

Episode: *Ethics Talk: The Generative Power of Abolition*

Guests: Yoshiko Iwai, MS, MFA; Zahra Khan, MS, and Sayantani DasGupta, MD, MPH

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[bright, folksy theme music]

TIM HOFF: Welcome to *Ethics Talk*, the *American Medical Association Journal of Ethics* podcast on ethics in health and health care. I'm your host, Tim Hoff. This month's issue of the Journal, [Toward Abolition Medicine](#), asks how abolitionist approaches to health care could develop in health professions education, clinical care, and research. In their landmark 2020 article, *Abolition Medicine*, medical student Yoshiko Iwai and faculty members Zahra Khan and Dr Sayantani DasGupta suggest that, "The essential work of abolition medicine is to interrogate the upstream structures that enable downstream violence like police brutality in addition to reimagining the work of medicine altogether as an anti-racist practice."

DR SAYANTANI DASGUPTA: And for those people who say, "Well, that's not the purview of medicine," yes, it is the purview of medicine. Because if you're treating diabetes downstream and you're not looking upstream to food distribution systems and what sorts of healthy foods are available in what sorts of neighborhoods and the affordability of insulin and on and on and on, you're not having a structurally competent approach to your health care.

HOFF: That was Dr DasGupta, senior lecturer in the Narrative Medicine Program at Columbia University in New York City. She, along with Yoshiko Iwai, a second-year medical student, and Zahra Khan, Instructor in Columbia's Narrative Health and Social Justice Seminar join me on this episode of the podcast to discuss how narrative is key to creating a more just health care system.

Everybody, welcome. Thank you so much for being on the podcast today. [music fades out]

DASGUPTA: Thank you for having us.

HOFF: Your article, *Abolition Medicine*, ends with the following quote, "Abolition medicine is a practice of speculation, of dreaming of a more racially just future and acting to bring that vision to fruition, to re-narrate and re-envision justice, healing, activism, and collectivity." Since stories and narrative seem to be so important to the work that you do, why don't we start there? What is narrative ethics, and what are its roles in abolition of unjust policies and practices in health care?

DASGUPTA: I'd like to maybe suggest a slightly different framing than narrative ethics, which we just heard. Zahra runs a seminar on narrative health and social justice, and I teach a course of that same name. And I think that our work, and particularly the work of this article on abolition medicine, is really at the intersection of story, health, and social justice, which is not that different from a narrative ethics approach, except in that it suggests a collectivity versus kind of a professionalization of the role.

HOFF: Hmm.

DASGUPTA: It suggests that no matter what side of the stethoscope or the clipboard or what have you, you may be on, we are collectively in this struggle of re-narrating, re-envisioning, and reimagining our futures altogether, right? Because we don't want to be too precious about stories, either. Stories can be harmful. They can be oppressive and unjust. In her great TED Talk, *The Danger of the Singular Story*, Chimamanda Adichie says that stories can be used to dispossess and to malign, but they can also be used to empower and dehumanize. And so, I think what we're talking about is really using the power of story and the power of speculation to envision a more just world and therefore, bring it to fruition.

HOFF: Zahra or Yoshiko, anything to add?

YOSHIKO IWAI: One of the things that the three of us have sort of been trying to do in this work around abolition medicine is kind of think about how we not only think about sort of the one-on-one stories that are shared in that clinical encounter between the patient and the provider or whatever other relationship that that might look like, but also the structure in which that story's embedded. Like, what is the larger narrative? What is the larger structural narrative that's happening around it, that's contextualizing that individual encounter? And I think when we think about abolition, abolition is always sort of a story between both the individual and others, like self and other, as well as the individual in a much larger societal and structural context. So, I think that's sort of where at least the narrative medicine component feeds in.

HOFF: I think that leads well into this next question about situating abolition medicine in the work that's being done now into this wider history, especially in the U.S., which has this long history of ethnic and racial injustice in various forms. Can you talk a little bit about how the history of health care in the U.S. informs this need for abolition medicine?

