POVERTY AND THE ART OF MEDICINE:
BARRIERS TO EMPATHY IN MEDICAL EDUCATION

Heather M. Sloane

A Dissertation
Submitted to the Graduate College of Bowling Green
State University in partial fulfillment of
the requirements for the degree of

DOCTOR OF PHILOSOPHY
August 2015

Committee:
Andrew Schocket, Advisor
Michael Strand,
Graduate Faculty Representative
Sarah Rainey
Ellen Berry
ABSTRACT

Andrew Schocket, Advisor

Medicine is caught in a contradiction between values of scientific distance and compassion. These seemingly opposite concerns are negotiated by physicians on a daily basis, but are not addressed explicitly in medical education curriculum. This study investigates poverty as one particular issue caught in the contradiction between science and compassion. Medical education culture implicitly creates a variety of understandings of what it means to be poor in the United States and how poverty contributes to overall health outcomes. A cultural studies approach was utilized to analyze the topic of medical education and poverty from a variety of vantage points. The shift of medical education to a science focus in the early twentieth century is explored historically by looking at the discourse within the Association of American Medical Colleges’ annual meeting minutes as well as discussions within the *Journal of American Medicine*. Twenty-four physicians were interviewed directly about their experiences with poverty. Contemporary critical theory was used to analyze medical education culture and better understand how power is negotiated in medical settings across class. A debate emerges from discussions of poverty in early twentieth century medicine about the potential loss of the art of medicine for the science. The art of medicine is not carefully defined but is discussed as the doctor’s personal experience, the relationship between the doctor and the patient and what is uncertain about medicine. Science cultures did come in the way of the art of medicine but so did class dynamics. For some physicians, middle-class sensibilities and science cultures of detachment create poverty as invisible. Compassion and feelings of responsibility for the poor were common feelings shared by the physicians interviewed. Empathy for what it must be like to live poor in America was less common. From this analysis, this dissertation argues that doctors
learn about medical solutions, not only from their science training, but also from their personal experience. Knowledge that is gained by personal experience in medicine, or the art of medicine, is not interrogated in medical education. This study looked more closely at physicians that were able to empathize with the poor and physicians that engaged in activities to improve health care for the poor. Doctors who empathized with the poor discussed solutions like community-focused care and the need for cost consideration in medical education. Doctors are gaining knowledge about poverty from their personal experience with the poor, which could prove helpful in macro level solutions to disparities in health care.
ACKNOWLEDGEMENTS

I am grateful for the guidance, patience, support, and sense of humor of my dissertation chair, Dr. Andrew Schocket. I remember when I approached him to help me with this project and he very humbly said that at any moment I felt I needed to, I could fire him. Just making that statement made him the perfect choice. He has been the best blend of tough and generous and an excellent mentor.

I would also like to thank the other members of my dissertation committee for their nurturing support. Dr. Ellen Berry indulged my fascination with theory and at the same time made conversations about gardening, rock music, and illness equals to esoteric thought. She made it safe to make theoretical mistakes and valued the importance of making an attempt. I would also like to thank Dr. Sarah Rainey for broadening my understanding of gender and sexuality and sparking my interest in innovative teaching. Her work has huge potential for medical education and her perspective on love and grief has been invaluable to me. I would also like to thank Dr. Michael Strand, who unfortunately for me, came to BG late in my degree process. His input was so helpful and in the back of my mind I hoped to have the opportunity to work with him on future projects; hopefully this will still be a possibility from a distance. I feel very lucky for his kind advice and expertise in science and medicine.

I am a better person and better scholar thanks to my professors at BGSU. I was inspired by the teaching and scholarship of Dr. Radhika Gajjala, Dr. George Agich, Dr. Jeremy Wallach, and Dr. Lesa Lockford and they will continue to influence my work. I would also like to thank my fellow graduate students with their wild variety of research interests that intrigued me and also made me feel proud to be a part of a group interrogating power. All of my social work
colleagues at University of Toledo supported my part-time Ph. D. pursuit, which was long and arduous. I need to give a special thanks to Dr. Janet Hoy and Dr. Aravindhan Natarajan for their enthusiasm for cultural studies to work beside social work. The topic of professional education culture is dear to me because of my social work students who challenge me and make me think hard about what social justice means and how to approach professional training in a way that challenges the status quo.

I am continually grateful to the twenty-four doctors who participated in my research. They have taught me so much about what can be learned from medicine not just about disease and illness and treatment and procedures, but also about empathy and political action. I am still shocked at their willingness to give up precious personal time and talk openly about an issue like poverty. Kathryn Garbacz, my favorite medical social worker and dear friend, let me stay with her while doing research in Illinois and our conversations helped me feel I was on the right track.

Lastly (but not least), I would like to acknowledge my daughters, Skye and Terra, who inspire me everyday. It has been a joy watching them influenced by my study, which includes heated debate at the dinner table each holding their own at twelve and fifteen. I would not be finishing this project without the love and support of my parents and sisters who weathered my neglect so that I could follow a dream.

Acknowledgements never acknowledge the labor of the partner in these endeavors. To finish a project like this is impossible without someone taking over the day-to-day of the home and sacrificing joy for drudgery. I am so grateful to have a partner that understands this and who loved me anyway through the rigors of a doctoral program. I want to thank my husband, Rob Sloane, for his patience, his wisdom, and his unrecognized brilliance.
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INTRODUCTION

Poverty & the Art of Medicine: Medical Education Culture and Empathy

I worked for many years as a social worker in medical settings. Many of my social work colleagues and friends find it curious that I would dedicate so many years of study to the culture of medical education. It makes sense to me because I had to work side by side with doctors and found parts of our work together frustrating. Living in the medical world is living in a contradiction. Medicine is expected to be about science and technology and is valued for being cutting edge and rigorous and at the same time doctors are expected to be compassionate and caring and concerned for their patients’ wellbeing. These very different expectations do not always line up, which makes living in the medical world difficult at times.

When I had just graduated with my MSW, I landed a job at my hometown community hospital. I was assigned to the critical care as part of my duties. We had a string of deaths and I was having a hard time processing and coping with all the sadness and sorrow. I approached one of my favorite doctors. I always gravitated to the grumpy doctors. I think I know instinctively that their grumping hides softness and caring. He was an infectious disease doctor, much older than myself, a veteran to the ways of the ICU. I asked him how he coped with all the death. I remember him looking at me like I was an alien from another planet. It was clear that was a question I was not supposed to ask a doctor. He walked away and then walked back to me and let me know in so many words, “You cannot care too much for these people, you will go mad. You need to detach emotionally.” He was hardly the last critical care physician that I asked this question and no matter how many times I heard the same answer over the years, I never bought the answer. I only became more curious as to why doctors feel detaching from their patients is so important.
I am interested in looking at interactions between the poor and those training to be physicians. Medicine is a small subsystem of the overall U.S. culture and medical education is a time in a physician’s professional life when their exposure to poverty is most concentrated. I will be looking at the medical training experience for times when doctors ignore poverty but also times when doctors resist cultures that separate class. Medicine has looked to social work, bioethics and the medical humanities to help increase compassionate on the part of doctors (Friedman, 2002). Bringing in outsiders to raise physician cultural competence and emotional intelligence is not a new intervention. Cultural studies and feminist theory could serve as other helpful partners in exploring the social aspects of illness in partnership with medicine and the poor.

This study looks carefully at the emotional disconnect described in my example that results from medical education culture. Poverty is used as a lens to better explore physician empathy. The primary concern of this dissertation is to better understand how the culture of medical education over time informs beliefs about poverty in medicine and how the largely unacknowledged relationship between the poor and medical education in the United States has informed the construction of today’s medical encounter. This investigation is not solely out of an interest in medical culture and class dynamics but also how closer analysis of the connections between medicine and poverty may prove fruitful in better understanding the impact of science on larger societal practices of class separation. Emotional connection and how emotions play a part in political engagement in health care disparities by doctors will be analyzed.

**Cultural Study of Medicine**

In the book *Medicine as Culture* (2012), Deborah Lupton discusses five main focuses within the current study of medical culture: the body, representations of medicine, lay people’s
experience with medicine, power within medicine, and the feminist critique of medicine. Two of these concerns, body and power within medicine, are addressed in this study. Bodies are the home of affect and emotion. The construction of detached empathy and political neutrality as values in medicine will be analyzed. Doctors are required to show emotional constraint and discipline as proof of their scientific objectivity and expertise. I investigate the importance of the body to empathizing with others out of my concern for both patient and physician bodies. I am interested in learning more about how physicians cope with regular encounters of suffering caused by poverty. In this study I also look at multiple conversations across discipline that are struggling with and complicating the concern for cultural competence in medicine. I believe the culture of medical education and the study of poverty fall somewhere in those concerns, if not explicitly, then hidden just below the surface. Better understanding class dynamics in medical practice should give insight into negotiations of power within the medical relationship.

Medical Education and Poverty

Medical school in the United States is four years of undergraduate study usually in a premed concentration and four years of graduate medical school. The first two years of graduate school consist of preclinical classroom work that goes over body systems and disease and then two years of training with hands-on teaching in the teaching hospital or in the clinic with the close supervision of an intern, resident or attending physician. Several of the doctors interviewed for this study went to medical schools that break from this traditional mold and actually have medical students work with patients from the first year of medical school. There is some variation in the structure of medical education across the country but all follow accreditation standards and have the same core curriculum (Becker, et al., (2007); Shem, (1978); Bames, 2009).
In general, at the end of graduate school the student becomes a doctor but is not able to practice as a doctor until completing a one-year internship in a teaching hospital. After the internship year, doctors complete from 2-7 year residency programs depending on specialization (some also complete post-residency fellowships). The patients often assigned to medical students, interns, and residents are those without private doctors, and are often the poor. As one doctor put it, “for most teaching hospitals, the poor are the teaching material” (July 3, 2014, Family Practice). Teaching hospitals that house internships and residency programs serve large impoverished communities in agreement for receiving government funds. University medical centers serve the entire community regardless of insurance status and have the reputation of providing the newest and most innovative care. University medical centers often draw patients from near and far, and both rich and poor. One doctor interviewed for this research put it this way, “We saw people from all walks of life. We were caring for people from one of the poorest parts of the United States and also the world’s elite” (August 25, 2014, Infectious Disease). One of the realities of becoming a doctor in the United States is there is no way to avoid exposure to poor populations (Becker, et al., 2007; Shem, 1978; Bames, 2009).

Poverty is not an official medical diagnosis, but is a social ill. Poverty has health consequences not only for the poor, who are more likely to become sick because of living and working conditions, but also for the non-poor. Research has been accumulating that income inequality also has health consequences for the non-poor (Anderson et al, 2002; Banks et al. 2006; Fiscella et al, 2000; Haider, 2011; Kirby, 2008; Nelson, 2002; Wilson, 2009; Van Ryn & Saha, 2011; Carter-Pokras & Baquet, 2002). The U. S. is a prosperous country with significant income inequality and this inequality, as well as discriminatory practices that are often experienced by the poor (racism, sexism, homophobia, class discrimination), help to maintain
this inequality within U. S. culture (Haider, 2011; Banks, et al., 2006; Marmots, 2004; Fiscella, et al., 2000). Inequality in income and practices of discrimination in the United States are contributing to poor health outcomes for all -- yes even the white, and the wealthy.

Health care disparity within the U. S. is a current concern of medical educators. Medical educators are aware of the research being done on health care disparity and feel an obligation to better train their physicians to be sensitive to class difference and to practices of discrimination. Research shows the poor are often under treated and their life expectancy is much lower than other classes. The main focus of medical educators to end health care disparity has been to improve the interactions between doctor and patient and to provide training on what they call “cultural competence” (AAMC, 2005, 2010; Braithwaite, 2007; Deardorff, 2009; Zander, 2007).

In general, social contributions to illness or the doctor’s ethical role in fighting larger social ills, like poverty, tend to be neglected within the formal medical education curriculum. Because doctors are trained to focus on illness as an issue of the individual body there is rare training within medical education that helps doctors consider the social causes of illness and social interventions to help prevent illness.

Class Formation

Class and social position are difficult concepts to investigate, because both poverty and the middle class are ill-defined groupings. These class categories are slippery and change with time and cultural context. Many scholars discuss class not as a precise financial boundary but instead as a formation. A. Richardo Lopez and Barbara Weinstein (2012) write in the introduction to their book The Making of the Middle Class, that the middle class, on some level, is an abstraction (p. 20). There is an abstract notion of what it means to be middle class. The doctors’ understanding of poverty in this study was discussed through the lens of middle-class
values and middle-class practices. Poor and the middle-class patients were both held to middle-
class standards (unspoken rules of the middle class). It was evident, though, when doctors were
asked about poverty, they often defined class and understood poverty based on their own values
and habits as members of the middle class. Doctors were not only vaguely aware of the realities
of poverty, but also they were unaware of the ways their middle-class perspectives may not be
shared by their patients from poor and working class backgrounds. Doctors themselves discussed
poverty as mostly an abstract concept. For poverty to transform into a tangible concept required
particular experience by the doctors. Often what allowed doctors to see the realities of poverty
and connect emotionally with the poor had very little to do with medical training.

Class

Doctors serve as windows looking into the middle class. The medical profession is firmly
within the middle class both economically and rhetorically. Not only are doctors middle class
due to income, but also due to what Max Weber (2010) described as “status honor” (p.123).
Because poverty is a reality of many doctors daily work, physicians serve as a helpful vantage
point to observe and analyze social identity, social position and social obligation. Understanding
of class is often understood through comparison of class experience and differing class values.
Doctors experiences of negotiating poverty are helpful in better understanding middle-class
sensibilities and the “symptoms” of the middle class that come in the way of class understanding.
Discussing poverty with physicians is a helpful way to look at class formation.

Historical Context

Poverty

There have been brief moments in American history since the turn of the twentieth
century when poverty became visible to the middle class and the elite. Jacob Riis (1970 edition)
provoked concern through photographs and essays in his book, *How the Other Half Lives*, and outraged the middle class who insisted on tenement reforms. During the Depression, Franklin D. Roosevelt Administration used photographs of rural poverty through the Farm Security Administration to provoke concern and illicit middle class support for policies to improve living and working conditions for the poor. This photo campaign was used to put a human face on the Depression (Finnegan, 2003). More recently American poverty was brought back into focus in the coverage of Hurricane Katrina and the televised shock of reporters and politicians witnessing the devastation of poverty in a storm. Many questioned how poverty, like the poverty visible after Hurricane Katrina, could be possible in America. Spike Lee’s (2006) documentary series *When the Levies Broke*, again, put a human face on the suffering after the storm, in hopes that the images and interviews would provoke concern and bring help to the region, as well as call attention to black poverty in every city in America that goes unnoticed and unrecognized.

These moments of awareness seem very difficult to sustain and poverty quickly returns to dark places away from middle class and wealthy eyes. The author that will get the most attention in this project is Michael Harrington (1962), for his book, *The Other America*. Harrington pointed out ways in which poverty remains invisible in the United States and his work helped to provoke the Johnson Administration’s War on Poverty. Again this political focus and middle class-concern for poverty, provoked by Michael Harrington’s work, was only temporary. There is a pattern of disappearance and reappearance of the poor over time in the United States.

In a dedicated issue (The Poverty Issue) of *American Prospect* (July/August, 2012) celebrating the fiftieth anniversary of *The Other America*, political progressives and poverty policy experts discussed the current state of poverty in America. Political rhetoric contributes to a lack of empathy for the poor. For example, Ronald Reagan’s stance on poverty during his
Administration and be summed up in the following quote, “We fought a war against poverty and poverty won” (Edelman, 2012, p. 12). The Reagan Administration framed poverty as natural, as something that is inevitable and ridiculous to fight. Much like the Reagan Administration’s policies on racial inequality, the Administration’s argument was that if poverty could not be overcome with the “generous” policies in place to assist the poor and bring about more equality, it was the person in poverty who individually failed not the policies or the politics surrounding poverty (Crenshaw, 1995). This Reagan era rhetoric seeped into the middle-class consciousness leaving the poor to blame for their poverty.

The strategy for dealing with poverty since the Clinton Administration has not been much better, according to the experts. The strategy, put simply, was to give money and demand work from the poor (Edelman, 2012, p.12). From Reagan to Clinton all that was necessary to erase poverty issues was to have a poverty policy strategy. If the percentage of those who are poor remained low, the poor remained invisible and government policies were a success (Edelman, 2012). Poverty is often spoken about as a percentage of the overall population, which masks the personal struggle and stress of experiencing poverty (O’Connor, 2001). Rarely is poverty represented in a personal way to the public. Hearing about poverty as a number without hearing the personal stories of poverty makes empathy difficult and population numbers rarely inspire concern for the situations of the poor (O’Connor, 2001).

According to poverty policy experts polled in American Prospect, middle-class isolation and separation from the poor has increased since the 1960s. Angela Glover Blackwell (2012) explains, “So much of the country is isolated from people who are poor” (p. 51). Distribution of wealth has also slowed considerably over the last fifty years. Poverty policy over the past fifty
years has not created the possibility of a better future for Americans in poverty. Despite Riis, FDR’s, Harrington and Lee’s efforts poverty remains invisible.

Medical Education

Paul Starr’s book *The Social Transformation of American Medicine* (1982) is a sociological, political, and historical look at health care in the United States. This book is very important to the current conversation about the history of medicine in the U. S. Starr’s work is a counter narrative to a more embraced history of American medicine as world hero and as “A+” example of what comes from democracy, capitalism and a belief in scientific progress. According to Starr, the right to the title “medical expert” was highly debated and brutally sought after within the United States. Prior to a full-scale adoption of scientific medicine in the early 1900s, America had multiple ways of treating illness and multiple types of trusted healers. Public embrace of scientific medicine was not a given in America. Starr argues that there has been a history of healthy skepticism about experts (particularly medical) within U. S. culture. Starr’s book gives critical insight into how the role of physicians has been culturally constructed within the U. S.

*The Report of U. S. and Canadian Medical Schools* by Abraham Flexner (1910) is mentioned within Paul Starr’s book as a catalyst to a general public acceptance of doctors as scientific medical expert. Flexner’s report was part of a trend during the Progressive Era when institutions were investigated for injustices and reformed to protect the public from greed and dangerous practices inspired by the industrial age. This tenuous public acceptance of doctors as expert was made possible through Flexner’s report urging medical educators to provide a guaranteed, standardized, formal, and scientific medical training.
Starr questions the benefits and the cost of the tie between medicine and science and the dependency on science for medicine to be expert. Starr’s questioning was an inspiration for this investigation. This dissertation looks more closely at the benefits and costs of the relationship between science and medicine. The current relevance of these medical education changes from the past to today’s medical education culture will also be explored. The Flexner paradigm shift may have altered the relationship between doctor and patient, particularly the relationship between doctors and the poor. This study investigates the cultural impact of new practices of medical education requiring medical students to complete extensive internships working directly with patients in teaching hospitals across the country. This standardization of medical education practice guaranteed a long-term relationship between medical training and the poor in the U. S.

This analysis looks more closely at the result of this mostly unacknowledged relationship between doctors and the poor and what is learned from this cultural shift.

The reforms in medical education that resulted from the Flexner Report are not without controversy and much has been written about how changes in medical education created increased barriers for the working class, blacks, and women to pursue medicine as a career (Ehrenreich & English, 1978; Coulter, 1975; Morantz et al., 1982, Gasman & Sullivan, 2012). The recommended requirement of expensive science labs and hospital affiliations also made medical schools less likely in rural communities and the South. The South was still recovering economically from the Civil War, which made maintaining medical school facilities with labs and with access to hospital patients economically challenging without wealthy benefactors. Also the southern areas of the country were still struggling to provide large-scale primary and secondary education to their children. Requiring undergraduate education limited those in the south qualified to become a doctor.
To access medical school after the Flexner reforms, a student needed to successfully complete high school and complete some college, which was a challenge for areas that had rare high school graduates. Many medical schools exclusively for women, blacks and the working class were closed down due to Flexner’s recommendations. Many of these schools were limping along on meager resources. The older medical schools around the country (particularly in the South) could not compete with endowed university teaching hospitals like Johns Hopkins, Harvard, Michigan, and Pennsylvania (Flexner, 1910). Flexner continues to be criticized regularly today for helping to create an elite system of education. There were several Flexner conferences and journal dedicated to discussion of Flexner reforms in 2010. Much of the criticisms of these reforms focused on the loss of opportunity for blacks, women and the working class to enter medical school. (Bonner, 2002; Jewish Hospital and University of Louisville School of Medicine, 2010)

Barbara Ehrenreich and Deirdre English (1978) address gender concerns within medical training extensively in their book, *For Her Own Good: 150 Years of the Experts’ Advice to Women*. The authors write, “The resulting Flexner Report, which has been hailed by most medical historians as the most decisive turning point in American medical history, was about as unbiased as, say, a television commercial for a cold remedy” (p.78). Flexnerian reforms guaranteed, “the only roles left for women in the medical system were as employees, customers, or material” (p. 88). This analysis will not focus only on what women and black men lost in this paradigm shift in medical education in the United States, but also on the experiences and knowledge lost by all doctors when medical education began emphasizing scientific rigor over other well-established aspects of medicine often labeled the art of medicine. The art of medicine
grew to mean the physician’s personal experience, emotion and intuition as well as care and understanding the meaning of illness.

This investigation looks more closely at losses within the dominant culture of medicine. Post Flexner Report, medicine emphasized emotional distance between doctor and patient in hopes of maintaining scientific-levels of objectivity. Doctors were given the label of expert (by Flexner) within U. S. culture when the profession embraced standardization in education that emphasized science. The value of science is crucial to the U. S. medical identity and the professions long-term fight for legitimization (Starr, 1982). Looking at losses in the art of medicine at the point of this paradigm shift in American medical education could be a helpful to better understanding culture that helps to maintain poverty. Practices in medicine that marginalize the poor impact an entire community’s health. Medicine is not only the treatment of individual symptoms, it is also about the connections between people.

**Cultural Studies Approach**

I used cultural studies method to look at understandings of poverty in medical education culture. Cultural studies method, as described by Johnson et al. (2004), approaches a research topic from a transdisciplinary perspective. In this case of this study, multiple methods were used to analyze medical education and poverty while being conscious of postmodern concerns for the partial and political nature of investigation. I approached the topic of medical education and poverty from three vantage points: cultural history analysis, textual analysis, and coded interviews of practicing physicians. All three approaches were used to further investigate the culture of medical education and how medical school constructs particular understandings of poverty.
For the historical analysis and the textual analysis of interviews, attention was paid to moments when poverty was left out of the conversation and when poverty was kept invisible in medical practice. Ann Stoler (2009) suggests in her book *Along the Archival Grain*, to look for instances of uncertainty and doubt, discussions of power dynamics, and things that are repeated throughout historical discourse to better understand culture. Ann Stoler’s suggestions for analyzing historical discourse were followed by looking closely at medical school rules that did not meet up with actual practice, and discussions of feelings and emotions. I explored medical education concerns voiced in the annual meeting minutes of the Association of American Medical Colleges (AAMC) to better understand how interactions and understandings of the poor play a role in defining good physician and how work with the poor informed this definition. In a similar fashion to Foucault, this investigation relies on historical discourse to observe the various ways that poverty has been understood including an understanding of poverty as individual deviance (Foucault, 1990). Like Foucault, this study focuses carefully on resistance to constructions of deviance, in the case of poverty, and understandings that frame poverty as an illness of economics and not of an individual. This investigation looks at the variety of ways that poverty was discussed or written about at two points in medical education history (1905-1915 and 2005-2015), within professional text, popular text, as well as through physician memory and shared experience.

I will use literary analysis techniques were also used to read historical, literary, and interview/oral history transcripts for both poverty and empathy. Scholars like Edward Said (2004) relook at text with a new focus keeping in mind the margins. This study used literary analysis techniques much like Said in his essay, “Jane Austin and Empire.” Said reread classic British novels for colonial relationships. Literary analysis techniques inspired by Said’s work
were useful in better seeing dominant rationale for marginalization. Reading a work for the invisible margins also uncovers the neurosis of discrimination – in the case of Said, colonial oppression, and it the case of this study, class and science practices that come in the way of empathizing with the poor. I will explore cultural concerns about class and power through the lens of medical education in hopes of understanding larger societal practices and understandings that relate to poverty. Capitalism and democracy have not served all equally and prosperity that has come from industrialization and technological advance has not been evenly distributed. Medical education in the Progressive Era and medical education currently serve as helpful places to investigate how inequality stays hidden and also has health impact.

**Methods**

This project was based mainly on 24 interviews with physicians practicing in Illinois, Ohio, and scattered throughout the country (California, Maine, New York, Tennessee, Maryland, and North Carolina). The interview was semi-structured and I asked questions about doctors’ current practice in medicine with the poor. I also asked doctors to reflect back on their experiences with the poor prior to medical school, during medical school, and during their time in internship and residency programs. Doctors in the sample received medical training from around the country: New York, Maine, Connecticut, Virginia, Illinois, California, Colorado, Texas, Florida, Arizona, Pennsylvania, Washington, D. C.; Michigan, and Maryland.

I not only asked the physicians about their current practice with the poor I also asked them to remember back to their medical education. Oral history taking in medical settings is not new. Several oral history studies about medical culture have been helpful in better understanding the culture of medical practice. Beier’s (2009) analysis of a rural hospital over 100 year span and Lewis’s (1994) oral history work capturing the staff experiences at Cook County Hospital served
as inspiration for the approach of this project. The interviews for this investigation were done in person, when possible, in Illinois and Ohio. When in-person contact was not financially or logistically feasible, the interviews were completed by phone.

I recruited the doctors from my own network of physicians who were former friends or colleagues. I had not maintained any of the relationships leading up to contacting the doctors to be interviewed. I would not classify any of the doctors as current friends. I contacted people I knew from my undergraduate days in psychology and biology from The College of William and Mary and the University of Virginia. I had a fair amount of friends and associates who were premed and went on to medical school. I also recruited physicians I worked with while living in Urbana, Illinois as a medical social worker. I worked closely with many of the med scholars in the MD/PhD program at the University of Illinois Medical School as part of my role within a hospital bioethics team and also reached out to these physician scholars. All had graduate degrees in the humanities as well as their medical degrees. Physicians were also recruited through my health care social work contacts in the Northwest Ohio area as an Associate Lecturer in Social Work at the University of Toledo.

The doctors interviewed were from a variety of age groups and medical school cohorts. All went to medical school between 1960 and 1993. There were six women and five doctors of color represented within those interviewed. There was also a range of social position experiences. Eight doctors claimed to be from working-class and poor neighborhoods. Doctors shared experiences from poor, working class, middle-class and wealthy families. The type of medicine practiced by the doctors interviewed varied. The following specializations were represented in the study: hospitalists, intensivists, physiatrists, OB/GYN, infectious disease,
neurology, emergency medicine, medical administration, medical education, pediatrics, internal medicine, oncology, perinatalogy, dermatology, psychiatry, and family practice medicine.

Doctors are a difficult group to pin down for research and my relationship with the doctors participating helped me succeed in recruiting willing participants. Out of forty doctors approached about the study, twenty-four consented to participate. In my recruiting emails to physicians I reminded them of the work I witnessed and admired. For the doctors who I had not met previously, I conveyed comments from mutual colleagues that had referred the doctors to me. The doctors involved in this study were physicians that came quickly to mind, who connected well with coworkers and with patients, and had inspired feelings of admiration from non-physicians. Looking for doctors who connected well with others was a conscious choice on my part. Because I planned to explore empathy and connection to poverty, it was crucial to have doctors who could engage in discussions about connecting with others. Through my experience as a social worker, working with doctors, it was clear to me that the type of doctors I wanted to interview were those that left an impression with others that they were empathetic and caring.

The interviews lasted roughly an hour and were recorded for transcription purposes. Physicians were alerted that the recordings would be deleted once the interviews were transcribed and that the recordings and transcriptions would not be stored with any identifying information. Time commitment for doctors was tricky but very few doctors asked to reschedule and no doctors dropped out of the study once they committed to the project via email. The proposal for this study was accepted by the Human Subjects Research Board of Bowling Green State University prior to recruiting or talking with doctors. The doctors entered into the research relationship voluntarily and were informed that they could end the conversation at any time. The physicians were given a brief synopsis of the project in advance of the interview and were given
a consent form to sign. Physicians are not named in the project and details about their location were taken out of the excerpts used in the analysis. The only identifying information given in the analysis is the date of the interview and the medical specialization of the physician. The excerpts from the physician interviews used within the analysis have been edited for clarity and to bring multiple ideas together that might have been separated within the longer conversation. For example, the doctors tended to lean on pronouns, which when excised from the larger interview, made the smaller section used in analysis confusing. Every effort was made to keep the spirit and language used by the physician in the interview intact.

The interviews were semi-structured to allow for the physicians story to evolve from their perspective. Physicians were asked about the following topics: what led them to medical school, where they went to medical school, what they valued most about their experience, what was most challenging about their experience, what part of their medical education most prepared them for practice, and what was left out of their education that would have been helpful. These topics were important to better exploring general experiences of medical training and what of that training was helpful to doctors. Doctors were also asked to reflect on their encounters with poverty prior to medical school, during their medical education, and in their current practice. Doctors were asked to share their feelings about what the role of medicine should be in improving conditions for the poor. Doctors were also asked to consider the political role medicine plays and should play in economic suffering, and to consider the emotional costs of class separation.

**Inductive Investigation**

This was an inductive, qualitative project. I made observations about medical education culture and poverty over time. I identified themes and patterns from observations of historical
discourse, historical documents, and physician interviews. I analyzed the themes and constructed a tentative hypothesis. I considered this hypothesis beside similar contemporary theory about science, class, empathy and political action.

There were three methodological phases to this inductive study. In the first phase I read the Flexner Report (1910), the Association of American Medical Colleges (AAMC) annual meeting minutes (1905-1915) (2005-2015) found in Mary H. Littlemeyer Archives “AAMC Collection,” and a sampling of the Journal of America Medical Association (JAMA) (1905-1915) (2005-2015) found through the HathiTrust Digital Library for discussions of poverty. I read these cultural artifacts for how medical educators and medical practitioners were connecting with poverty and for concerns for the poor. I also read every AAMC presidential address from the timeframes for discussions of poverty. I also searched the annual meeting minutes and a random sampling of JAMA issues from these years for the words: poor, poverty, destitute, dependents, defectives and delinquents – all common words used for the poor (Henderson, 1893).

From this reading, the following themes emerged: the importance of personal experience to medicine and medical education, and the battle between what doctors framed the science and art of medicine. Physicians’ discussions of poverty emphasized the importance of doctors’ experiences with poor populations and their illness were as important if not more important than the science knowledge about these illnesses. Also doctors working with the poor often did not have science resources and therefore defended the value of the art of medicine, which involved the relationship with the patient, the importance of nature and the body to recovery from illness, as well as the physician’s intuition. Doctors discussed the art of medicine as the knowledge gained from the relationship with the patient, the environment of the patient, the meaning of
illness to the patient and the intuition of the physician that comes with time. The art of medicine stood in for the “old ways” or the practical application of science and not abstract, theoretical science. The art of medicine was always mentioned as separate from the science of medicine. Some doctors argued for the art as a valued part of medicine and considered the importance of non-science subjects as at least necessary to enter medical training.

From this initial exploration into the conversations about poverty, I created questions for the interviews/oral histories to better investigate more thoroughly doctors’ experiences of medical education both positive and negative and their experiences with the poor. The questions were designed to have doctors draw from their own personal experiences within medical school and medical practice and experiences of working in aspects of medicine that fall outside of science, like poverty, to better understand doctors’ use of the art of medicine.

After completing the physician interviews I coded the data, using ATLAS.ti, for the art of medicine experience and focusing on working with the poor. From this coding process two main themes emerged for analysis, class dynamics and science cultures. I read the physician interviews again carefully for discourse about class dynamics and science culture. I then analyzed physician experience with class dynamics and science culture to see what could be learned from physician experience about cultures that create class separation and that maintain practices that marginalize the poor. I analyzed physicians’ experiences that resisted dominant medical cultures and moved toward class connection as well as problem-solving and political action on the part of doctors around issues of poverty. Interviews with practicing physicians about their current practice and their memories of medical school were analyzed and read for experiences with poverty and understandings of poverty. Looking more carefully at physician
views about poverty, over time, and within various medical conversations helped to uncover ways that medicine and poverty relate within the U. S. culture.

I re-approached the interviews and read for empathy for the poor. Because there was little evidence of empathy and I discovered much more evidence for feelings of compassion and responsibility on the part of doctors for the poor, the novel *The House of God*, by the author Samuel Shem (1978), was used comparatively as an artistic investigation into medical education culture, class dynamics and empathy. Samuel Shem wrote *The House of God* about his experience as a medical school intern in the early 1960s. The book is fiction, but the author admits that much of the book reflects his feeling and experience as an intern in New York. This comparative analysis of interview/oral history and fictional account of medical education culture served as inspiration for imagining a medical education culture that emphasizes doctors as gifted problem solvers and how physicians could be crucial to political actions toward social justice because of their unique relationship with the poor and because of their valuable experiences with the art of medicine.

**Ethical Considerations**

My overall method for this study is influenced by feminist research ethics discussed within books like Allison Jaggar’s (2008) *Just Methods* and Soyini Madison’s (2005) *Critical Ethnography*. Feminist methods emphasize the limitations of the researcher’s perspective, and question the possibility of objectivity in observation. I am not a physician and I have not been a direct participant in medical education culture. I do have experience working directly with physician as a health care social worker working beside physicians but this is an outsider’s perspective. My observations will be partial and are informed by my personal experience and I see my role as an interpreter of text informed by theory, not as an objective social science
researcher. My work is clearly political and I hope to learn more about partnerships and increased empathy across class in hopes that this knowledge will lead to political action and advocacy to end injustices in health care. I have chosen purposefully to have research subjects who are in power and who have advantages that I do not have. Ethically, I still feel it is important to treat my research subjects with respect and use their words as much as possible and to learn from the personal experiences (often marginalized) of the physicians interviewed.

Cultural studies method, much like feminist method, challenges concepts like objectivity and understands research as a political space from a partial perspective. I have played a particular role beside physicians that is feminized. Medicine is a culture that relegates caring for the poor to allied professions of nursing and social work. The care of the poor has been historically constructed as requiring more emotional and behavioral expertise than scientific expertise (Cabot, 1977). I am aware that because of the role I have played beside physician as emotional expert that I might be reluctant to question physician authority and be critical of medical cultures. Because my research subjects hold power, this creates an interesting dynamic that is not normally discussed within feminist research ethics.

Feminist methods regularly focus on the ethics of research subjects with less power than the investigator. In the case of this study, the doctors have more status than the investigator. Where I do have power is in the use of the doctors’ words and in editing their comments. I could choose only to share excerpts from the interviews that serve my political concerns. I have tried to approach the data as examples of physician experience and feel it is important that multiple and varied experiences be highlighted to complicate how doctors form understandings of poverty. As Ann Opie (2008) points out when discussing ethics in qualitative research, it is important to use a wide variety of experiences when representing a group (p. 370). I dedicate an entire chapter of
this investigation to exploring those doctors who showed empathy for the poor and who actively consider solutions to health care disparity. Several doctors interviewed are active politically in ending injustices in health care. There was a conscious effort on my part to make sure not only to critique medical culture but also to emphasize strengths of medical practice and identify potential medical partners in political action.

I received feedback when discussing my research project from classmates and professors concerned that I would not be empathetic enough to the physicians’ situation and I was regularly warned that I could not possibly understand the emotional difficulty of practicing medicine because I have not physically practiced medicine as a physician. Empathy, however, does not require firsthand experience. In this project I am doing my best to practice what might be called “critical empathy” for my research subjects. I am trying to imagine through the doctors’ experience what it must feel like to practice medicine with the poor, and I am valuing the doctors’ experience with the poor as a space to gain valuable knowledge. That I am a woman critiquing medical culture also seems to transgress popular ideas of how women empathize, which seems to include not questioning.

I have received regular push back as an investigator of medical culture, and this behavior warrants future investigation. Reactions to my research approach have been a challenge and deserve further examination but not in this study. I did not however receive concerns on the part of the physician participants who seemed to find it perfectly reasonable that a social work investigator would want to ask doctors about poverty. Moments of anxiety, which were rare for the physicians interviewed, were about making sure their words could not be linked to them and their medical institutions and on even rarer occasions there was concern that they sounded to crass about medicine or about poverty.
Theory Medicine

Frantz Fanon’s (1952) work is helpful in better understanding the psychological effects of practices of domination and discrimination not only on the part of the person oppressed but also the oppressor. In his book *Black Skin, White Masks*, Fanon makes clear that discrimination is a social pathology that causes neurosis for both the marginalized and those engaged in marginalization. In the case of doctors, being asked to stay emotionally detached and politically neutral while watching suffering is a likely space for this type of neurosis to develop. Doctors are asked to be compassionate but at the same time objective and are warned that connecting with the patient will cause emotional damage (Halpern, 2001). Fanon’s work gives psychological insight into why income disparity causes health problems (Marmots, 2004). Both the haves and have-nots pay an emotional price when they are aware of inequality.

