvard University noticed that "conventional medical history has bowdlerized his credo to suit the priorities of the establishment by eliding his emphasis on social reform" (Eisenberg 530). Thus, addressing the broader social inequalities perpetuated by neoliberalism should form the basis of any intervention towards better healthcare for all (Shukla 165). With this in mind, the key issues that I would like to discuss in this paper are whether medical education, that is, real-life classroom education and more specifically the Medical English class should deal with issues of social medicine and, if that be the case, how should we engage in such an endeavor, what are the challenges and opportunities presented by this approach, and ultimately whether education should refer to individual students or should it refer to social realities, communities, and politico-economic contexts. In other words, should we teach for social change, or should we simply teach for the development of skills required by contemporary biomedical jobs?

The most useful concept that has gained traction in recent decades in regard to medical schools is that of social accountability. Proposed in a World Health Organization paper from 1995, initially with limited distribution and restricted to the general public (now freely accessible), the concept of social accountability means that medical schools should not be limited to training medical professionals able to provide high-quality

healthcare (Boelen et al 3). Instead, medical schools should broaden their range of contributions to society by directing their teaching “*towards addressing the priority health concerns of the community, region, and/or nation they have a mandate to serve*” (Boelen et al 3, orig. emphasis). As the paper insists, the concept of social accountability is preferred to that of social responsibility because, even if they seem similar, the former incorporates the idea of medical schools being held accountable by society (Boelen at al 3). Thus, medical education is to shift from a traditional model, where schools focus on preparing competent medical practitioners, to a new model where medical education is understood as “the art and science of (1) preparing future medical graduates to function properly in society and (2) influencing the environment in which these graduates will work, to the greatest satisfaction of the health consumers, the health authorities, and the graduates themselves” (Boelen 83). Social accountability, clearly drawing from the Declaration of Alma-Ata, implies that medical training should focus on a closer relationship with the community and on the development of social, or “soft,” skills needed to efficiently work in the given community. Thinking at the low level of the Medical English classroom, my initial questions can be summed up as follows: how can we create a framework that acknowledges the social accountability of the Medical English class? Recuperating social medicine and promoting social accountability in the Medical English classroom, given its importance in a world plagued by inequalities and health disparities, requires a certain kind of critical approach, that is, a recuperation of critical pedagogy.

Revisiting critical pedagogy

The theory and practice of critical pedagogy appeared in the 1970s, with the publication of Brazilian educator Paulo Freire’s *Pedagogy of the Oppressed*. Freire’s humanistic approach begins by balancing two historical realities, humanization and dehumanization, in order to construct an opposition between oppressors and oppressed, especially in the context of Brazilian society (Freire, *Pedagogy* 43). The oppressed, dehumanized by exploitation, injustice, and violence, struggle to gain their humanity, to be recognized as human beings, but they quickly fall into the same old pattern, into the same relationship of dominance. For Freire, teaching and pedagogy mirror this relationship. In what he refers to as the “banking” model of pedagogy, the teacher-student relationship is “narrative” (Freire, *Pedagogy* 71), that is, the teacher tells stories that have little to do with the social and political reality

and the students are then asked to memorize the contents, becoming “containers” or “‘receptacles’ to be filled by the teacher” (Freire, *Pedagogy* 72). By design, the banking model of education implies that it is a process in which knowledge flows unidirectionally, from those who are knowledgeable to those who are ignorant, and it is thus an expression of the “ideology of oppression” (Freire, *Pedagogy* 72). However, Freire argues that this relationship impedes any kind of development of a critical consciousness by the majority of students, who are simply turned into passive elements in the educational relationship (Freire, *Pedagogy* 73). An alternative to the banking model should solve this contradiction and this dehumanization of the students; Freire proposes that the relationship between teachers and students should become a partnership based on dialogue, that there needs to be an engagement in critical thinking, and ultimately a “quest for mutual humanization” (Freire, *Pedagogy* 75), so that the students will be better equipped to challenge established structures of dominance and oppression. He calls this approach “problem-posing education” (Freire, *Pedagogy* 79), where there is a dissolution of power and authority in the classroom so that teachers and students no longer hold on to their traditional roles. By engaging in dialogue, both parties manage to form a learning and debating community that may then perform a “*critical intervention* in reality” (Freire, *Pedagogy* 81, orig. emphasis).