ZAHRA KHAN: Yeah, I think it's important for us to think about how racism has been baked into, yes, the U.S. health care system. But in terms of medicine, scientists, doctors, these guys are at the forefronts of creating racial categories in the first place, emphasizing their biological components when we know that they're just, they're social categories. And those biological components were used to justify colonization; enslavement; claiming that Black people were less capable, they were biologically inferior, they felt less pain, and therefore, they're more naturally suited for slave labor. And even during periods of enslavement, we see how doctors would diagnose Black enslaved people with there's a mental illness that they called "drapetomania." And that was to describe a condition of wanting to escape, wanting to escape enslavement. And I think those diagnoses, and this is something that Harriet Washington talks a little bit more about in *Medical Apartheid*, is that that's rooted in eugenics, right?

So, Talila Lewis wrote a chapter in Colin Kaepernick's new essay collection called *Abolition for the People*, and in it talks about how doctors and scientists who supported enslavement were committed to proving that Black people couldn't handle freedom. And so, they honed these logics of eugenics and these practices of eugenics to prevent Black and Indigenous people from reproducing. So, that's one thing.

And I think it's also important for us to think about how that shows up now in medicalized carceral spaces, in nursing facilities and psychiatric treatment facilities. And how under the pretense of care, under the pretense of rehabilitation, these systems continue to

criminalize and cage and disappear people across marginalized communities. So, all of that's one part of the conversation related to medical and carceral connections.

And I guess, before jumping into the police abolition portion, I wanted to invite Sayantani to say any words that she wants to say about the classes she teaches about all of this!

DASGUPTA: So, yes, but I started teaching a class at Columbia called Abolition Medicine: Medical Racisms and Anti-racisms only after Zahra, Yoshiko, and I started working together and published a piece in *The Lancet* called *Abolition Medicine*. And I realized that contextualizing these histories of structural racism in the history of medicine was very important, but it was equally important to also gesture to kind of anti-racist practices. And so, one of the many people who've used this phrase "a public health approach to public safety" is Minnesota Councilperson, not Congressperson—

KHAN: Councilperson.

DASGUPTA: Councilperson, yes. Excuse me. So, one of the people who has used the expression "a public health approach to public safety" is Minnesota Congressperson Phillippe Cunningham. And the first time I heard this statement, I thought, well, if we're trying to envision a public health approach to public safety, where are the health care folks? Isn't this our purview? Isn't this our responsibility, in fact, to be a part of this conversation? And that's really when I started thinking about, not only with my colleagues Zahra and Yoshiko, not only, although we were primarily focused on U.S. contexts of medical racism, but also the kind of broader global way that medicine and public health has been used as a justification for imperialism and kind of colonialist kind of practices, right?

So, we can trace it all the way back to kind of yellow fever, or we can trace it back to the history of research around cholera. There's all of these justifications of imperialist force and imperialist kind of entry into countries in Asia and Africa with the thought that, well, we need to go— You know, it's for the public health. It's so that people dig latrines properly or so that we can limit infections of yellow fever and cholera among the imperialist officials that we're sending over to these places, right? So, although today we're talking primarily about the U.S., we have to understand that the history of medical racism in the U.S. is deeply tied to histories of oppression outside of the U.S. as well.

But again, to go back to the anti-racist component, if that is so, right, if we know that the basis of so much of medicine and public health is the marginalization and the oppression of primarily people of color, what's the solution? What is our responsibility to contribute to a more just future?

HOFF: We're talking a lot about these sort of broad histories and structures that demonstrate how medicine was and is unjust in many ways. But for many people, this particular conversation and even the phrase itself of "abolition medicine" might be a new one. And so, what should someone coming to this, essentially, someone might come to this conversation saying, "Abolish what? What parts of medicine are we abolishing, and why abolition in the first place rather than reform or stricter policy or something?" Can you give somebody who's unfamiliar with these larger conversations a pathway into what we're talking about?

IWAI: I guess I can start. So, initially, when we were sort of thinking about how to frame what we were feeling in medicine and like how, you know, so, we looked at W.E.B. Dubois'

concept of abolition democracy, which is not only this idea of breaking unjust systems or deconstructing unjust systems, but then rebuilding more just systems in their place. So, when we were thinking about abolition democracy and trying to honor that sort of dual thinking, we felt that abolition medicine as an organizing thought, as an organizing tool—which I'm going to hand off to Zahra to talk a little bit more about when we think about like carceral systems, policing, and then medicine with sort of in broad strokes—that idea of in medicine, how do we think about ways that we can get rid of these racist, oppressive, carceral methods and structures that exist in medicine? But then how can we, in their place, build up new and more just ones? And so, that's kind of the, and you know, that is again, very, very, very broad.