Foucault’s (1973) discussion of doctor’s power (particularly in *Birth of the Clinic*) not as top-down domination, but as nuanced complicated negotiation of public, state and economic power, is helpful to an analysis of medical education culture. The physician role is a unique place to investigate power dynamics because the role tends to mediate between the classes. Power and how power works within culture is an important topic to cultural studies. For Foucault, knowledge creation is a part of power, so discourse formation and resistant strains of argument are part of the exchange of power. The poor rarely have a voice in knowledge creation or discourse formation because they are often at an educational disadvantage and their cultural creation often goes unacknowledged. Thinking about how the poor exercise or possess power is an important conversation when looking at how medical institutions work in the United States.
Foucault reinterprets power in a way that is very helpful in considering the importance of connection and partnerships across class. Foucault’s work explores power without suggesting ways, which interest me as a feminist scholar, of advocacy and change. I believe considering class connection and partnership as resistance to capitalist practices of inequality is a new consideration. Imagining how medicine could be different if doctors recognized the contribution of the poor to medical knowledge and what would happen if doctors used their well-fought power to partner with the poor in a fight against social causes of poverty goes beyond Foucault’s investigations into health care culture.

The concept of biopolitics, analyzed in Foucault’s (2004) lectures in *The Birth of Biopolitics* and Thomas Lemke’s (2011) *Biopolitics: An Advanced Introduction*, is used to better understand the politics, economics, and culture of the U. S. after WWII. Very briefly, the fear of fascism and a global effort to prevent large-scale dictatorships after WWII led to concerns about government power. Foucault writes about how the free market would more likely lead to equality and justice than government intervention. Individuals in a biopolitical climate begin to value self-regulation and control at the level of the body and are motivated by industrial ideologies of productivity. According to Foucault, these motivations and behaviors turned out to be a much more effective way to maintain order than state facilitated physical coercion. A scientific and medical focus on populations also helped contribute to the ideologies of productivity and therefore science and medicine helped reinforce self-regulation as the norm.

In a biopolitical environment, those individuals who fall out of productivity (unable to flourish within the free market) are statistically insignificant anomalies. The poor (if kept below a certain percentage) are a natural occurrence and unavoidable. When the poor are understood as unproductive and poverty is understood as unavoidable, poverty ceases to be a concern for the
general public. Doctors are also perceived differently in a biopolitical climate. The doctor’s role changed to encourage self-regulation and body diligence and to prevent unproductive behavior and illness when possible. The doctor’s role shifted to a concern for industrial productivity.

**Poverty**

Frantz Fanon’s (1961) understanding of the power of the poor as crucial in post-colonial movements in his book *The Wretched of the Earth* also proves very helpful to this investigation. Fanon’s view of the poor as having power and knowledge that is crucial to an overall change for the better in our world inspires this investigation. Physicians take credit for the great medical advances of the industrial age, but when one looks closely these discoveries would not have been possible without the contributions of the poor as specimens in medical experiment. The poor’s contribution to medical discovery and the overall prosperity of the U. S., through labor, goes unacknowledged. Frantz Fanon makes a strong case that the poor have power and have been crucial to postcolonial revolution. Fanon argues that those who suffer at the hands of Imperialism are more likely to risk their life for any improvement. Historically, theory (particularly Karl Marx, 1955) leaves the poor out of political fights against injustice because the poor are made either invisible or the enemy of the working class – the true revolutionaries of Marx theoretical model. How the poor live and survive is important to all. Even though the lives of the poor are kept separate and invisible to other classes, all of the public pays the price for injustice and inequality. The health consequences of inequality are particularly clear when looking at epidemic illness globally. Much like in the classic short story by Edgar Allen Poe *The Mask of the Red Death*, the rich think they will be able to avoid the plague be separating themselves from the poor and in the end this is not the tragic case.
This investigation considers power and how it works both at the level of the body between the doctor and his patient but also on a macro scale. I will explore more thoroughly practices in medical education that are used to separate the poor from the middle class and the wealthy and how these practices come in the way of the poor having power in the current medical system. Doctors witness medical injustices toward the poor regularly, therefore I will analyze the medical encounter between the doctor and the poor.

Feminist Theory

Feminist theory has forcefully examined the importance of personal experience to knowledge creation. The experiences of women, the working class, people of color, the disabled and those that identify as queer have contributed immensely to our current understanding of the world. Experience from the margins has contributed to political movements and the knowledge from these experiences has helped to increased equality and justice for more people. The poor, however, have continued to be left out of this change and this conversation (Fraser, 2013). Medicine has been open to advisors from the humanities in the past, particularly at times when concerns increase about the profession’s lack of empathy (Friedman, 2002). Feminist theory complicates the understanding of objectivity by considering embodied empathy and an ethics of caring. Questions about objectivity, about power, and about emotion are not unusual for feminist cultural studies but are highly unusual for medicine. These theoretical considerations could contribute a different type of humanities analysis to medicine.

Experience

Alison Jaggar (2008) in her overview of standpoint theory addresses how knowledge is often acquired through practice and that knowledge is socially constructed. Jaggar explains that the way that people make sense of their world is through the values that surround them and
through the material reality of their day. Medical education plays a part in what doctors value and contributes to the material reality of their practice as medical students, interns, residents and doctors. When science and technology became more valued in medical education this sets up what knowledge is dominant as well as what Foucault termed “subjugated knowledge” (Foucault, 1980, p. 304). As science became the dominant knowledge of medicine, the art of medicine became subjugated knowledge. Science creates doctors as “disinterested” knowers who trust laboratory results instead of “connected” knowers, who trust knowledge that comes from personal experience (Jaggar, 2008, p. 239). Even within the uniformity of standardized medical education, there are bound to be differing standpoints and use of dominant and subjugated knowledge within medicine.

Objectivity

I will be looking at the barriers to a partnership between doctors and the poor and carefully at the medical concept of “detached empathy”, which is when a doctor shows compassion for a patient while also staying disconnected emotionally in order to be scientifically objective and rational within the clinical process. I will be using Donna Haraway’s (1991) work, “Situated Knowledges: The Science Question in Feminism and the Privilege of Partial Perspectives,” to complicate emotional objectivity on the part of physicians. Much like people bring lived experience to scientific observations of others, doctors also bring personal lived experience to medical practice. Haraway and other feminist thinkers have questioned the ability of researchers to be objective and have considered other ways of conceptualizing scientific objectivity.

Some of the practices of scientific research have also found their way into the direct relationship between doctors and patients. Detached empathy for the patient, and political
neutrality on the part of physicians are concepts that are commonplace within the practice of medicine that have their roots in scientific experiment and a concern for scientific objectivity (Halpern, 2001). Doctors use the language of science when discussing interactions between doctors and patients but there has not been an acknowledgement of the relationship between the doctor and patient as being similar between scientist and subject. It stands to reason that detached empathy is also a practice, like objectivity, that can be questioned as possible. Thinking about the doctor/patient relationship in this way complicates our understanding of ethical medical practice. I am suggesting in my dissertation to imagine each interaction between doctor and patient as scientific experiment. In other words, the physician makes scientific gains through observations of each patient. So science and non-science knowledge is gained from each therapeutic intervention.

**Emotion**

Skills of empathy and care are often dismissed as irrational and feminine in traditional environments like medicine (Halpern, 2001; Goleman, 1995). As the environment of medicine changes quickly with new technology and a biomed global focus, emotional intelligence may prove crucial to finding connections between people and creating partnerships across class (Cheng, 2007; Hampden-Turner, 2000). It makes sense that scholarship from the margins should become highly influential in the current cries for medical education reform. I will be using feminist theory to analyze how medical knowledge is created and also to consider ethics of medicine in a different way that values connection and emotion and that questions the ethics behind claiming expertise and objectivity in applied scientific practice.

When looking at an understanding of embodied empathy I will be bringing in the work of the philosopher Edith Stein (1989), *On the Problem of Empathy*, to consider more closely how
empathy happens and how our body and emotions are needed to empathize with others. My political hopes for this project are to discover ways to develop empathy on the part of physicians that will lead to partnership and social action. Feminist theory’s aim to recapture the body and emotions as a part of knowing and finding meaning; as well as valuing “connected knowers” will also serve as theoretical grounding for my investigation into medical education culture and its intersection with poverty (Jaggar, 2008, p. 241). Medical educators are calling out for cultural experts in their negotiation of public outcry over health care disparities. I would argue that feminism and cultural studies scholars fit the bill as cultural experts.

I will not be the first to look at the culture of medical education or to imagine a different approach to the way doctors are taught. D. A. Schon’s (1987) book *Educating the Reflective Practitioner*, Paul Farmer’s (2001) book *Infections and Inequalities*, and Albert Carter’s (2006) book *Our Human Hearts: A Medical and Cultural Journey* are just a few authors who have considered different ways of going about educating thoughtful and politically engaged physicians. I will, however, be considering the cultural emphasis on a relationship between science and medicine and the practices used to maintain objectivity between doctor and patient, like detached empathy, as well as class practices that likely come in the way of understanding.

**Significance of Research**

An investigation into medical education culture and understandings of poverty are important to me because of my experience working in medical settings. The contradiction that exists within medicine to be scientific and technical and at the same time caring and compassion can create a difficult environment to negotiate. This study of how physicians construct understandings of poverty can also contribute to theoretical considerations within cultural studies and feminist theory about medicine, poverty and experience, objectivity and emotions.
Cultural Studies

Cultural Studies started with the aim to improve living conditions for all by fighting for equality (During, 1993; Williams, 1996). The entry of working class youth into the academy in large numbers after World War II brought people with working class perspectives to higher education, which was geared toward the elite. What was being taught did not fit the everyday life experience of the working class students. Scholars with cultural studies commitments pushed to study everyday practices and folk art. Both high art and low art became worthy of study due to cultural studies scholars. Cultural studies scholars demanded that culture became crucial to understanding how power worked within society as well as emphasized the importance of critiquing capitalist economic practices that stood in the way of equality.

In the criticisms of cultural studies and discussions of the future of cultural studies there is skepticism that some of the earlier concerns about class at the point of creation of cultural studies have been lost. Michael Bérubé (2009) makes this point when he cautions that cultural studies scholars are often unaware that there is more to the academic structure than English departments. Cultural studies could benefit from casting its net a bit farther out into the academic waters. Lawrence Grossberg (2012) brings up the long-standing question about the ethical obligation of the intellectual to address inequality. Addressing inequality directly instead of through cultural critique will require development of collaboration skills, which include finding strengths in potential discipline partners. Better understanding the sociopolitical aspects of culture has been an invaluable tool to cultural studies, and cultural interventions could prove helpful in direct practical ways in medicine to better understand how to fight against injustice.

Cultural study scholars have not worked on a large scale beside the professions (medicine, law, counseling, social work, nursing) in that very few professionals are also cultural
studies scholars. There are many possible reasons for this. The professions however are very concerned with culture currently not from a sociopolitical standpoint or how culture plays a part in power, but how insensitivity to cultural difference is impacting their relationship with the community. The professions, in general, have not fully embraced postmodern theory and the work of the humanities or interdisciplinary scholarship like cultural studies. Medicine, like the rest of the academy, has had more of a presence of working class and members from the margins since World War II. Medicine was not always so elite a practice (Starr, 1982). The concern about the general public’s attitude toward medicine continues and changes in form over time but remains vital to medicine being conceived as expert with unique knowledge that deserves class status. Trust by the public is very important to remaining expert, so accusations of insensitive practice are serious concerns for medicine.

When scholars like Grossburg and others discuss the future of cultural studies, they often talk as if the academy has been fully reformed and that all academic disciplines have taken the cultural/interpretive turn but this is not the case. The professions (including medicine) and poverty studies have not fully embraced the contributions of poststructural and postmodern theory. Exceptions to this would be emerging fields of medicine like narrative medicine and radical/critical social work. (Shapiro, et al., 2006; Klosterman, 2009; Reisch, 2002). Medicine generally is not aware of the cultural turn but could benefit from what has been learned by postmodern humanities scholars about culture, particularly medicine’s concerns about cultural competence.

Feminist Theory

Cultural studies and feminist theory are helpful to an analysis of medical education culture and poverty. In some of the newer discussions about class and feminism, Nancy Fraser
(2013) writes about the second wave and the two major political agendas that were initially supported by the movement, a redistribution of opportunities (promoting economic equality) and recognition of difference/marginalization (“valorizing difference” p. 4). Fraser argues that concerns for inequality were abandoned for difference in the United States and it is clear both difference and distribution are important to changing the everyday lives of women. Second-wave agendas have not been completely successful because domination can still be found in the daily lives of women. Fraser suggests as a solution a feminist agenda that actively makes “gender-sensitive revisions of democracy and justice” (p. 1).

Fraser urges that feminism work not only toward public equality with men but also the more private-sphere “equal standing of partners in interactions” (p. 11). She also suggests that second-wave approaches to inequality and the two apposing economic approaches to inequality (self-regulating free market and protecting people from the free market) have been shortsighted. She adds that both economic and societal answers to inequality can mask “vehicles of domination” (p. 229). It is important to emancipate people who are economic disadvantaged by exposing practices of domination (p. 230). In this study I make an effort to expose practices of domination that go on in the interactions between doctors and their patients as well as the interactions between medical schools and their students.

This investigation will not only look at cultures of domination in medical education and medical practice but also it will contribute to the cultural studies conversation about poverty, particularly within the U.S., where cultural studies has been criticized for being too focused on identity and not enough on policy, economics, and the early concerns of class inequality (Grossberg, 2010; Berubé, 2009). Scholars concerned with poverty in the U.S. discuss how the practice of segregation of the classes has been helpful to maintaining stereotypes about the poor
(Rachlis et al., 2012). This study looks at class interaction between poor patients and middle-class physicians. It is unclear if the current framing of the relationship between patients who are poor and their physicians benefits either group. There has been little focus recently on the cultures that help to construct the U.S. understanding of poverty and in this project I hope to explore how medicine contributes to this construction (O’Conner, 2001).

Research about health care disparity shows proof of potential health consequences to income inequality and that those from affluent neighborhoods, regardless of class, enjoy better health outcomes. These findings beg the question, what is the impact on general health of the medical practices keeping poverty invisible and separate from other classes? Doctors are firmly within the middle to upper class and their work brings them into regular proximity to the poor. Because doctors’ experience is unusual for their socioeconomic status, physicians are a helpful group to question about their experience with the poor and how these experiences alter (or do not alter) their understanding of poverty. The rare medical educator concerned with cultural insensitivity teaches their students facts about various cultures and often poverty is included as a culture. Conflicts between medicine and the public have resulted in education practice reform like cultural competence training, so this conflict seems a helpful place to complicate and examine as a cultural studies scholar. Feminist understandings of body, empathy and caring could also be helpful to rethinking of the relationship between doctor and patient that not only encourages empathy by doctors to experiences of poverty but also fosters partnership and political action.

Summary

Chapter One gives historical context to the rest of the investigation. At the point of the Progressive Era and the famed Flexner Report, American culture shifted toward science both
publicly and privately. It is important to look back at the historical event of the Flexner Report to see what was lost during this paradigm shift toward science and the changing economic scenery. With the move from bedside to laboratory medicine the art of medicine became threatened. In Chapter One I read the Flexner Report, the AAMC annual presidential addresses and JAMA for the art of medicine. This chapter begins to investigate what can be learned by looking closely at the art versus the science when considering understandings of poverty by medicine. At the laboratory science shift in medical education in the United States, medical education practices, values, and attitudes reflected a cultural emphasis on rigorous science training and the need of science knowledge to cure illness and disease. Solutions to medical problems are complex and benefit from a blend of knowledge from science and art.

Chapter Two considers the critique of other scholars that the Flexner Report solidified medicine as a white, male and middle-class pursuit catering to a middle-class clientele. I explore class dynamics by looking at the physician interviews for how doctors spoke about poverty and how doctors constructed poverty through the lens of middle-class sensibilities. The middle-class importance of professionalism, status, independence, democracy and discipline is investigated. This chapter focuses on class dynamics in medical training and medical practice and attempts further theoretical consideration of cultural strategies like class separation from a physical, psychological and social standpoint. The construction of the poor as invisible made famous by Michael Harrington is analyzed and complicated with a close exploration of what causes social blindness in doctors who represent rare members of the middle class by being in regular physical proximity to the poor. This chapter considers Harrington’s charge that if we solve the poverty problem in the United States, we solve most of the other social problems plaguing the nation. There is a complexity to class dynamics in medical settings. The poor do not always remain
invisible as Harrington suggests. Some doctors did have social blindness and even though in regular proximity to the poor did not see their lived experience. However, other doctors were able to see the circumstances of the poor even in an environment that does not encourage this recognition.

Chapter Three investigates how linking middle-class status to scientific expertise of the Progressive Era impacts the practice of medicine today. I explore more carefully the impact of science values of sacrifice and specialization. Doctors mention both science and human motivations for coming to medicine, however medical training, as it is currently structured, emphasizes the science only. Poverty is a problem faced within medicine by doctors but poverty can’t be solved through laboratory science. Some doctors continue to lean on values of science while discussing poverty. Asking doctors to consider poverty required doctors to rely on knowledge from personal experience and falls into what doctors term, the art of medicine. I highlight several medical specializations in this chapter to get a better understanding of what is meant by the art of medicine and how different training and different approaches to medicine are more likely to create concern for the poor. Some doctors are more comfortable with the use of the art of medicine than others and these differences are informed by a doctor’s embrace of science.

In Chapter Four I complete a comparative analysis, reading for demonstrations of empathy for the poor, in both the physician interviews and the novel *House of God*. There was evidence in the physician interviews that doctors exhibit compassion and feelings of responsibility for the poor. The desire to help and feeling guilty about not being able to help the poor is not the same as empathizing with the poor. Feelings of compassion and responsibility do not always lead to thoughtful consideration of what it must be like to live poor in the United
States. Empathy is a necessary catalyst to people taking action against inequality. The physicians interviewed, in general, did not discuss emotions, which made observations about empathy difficult. Empathy expressed by the character Basch in *The House of God* proved to be helpful in considering the possible importance of empathy to medicine. This chapter considers the possible importance of empathy to political action and physician’s love of problem solving to issues like poverty. I looked more closely at doctors who did demonstrate empathy for the poor in their answers to questions in the interview as a way to better learn why these doctors are different. Empathy does appear to be important to a more complex understanding of poverty by doctors to include social a political reasons for poverty.

Chapter Five explores solutions suggested by doctors to health care disparities and the health impact of income inequality. This chapter also looks at political projects that doctors are involved in that advocate for social justice in health care. Several doctors discussed how new students coming to medical education today are concerned about social injustice. Doctors who were able to see the complexity of poverty as having social and psychological impact, and who had experiences with the poor that moved them from abstract to tangible understandings of what it means to be poor in America, were the doctors engaged in problem-solving with the poor. Cost-considerations in medicine and community-centered care were common concerns by these doctors. Many physicians felt that political engagement was crucial to health care at this point in history. Doctors are learning from their experiences with poverty and are coming up with solutions to better care for patients who are poor because physicians are empathizing. Doctors are making the link between living poor in America and injustices that lead to overall poor health outcomes. Doctors are coming to these conclusions without formal training that fosters macro level problems solving as the responsibility of medicine.
Physicians, unlike other members of their class, actually work with the marginalized. Medicine is a place of class integration, even if this is not formally acknowledged and addressed formally in medical education. Unfortunately, the culture of medicine and the practice of medicine often deny the potential of the relationship between the poor and medicine. How can the culture of medical education help physicians better see oppression and speak out about oppression? Doctors are important to helping the public begin to see that inequality is one of our most deadly illnesses. The skills that physicians are asked to develop in medical school and over years of practice are used almost exclusively in making decisions on a micro-level, between individual patients and doctors; about specific presenting symptoms. Doctors’ experience with the poor and the medical treatment of the poor are an important element of medical education in the U.S. The potential of doctors as helpful partners in better understanding poverty should not be dismissed. The skills that doctors develop from years of experience could also prove helpful to macro-level illnesses, like poverty, where there are no simple solutions. Those schooled in medicine have unique problem solving skills developed in complex environments. Doctors have years of observation about illness, and gain knowledge from their experience working across class, knowledge that often goes unacknowledged and is rarely tapped into by the public. Recognizing the silent relationship between medicine and poverty could be helpful in imagining medical practice that might foster equality and justice.
CHAPTER I: AMERICAN MEDICAL EDUCATION: LESSONS FROM THE
PROGRESSIVE ERA

We have a profoundly unjust health care system in the United States. The imperative to transform academic medical centers and health care are [is] an ethical imperative for us [medical educators], not a political choice we make. (Darrell G. Kirch, 2010)

Darrell G. Kirch, the current president of the Association of American Medical Colleges (AAMC), in his annual address in 2010 to the membership, linked the current concerns of American medical education to the year 1910, the year of the Flexner Report (AKA: Carnegie Report on Medical Education in the United States and Canada). The Flexner Report was a scathing review of the condition of medical schools in the United States and Canada during the Progressive Era. The Flexner Report served as catalyst to public outcry for medical education reform and resulted in a paradigm shift in medical education that required rigorous scientific training and increased hospital clinical experience. The 100th anniversary of the Flexner Report caused many medical educators in the United States to reflect back on the history of the American medical college and the structure and traditions of medical education that were firmly established. Dr. Kirch (2010) remarked in his presidential address to the AAMC, “While some have viewed the Flexner-centric focus of this year as an indictment on our educational programs, I see it as providing new energy for accelerating the collaborative educational innovation being driven by many of the people in this room.” Reflecting back on a hundred years of medical education was more than an opportunity to critique the past, it was an opportunity to look at what was lost and what could be gained if medical educators take a moment to consider and even imagine new approaches to professional training while also considering medical practices and traditions that may have been lost in the Flexner paradigm shift.
Importance of Looking Back

The paradigm shift of American medicine to laboratory medicine is often credited to Abraham Flexner as a result of a simple report assessing the conditions of medical schools in America and Canada. In an essay titled, “How Does Illness Mediate Social Relations?” Karl Figlio (1982) is critical of how historical events are processed. He writes, “We have a tendency to think of events as over and done with, and somehow put out of the reach of change,” and he goes on to write, “Then we call these settled things, ‘natural,’ and we use them to judge the limits of change in the future” (p. 176). The Flexner Report is just such a historical event. Abraham Flexner was an education reformer. Like many educators during the Progressive Era, he believed that education would lead to more equality and that learning from experience was vital to knowledge creation at a time when industrialization and science were changing lives at a dizzying speed. Both those who champion Flexner’s reforms and those who critique him still tend to speak about the Flexner Report as over and done with.

For those unhappy with the state of medicine, the Flexner Report is held up as the beginning of corporate medicine and the political protection of the medical profession (Starr, 1982). However, those who take pride in the advances made by American medical education since the 1900s, credit Flexner with being the beginning of state of the art medical care available at least to the well insured in the U. S. (Duffy, 2011). But even within these arguments, the importance of science to medicine is a given. Physician critics of the Flexner reforms warn that the lack of concern by medical educators about the social and emotional aspects of medicine in favor of expertise in body systems and disease has become “natural” (Duffy, 2011).

The general public rarely questions the traditions of medical education that were put in place in the early 1900s or the traditions that likely contribute to the public’s well documented
dissatisfaction with doctors with issues like the treatment of pain and physician inability to be caring when a loved one dies (Duffy, 2011, p. 274). Looking back into medical history seems antithetical to encouraging medical progress, but Figlio points out, what might seem settled could be important to imagining change and pursuing needed reforms in healthcare today. The Flexner Report was only a part of a much more complicated change in American culture. The Progressive Era was not only a time when science becomes more important to medicine, but also science became more important to everyday life.

Access to everyday technologies was not equal. The middle class could afford pasteurized milk, flush toilets, vacuum cleaners and tile surfaces that were easier to clean (Tomes, 1998). Understandings of illness and the use of medicine during this time differed by class. These differences contributed to class practices that continue to this day. Class practices, experiences of illness, and the modern push for scientific progress may prove important to imagining reductions in inequality and marginalization that are a part of the “profoundly unjust” American medical system of today that Dr Kirsch warns against.

**Review of the Flexner Report**

In 1910, the Carnegie Foundation commissioned the Flexner Report or more formally known as *Medical Education in the United States and Canada*. This report was the end product of an investigation into all of the medical schools in the United States and Canada. According to many medical scholars today, the report was the catalyst for the Flexnerian revolution in American medical education. Flexner had a vision to create American medical colleges into public institutions that safe guarded public health and advocated for social change (Muller et al., 2010). But Flexner’s vision was a short-lived reality. Over time, Flexner’s hope for American medicine eroded. Instead of maintaining a focus on improving the human condition, the focus of
medical education became advancing medical technology and medical science discovery (Muller, 2010). The roots of today’s medical education structure, practices and values can be found in the Progressive Era’s embrace of science and the rapid changes spurred on by medical education reformers of that time, as well as shifts in class dynamics resulting from the industrial revolution.

**Abraham Flexner**

When reading about this time in medical history it is hard not to get caught up in the romanticizing of men like Abraham Flexner. Flexner came from poverty and his humble beginnings did not stop him from becoming an influential and an innovative citizen. Abraham Flexner has been written about quite a lot within medical history and he has been studied in a traditional way as a great man of his time (Bonner, 2002; Flexner, 1960; Nevins, 2010; Wheatley, 1988). Flexner was a celebrity and covered in the papers as a man fighting for the little guy by uncovering the greed and corrupt underbelly of U.S. medical education. Flexner was an outsider. He was not from wealth, he was not a doctor, and he was a Jewish educator from Kentucky. Flexner seems an unlikely hero of his time (Wheatley, 1988, p. 47). Even though he had no medical experience and came from modest means, Flexner was welcomed by academics, philanthropists, and government officials and was adored by the public (Bonner, 2002). Flexner was crucial in getting the public involved in the process of reforming medical education. *The New York Times* featured the Flexner Report and titled its coverage, “Factories for the Making of Ignorant Doctors” (Bonner, 2002, p. 69). The Report made the front page of many newspapers particularly in communities where medical schools were found lacking in Flexner’s investigation. Out of fear of public outrage, many medical schools merged or invested money to improve their medical programs. Flexner was able to involve the public and the media in ways
that the AMA and the AAMC had failed to do. Flexner helped to create many partnerships among the wealthy, higher education, state government and medical associations, by publically unearthing the corruption in medical schools. These reforms were possible in part because of public outrage and a changing public expectation for medical practice.

Abraham Flexner was described as soft spoken and shy in person but his writing style was bold and he stubbornly held strong to his vision of social justice through progressive education (Wheatly, 1988). Out of 155 medical colleges total in the nation at the time, only fourteen colleges met Flexner’s expectations (Flexner, 1910). Flexner was a student of the newly formed Johns Hopkins University. According to historians like Bonner (2002) and Wheatly (1988), Flexner was a loyal alumnus and believed strongly in the progressive values of this institution. Flexner unapologetically modeled the structure of his ideal medical college after Johns Hopkins Medical School. His brother, Simon Flexner, was a physician and a great help to him with the medical aspects of the report for the Carnegie Foundation.

Abraham Flexner visited all (155) of the medical schools in the U. S and Canada. He spent very little time at each school, only hours. He focused on entrance requirements, the size and training of the faculty, the size of endowments, and the condition of laboratories and available clinical resources (Wheatley, 1988, p. 48). Many medical educators were outraged by his report and the approach of his investigation. The President of Tufts University, F. W. Hamilton, fumed to the press that the report was “neither fair nor accurate” and “misleading even where its statements are not technically incorrect” (Wheatley, 1988, p. 51). He continued, “The investigation which Mr. Flexner has undertaken is utterly worthless because of its vicious method of approach” (Wheatley, 1988, p. 51). The Flexner Report was very influential to the redesign of medical education, but was only one event in complex cultural changes.
Reading the Flexner Report for Class Dynamics

Many claim the Flexner Report helped to transform institutionalized healing into a middle-class practice (Ehrenreich & English, 1978; Starr, P. 1982). Prior to his reforms, people could go to medical school without a high school diploma and so, medicine as a trade and was not off-limits to people of modest means. The rigorous education to become a doctor that Flexner was endorsing would put medicine out of reach for any person that was not already a part of the middle class. It became much harder to work while in medical school, and a person needed the financial backing of his family or a benefactor to pursue medical education. Flexner was aware of these criticisms at the time that his report was published and his view was that "poor boys" needed to meet the standards of good doctor because the “cost of a bad doctor was too high” (Flexner, 1910, p. 43). Flexner wrote, “Your ‘poor boy’ has no right, natural, indefeasible, or acquired, to enter into the practice of medicine unless it is best for society that he should” (p.43). Flexner did not think educators’ concerns were warranted about the new scientific medical education excluding potentially talented students from the working class. Flexner was convinced working-class youth would continue to want to be doctors and nothing would stand in the way of their pursuit.

It is possible Flexner’s understanding of poverty was informed by his own childhood experiences with poverty in Kentucky after his father’s death. Flexner described his mother as poor but she persevered. She made great sacrifices for her children and always stressed education (Flexner, 1960). For Flexner, a poor person merely had to believe he could overcome obstacles to overcome what stood in his way (Flexner, 1960, p. 8). Quite naively Flexner discussed how the poor would not be excluded from new requirements in medical education because money
would come in the form of philanthropy (Flexner, 1910, p. 43). According to Flexner, all the “poor boy” needed to do was be a good student and graduate from high school.

What Flexner did not address was the reality for many poor children. In the Progressive Era children worked in factories to support their families and earning a high school diploma was difficult for the poor. Often working-class youth who pursued education did not have the blessing of their families and had to figure out how to juggle work and school (McGerr, 2003). Medical school for the working class would mean many years of working hard outside of school, maintaining the appearance of complete dedication to medical education, while also facing a multitude of barriers to get to medical school. Scholarship assistance would not erase this reality for the poor boy. The rapid move from not needing a high school education to requiring a college degree to enter medical school did create barriers for the working class (Ludmerer, 1999).

Flexner did feel, however, that there needed to be black medical colleges and he spent time, after his report closed several black medical schools, finding philanthropists who would help endow the most healthy of the black schools (Wheatly, 1988). In Flexner’s political plea to help save black medical colleges he wrote, “The negro must be educated not only for his sake but for ours. He is, as far as human eye can see, a permanent factor in the nation. He has his rights and due and value as an individual; but he has, besides, the tremendous importance that belongs to a potential source of infection and contagion” (Flexner, 1910, p.180). Throughout Flexner’s report there is evidence of his fear of illness generated within the poorer classes and in particular the poor of color. He warned that without black doctors the diseases of the black poor would penetrate the middle class.
Flexner wrote that the medical profession had an ethical obligation to prevent disease; in his report he urges his physician audience to "heal the sick and protect the well" (Flexner, 1910, p. 68). Unfortunately Flexner’s concern for the future of black doctors was limited and informed by an understanding of race during his time. During the Progressive Era, it would be rare for white middle-class Americans to feel comfortable seeking the services of a black physician, so in reality most black medical students trained to serve the black community exclusively. Women were becoming more of an accepted presence within medicine at this point in history but this was about to rapidly change. Medicine became a much stranger pursuit for women when medical education became an elite, middle-class and scientific endeavor. Women physicians were considered less capable, much like black doctors, in the new medical setting that involved science and ration. Black doctors were dissuaded from more scientific and “rational” medical pursuits like surgery. Black doctors were encouraged instead to excel in public health and preventative medicine specialties (Flexner, 1910).

Critics of Flexner discussed how his report created medicine as a middle class and white pursuit. The schooling required of the new (laboratory) scientific physician also made doctors more attractive to the increasingly important white middle-class consumer (Haley, 2011). Middle class demand for well-educated doctors helped to establish the profession’s status, which had been on shaky ground in American history (Starr, 1982). There were a variety of well-established alternative healers and approaches to medicine (Coulter, 1973). Also, women were barred from regular medical schools and could only attend separate medical schools for women. This ban had been lifted by many of the better medical schools by 1910. Due to the new trend of accepting women to medical schools, Flexner did not feel that closing several medical schools for women would keep women from medicine (Flexner, 1910). Flexner was also aware that medicine had
become less attractive to women of the Progressive Era because of the intense scientific training over many years; this training would limit women’s opportunity for a family, which was a strong middle-class value (Flexner, 1910). Women were an accepted part of bedside medicine prior to the Flexnarian revolution and a noticeable presence within the annual meetings of the AAMC. Many women doctors were among those cautioning and skeptical of what would happen to medicine due to the science paradigm shift (Dyer, 1915).

To be able to dedicate most of one’s young adult life to medical education was only possible with support of family or scholarship. Women of the middle class were not willing to give up being mothers and wives to become doctors. For example, Johns Hopkins Medical School accepted women from the beginning. In pictures of each incoming class women were scattered among their colleagues in dark dresses and not in nurse’s garb. Rarely did the women accepted to the medical school at Johns Hopkins graduate in these early days. Instead they married their professors or fellow students or went on to work with the poor in Baltimore as social workers and nuns (Grauer, 2012).

The Scientific Shift of Medical Education

Understandings of gender, class and race were reflected in Flexner’s report, which contributed to the creation of medical education practices in the United States that excluded or marginalized those felt incapable of laboratory medical training as well as those that did not appeal to a white middle-class clientele. The Flexner Report resulted in a reduction of working class, women, and black students pursuing medicine, but the main accomplishment of the Flexnerian revolution was the elimination of non-university teaching hospital medical schools known as proprietary schools (Ludmerer, 1999, p. 4). Proprietary schools provided medical training for anyone willing to pay the fees to hear medical lectures. The number of lectures
required to be a doctor differed around the country. Some schools had clinical components but
most finished their medical training with very little exposure to working directly with people. In
this system, a person could slowly pursue medicine while working. This system also allowed
doctors to make extra money while maintaining a clinical practice. Ending proprietary medical
schools further established American medicine as a white, middle-class, and male professional
pursuit (Ludmerer, 1999).

Less than a handful of medical schools—Harvard, Pennsylvania, Michigan and the
newly-built Johns Hopkins—actually had close university involvement, laboratory facilities and
training, large hospital affiliations, and the endowments to support such a system. As Ludmerer
(1999) writes in his history of American medical education, the new laboratory trained doctors
needed to be flexible in their pursuit of cellular understanding. Laboratory medicine emphasized
the pursuit of new knowledge and distrusted old understandings of illness (p. 9). The thought at
the time was that only through scientific practices would new medical discoveries and medical
progress be made possible. For the benefit of the public and society, medical schools of the
Flexnerian revolution would have scientifically-trained doctors—doctors who were good
problem solvers and critical thinkers. To insure a cultural shift from proprietary doctors to
scientific physicians, new medical schools would need to be created with a uniform structure
(university teaching hospital) and these medical schools would be philanthropically funded with
labs, clinics and scholarships because such training would be expensive (p.6).

American medical educators realized that they would need to improve their professions
reputation and combat the greed of medical schools if they hoped to contribute in any way to the
world’s medical discoveries. To counter the years of American quackery and proprietary schools,
the AAMC began to discuss standards of American medical education that would prepare
students to become “scientific physicians” (Taylor, 1904, p.36-37). As Dr. Henry L. Taylor remarked in his address to those gathered for the annual meeting of the AAMC in 1904, the “scientific physician is a man, who, because of his knowledge of the sciences on which medicine is founded, has such a firm grasp and a clear comprehension of his subject matter as will enable him to become not only a successful practitioner, but also an intelligent student of progressive medicine” (p. 37). To become a doctor should be difficult. There needed to be proof of commitment and a willingness to sacrifice. No boy should be allowed to become a doctor, medicine was being constructed as a pursuit of men (white, middle-class), and the length of time in school continued to increase with the purpose that only wise men should be allowed to practice medicine. The discipline of medical school was a way to prevent greed, and medicine becoming a business. Evidence within the medical education discourse made clear medical training discipline served as a guarantee that men who entered medical school were willing to sacrifice and to serve a larger calling.

There were, however, multiple consequences to this revolution. The change in American medical education not only created medicine as white, middle-class and male but also it encouraged knowing through science and changed the way that illness was interpreted by society. Medical students were encouraged to “self educate,” which meant using their knowledge of disease and illness they had learned in the medical school classroom and blending that information with their new clinical experience with patients (emphasizing laboratory results) in the hospital or clinic to create new knowledge (Flexner, 1910, p. 9). The clinical experience required for the scientific physician was a hospital that provided necessary human specimen for study. Flexner writes, “Knowledge derived from personal observation and experience was to be trusted far more than the dictates of any authority” (p. 9). Flexner was convinced that it was
experience with disease that would make for a better doctor, not necessarily experience with the
people suffering disease nor experience with the environments that patients lived in. Medical
practice was like looking through a microscope; and patient/doctor interactions were seen as a
means to “collect and impartially evaluate the facts that were locked up in the patient” (Bonner,
2002, p. 84).