Of course, ideas such as student-centered education and the decentering of authority in the classroom are by no means new today. Freire’s approach, however, was indeed revolutionary in the 1970s, in Brazil and elsewhere but it’s continuous relevance stems from the fact that he saw the ideological, social, and political conditioning at play in the educational process. With the objective of creating a more democratic, open society (Freire, *Education* 3), Freire’s critical pedagogy noticed that the banking model perpetuated inequalities and failed to create the critical consciousness needed to address them. Following Freire, Black feminist bell hooks argued in favor of an “engaged pedagogy” whose purpose is to develop critical awareness (hooks, *Teaching to Transgress* 14), “a way of approaching ideas that aims to understand core, underlying truths, not simply that superficial truth that may be most obviously visible” (hooks, *Teaching Critical Thinking* 9). Hooks too proposes the use of a dialogic environment where sharing ideas and thoughts in a democratic manner empowers the students to find their own voices. In practice, this may be easier said than done, given the challenges posed by a wide range of factors (which I discuss in the following

paragraph), but hooks offers some classroom tactics that the teacher can use to break the ice and encourage students to express their views and opinions (hooks, *Teaching Critical Thinking* 21-22). Ultimately, both Freire and hooks propose “problem-*posing*” as a classroom strategy, and not “problem-*solving*,” so the focus will always be on the discussion and the underlying critical process, not on reaching some solution.

There are, of course, a number of challenges to critical pedagogy in the classroom and beyond, many of them stemming from what Freire insightfully identified as the “dehumanization” of the roles assumed by the parties in the traditional, or “banking,” educational process. Critical pedagogists have always understood that the same social and political conditions they addressed as issues have also been their main challenges. For critical pedagogy, the entire domain of education is never politically neutral. Even if it may seem neutral because it is traditionally isolated from the broader issues of the community, education promotes “middle-class” (Apple, *Ideology* 84) or “bourgeois” values (hooks, *Teaching to Transgress* 178) that, as Freire noticed, reproduce the existing systems of domination in society. The concept of a “hidden curriculum” (Gair & Mullins 23; Apple, *Ideology* 87) encapsulates these values of “silence and obedience to authority” (hooks, *Teaching to Transgress* 178). Moreover, Giroux identifies the entire socio-economic and political complex of neoliberalism as a major threat to critical pedagogy because “dominant sites of pedagogy engage in diverse forms of pedagogical address to put into play a limited range of identities, ideologies, and subject positions that both reinforce neoliberal social relations and undermine the possibility for democratic politics” (Giroux 134). Obviously, education’s neutrality is only a mask for reactionary politicization that promotes neoliberal middle-class values such as the individual over the community, private concerns over public or social ones, silence and silent acceptance over democracy and free speech.

Critical pedagogy is a way to move forward in the process of recognizing and achieving the goals of Virchow and Alma-Ata, and also a way to integrate social accountability in medical education. However, its application to medical education does come with its own set of challenges, but also with opportunities.

Critical Pedagogy in Medical Education

In light of these considerations, using critical pedagogy seems like a proper choice of strategy for a progressive medical education. In order to do this,

Freire’s original model is insufficient, since he mostly dealt with oppressed populations in Brazil, with a focus on developing literacy. Applying critical pedagogy to medical education thus requires taking Freire out of his initial context and reinterpreting his concepts, adapting them to the specific issues raised within medical schools.

Contemporary medical education in the West is, according to many accounts, stuck in an individualistic, neoliberal framework that emphasizes the aforementioned political neutrality of the biomedical approach (Bleakley 1178; McKenna 96; Ross 170). This pretense of neutrality is what actually allows “conservative heroic individualism” (Bleakley 1178) to be perpetuated in medical education. As medical educator Alan Bleakley shows in his Weberian analysis, this reactionary individualism tries to preserve the medical professional’s authority as part of a dominant system of values, most important of which is the profit motive (Bleakley 1179). He also shows that “the individual, and the cult of individualism expressed competitively (prizes! Awards! Leadership! Mastery!), has been the primary driver for medical pedagogies” (Bleakley 1182). This ideology acts on two fronts: firstly, the medical professional is encouraged to focus on a strictly biomedical framework and to be motivated by profit; secondly, a patient’s health is understood sometimes as a (lifestyle) choice, sometimes as bad genes (Bleakley 1182; McKenna 96). By emphasizing lifestyle choices, biomedical medicine does not really take the social determinants of health seriously and marginalizes and silences the patient (McKenna 97). In this context, the preferred pedagogical strategy is, obviously, what Freire referred to as the banking model of education, often under the guise of “problem-based learning” (Cavanagh et al 2), that is, reaching conclusions only within a narrow pathophysiological approach and disregarding social factors. Even the inclusion of content regarding the social determinants of health fails, according to a study of the American Association of Medical Colleges, to link poor health with the unequal distribution of resources (Sharma et al 2).