And our also thought was that these things are already happening across medicine. They've been happening across medicine. And it's just a matter of like, there are all these different movements and smaller pieces happening in medical education, in health care, in public health, in communities, which is where it's primarily happening. And so, how can we sort of think about all of those things as being one movement together?

DASGUPTA: I'm just going to hop in with a quote, Zahra, because I know you have all sorts of smart things to say.

KHAN: No! [chuckles]

DASGUPTA: But I just happen to have the Ruth Wilson Gilmore quote in front of me. And Tim, you were asking, well, what if people feel anxious? Maybe you didn't use the word "anxious," but I heard the word "anxious" in there, in the question.

HOFF: Mmhmm.

DASGUPTA: What if people say, "Well, what do you mean abolition medicine? What are we abolishing?" And the brilliant abolitionist scholar and geographer, I believe, Ruth Wilson Gilmore says, "Abolition is not absence. It is presence. So, those who feel in their gut deep anxiety that abolition means knock it all down, scorch the Earth, and start something new, let that go. Abolition is building the future from the present in all the ways that we can." Right? So, it's a generative framework. It's a generative framework. It's yes, critiquing and pushing aside that which is oppressive. But it is as importantly, or I think, more importantly, it is creating something new and just together.

HOFF: Mmhmm. Yeah, I love that conception of abolition as a generative force, so thank you for laying that out. With that in mind, Yoshiko, you mentioned that there are already abolitionist efforts happening kind of all over the place through various independent groups and small organizations. Can we get a few examples of folks who are doing this generative work to address the needs in their own communities?

IWAI: So, I think we can also think about the way that Ruth Wilson Gilmore, who Sayantani mentioned earlier, talks about this idea of organized abandonment, which is this sort of idea that when communities are abandoned by legal, institutional, structural sort of support systems that other communities have access to, which all ties back to what Zahra was also just saying, then there are all these efforts that sort of sprout from the cracks. And I think when we look across the country, we can see those efforts as being abolitionist, I think, in many cases.

And so, the MH First, or Mental Health First initiative, for instance, is an anti-police-terror project that tries to sort of disrupt the need for police force in mental health crises. Right now, when we think about it, it's like why, when you call 9-1-1 for whatever crisis that is happening, why is it that police presence are even there, period? And when we look to lots of the populations that are incarcerated, mental health burden is so, so high, and you have to sort of start to ask with, I think, the questions of like, well, why are they here to begin with? Why was it that these forces of organized violence showed up instead of health care forces? Which is what, in most cases, people need first or people need, period, because they didn't have access to medication, to health care, to preventative care. Like Sayantani was saying, why are these people, why are some of these people, falling into the crisis to begin with more than other people? And I think MH First, for instance, is a really great example of that.

I know that across, I think it's starting in California, but just like these efforts to create a separate mental health crisis line so that people don't call 9-1-1, period. I think 3-1-1 line is coming up across the country, which is really exciting to see. But we also see them, I think, in smaller ways.

There are a lot of student clinics—which of course, we can go down many rabbit holes as to how we think about care and which populations are receiving what types of care, have access to student care versus other types of professional trainee care—but we see different efforts with student free clinics and how in particular their efforts around like gardening and giving free produce to patients who show up at these free clinics. Vanderbilt is a great example of this. I believe Rutgers also has one, too. And I think those are really exciting ways that we can see how people are reinvesting in community health.

In my area where I'm living right now—so, I'm calling in from Chapel Hill right now—the Durham Police just reallocated. They had 10 percent of money that was just not being used for anything. And so, they reallocated it and are basically investing, saying that they're investing, in community safety. And so, right now, they basically have a totally open white board. And scholars and students, all sorts of community members, people in health care are showing up to literally think about new ways that we can sort of disrupt that need again. And in many cases, it's sort of starting with that initial contact of police presence. But thinking about new ways that we can reinvest in community safety. So, I think I'm really excited to see it right where I live as well. But there are countless, countless efforts.