**Progressive Thinking**

Medical schools, which had just been side businesses for universities and for practicing
physicians, now had the potential to make universities and medical educators famous through
highly publicized medical discoveries (Ludmerer, 1999). Once science was embraced by
American medicine, a relationship between medical schools and universities became desirable.
Medical schools served as a practical example of how university education could benefit the
community and the university infrastructure and endowments were very helpful in providing lab
and hospital access. Medicine also served as an excellent example of “learning by doing” that fit
nicely with progressive education reforms. Medicine was a shining example of how education
could have practical application, since medicine was becoming an applied science (Flexner,
1910). The purpose of education for reformers like John Dewey and Abraham Flexner was not to
have students memorize “facts” that were changing rapidly due to industrial progress, but the
purpose of education was to create students who were good problem solvers and who could face
the challenges of the modern age.6

Johns Hopkins was “the” example of an institution that produced scientific physicians.
Johns Hopkins was a relatively new school of medicine that had started with a commitment to
creating scientific physicians who would contribute to progressive medicine. Johns Hopkins had
the luxury of being new when new discovery became a priority of medical science. The Dean of
Johns Hopkins, William Welch, proved to be an excellent proactive thinker, political activist, and effective community organizer (Ludmerer, 1999). American medical education would continue to build off of Welch’s example by making medicine an important part of higher education, by actively seeking government approval of medical education reforms, by strengthening relationships with wealthy financial backers, and by gaining public support often through the use of the media and seeking the opinion of objective outsiders to medicine, like Flexner.

What often gets lost in history is the justice goal of progressive education. Progressive educators saw education as a place to foster unity and social harmony. Educators like Dewey and Flexner argued that widespread education would bring increased equality (Maher, 1999). Progressive educators saw value in the heart and the mind and were concerned with both emotional and intellectual growth. Medicine was seen as a helpful place within higher education to use progressive education models. Ludemerer (1999) points out in his history of medical education that "Progressive education has traditionally been considered a representation of the democratic spirit in education, but, ironically, it survived in institutional form in the United States largely at a level of instruction targeted for the elite” (p. 10). Today’s medical practitioners often lose sight of their original cultural context. The Progressive Era reforms of medical education and medical practice have become the long-standing traditions of how doctors continue to be trained.

**Relationship Between Doctor and Patient**

There was very little discussion by Flexner and medical educators about the possible consequences of the shift to science on the patient. In the annual meeting minutes of the AAMC in the years leading up to the Flexner Report and immediately afterward (1905-1915), the patient
perspective was not seen as crucial in the debate about medical education reforms. The medical education reform discourse was framed instead as a concern for new doctors, a concern for the middle-class public, and a concern that the U.S. be seen as the best medicine in the world. The role of the state in regulation and reform was established and feelings of nationalism at the time were also highly influential in large-scale medical education decision-making.

The similarity of priorities between Flexner and the AAMC is evidence of how much Flexner relied on his elite medical education advisers in how he approached his study. Flexner looked to medical educators for how reforms should be made based on his progressive respect for experience as the root of modern knowledge. What Flexner gathered from his discussions with medical educators was that laboratory and clinic (framed as human lab) observations were the most important experiences to making good clinical decisions. When Flexner addressed the patient in the teaching hospital in his investigation, he focused on the hospital being set up much like cars in a mechanic’s garage. Flexner wrote about how “the student [must] be brought into immediate and increasingly responsible contact with the disordered machine” (Flexner, 1910, p. 96). Flexner was an outsider who valued experience to learning and knowledge creation and so he imagined (because he did not know from doing) that the new space of medicine needed to be conceived as laboratories with human specimens.

Flexner did not watch the interactions between doctor and patient as part of his investigation of medical schools and in his report he never considered how medical school reforms could possibly harm the lives of patients in the university teaching hospitals. There was no evidence of soul searching by Flexner about how the change in focus from bedside medicine to hospital/laboratory medicine might impact understanding of illness and the relationship between doctors and their patients. Flexner’s answer to physicians concerned that these new
education practices would put patients in danger was that medical students needed to take risks and work independently to learn how to be good doctors. Flexner expected faculty of the teaching hospital to insure patient welfare, even though there was no guidance as to how faculty would protect patient welfare from medical students taking independent risks (Flexner, 1910, p.65).

Reflecting on the Flexner Report and the discussions between medical educators at annual meetings of the AAMC is helpful to better understanding the complexity of the cultural shift from proprietary medical schools to university medical centers at the turn of the twentieth century. Medical education reforms helped to construct medicine as a middle-class pursuit for middle class clientele and constructed medicine as reliant on scientific training and a clinical space framed as a laboratory. Medicine became the best example of progressive higher education that valued critical thinking and direct experience. Universities embraced expensive and intense curricula from progressives but concerns for democracy and a balance between ration and emotion were lost in the rush for modern scientific discovery and an end to all disease. Very little thought was given by Flexner and medical educators about how the changing in class dynamics and scientific medical institutions would impact the human specimen. Rare consideration was given to how these shifts would change the experience of medicine for the physician. The old ways of medicine were aligned with the ways of the proprietary schools and the old understandings; logics that relied heavily on the doctor and patient relating were boarded up and left unattended.

**Bedside to Laboratory**

The Flexner Report marked a paradigm shift in medicine in the United States, which was part of a larger movement in medicine for modern, industrialized nations around the world.
N. D. Jewson (1976) writes about the global shifts in medical thought over time in his article, “The Disappearance of the Sick Man From Medical Cosmology.” When medicine was mostly practiced at the bedside and in the home, the “sick man” was asked about treatment preferences as well as emotional and spiritual aspects of his illness and illness was understood as outside of the body (p. 29). The heroic treatments (bleeding, purging, blistering) that accompanied bedside medicine were expected to create balance on a physical, emotional and spiritual level. Bedside medicine was unique to the person, illness had multiple meanings, and there were a variety of treatment possibilities. The success of the doctor relied on caring for the patients on a physical, emotional and spiritual level.

Medical knowledge shifted as technology advanced. Jewson writes about a shift to “hospital medicine when dead bodies became a part of an understanding of illness” (p. 229). Once a belief in science allowed for doctors to overcome the taboo of cutting into the dead, doctors discovered diseased organs within the body. Crowded hospital wards also allowed doctors to see many people with similar symptoms and symptom patterns could be categorized and named for more efficient treatment. The move to the hospital started an understanding of illness as hidden in the body and as a result of the malfunction of various organs. The job of the doctor was to “correlate external symptoms with internal lesions” (p. 230). The patient was seen more as an object, like a “disordered machine” and the sick man began to disappear from concern.

Laboratory technology like the microscope further shifted the focus of the doctor to the “fundamental unit of life,” or the cell (Jewson, 1976, p.231). Understanding the chemistry within the body’s cells became the optimal way to understand illness. It was no longer necessary to even see the whole body. The patient was the storage space for healthy cells and germs. In this
way, “the study of life was [is] replaced with the study of organic matter” (p.232). As institutional healthcare developed medicine relied on “powerless patients subordinate to the control of the doctor” (p. 234). Laboratory medicine benefitted from large numbers of patients or “an inexhaustible fund of acquiescent research material” (p. 235). With technological advances like the autopsy and the microscope, knowledge of social, emotional and spiritual aspects of illness disappear along with the sick man.

The loss of the “sick man” happened at the same time that medicine was constructed as a middle-class endeavor catering to middle-class patients to increase the status of allopathic medicine and the status of medical schools in university systems. The physician and the medical school take on responsibility for modern scientific discoveries that would surely improve the quality of life for all. Pushing for medical discoveries to be made by Americans, also fed into nationalist sentiments of the time. The possibilities of laboratory science were much bigger than the patient and much bigger than the doctor. Rigorous and expensive medical education that could easily be financed by the American captains of industry would prove the superior nature of American values and economics in a race with European alternatives.

The personal (experience and interaction) in medicine became dismissed in the scientific reform process. Not only was the sick man lost but also the personal aspects of medicine for the doctor. Doctor as interpreter of each unique patient, of the multiple meanings of illness, and the balance between mind, body, heart and soul were no longer valued by medical educators. The skills that developed in cultures of bedside medicine were not blended into the concerns for training the scientific physician. The emotional and spiritual aspects of medicine were lost and not explicitly addressed in medical curriculum. Doctors continued to experience medicine in emotional and spiritual ways and were left on their own to negotiate these aspects of medicine.
Scientific explanations are not always helpful to these negotiations. The human aspects of medicine lingered for both the doctor and patient even after the scientific physician was created.

**Public and Personal Aspects of the Germ**

The public duties of medicine began to divide along gender lines as well. Even prior to the Progressive Era middle-class women found purpose in institutions that served the poor.9 Women’s charity groups became highly involved in hospital management. The cold and rational aspects of medicine were culturally assigned to the scientific doctor and the warm and nurturing as well as social aspects of medicine were the responsibility of middle-class, female professionals in social work, nursing and public health. The private sphere (the home and community) of disease prevention was assigned to women and the public sphere (clinics and hospitals) belonged to the male physician (Ehrenreich and English, 1978, p. 11).

Women were considered better at educating the poor about health and morality in the home. Women were thought more capable than men of assessing the morality and the environmental conditions of the poor and reporting back to the doctor in the clinic or hospital. Progressive Era physician Richard Cabot (1977) provided evidence to this gender divide. Cabot was highly influenced by the work of Jane Addams, the famous founder of Chicago Hull House settlement for the poor. Cabot, famous for being the father of medical social work in the United States, was influential in the economic support and training of medical social workers of the time. Cabot was very concerned with the suffering of the poor and the ethical obligation of scientific physicians to community welfare. Even though Cabot was a doctor with social concerns and considered progressive in his day, he is a helpful representation of the gendering of care for the poor in his writings. Cabot alerted his fellow doctors that to get to the root of illness it “compels us [doctors] to undertake through others [nurses or social workers] investigations for
which we as dispensary physicians have neither time nor training” (p. 15). Cabot advocated for middle-class women to be a part of medicine by assessing habits, family economics and domestic conditions of the poor in only the way a woman could. For many middle-class women, social work and work with the poor served as an opportunity to have a public life when the gender expectations were for women to work in the home.

During the Progressive Era medical knowledge also became more crucial to everyday lives. The middle class and wealthy became consumers of elite medicine that relied on science and these consumers fought to end other forms of medicine (Tomes, 1998). When the laboratory understanding of illness became public, the danger of germs and fear of germs became culturally significant. In Nancy Tomes’s (1998) book, *The Gospel of Germs*, she argues that the middle class began to fight germs on the home front. Middle-class families were able to afford disinfectants, flush toilets, clean running water, safe milk supplies, vacuum cleaners, appliances and new floor and counter surfaces that could be scrubbed free of germs. Coughing, sneezing, spitting and sharing food and drinks became improper in middle-class circles. Middle-class women were enlisted through product advertising to fight for hygienic behaviors in their husbands and children and were eventually hired to teach these behaviors to the poor. According to Tomes, washing hands became a middle-class obsession. During the Progressive Era, middle-class women were aware of science practices in the home.

This middle-class gendering of science and the negotiation of medical science and the poor created even further distance from the doctor’s experience of medicine and the realities of the poor. The sick man disappeared but so too did the class reality of the majority of human specimens in medicine. The tragedy of the loss of the sick man and the loss of the human aspects
of medicine pales in comparison to the loss of the patient who is poor because it is in this loss where the most heinous of the medical injustices happens.

**Class Negotiation of Scientific Medicine**

Medical technology is but one aspect of culture that influences interaction between doctor and patient. The time between the Civil War and World War I was a time of great change economically and intellectually within the United States. American medicine played a key role in the public understanding of the potential of science and the benefits of laboratory experiment to improvements in quality of life. Experiences of illness and new discoveries about germs fueled hope that science would be the answer not only to disease but also to social problems like poverty (Addams, 2000). The moral obligations of the upper, middle and the lower classes were considered carefully and the part that each class needed to play in the discovery of cures to illness was part of this consideration. In the end, the development of medicine as an applied science was experienced very differently depending on class.

Experiences of illness and the ways to treat illness were also very different depending on a person’s class during the Progressive Era. Mary F. Fissell (1995) writes about the intersections between class and medicine in her book *Patients, Power and the Poor in the Eighteenth Century Bristol*. Fissell’s historical investigation into class and medicine expands on Jewson’s investigation into paradigm shifts in medical knowledge and the way that medicine determined the cause of illness and the institutional changes within medical education changed how doctors approached patients. The means of medical approach also changed depending on the class of the patient and how class influenced understandings of illness and disease.

Fissell writes about hospitals prior to scientific medicine and how these institutions served mainly the poor. Even before the large university hospital endowments of the Progressive
Era, the wealthy had been acting as benefactors to the poor. Wealthy benefactors had a history of benefitting from the social construction of the poor as immoral to avoid discussion of questionable industrial practices of the rich.

As medical education practices changes after the Flexner Report, so did knowledge of illness. The poor hospitals continued, and hospitals, particular university hospital, began to change purpose. Most importantly, university hospitals became the training ground for doctors, who worked within the hospital to gain experience with illness, disease and disability both in the laboratory and at bedside with experienced doctors. Even when university hospital systems administered the bulk of medical training, medical student often relied on experience in poor hospitals for part of their medical training. Students were taught obstetric medicine in hospitals for the poor because middle-class women would not allow student intrusion on very private birthing moments. The poor provided helpful examples of infectious diseases, some of which had gone missing in middle-class neighborhoods due to household technologies that were out of economic reach for the poor (Ehrenreich and English, 1978). Fissell writes about how as medicine became more and more about diagnosis and science, this led to medical practices “denying the poor ownership of themselves” (1995, p.15). The market and medicine started to have many things in common - where the businessman was motivated by profit the doctor became motivated by new medical discovery for the common good (Ehrenreich & English, 1978, p.67). Because of these motivations, the suffering of the patient became less of a concern and rarely a topic within medical writing (Fissell, 1995; Armstrong, 1982).

Due to the harsh treatment in institutions for the poor, which included a history of dissection of individuals considered criminal or deviant and practices of grave robbing from poor communities, poor communities grew to fear and became skeptical about scientific medicine
The poor continued to see lay healers and to see religious meaning in illness. The patient’s story and understanding of the illness was no longer important to the scientific doctor but it remained important to the poor. Understanding of illness as balance between the emotion and the spiritual that relied heavily on the doctor and patient relationship remained valuable to the poor. In the end how a person pursued and valued medical treatments became a mark of class.

Class played a role in the practices of medicine and how the new concerns of science were explored. The poor became soldiers of medical discovery, the middle-class consumers of medical discovery and the wealthy the sponsors. Ehrenreich and English (1978) quote a physician to illustrate the class influence on medicine:

> There are heroes of war, who give up their lives on the field of battle for country and for principle, and medical heroes of peace, who brave the dangers and horrors of pestilence to save life; but the homeless, friendless, degraded and possibly criminal sick poor in the wards of a charity hospitals, receiving aid and comfort in their extremity and contributing each in his modest share to the advancement of medical science, render even greater service to humanity” (p. 85).

Everyone in this new scientific medical world must sacrifice for the better good - the poor as the material of medical learning, the middle-class physician through years of dedication to education and the wealthy giving a bit of profit to provide the necessary laboratory and clinical settings.

Medical knowledge, practices and technologies are influenced by social interests, by cultural preferences and by economic status. Fissell helps to add to Jewson’s consideration of technological advances in medicine by considering the economic differences in technology access and meaning across class. Because the focus of Jewson, Fissell, Ehrenreich and English’s
investigations are solely on how medical advances impacted patients, they do not concentrate on how the science paradigm shifts changed what is valuable about being a doctor. As doctors focused in on the germ, the disease, the treatment options and the procedure, physician’s bedside experience became less important over time. The social aspects of medicine also begin to fade out of view because the patient’s and the doctor’s story and experience became irrelevant to knowledge of cells.

**Not Fully Dead: The Poor Sick Man**

The sick man, human (emotionally-connected) care of bedside medicine, and concern for the poor were never completely lost in the transition to laboratory medicine. There were doctors who actively resisted the dominance of science in medical education. Often this resistance was demonstrated in the form of caring for the margins. Many doctors blended the old ways of medicine with the new ways. There was evidence of this negotiation in statements and articles published in *Journal of American Medical Association (JAMA)* from 1905-1915. One example is Dr. Pauline M. Townsend (1912) who spoke back to several of her scientific colleagues at a conference recorded in *JAMA*, “In this day of speedy processes of manufacture, of increased scientific knowledge and of rapid production; it is a disgrace that we have poverty in America, or anywhere else in the world” (p. 2025). She continued to illustrate, “If any physician of the American Medical Association had to live on 10-cent meals three times a day for a year, that physician would be very apt to feel sick and grievous, but there are thousands of men, women and children who cannot afford ten cents three times a day for a meal” (p. 2025). She urged her colleagues preoccupied with science to remember the human aspects of medicine. For this doctor, understanding the health risks of the poor did not come by looking through a microscope, but through empathy.
After the germ theory was embraced, the middle class experienced drastic decreases in death from diseases like tuberculosis. This was not the case for the poor, who continued to suffer the ravages of the “white death” for much longer (Dormandy, 2000). Older doctors, doctors who continued to work with the poor (which included black doctors), rural doctors and doctors from working-class beginnings had personal experiences with tuberculosis and other illnesses, disease and injuries that the middle-class scientific physician working in the urban medical college would not have. Bedside, personal experience with illnesses of the poor became less common for the attending specialist in the university medical teaching hospitals (Ludmerer, 1999). The difficulty of having middle-class doctors focusing on the needs of the middle-class patient was that the white male, university medical center physician had a very limited experience with infectious illness, diseases and deaths that were more common and lingered among the poor. Broad knowledge and skills from bedside personal experience were lost within medical education with the devaluing of doctors who understood the old ways of medicine and the health care realities of the poor. Physician bedside experience with patients was in direct conflict with medical advancement.

The new middle-class at the turn of the century included doctors and university educators who were members of the Progressive movement. This progressive middle class was grappling with what should be done ethically with the prosperity of the industrial age (Painter, 2008). There was general outrage within the middle-class at the time about the extreme wealth and extreme poverty that was the result of industrialization in America. People like Abraham Flexner, Richard Cabot, and Jane Addams believed in class harmony, and a democracy that worked toward equality. The middle-class leaders of the Progressive Era stirred up public outrage to improve living and working conditions for the poor. It was this advocacy and
recognition of the social aspects of medicine that in the end eradicated tuberculosis from the U. S. and not the scientific reforms of medical education (Dormandy, 2000).

The human aspects of medicine and concerns for the poor did not fully disappear from medical practice. These old ways were much more evident in JAMA, designed for practicing physicians, than in the AAMC annual meeting discussions. There begins a divide between academic medical values and community practice values. Many of the doctors in JAMA embraced the new scientific shift but there was a small vocal faction that continued to be skeptical of the whole-hearted adoption of science-only training in medicine. The progressive political climate likely contributed to this resistance by some doctors to give up on the human aspects of medicine and the ethical obligation toward the poor.

When looking at the conversations between doctors in the articles and letters published in the JAMA during the Progressive Era, there were still forms of bedside, hospital and laboratory medicine being practiced at the same time. Medical colleges were still recovering and restructuring after the Flexner Report. Those doctors working with the poor at the time were still concerned about the patient’s story and still often defined illness as the result of something external. These doctors were not defining illness as just cell chemistry. These doctors also believed in their own experience with people and believed the conditions of a patient’s life and work also contributed to illness. These doctors were aware that science could not explain everything and that illness was a complex combination of the internal and external and that medicine was part heart as well as part mind.

**Reading for the Art of Medicine**

Flexner’s argument for medical education reforms was benevolent and altruistic; once commercialism was gone the doctors who remained would be good people always in search of
the end of suffering. He reflected on his understanding of medicine as innately altruistic when he wrote,

> Thus the laboratory sciences all culminate and come together in the hygienic laboratory; out of which emerges the young physician, equipped with sound views as to the nature, causation, spread, prevention, and cure of disease, and with an exalted conception of his own duty to promote social conditions that conduce to physical well-being” (p. 19).

Michael Nevins, (2010) a critic of Flexner acknowledges that as a man Flexner is often misunderstood, “Flexner was concerned about humanism and the patient-doctor relationship even if this emphasis was missing in his report” (p. 87).

Flexner wrote about medicine as more than prescribing and cutting but as healing relationships between doctor and patient. Flexner hoped, through reform, that American medical schools would represent “the highest modern ideals of efficiency” and at the same time would model “the finest conceptions of public service” (Flexner, 1910, p. xvi). Flexner differed from his medical education advisers in his views about the value of body and mind as both important to learning. Flexner wrote about science as an extension of the body and that medical students needed to “learn how to sense through science” (p. xv). For Flexner, reducing the number of medical schools would help eliminate greed from medical education and would attract only individuals called to medicine, who were “moved by a significant prompting from within” (Flexner, p. 19). Flexner described the function of physician as social and preventative and less individual and curative. He shared in the progressive hope of his time that developments in medicine would “rid the ill’s sacrifice” and that the need for laboratories with human specimens, with medical students taking inexperienced risks with patients would be short-lived (p. 26). Once doctors better understood disease, the hope was that doctors could go back to bedside medicine
and a focus on caring for the patient. All people, not just the sick, would benefit from the changes in medical education. Flexner looked to his medical education advisers for how to reform medicine to be more scientific but Flexner also wrote about the value of blending the science of medicine with the art of medicine.

Flexner’s concerns for the art of medicine played out differently among medical educators of the time. There was much debate in these early years of the Flexner revolution about how to create the scientific physician. One example of how to create the scientific physician was offered by Dean Seneca Egbert (1904) of the Medico-Chirurgical College of Philadelphia. In an address titled, “Teaching Methods in Medical Education” (p. 45). Egbert voiced his concern that the new emphasis on science and theory neglected the art of practice, “Do not forget that we are training men to be doctors – most of them to be just plain, country doctors, the kind that has added so much glory to our profession” (Egbert, 1904, p.49). This is just one example of concern at the time about what would be lost when students were taught to be scientific physicians, which included how science education alone would create a cold and calculating person. Several doctors within the AAMC argued that to be a fine doctor a young man needed not just science but a variety of classes in order to foster warmth and connection with other humans.

Flexner himself was a strong advocate for the integration of humanities and medical science because this type of training would prepare mind and body for medical practice (Nevins, 2010, p. 89). Flexner questioned if “there [was an] essential place in the curriculum for humanistic studies, communication skills, and the history of medicine” (Bonner, p. xiii). Flexner continued to mention medical education as more than science, “Medical education should thus be a union of the scientific and the practical, the laboratory and the clinic, both art and science”
Flexner did not see a conflict between science training to extend the physician’s bodily capacity to sense and empathize with those suffering with illness. Flexner wrote that medicine must be at the same time science and "useful human service" (Bonner, p. 84).

Flexner was not alone in his hope for well-rounded education, and his sense that good critical thought and good problem solving involved a variety of skills and knowledge of many subjects not just science. Frederick S. Lee (1906) professor of Physiology at Columbia shared with his AAMC colleagues,

We send our boys to college to develop them intellectually, physically and morally, to quicken their memories and imaginations, to make them sympathetic, to give them high ideals of character and ambition, to give them the culture that the well-bred man of today is expected to possess, to enable them to develop helpful and stimulating friendships, and to make them so efficient bodily and mentally that in whatever sphere they find themselves later in life they will do worthy work (p.20).

Within the AAMC there was concern that because medicine was so personal, doctors would need to be open-minded in their views, as well as technically proficient. There was discussion about what is needed for a well-balanced intellectual. Because medical training focused on the process of critical thinking, problem solving and “teaching self” these skills did not need to be limited to science. Medicine was very different than science in that practice was often outside of the laboratory and dealt with live people.

Many doctors in the AAMC wanted to make sure that doctors had a variety of classes, often in the humanities, prior to medical school, and this was based on their positive experiences with students that had completed a literary degree. In the AAMC proceedings of 1913 Dean
Egbert Lefevre, M. D. again brought up concerns about the art of medicine, “For members of the general profession one constantly hears the harsh criticism that recent graduates are deficient in detailed knowledge of this or that specialty; that while skilled in laboratory methods of diagnosis, they have acquired little of the art of medicine” (p. 16). This is one example of many concerns voiced about the fate of the art of medicine by medical educators during the Progressive Era reforms.

**Carefully Considering the Lost Art of Medicine**

The art of medicine for some doctors was what made special the doctor from the scientist. The art of medicine was technical training no different than a butcher or baker. In this way, the art of medicine’s goal was the opposite of profession and status. The art of medicine was what cannot be explained by science and stands in for all matter of evils. The art side of this dichotomy was also where imagination and utopian hopes for medicine lie.

**Conclusion**

The reputation of U. S. medical education rapidly changed around the world from illiterate and backward to scientifically rigorous and challenging. What happened within the United States culture to change medical education practices was not, however, solely as the result of the Flexner Report. The shift in American medical education was the result of a series of complex changes that involved the new role of medical associations and state government as regulators, progressive reforms in higher education, the development of philanthropy, the large-scale advocacy function of the middle-class, and the experiences of illness of the time.

It is important to remember that new medical discoveries were not always the result of hospital laboratory medicine. What often gets lost in the myths of the golden age of medical discovery is that one of the greatest pioneers of the germ theory was a German physician
working in a small rural community (Dormandy, 2000, p.132). Robert Koch was in every way a
country physician who was given a microscope as a birthday present from his wife. His work
investigating anthrax started out as a hobby, out of curiosity and a desire to solve a problem. He
was frustrated by diseases like tuberculosis that were killing the people in his community and it
was out of caring and beside medicine that he was inspired to try to understand what caused
these devastating illnesses. His observations about the everyday practices of life and living and
working conditions in his community contributed to his cellular discoveries. Koch’s practical
experience as a physician and his practice at listening to his patients’ experiences were essential
parts of discovering the microorganisms causing illness. These experiences also inspired the
endless hours in the lab that resulted in changing the quality of life for all the citizens of the
world. Robert Koch is an excellent example of what can happen when the art and the science of
medicine work together.

As I looked back at the discourse between medical educators at the annual meetings of
the AAMC from 1905 – 1915 and each years presidential addresses, many physicians on the
margins continued to express their views and share in Flexner’s dream of American medicine
being a public trust concerned with the public’s health, and that doctors felt an ethical obligation
to engage in social reforms as needed. Resistant voices were evident throughout the development
of American medical education as the dominant push by the majority of medical educators was
for increased rigor, more science and a profound skepticism about the art of medicine.
Investigating moments leading up to the Flexnerian paradigm shift is helpful in better
understanding the current construction of modern American medical training. Identifying what
aspects of medicine were lost in these changes could serve as helpful lessons to current day
difficulties with health care disparity and cultural competence.
The beginning of the Twentieth Century was a time when the art of medicine became unhinged from what was necessary to the training of physicians and what was considered essential to medical practice. With this unhinging was also disconnection between mind and body and an emphasis on ration over emotional connection as the likely arbiter of modern medical dilemmas. As Fissell (1991) points out the middle class and elite were hopeful that scientific progress would bring to an end the suffering of disease and illness, while the poor preferred the old ways of medicine where their lives still held meaning and spiritual and emotional balance were considered equal to body in the doctor’s consideration of treatment. I would argue that the unhinging of the art of medicine came in the way of medical innovation. Connection between mind and body, the science and art of medicine and the recognition of the interdependence between the classes are necessary ingredients for innovation.

Dr. Koch is a helpful guide to what is needed to nurture medical innovation. Koch was not simply a scientist; he was emotionally connected to the patients in his community, and was aware of how diseases like tuberculosis take advantage of class difference. Poverty is not that much different from tuberculosis. Poverty is a cause of illness and disease, disability and early death. However poverty is not easily investigated or understood through laboratory science. Poverty is not a germ that can be looked at through a microscope. Poverty is a health problem that could benefit from physician involvement due to their unique experience, knowledge and skills. Doctors could be very helpful to considering macro solutions to poverty but this would require them drawing from their experiences with the art of medicine. The human aspects of medicine were what motivated Koch to find solutions to tuberculosis and it is the human aspects of medicine that will be needed to motivate doctors to find solutions to poverty.
In 1962, Michael Harrington wrote *The Other America*, which introduced the idea that practices and values developed in the United States that helped to make the poor invisible to the middle and wealthy classes. Harrington’s book unearthed the realities of the poor across the United States and the different challenges being faced by the poor in the North and South and in urban and rural communities. Harrington’s detailed reporting of living and working conditions of the poor in *The Other America* helped to create public outrage about the high levels of poverty at the time. He uncovered the suffering of the poor that had been hidden, kept invisible in the economic success of the American middle class. Harrington urged every citizen to be committed to ending poverty in America, “for it is intolerable that the richest nation in human history should allow such needless suffering” (p. xxix). Harrington was a keen observer and in his ethnographic-like investigation into poor communities, he realized the poor were invisible in part because the middle class remained physically separated from the poor.

Harrington wrote, “The slums are no longer visible to the middle class, so much of the idealistic urge to fight for those who need help is gone” (p. 6). Harrington seemed convinced that if the middle class were aware of the suffering of the poor, the group would not stand for inequality and would fight for policies that would improve living and working conditions of the poor. For Harrington, social separation came in the way of the middle class is “idealistic urge to fight” for reductions in poverty (p. 6). In this statement, Harrington is likely reflecting back to the Progressive Era when the middle class battled to end child labor, to unionize workers and to improve the neighborhoods of the immigrant poor. *The Other America* stirred middle-class readers to action fifty years later by making the lives of the poor visible again. Harrington made the suffering of the American poor visible through emotional connection with the poor provoked
by his detailed writing of the lived experience of poverty. *The Other America* was so influential that it is the catalyst of the war waged on poverty by the Johnson Administration. The success of Harrington’s book to win hearts to the cause of poverty is evidence that it is not only the physical distance between the middle class and the poor that encourages invisibility, it is also the result of emotional distance from the realities of poverty.

**More than Social Separation**

From Harrington’s experience in poor neighborhoods he observed one exception to the middle class social separation. Harrington noted that the only middle-class people he observed in poor neighborhoods were doctors, nurses, and social workers. He wrote, “Only the social agencies have a really direct involvement with the Other America and they are without any great political power” (p. 6). Most of the doctors who I interviewed (all but one) cared for a patient panel that included patients who were poor. The percentage of the panel who was poor ranged from ten to seventy percent of the doctors’ daily practice with patients. Doctors make an interesting case example of negotiations of social position and class understanding because they are a rare group forced to see the poor who are hidden from the doctors’ family and neighbors. As Harrington pointed out, in *The Other America*, doctors are unique members of the middle class because as part of their work, they come into regular contact with the poor.

Invisibility and social separation continue to be major factors in maintaining poverty in the U. S. Poverty policy experts and scholars studying poverty still consider social separation one of the leading reasons for sustained income disparities (Starr, 2012). The visibility of poverty that was made possible through *The Other America* was temporary and poverty continues to remain mostly invisible to the middle class and the elite in the United States. Physicians are a strange example of American middle class, because doctors are not kept physically separate from
the poor and the majority of patients who they care for as part of their medical training are poor. If doctors remain unaware of the realities of poverty in America, it is not from a lack of exposure. Doctors do not organize in large numbers after witnessing economic injustice as part of their work. Exposure to poverty on its own does not seem to inspire a fight for the poor as Harrington argues.

I agree with Harrington that there are physical and social practices in the United States that separate class and create the poor as invisible. Medical culture helps to support these practices of separation by creating medicine as a profession for the middle class serving the middle class. The middle class is culturally constructed as productive, independent, disciplined and democratic and so healthy also becomes defined in this way. Unhealthy then becomes defined as the opposite of middle class. The poor are described as lazy, dependent, undisciplined and not healthy citizens. Physicians’ attitudes toward the poor help to make invisible the unique health concerns, which come from living in poverty. Social separation is only one of many factors that help to make poverty invisible.

In a system defined by middle-class ways, physician status also becomes linked to serving middle-class consumers. The poor are very helpful in providing practice for those training to be physicians and also as subjects for medical research, but provide very little status value when the priority remains the health of the middle class. Doctors are representative of the middle class, with the exception that they engage with the poor regularly and do not maintain social separation. If poverty remains invisible to the physician, it is likely that poverty also remains invisible to the public. By looking closely at how doctors learn to understand poverty I hope to better understanding class dynamics in general.
Middle-Class Sensibilities

Doctors from middle-class backgrounds described an abstract understanding of poverty prior to medical education. Medical school exposes students to poverty but there is very little guidance about how to interpret or understand class difference. Doctors described cultures of silence surrounding feelings of shock with initial encounters with the poor. Poverty concern was to be kept quiet. Doctors become aware that the poor make decisions and behave differently than middle-class patients. The physicians made class comparisons and often those doctors who grew up in poor households are judged as unhealthy when compared to the health-conscious middle-class. Barbara Weinstein elaborates in her commentary to Part I of *The Making of the Middle Class*, that there are “symptoms” of the middle class or commonalities that emerge for those in the economic middle (p. 6). She describes the middle class as much more likely to value the modern over the traditional, and urban lifestyle over rural lifestyle. The middle class values self-sufficiency, order, discipline and hard work, and these values constitute what Weinstein calls a “middle-class sensibility” (p. 6). Being considered a part of middle class is not simply an issue of birth, according to Weinstein. Talent and hard work are also necessary qualities to enter into or remain in the middle class. When the doctors compare the poor to these middle-class sensibilities the poor’s choices and attitudes seem to contradict middle-class values, which is why the poor are often labeled pathological on some level.

The Shock of Poverty and the Silence

When doctors discussed their first experiences with poverty in medical school they described becoming aware of the invisibility of poverty to the general public. The doctors described feeling shocked that poverty could be so easily hidden from them up until medical school. Even when doctors were able to see poverty for the first time, they noted how medical
education culture encouraged attitudes and behaviors toward the poor that attempted to make poverty invisible again.

For many doctors their first encounters with poverty were rude awakenings and the doctors discussed being ill equipped in their struggle for class negotiation. Doctors described being expected to learn on the fly with little discussion by their teachers of what to do or how to handle class differences. One of the doctors reflected back on his early days in a large city academic medical center,

I came from a very different environment than the patients I was seeing. This was true for a lot of my classmates. During my clinical rotations I was spending day in and day out seeing people very different from myself. In the city, where I completed my clinical rotations, I would find one block with housing projects, the next block with a cricket club, and the next block over I would come to find is where the drug dealers do business. The city itself was very different from the suburbs where most of us grew up. Almost all of the patients I worked with during my medical education were poor. It was an eye-opener and almost startling (June 26, 2014, Family Practice).

Poverty, as a topic of concern within medicine, remains unseen much like poverty within the middle class. As one doctor put it, “Poverty is an invisible topic in medical education. Poverty is still hidden and students need to seek out information. As medical education exists today, there is nothing preparing doctors to work with the poor” (Dec 2, 2014, Pediatric Intensivist). Poverty only becomes a topic of concern for the doctor if she pursues information on her own as part of her medical training. Better understanding poverty is treated like an extracurricular activity in medical training. Better understanding of the impact of poverty on health outcomes, is not openly encouraged by medical school. Students must be somehow
provoked to study the topic out of their own curiosity or out of empathy to better prepare themselves for working with the poor.

Another doctor described his first exposure to poverty:

I was shocked from my waspy world in medical school. I was examining a child’s head and what I thought was a mole, ran in three directions. I had never seen fleas on humans until that point. Hygiene was absent and people had scabies. Children were in rags with no shoes and so were their parents - people did not have running water or electricity. I had taken those things (running water and electricity) for granted. I was meeting people in extreme poverty. The poor would come to the clinic and they did not have enough bus fair to get home. This level of poverty was a new notion to me. In medical school I started meeting the faces of people who were truly poor” (July 10, 2014, Pediatric Intensivist).

Doctors shared these feelings of shock and their lack of awareness of the levels and severity of poverty that still existed in America. Prior to medical school most doctors were not forced to consider poverty as a real issue.

These physicians’ experiences are just a few examples of many stories doctors shared with me about doctors’ initial shock over their first encounters with poverty in medical school. The majority of doctors interviewed did not feel prepared by their medical education for working with the poor and very little if any medical school curriculum was dedicated to the unique health care concerns of the poor. The majority of doctors interviewed had very limited exposure to poverty leading up to their medical training. Most understood poverty as bad neighborhoods in their community they were warned to avoid. For most of the doctors interviewed, class
difference and social position did not occupy their thoughts until they became aware of the reality that medicine education involved working with the poor.