In contrast, a Freirean approach to medical education would expand the focus towards the community and towards understanding the social conditions involved in both health and healthcare, and simultaneously employing democratic strategies in the classroom. As I have previously mentioned, Freire’s work focused on developing literacy among the lower classes of the Brazilian society (Freire, *Pedagogy* 110). However, for the purposes of a progressive medical education, the very concept of “literacy” can be expanded to include acquaintance with the social issues of the

community. This “literacy” would then mean making visible both health inequities and their determinants and would be directly translated into greater social accountability in medical education (Ross 172). Cavanagh et al suggest a practical approach to incorporating critical pedagogy in medical education by first noticing that, while problem-based learning is grounded on a biomedical view, critical pedagogy’s problem-posing education may be used to advance health equity (Cavanagh et al 1). Although problem-based learning and Freire’s problem-posing education share some practical elements, such as the strive towards a more democratic teacher-student relationship in the classroom and the emphasis on critical thinking, they are separated by critical pedagogy’s social focus and wider scope. In problem-based learning, the “problem” is usually a case study that presents a particular patient, their presenting complaint, their medical history and so on. The students are required to apply their biomedical knowledge to that specific case in order to outline the process of critical thinking and to reach differential diagnoses. In short, the students are given a problem to solve. On the other hand, problem-posing education focuses more on the social, economic, and political circumstances in which the patient’s illness developed and on how the illness may have been influenced by them (Cavanagh et al 2). Moreover, biomedical problem-based learning uses a relatively new framework called evidence-based medicine. With its pretense of scientific objectivity, evidence-based medicine disengages both the patient and the practice of medicine from their social context (Goldenberg 2621; Cavanagh et al 3). Problem-posing medical education encourages students to question the foundations of more established or more recent biomedical knowledge and to keep in mind the fact that data offered by evidence-based practices is still subject to interpretations which are often conflicting (Goldenberg 2624). Thirdly, problem-based learning tends to think of patients as individuals suffering from illnesses separated from their actual lives, without social identities. However, problem-posing education looks at ill health as a structural issue, in keeping with the perspective of social medicine (Cavanagh et al 3): “if the SDOH [social determinants of health] are human-made, then they can also be dismantled by human efforts” (Sharma et al 3).

A practical model of Freirean problem-posing was developed by some researchers, consisting of three phases: firstly, listening, or investigating relevant issues for the community; secondly, dialogue, or subjecting the actual problem to critical investigation; and thirdly, action, or

envisioning changes that would help with the problem (Wallerstein 35; Matthews 603-606). More specifically, Wallerstein suggests that "listening" should allow the students to formulate their own concerns for future dialogue and should be aided by various materials, photographs, videos, texts and so on (Wallerstein 36; Matthews 603). The "dialogue" phase involves open-ended situations in order to promote critical awareness and thinking. The students should describe what they see, define the problem, share similar experiences, question why there is a problem, and finally strategize what they can do about it (Wallerstein 39; Matthews 604). The "action" stage hopefully translates the results of the previous stages into practical changes outside the classroom (Wallerstein 42-43; Matthews 606-607). When applied to medical education, this framework can be extremely useful in raising awareness of social accountability and social medicine, as I explain below.