HOFF: Mmhmm. Yeah, this is reminding me of the conversation that was featured in our February podcast, talking a little bit about the redistribution of police budget funds in order to support things like increased mental health outreach. And that episode will have come out a month earlier than this one. So, folks who are interested should go check out that conversation with Dr Amy Watson.

Syantani, did you have anything to add to this discussion about where to look for good examples of abolition in practice?

DASGUPTA: Yeah. So, there's beautiful historical examples of communities taking care of themselves. We can go back and look at the Black Panther Party and my colleague Alondra Nelson, who's now actually working for the White House. She has written a book about the Black Panther Party's free health clinics, and we can go back and look at their work doing sickle cell screening and free breakfast programs, which counts as health, right? That's health. We can look at another colleague of mine has written about, Johanna Fernández, an old friend of mine, has written about the Young Lords and their sanitation

programs in the Bronx, the ways that they took over Lincoln Hospital to pressure that hospital, which primarily served that community, that local community, which was very heavily Puerto Ricans, Puerto Rican community, to do better. They brought in all sorts of new, innovative ways to treat, to do treatment around folks who were using drugs. They brought in training around acupuncture. So, I think there are really interesting historical examples of communities doing this sort of care when their local health care systems fell down or pushing their local health care systems to do better.

HOFF: Hmm.

DASGUPTA: And I think the question remains, well, how can we not put that burden upon the communities? How can we not, as a health care system, fall down but learn from these community movements and be in partnership with these community movements and allow community members to kind of guide our resources and efforts as medical professionals?

HOFF: Zahra, do you have anything to add?

KHAN: I just wanted to, I wanted to plug a new kind of movement/project. Miriam Kaba, who is a voice that has been present for a long time in kind of abolitionist organizing and movement making, is working on a new project that she's co-organizing called Interrupting Criminalization. And it's in collaboration with Project NIA, which is another organization that she started. And AirGo Radio, which is a new podcast, they're starting a podcast called *One Million Experiments*. And *One Million Experiments* is showcasing examples of how we define and create safety in a world without police intervention, without prisons. And they're doing this by sharing interviews with movement workers and people who are already keeping us safe through community-based safety projects. So, I wanted to plug that for folks who are listening in case they want to look into another podcast that is highlighting movement workers who are really doing the work.

But to Sayantani's point earlier, I kind of wanted to make mention of what we ourselves can do too, kind of on an individual level. And I think it's important for us to think about what we have direct power over right now and the areas that we can directly influence that can lessen and alleviate harm because those are the things that can produce ripples of change. And maybe that sounds kind of cliché, but it's true. Those are the things that can produce ripples of change. And Mariame Kaba, she talks about this by saying that it's about shrinking the space between our values and our actions and recognizing that that's a lifelong process. And it's not necessarily linear. It's sometimes us taking two steps forward and then three steps backward, but it's recognizing that we can. We can totally build wondrous things that are parallel to the challenging things that exist around us, and we just kind of have to try.

And then another quote I think that is useful is Naomi Murakawa's quote from her introduction to Miriam Kaba's book *We Do This 'Til We Free Us*, in which she's talking about how transformative abolition is. She says that abolition requires dismantling the oppressive systems that live out there and within us. And that's really, really central to what we're trying to get out with abolition medicine.

HOFF: Mm. I think that leads well into another question I had about the challenges of integrating abolitionist approaches to health care into current health professions education curricula. And Sayantani, if you want to respond first here, how do you find that students generally approach this topic? What's their either familiarity or openness to discussing these kinds of things?

DASGUPTA: Recently, we were working with a group at UCSF, and we used this question from Miriam Kaba and Naomi Murakawa's parts from that book. We asked these doctors in training, "What is the healing work you aspire to?" And I think we can each ask ourselves, what is the healing work we aspire to? And for me, as primarily somebody who is a scholar who writes but who teaches and who takes that role in a classroom very seriously, I think that those spaces within a classroom can be spaces where we individually and collectively speculate out better futures. And those classrooms can then be models for work that happens. Particularly when you're teaching health care professionals, what you do in the classroom can then translate into the clinic room, can then translate into the work that folks do in the community.