**Doctors from Modest Means**

Doctors come to medicine with ideas, values and practices from their families and communities and are not often aware of these influences. Medical school creates a whole new set of ideas, values and practices. Not all doctors demonstrate where they come from in the same way. Several of the doctors from poor backgrounds were very outspoken about poverty and at the same time there were doctors from modest means who keep their thoughts about class quiet. A doctor’s early exposure to poverty did not predict a particular approach to poverty and medicine. How social positions influences medical interactions is a jumble therefore needing more thoughtful consideration.

Not all of the doctors interviewed were from middle-class neighborhoods. Of the twenty-four doctors interviewed eight described their childhoods as poor or working class. I was surprised that poverty was also invisible even to the doctors who came from poor neighborhoods. One doctor joked, “My parents never told me I was poor. They just worked harder to get the things they needed” (May 22, 2014, Emergency). Another doctor from a poor neighborhood admitted to a lack of class awareness as a child; he put it this way, “I had a vague concept of poverty.” He continued, “I grew up in the inner city; looking back we did not have a lot. I did not think we were poor. I was one of five kids and both my parents worked. I saw poor families in my neighborhood and children did not have clean clothes for school and you would go to their house and it was in shambles” (July 11, 2014, OB/GYN). In this physician’s case, he grew up in a poor neighborhood. He was much better off than many of the families in his community, but all of the families he lived beside were experiencing varying levels of poverty.
Several other doctors discussed their childhood in poverty or in working class neighborhoods with similar memories, “I did not think about class when I was a child” (July 9, 2014, OB/GYN). In light of Harrington’s observations and the observations of current progressives about social separation, it makes sense that elementary schools and middle schools would be more class homogenous because these schools tend to be neighborhood specific. As the pool of students becomes larger, in high school and college, there is more of a likelihood of increased class diversity, and these experiences could lead to insights about class. Unfortunately the opportunity in public school to learn about class difference seems lost on middle-class students. After I reviewed the doctors’ experiences with public high schools and with universities, these institutions also maintain invisibility of poverty for middle class. It does not appear that the mixing of social position within public schools makes clear the advantages of being middle class to middle-class students. Even though doctors from modest means were unaware of class as small children, the realities of class difference became apparent as they entered high school. The doctors interviewed from modest means reported earlier experiences with negotiating class than their middle-class colleagues.

Class differences became more apparent for the doctors interviewed who were from poor and working class families as they moved into high school and college. These doctors began to realize that they were different from their middle-class classmates. Exposure to class difference in high school and college held a much different meaning for doctors from poor and working class households. One doctor described his realization of his family’s disadvantage, “We did not think we were poor until I was in high school and my classmates’ parents were buying them new cars and they were wearing the JC Penny and not the Levis or Sears jeans. That is how I figured out we were not well off” (July 10, 2014, Pediatric Intensivist). Another doctor described similar
revelations about class, “It was not until college when I realized we did not have what others had. I did see poverty as a child but college gave me new insights into wealth” (July 11, 2014, OB/GYN). Similarly a doctor remembered, “In college all of the sudden I was around insanely rich people. I was living in slovenly apartments and felt my fellow students were just like me until I found out their parents were CEOs. It was weird and oblique” (October 20, 2014, Dermatology). Doctors from poor and working-class neighborhoods became acutely aware in high school and in college that they were different and at a disadvantage and that the inequality was not discussed or mentioned. There was no discussion about the economic differences.

One of the doctors shared his memories of moving from a small rural public school system to a private school in the city. He explained to me:

I was only able to go to my high school because I qualified for massive financial aid. I learned early that being friendly seemed to override not having money. I do not think I would have gone to medical school without my private school experience. I would not have imagined the possibility of becoming a doctor without being surrounded by people with those dreams and their parents who were already successful doctors. I am not sure I would have thought college was doable if I had stayed in public schools (Nov. 7, 2014, Infectious Disease).

This physician’s insights that come from his experiences of class travel are very helpful. Moving up the ladder helped him to see the privileges of middle class life. Privilege is not just monetary, it is having room to imagine a better future. Physicians from modest means have a unique vantage point into class dynamics.

When doctors from poor and working class neighborhoods faced poverty in medical school they were already familiar with the realities of poverty. The poor and working class were
their friends, their family and their neighbors. Several of the doctors were able to reflect on their early experiences with poverty only now as adults after learning about how middle-class and wealthy people live. Now looking back, one doctor realized:

I grew up in a community where there was forced bussing, so I grew up with a group of kids that were not from our town. There were several kids, a little girl from Puerto Rico and a black girl and we became friends. My parents would let me go home on the hour ride by bus for overnights to their houses. I saw government supported high-rise buildings and there was garbage on the street (July 9, 2014, OB/GYN).

This doctor described her neighborhood as white working class and that she lived on the wrong side of the tracks, so all of her friends tended to be poor.

Another doctor reflected back on his childhood:

I grew up in a rural area. My dad was a public school teacher in the poorest county in the state. I was exposed to abject poverty as a child, but I was not aware. That was just the way it was. I never thought, wow, they’re poor. My mom had been very poor and we would hear family stories about feeding many from a can of tuna or having neighbors loan my mom and her sisters’ dresses for the dance. I did not think I was poor. I do remember being aware that I had the lame Star Wars figures and only a couple of my friend’s families could afford the Millennium Falcon (August 6, 2014).

Much like the doctors who had been raised in middle-class households, those from working-class and poor neighborhoods knew no different because in their neighborhood families were very similar. These doctors were however less shocked by poverty in medical school and explained how their childhoods had prepared them for working with the poor. Poverty for these doctors was not abstract but tangible.
Several of the doctors, from modest means, found their classmates’ reactions to poverty funny (in the beginning days of medical training). The middle-class reactions to seeing poverty for the first time were yet another indicator that the doctors from modest means were different. This difference, however felt good to the doctors I interviewed. These doctors claimed an advantage over their classmates because they were not frightened and could relate and communicate easily with their patients who were poor. One doctor explained to me what he keeps quiet from his “right-wing” colleagues, “If you grow up poor, you look at the world a very different way than if you grew up with affluence. You have to struggle with things that middle-class folk do not have a clue about. They are worried about which car to drive and I am thinking about what I need to prepare for the long walk” (May 22, 2014, Emergency). The middle-class medical student shock when seeing poverty is noted not just by the middle-class student but his fellow students from modest means. It is helpful to put the experiences of the middle class and those of modest means together to better understand class dynamics and the cultural erasing of poverty. Regardless of class upbringing, doctors silence discussions of poverty in medical school.

**Social Blindness**

Overall attitudes about the poor by doctors also serve as a way to separate. Harrington writes, “There are sociological and political reasons why poverty is not seen; and there are misconceptions and prejudices which literally blind the eyes” (p. 15). Harrington names this phenomenon, “social blindness” (p.15). Harrington gives the example of the misconception that the poor are lazy. The misconception and prejudices about the poor of which Harrington discusses were evident in the answers about poverty by the physicians interviewed. Poverty was discussed as a flawed mindset as one doctor explained, “Poor is in the mind of the beholder.
Labels can paralyze you and keep you from achieving things. Sometimes the poor can take on the mindset of the label. They think I am poor, so I cannot do anything” (May 22, 2014, Emergency). This doctor did not come out and say that the poor are lazy, but he did express an opinion that the poor can take control of their lives and move out of poverty but choose not to. Doctors also discussed the poor as making bad decisions: “At the end of their misadventure they come to my ER and demand I care for them. If you have a health problem or an accident due to poor decisions [including not pursuing insurance] your care should not be paid for” (May 22, 2014, Emergency). Blindness to the realities of poverty is maintained through beliefs and attitudes that the poor are ignorant about their own bodies and their minds are ill equipped to make the smart, healthy choices.

**Poor as Sick**

The doctor’s proximity to the poor in medical school does not guarantee that doctors will see the poor or connect emotionally with the experiences of the poor. There are other cultural practices that come in the way of class understanding. As Harrington mentions in *The Other America*, it is not just physical separation from the poor that allows the group to remain invisible, it is “social blindness” as well. When doctors construct health as middle-class those patients who do not share in the same values of health are often determined sick; not necessarily sick in body, but sick in mind and attitude. One doctor explained that the poor “do not have a good working knowledge about how their bodies work. People with a decent education [middle class] seem to know the health consequences of their behaviors. For example the poor do not seem to know that smoking can lead to lung cancer. When they seek treatment it is too late” (May 22, 2014). A preoccupation with health is only one way that the poor are measured on a middle-class scale.
Doctors struggled with why the poor had different values, different behaviors and a lack of understanding about what is healthy. For the doctors, understanding of poverty seemed highly influenced by their emphasis on personal character. The poor lacked qualities that allowed them to resist labels, to take responsibility, to work hard and not take handouts. Doctors were very aware of how their values differ from the poor. One doctor shared his outrage, “When I worked at the Children’s Hospital the poor would drop off their sick kids and would never come back. Their problems are almost self-imposed problems. You realize that an awful lot of people have very different values than you do” (July 11, 2014, Perinatologist). In such examples, the actions of the poor are judged in comparison to middle-class values, which are influenced by middle-class experiences. Doctors saw poverty as individual weakness, and unwillingness to accept responsibility. There was very little reflection on the part of these doctors on how the environment of poverty and the stress of poverty impacted health. Doctors did not regularly consider how a lack of education, risky and often unstable working conditions, corrupt landlords and regular acts of discrimination could play a part in decisions and behaviors doctors witnessed by the poor. Many of the doctors were unaware of poor lived-experience and instead understood the poor through the worldview of the middle class.

Middle-class medical students are initially shocked when they discover the extent to which poverty exists in the United States and how poverty was hidden to them prior to going to medical school. Social proximity in medical training however does not necessarily keep the physician’s eyes open to the realities of poverty. It was evident in the doctor interviews that some physicians adopt the myths about the poor as lazy, dependent and pathologically minded. Even in the face of poverty through their daily work with the poor, some doctors are able to maintain social blindness. Because there is rare explicit curriculum about poverty and about
privilege, medical training models social blindness. That poverty is not a topic of conversation makes myths of poverty the more likely understanding doctors develop.

**Healthy is Middle Class**

When asking doctors about poverty, I did not expect the conversation to be so much about poverty in comparison to middle class values. Understanding of poverty by the doctors involved their experiences of class more broadly and how social position related to health in general. This observation that the doctors define through class comparison, agrees with T. C. Wright Mills’s (1951) analysis of the middle class in *White Collar: The American Middle Classes*. Mills writes, “For the character of any stratum consists in large part of its relations, or lack of them, with the strata above and below it; its peculiarities can best be defined by noting its differences from other strata” (xx). The middle-class is defined by its interactions with wealth and with poverty. To better understand the relationship between the classes it is helpful to ask the middle-class physician about poverty. When doctors discussed poverty they were also defining their own social position and class values. From the interviews it appears that when doctors were put into a situation in which they needed to negotiate poverty, they often defined the middle class as healthy and the poor as ill.

**Independence and Discipline**

In the physician answers about understandings of poverty doctors also gave clues into middle-class sensibilities. Several themes emerged from a careful reading of the interviews, which included physician feelings about independence and discipline. Middle-class sensibilities not only constructed what it meant to be a good doctor and a good citizen, it also helped to frame dependency as deviant and pathological. In Nancy Fraser’s (2013) book *Fortunes of Feminism*,
she argues that key words like independent and dependent are “taken-for-granted commonsense beliefs that escapes critical scrutiny” (p. 85).

Fraser writes that doctors have increased possibilities for independence (control of day to day) at work in comparison to factory work. For many of the doctors interviewed, medicine was a practical pursuit, and being a doctor allowed for economic independence and was more practical than philosophy or English. One doctor joked, “My parents were happy that I chose medicine because it was more practical than my first choice, comparative literature” (Oct 14, 2014, Pediatric Intensivist). Many of the doctors shied away from specialties like surgery because they wanted to have a family and not dedicate their whole life to medicine. An example, “I had been in school forever and did not want long hours and wanted to make enough money which would allow me to divide my time between seeing patients and doing research” (Oct. 20, 2014, Dermatology). Doctors mentioned areas of medicine that would allow them to work anywhere and areas of medicine that seemed to have a long-term future in medicine. One doctor explained, “I could go anywhere with family practice. I could practice in a small town, Alaska, a doctor without borders, the city and the suburbs. I think health care will continue to change and in the end I think family medicine is well-positioned to weather those changes” (August 6, 2014, Family Practice). For many of the doctors interviewed becoming a physician allowed them to live a comfortable, middle-class lifestyle. Having workplace control is important to doctors. Middle-class sensibilities are evident when doctors discuss choices they make which impact their ability to have control over their daily life. In their own choices it is clear that they value independence.

The poor are often, however, constructed as dependent because they are accessing benefits and therefore not productive or ambitious. Nancy Fraser (2013) claims the label of
dependent is a judgment of a person on a moral, psychological level instead of an economic level. Those who are dependent economically are also seen as emotionally needy. Historically those dependent on assistance were seen as defective (p. 92). Not only was flawed mindset and bad decision making seen as common traits of the poor by the doctors interviewed, but there was also regular discussion by the doctors about the poor taking advantage of the system and that many poor people receiving benefits are not legitimately in need. One doctor fumed:

Now I get angry in the clinic when people are on the medical card and they are smoking and asking for scripts for Tylenol. I would get in trouble early on in practice for saying ‘no’ to requests by patients on Medicaid. For example, I was on call and this girl felt for certain she was in labor but she was not, and I advised: ‘no you do not have to come in because you are not in labor.’ She insisted that it was fine for her to come in because she was on the medical card and it would pay for her to be in the hospital. I explained to her, ‘the government pays for you to come in; it is not free.’ I received angry calls from her father about how I was discriminating against her because she was on public aid. All hell broke loose, she was not in labor but she was admitted because my actions were being framed as discrimination. It is crazy. There is a lot of abuse of the system. The system needs to be scrapped and we need to let whatever happens happen (July 23, 2014, OB/GYN).

Several doctors seemed upset that people would take benefits from the government and not work. To receive benefits was often seen as a sign of something wrong with an individual – a lack of productivity. Another doctor agreed with the widespread misuse of government benefits by the poor, “There are truly homeless people and I realize this. On the other hand, I have patients on public assistance with nice clothes and telephones. I have been punished for things
that are my fault. I am still conflicted about the concept [of poverty]. There is no agreement on approach, right” (June 23, 2014, Neurology)? The doctor equates being poor with wrongdoing. The poor should not receive benefits. They should have to suffer the consequences for the bad behavior that is assumed led them to poverty. When the poor are judged through a physician’s values of independence, they are often judged harshly. To be independent instead of dependent is an easy personal choice, not taking into account the barriers that are present that make independence very difficult to achieve for some.

In the introduction to Death as a Social Disease, (1982) William Coleman wrote about the worldview of the middle-class public health care workers and their exposure to the poor at the turn of the Twentieth Century in France. These workers went out into the homes of the poor with the objective to teach the families (usually mothers) about the prevention of infectious disease. This pursuit was in part for self-interest because being public health worker earned an individual middle-class status. The workers viewed the poor through a lens of self-sufficiency that was a part of middle-class sensibility at the time. The work was approached with the belief that discipline and hard work were all that was needed to be independent. For these workers it was important to hold true to values of democracy and capitalism, which were necessary to maintaining status within the middle class. One way to hold true to middle-class values was to believe that poverty was not a failure of capitalism or democracy but as a result of “irreparable flaws in the nature of man”(Coleman, p. 303). The doctors interviewed were very similar to the workers investigated by Coleman. Doctors valued their own independence and stress how they had earned their independence through hard work and in comparison were convinced the poor were just not trying hard enough or had flawed priorities.
For the doctors being interviewed, healthy was not only being constructed as having a symptom-free body, healthy was also being framed as having an appropriate attitude toward life. Appropriate was being defined by middle-class experience, values and middle-class sensibilities. Much like how Wright explains how the middle class defines its character through relationships with the rich and the poor, Johnathan M. Metzl and Anna Kirkland (2010) write in *Against Health*, “the definition of our own health depends in part on our value judgments of others” (p. 2). According to Metzl and Kirkland, to better understand disparities in health care it is important to understand how health is constructed. Metzl and Kirkland reference Ivan Illich’s essay “To Hell with Health,” about the “excessive preoccupation” with health in the U.S. and the industries making profit from maintaining this preoccupation (p. 5). Health is constructed in the United States for a middle-class consumer that can afford the products created by the health industry. Illich writes that health is one of the most “destructive addiction” in the United States (p. 5). The middle class preoccupation with health influences doctors who are not only a part of the middle class but also are in charge of middle-class health. Because of class values, doctors tended to see people not preoccupied with health as pathological. If a patient does not understand how his body functions, does not come see the doctor when first feeling bad, and does not take control of his own health then the patient is to blame. How can a doctor be expected to be helpful when her patient does not except responsibility for his own health?

**Obesity as Case Study**

I was shocked at how many doctors mentioned obesity as a major concern for the poor in America. Obesity was mentioned by six of the twenty-four interviewed as a major concern for the poor. For one doctor, obesity is a concern across class. He explained how obesity tends to hit the poor very hard, “Obesity is the great plague - slow but the new great plague. Obesity is
multifactorial and I am not convinced that we understand the ins and outs of what causes obesity. We are just starting to figure it out” (Aug. 6, 2014, Family Practice). Poverty, one doctor explained, “contributes to a variety of costly health concerns that include obesity and violence” (May 22, 2014, Emergency). In her essay “Risky Bigness: On Obesity, Eating, and the Ambiguity of ‘Health’,” Lauren Berlant (2010) lends insight into the cultural concerns around obesity. She suggests, “Obesity and eating in everyday life are not just symptoms of something off in individuals. Obesity also points to social problems in maintaining equilibrium and optimism in everyday life” (p. 27). Berlant points out that obesity (and I would argue her point also applies to obesity in the poor) acts as a “symptom” which is trying to tell us that something is “awry” (p. 27).

Obesity was mentioned much like drugs and alcohol were mentioned as plaguing the poor. The doctors however tended to be more sympathetic about drug and alcohol addiction. The doctors interviewed could understand why their patients who were poor get involved with drugs because drugs and alcohol are “a cheap anesthetic to the suffering in their lives” (July 9, 2014, Physiatrist). Doctors spoke very differently about obesity, however, “In the United States, overnutrition is more of a problem. Those with a body mass index of 80, which is super obese, they are almost always public aid patients. In the case of my patients, obesity leads to preeclampsia, stillbirth, and complications from c-section” (July 11, 2014, Perinatologist). Doctors saw obesity as a problem for the poor, but eating was not seen as an anesthetic used to relieve social pain. Scholars like Berlant see obesity as just that, a way to balance suffering with optimism.

Obesity as a repercussion of poverty does not make sense to the doctors. Seeing heavy poor seems a contradiction, as one doctor explains, “In America they say they are poor but they have running water and enough food that most are morbidly obese. The U. S. is the only place in
the world where the poor are fat” (June 23, 2014, Neurology). Another doctor shares in the
confusion, “Why are poor people so heavy? Poverty is supposed to be about not having enough
food. Poor people are not as healthy. I do not know why that is. There is more drug abuse,
smoking and obesity, and not taking care of themselves” (July 23, 2014, OB/GYN). When
popular notions of poverty are linked to images of starving bodies, heavy bodies contradict this
understanding of poverty. Obesity helps to make the poor invisible if the common understanding
of poverty is wasting away. Obesity contradicts older notions of the poor as starving.

The Obama Administration has paid a great deal of attention to obesity through programs
like the Childhood Obesity Task Force. The federal government has pushed for electronic
records so that data can be used to help cut costs and to implement prevention programs with the
goal to cut health care costs. One piece of data that is of interest to the federal government is
obesity and weight in general. Many of the doctors interviewed complained that they now have
to engage in discussions of BMI (Body Mass Index) even when it has nothing to do with why the
patient is seeing them. Because obesity is a current health concern, ever present in the media, it
seemed a regular topic of conversation with the doctors. Obesity is an area where doctors can
openly and safely discuss their anger over poor patients’ lack of control and discipline. Obesity
in some respects seems to be the new lazy.

The poor, by eating to the point of obesity, fall outside of middle-class norms of
discipline and are then constructed as undisciplined and therefore unhealthy. The middle class,
Berlant (2010) argues, are marked by body projects and health obsession. Cultures around body
discipline are created to give a sense of control or to maintain an illusion of control (Berlant,
2010, p. 29). Doctors are an important part of health cultures that pride themselves on having
self-control proven through years of dedicated medical training, plus doctors are also held
responsible for other people’s health. The physician concern with bodily discipline serves as proof that the doctor is in charge and healthy. The middle class is also more likely to access preventative care and consider future health than the poor. Berlant writes that eating pleasure is a momentary relief from middle-class obsession with maintaining health for optimal productivity (p. 35). Eating serves different purposes it seems for the poor and the middle class. The privileged have the resources and therefore work to prolong life. Control over eating is a luxury in which those who have food in abundance can enjoy. The middle class judge the poor based on their class body sensibilities that emphasize control, discipline and productivity. Treating the poor the same as middle-class patients means having expectations of thin, productive bodies for everyone. Healthy is constructed from middle-class sensibilities of eating discipline.

**Medical school guidance**

Expectations of independence and discipline were not the only evidence of middle-class expectations informing approaches to medicine. In the book *Boys in White* (1961), a study of medical school students, Becker and his colleagues observed medical student attitudes that the investigators linked to medical culture but also to “lay cultures” (p. 323). In Becker’s study medical students brought with them to medical school “social class, sex and lay cultures about pain and disease” (p. 323). In Becker’s interviews with medical students he concluded doctors made moral judgments based on middle-class expectations of the poor as submissive subjects of charitable care (p.324). In Becker’s research, the investigators observed the poor treated as if they should know their place and listen to the medical student with his superior knowledge and discipline. The poor were expected to not question treatment and be grateful for charitable care. The doctors that I interviewed shared encounters with poverty in medical school and experiences with a medical culture that included unspoken rules of how to negotiate class difference without
explicitly talking about poverty. The doctors I interviewed discussed feeling pressured to keep quiet any concern they might have for the poor. From my discussion with doctors it appears that poverty is something each medical student learns to cope with on her own, in silence.

In my research, when asked about experiences with poverty in medical school, many of the doctors discussed being left on their own to learn and negotiate poverty. One doctor described this negotiation, “In medical school you learn by doing and I was caring for the poor. I was not taught how to marshal resources or how to work in a sophisticated way with social workers. We were given access to impoverished populations so that we could learn, but you are not going to simply discover a better way on your own” (Nov 7, 2014, Infectious Disease).

Medical school does expose students to poverty but there is very little explicit education about health outcomes for the poor or social determinants of illness. Exposure to the poor seems to be the soul educational intervention utilized in most medical schools and residency programs. Negotiation of class difference is left to each individual doctor and those who have personal concern for the poor are expected to pursue further education independently.

Medical students are not aware that the expectations they have for middle-class consumers as partners in medical treatment and the expectations they have for poor patients as submissive to the doctor’s expertise are very different approaches with very different outcomes. With little guidance, most of the doctors learned to negotiate on their own how middle-class social position impacted their relationship with their patients who were poor. Doctors explained there was no direct, formal discussion in medical school about how privilege and status helps to frame understandings of poverty. There were some exceptions to the dominant culture of medical training about poverty. Less than a handful of the doctors interviewed received some training in
medical school or in their residency that was helpful to better understanding poverty and the role medicine plays in poor communities.

**Medicine and Society Class**

Only three physicians who participated in the study had formal discussion and planned curriculum about poverty and health care in medical school or as part of their residency training. The first doctor described the inadequacies of his classroom lectures to learning about the poor, “Learning pieces of language and some history and details about the poor was inadequate. The classroom content was only useful as a measuring stick for how poorly what we learned described the reality we eventually would see. The information from classes does not teach you where the person is coming from and it does not tell you whom a person is (June 26, 2014, Family Practice). Understanding the realities of poverty was much more important to this doctor than a historical overview. To better understand his patient’s obstacles to a healthy life, this doctor argued that he needed to learn interpersonal skills that would get to his patients’ stories. This doctor taught himself how to go about these conversations. He had learned on his own, by working in a small rural town, how to see the reality. Learning about home life and work life was important for him to find the best medical solution that works for his patients who are poor and working class.

Two doctors described formal medical school curriculum that covered issues of poverty. Both of these doctors had classes titled, “Medicine/Physician and Society” that were a required part of the fourth year of medical school. Both described the classroom discussions of poverty as insufficient and too late in the process. One remarked, “Understandings of how medicine should be approached were already solidified. My colleagues already had taken-for-granted assumptions about the poor. Up until that point, in my medical education, the learning was technical and you
were taught to answer in a standard way” (Nov. 7, 2014, Infectious Disease). This class covered all the issues that are classically neglected in medical school. The other doctor remarked, “Poverty was a constant feature in those discussions as well as international health issues. Many topics were covered in that class from religion to nutrition” (Aug. 25, 2014, Infectious Disease). Doctors discussed how the classic medical school curriculum was always kept intact and that it was difficult to find room in an already packed curriculum for the neglected issues in medicine. Both doctors wished that these classes had covered other concerns about working with the poor. One listed a desire to better know “how medicine works within society” and how to engage in cultural critique, while the other doctor wished he had learned more about “models out of poverty” (Nov. 7, 2014, Infectious Disease; Aug. 25, 2014, Infectious Disease). Both of these doctors discussed how the content on poverty (which both understood was rare content in medical schools) was inadequate or too late in the process.

**Exposure to High Volumes**

When asked directly if doctors were prepared by their medical education to serve the needs of their patients who are poor, the doctors unanimously agreed they had not been prepared for working with poverty in practice. Without formal education about poverty, doctors are left on their own to negotiate poverty as it relates to medicine through regular contact with the poor as medical students, interns and residents. A small group of doctors acknowledged their exposure to high volumes of poverty in residency and being held responsible for poor patients as residents was somewhat helpful preparation for working with poor patients in their current practice. One doctor explained, “Working in the 1000-bed hospital; being exposed to so many different things was helpful. Just having those unique experiences was very positive” (July 9, 2014, Physiatrist). This doctor agreed they were well versed in the illnesses and diseases found in poor populations
but little was taught in medical school and residency about anything but treatment inside the hospital. Once the poor left the doors of the institution, the doctors had no sense of what happened to the poor.

Another doctor who completed his residency in the south and worked predominantly with African American poor explained, “Yes, I was prepared by my medical education on some level to work with the poor. When I started my medical education it was 1981 and the Tuskegee anger and distrust was so palpable. The hostility often directed at doctors by the poor came from actual incidents.” This doctor went on to say, “When dealing with poverty today, I think medical students and residents often do not understand the history” (July 10, 2014, Pediatric Intensivist). The hostility and anger expressed by patients who are poor are not seen in historical context [by the doctors], so the anger seems odd and further proof of deviance.

Both of these doctors explained how being in hospitals that served high volumes of poor patients was helpful in better understanding the health challenges of being poor, but it was inadequate. Doctors described a limited understanding of the lived experience of the poor when they worked in hospitals with high volumes of poverty. For both of these doctors it would have been difficult not to glean something about the home and work life of the poor they were serving because of the sheer numbers of history and physicals they had to complete. Both described their work with the poor as crisis work with very little time available for each patient and a lack of resources to really help make a long-term impact on the health of the poor. Observations of the poor in the large medical center environment are varied but also limited to what is possible through the typical medical encounter and how that encounter is constructed through medical training.
Directly Serving the Disadvantaged

Three doctors actually enrolled in training programs specifically geared toward serving disadvantaged communities in part to assist in paying for medical school. These experiences appeared to have mixed results. One of the doctors who served in the National Health Service Corps as a medical student has gone on to serve the poor in large numbers throughout his career and is an outspoken advocate for universal health care. Of those interviewed, this doctor was by far the most aware of poverty research of those interviewed and is very concerned about the impact of poverty on health outcomes. He said, “If I could do one thing to improve health in America it would be to eliminate poverty” (July 3, 2014, Family Practice). The other doctor involved in a program for disadvantaged communities, on the other hand, discussed how the experience was not for her and the sacrifices made by physicians working particularly with the rural poor were laudable to her but for a doctor who wanted to have a family and have other things in her life besides medicine, working exclusively with the poor was not appealing. She explained, “Those family doctors, they were doing more than most family doctors were doing. It was not exciting enough there was no adrenalin rush. I could not see myself in a community like that - rolling hills and buggies” (July 23, 2014, OB/GYN). When this doctor used the words, “exciting” and “adrenaline” these seemed code for a lack of status. Those doctors working in rural areas were constructed as old-fashioned and inferior whereas modern medicine was seen as more of an intellectual challenge.

Those doctors who had specific classes about poverty, had the opportunity to work with high volumes of poor patients, or those who enrolled in medical training programs specifically geared at training doctors to treat the disadvantaged generally explained that these training opportunities were somewhat helpful to better understanding health care disparities and how
doctors could be helpful. These experiences much like general medical education offered limited guidance about class difference. These specific interventions that are meant to raise sensitivity and awareness about poverty did not counter the more general approaches to poverty in medical training.

**Importance of Status**

Middle-class sensibilities of independence and discipline influence how health is constructed and how the poor are constructed as ill. Another way in which middle-class sensibilities maintain social blindness and the invisibility of the poor is through the value of status. The middle class relies on status for economic stability.

Max Weber (2010) points out in *The Bureaucratic Machine* that economic security and owning property are not the only things that give people power within a capitalist society. Weber points out there are differences between class and status—one is the result of property ownership and one is the result of honor. “Status honor” comes with shared qualities that are often the result of class situation (Weber, 2010, p. 123). For medicine, power and influence has come through class and through status honor.

During the interview several doctors discussed increased status as important to why they chose medicine. One doctor who had grown up in a small rural town explained the status of the doctors in his community. He remembered their names and he remembered his doctors as the most educated and admired people in his community. By going to medical school he wanted to make his mother proud and he wanted respect for his work from the community at large (Nov. 7, 2014, Infectious Disease). Status is important to those going into medicine. Status is also important to the middle class. Studying to become a doctor holds the possibility for future power and prosperity.
Status also informed where doctors went to medical school and how much they valued their medical school experience. A Johns Hopkins graduate described his medical school experience in this way, “I can brag that I learned the standard of excellence from those who created the standard of excellence in medicine. No matter where I go to practice medicine and no matter what area of medicine I chose to practice, I will always have my elite medical education to draw upon” (Aug. 25, 2014, Infectious Disease). Deciding to go to medical school and deciding where to go to medical school are only the beginning of the status journey for doctors. This valuing of status was evident throughout the interviews.

Many doctors stressed the status of people they worked with or the reputation of where they worked. For example one doctor emphasized how his medical specialization found him and not the other way around, “In the National Health Service Corps I had the option to work for the National Institute of Health [NIH]. I was asked to work specifically with children with Leukemia. I continued in this work because I did not want to give up the experience I had gained at the NIH” (June 8, 2014, Pediatric Oncology). Working for the NIH helped to raise this physician’s status so he stayed with an area of medicine that was not as interesting to him as other areas of medicine.

Doctors also mentioned the reputation of residency programs as a mark of status. One doctor described his prestigious pediatric residency, “There were two iconic figures taking over the pediatric department, they ended up being very important people in pediatrics and they were building the residency program from the bottom up. It was a vibrant and demanding experience unlike the other rotations I had experienced” (Oct. 17, 2014). Another doctor was proud to discuss the notoriety of her department and the privileges that came with this status, “I work at a referral center and we are the best in the world at what we do. It is rewarding to take care of
people who other doctors have had a hard time figuring out what is wrong” (Oct. 20, 2014, Specialization Confidential). This doctor went on to explain that the status of her department gives her some control over her work day and allows her to be involved in interesting work instead of the drudgery of general practice.

**Specialization Status**

Status was discussed most often when doctors described how they chose their specialization in medicine. Doctors describe particular areas of specialty of having inherent status. The doctors interviewed who cater to middle-class consumers tended to have higher status than those doctors serving the poor in larger numbers. Choices made about specialization are complicated and political and are often informed by understandings of class. One of the doctors helped to complicate choice of specialization by highlighting the common debate between general and specialized medicine about status and also about providing care for the poor. This doctor started off by saying she was a “compromised actor” within the medical system and went on to clarify, “I think doctors are doing their best to negotiate a broken system which does not treat health care as a political right” (Oct. 20, 2014, Dermatology). The class of the patient served and the status of the doctor are closely linked. As a specialist working with the elite she explained,

Health care is a part of the free market and because of this I have to work against my morals all the time. The free market is a hot mess. Picking a medical specialization and deciding where a doctor will practice as a physician is often simplified as a decision between serving the poor out of humanitarian concerns or the opposite, serving the rich out of individual interests (mostly greed). The economic pressures pull you in so many directions. You have to decide if you become the young, junior faculty member who
serves the poor and is treated like shit by her male partners, or if you will do something considered more valuable, like attracting a decent number of elite patients to your shared practice? Making these decisions is an issue of race, gender and economics. These issues are much bigger and much more complicated than they appear from the outside. Constructing worthy medicine as serving the poor or constructing unworthy medicine as doctors pursuing status is not a good answer because the system is broken (Oct. 20, 2014, Dermatology).

For this doctor, honor and economic status are often pursued within medicine to overcome a lack of status as the result of discrimination for being a woman, doctors of color and doctors from poor and working class backgrounds. She goes on to explain, “Medicine is not an easily negotiated political space. I see students coming to my specialty very motivated by the market, but I am also sympathetic to women who want to make a lot of money in a short time because they want to have a family. It is awful seeing the best and brightest in medicine fall prey to the market” (Oct. 20, 2014, Dermatology). In the end she made the distinction that doctors are very different from the elite in the United States because they work hard for their money and are not simply given advantages. Doctors earn status the hard way. This doctor’s insights lead back to Lopez and Weinstein’s (2012) discussion of middle class formation and the importance of talent and hard work to maintaining class status. The middle class must earn and maintain its status; it is not given. Achieving and maintaining status is a middle-class sensibility that is firmly a part of medical culture.

**Women and Status**

Unlike the for the men interviewed for this study, for many of the women interviewed going to medical school went against middle-class gender values and norms. The majority of
women shared feelings about how their parents were less than supportive. One doctor noted, “My parents did not play a role at all in my attending medical school” (July 9, 2014, Physiatrist). Another doctor recalled, “My parents were extremely upset. My mother cried. For her, me becoming a doctor meant I could not have a family or a life with kids and that stuff. My parents were not supportive” (July 9, 2014, OB/GYN). Male physicians did not share the same types of reactions from parents about deciding to become doctors. To be a woman and a physician seems to transgress middle-class sensibilities about gender roles, “My dad is in the habit of asking waitresses when we go out to dinner as a family, ‘I bet you cannot guess what she does?’ When I first graduated from medical school he would tell people I had a degree in nursing” (Jun 20, 2014, Psychiatry). Many of the women had to face ridicule for their pursuit of medicine. Status has very different meanings in public and in private for women in medicine.

Women not only have to negotiate gender expectations in medicine and at home but also internally. One doctor shared her own skewed expectations of self in which she must balance multiple roles successfully, “There was a commercial for the perfume, Enjoli, and the model in the ad would say, ‘I can bring home the bacon and fry it up in a pan and never let him forget he’s a man.’ I believed that you could do it all. That was the expectation I had for myself” (July 23, 2014, OB/GYN). This woman had the support of her parents and husband and also worked in a specialization of medicine that is more open to women, however the middle-class messages in advertising influenced her feelings of self-worth. To be the ideal women she needed to be the best doctor and the best mother, wife, and daughter as well.

Even though women pursuing medicine also discussed status as important to them, attaining status as a woman through the role of physician had very different implications than for the male doctors. One doctor shared her experience of being a nurse and not being satisfied with
the role. She stressed, “I wanted more status and felt hemmed in as a nurse. I thought I would be allowed to do more as a physician” (July 9, 2014, Physiatrist). This doctor pointed out that other women (nurses and social workers for example) in medical settings had very little status and without the status of physician, women have very little impact on patient care. Several of the women explained that male-dominated high-status specializations were out of their reach, “I wanted to be a surgeon but there was not a single female surgical resident or attending. I had no potential mentor. Surgery did not feel like a real option” (June 18, 2014, Psychiatry). Women going into medicine have to negotiate gender expectations and must negotiate how being a woman influences the status they hold in medicine. One doctor described comments she received when in male dominated rotations in medical school. She was told she was ugly and unattractive, so it made sense she would go into medical school because no man would want her (July 9, 2014, OB/GYN). Women described similar experiences of sexual harassment and sexism that made certain areas of medicine unfriendly to women.