In trying to include critical pedagogical strategies in medical education, one may find a number of challenges that need to be addressed. In my opinion, the main two are the fact that medical students come from a background of relative affluence and are therefore less likely to have developed an awareness of social issues (Ross 172; Murray et al 1) and the fact that they may have internalized what Bleakley has dubbed "conservative heroic individualism" (Bleakley 1178). In addition to these, the informal and hidden curricula usually promote a banking style of pedagogy. It is my belief that these challenges can be overcome by using the Freirean framework and by adapting it to suit specific groups, communities, and situations. For instance, the first phase, "listening," is very important because it offers the students a chance to become familiar with the issues at play in social medicine. This phase can include a short history of social medicine, various case studies that show social medicine at work, and explanations regarding the social and environmental determinants of health. In regard to the culture of individualism, getting the students acquainted with alternative approaches to medical care may open up new perspectives. Encouraging collective efforts towards a shared goal in classroom activities may unravel this "heroic individualism." Once these challenges are addressed, the opportunities presented by critical pedagogy can contribute to the transformative objectives of social accountability and social medicine.

Critical Pedagogy in the Medical English Classroom

Medical English teachers are a privileged bunch among academics. They can experiment with different strategies and tactics, they can devise their own

learning contents, and they can involve the students in very diverse activities. Including critical pedagogy in the Medical English class can help bring about new forms of understanding of the medical profession that are otherwise inaccessible to biomedicine classes. Taking advantage of this freedom, the Medical English class can deal with issues that are generally outside the scope of pathophysiology, biochemistry and so on, in an attempt to expose broader social problems.

There is a wealth of available information regarding social inequities in health and healthcare, from the 1980 UK Black Report to the latest reports from the World Health Organization on the effects of COVID-19. For instance, the highly influential (at the time) Black Report began with the distinction between an "engineering" approach (what we call today "biomedical" approach) and a social approach in medicine, arguing that the latter exposes the deep inequalities in health among social classes (*The Black Report* 1.2-1.6). In 1998, the World Health Organization office in Europe issued a publication that summarized the effects of poor social and economic circumstances on health (poverty, stress, unemployment, addictions, etc.; Wilkinson & Marmot 7-8) and, in 2020, one that charted the social and economic effects of the coronavirus pandemic, showing that unequal impacts are caused by socioeconomic inequalities (Goldblatt et al 2). In 2022, in a what seems like yet another attempt to warn about the risks of ignoring social medicine, the Lancet COVID-19 Commission issued a report in which it argued for a necessary shift from individualism to "prosociality," that is, "the orientation of individuals and government regulations to the needs of society as a whole, rather than to narrow individual interests" (The Lancet Commission 4). Among other recommendations, the Lancet Commission mentions essential social medical objectives: access to health care for all, protection of vulnerable groups, such as the elderly, women, children, and so on, the establishment of safe public spaces, schools, workplaces, and social support services (The Lancet Commission 43). These pieces of information (and many others) stand as proof that the integration of social medicine topics using critical pedagogy in a Medical English class is a necessary intervention in order to offer our students a deeper understanding of contemporary medical practice.

Critical pedagogical strategies can be incorporated into the Medical English class especially when working within the framework of content-based language teaching (CBLT). In CBLT, as opposed to more traditional language learning methodologies, we tend to assume that the focus on

contents brings about language learning and thus we tend to shy away from teaching grammatical structures and directly emphasizing skills (what is generally referred to as the bottom-up approach). As per the suggestions given by Stryker and Leaver, Medical English CBLT uses authentic language and texts (Stryker & Leaver 8), authentic videos, articles, recordings, and so on, tries to give a voice to the students, and shifts the relationship between teacher and students much in the same way critical pedagogy does. In a sense, critical pedagogy can be considered a critically oriented CBLT and, as I have already explained, medical critical pedagogy focuses on the Virchowian tradition of social medicine. With these in mind, the Freirean problem-posing model previously presented can be adapted in the Medical English classroom.

Between 2018 and 2020, the *New England Journal of Medicine* published a new series called *Case Studies in Social Medicine*, consisting of 15 cases. One of them presents the case of a malnourished indigenous 18-month-old from a village in Mexico with pneumonia. The patient was eventually cured after treatment with antibiotics in a hospital setting, but the predisposition of children in that community towards pneumonia was a cause for concern. Linking this predisposition to malnutrition, the local medical professional noticed that eighty percent of the families suffered from food insecurity. He then tried to set up a nutrition education program that eventually failed not because of a lack of interest from the community, but from a lack of food. Other interventions were attempted, growing crops and raising animals, but they too failed due to poor soil quality and a viral infection among the animals (Carrasco et al 2385-2386).