So, I have found health care students, pre-health care students are eager, are eager to not just learn about medical racism and histories of medical oppression, but they are eager to formulate together models of medical anti-racism. What's the problem I've come up against? It's not enthusiasm, it's not interest, it is a structural problem.

HOFF: Mm.

DASGUPTA: It is timing. So, my undergraduate students have the time, have the space to do this kind of classroom learning. My graduate students in the Narrative Medicine Program have the time, have the space to do this kind of classroom learning. Medical students from right up the road at my same institution are contacting me, saying, "Well, how do we get—this is integral to my passion. This is why I came into medicine—how do I get to learn the work of abolition medicine together with these colleagues?" And you know what? There's just not, at this point, the structural room for them to do so. There's these barriers. Even if, let's say, individual professors and Deans are enthusiastic about it, the curriculum is so tight, right? There's a Physics test at noon and a Physiology class at 2:00. And maybe if you can squeeze from uptown to downtown between 12:00 and 2:00, maybe you could squeeze in one hour in one semester. That's not the way, right? That's not a feasible solution.

And so, I feel like as critical as this work is to medical institutions, we've got to figure out a way to not have it be an adjunct, not have it be some add-on concept that comes on at the end of a long Anatomy lab day. This needs to be part and parcel of everything that people in health professionals' education do, every single thing, and that's been the challenge. It's not about enthusiasm or interest or passion. That is there among students, among professors, among administrators. But the willingness to kind of reformulate what a medical student's day and what medical education itself looks like, that's, I think, been the challenge.

HOFF: Hmm. Yoshiko or Zahra, anything to add?

IWAJ: I don't know if I can phrase this well. But I think in general, I also think with the nature of abolitionist work, is that, like Sayantani said, it's a structural issue. And so, you have the structural goal, which is abolition of policing and carceral structures. But then you have people who are incarcerated right now, and you have people who are dying right now under the hands of police guns and boots and all sorts of things. And you have people who are, you know, you have Black women who are dying right now from disproportionately high mortality rates when they're birthing babies. And it's like, I think it's really hard as a student, for instance, who wants to do this work, who aspires to continue to do this work, is to keep that structure, to fix a structural problem, but also recognize that there are the

immediate things that need to be done sort of now. And I think those don't necessarily always feel like they're going in the same direction.

HOFF: Mmhmm.

IWA: They don't feel like they're going hand in hand. And I think that also maybe ties into one of, the sort of anxiety question that you asked earlier, too. It's not that when we say this abolitionist effort, abolition of medicine, that we mean get rid of everything this second. Because, then there are no structures for people who are most vulnerable to oppression.

HOFF: Mmhmm. Yeah, that seems like a difficult space to inhabit and an intimidating one to get into.

So, I'd like to wrap up by asking how health professions students and trainees can get involved into this work. And Yoshiko, maybe you can speak to that specifically. And then how folks, even those who might be medicine adjacent or even just interested in the kind of community support that we've been talking about can assist in ongoing efforts to address broader health injustices.

IWA: Like Sayantani was saying, medical school, which is where I am currently, is so limiting. But I think one thing that I've found to be really exciting is finding those people. I've been really surprised. I'm at a medical school in the South, and I moved here from New York. And I was nervous. I was really excited about this work, but I was unsure if I was going to find people, if I was going to find faculty who I could do research. And I used to teach at a jail in New York. And that was really important to me, and that really sparked sort of my interest in carceral health. And I was wondering how I could continue this work and find those people who've been doing this and plug in to the existing channels so that I could contribute in my small way to the local community.

And I've been so surprised with the people that are doing work on the ground, whether it's MDs who are somehow carving out time between their clinic and their research and their community activism. And I have faculty mentors who go to town halls, who protest, who encourage students to go to those town halls with them and who will carpool with them and say, you know, "Hey, there's a town hall happening here. There's a juvenile correctional facility that's going up, that's supposed to increase capacity by X amount. I will be there," and who offers a hand to students who are interested in that work to show up and be a part of, I think, this political landscape and moment.