Medical educators predict that the majority of medical students will be women in the next couple of years (Carvajal, 2011). This gender shift in medicine comes with concerns that when the number of women in medicine increases there will be a loss of status by medicine. As Carvajal (2011) points out in her article, “The Changing Face of Medical Care,” some male doctors are leery that salaries and prestige will be lost when medicine becomes a profession no longer dominated by men. Two doctors discussed worry over the female domination of their specializations of obstetrics and pediatrics. The one doctor quipped, “I liked that obstetrics and gynecology would allow me to spend a third of the time in the office, a third of the time in surgery, and a third of the time delivering babies. I do not think I would decide to go into this field today because it is eighty percent female. I would not feel comfortable knowing I would be
one of few men” (July 11, 2014, Perinatology). The other doctor discussed how the current
gender dynamics in medicine have happened very quickly, “Back then men were doctors and
women were nurses. Pediatrics is a female dominated specialization and I am now a minority.
When this shift happened I remember nurses making clear to me that I need to treat them as a
colleague and not as a servant. The pecking order has changed” (July 10, 2014, Pediatric
Intensivist). Women were reluctant to go into male-dominated areas of medicine and men were
equally reluctant to go into female-dominated areas of medicine. As the gender makeup of
medicine changes this shift will at least alter current understanding of status in medicine.

The importance of status is one more middle-class sensibility added to the list of concerns
that doctors have when comparing their values and behaviors to those of the poor. Feelings about
independence, discipline and status by the middle class play a part in what is healthy. Poverty
remains invisible in medical training because the poor are constructed as dependent and
undisciplined and because those doctors who serve the poor are often determined to be of less
status within the medical culture. Doctors described the aspects of medical training that help
maintain social blindness.

Democracy

The physician practicing in the current medical climate is in reality dependent on the
hospital and clinic for expensive medical technology and is dependent on insurance companies
and government for payment and funding. The rhetoric of independence remains in medicine but
the economic reality of independence on the part of the doctor becomes less and less so. Fraser
(2013) argues that the myth of equal opportunity continues in the United States and if a person
does not succeed in being independent, it is because the individual is a failure and defective (p.
101). Part of this myth is that a good citizen always continues to strive for independence. Frazer
adds that the rhetoric of independence and dependence helps to maintain inequality and a false sense of independence that hides interdependent economics.

The rhetoric of democracy within medicine is used as yet another way to make the poor invisible. One practice that washes away class is the view that it is always important to treat all patients the same regardless of class and regardless of insurance coverage. Treating all patients as equal is seen as the only just way to approach medicine. One doctor explained:

There is no difference between patients in medical education. Our teachers did not distinguish between classes in medical school. All patients are treated the same in the inpatient setting. Specialty clinics will turn down patients because of a lack of insurance, but this is not a part of my practice. For example in the ER as a resident, if a patient was sick we treated. It was someone else’s problem if the patient did not have insurance (May 22, 2014, Hospitalist).

Another doctor shared in this observation about medical culture:

As a physician and a resident you were seeing people who were poor but you had no idea of income, not really. It was not clear if people had or did not have insurance. Everyone was treated the same- exactly. There are differences in how the poor are socially treated but where I do not see a difference is at the point of diagnosis, there is no difference in how they are medically treated. The income piece is not a factor on what tests are ordered or what medication is prescribed” (July 9, 2014, Psychiatrist).

This physician’s sentiments seemed typical of most of the doctors interviewed. Many of the doctors shared similar observations about democracy in medicine: “Where I did my residency it served an impoverished community, largely Hispanic, with very little insurance. Those served with insurance tended to be staff of the hospital. It was accepted and we did not treat people
differently. The care was not segregated out based on class. A few of the attendings would treat people differently, but most people did what was appropriate. It was a Catholic institution so the mission was to treat everyone the same” (July 9, 2014, OB/GYN). Many of the doctors argued strongly that social position of the patient should not alter a doctor’s approach to medicine.

**Invisibility through Democratic Ideology**

The majority of doctors interviewed who grew up in middle-class households admitted to not seeing poverty until they were in medical school. Until medical school, their experience gave them the impression that everyone was the same. For example,

> In public school I am sure there were folks who did not know where their next meal was coming from and I did not really have a feeling for what those kids were going through because from my perspective they were doing most of the things I was doing: playing sports, performing in band and they were in my different classes. Poverty did not sink home in a way in which it did in medical school. Prior to that (medical school) poverty was fairly abstract (June 26, 2014, Family Practice).

Even if the life of students in poverty attending public school might be very different, middle-class children saw their classmates as the same and as equal participants in school. This ethic of treating people equally as a way of understanding class difference repeats throughout the discussion of class. Sameness then becomes another way to obscure the material reality of the poor.

The challenge of treating all patients the same is that patients tend to be treated from a middle-class sensibility, with middle-class experiences of home and work informing medical solutions. A physician’s approach to patient class is informed by the doctor’s experience of his own social position. The poor, who face very different realities who often favor interdependence
for survival, do not share middle-class sensibility and middle-class experience. One doctor explained, “For me I was a typical middle-class guy going to college. Poverty was not part of my day-to-day prior to medical school. Because I lived in places like University of Virginia and Georgetown poverty was not on my radar based on my experience. It was emphasized that everyone is the same. You can make assumptions about a person’s social position even though I still do not know if my patients have insurance” (June 27, 2014, Emergency). This doctor points out there are problems with assuming that his patient has the same resources available to the doctor because this leads to treatment decisions that could create barriers to feeling better.

In a democracy with myths of ample opportunity for independence and prosperity, those that don’t succeed economically are constructed as choosing not to pursue opportunities. Poverty then go against the ideals of the country. This view of poverty on the part of doctors threatens values of independence and also threatens democracy. Independence and democracy are both middle-class sensibilities. Fraser (2013) argues that those that are perceived as a threat to independence and democracy are incapable of full, healthy participation as equal citizens (p. 94). The rhetoric of dependency helps to maintain that equality is ideal for those who are independent and healthy citizens but those who are dependent are defective and therefore incapable of full, healthy participation as equal citizens (p. 94). In reality health care disparities lead to costly illness and disability and large gaps in income in a community lead to poor outcomes for the poor and the wealthy in the community (Anderson et al., 2002). Illness it turns out is interdependent. The health of the poor impacts all of us. Sickness does not recognize social separated and is not socially blind. Maintained pockets of poverty contribute to health around the world. The Ebola fears of this year serve as a helpful reminder that the poor are hit the hardest by infectious diseases but Ebola has moved out of poor neighborhoods (Leach, 2014).
According to Fraser (2013) and Coleman (1982), self-sufficiency is seen as a crucial part of liberty and democracy and maintaining middle-class status. Independence was crucial to the overall philosophy of liberty that if a doctor puts his mind to it he could achieve anything. This understanding of independence as necessary to good citizenship and what stands in as independence in medical cultures, things like productivity and responsibility, colors views of the poor. If the poor are viewed as dependent, then dependence comes with stigma. Part of the stigma of dependence is individual defect that cannot be overcome. With all of this in mind, ideology of sameness also plays a part in how doctors are able to be socially blind even when working in close proximity to the poor. Physician discussion about topics like obesity and poverty give insight into the complexity of social position and how myths of poverty are maintained without awareness on the part of doctors.

Conclusion

Modern sensibilities became middle-class sensibilities in the Progressive Era and bringing science to medicine played a role in this change. Today the middle class is a trending topic in political circles, and the “global middle class” is of particular interest (Lopez & Weinstein, 2012, p. 1). Many economic experts believe that if more and more countries have a middle class, this group will prompt economic reforms. Historically, the middle class in the United States and Europe have demanded increased regulatory involvement by government and have “promoted worldwide democratic development” (Lopez & Weinstein, 2012, p. 2). According to Lopez and Weinstein, there is often hope on the part of progressive economists and politicians that shared middle-class values of equality will lead to increased quality of life for all across the globe. Critics of the idea that the middle class are transformative point out that in America the middle class has been losing financial stability and political influence since the
1960s, and that the once politically powerful and economically privileged middle class of the Progressive Era is gone (much like Harrington warned over 50 years ago).

The middle class has long been the “engine of innovation”, even though in reality, Lopez and Weinstein (2012) argue, the middle class is constantly battling between traditional and modern sensibilities and is regularly negotiating this contradictions (p.111). The battle that Weinstein describes between tradition and innovation is very similar to the battle between the art and the science of medicine. The United States is often represented as a middle-class country pushing its middle-class values on the world. These values are being questioned because, as it turns out, independence, productivity, discipline and democracy have not proven to be solutions to social problems like poverty, which continue to plague the United States and the world.

Much like the doctor interviewed who experienced fleas on a child for the first time after a lifetime of no experience with extreme poverty, the middle class often remains unaware of the poor until they are forced to see them due to media coverage of economic or natural disasters. When looking at the history of poverty in the United States there is a recurring theme in which the poor remain invisible to those benefitting from economic success and technological advances mainly the middle class and the elite. Class separation and differing class values help to maintain the belief in which the entire nation is sharing in economic prosperity (Harrington, 1962). The myth is that poverty exists but not in large enough numbers to intervene. Poverty is framed as a natural part of any population. The other part of this myth is that the poor are unfortunate or deviant, non-productive members of society. It is now a given that there will always be people who cannot compete in the free market. Policies are put in place to provide “generous” government benefits to take care of those legitimately poor. (Edelman, 2012)
Doctors are different from other social service laborers in that they do have power that comes with their social status. Increasing professional status by attracting white middle-class men also means medicine has the political status of white, middle-class men. Scholars like Paul Starr (1982) argue doctors have historically used their political clout to maintain and preserve the status of their profession. In the Progressive Era when the laboratory scientific physician became emphasized, U. S. medicine was framed as a middle-class profession catering to middle-class consumers. Does the middle class culture of medical education contribute to a social blindness about poverty? How does this link to class status?

Medical training in the United States relies heavily on the poor for a variety of complex reasons. Doctors, unlike other members of the middle class, do not get to maintain social distance from the poor. That medicine works closely with the poor often shatters middle-class fantasies of doctors caring mainly for patients similar in class. According to scholars like Howard S. Becker et al. (1961); doctors maintain different expectations for middle-class and poor patients in their practice; doctors tend to partner with the middle class and desire submissive behaviors on the part of the poor. Middle-class sensibilities of the doctor are often in conflict with how the poor live their lives, and because of this conflict, middle-class values of independence, body discipline, and democracy (defined as treating everybody the same) contribute to “social blindness” on the part of doctors. Learning from doctor’s experience, values and behaviors could prove helpful in better understanding the inability of the middle class to see the poor on a larger societal level.

Harrington goes on to write, “if we solve the problem of the other America” we will learn “how to solve the problems of all of America” (p. xxix). If what Harrington says is true, and the problems of the poor are closely connected to the problems of America, what could we learn
from solving the health problems of the poor? What solutions can be found for the poor that could improve the overall health of America? Harrington does not hold doctors, nurses, and social workers accountable for their lack of action when faced with the realities of poverty in their daily work because he claims these groups have very little political power. More explicit medical training about how to learn from the experiences of the poor, about how medicine plays a particular role in American culture, and learning about models of ways to move toward equality could serve as a helpful beginning to Harrington’s call that all citizens of our wealthy nation get involved in ending poverty.
Yet visibility is not transparency. Rather, we argue here, visibility is itself a claim that must be carefully examined: in acknowledging what is seen, and newly seen, we need to be equally vigilant about what is not seen, or no longer seen (Triechler, 1998, p 3).

Paula Triechler (1998) reminds us in this quote that science and technology, for example the microscope, allow doctors to see some aspects of the body for the first time, but even with these medical advances there are still things about the body that remain a mystery. Ehrenreich & English (1978) and other scholars have written about the loss of knowledge from lay healers and other approaches to medicine that were popular throughout the country prior to this time when medical practice became dominated by science at the turn of the twentieth century (Coulter, 1975). Instead of pooling all of the knowledge of healing, non-scientific approaches to medicine were chloroformed in American history, mostly through regulatory policy. There are many layers of knowledge of illness and healing/treatment that were at least partially lost. Also Ehrenreich & English (1978) and others point out, women, doctors of color, and working class contributions to healing were lost as the paradigm shift moved to laboratory science, but much more was lost as well (Coulter, 1975).

Not only were other healers disregarded, the knowledge of the patient became less valuable. Prior to this, vitalism was still an active consideration within medicine; many doctors argued that the body itself has healing knowledge and power that cannot be investigated through scientific methods (Fraser, et al., 2005; Greco, 2005; Hume, 1923). The notion that patients know their bodies and that the body can heal itself without medical care; are ideas that threatened scientific medicine. The old ways of healing and understanding of illness were forgotten in the cultural push for tests, new technology, and reliance on the scientific physician as expert.
In the paradigm shift toward laboratory science in medicine, the doctor alone begins to possess the solution to illness and the patient and his body becomes a passive part of the process. Once technology allowed for the unseen to be seen (mainly germs at this point), the thought was that, very soon, the medical community would know everything about the body, so the body would be easily fixed, improved, and made more efficient. The body then begins to be seen as a clock, and a clock cannot fix itself. A broken clock needs a skilled clockmaker. A clock does not start ticking on its own. The mystery of the body and the power of nature to heal are unseen and uncertain and unnerving for a public beginning to put faith in medical expertise and the progress that would come from rigorous scientific investigation.

The Resistance of Art of Medicine

Many of the doctors who were interviewed for this study were drawn to medicine for two main reasons: they loved science and they wanted to work directly with people. In general they bragged of being excellent students and were aware fairly early on in life that medicine was a real option for them as a career. Medical training is structured to value science but there is also talk vaguely about the art of medicine. The art of medicine is constructed as all parts of medical practice that fall outside of science training. As technology advances, and as new medical discoveries bring new scientific theories to medical practice, there is consistent concern that this new information will cause a loss of the art of medicine, particularly the humanitarian aspects of medicine. The art of medicine becomes what Foucault (1980) termed a “subjugated knowledge,” a knowledge considered naive. Discussion of the art of medicine by doctors is often in resistance to an overemphasis on science in medical training. Science is often portrayed as cold and detached and science cultures of sacrifice and specialization contribute to this coldness. Doctors are concerned about lack of sensitivity to difference and a better understanding about the heated,
long-term debate between the art and science of medicine seems crucial to addressing accusations of cultural incompetence.

**Subjugated Knowledge**

If you isolate man and deny that he is animal and flower, stone and wood, then you are like a person who does nothing else during his whole life but look through a microscope: He is in danger of denying heaven, earth, the stars, since he cannot look at them through a microscope. Remember that the human being in front of you is an arbitrary figment of your lack of imagination…. (Greco, 1998, p. 1) *The Meaning of Illness.*

Monica Greco (1998) uses this quote by George Groddeck in the introduction to her book, *Illness as a Work of Thought.* Groddeck (1977) points out what is lost about the world when a scientist looks only through the narrow lens of a microscope. Groddeck uses images of starry skies to make his argument about loss, but less pretty parts of life go missing outside of the microscope. Knowledge about poverty is one aspect of medicine that is lost in a scientific training of medicine. Medical educators make an assumption when training the scientific physician, that to see all the diseases, and know all the treatments that work by learning from treatment failures, this exposure is all that is necessary to be a competent doctor. As each new technology arrived on the medical scene there was an argument by older physicians that the technology would only give partial answers and that new knowledge did not have all the answers to medical problems. Doctors would argue medicine should ideally blend the new scientific discoveries with the older knowledge of healing.

This argument for blending was often seen by newer physicians as resistance to new ideas and progress (Warner, 2001). An example of this was shared by one of the doctors
interviewed: “Our attendings warned us about the evils of malpractice insurance and how doctors would continue to lose freedom. I think the same kind of warnings happen today about other issues in medicine. Every cohort of residents starts out at one point in time with little understanding of the medical past” (July 11, 2014, Perinatologist). This debate between the old and new complicates Thomas S. Kuhn’s (1962) discussion of scientific paradigm shifts. In the debate within medicine, art tends to be represented by the practitioners and science is regularly represented by medical academics. The medical practitioners, and not the scientists, tend to resist change and see new discovery and technology as anomaly, and this contradicts Kuhn. Medical educators rely on novel discoveries because this is how they receive funding and build reputation. In this way, medicine makes an odd science in that instead of resisting the new it dismiss the old. Medicine is an odd example of scientific paradigm shifts in this way. According to Kuhn, scientists normally resist the new and cling to old ways of thinking.

In the paradigm shift marked by the reforms of the Flexner era, medical knowledge from experiences outside of science and outside of narrow clinical experience (differential diagnosis, treat and repeat) becomes subjugated. Michel Foucault’s (1972) theory of dominant and subjugated knowledge is frequently used when discussing the knowledge and power of those on the margins, but also it is helpful in thinking about knowledge that is lost within dominant cultures like medicine. In reality, doctors use knowledge not only from rational sources, formal science training, the laboratory, and narrow clinical experience, but also from emotions, from patient story, and from their own personal experience.

Anecdotal Evidence

The knowledge created from these non-science areas is not trusted and often dismissed by the scientific physician. For example, it was not unusual for the doctors interviewed in this
study to discuss poverty based on their personal experience with poor patients and then stop and say statements like the following: “I do not know the numbers on this issue. To properly discuss poverty and medicine, you need hard-nosed evidence-based medicine to best find solutions. Approaches to poverty need to be data driven when possible” (Aug. 6, 2014, Family Practice). Another doctor resisted talking about his own personal feelings on the topic of poverty by saying, “I was taught how to practice medicine based on science and evidence instead of anecdote, whim or based on my own personal bias” (Aug. 25, 2014, Infectious Disease). If doctors are in the practice of discounting knowledge from their own experience it seems likely they are discounting the knowledge they gain from their patients’ experiences.

**New Doctor Identity**

The modern sensibility of prioritizing the new and valuing progress impacts the exchange between doctors about the art and science of medicine. Medical students are taught the newest developments in medicine and as a group are framed as the future of medicine. The new doctor’s identity is then linked closely to an understanding of new technology and new practices that are better than the old ways. One doctor explained, in his concern over decreased residency hours, that this new practice expectation fosters “technology reliance” on the part of students and “deemphasizes direct care and the relationship with the patient” (Oct 14, 2014, Pediatric Intensivist). Old logics of medicine are dismissed as antiquated, even when it is helpful to think about the body as something other than a clock and helpful to understand the patient as more than a body. Medical students fresh from medical school are likely more loyal to their teachers and science than are older colleagues in practice, who advocate the art of medicine. The new physician embrace of technology versus the old skepticism of the transformative nature of technology continues as opposite sides of a debate, instead of a call for blending knowledge.
Science Purity

As the scientific physician became a reality at the turn of the twentieth century, clinical experience was losing value, and in this loss so was a consideration of suffering and care for the patient. In the essay “Professional Optimism and Professional Dismay over the Coming of the New Scientific Medicine,” John Harley Warner (2001), looks more closely at the fight between the old ways of medicine and the new. The old ways that relied on clinical observation, relationship with patient, and an understanding of environment were losing respect, according to the author. He writes, “the art of medicine completely eludes or, flatly contradicts science” (p. 218). Ideally, medicine, according to Warner, is the use of the art of medicine to end suffering, a “cultivated art informed by science” (p. 219). One piece of evidence Warner uses as proof of a disintegration of the doctor patient relationship was the push of science-focused doctors to get rid of the professional codes of ethics. It was argued that ethics were no longer necessary because the scientific process would insure good behavior on the part of the doctor. Faithfulness to the scientific model was proof enough of purity. Scientific method would approach a problem the same way every time, so there would be no need for guidance about varying approaches, because there would only be one right way, the science way. Older doctors argued that, “The problems of disease embrace many and varying elements, which cannot always be estimated with absolute certainty” through science (p. 221). Because medicine was not an exact science in actuality, these old-way doctors debated that medicine still required a code of ethics to guide the art of medicine. Medicine also involved working directly with people who are complex and unpredictable.

In the paradigm shift to medical training requiring rigorous laboratory science training and the framing of the clinical encounter as differential diagnosis, treat and repeat, academic
physicians and their students began to wholeheartedly embrace the modern and new approaches to medicine while disparaging the older ways of healing. Each new set of doctors finishing medical training was the future of medicine and their identities as doctors were closely linked to the newest technology. Even today, when looking at JAMA and in the group of physicians interviewed, older doctors defend the way that they were trained and warn about the loss of the art of medicine. Ethics, the doctor-patient relationships, the personal experience of the doctor, and the experience of the patient become subjugated knowledges.

Science as Motivation

Many of doctors interviewed for this study were motivated toward medicine in hopes of gaining status. Medicine held promise of a decent salary, independence, respect and meaningful work. Science was also a motivating factor for almost all of the physicians interviewed. Doctors mentioned a love of science or at least an easy mastery of science. One doctor became very animated as he described his science calling: “As an undergraduate, I would sneak out at night to learn about botany – I loved all of the biology book not just the human parts” (Aug. 6, 2014, Family Practice). Others shared their affinity: “I liked science and was good at it but it got very lonely. I was really good at chemistry. I was not interested in puzzles without people attached to them. Medicine was a way in which I could stay in tune with problem solving and people” (Oct. 20, 2014, Dermatology). Science teachers were often blamed for the pursuit of medicine: “I had a teacher say, ‘you do not have to study and you do really well in science. Why do not you think about medicine’” (July 9, 2014, OB/GYN). Not only did doctors describe a gravitational pull toward science but they also enjoyed studying. For example, one doctor bragged, “A lot of people need medical care and I was a good student. Medicine felt like it would be a good thing to do. I liked talking to people and I liked studying” (June 23, 2014, Neurologist). All physicians
interviewed seemed aware at an early age that they were good students and were also accustomed to academic success. Confidence was shared among many of the doctors about their academic ability. No doctor discussed struggling in school.

**Good Students Good at Science**

Laboratory science knowledge becomes important to medical culture in America through various means: laboratory science training has been emphasized in medical education since the reforms surrounding the Flexner Report, and each new cohort of physicians moving into practice has been valued for their knowledge of new medical discoveries and competency with new technologies. Medicine, at the point of laboratory science, attracts doctors who have a personal fondness for science that starts at a very young age. Doctors often begin medical school believing that science knowledge will be what is most crucial to solving medical problems. It is important to keep in mind that the pursuit of answers through scientific inquiry is what medical students understand about medicine prior to medical education and medical practice. Those entering medical school must prove they are good students of science through standardized tests and grades in science in their undergraduate education. The preconceived notion that science is important to medicine turns out to be a reality of medicine. The human aspects of medicine, however, are much less predictable and are not an explicit part of medical training.

Physicians hold on to the idea that they are good students of science and fall back on that science knowledge when times are uncertain. One doctor finds this reliance on science by physicians troubling: “I did freakishly well in medical school. If only patients were multiple-choice questions, I would rock, but patients are much more essay test” (August 6, 2014, Family Practice). This doctor points out that being a good science student does not always translate into good medicine. Medicine is more than having the right answers on a test. There is uncertainty in
medicine particularly the human elements of practice. Medicine is, in actuality, a balance of science and art.

**Human Motivation**

Several doctors, when asked what medical education had not prepared them for, discussed the overemphasis of science training and not enough time spent on critical thinking. Most of medical practice in reality, according to several doctors, is not certain and there is no clear right answer. One doctor reflects on encountering uncertainty as a practicing physician: “Instead of teaching doctors to be detectives who come up with a plan and argue the right answer, which implies medicine is certain, medical school needs to acknowledge that even when you have the answer, you only have a part of the solution. Being a doctor is living with uncertainty” (June 26, 2014, Family Practice). The point of this doctor’s statement is that science only helps in understanding particular aspects of medicine. Science training is not helpful in assisting the doctor in the uncertain aspects of medicine, which is most of medicine, according to this doctor.

The adoption of germ theory (the belief that illness was caused by organisms that could be seen in a microscope) made the experiences of patients, experiences of doctors, intuition and what is labeled the ‘art of medicine’ a subjugated knowledge. The “art of medicine” becomes language that stands in for what doctors do when there is uncertainty and there is no obvious scientific explanation for their actions. Foucault describes subjugated knowledge as “a whole set of knowledges that have been disqualified as inadequate to their task or insufficiency elaborated: naive knowledge, located low down on the hierarchy, beneath the required level of cognition or scientificity” (Foucault, 1972, p. 82). As science and technology became valued more and more, bedside medical knowledge moved lower on the hierarchy, but even lower was the patient’s
understanding of illness and the doctor’s personal experience with patients and illness. Before germ theory, the doctor had only his experiences from his relationship with his patient, and as the knowledge from this relationship waned in importance to the doctor, so did knowledge of the environment. Understanding of the social aspects of disease became unnecessary as serious illnesses of the time, like tuberculosis, become rare (Dormandy, 1999). The art of medicine becomes subjugated and is no longer stressed in training, even though it remains a necessary part of the medical language.

**Coldness of Science**

The enthusiasm for science was a common theme within the interviews, as was the belief that laboratory science was dull and esoteric. One doctor who earned a PhD prior to medical school in neuroscience explained his calling to medicine: “I would sit in my spot in the lab staring at a microscope eight to ten hours a day. There were only twenty people in the world that understood my research. I wanted to use my love of science to provide direct service to people” (Aug. 26, 2014, Family Practice). Two of the doctors interviewed had fathers that were corporate scientists but in the end this world did not appeal to them. Human interaction was also a motivation to become a doctor for many interviewed. When looking at the answers to the question about why doctors went to medical school, physicians gave a blend of art and science reasons.

**Rebels of the Art of Medicine**

Not all new doctors embrace new medicine. There were some doctors interviewed that saw the value in old ways during their medical education. For example one said, “I think my medical school training was unusual because our teachers emphasized physical exams and history gathering. Not relying on tests and specialists was not only seen as cost effective but also
as the best way of getting to know patients by taking the time to better understand” (July 11, 2014, Family Practice). Several doctors shared going against the grain of medical progress by choosing instead to listen to their older mentors’ cautions about the importance of a good physical exam. These doctors were taught to rely on and hone their senses, instead of relying on technology and tests when practicing medicine.

When looking at doctors’ discussions of poverty, which is a problem faced in medicine that falls outside of laboratory science investigation, the doctors often entered into the debate between science and art. Science knowledge did not assist the doctors in the uncertain territory of poverty. Doctors instead had to rely on personal experience to discuss poverty and this revealed their comfort level with the art of medicine. Some doctors were able to discuss intuition and patient relationship without difficulty and other doctors struggled to answer questions that did not have a definite answer. Much like poverty was discussed in comparison to middle-class sensibilities, the art of medicine was discussed through values of science. The two main themes that emerged when doctors used science logics in their answers were a value of sacrifice and suffering for knowledge and the value given knowledge that comes through specialization and intense study of one topic.

Sacrificing for Science

Unlike the average human, doctors are expected to become the ultimate rational citizen that needs only the pursuit of truth to sustain them. The rigor and length of medical training put in place in the early 1900s firmly secured practices of sacrificing for science knowledge as a necessary part of the physician identity. Here is one of many examples of sacrifice on the parts of the doctors: “When I was in medical school I was destitute – I did not work at all, but I knew that would not last. I was thirty-eight when I got my first job” (Oct, 20, 2014, Dermatology). Medical
education is a monk-like existence similar to poverty, but it is different in that the suffering on the part of the doctor is voluntary. Medical students sacrifice relationships and comfort to become a doctor. Through experiences of medical education, doctors are familiar with living without food, sleep and relationships.

**Compulsive Problem Solvers**

The love of science in medicine also comes with a love of solving problems and dedication to finding answers. A certain level of devotion, compulsion and sacrifice are expected from scientists, including doctors. When discussing the importance of physicians being life-long learners, one of the doctors shared, “My theory, at least, is we make medical students take organic chemistry, which has almost nothing to do with medicine, to test the student. We want to know that most of our medical students, when they do not know something, will go home and read. We want medical students to demonstrate some level of compulsiveness” (June 18, 2014, Pediatric Oncology). Medical school discipline is informed by the cultures of science, which demand sacrifice. In her book *Suffering for Science*, Rebecca Herzig (2005) writes, “Science is horrible, and just as you suffer in science lessons, so do scientists suffer for science. Scientists endure pain and suffering …not to make life more comfortable for the rest of us but for one overarching reason …science is fascinating” (p. ix). Herzig also writes about this compulsive problem solving by scientists and doctors as a “brutal assault on truth” (p. 113). Doctors discussed a love of solving problems and that medicine can at times be a culture that rewards solutions by any means necessary.

The setup of the residency as intense personal sacrifice also seems to create an inside-the-institution focus. If every hour is spent compulsively within the walls of the clinic or hospital, this narrows the resident’s view of the world. Medical students focus on their own weakness
while surviving rigorous medical education conditions and this often does not allow time to stop and wonder what causes the bodies, injuries, and illnesses that they are asked to treat (Becker, 1961; Shem, 1978). At times, medicine seems more about successfully surviving the rigor. When asked about what was going on politically when in medical school, many of the doctors interviewed talked about a focus only on passing exams and not looking foolish in their clinical rotations. I heard often that, “My classmates and I were not talking about or aware of what was going on politically in medicine or otherwise while in medical school. We had to be focused on learning the facts of medicine and that was sort of wonderful” (Oct. 20, 2014, Dermatology). The structure of medical school and the focus required to not be embarrassed in medical training inspire compulsiveness in doctors. Herzig writes that there is a “curious misconception” that doctors are motivated by finding a cure or saving a life but in reality science is often framed as “advancing human knowledge at any sacrifice of human life” (p. 13). The doctor’s sacrifice and the patient’s sacrifice are all in the service of knowledge.

**Rigor**

Not only did doctors talk often of the sacrifices they made to become a doctor, they also talked about the importance of rigor. The long hours of study are necessary to becoming an excellent problem solver. Herzig writes in her book about science and sacrifice about the long history of pain being linked to wisdom. If a person suffers freely at his own choice, the reward is knowledge. However, scholars and scientists are not as quick to recognize the knowledge that comes from suffering that is not purposeful and under the control of the sufferer, like the suffering and sacrifice required when living in poverty. On a societal level, we value the experience and knowledge of those with privilege that give up privilege for truth, but we do not
value experience and knowledge that might be gained from pain of poverty because there is no sacrifice of privilege.

A moment within medical training where sacrifice is processed is in deciding on what area of medicine to specialize. Many doctors discussed a love of surgery (nine out of twenty-four doctors mentioned this). The decision not to pursue this field was a worry that they could not survive the dedication and sacrifice surgery required. One doctor shared the following: “I did not think about it at the time but I am sure I was considering the quality of life particular areas of medicine would afford. I had a heart for surgery, but I did not think I could do it. I felt I might change as a person if I became a surgeon” (June 18, 2014, Internal Medicine). Another doctor with a fairly similar sentiment shared, “I liked surgery, the technical parts of it, although with surgery there is a certain amount of sameness. The lifestyle of a surgeon is not conducive to family. I am obsessive compulsive when it comes to the patients I care for and if I had become a surgeon, I would have been in the hospital all the time” (May 22, 2014, Emergency).

Another aspect of sacrifice described by doctors, when reflecting on their experience as medical students, interns, and residents, was feeling exploited without luxury or love by the institutions they served. One doctor explained to me the fairly recent shift in residency requirements that are in answer to student resistance to the routine exploitation that started as medical education traditions during the Progressive Era. He shared the following: “In 2003, there was a lot of talk about duty hours [the time residents spend in the clinical aspects of learning]. Many medical educators discussed how these hours should be limited to give learners an opportunity to process what they have learned and to recover from the intensity of the clinic settings” (July 11, 2014, Family Practice). According to this doctor, residencies became much more structured and were less about exposure to a variety of illnesses and diseases and more
about demonstrating competency. The new rules limited shift lengths and increased the number of days off between shifts (ACGME, 2004).

Several of the doctors made a point of saying they thought the old ways of exploiting residents were ideal for learning. Even when doctors insisted the hours were abusive, they continued to advocate for the intensive residencies of the past. One doctor described, “Medical school was a brutal experience – the lack of sleep – but because of what you experienced in those hours, you felt you could handle any set of illnesses and that was key” (Aug. 25, 2014, Infectious Disease). Many of the older doctors shared stories of feeling exploited as residents on the one hand and on the other claimed the exploitation was necessary for really learning. One doctor reminisced, “They [new doctors] did not see as much as I saw. You saw the patient care from beginning to end. You could follow the course and all the nuances from the beginning” (July 10, 2014, Pediatric Intensivist).

This doctor went on to discuss the value of intensive internship and at the same time described the brutal and dangerous practices of residencies past, “I fell asleep standing in the shower. I feel asleep sitting on the toilet. I fell asleep while driving home in the middle of the afternoon. I ran into a bush driving to the bank. Exercise and nutrition went out the window because you did not have time” (July 10, 2014, Pediatric Intensivist). Herzig points out in her book that this level of sacrifice in not just about sacrifice for science knowledge, it is also about how masculinity was framed is the Progressive Era. Scientists compared themselves to explorers, who faced unknown territory. Exploration required braving the extreme elements and facing down experiences that always put the explorer at the brink of death. These notions about masculinity seem to be preserved in amber in American medical education culture. The sacrifice
and rigor are seen as necessary to achieve science knowledge, when these traditions were likely started as necessary to prove masculinity and to appeal to a middle-class clientele.

The doctors interviewed demonstrated some of the contradictions that Herzig presents as necessary for science knowledge, particularly that knowledge must come through pain. Again, there was concern that learning is lost unless medical students are asked to make extreme sacrifice and are required to be exposed to high volumes of patients (including the poor). Cultures of sacrifice and rigor mistaken for science are seen as key to medical learning. As one doctor summarized, “The most recent changes are detrimental. We are training people to follow protocols and emulate instead of think. We no longer teach residents to work with clinical data, to learn with eyes, ears, and hands. I believe medical education has been threatened. The new doctors approach relies on testing instead of direct care” (Oct. 14, 2014, Pediatric Intensivist). In this concern there also seems a concern for the art of medicine. What this doctor describes being lost is not scientific knowledge of medicine through experience, but the interpersonal and intuitive parts of medicine. Medicine delivery to the poor was discussed by the doctors interviewed as part of the sacrifice and rigor of scientific medical training. Attitudes toward the poor are likely influenced by the poor being framed as part of the punishment required to develop science knowledge.

Public Expectations

According to Herzig, the public expects doctors to be powerful and vulnerable, to have status and humility, and to gain pleasure from painful dedication at the same time. In the United States during the Progressive Era, increases in class times and increased years of school were early indications of sacrifice, of integrity, and of devotion to the public, at a time when medical education practices were accused of being corrupt and a way of making money. Rigor continues
to stand in as necessary sacrifice and a sign of ethical devotion to the public. In response to what it means to be a good doctor, one of the doctors responded, “It has to do with people’s training. You need to receive your medical education in a setting where you see a diagnosis ten times a week and not once in a decade. If medicine is that important, it is necessary to sacrifice” (July 21, 2014, Pediatrician). The value of a doctor is tied in with his ability to compulsively seek answers and survive the rigors of medical training.

**Significant Sacrifice**

Science sets up a strange understanding of suffering and sacrifice that differs based on privilege. One doctor, who had visited Guatemala to provide care as part of a mission trip, discussed how American poverty does not really seem like poverty in comparison to other countries. She observed, “I would like to think that if I lost everything, I would be OK. I could eat corn bread and crap in the woods if needed” (July 23, 2014, OB/GYN). Because this doctor has experience with sacrifices as a physician, this makes her confident she can survive impoverished conditions. What she is not acknowledging is that poverty is not voluntary and medical school is. Voluntary sacrifice has a very different meaning in society than economically imposed sacrifice. Sacrifice and rigor are then linked to scientific knowledge. The suffering of medical training then skews understanding of suffering. For doctors suffering is voluntary and can be survived. This understanding of suffering then frames how they understand the poor.

Some doctors expressed almost a longing for the simpler life of the poor, a life that is uncomplicated and opposite to the demands of being a doctor in the United States: “My kids and I were much happier and aligned with things when we stayed in a home in Africa with concrete floors and foam beds that squish right down. We were happier there than in our 6000-square-foot home in the United States. In Africa things are simpler but genuine” (June 20, 2014, Psychiatry).
This Rousseau-like romanticizing of the poor was fairly uncommon, but there seemed to be an equalizing of suffering and sacrifice across class. Regardless of economic situation, the doctors discussed how all people regardless of class have a cross to bear. The sacrifices demanded of doctors in medical education could play a part in setting up unrealistic views of the suffering and sacrifice experiences by the poor within medicine in the United States.