This case (and others from the *New England Journal of Medicine* series on social medicine) can serve as the first phase of the problem-posing model, “listening.” It allows the students to get acquainted with a medical problem that has deeper roots that simple microbiology or lifestyle. In the second phase, the students are asked to describe and define the problem and to question why the problem appeared. The aforementioned case study also presents a somewhat lengthy analysis of the situation, identifying that deprivation is the main cause of illness, and stresses the fact that this is an example of misrecognition due to biomedical bias. In the third stage, the students should hypothesize on a future course of action in this situation. By being confronted with social realities, they will implicitly tend to think outside the narrow scope of traditional medical practice.

However, one should not limit the available pedagogical strategies to the Freirean model. Any tool can work, from analyzing reports that present raw data on the social determinants of health to explaining and researching the history of social issues and their relation to medicine (Martinez et al 1-3). One kind of competence, whose importance cannot be overstated, is presented by Martinez et al as “cultural humility” (4), meaning the skill of self-evaluation, reflection, and critique, together with a more-patient centered approach to healthcare. In the end, critical pedagogy is about transformative social action, which also includes a practical redefinition of the relationship between patient and physician.

Reality check

In this paper, I have outlined a way of using critical pedagogy in the Medical English class in order to promote social medicine and social accountability, with a special emphasis on the opportunities and challenges of practicing it in the classroom. However, I must admit that these main objectives seem to be difficult to achieve. After all, since Virchow, many voices have reiterated the need for a shift in both medical practice and medical education to little or no effect. Contemporary medicine is stuck in the narrow confines of the biomedical model, affecting medical professionals, patients, social groups, and the entire world. To oppose the biomedical model and to look for alternatives means to oppose the dominant ideology of our society and to practice democracy, dialogue, and critical thinking. At the same time, all these voices that argue in favor of social medicine and critical pedagogy have been hopeful. It is only natural that I do the same and hope, alongside them, for a time when the biomedical framework will be superseded by the prosociality advocated by the Lancet COVID-19 Commission. In the meantime, including the methods, strategies, and tactics presented here into the practice of Medical English teaching may contribute to the training of future medical professionals that are more sensitive about social issues, that are more democratic in their relationships with the patients, and that are more vocal regarding social inequalities.

Works Cited

Apple, Michael W. *Ideology and Curriculum*. New York: Routledge, 1990. [1979]

Bleakley, Alan. “Embracing the collective through medical education.” *Advances in Health Sciences Education* 25 (2020). 1177-1189.

Boelen, Charles, Jeffery Heck, World Health Organization. Division of Development of Human Resources for Health. *Defining and measuring the social accountability of medical schools*. Geneva: WHO, 1995. Available at Defining and measuring the social accountability of medical schools / Charles Boelen and Jeffery E. Heck (who.int). Retrieved September 26, 2022.

Boelen, Charles. “Interlinking medical practice and medical education: prospects for international action.” *Medical Education* vol. 29, issue 1 (1994). 82-85.

Carrasco, Hector, Luke Messac, Seth M. Holmes. “Misrecognition and Critical Consciousness – An 18-Month-Old Boy with Pneumonia and Chronic Malnutrition.” *The New England Journal of Medicine* 380 (2019). 2385-2389.

Cavanagh, Alice, Meredith Vanstone, Stacey Ritz. “Problems of problem-based learning: Towards transformative critical pedagogy in medical education.” *Perspectives on Medical Education* 8 (2019). 38-42.

Declaration of Astana. World Health Organization and the United Nations Children’s Fund, 2018. Available at Declaration of Astana (who.int). Retrieved September 26, 2022.

Dukes, M.N.G. “Declaration of Alma-Ata.” *The Lancet* vol. 312, issue 8102 (1978).

Eisenberg, Leon. “Rudolf Ludwig Karl Virchow, Where Are You Now That We Need You?” *The American Journal of Medicine* vol. 77 (1984). 524-532.

Fendall, N.R.E. “Declaration of Alma-Ata.” *The Lancet* vol. 312, issue 8103 (1978).