And I think right now it is sort of the perfect time. I think medical schools and leadership are recognizing that they have to do something, that they have to pay attention. And so, I think to really sort of maximize that and find the outlets that you're most excited about, for me, that's going to look so different for me than it's going to look for my friends, my peers, my colleagues, my colleagues across the country. I found it to be most exciting to find those mentors who are doing the work that I'm most excited about, which happens to be in the work of carceral health and at the nexus of sort of cancer care and education and how can we get medical schools to better integrate carceral health education into the foundation? It's like whatever specialty you go into, whatever hospital you're in, most students will care for somebody who's experienced incarceration, and that was something that I was really excited about. So, I found mentors who have really pulled me and pushed me, and I think especially when medical school and education feels so restrictive sometimes.

And there are days when I do my flashcards for like seven hours, and then I do my UWorld questions. And I'm like, well, it's dark outside. I think having those outlets where I feel like I can make tiny sort of reverberations and then hope, that will hopefully turn into ripples that will hopefully maybe, far, far, far down the line, turn into a wave somewhere, I think is really exciting. And for me, that's the way that I keep sort of my, yeah, my excitement and my energy and my momentum going.

And I've been really excited to see undergrads here reach out and say, like, "Hey, as a med student, I would like to do something like what you're doing." And I think that kind of, you know, those small gestures make me really happy and make me really hopeful that the base of the tree is only growing. And so, I think, yeah, I think finding people, finding community, and then being active in the ways that feels right for you. I think for some people, treating patients well is the activism, is the work. But I think for people who want to do other things, I think finding those pockets. And there's no other, there's no better place than medical school when your sole responsibility is to be a student, I think, to find those outlets. I would just say to be curious.

HOFF: Mmhmm. Yeah, that seems important. Thank you. Any final thoughts, Dr DasGupta or Zahra?

KHAN: I would say get excited, honestly. Because there are lots of toolkits and there are lots of lessons at our disposal, and we can use them to inform how we continue building on this moment in this time. And I would say maybe first and foremost, take pause, and take a moment to recognize the mentors in your life, be it the doctors or the aunties or the musicians from whom your knowledge and your inspiration extends and to bring them into this work with you. Because abolitionist thinking at its core is about building on ancestral efforts and the decades of work by Black and Indigenous and people of color elders who've been actively envisioning systems of care and who've been striving to achieve them for many, many years.

And then I would say to read and to study as much as you can and as much as your time allows. Study independently, but also build your political education collectively and then tap into existing organizations. Join groups that are doing the work already, build concrete skills, and share them generously. Yeah, maybe that looks like starting a reading group about abolition in health. Or maybe it means joining a peer-led mental health crisis response team like Mental Health First or a group that might be emerging somewhere near you or doing an online training. And maybe it means joining a mutual aid group. Maybe it means starting a community garden like Yoshiko was talking about a little bit earlier at your medical school or at your hospital or even at your own house to address food insecurity and to facilitate these movements for collective care. Or maybe it's getting out there and supporting legislation, right, around abolition, around reparations, abolishing the death penalty.

I mean, there's lots of stuff that we can do. And I think the fact that there are so many possibilities for me feels exciting because that's just it, right? Abolition is about radical creativity. It's not just a final outcome. It's not just an end goal. It's a creative act. And we do that together, right? When you do that creative work in community, our perceptions around just the range of possibilities that can exist just rapidly expands. [bright, folksy music returns] So, earlier, going back to earlier, Sayantani's point about what healing work we want to do in the world, let's think about that in community. And I think that's one way we can get closer to a world that's healthier and safer for all of us.

HOFF: Well, with that, thank you all so much for joining me today, for being on the podcast, for contributing to the Journal, for all of the research and scholarship and community support that you all do. It's been wonderful to talk to you all.

IWAI: Thank you.

KHAN: Thank you. This was great.

DASGUPTA: Thank you so much for having us. It's been a joy.

HOFF: That's our episode for this month. Thanks to Yoshiko Iwai, Zahra Khan, and Dr Sayantani DasGupta for joining us. To read the full issue and listen to our Author Interview podcast series, head to our website, JournalofEthics.org. For all of our latest news and updates, follow us on [Twitter](#) and [Facebook @JournalofEthics](#). And we'll be back next month with an episode on Latinx Health Equity. Talk to you then.