The public requires doctors to be devoted to objective observation and scientific exactness, and at the same time demands that members of the medical profession dedicate their lives to the pursuit of truth. Physicians’ acts of sacrifice help to secure the profession as secular priest, or as Herzig (2005) describes, “soldiers of science” (p. 98). According to Herzig, sacrifice only has social significance when a scientist/doctor gives up privilege in some way and doctors must be pursuing science for science’s sake. Herzig not only highlights the ridiculous risks early laboratory physicians were willing to take, but also she gives multiple accounts of the sacrifice and suffering of regular citizens that were also involved in medical discoveries over the past hundred years. Sacrifice by non-physicians is unseen and involuntary, a result of low status within society. Poor subjects of medical research are involved in discovery because they cannot afford health care and therefore their suffering is a given; it has no social significance because they are receiving a service and not giving anything up. Doctors have personal experience with sacrifice and suffering and these experiences could be helpful to empathizing with the sacrifice and suffering experiences by the poor, but cultural implications of voluntary and involuntary suffering come in the way of acknowledging the sacrifices of regular people in economic and medical progress.
**Relationship Sacrifice**

Medical school normalizes the practice of medicine as compulsive and requires demonstrations of personal sacrifice. Another doctor references the sacrifice required in medical school when he said, “In any professional degree there is pain and suffering. You learn to live with the feeling that there is not enough time and it is hard to maintain social support systems. Relationships are neglected because you are doing your best to manage all that is being piled on top of you at the same time” (May 22, 2014, Emergency). Medical education sets up the necessity that doctors prioritize medical progress over personal relationships. One doctor talked about how her dedication to medical education and medicine made starting a family and finding love difficult: “I wanted to have a family and it has not worked out yet but it hopefully will” (Oct. 20, 2014, Dermatology). The rigor of medical training creates a value system that rewards time devoted to solutions over time dedicated to personal connections with people.

Rigors of medical school take their toll on relationships, but also they create bonds between medical students and physicians. The doctors discussed having very small social networks while in medical school. Several doctors talked about their favorite aspects of medical school being their classmates and fellow residents. One of the doctors was discussing his love of medical challenges: “That was the fun part, the challenge of difficult disease and that my friends in medical school and residency also enjoyed the challenge of medicine. We bonded in that way” (May 22, 2014, Hospitalist). Another doctor discussed how she felt her classmates were very different: “I learned about team work from my medical school cohort. It was a very helpful group, with no competition. People would take notes and send them out to the class. We worked in study groups. I learned so much more by working with the group and I was so grateful that we did not work against each other” (June 18, 2014, Psychiatry). Paul Starr (1982) writes cynically
about these cultures of bonding in medical school that started in the Progressive Era. Camaraderie between medical students in the newly formed university medical centers helped to make physicians a strong political force. Brotherhood between physicians also perpetuated traditions in medicine and made reforms less likely. Not only were doctors loyal to each other, they were also loyal to the traditions started as a part of the Flexner shift (p. 115).

Of the twenty-four interviewed, seven of the doctors were married to doctors. I did not ask specifically how medical education impacted their relationships, but doctors marrying doctors could speak to the isolating nature of medicine. Who better to understand the relationship sacrifices required of medicine but another doctor. One of the doctors explained how being married to his physician wife was ideal. They traded days in the office and days at home and one day they dedicated to administrative issues, “After years of working in hospital-based systems and community health centers serving rural underserved areas, we opened our own practice and provide care to a school district that encompasses six small towns” (June 26, 2014, Family Practice). Doctors are aware that sacrifice is a part of medicine but they seem to have contradictory feelings about it. On one hand, they think an exploitative medical education environment prepares them best to be doctors, and yet they also want a balanced life where they can have relationships and at the same time be considered dedicated doctors.

If being a doctor means sacrificing personal relationships, it makes sense that these practices would complicate the relationship between the doctor and the patient. Providing medical care for the patient takes away from the doctor’s personal relationship time and from his emotional balance. If the reality of medical practice keeps a doctor from moments of emotional connection with the people they love, emotional connection with patients becomes complicated. Connecting with patients could serve as a painful reminder of personal relationships that are
being neglected away from medicine, but cultures sacrifice and rigor frame patients as tests of the doctor’s toughness and ability to survive the medical culture. If doctors are the soldiers of science, then the patients who are poor and the illnesses associated with the poor are often framed as the foes the physicians must defeat in battle.

**Science and Specialization**

Doctors were motivated to pursue medicine based on a love of science and a desire to help people. The physicians not only talked about sacrificing as part of medical culture, but also discussed specialization. Learning specific skills about a very specific area of study is similar to practices of categorization that are also an important part of biological science (Bowker & Star, 2000). Social scientists studying professionalism (Freidson, 2001) and doctors like Atul Gawande (2009) also talk about specialization as necessary when societies became more technologically complex. Illness and disease are the focus in the science of medicine, and so specializations are often linked to illness, disease, or body system. Other areas of medicine, however, prided themselves on a general approach to health care. Certain specialties stressed science and some the art of medicine.

Doctors interviewed were also asked directly why they chose their area of specialization. Physicians were quite loyal to their chosen area of medicine and each specialization appeared to have its own culture and own priorities in the curriculum. For example, the doctors interviewed from infectious disease and family practice talked about being exposed to public health as part of their education. Doctors also talked about subspecialties, which require more training to be an expert in – for example, nephrology, or in the case of a Perinatologist going on to learn about high-risk pregnancy after practicing as an OB/GYN.
The Big Debate

When doctors spoke about solutions or discussed the ethical obligation of medicine toward the poor, a debate emerged out of the physicians’ answers about general medicine and specialized medicine and which approach was more effective at solving problems. In Eliot Freidson’s (2001) work on applied knowledge and professional logic, he argues that conflicts are common in professional cultures where there is a mix of abstract/theoretical knowledge and concrete/practical knowledge. The specialists I spoke with argued the need for intense study on a very narrow topic in medicine as necessary for finding a solution, while the general practitioners interviewed disparaged this same narrow focus and argued that doctors needed a broader training to determine solutions.

Doctors draw knowledge from multiple sources. The most reliable source is their formal training, then clinical training, and then finally personal experience. Science values in medicine create a hierarchy of knowledge by prioritizing codified formal training where medical students learn about abstract concepts, theory and about ideal medical practice (Freidson, pp. 99, 2001). In the clinical years, internship and residency, doctors receive more intense clinical training that is concrete and practical, focusing on the source of the problem and ideas about what will solve the problem (Freidson, p. 100, 2001). Before medical school and throughout medical training, doctors also learn from personal experience. Freidson calls this “tacit knowledge” (p. 28). In general, specialists from my interviews argued that understanding abstract concepts and theory was important to critical thinking in practice and they were very reluctant to discuss tacit knowledge. Broadly speaking, general practitioners tended to rely on knowledge from clinical experience and were less reluctant to draw from tacit knowledge when talking about poverty.
Specialists

Specialists and sub-specialists go through more academic training and because of this training are tied more closely to medical research. Specialists have higher status in medicine and cost more money for the patient. Several specialized areas of medicine are not paid for by Medicaid and can be unaffordable to someone with no insurance. One example discussed in the interviews was infertility treatment:

Medicaid and our system’s community care funding program does not cover infertility. You cannot go through an infertility work-up without insurance approval and most people cannot afford infertility medicine. It is not covered automatically. The university in town covers their employees so maintenance workers from the university can get IVF [in vitro fertilization], but our system does not, so a doctor here would have to pay out of pocket” (July 9, 2014, OB/GYN).

As discussed in previous chapter, the wealthier the clientele, the higher the status of the physician. Becoming a subspecialist is often a way to earn increased wealth and status. Subspecialty training also requires more sacrifice and rigor, which also earns the physician status as a scientist and suggests that the doctor has earned more knowledge.

Specialists and subspecialists talked about not being specialized in issues of poverty and therefore felt unqualified to speak intelligently about approaches to poverty in medicine, but they did talk about specialists being better problem solvers. Knowing the limits of expertise is also a value within science. If a doctor has not studied a subject for decades, he must be cautious in trusting his expertise. Specialized training and knowledge are needed as science knowledge and technology advance. As the doctor narrows her area of expertise, she gains more intimate knowledge of the science, the specialized area of the body, and the illness. Nearly all doctors
were aware of connections between illness and poverty. Many doctors concluded, however, that
poverty was outside of their expertise: “Poverty is a peripheral issue, you must solve the most
dangerous situation first. Impoverished or not you need to ask what is the main problem that as a
doctor I can help with” (July 21, 2014, Pediatrician). Thus, doctors see the poor daily and are
aware that social position and economic situation contributes to illness, but poverty is not their
issue to address because they do not have expert training in issues of poverty.

Specialist and subspecialists discussed problems in the health care system, and often
grew defensive about what they perceived as an emphasis on general practice by the federal
government. A nephrology sub-specialist explained his frustration with recommendations to
increase general practitioners: “The suggestion that we need more primary care doctors is a
flawed paradigm. Decisions are being made about medical training by politicians and they do not
understand, because they are not scientists” (July 21, 2014, Pediatrician). This physician was
frustrated that the government keeps asking for and funding training for general medicine as a
way to solve the cost problems in health care. He continued, “We know that the problems we are
facing in health care need subspecialists” (July 21, 2014, Pediatrician). He went on to describe an
opportunity in his fellowship to work exclusively with specialist to cover the hospital when non-
specialists were having an annual celebration: “Subspecialists working together works like a
dream. The NIH has a hospital in Bethesda and there are no generalists. It sounds weird but it
works” (July 21, 2014, Pediatrician). It works because each of the specialists focuses on their
area of expertise, and when the health issue falls outside of their area of study, they pass it on to
another specialist. Specialists, because they focus on a narrow area, figure out problems “in a
heartbeat” (July 21, 2014, Pediatrician). This doctor favored science and argued science was the
quickest way to the best answer in medicine and proceeded to categorized generalists as worried
about feelings and patient story or as he phrased it, the “Marcus Welby” [a television medical drama series from the late 1960s] side of medicine (July 21, 2014, Pediatrician).

This subspecialist values regular exposure to a very narrow area of medicine that allows for expertise in complex systems. Medical specializations are not all the same in how they value abstract and practical knowledge. From the interviews, there was evidence that doctors from rehabilitative medicine, emergency medicine, and infectious disease have more of a tendency to value their own practical experience as physicians, and also value their patients’ experience: “You remember patients forever that you have taken care of. Your patients are your best teachers. Every single patient has the ability to teach me. Every patient helps us learn how to take care of the next patient” (May 22, 2014, Emergency). This doctor represents many of these physicians within these specialty groups that approach medicine in a more general and practical way.

It makes sense that these areas of medicine rely on information from their patients and are attuned to environmental issues. Inpatient rehabilitation works with patients with new disabilities and has to be in the home and community to assess accommodations needed in the home. Physiatrists need to know the size of doors and how many stairs are in the patients home. The rehab team goes to the patient’s home and work setting as part of their routine assessment. This concern for environment and quality of caregivers gives these type of doctors a bigger-picture view. The emergency room is where all people without insurance go to receive help. If patients are turned away from specialists and general practitioners in the community, they are aware the emergency room will help them in a health emergency. Some of this is policy driven, in that to receive federal and state funds, hospitals agree to care for all of the community regardless of ability to pay.
Infectious Disease has a long history of considering the patient’s environment as part of the problem. Many doctors (Infectious Disease specialists and other doctors) talked about the impact of HIV/AIDS on their medical education. For some, HIV/AIDS was “the” experience of the poor in medical school: “Back then we had really sick AIDS patients – near death. It is fairly rare now. We are not seeing end stage as often and people are not wasting away dying. Things have changed drastically. A ward full of people just dying, I will never forget that” (June 27, 2014, Emergency). Infectious Disease medicine much like emergency medicine and rehabilitative medicine, either train their doctors to be aware of environment or they quickly learn on their own to pay attention to environment to best serve their patients.

Infectious Disease is an interesting specialization that deserves extra mention and further research. The medicine surrounding HIV was mentioned as one of the most rigorous: “HIV was front and center back then and one of the most popular elective rotations. HIV medical care in my medical college was recognized as both outstanding and also served patients in dire need. The doctors I worked with there are the best physicians I have ever encountered. It was a time when there was a tremendous need for HIV specialists” (Aug. 25, 2014, Infectious Disease). Even though the specialty of infectious disease currently works almost exclusively with poor patients, the specialization is on the cutting edge: “Infectious disease is intellectually challenging, we get to see the new diseases and help with emerging health issues: West Nile, SIRS, H1N1, and now Ebola” (Aug. 25, 2014, Infectious Disease). Infectious disease is the place in medicine for new discovery, where hard problems are successfully solved.

Infectious Disease is in many ways the most scientific of medicines, which is, of course, marked by rigorous training and involves fellowships beyond residency. One doctor described the allure of infectious disease: “I was interested in international health and infectious disease but
it is pretty damn intense training that goes on for years and years” (Oct. 20, 2014, Dermatology). HIV medicine was where academic medicine shined: “There was optimism in the future. Antiretro drugs were coming on board and we saw the possibility. Remember at the time HIV/AIDS was a disease that was one hundred percent a death sentence and it was killing young people. It was great to be a part of such a drastic change in medical care” (Aug. 25, 2014, Infectious Disease). Infectious Disease doctors appear to be in a unique position in that they have a great deal of status within medicine and they also have personal experiences with the poor. Because of the uniqueness of Infectious Disease, this group makes for an ideal partner for those advocating for changes that end disparities.

Infectious Disease medicine is a specialization that cannot really refuse the poor and is dedicated to serving a population at economic risk: “Our hospital is situated in an impoverished part of the inner city. Our walk-ins are homeless or precariously housed. Most of my patients are marginally employed, with little education and are often unable to read. Infectious diseases are highly concentrated in poor neighborhoods” (Nov 7, 2014, Infectious Disease). This doctor went on to explain that HIV treatment is life-long because there is no cure, so there is a great deal of time spent with poor patients.

The increased prestige of infectious disease in the age of HIV is an interesting development in medicine. Several of the doctors discussed the fear about HIV/AIDS while they were in medical school. They described the anxiety of physicians and the gowning and gloving to see all patients. One doctor remembered, “AIDS was all we talked about” (July 11, 2014, OB/GYN). HIV medicine has been right in the middle of the most provocative bioethical arguments of the past twenty years. One doctor picked infectious disease as a specialty because it positioned him in an area of medicine where he could engage politically: “The AIDS crisis
caused draconian public health measures. People with AIDS were subjected to detention and isolation and people were forced into treatment. The magnitude of HIV on medicine made infectious disease a clear choice for me” (Nov, 7, 2014, Infectious Disease). HIV had a profound impact on physicians who came through the system in the eighties and nineties. That HIV raised the status of infectious disease as a discipline is interesting. These doctors are of particular interest to me because the focus of medicine is both scientific in nature and possible only through serving the poor not just in the United States, but globally. Unfortunately, I had only two of these doctors in my sample; it would be helpful to investigate the feelings of more of these doctors to see what impact they might be having overall on the culture of medicine.

Being a rehabilitation, emergency medicine and infectious disease physician requires consideration of the patient at a material level to solve health care problems. Medicine in these areas cannot rely simply on formal training and experience with disease. These physicians’ surroundings dictate a bigger-picture level of understanding about illness. When talking about the poor, these doctors tended to use examples from their life and from their experiences in medicine that fall outside of disease and treatment. These doctors were well versed in or at least relied more heavily on, the art of medicine. Infectious disease in particular seemed to be a blend of art and science that is intriguing and is in an unusual position of privilege, despite being dedicated to the poor.

**General Practice**

Several doctors shared why they shied away from becoming a specialist: “I would be so bored as a subspecialist. Being a subspecialist is doing the same thing over and over again. If I just looked at cataracts all day, I would drink. There would be no intellectual challenge” (Aug. 6, 2014, Family Practice). General practitioners saw specializations as too certain and too exact,
and with no uncertainty there would be no challenge. Generalists missed the art of medicine, when considering specialization and mentioned the lack of interaction with the client and dismissal of medical intuition by specialists.

One of the family practice doctors gives the example of what he has learned from partnering with his patient: “I have patients who come in and ask me, ‘what can I do if I only have $10 a month to resolve the health problem? The presumption is that the more expensive treatment is better and that is not always the case. Sometimes I have to say to my patients, ‘I have no idea how to help but this is what I see that might help.’ In the end it is the patient who works to get healthy and not the doc. The treatment needs to work for the patient” (June 26, 2014, Family Practice). Family practice doctors tended to talk about solving problems as a team with the patient and family, while also keeping in mind community resources.

Family practice doctors are trained to work with the entire family system and this valuing of systems also brings up concerns by family practice doctors about the role of physician in the community. One doctor explained, “Your role in the community is a huge part of the daily life of the doctor but it is never really touched on in medical training. It is assumed that you will fit right in, obviously this is a much bigger deal for a rural family practice doctors than a Boston orthopedic surgeon” (June 26, 2014, Family Practice). Two of the four family practice doctors interviewed, with this same concern about lack of training about community-level health, went back to school after practicing for years to get a masters degree in public health. The specialization of family practice instills values in its students to engage in the community.

Freidson (2001) points out that the increases in population and technology during the industrial age created a new division of labor. The professional not only learned the technology but also created his own body of knowledge and skills, while remaining flexible to social change
For medicine, there is the blending of science rigor and divisions of labor that come from technological advances. The push for medical specialization, Freidson would argue, keeps physicians out of touch with what is important to their patient; instead, the doctor focuses on his profession which is his “whole life”, and this results in the doctor living in a “closed universe” (p. 113). Once knowledge and understanding of illness becomes specialized, the doctor loses his ability to integrate and be flexible, according to Freidson (p. 113).

Freidson makes clear that close study of one particular area of medicine is a way to improve efficiency, but practices of specialization separate doctors from each other and come in the way of organized social action on the part of physicians (p. 3). Specialization belittles the importance of solving big-picture problems like poverty. It is telling that many doctors who valued their specialized knowledge mentioned others being responsible for fixing poverty. Poverty and thoughts of poverty really were distractions away from what doctors truly needed to focus on, which is the health crisis that they are expert about in their specialization. Many of the doctors interviewed claimed poverty was a “peripheral issue” and the central problem is what the patient comes to the doctor to help fix (July 21, 2014, Pediatrician). Poverty is not the crisis and it is not something that can easily be broken down into “smaller understandable pieces” (July 21, 2014, Pediatrician). Poverty does not fit into the profile of a problem doctors are expert at solving. The doctors mentioned in their responses who they felt were responsible for the problem of poverty or were specialists at facing issues of poverty, this included: social workers, psychiatrist, teachers and politicians. Doctors were unanimously aware that poverty puts people at risk for serious and untreated illness, and most of the doctors feel medicine has an ethical obligation to the poor, but many doctors did not feel it was their individual responsibility to play a part in the solution to health care disparities involving the poor.
According to Freidson (2001), those that value specialized knowledge tend to see doctors without high levels of training and focused knowledge as amateurs (p.114). Freidson argues that such a focused knowledge weakens the specialist’s awareness of interdependence between specializations and general practitioners. Tacit knowledge is understood by doctors as common sense, which is taken for granted or goes unrecognized. Tacit knowledge also falls within the art of medicine. This debate between specialization and general medicine mimics the debate between scientific medicine and the art of medicine.

**Art of Medicine**

The knowledge of the patient and the healing power of the body never disappear completely from medicine. At the time of the science shift and the Flexnerian revolution in medical education, there was still an honoring of the mysterious, non-science parts of medicine. Dr. Albert Rufus Baker’s warns in 1910 to the AAMC – that without practicing physicians as equals to the lab teachers, the art of medicine would be lost forever expressed his fear that new doctors obsessed with the new laboratory techniques would not benefit from the seasoned physician’s experience and knowledge from years of working with patients. Today, medical educators like Jeffrey Campbell (2014) at Harvard Medical School are using art work to teach doctors about the art of medicine, what he frames as “tolerance for uncertainty” and a better understanding of the “physician’s limitations” (p. 2339). The art of medicine is constructed in today’s medical environment as learning how to empathize with the patient. The language of the art of medicine is still used today as a counter to concerns of science and technology, even though what is emphasized about the art of medicine shifts with time. Discussions of the art of medicine are used as cautions against scientific obsession in medicine, but rarely is there discussion about how both the science and art are equally important to good medicine.
The art of medicine is synonymous with compassion and is the part of practice that remains warm and human (Gillon, 2000). Flexner softened science talk within his report by discussing how science rigor would guarantee doctors with an emotional calling to medicine (Flexner, 1910). In other words, a student must have a strong emotional connection to medicine in order to endure the intense challenge of medical training. For Flexner, the art of medicine countered anxieties on the part of the public that medicine was a greedy pursuit, where doctors took advantage of people vulnerable from illness. The battle for balance between science and art in medicine is long standing. Poverty is often seen as a moral illness and a societal illness, but not as a diagnosable illness in the body, evidenced by a germ. Doctors learn about poverty through interactions with poverty, which rely heavily on the non-science aspects of medical practice. Discussions of poverty by doctors then serve as a helpful place to better understand the arguments between science and art within medicine.

Only one of the doctors interviewed explicitly discussed the art of medicine: “I had some good mentors. They taught me the practical aspects of medicine, what I call the ‘art of medicine’” (July 9, 2014, OB/GYN). This doctor’s mentors taught her how to listen to people and be aware that not everyone is the same. She learned never treat people like “recipes in a cookbook” (July, 9, 2014, OB/GYN). This doctor explained that the art of medicine involved an awareness that, “there is more than one right way to approach a medical problem” (July 9, 2014, OB/GYN). It was not uncommon for doctors to talk about what they learned about the art of medicine; rarely, however, did they reflect on learning scientific facts with such fondness.

**Mentions of the Art of Medicine**

The doctors interviewed rarely discussed their patients as if they were specimens in an illness experiment. In general, there was a lot of what I would call “patient-centered” talk, not
disease or illness-centered talk. A lack of explicit education and training about the human aspects of medicine were evident in the doctors’ answers to what they would have changed about their medical training. Several of the doctors interviewed wished that they had received more information in medical school about how to cope with the diversity of their patients so that they could better serve their patients’ unique health care needs (July 11, 2014, OB/GYN). Doctors also mentioned wanting more education on how to approach death and dying, hostile patients, and patients who do not appreciate the unspoken rules of the medical setting (May 22, 2014, Emergency; May 22, 2014, Hospitalist; June 18, 2014, Internal Medicine). One doctor in particular urged that patients should be taught more often how their bodies work and heal often without medical intervention (July 23, 2014, OB/GYN). Doctors talked a great deal about and seemed to value the art of medicine. The human aspects of medicine were what doctors discussed most often as missing from their medical training.

When reflecting on medical school in particular, several doctors mentioned that, “Sometimes what we learn in medical school is not all that helpful and has nothing to do with the reality of medical practice” (Oct. 20, 2014, Dermatology). Also, in a technologically reliant medical environment, one doctor reminded me it is important to remember that sometimes, the best thing is to do nothing (Aug. 6, 2014, Family Practice). All of these aspects of medicine fall within the art of medicine. Doctors did not gain knowledge of the art of medicine from formal medical school curriculum, but from mentors and experiences with their own patients. Those mentors that were really good at the art of medicine were described as rare finds in the medical culture and counter to the scientific physician that dominates medical practice.
Technology and the Complexity of the Modern Medicine

In the book *The Checklist Manifesto: How To Get Things Right*, the physician-writer, Atul Gawande (2009), describes the challenges to the medical world in an environment that continues to increase in complexity. Doctors’ work is becoming even more specialized and even more microscopic in its focus. Gawande points out in his book that simple mistakes are becoming more commonplace because of information overload, and he suggests implementation of a checklist for proper surgical procedure that has proven to save many lives. Nicolas Carr (2013) writes about this phenomenon of forgetting simple things in the service of technological advance in his article, “The Great Forgetting.” As society becomes more reliant on technology for our thought process, we lose critical thinking skills, and this may also be true for doctors. Reading through Gawande’s list can be quite shocking. It is disheartening to find out that a surgeon needs a checklist to remember to wash his hands. Gawande’s concern in his book leads to questions about what else is missed by doctors in their pursuit of complex scientific understanding. Again, medical educators are concerned at this point of increased technology about the art of medicine. One doctor interviewed observed, “My daughter is thinking about medical school and I have noticed that today medical schools want to make sure students are coming with lab experience and volunteer experience so that their view of what medicine can be is not such a narrow view” (July 9, 2014, Physiatrist). This example points out the emphasis by some medical schools on attracting students with both a love of science and humanity, or at least experience with both, prior to taking on the challenges of medical school.

As technology advances, this not only changes the relationship between the doctor and the patient’s body, but also it changes the relationship between the doctor and his own body. Computers are even better at being objective and thinking about the world only through science
logic. Doctors are aware that they gain knowledge from other areas besides scientific inquiry (art of medicine), so if they continue to value themselves as objective observers only, their expertise is threatened by technological advances like the computer. Computers can truly be objective with no emotional connection to patient. As medical technology exceeds human body capacity, these developments threaten the value of the physician’s expertise, unless doctors begin to embrace the art of medicine. Advancing medical technology forces doctors to reconsider the importance of their lived experience and the part their body plays in medical knowledge. The threat to medical expertise today is no longer alternative medical approaches and treatments of the Progressive Era, but of computers that can take in and utilize information in a more objective and exact way than is humanly possible. A computer can eliminate the “the art of medicine.” In the Checklist Manifesto, Gawande does discuss the importance of human interaction between the surgical team. Simply knowing the team’s names and the team’s concerns prior to the surgery cuts down on errors. The checklist idea not only highlights the likelihood of human error in complexity, it also highlights the importance of relationship and communication in coming in the way of potential errors. Foreseeing potential problem requires intuition and the medical team’s experience with uncertainties in medicine.

**Poverty and the Art of Medicine**

Poverty is a helpful topic for investigating knowledge that is created from experience outside of formal medical training and outside of narrow clinical experience that focuses on disease, because poverty can lead to health problems but is not biological. The poor have been a major part of medical training since the Flexner reforms, and poverty makes up a proportion of most doctors’ daily work, but poverty is not formally addressed as a part of medical training or as a desired part of clinical experience. Doctors are forced to use logic outside of their formal
training and clinical experience to cope and interact with poverty. Therefore, the physician’s understanding of poverty comes from other non-science experiences.

Discussions by doctors about the art of medicine often serve as resistance to medical education shifts to new trends in science and technology. Older doctors tend to argue that the human aspects of medicine will be lost in the pursuit of modern scientific discovery. New doctors and medical educators value new innovations in medicine, because their identities rely on these new discoveries. New doctors are constructed as the future of medicine, which needs to be forward thinking, and medical educators are often funded to help develop the newest, most updated approaches to disease and treatment. Students are attracted to medical school both for the promise of solving problems through science and the promise of helping people. Science values of sacrifice and specialized knowledge reinforce the necessity for intense science training in medical school. The human aspects of medicine are also discussed and valued but receive little attention in formal education training.

As technology increases, the debate about the loss of the art of medicine becomes stronger. The Flexner shift in medical education established medicine as a middle-class pursuit serving middle-class consumers. This shift also established the importance of science to medical practice by increasing science rigor and sacrifice and by creating specialized medical training in terms of body systems and diseases. Talking to doctors about poverty helps to uncover how doctors use and value the art of medicine. The doctors interviewed wished for more training on the human aspects of medicine, which include both the doctor’s and the patient’s personal experience and emotions about medicine.
CHAPTER IV: EMPATHY AS A BRIDGE

In 1890, not long before the Flexner reforms, Jacob Riis, himself a survivor of the tenements of New York, revealed the living conditions of the immigrant poor through photographs, illustrations, and essays in his book *How the Other Half Lives*. Riis wrote, “one half of the world does not know how the other half lives (p. 1).” Riis revealed the tenements to the public in great detail. He describes the scratch of bedbugs, the smell of kerosene, the thirst for water, people crowded together, and the cave-like dwellings with no windows and no fresh air. Because of Riis the middle class and wealthy could visualize the realities of the poor at the time. Riis helped to raise awareness about corruption in the living and working spaces of the poor, and his journalism led to middle-class outrage and reforms much like the work of Michael Harrington (1962) in his book *The Other America* (Pimpare, 2008).

Riis (1890) wrote about the lack of concern for the poor in *How the Other Half Lives*, “The gap between classes in which it [poverty] surges, unseen, unsuspected by the thoughtless, is widening day by day. No tardy enactment of law, no political expedient, can close it. Against all dangers our system of government may offer defense and shelter; against this not. I know of but on bridge that will carry us over safe, a bridge founded upon justice and built of human hearts” (p. 296). Riis argued strongly that the only things that will get at the health hazards of poverty are an understanding of justice as equality and compassion, or more likely empathy, for those left out of the economic successes of the United States. Riis raised the question: is equality possible without emotional connection across class?

Empathy is explained as knowing how it feels to be in another person’s shoes. I hear this definition regularly from social work students and my social work colleagues. I also hear that empathy is something that cannot be taught; a person either has it or does not. These repeated
phrases create myths about empathy that oversimplify the concept (Gair, 2008). Edith Stein (1970) complicates an understanding of empathy by describing it as an embodied experience. Empathy can be learned, in fact, it needs to be actively learned. Stein insists a person must share sensations and experiences with a person to empathize. This process takes time, patience, and close engagement. The feelings that are inspired by connecting with people on an embodied level can stir hearts to action (Behar, 1996). If the poor go unacknowledged in medicine due to class and science practices, discomfort is never created about inequality. If the medical environment takes away the sensations of how it is to live in poverty, poverty goes unnoticed, and outrage has never been stirred by something invisible.

Many of the doctors I spoke with struggled with the poverty-related questions in the structured parts of the interview. They became defensive when considering the possible ethical obligation medicine has toward the poor. For example, one doctor commented that, “American society already has crazy expectations of what medicine should do. Does medicine need to help with the poor, sure but we are not alone. The American medical system is broken and I do not know how to fix it” (June 23, 2014, Neurologist). Poverty did not seem to be a topic of regular conversation for most of the doctors and many admitted that I was the first to ask them about the subject. I expected there to be more soul-searching on the part of doctors about what it must feel like to live in poverty in the United States. I expected contemplation on the part of doctors because of their consistent work with the poor on a daily basis. If the human heart is the bridge to justice and equality, as Riis proposes, this lack of emotional consideration about poverty is concerning. Empathy requires not just exposure and experience with the poor, but recognition of difference as well and imagining what it would be like to be poor based on the experiences of the poor. Riis suggests the solution is recognizing injustice and being emotionally motivated to
change. To end disparities will take action on the part of doctors to reflect on the current medical encounter with the poor and to change approaches to medicine. Without empathy with the poor on the part of doctors, ending health care disparity will be a challenge.

Art and Science: Metaphors and Organs

The word “empathy” actually comes from a German word “Einfühlung,” which was coined to describe how a person views a piece of artwork; “empathy” was originally used to describe the “physical connection between viewer and art” (Foster, 2011, p. 10). When empathy moved from the German language into the English language at the beginning of the twentieth century, “it likewise connoted a strong physical responsiveness to both people and objects” (Foster, 2011, p. 10). Empathy was a person’s capacity to “enter into a piece of artwork to feel the emotions the artist intended” (McLaren, 2013, p. 24). That empathy has lost its artistic origins is telling, but this initial connotation is important to remember. The description of “strong physical responsiveness” will be used throughout this analysis as a way to evoke the emotional connection required for understanding. Empathy lost its connection to art at the same time that formal training about the art of medicine begins disappearing in American medical education. Empathy is not a requirement for learning the science of medicine, but it is, however, important for learning the art of medicine. The more contemporary (and American) understanding of empathy still requires using imagination to better understand another’s emotions, and is therefore not part of the rational world, but part of the emotional world.

In his book Our Human Hearts: A Medical and Cultural Journal, Albert Howard Carter (2006) considers the importance of the heart as organ and heart as metaphor to medicine. Doctors not only use metaphors to understand medicine, they use metaphors to teach their patients about illness and treatment. When Riis talks about hearts being necessary to build a bridge to equality,
he is not literally meaning hearts ripped from chests, but the metaphor of heart that means warm, connected feelings for others. In medicine there is often a biomedical meaning to words and a linguistics meaning, just like there is a scientific and artistic approach to medicine. According to Carter, William Carlos Williams (famous physician-poet 1883-1963) compares doctoring to the interpretation of a poem. The patient gives the doctor hints of a story, and it is up to the physician to interpret the larger meaning from the poem of hints written by the patient (p. 7). For doctors to learn to interpret the physical and the metaphorical aspects of the patient’s medical story, ideally the doctor would need to put both the science and art of medicine in conversation. To approach medicine like a poem requires understanding at a sense level. Ideally, the doctor approaching his work with his patient as a poem would empathize in an embodied way.

Doctors in this study acknowledged that to understand the health care needs of the poor the answers could not be found through labs or through differential diagnosis, but answers must come through the patient’s story and shared experiences of living and working conditions. One doctor elaborated, “My most useful tool as a doctor is information I get from the patient and I never presume I have all the information. You never know what resources they [patients who are poor] have available to them unless they share their story. I wait patiently and keep checking in with my patients. The more I know the better I can help find a solution” (June 26, 2014, Family Practice). Knowledge from patient experience falls outside of science training and narrow clinical experience and relies on intuition, connection, and physician experience. Therefore poverty, much like the art of medicine, becomes an uncertainty that is a part of the medical day-to-day but is not reflected upon regularly by doctors. Understanding poverty requires imagination, intuition, and empathy.
I was surprised by the lack of thoughtful consideration about poverty and class difference by many of the physicians interviewed. To be fair, I did not ask doctors directly to describe what it must feel like to be poor. My questions did not ask doctors to share their feelings. Most of the physicians approached each question as a problem to solve. The way I framed the questions likely got in the way of discussions of empathy. That I expected emotional connection to be expressed by simply bringing up the topic of poverty with physicians is a limitation of this study. However, by asking questions about experiences with poverty and about ethical obligations about poverty, the physicians’ answers gave me insight into how they constructed understandings of poverty often without emotional connection to the poor.

It was very rare to hear doctors discuss an active concern about poverty as “the” healthcare issue of our time. One rare physician remarked, however, “If I could do one thing to improve health in America it would be to eliminate poverty” (August 6, 2015, Family Practice). Within the sample of doctors interviewed, there were physicians dedicated to providing health care to the poor. There were also doctors advocating for change in health care policy so that medical access is more equal in the United States. That doctors go against the grain is very important to investigate and will be explored more thoroughly in the next chapter, but also it is important to look more closely at the larger number of doctors interviewed that were not provoked by the inequality they witness daily. Doctors’ hearts are but one set of hearts that make up the bridge Riis described, but I do think understanding doctors’ hearts could prove important to understanding why many do not actively join the fight for justice in health care.

*House of God*

Early on in my study of medical education culture I was led by several sources to the book *The House of God* by Samuel Shem (1978). This fictional work explores closely the
internal battles that medical interns go through between what is expected in medical education hierarchy and how interns feel about the work they are doing directly with their patients. The book represents medicine as an ethical battle between self-interest and altruism and a battle between mind (ration/science) and body (empathy/art). Shem describes the world of the interns as a competition between surviving the medical hierarchy and surviving concerns for patients. *The House of God* left me with the impression that all doctors are emotionally concerned about how the poor are treated within medical education.

Shem’s book was lauded at the time (and still is today) for being critical of medical education and the medical profession and was seen as brutally truthful for representing medicine as disconnected (Kohn & Donley, 2008). *The House of God* was written in 1978 as a fiction closely influenced by the author’s actual experience in his internship in the sixties. Shem, as an artist, is able to articulate the emotional struggle within medical culture that was missing from the physician interviews. An analysis of *The House of God* will be used in comparison to the doctors interviewed as an example of the conversation between the science and the art of medicine and as an artist’s analysis and investigation into medical education culture.

*The House of God* centers its story on a Jewish intern, known only as Basch, who is living out his father’s dream of becoming a doctor. Basch describes a time in American medical education when doors were opening again to the working class, women, students of color, and banished ethnicities due to increased prosperity and access to higher education after World War II. Basch shares with the reader his early experiences of his internship, when he questions the medical structure and is sickened by the habits of doctors in the hospital. Basch describes the language and rules of the internship, which include using the word “gomer” being used instead of names for all elderly, poor patients with dementia (p. 38). Paying patients are reserved for the
house doctors and the poor are the responsibility of the medical students, interns, and residents. Who is assigned to what class of patient is a part of the power structure and medical hierarchy that Shem describes.

**Self Preservation versus Emotional Connection**

*Gomer* serves as an acronym for “get out of my emergency room” (Shem, 1978, p. 34). This is a fitting nickname for patients who become despised by the exhausted and often mistreated interns. Basch is taught (by his head resident) that *gomers* want to die but as interns, they must not let the gomers die. The interns are also taught that out of retaliation the *gomers* “fight tooth and nail against” the doctors “saving them” (p. 38). Early on, the author sets up a heated animosity between patient and medical intern. He writes, “They hurt us; we hurt them” (p. 38). Creating animosity between doctor and patients seems necessary to surviving the conflict between medical education expectations and the emotions stirred by exposure to pain and suffering of the patient. Basch is outraged continually by the use of aggressive treatments by interns on patients just to do something and to get educational experience. Doing “something” is particularly troubling to Basch when he realizes, through experience, that his patients do better when he does nothing. Basch becomes disillusioned: “Long ago I’d given up the idea that what I did to these bodies had any relevance to whether it did any good” (Shem p. 351). Shem describes a medical education culture that forces a doctor to choose between requirements of the medical hierarchy and the personal connection between doctor and patient.