Freire, Paulo. *Education for Critical Consciousness*. London: Continuum, 2005. [1974]

Freire, Paulo. *Pedagogy of the Oppressed*. Translated by Myra Bergman Ramos. With an introduction by Donald Macedo. New York: Continuum, 2005. [1970]

Gair, Marina, Guy Mullins. “Hiding in Plain Sight.” *The Hidden Curriculum in Higher Education*. Edited by Eric Margolis. New York: Routledge, 2001. 21-42.

Giroux, Henri A. *On Critical Pedagogy*. New York: Continuum, 2011.

Goldblatt, Peter, Amanda Shriwise, Lin Yang, Chris Brown. *Health Inequities and the Effects of COVID-19*. World Health Organization, 2020.

Goldenberg, Maya J. “On evidence and evidence-based medicine: lessons from the philosophy of science.” *Social Science & Medicine* 62 (2006). 2621-2632.

Hooks, bell. *Teaching Critical Thinking. Practical Wisdom*. New York: Routledge, 2010.

Hooks, bell. *Teaching to Transgress. Education as the Practice of Freedom*. New York: Routledge, 1994.

Lange, Klaus W. “Rudolf Virchow, poverty and global health: from ‘politics as medicine on a grand scale’ to ‘health in all policies.’” *Global Health Journal* 5 (2021). 149-154.

Martinez, Iveris L., Isis Artze-Vega, Alan L. Wells, Jorge Camilo Mora, Marin Gillis. “Twelve tips for teaching social determinants of health in medicine.” *Medical Teacher* (2014). 1-6.

Matthews, Catherine. “Critical pedagogy in health education.” *Health Education Journal* vol. 73 (5) (2014). 600-609.

McKenna, Brian. “Medical Education Under Siege: Critical Pedagogy, Primary Care, and the Making of ‘Slave Doctors’.” *International Journal of Critical Pedagogy* vol. 4, no. 1 (2012). 95-117.

Murray, Richard B, Sarah Larkins, Heather Russell, Shaun Ewen, David Prideaux. “Medical Schools as Agents of Change: Socially Accountable Medical Education.” *Medical Journal of Australia* 196 (10) (2012). 1-5.

Passmore, R. “The Declaration of Alma-Ata and the Future of Primary Health Care.” *The Lancet* vol. 314, issue 8150 (1979).

Primary Health Care. Report of the International Conference on Primary Health Care, Alma-Ata, USSR. World Health Organization, United Nations Children’s Fund. Geneva, 1978.

Redmond, Stephen R. “Declaration of Alma-Ata.” *The Lancet* vol. 313, issue 8109 (1979).

Robertson, J.S. “Declaration of Alma-Ata.” *The Lancet* vol. 312, issue 8100 (1978).

Ross, Brian M. “Critical pedagogy as a means of achieving social accountability in medical education.” *International Journal of Critical Pedagogy* vol. 6, no. 2 (2015). 169-186.

Sharma, Malik, Andrew D. Pinto, Arno K. Kumagai. “Teaching the Social Determinants of Health: A Path to Equity or a Road to Nowhere?” *Academic Medicine* vol. XX, no. X (2017). 1-6.

Shukla, Abhay. “Re-Reading the Alma-Ata Declaration: The Need to Say the Unsaid, to Do the Undone, and to Think for the 21st Century.” *Global Social Policy* 8 (2008). 164-166.

Stryker, Stephen, Betty Lou Leaver (eds.). *Content-based Instruction in Foreign Language Education: Models and Methods*. Washington D.C.: Georgetown University Press, 1997.

The Black Report. Black Report material (sochealth.co.uk). Retrieved September 26, 2022.

The *Lancet* Commission. *The* Lancet *Commission on lessons for the future from the COVID-19 pandemic*. Elsevier, 2022. Available at The Lancet COVID-19 Commission. Retrieved September 26, 2022.

Wallerstein, Nina. “Problem-posing education: Freire’s method for transformation.” *Freire for the Classroom. A Sourcebook for Liberatory Teaching*. Edited by Ira Shor. Afterword by Paulo Freire. Portsmouth: Boynton/Cook, 1987. 8-33.

Wilkinson, Richard G. Michael Marmot, World Health Organization. Regional Office for Europe. *The Solid Facts: social determinants of health*. Copenhagen: WHO Regional Office for Europe, 1998.