Occasionally, Shem’s description of his internship in the *House of God* matched the sentiments of the doctors I interviewed, but in general, the doctors did not discuss emotions much; when asked about what they disliked about their medical education, it tended to be about curriculum content. One doctor was very open and discussed what she now sees as a failure and
a crassness that developed as a result of the rigors and expectations of medical education, but her level emotional honesty was rare:

I was in my cardiac rotation and some patient kept going into V-fib. Every time this happened I was expected to go back to the ER and check the patient. This patient was eighty-seven years old and I remember thinking [in my exhaustion], Why do not you just die so I do not have to admit you. Maybe others are able to go through medical education and not be as hard-hearted as I became. Once my medical training was over it took a long time to be able to feel again. It was hard to survive it (July 23, 2014, OB/GYN).

This doctor described, much like Shem, that the medical education experience was a balance of expectations between educators and patients. The doctor interviewed described the emotional difficulty and internal battle between distancing to satisfy her own physical needs and connecting with the patient to fulfill emotional needs. She chose the word “survive” to describe her medical school experience. The medical student is placed into a game where there is no winner; she has to decide the lesser of two evils, either care for her self, to advance in the hierarchy or care for the patient, and not play the hierarchy game. Honest exploration of emotions stirred by working with the poor in medical education was rare in my interviews. *The House of God*, as a physician-valued representation of the internship experience, serves as a helpful example of the tensions between rationality and emotion in medical education, when I was unable to find evidence of these tensions in the interviews (Kohn & Donley, 2008). *The House of God* allowed me to look more closely at emotion and how emotion impacts understanding and empathy between doctors and their patients who are poor.
Return to Humanity

During medical school the student is asked not to think about the human aspects of medicine because the object is to learn as many facts as possible, and so the emphasis is on exposure to a variety of diseases prior to practicing. In the book *Boys in White*, Becker and his colleagues (2007) lend insight into the expectations of medical school. Medical school teaches the student that they must learn huge amounts of information in order to pass exams so that they can eventually practice medicine. Medical school stresses the importance of taking on “medical responsibility” and gaining “clinical experience” (p. 223). The authors argue that the students come in with idealistic concerns for patients, but leave with cynical views of the medical encounter that reward learning facts over concern for a patient’s wellbeing. Once the student has consumed the necessary information to pass exams and licensure tests, she can go back to the work she wanted to do, which is often helping people (p. 423). Thus, the emphasis is on the “rudiments of scientific medicine” (p. 223). The hope of medical educators is that once in practice, a doctor’s concerns for humanity will somehow “burst into full bloom” once the pressures of learning facts have subsided, and that the actual practice of medicine will inspire the doctor to resume concern for humanity (p. 425).

Unfortunately, a student culture develops that stresses medical hierarchy responsibility over concern for patient or humanity (or self for that matter) that seems to carry over to internship and residency (p. 442). From Shem’s novel, it appears he would also agree with Becker and his colleagues’ observations about medical hierarchy. In Chapter Three, which analyzes science culture, I discussed that the doctors interviewed not only brought up human motivations for entering medicine, but also they listed their love of science. If the brutality of the
medical hierarchy is a necessary part of gaining science knowledge, then the connection between science and sacrifice may also complicate doctors reconnecting to the human aspects of medicine after training.

Because emotions are not discussed formally in medical education, this entire process is left to the doctor to negotiate alone, and the terrain is rocky. The student is to give up idealistic human concerns to learn facts, but at some point go back to caring about patients as humans. When doctors are drawn to medicine with science motivation and then go through intensive science training, it make sense that doctors continue to approach medicine through the science emphasis, which is framed as the opposite of human aspects of medicine. Nothing explicitly guides medical students to reconnecting with their patients after medical training. How to reconnect after training is unspoken and uninvestigated; it is assumed that people can make this leap back to caring and connecting with their patients and their human idealistic motivations, simply by being doctors.

**Responsibility**

When discussing poverty with doctors, there was also a lot of talk of responsibility. The structure of medical education teaches the importance of taking on responsibility, and doctors are expected to work towards independence. A doctor explained the importance to me: “When you are done with medical school you are at a point where you are able to learn a specialty. Yes, you would like to be done learning. Learning about my specialty was fun, though. You get to write orders and take care of patients it is fun” (July 11, 2014, Perinatologist). The reward for surviving medical training is increased independence and responsibility, which is also a sign to the medical student/ intern/resident that he is gaining power and status within the system. This doctor continued by saying, “Eventually they expect you to do everything on your own because
you are almost ready to practice independently” (July 11, 2014, Perinatologist). When a doctor is put in charge of patient care as a resident, this means he has arrived.

Responsibility for patients is reward for hard work. Doctors found responsibility practices valuable in their medical education: “I trained in an amazing institution and learned from amazing teachers. As an intern you did not have as many people to lean on, and you have the responsibility for everything that happens. I had a lot of confidence when I left there” (Oct. 20, 2014, Dermatology). According to several doctors, this confidence instilled by taking on responsibility can create for some doctors “a lack of humility” and create a sense of “entitlement” (June 20, 2014, Psychiatrist). Some doctors observed that the responsibility required of medical education also served as an “ego-breaker” because there was often no obvious right answer in medicine, so the doctor rarely felt that she had met her intellectual responsibility to her patients (Aug. 6, 2014, Family Practice). Regardless of outcome, taking responsibility is valued within medical cultures.

The way doctors feel about responsibility also reflects how they feel about approaches to poverty. To solve the poverty problem, several doctors talked about how responsibility was the solution. One doctor explained, “Society is going to have to answer some hard questions. If you cannot pay your medical bills then you will need to volunteer and work in the community garden or help clean up road kill. If patients who cannot pay were expected to volunteer, they might learn something and gain skills to contribute to society” (May 22, 2014, Emergency Medicine). This doctor sees a medical responsibility for the broken health care system. Part of his responsibility as a doctor is to have hard discussions about health care costs. Part of the solution to high costs is for every person to take responsibility for their body and their behaviors. This doctor also holds the poor partially responsible for their situation. Either way, taking on
responsibility is the solution. Taking on responsibility has different implications in medicine than in the public. For a doctor it brings respect, but for the poor it may go unnoticed due to the person’s social position. Doctors may not be able to see all the other responsibilities or the barriers to fulfilling those responsibilities faced by the poor. It is assumed the doctor is extremely responsible, or he could not be a doctor, and that those in poverty are not responsible or they would not be in their situation.

The traditions of medical hierarchy are also seen as emotional protection, while connection with patients is often framed as dangerous. One doctor shared his reluctance to take emotional responsibility for patient care: “It is a lot of responsibility and you are afraid you will do something wrong. Fortunately, the hierarchy protects you from big mistakes. You get more and more responsibility as you move up” (July 11, 2014, Perinatologist). Taking on responsibility has mixed results, because it is emotionally dangerous at the same time it is intellectually rewarding. One doctor explained how he handles the emotions of the emergency room: “You have to realize that many of the things that are in our hands as doctors are not our responsibility. This helps me not to get overwhelmed and helps me know I have done what I can” (May 22, 2014, Emergency). This doctor takes on intellectual responsibility for his patients while avoiding too much emotional responsibility, which is seen as dangerous. Talk of responsibility parallels middle-class sensibilities of independence, democracy and discipline. A value of responsibility also seems similar to science values of rigor and sacrifice.

Intellectual responsibility is important to middle-class sensibilities. Emotional responsibility for patients, however, is complicated within a medical climate that no longer relies on patient-doctor relationship to solve medical problems. The research about responsibility is often framed in terms of philanthropic giving. If doctors approach emotional responsibility in the
same way that philanthropists decide to give money to a cause, this research then has implications for when doctors may feel emotionally responsible for poverty. It turns out that charitable givers need to feel emotionally responsible in order to be compelled to give (Bekkers & Wipking, 2011). The charitable giver must also feel convinced that the recipient is a responsible person, worthy of assistance, who needs help intensely, and is depending on the charitable giver to relieve discomfort (Bekkers & Wipking, 2011, p. 929).

Doctors are often blind to poverty due to myths about the poor that attribute their lower social position to personal failure. People are more likely to feel responsible to help another person if the person receiving the funds is considered by the giver to be deserving and dependent. This makes feeling emotionally responsible for the poor in medicine unlikely, because when the poor are perceived as dependent, they are also simultaneously undeserving.

According to Rene Bekkers and Pamala Wiepking (2011), the charitable giver must know of the worthy cause. Because the suffering and sacrifice of the poor remains invisible within health practices, the motivation to intervene in issues of poverty is a challenge. Contradictions created by class and science cultures could come in the way of doctors feeling emotionally responsible and come in the way of taking action in improving medicine and the medical encounter for the poor.

**Compassion**

Doctors not only discussed the importance of being responsible, they also discussed the importance of being compassionate to patients. Even though evidence of empathy for the poor was rare within the interviews, compassion was much more present. Compassion and empathy are very different words, even though related. Compassion is a desire to help and empathy is a strong physical responsiveness to a person’s situation. Both of these concepts, compassion and
empathy, require emotion. Compassion, intuition, communication, and caring are not formal parts of the science of medical education, or of a narrow clinical training that focuses on disease, illness, differential diagnosis, medicines and procedures. Compassion, therefore, is evidence of a value in the art of medicine.

Doctors did see the value of compassion and understanding in their own education and talked poetically about mentors that were able to display compassion towards them as students. One doctor shared her experience with mentors: “The most positive aspects of my medical education were the people. I admired these teachers because they connected with students and with patients. They modeled the belief that something powerful could happen if health care is approached in a certain way – with caring” (June 20, 2014, Psychiatry). Compassion is learned by example either in a doctor’s personal life or through physician mentors. Knowledge about compassion comes from personal experience prior to medical training or as part of the non-science (or explicit) parts of medical education.

Doctors interviewed tended to agree that medicine should be approached in a compassionate way and that the ability to show compassion was given as an example of being a good doctor. Refusing to serve the poor was often used as an indicator of doctors with no compassion, as one doctor explained with emotion, “It disgusts me sometimes when a physician is consulted with an urgent need and when they find out the patient does not have insurance they refuse to be involved. This is the antithesis of professionalism. You have to put the patient’s interests above your own” (August, 6, 2014, Family Practice). When those interviewed discussed doctors having difficulty showing compassion, this was often linked to being in medicine for money and greed and was unethical medicine.
Compassion is often framed as serving the poor; the poor help in creating a doctor as compassionate. Serving the poor seems to give the doctor a type of compassion status. Too much compassion for the poor, on the other hand, was seen as odd: “There are some doctors out there that are more sympathetic to the poor. They are willing to work for $50,000 a year indefinitely. It is rare to see this but I do see this” (June 23, 2014, Neurologist). Several doctors interviewed wanted to make clear to me that they were not “boutique” physicians within their specialty and looked down on doctors who only served the middle class and refused to see Medicaid patients. An OB/GYN shared a story with me about a new partner: “She is a very talented and smart physician with a good bedside manner. Middle class and wealthy clients started to flock to her. I have seen this happen before where the best and the brightest that have a commitment to serving the community and have compassion for the poor are swayed to give up their altruistic notions” (July 23, 2014, OB/GYN). There seems to be a moral sweet spot when it comes to medicine and poverty. Doctors do not want to see too many poor people, but also do not want to work exclusively with the rich and middle class either. The poor serve a role in the construction of doctors as either compassionate or greedy.

In general, there was rare demonstration of empathy for the poor by the doctors interviewed; however, there were hints of empathy-like concerns for the poor, mainly feelings of responsibility and compassion. Medical education culture emphasizes learning facts, taking on patient responsibility, and acquiring clinical experience over concerns for patient and humanity. The hope is that once training is completed doctors will naturally return to idealistic and human practices. This transition is taught implicitly instead of explicitly. If the art and science of medicine were taught as equally important, reconnecting emotionally after medical training would be discussed openly instead of being intuited and negotiated by each doctor without
guidance. Class and science cultures contribute to a science problem-solving approach to poverty instead of an empathetic, sensory understanding of the poor.

**Detached Empathy**

Detached Empathy is one technique of distancing that is widely used in medicine but has not yet been explored in this analysis. Physicians created the concept of detached empathy as a way to maintain scientific objectivity in a health crisis. It is a pushing together of values of both science and art of medicine that at times seem contradictory. How can a doctor detach and at the same time maintain a strong physical responsiveness to better understand the poor? Detached empathy was created as a way to look at a medical problem unclouded by emotion, but also as a way to protect doctors from the sadness and pain that is often associated with illness (Halpern, 2001). It is not shocking, after what has been analyzed so far in this study, that concepts of detached concern in medicine developed as laboratory science training became a standard part of medical education in the United States.

At the turn of the century, emotions, unfortunately, were linked to folk practices of medicine that could not be trusted by the public. Science training was the solution to the quackery and corruption in medical education. Values of detachment were linked to scientific investigation and to medical treatments for different reasons. Technological advances like the autopsy and the microscope aided in further detaching doctors from their patients physically, which also made it more likely to detach emotionally (Halpern, 2001). Finding answers in dead bodies or in cells through a microscope allowed doctors to distance themselves physically from the emotions and stories of their patients. Technology assisted in detaching for the sake of scientific observation and technology also helped to remove doctors from the emotionally painful aspects of medicine.
The early applications of detached concern are linked to William Osler, an important physician and leading educator at Johns Hopkins in the early 1900s. Osler approached medicine with the philosophy that doctors should be able to control their emotions to the point of never sweating or blushing and by maintaining a calm heart rate even in the worst of situations (Halpern, 2001, p. 22). Medical students at Johns Hopkins at the turn of the century were warned that seeing patients at moments of weakness would remind them of their own mortality, so doctors should be prepared and resist their emotions. Showing emotions or feeling emotional was a sign of physician weakness (Halpern, 2001). Overall, medical students at the time were taught that there is no certainty in emotions, whereas there is certainty in science. Those trained at Johns Hopkins at this point in American history went on to be the leading educators across the country. So the values of emotional detachment became a fixture of medical education in the United States.

It is not only Osler’s influence on medical education that encourages the value of detachment in medicine. Jodi Halpern (2001) writes in her book *From Detached Concern to Empathy: Humanizing Medical Practice,* that doctors are also influenced by the philosophies of Descartes and Kant that viewed emotions as having very little intellectual value (p. 11). This philosophical view that emotions cannot be important aspects of knowledge creation could come in the way of connecting with the poor, as well as with patients in general. Science and the value of objectivity also inspire the concept of “neutral empathy” in medicine (p.19). Detached empathy between a doctor and his patient is very similar to the objective relationship that is ideally maintained between a science investigator and her subject. When science values became essential to medical practice, so did the practice of “emotional skepticism” (p. 21).
There are cultures of medical education that foster psychological distance from patients who have already been discussed in previous chapters, like the invisibility of the poor and the way that sacrifice is framed in medical science. These distancing techniques of class and science likely contribute to talk about poverty by doctors framed as responsibility and compassion instead of through language of emotion and empathy. Poverty is also often seen as a problem outside of scientific medicine and not the responsibility of doctors to find solutions. Dealing with poverty falls outside of doctors’ specialized expertise; as one doctor put this, “If I had a solution to fix poverty I would be behind a very different desk than this one” (Aug. 6, 2014, Family Practice). Bekker and Wiepking (2011) also discovered in their research that “psychological distance” comes in the way of giving (p. 930). Psychological distance between the charitable giver and the recipient means the cause goes unnoticed and the recipient is not seen as dependent or deserving. When there is psychological distance, it makes sense that emotional responsibility and compassion on the part of doctors, let alone empathy, for the poor may be difficult to achieve. So while the concept of detached empathy may be helpful to scientific observation in medicine and protecting doctors emotionally from the discomforts of medicine, it is not helpful to connecting doctors emotionally to the poor. Without emotional connection, doctors (much like charitable givers) are less likely to act, help, or make better the medical encounter for those in poverty.

**Scientific Objectivity**

In the interviews, poverty is addressed within medical education through exposure to high volumes of poor patients with an emphasis on remaining emotionally detached. One doctor explained, “The poor were cared for in large numbers and pushed out the door. That was the end of it. Call a cab, get a bus, or hang out by the back door” (July 9, 2014, Physiatrist).
dynamics, in combination with practices of detachment from medical education culture, make it less likely that doctors will understand the realities and the injustice of poverty. Listening to a patient’s story puts doctors at risk of emotion connection that might prove personally painful. Seeing high volumes of patients may be good for gaining scientific knowledge about disease, but seeing high volumes at a quick pace is not as likely to aid in knowledge that can be gained from the art of medicine.

The House of God gives insight into emotional detaching and how this practice impacts the relationship between doctors and the poor. Basch talks a lot about the intern as the lowest person on the medical hierarchy, lower than the “private doctors, house administrators, nursing, patients, social services, telephone and beeper operators, and housekeeping” (Shem, 1978, p. 21). The first thing that an intern must learn in medical education is the bureaucracy of the hospital. To move up the medical hierarchy, he must lose humanness. In payment for the loss of humanness the resident earns more time with family, increased income, and more time away from the hospital, as well as status among peers. Again, the poor in large numbers are helpful in increasing the doctor’s knowledge of disease and treatment, but these conditions do not encourage knowledge that could be gained from a patient’s story and from a physician’s emotional connection to patients who are poor.

The privileges of the medical hierarchy that require distancing behaviors are often held up as a carrot-like reward for completing internship and residency, in a way that falls in line and never questions the abusive system. In the book, Basch describes his Chief of Medicine in this way: “all the human juice had been sucked out of him, and he had been left drained, dehydrated, even uremic” (p. 25). It appears from the character’s observation that to be a successful applied scientist (doctor), you must be free of emotion and connection to your patients. Interns sacrifice
relationships and comfort to become a doctor. This sacrifice is clear when Basch says to his girlfriend about his experience as an intern, “You’re right, …every part of my life had suffered from my experience in the House of God, and now, from all the awful venerealia, even my sex life had curdled and quit” (p. 249).

The internship experience is spartan and similar to poverty in that the student often has to fight for basic resources, but the student’s sacrifice is in service of the greater good, instead of from social circumstances. The problem is that doctors are aware that living without power is awful from their experiences in medical training and negotiating the medical hierarchy, but do not see the commonality of feeling powerless to their patients’ lives in poverty. Both class dynamics and cultures of science encourage detaching from the patient and the value of emotional distance, rationalized as objectivity, comes in the way of possible connections and emotional commonalities between doctor and patient. Seeing high volumes, having brief encounters, emphasizing hierarchy over human aspects of medicine, and framing emotional connection as dangerous all make a disconnect between doctor and patient more likely.

**Emotional Protection**

In *The House of God*, Shem (1978) expresses concern for the lack of empathy in medical culture. Relationships do not seem to matter within the medical institution, and Basch becomes acutely aware of this when one of his intern “friends” commits suicide from the pressures of medical education. The medical machine goes on even when a doctor perishes and leaves behind only a gruesome blood spot on the pavement that catches his fall. Shem writes, “So nothing ever changes. Personal history and experience mean nothing. There’s no growth. Unbelievable: all across the country, interns are going through this, and going on each day as if nothing had happened the day before. ‘Forget it; all is forgiven; come home; love, the Medical
Hierarchy.’ It rolls on, greater than anyone’s suicide. That’s what makes a doctor. Terrific” (Shem, 1995, p.331).

The statistics are grim: “Doctors are twice as likely than non-physicians to kill themselves” and “400 doctors kill themselves each year” (Sinha, 2014). According to experts, medical training does not encourage emotional sharing between colleagues, which leaves medical students feeling lonely, tired, depressed, and convinced that they are the only ones unable to cope with the environment. Osler’s philosophy that emotion makes for weak doctors is living on in the halls of medical education. Practices of detachment appear to not only create disconnect between doctors and patients, but also between doctors themselves. From these statistics, emotions have no place in medical training, which leads not only to health care disparities but questionable physician wellbeing.

Shem’s view of what makes medicine psychologically risky is not giving in to his own emotions or caring for his patients, but it is actually the opposite, detaching from the humanity of medicine. Empathy resists Osler’s idea of detached concern. Osler developed the idea of detached empathy not only to improve scientific observation with patients but also to protect the doctor from the traumas of medical practice. In the interviews with doctors there was no discussion about how empathy might ruin medical observation and scientific objectivity. There was, however, fear that emotional concern on the part of the doctor for his patient could result in hampering a doctor’s ability to weather the sadness of medicine.

**Weathering the Emotional Toll**

Several doctors claimed medical school did not prepare them for the emotional pressures of medicine, and doctors discussed being left on their own to negotiate the emotional toll. Many credited this lack of acknowledgement of the emotional intensity of medicine with
leaving doctors “hard-hearted” (July 23, 2014, OB/GYN). Doctors expressed their frustrations: “You go from being a medical student to the ugly reality of what medicine really looks like. You are instantly implicated. Your livelihood comes from a system that is nefarious. You are forced to practice medicine with a detached approach and left to negotiate this world on your own” (Oct. 7, 2014, Dermatologist). Instruction on how to exist in a contradiction by remaining detached emotionally does not properly guide or protect doctors from the emotional world of medicine, especially those doctors connected and empathetic with patients.

Dr. Halpern (2001) writes about the contradiction between detaching and being empathetic, and that doctors are influenced by emotions even when they think they are detached and objective. She explains, “Physicians believe that they need to detach to protect themselves from burn-out as they cared for one suffering person after another under great time constraints” (p. 14). Several physicians talked about the trauma and emotional complexity of their work. These doctors discussed how they taught themselves to stay well. The concern about empathy causing burnout seems well represented within doctors interviewed. One doctor shared his way of coping with the emotional intensity: “When things happen that are traumatic, my way of dealing with it is I try to help and support the family in the moment. Those things that happen are out of my hands. I cannot go home and go ‘that was awful, that was awful, that was awful.’ That does not help me. Early on I decided I am going to deal with the moment and move on. I do not like to dwell. Something happened and now it is history. Time to move forward” (May 22, 2014, Emergency). This doctor allows himself momentary emotional connection in the crisis and has developed techniques of detachment that allow him to cope with the emotion of his work. His way of coping is clearly influenced by principles of detached empathy.
Doctors are not free from feelings. Emotion contributes to understanding between doctor and patient and plays an important role in medicine even if this goes unacknowledged. Emotional knowing is also placed into the mysterious category of the art of medicine. According to Halpern (2001), doctors and patients both have irrational emotions and project them onto one another, and she continues, “emotional communication takes place between doctors and patients and helps shape the medical reality facing the patient” (Halpern, p. 15). In reality, detachment can be harmful because it often leads to miscommunication and misunderstanding between doctor and patient (Halpern, p.16). One doctor said in response to medicine having an ethical obligation to concerns of poverty, “You cannot let yourself be distracted by these thoughts. You must focus on the presenting problem. There is a flood of concerns with each patient but you must prioritize where you are most likely to be helpful” (July 21, 2014, Pediatrician). In this case, the doctor is talking about focusing on the presenting problem as illness or disease, leaving out all other concerns, including emotional concern, that might be inspired when recognizing poverty that results in suffering. These are just a couple of examples of how doctors attempt to protect themselves from intense emotions by using techniques of detachment.

Embodied Empathy

Much of the current research and discourse on empathy mentions the work of Edith Stein, who wrote On the Problem of Empathy (1989). Stein conceptualizes empathy as an embodied experience that relies heavily on the senses, particularly when attempting empathy across cultures. She writes that empathy is “an experience of being led by the foreign experience. Empathy is the recognition that our body is one of many bodies – sensing the outside world” (xviii). For Stein, empathy is not to be confused with sensation; it is imagining the experience of others through our senses. Strong physical responsiveness to another person becomes difficult
when doctors are taught not to trust their emotions, which are considered by many feminists a part of the body. If doctors are taught that emotions have no intellectual purpose and that they should not listen to their own emotional connection with patients, in fear that connection will cause errors in judgment, then doctors are being encouraged to use science knowledge only and are cut off from knowledge that could come from embracing the art of medicine.

Stein’s understanding of empathy involves sensation, emotion and intuition, which is at the level of the body. When first attempting to empathize in this way, a doctor must approach her patient’s experience with the knowledge that she is comparing her patient’s experience to her own experience. Also, the doctor must be aware that she compares the patient’s experience to what is the common experience—what most people would do in the same situation. Stein argues that this is the part of empathizing that is culturally influenced and can cause miscommunication and disconnections. She urges that to empathize beyond cultural constraints, a doctor must go even further and imagine the patient’s experience as her own new experience using the senses to take in the story uninfluenced by her past or the common knowledge of the patient’s situation. This approach to empathy takes patience, flexibility, and tolerance for mistakes (Lakoff and Johnson, 1980).

Instead of relying on old information and ways of knowing, how would practices of empathy be different if doctors approached each new person as a new experience? If empathy is approached as a comparison between experiences, this practice can be problematic, because often patients have very different lives and often very different values about behaviors and emotions, as in the case of class dynamics that has already been explored. Unfortunately, empathy is not free from social norms and dominant ideology (Gair, 2008). Empathy is more likely when a doctor: (1) sees similarities in the patient; (2) the doctor senses severe distress on
the part of the patient; (3) feels the patient is from a socially approved dependent group; or (4)
will benefit from assisting in some way (Gair, 2008, p. 23). The research on empathy and the
research on the importance of feeling emotionally responsible in charitable giving are
comparable (Bekkers & Wiepking, 2011). The similarities are important. It is possible that
empathy is necessary for charitable giving. Charitable giving is an action to try and better a
situation. Empathy is then tied at least to the simplest of social actions – taking out a checkbook.
Physician discussion of responsibility and compassion may be precursors to empathy. Again
empathy appears to be necessary for even the smallest of political actions.

**Combining Rational and Emotional Reasoning**

Little effort was made by most doctors to learn how the poor think and how poverty leads
to important knowledge about illness and health. One of the doctors who works as a family
practice doctor in a small rural community speaks to the importance of relationship, trust and
empathy between the doctor and the patient:

> My patients do not always tell me the full story, particularly when we are first
> establishing a relationship. I expect this and am aware I only have a limited view
> of the problem. I have learned to do the best with uncertainty and respect my
> patients for not fully discussing all that could prove helpful to me helping them
> with their health problems. Once my patients are aware I want to partner with
> them and that we can only solve the problem together, using all the knowledge
> that we both have, can we come up with what will work. Medical school gave
> me the impression that I would find the best answer without the partnership with
> my patient, and this has not proven true. Also, the trust I build and the
> relationship I build with each family then makes trust development with other
families easier. Once I become more established within the community the better
my medicine becomes (Family Practice, June 26, 2014).

Embodied empathy, as described by Edith Stein and others, is not detached; it is a
connected empathy. In Dr. Halpern’s concern for a more empathetic medical practice, she urges,
“the key issue is for physicians to become more reflective about their own emotional responses
and learn to use these responses skillfully, rather than try to detach from them and be influenced
by them anyway” (pg. 10). Much like the family practice doctor quoted above, doctors who
empathize seem to see the benefit of partnering with their patients, not only for the benefit of the
individual, but to better understand medicine for the larger society as well. This doctor was
trying to explain to me that medicine could learn a lot from connecting emotionally with the poor
instead of detaching. Medicine in the United States could be better if we were willing to learn
from the experiences of the poor.

Several doctors shared the importance of context to poverty and were very careful to
make sure I understood that poverty does not always lead to unhappiness. Wealth does not
always make a person happy. One doctor gave a helpful example: “If we have a Mendicant
monk, who is a beggar with no assets and travels from shrine to shrine and he lives off of
handouts and is happy and healthy, I am not sure he is in poverty despite his vows. Poverty on
some level must result in negative impact for the disadvantaged to have negative health
consequences” (August 6, 2014, Family Practice). For this doctor, being poor has different
implications for each person and should be approached through the eyes of the patient, not the
doctor’s preconceived notions of what it means to be poor.

Other doctors saw the strengths of their poor patients and wanted to shy away from the
notion that the poor are always unfortunate: “A lot of folks that are scraping by, or almost
scraping by, seem to be doing OK with simple approaches to medicine. The presumption that more expensive is better is not the case here” (June 26, 2014, Family Practice). The larger society could learn from how the poor approach health problems. One doctor explained, “Some of my poor patients have the most support. The families seem more tightly woven. It may be out of economic necessity but there appears to be more hands on deck to help out in a health crisis” (July 11, 2014, Physiatrist). Doctors who were able to empathize with the poor also saw the value in their experience and the solutions that they devise with limited resources. These solutions could have valuable lessons for all of medicine.

Halpern (2001) argues that emotional skepticism is an unfortunate development of scientific medicine, and that accepting emotions as a part of medicine helps a doctor not only gain knowledge and avoid miscommunication, but emotional connection also helps a doctor stay motivated in caring for patients (p. 34). Several of the doctors agreed with emotional connection as a motivator and described, instead of compassion fatigue, compassion satisfaction. One doctor that works with children with terminal illness described how rewarding it was to be present with a child and family as they go through the most difficult time in their lives: “I cannot cure them but I can help them to be children. I care for each kid I treat. If I cannot care about them I cannot care for them” (July 10, 2014, Pediatric Intensivist). This doctor sees his work as making the time of dying better for children. He is able to make this time more meaningful because of his expertise, not just in the medicine, but in the emotions of end of life. It is this part of his work that he finds most rewarding. The doctor explained to me that without the support of his colleagues and a respect for a similar approach to medicine, his emotional connection with his patients would not be possible: “I work with a team that is not afraid to get involved enough to leave families knowing that someone really cared. We grieve together as a team and support each
other. We all know that providing care in this way makes a positive difference” (July 10, 2014, Pediatric Intensivist). There is labor involved in connecting with patients, but it is a labor that also can result in emotional reward for the doctor. Being fearful of the emotional parts of medicine blocks a doctor’s chances of emotional reward.

One physician educator talked about having his family practice residents go through a poverty simulation, which forced them to negotiate the world as poor for a day. After this experience, the residents could not stop thinking about how the clinic where they saw patients was difficult to access, so the group insisted that they move care to the health department so that the patients did not have to drive to multiple places. The residents in this example were able to connect emotionally, and this emotional connection led to problem solving taking the realities of their patients’ lives into consideration. Dr. Halpern (2001) sees the potential of “emotional reasoning” to medicine (p. 11). Empathy, for some doctors, is therapeutic if they place value on their ability to understand their “patient’s emotional point of view” (p. 17). Emotional problem-solving can be as rewarding as illness problem solving. The emphasis on detached empathy denies doctors skills at both the science and the art of medicine, and it also denies doctors the reward of both. Doctors who are encouraged to develop rational and emotional reasoning are that much more likely to come up with the best solutions for their patients’ medical problems.

**Different Kind of Doctor**

Shem (1978) questions Osler’s detached concern as protective to the doctor. His character Basch is saved from madness by connecting to his patients instead of detaching. Basch decides to become a different kind of doctor through embracing his own personal experience and his emotional understanding of his patients. He learns about the power of connection when he
becomes attached to a dying patient, who happens to be a retired doctor. Basch and his dying doctor talk about the falseness of medicine:

No we do not cure. I never bought that either. I went through the same cynicism – all that training, and then this helplessness. And yet, in spite of all our doubt, we can give something. Not cure, no. What sustains us is when we find a way to be compassionate, to love. And the most loving thing we do is to be with a patient. Like you are being with me (Shem, 1995, p. 175).

Again, the value of compassion is evident within the physician interviews, and so is the value of detachment. The feeling of wanting to help is set up as the enemy of scientific medicine. Because emotions are not discussed, nor are the ways emotional knowledge can be helpful to the doctor and the patient, doctors are left on their own to negotiate how to be compassionate in a dominant medical culture that often makes compassion a challenge, by emphasizing techniques of detachment as necessary to being a good doctor. Even when the odds are against doctors connecting emotionally with their patients and learning from this connection, there was evidence that some doctors do participate in connected knowing and, like Basch, become doctors who approach medicine differently.

Empaths Interrupted

When questioning the doctors involved in this project about poverty, there were rare glimmers of empathy for the struggles that the poor might face in our current economic climate. There were even more faded and fuzzy ideas about how the health of the poor impacts the rest of us, and how the classes are interdependent. In *The House of God* (1978), it is the patients who give Basch insight into the experience of his own suffering as well as wisdom about how he could learn to survive life and the medical hierarchy. Basch struggles for class consciousness by
recognizing the struggle of his patients and by valuing humanity over medical school status. Emotions were one thing the character seemed to discover in common with his patients.

There was very little conscious negotiation of social position by the doctors interviewed. Poverty tended to be discussed as a reality of medicine, but a reality that could not be impacted by the physician. For example, when asked if medical school involvement with the poor changed the physician’s understanding of poverty, one doctor said, “Not really, from the time I started training there were lots of poor people. The focus, however, was on the medical problem. Much of my medical training did not focus on poverty even though poverty was easy to see” (July 21, 2014, Pediatrician). *The House of God* gives clues into what experiences may prompt empathetic responses on the part of doctors. Language of emotion, sharing of emotion, and recognizing emotion are important parts of the transformation to empathetic connection with the poor in medicine.

Those doctors who allowed themselves to connect emotionally with their patients, realized early on that they were not like the majority of doctors. The empathy they felt for their patients particularly as medical students, interns, and residents, was kept internally protected from the watchful eyes of leaders that saw emotion as weakness. One doctor recalled being scolded by her surgical attending because she had helped a nurse pick up instruments that had been dropped in surgery. This kindness was perceived as weak by the surgeon, who also said her kindness was a sign that she would never be accepted as a surgeon (July 9, 2014, OB/GYN). These doctors shared stories of holding on in non-empathetic environments, thinking that once they had power as a full-fledged physician they would practice with empathy. Doctors across class shared experiences of witnessing attending physicians stereotype and disparage the poor in front of them as part of their medical training. Witnessing these incidents created an internalized
pressure to hide disgust or behave in the same manner. The dominant medical education culture permitted insensitivity toward the poor.

The doctors interviewed discussed being unable to speak out about these injustices and were taught to stay silent about their shock over the treatment they were witnessing. One doctor told of doing rounds and having the attending talk to the medical students, interns, and residents in the elevator about how fat, lazy, and unattractive one of the patients was, and that the patient’s medical troubles were of her own making (June 20, 2014, Psychiatry). The doctor I interviewed did not feel comfortable speaking out during this incident and it made her very uncomfortable to see many of her colleagues laugh at this doctor’s behavior. The doctor I interviewed knew this was not how doctors should behave, and held onto the idea that once she started practicing independently, she would not engage in these practices, holding herself to a higher standard.

Another doctor shared the following about what she learned in medical school about how to approach poverty:

In my OB/GYN rotation I was working with a majority of women who were giving birth and were young, unmarried, from rural communities, and had little emotional or financial support. There was a resident that was recently engaged and was fond of her enormous diamond engagement ring. She would play with it and hold it up to admire it continually. It seemed insensitive to fawn over a ring around people that could barely make ends meet. The resident’s behavior made me so angry (June 18, 2014, Psychiatry).

Again, this insensitivity was not confronted directly by the concerned physician, but was noted as something this doctor did not want to repeat. For these doctors, poverty had to be faced (as well as the dominant approach, which seemed callous), much like illness, disability, and death, as unfortunate realities of medicine. Doctors put poverty in with the sad parts of medicine
that they had to consciously learn how to cope with emotionally on their own. Emotional negotiation was left to the individual doctor to learn how to accomplish because the emotional impact of medical practice was not formally discussed in medical training. Also, those that did feel connected to their patients emotionally were made to feel odd, alone, or incompetent for this connection.

Goleman (1995) in his book *Emotional Intelligence*, points out multiple studies that show those in power are less compassionate. Several doctors witnessed mistreatment of the poor by medical and mental health facilities: “Seeing that some people were treated so badly was difficult. I remember as a third-year, I would stay in the back on the unit to see what happened when I could not be seen and I was horrified. I would observe patients being treated inhumanely. It was telling, the sheer horror on the staff’s faces, when I would confront them on their behavior. It is not OK” (June 20, 2014, Psychiatrist). Another doctor, aware of how the poor are often treated in medicine, described to me the free clinic as an oasis run by medical students in his area: “The poor are looking for a magic answer after being treated badly by doctors in mainstream medicine, and that is why they are coming to the free clinic that has a reputation of treating poor people in a kind way” (July 3, 2014, Family Practice). For many of these doctors, it was not the discomfort that came from sensing their patients’ pain, sorrow, and humiliation that made medicine hard, it was the environment that did not value emotional connection that made life difficult for them. The detached nature of the medical environment makes being a doctor in an empathetic way very difficult. Doctors are made to feel wrong for connecting emotionally with their patients.
Where Do Doctors Learn to be Different?

Those doctors who discussed empathy for the poor credited parents modeling care, religious upbringing, and experiences with friends and family that were poor for creating unique concern for those with lower social position. One of the doctors who had grown up in a poor neighborhood described his middle-class colleagues as avoiding and fearful of the poor: “I went into medical school knowing how to relate to people on many levels. Medical school did not change my understanding of poverty; it did, however, change the understanding of poverty for my classmates. Formal preparation for working with the poor could be beneficial to countering an environment where doctors are put off by the poor” (July 11, 2014, OB/GYN). The doctors interviewed that demonstrated empathy for the poor could be helpful examples of how empathy can be fostered and encouraged in medical environments.

A personal connection to poverty seemed to increase the chances that a doctor would empathize and connect with the poor. This finding supports research on charitable giving and empathy. Bekker and Wiepking (2011) explored the importance of knowing a person (relative/friend) to the likelihood of giving. People are even more likely to give if they have had a personal experience with the social problem (Bekkar & Wiepking, 2011, p. 930). Doctors interviewed that had personal experience with poverty, or that had parents and friends who were poor, did talk more compassionately and empathetically about the poor. For example, a doctor described his visits to family in India: “In India there is a lot of poverty. My family there was considered middle class because they had regular jobs and a good place to live. When I was young they did not have indoor plumbing. There was no heat nor air conditioning, and many people living in smaller spaces, but the kids were able to go to school. I learned to live in the midst of poverty” (July 11, 2014, Physiatrist). Doctors with personal connections with poverty
came to medical education with an awareness of the realities of poverty. In other words, the poor did not stir extreme emotions that then require detachment.

Bekkers and Wiepking (2011) also found that people are more aware of the needs of the poor when they are exposed more regularly to the living situations of the poor (p. 930). One doctor described what she saw: “I remember going into the house and they did not have a door, just a curtain. The floor was dirt and all I could think about was how I did not realize what was under the floor of my house until that moment” (July 23, 2014, OB/GYN). Seeing the homes of the poor provided a very different perspective of poverty than experiences in the clinic or hospital. Doctors exposed to the everyday life of the poor did not feel they had to be protected from the sadness of poverty. These doctors were able to empathize in part because their personal connections with poverty framed their connection with their patients who are poor.

The Importance of Mothers

Several doctors mentioned their mothers as the foundation of their concern for the poor. Mothers were integral in encouraging a relationship between the middle class youth and the poor. Doctors shared stories about working beside their mothers to give back to the poor by volunteering in soup kitchens or participating in periodic food drives for the hungry. Another example was a doctor that described how her mother insisted that the migrant workers who worked on their large family farm be treated like family instead of as below them (June 19, 2014, Psychiatrist). Another doctor described traveling with his mother through tough neighborhoods as part of her job as a forensic pathologist. She would also volunteer with him at a charity and shelter for the homeless (July 11, 2014, Family Practice). Several doctors discussed their early exposure to poverty being motivated by their mother’s religious devotion to people less
fortunate. These experiences seemed to make a big impression on how doctors chose to approach medicine.

Religious upbringing and religious belief were also mentioned as value systems that encouraged class humility. Many of the doctors argued that religion instilled an obligation to give some time and money to helping those less fortunate. When asked about knowledge about poverty, many doctors relied more heavily on lessons taught in their childhood by mother or religion than lessons they learned in their medical education. Mothers and early religious teaching and experience are the cultural antithesis of rationality and objectivity, and yet doctors who were interviewed leaned on this early knowledge in their dealings with the poor. The fact that doctors are learning more about the art of medicine from their mothers and from their place of worship than in medical school is telling. Bekkar and Wiepking (2011) also found in their research that people give to charity for the psychological benefits of serving and people are motivated if they think giving will make the world a better place. People with “prosocial, humanitarian, postmaterialistic, or spiritual concern for equality” are more likely to give and feel “empathic joy” after giving (p. 938-939). People are also more likely to help if the cultural norm surrounding them is to help and if they have leaders engaged in helping activity (p. 952). For doctors to be empathetic it would be helpful to be in surroundings and a culture that encourages connected knowing.

There is little support within professional cultures to empathize in a connected way being aware of emotion and developing sensitivity to patient and environment. Several doctors interviewed discussed their undergraduate experiences with poverty as volunteers and in classes and how they considered how these experiences served the purpose of making them feel uncomfortable with their privilege, and provoking shock at their lack of knowledge about
poverty. This exposure and shock was not followed up with debriefing and processing to better understand the emotions stirred up by this exposure, the cultures that make poverty invisible, and what doctors could actively do with their outrage (June 26, 2014, Family Practice; June 27, 2014, Emergency; Aug. 25, 2014, Infectious Disease). The doctors interviewed regularly talked about the ineffectiveness of simply exposing those in training to poverty. Their perception of exposure as the only way to learn about poverty was that it only served to point out a doctor’s incompetence with the poor.

**Connected Knowing**

From the physician interviews it appears that empathy is influenced by worldview. Detached empathy was created as a way for doctors to be objective scientists in emotional settings. Techniques of detachment were also put in place to protect doctors from emotional connection, the thought being that if they took in all the sadness, it would continually remind them of their mortality. Atul Gawande’s (2014) most recent book, *Being Mortal*, is on this very subject. He argues that doctors pursue medicine in part to help, but the group is inspired more by their competence to solve puzzles. This means that the biggest threat to the physician’s identity is a patient’s problem that cannot be solved. Gawande urges that the job of medicine is not simply solving problems, it is taking the time to understand and “enable well-being” (p. 259). Instead of focusing on finding the solution to illness, the doctor should find out the reasons his patient “wishes to be alive” (p. 259). This type of understanding comes through empathy and connected knowing.

It is important to recognize that the science and art of medicine work closely together - one informing the other, and both necessary to good medicine, which sees the value of framing medicine as an issue of wellbeing. Donna Haraway, in her essay “Situated Knowledges,”
considers a different way to approach the scientific relationship between scientist and subject by borrowing the term “passionate detachment” from Thomas Kuhn (p. 192). She sees science as an approach that ideally acknowledges that the “imaginary and the rational and the visionary and the objective all hover close together” (p.192). Using Haraway’s conception of passionate detachment, one could imagine medicine that used the best of both worlds and that recognizes the interdependence of the two approaches of science and art of medicine. As has been discussed throughout, doctors do use art and science approaches to medicine. The science approach is taught and acknowledged, while the art is rarely mentioned and kept invisible.

Donna Haraway (1991) describes her feminist counter to scientific objectivity as an embodied objectivity (p. 188). Objectivity is limited like the eye is limited in what it can see. A person can physically see only what is in their field of vision. The ways we interpret what we see is limited by our worldview. Emotions are also part of the body and are influenced by worldview. To observe in medicine without emotion seems unlikely. Emotions are a hidden part of medical observation. Observations that inspire emotions remind doctors that their rational mind is attached to a body, and therefore serves as warnings that they are not looking at the situation rationally. Because science and art are set up as opposing forces and not partners, emotional connection is fought instead of embraced in the medical encounter. Therefore, what could be learned by emotional connection is lost.

Vision and emotion seem just as important as life experience and political views to embodied objectivity. In the essay “Procedural Knowledge: Separate and Connected Knowing,” Mary Field Belenky (2008) and her colleagues reference Carol Gilligan’s research on ethical development, where Gilligan observes how girls and boys are conditioned to interpret behavior differently. Women are trained to consider how others think, which Gilligan calls “connected
knowing,” whereas men are trained to consider the rules that govern a situation; Gilligan calls “separate knowing” (p. 236). Feminist scholars like Haraway and Gilligan caution against separate knowing because it leads to biased interpretation of research subject’s behavior based on the investigator’s worldview. Connecting knowing is similar to embodied empathy. To scholars like Belenky (2008) and her colleagues, "connected knowers begin with an interest in the facts of other people's lives, but they gradually shift the focus to other people's ways of thinking; connected knowers as those that ‘learn through empathy’ (p. 242–243).

**Sensuous Consciousness**

The shock that doctors describe when first encountering poverty is very similar to descriptions of what feminist scholars discuss as cultural contradictions that exist between body, other and environment. Jeanine Mingé and Amber Zimmerman (2013) describe the feeling that comes when a person experiences these contradictions as “immense jarring, a cacophony of senses” (p. 231). The authors go on to say that these sensations create both a desire to learn more and at the same time a desire to walk away from what is causing the sensation. Walking away from the distress that is caused by contradictions is often framed as survival instinct. For medical educators like William Osler, walking away from the distress caused by contradictions in medicine between mind and body, hierarchy and patient, and art and science seems like a set of necessary protections. But, for scholars like Mingé and Zimmerman, a lot can be learned from walking toward the distress and looking carefully at cultural contradictions. Instead of detaching emotionally, they suggest “cultivating mindful action,” by being aware of what comes in the way of love and caring between body, place, and other (p. 230).

In *Concrete and Dust: Mapping the Sexual Terrains of Los Angeles*, Mingé and Zimmerman (2013) write about how the use of senses to imagine other’s experience, to
empathize, becomes difficult when everyday practices involve regular detachment between body and mind. Mingé and Zimmerman make specific observations about how American culture creates detachment between mind and body through values of thinness and denial of pleasure as necessary for being accepted as beautiful. Mingé and Zimmerman’s observations about larger-scale cultures of detachment could prove helpful in thinking through the impact of detached empathy in medicine.

Conclusion

Daniel Goleman (1995) points out that interpersonal practices can inform larger economic decisions; therefore, how doctors relate to the poor in their daily interactions likely has implications for the way class is understood on a macro level within the larger middle class. Goleman argues that metaphors like “turning a blind eye, giving someone the cold shoulder, looking down on people, and seeing right through them” are not just helpful descriptions, they are also accurate descriptions of the social distance between the classes (2013). Goleman argues that not only do people in power not notice those below them in status, they are also unable to empathize. He suggests that this lack of empathy has played a role in the “soaring inequality in the United States” (Goleman, 2013).

Riis pointed out over a hundred years ago that the only way that poverty conditions will change is through emotional connection – through human hearts. A recent article in The Atlantic (Boodman, 2015) speaks to the emerging solutions to creating more empathetic doctors. Courses are being developed with titles like “Oncotalk” and “Empathetics” that teach doctors the micro-skills of listening. I worry that these interventions focus more on doctors appearing empathetic rather than having doctors feeling a strong physical responsiveness to their patients who is needed to provoke action. There is no opportunity for strong physical responsiveness in a climate
that fears emotions. From my investigation there is evidence that doctors are empathizing with the poor. It is important to consider how to increase the numbers of doctors who can empathize, if the goal is to reduce health care disparities. This will not happen if doctors who do allow for connected knowing are left feeling like outsiders in medicine. Doctors who partner with the poor to learn solutions to major health problems should be encouraged. Doctors can become pieces of the bridge of hearts Riis suggests as a solution to poverty only if the science and art of medicine are considered with equal thoughtfulness and with equal value.

Practices and values in medical education that encourage disconnection come in the way of creating understanding across class. There were sparks of emotional connection by the doctors in the interviews, mainly in the form of compassion and feelings of responsibility for the poor. Feelings of compassion and responsibility frame the poor in a way that is problematic not as partners in general health improvements but as victims of self-inflicted illness. Compassion and responsibility connote sympathy and not empathy. Feeling sorry for someone is very different that understanding another person’s situation. There was evidence in the interviews of doctors attempting to connect and learn from their patients’ experience and it is this evidence that may give insight into how to end health care disparities as well as ways to renew a middle-class push for equality. A transformation of medicine that is sensitive to poverty, on this level, will not happen without empathy.
CHAPTER V: ART KNOWLEDGE AND THE POLITICALLY ENGAGED PHYSICIAN

In the interviews, when doctors became aware of suffering and faced the causes of suffering, they became more aware of injustice in general. The doctors interviewed who considered solutions to disparities in health care and the importance of social determinants of health had one thing in common: they were able to empathize with the poor. Emotional connection to the poor seemed to inspire action and innovative approaches to medical care and medical education. Scholars like Rosemary Green, Raeleene Gregory, and Robyn Mason (2003) resist the valuing of emotional detachment because it is a political stance that “neuters” professionals from taking action against injustice and that encourages alliances with the status quo (p. 452). Detachment is often seen as emotionally necessary within medical cultures when facing suffering and injustice on a regular basis. Detachment is also necessary to being scientifically objective. Not only does the value of emotional detachment come in the way of empathizing with the poor, it also comes in the way of taking a political stance on poverty and health care. Doctors who resist emotional detachment and political neutrality in medical settings could be very helpful in reimagining a new connected, political approach to medicine.

Most of the doctors interviewed talked about compassion and emotional responsibility toward the poor, but at the same time talked about how doctors were not trained properly to intervene in poverty and that physicians should focus on what they are trained to understand: illness, disease and treatment. There were fewer doctors who described deep concerns for how the poor were treated within the medical system and who refused to support what they considered inhumane treatment of the poor. Doctors shared negotiating emotions of medicine on their own, but a small group of doctors were able to talk about the knowledge they have learned
from empathizing with the poor. Only one doctor talked about empathy directly and the importance of empathy to political engagement:

Empathy is the key difference in who is progressive and conservative. In general, I feel, conservatives lack empathy unless something impacts them personally. If an issue impacts them personally the empathy they feel for people is incredibly intensified. An example that sticks in my head the most, involved the Cystic Fibrosis Foundation. Normally, my conservative colleagues would say that socialized medicine is awful and yet they lobby for government involvement for research in finding a cure for cystic fibrosis because they had a family member or neighbor with the illness. There was a display of incredible empathy for cystic fibrosis but this empathy did not carry over to concerns about general health care (July 3, 2014, Family Practice).

For many doctors if there is not a personal connection to a health care issue they are incapable of empathy. Many of my doctor friends find it hard to empathize with the poor, and if anything they feel put upon by the poor. I know these doctors are capable of empathy, but unfortunately, not in all cases - they do not generalize empathy. The progressive perspective, however, is to see how anyone can experience misfortune. Progressives do not see themselves as so different from the poor. Conservatives view the poor as very different, which complicates their ability to empathize (July 3, 2014, Family Practice).

This doctor points out that empathy is possible for all physicians and that, at times, empathy for the poor results in a push for health care reform on the part of doctors. This doctor also sees obstacles to empathy by physicians as political difference. I am arguing throughout this analysis that the lack of empathy for the poor by doctors is much more complex than claiming
Democrat or Republican. There are barriers to empathy that are the result of medical education culture in the United States. Both class dynamics and science cultures contribute to distancing practices that make emotional connection between doctors and the poor difficult.

**The Dance**

The dance between connection and detachment in medicine and the conversation about art and science as partners are not new. Nancy Tuana (2008), in her essay “Revaluing Science: Starting from the Practices of Women,” uses medicine as an example of a discipline that does not rely solely on science observation for knowledge creation. Tuana describes the medical model as a blending of empathy/intuition and reason to make decisions. Medical investigators, she argues, are “both engaged and objective,” and adds that a doctor’s “knowledge is embodied” and relational as well as rational (p. 263, *Just Methods*). Tuana’s understanding of medical knowledge and the medical approach seems generous when considering what has been explored so far in this analysis. If doctors, as a profession, are more likely to value what they can physically see over intuition and value objectivity over empathy, then medicine does not serve as a good model of embodied, relational knowing.

Flexner hopes for science, in the Progressive Era, are similar to Tuana’s current day hopes that medicine represents the best example of scientific rational knowledge and experiential emotional knowledge. I would argue that both Flexner’s and Tuana’s ambition for medicine have not come true, and that the knowledge that is created from experience and emotion has been neglected due to the values of science and rationality being instilled in medical education culture, as well as, ideologies of dismissing and distancing found in the middle class. I do wonder how medicine might change for the better if the use of relationship and emotions were explored as closely as science in medical education.
Doctors in reality are not free of emotions, and emotions influence practice, even if they are denied. Even though there is not an emphasis on learning from emotional connection and the art of medicine is not formally discussed or taught in medical school, doctors are learning from their art of medicine experiences. Doctors who connect emotionally are learning about poverty and approaches to health care from working closely with the poor. Doctors are learning about medical approaches that may be beneficial to every person, and not just the poor, from their partnerships in finding medical solutions with the poor. One lesson being learned by doctors is that medicine has political obligations outside of protecting the status of the profession. Doctors are urging their colleagues to speak out about economic atrocities and to get involved, because improving health outcomes for the poor will improve health outcomes for everyone (Marmot, 2004).

One of the lessons learned by these doctors is that they feel odd and rare in their concern for the poor, or in coming up with solutions to health problems for the poor. Because emotions and poverty are silenced topics in medical cultures, doctors rarely discuss or know of other physicians who might have similar feelings and concerns about the poor. Ruth Behar (1996) points out in her book *The Vulnerable Observe* that empathy often serves as a building block to taking action, to help, to speak out, to organize, and to end injustice. Behar expresses outrage at the intellectual dismissal of a fellow anthropologist’s writing on death and grief as sentimental because he shares his feelings as well as his observations in his work. She concludes from the reactions of her colleagues that feelings are not for proper anthropologists. Behar calls the outcry against her colleague’s work an injustice toward the feminine. She explains in more detail, “to privilege sentiments, he dares to be feminine - that is, feminine in the terms of cultural logic and the way we [as a culture] ascribe gender to our writing” (p. 170). This same dismissing of
sentiment happens within medicine. Empathy and the art of medicine become gendered and dismissed as not proper medicine. To care for the poor and partner with the poor may be perceived as feminine in a climate that prides itself on being masculine. This gendering of approaches to medicine is unfortunate if the relationship with the patient and a doctor’s own emotions could serve to be a catalyst for taking action, helping the poor, organizing, and ending injustice.

**Poverty as a Complex Concept**

Several doctors interviewed talked about seeing large volumes of poor patients as part of their medical education. Doctors claimed that exposure to poverty in this way was helpful in learning about illness and disease, but exposure did not always lead to better understanding the lives and challenges of the poor. Exposure to the poor does, however, complicate doctors’ definitions of poverty. The doctors interviewed understood poverty as complex and relative. Even if doctors were unaware of the challenges of poverty outside of the clinic and the hospital setting, they were well aware of the consequences of not having access to health care.

It is helpful to revisit Harrington’s (1962) *The Other America* for eloquent personal descriptions of injustice faced by the poor that continue today in America, and how the health care system plays a part. Harrington writes:

The poor get sick more than anyone else in the society. That is because they live in slums, jammed together under unhygienic conditions; they have inadequate diets, and cannot get decent medical care. When they become sick, they are sick longer than any other group in the society. Because they are sick more often and longer than anyone else, they lose wages and work, and find it difficult to hold a steady job. And because of this, they cannot pay for good housing, for a nutritious diet, for doctors. At any given point in
the circle, particularly when there is a major illness, their prospects are to move to an even lower level and to begin the cycle, round and round, toward even more suffering (p. 16).

The doctors interviewed, much like Harrington, are aware of the “vicious cycle of poverty” (p. 17). Harrington continues to describe poverty in the United States as “a culture, an institution, and a way of life.” He adds that everything about the poor, “from the condition of their teeth to the way in which they love, is suffused and permeated by the fact of their poverty” (p. 17). Harrington’s words are very similar to one of the doctors interviewed when she described how poverty impacts a person “in a million ways - from the moment you are born to how you die. It [poverty] colors what you eat, what you do with your ‘free’ time, how you deal with stress, how active you are and these stressors are carried with you from childhood” (Oct. 20, 2014, Dermatology). Harrington describes poverty as a world-view that has its own language and psychology. Poverty is a world-view that can only be understood through story – through emotional and relational connection with a person who is poor.

**Basic Needs Met**

If I were to distill down the answers I received for the definition of poverty to one sentence it would be, “poverty is when a person is unable to meet their own basic needs” (July 23, 2014, OB/GYN). Many doctors started off with government definitions of poverty, but rarely did a physician feel the government definitions were sufficient. The conclusion was nearly unanimous: poverty is more than income and the number of people in a family household. What was listed as basic needs, however, differed among physicians. All mentioned food, and shelter (not living on the street), and health care. Some added details like laundry detergent, shampoo, dental floss, shoes, clothing, indoor plumbing, hygiene, work, a safety net, and not having to beg.
Several doctors pointed out that not everyone should be required to meet their own basic needs but that most adults should be able to independently acquire food, shelter and clothing.

One doctor explained: “Well yeah, everyone understands if someone is emotionally and intellectually challenged that a person with these challenges might not be able to work” (July 11, 2014, Perinatologist). The doctors were aware that meeting basic needs might be a challenge for some, but the general sentiment was everyone deserved to live in a society where basic needs are met. Even physicians that adopted more stereotypical views of poverty as an individual deviance were generous in believing that to survive the competitive nature of employment in the United States, it is difficult when there is mental illness or intellectual disability. Mental illness and cognitive disability were made exceptions to the productivity/independent rules of class.

**Health Care a Basic Need**

The two main things I was able to discern from doctors’ experiences is that poverty is a complex issue in the United States and globally, and doctors feel strongly that health care is a basic need that must be met by a just society. A lack of health care should not be tolerated, according to most of the doctors. For the doctors interviewed, health care access was personal, so regardless of political leaning, both progressives and conservatives agreed that not having health care access was inhumane. Doctors were universally able to empathize with their patients who did not have access to health care and to understand what it means physically to not have care when ill. Lack of health care access was often where discussions of compassion, emotional responsibility, and empathy were found in the interviews.

Despite differences in specialization, politics, and understandings of and approaches to the poor, doctors agreed that people should have health care when ill or injured regardless of ability to pay. Doctors discussed frustrations with experiencing barriers to care that they argued
hurt the poor and made the doctor’s job more difficult. Also, when the poor are only able to access health care when they are very sick and in crisis requires expensive medical treatments, and this puts a financial strain on the overall health care system. Doctors explained how a preventive approach to poverty would impact everyone in a positive way. One doctor shared, “They [the poor] come to the ER and they wait so long and they are sicker. Sometimes it is the first time [they have seen a doctor] in twenty years and they are in the late stages of serious illness” (May 22 2014, Hospitalist). Another doctor explained, “When people are poor you can diagnose but that tends to be it. Treatment, equipment, and medications are too expensive. They [the poor] do not have the money to see a specialist or to have surgery” (July 3, 2014, Family Practice). Health care in the United States is expensive. According to the doctors, the poor access healthcare in limited ways because of fears of expense and discrimination by the system.

Access to health care was the biggest concern by doctors for the poor. There were different levels of understanding among the doctors about how health care and poverty intertwine. Noting obstacles and coming up with solutions to these obstacles required connection with the poor for doctors. Doctors have to become aware of the poverty to attempt alternative approaches to medicine that better fit the unique needs of their patients in poverty. One doctor explained, “With my patients now I start with plan ‘A,’ prescribe a medicine that will be paid for, but this solution is not always going to work because often my patient cannot take their medications four times a day for a variety of reasons. It is then my job to come up with plan ‘B’, ‘C’ or ‘Q’ depending on what the patient needs” (June 26, 2014, Family Practice). An integrated care approach that helps doctors think through a variety of treatment options is not taught in medical school, according to this doctor: “I never had the experience in my medical education of
asking the question, ‘is this treatment going to work for you when you leave the office’ (June 26, 2014, Family Practice)?

Doctors are left on their own to learn about the cost of medicine and the barriers to accessing health care. Another doctor explained, “We are taught to think about what is the best medicine for pneumonia. We are not taught to think, ‘But what if our patients are not going to get the prescription filled because I wrote it for $150 med?’” (June 27, 2014, Emergency) This doctor talked about facing patients with the big diagnoses like diabetes. Those diabetic patients who are poor do not have their blood sugars under control because they do not have a primary care physician monitoring and adjusting their diet and medication. They go periods of time without insulin: “We give them samples that last for a month and then they are back to the ER. Regardless of what you are taught in medical school, over time you start thinking about the cost of medical care” (June 27, 2014, Emergency). Doctors in emergency medicine, in particular, see the revolving door of medicine and the poor. Each time patients come back with untreated chronic illness, they get sicker, and the threat of disability and death become more likely.

Not only are doctors forced to consider other options for the patient because of poverty but some doctors are also aware that patients are forced into very difficult choices that lead to injury or that create barriers to recovery. Doctors empathized with these hard choices. One doctor expressed concern for his patients: “They [the poor] care for their kids instead of themselves. There are lots of parents that do sacrifice their health to pay for other necessities for their family. They [poor parents] ignore their own health to take care of the kids, and it is hard to watch. It happens” (July 9, 2014, OB/GYN). This doctor pointed out the cruelty of sacrificing a parent’s own health for the survival of her children. Another physician told the story of a patient who needed a brace to save his leg: “Given the choice that you might lose your leg, if you cannot
afford to do this [purchase a brace], then you are poor. These are $100 interventions” (July 11, 2014, Physiatry). This doctor was outraged that no person should have to make this choice; no person should have to lose a leg because they cannot pay $100. Avoiding disability should be a priority of a just society. This same physician described the dangerous choices the poor face regularly: “The things that people try to do when they do not have the money are risky, like getting up on the roof and cleaning gutters. This is not the best choice” (July 11, 2014, Physiatry). The poor have to consider risk in the moment and do not have the luxury of thinking of a healthy future. Through this doctor’s description, it is clear that poverty is a health risk. Poverty forces people to focus on their present survival. This often translates into risky decisions, including waiting for a health crisis to pursue care.

**Abstract to Tangible Poverty**

Doctors define poverty through their direct healthcare experiences with the poor. Poverty is defined through the lens of healthcare because the physician’s knowledge of poverty comes from his personal medical experience and the stories shared by their patients. A medical understanding of poverty comes from emotional connections with patients. Some doctors are able to empathize with the poor from their clinic and hospital experiences with the poor but for others, this only happens once they see poverty from a perspective outside of the medical setting. An example of this learning was shared by one of the physicians who had recently had personal experiences with children in poverty in the city where he practices:

I think to some extent poverty has been an abstract concept to me and had nothing to do with medicine. More recently it has become more real. Being in an academic medical environment, I have been in situations where health care delivery had nothing to do with a person’s ability to pay. I did not even know. You would get a sense of class through
social interactions. You could tell [that a person was poor], but beyond that it did not matter. I had been sheltered as a doctor. I went to visit three of the elementary schools in poor neighborhoods and it was awe-inspiring. It was like going to a third-world country. That experience has now become my definition of poverty. There is just no access- the schools have to provide two meals a day and food for the weekend, the kids have no boots for the winter, and the only health care the kids, get is through the school nurse. That has become my definition of poverty. My view of poverty is now colored by health care needs in these neighborhoods. Poverty is now tangible to me and it is no longer abstract (Oct. 14, 2014, Pediatric Intensivist).

This doctor’s epiphany about poverty came after seeing children in poverty in their communities and schools. He learned something new about poverty by empathizing for the first time with these children. For this doctor to move from an abstract understanding to a tangible understanding of poverty required him facing health care concerns from the viewpoint of a child in poverty. This required being in the neighborhood of these children, hearing stories from the staff working closely with the kids and connecting personally with kids who are facing poverty daily. He was unable to understand the viewpoint of a child in poverty from the setting of the clinic office or the hospital ICU.

This doctor’s experience is a helpful example because he gained the insight that for him to want to help and be involved, poverty needed to go from an abstract concept to a tangible concept. For many of the doctors, this transformation to a tangible understanding would only be possible through their health care experiences with the poor in the clinic and hospital because doctors rarely have experiences with the poor outside of medicine. This doctor had no meaningful exposure to poverty until very late in his career. He was unable to see poverty from
the poor person’s perspective in his medical education and through most of his practice, even though he was working with the poor. This doctor’s experience is helpful in considering what can be done to better understand the medical encounter, so that this transformation from abstract poverty to tangible poverty can occur more often.

Several doctors shared those moments of epiphany when their views of poverty went from abstract to tangible and from objective to empathetic. It happened for different doctors at different times and did not happen at all for others. One doctor shared, “Poverty did not really sink home for me in the same way that it did when I had to face ten hours of the day questioning people about what was going on in their lives. Before hearing the stories of poverty, the meaning of poverty for me was fairly abstract” (June, 26, 2014, Family Practice). Another doctor shared in these sentiments: “I was oblivious; I did not make a connection to poverty and health. As a premed student working in the university clinic, you had people who would get medical care who did not have much going on. You begin to realize what it really means to be poor” (September 24, 2014, Infectious Disease). Again to empathize, doctors had to encounter the personal stories of their patients or be in the neighborhoods and homes of their patients to alter their understanding of poverty from an abstract understanding to a tangible understanding.

**Psychological Impact of Poverty**

Those that look at medical culture and poverty also highlight, like Harrington and the doctors interviewed, that the poor are more vulnerable to illness. In Michael Marmot’s (2004) book *The Status Syndrome*, he writes, “Where you stand in the social hierarchy is intimately related to your chances of getting ill, and your length of life” (p. 1). There are more health risks for the poor and this has to do with how they live their daily lives. A person’s home, neighborhood, and workplace have a huge impact on overall health. Marmot emphasizes that...
even in an epidemic, where no person can escape illness, the poor still fair worse. What Marmot shines a light on that normally goes undetected is that “the psychological experience of inequality has profound effects on body systems” (p. 6). Focus and concern for the health of the poor is not just about the poor, it is about the overall improvement of the health of the nation as a whole. According to Marmot, those nations that decrease income disparity recognize the interdependence of a population’s health and have better overall health outcomes.

Very few doctors interviewed were aware of the research on the psychological impact of inequality and research being done about health outcomes and income disparity. One of the few doctors who had looked at this research explained, “There are things about poverty; it is different when everyone is poor and when there are poor and wealthy. It is relative poverty that matters. When looking at poverty by state and by country, the bigger the difference in income between the poor and the rich, the worse the medical outcomes. Inequality is toxic, it is not good for rich people either” (July 3, 2014, Family Practice).

Several doctors described how the U. S. poor had very different challenges than those in developing countries. A doctor shared a story about her time practicing in Sub-Saharan Africa and how what she witnessed there compares to New Orleans after Hurricane Katrina: “[Poverty] it can be looked at in so many ways – it is community and culture specific. In Africa, where it might be seen as much worse materially, they [the poor] grow their own food. If they [the poor of Africa] could not buy things it would not cause the same treacherous situations that the people in New Orleans faced” (June 20, 2014, Psychiatry). The poor of New Orleans were invisible until the storm and the temporary and limited nature of these neighborhoods’ resources quickly caused health crisis. In this example, the impact of inequality in the United States, where classes are separated and the poor are forgotten, makes poverty treacherous in psychological ways that
would not happen in impoverished agricultural communities in Africa. The storm in New Orleans made visible the inequality that the poor face and what it means to live in poverty in the United States.

Several doctors shared their experience with extreme poverty in the United States that seems hidden away from most doctors, or at least masked by the clinic and hospital settings. One doctor shared his experience of residency in Florida: “I started my medical education in 1981 and the Tuskegee anger and distrust in medicine was so palpable. The anger was not a cultural difference as some people misunderstand. The anger of the black community was as a result of a real injustice. The hostility you often feel as a white doctor from black patients has a historical context that I fear newer doctors do not understand” (July 10, 2014, Pediatric Intensivist). This doctor makes clear that poverty is location-specific. Poverty in the southern rural parts of the United States looks very different than the rest of the U. S., and the poverty in America is different from the rest of the world. The psychological impact of poverty and how it influences the medical encounter is very different depending on location and, as this doctor also points out, the historical context. The psychological impact of poverty often goes unnoticed or is misinterpreted.

Being poor and sick in America is a psychological strain, according to one of the doctors, who described his years of work in a small, post-industrial city in the U. S: “I tell residents that I teach that there is an iron triangle for people with regards to outcomes about health. If you are crazy and sick, you are poor. If you are poor and sick, you will go crazy. All of this is together [poverty/illness/mental illness]. The amount of psychopathology in my practice is overwhelming. For most doctors, five percent of their patients need to be on psych meds for anxiety and depression. Here at the clinic where I teach (that focuses on serving the poor), the number
needing psych meds is twenty percent” (July 3, 2014, Family Practice). This doctor sees the psychological aspects of poverty. If you are poor, you are more likely to be ill and not have resources when you are in pain and not feeling well and this has a psychological impact. Health institutions that do not understand the barriers that the poor face, and that blame the poor for their situation, use language and practices that marginalize the poor, and these acts of marginalization have emotional consequences. The poor are constantly aware of their inability to access wealth and resources. This constant reminder contributes to mental health problems, or the “iron triangle” of poor/sick/mental illness that this doctor describes.

**Social Aspects of Poverty**

For a smaller number of doctors, poverty went beyond being able to meet basic needs. For some, poverty was much more complex of an issue and “multidimensional” (November 7, 2014, Infectious Disease). For these physicians, poverty included equal opportunity, social mobility and access to love. Doctors who understood poverty as multidimensional were not only aware of the material and emotional realities of poverty, but of the social aspects as well. Several doctors seemed acutely aware that people do not start off from the same starting block. One physician explained, “A person gets locked into a certain situation because of religion, sex, color” (Aug. 25, 2014, Infectious Disease). This doctor was very much aware that discrimination based on race, religion and gender can stand in the way of opportunities.

Another physician went on to discuss, “You know, I guess technically what it means to me [poverty] is the lack of control of the conditions needed to live your life in the way you wish to live it” (Nov 7, 2014, Infectious Disease). Again, this doctor is acknowledging that there are social pressures outside of one’s control that contribute to economic success or failure. He added, “[Poverty is] shortfalls in resources to conduct your life in the way that you value. It could be
shortfalls in income and education and status. If you are stigmatized for any reason you are often not given opportunities. Any factor that has an impact on opportunity can be counted as a form of poverty” (Nov. 7, 2014). These doctors are recognizing social aspects of poverty. These doctors were more likely to see environmental causes of maintained poverty instead of poverty due to individual flaws.

One example of the impact of inequality and discrimination was suggested by one of the doctors. At the end of life when a person’s loved one is going to die, the family is asked for the first time how medicine can help. The American system is generous only at the end of life: “It is the ultimate crisis. Imagine you are given nothing, nothing, no doctors, no insurance and then you are in a high tech-end of life situation and everything is expensive and you are finally being offered help” (Oct. 20, 2014, Dermatology). Again, this example gets back to the injustice of a system that only gives access at the end, at the crisis point that is so expensive. This approach to medicine and the poor is not only frustrating for the patient and their family, it is also frustrating for the doctor. The cost of this approach impacts the cost of health care for everyone.

For several of the doctors, it was not just the impossible health care system, the lack of resources, and hard decisions required of the poor it was also the emotional toll of living in poor communities. One doctor explained, “Living is stressful when you are afraid your child will be shot on the way home from school. PTSD is not uncommon with the poor and I could go on and on. No access to health care causes stress. Every little thing is against you and nothing helps you with your health care” (June 18, 2014, Psychiatry). When asked how poverty impacts health outcomes, another doctor answered, “There is a connection between poverty and psychiatric illness. The stress of poverty drives the depression, abuse, suicides we see in this population and is a huge factor there. The reverse is also true. Medical illness and psychiatric illness drives
poverty because it often makes people unemployable – it is a cycle” (Aug. 25, 2014, Infectious Disease). Several doctors were able to empathize with their patients feeling stuck in living situations with no opportunity to get away.

Several doctors mentioned love and acceptance as needed to thrive: “So you could work with a rich kid that did not have the support of his parents or whatever he needed emotionally; in a more broad context this could be considered poverty of sorts” (June 26, 2014, Family Practice). Another doctor explained: “I tend to define it [poverty] in terms of relationships. Poverty is people that are isolated – particularly when I think of poverty in Sub-Saharan Africa and poverty here [US]” (June 20, 2014, Psychiatrist). For these doctors it takes more than money to thrive. Love and acceptance, which is important to wellbeing, can be missing across class.

Much like belief in self, love and support are seen as necessary to life. One doctor was concerned for people without friends they can trust. This doctor described a physician friend that works with inner-city children, and a poem his friend shared written by one of the children. In one line of the poem, the child wrote, “I do not have friends, I have associates, because friends are someone you can trust” (May 22, 2014, Emergency Medicine). The love and care of others is essential to getting by. One doctor made the observation when caring for HIV patients,

I see loners they are really alone and another set they are coming with a partner and a family member. That person with the support does a lot better. It [social support] is an incredibly powerful resource. This contact person makes sure they get there and asks follow-up questions and can be reached often when a patient cannot be reached – there is more ways for things to go well. There is so much a person with social support can do” (Nov 7, 2014, Emergency Medicine).
Social connections are very important to health outcomes. For several doctors, it was not only the love and care of others, but the love and care of society that is essential: “In communities where people do not care for each other, violence increases, like child abuse and sexual assault. It is hard [as a doctor] to consider increasing the wellness of society without facing poverty” (May 22, 2014, Emergency Medicine). As doctors talked through what poverty meant to them they were often aware of the societal contributions to poverty and were at times upset by the lack of involvement by the community and by medicine in stopping what they perceived as suffering. One doctor puzzled at the lack of societal understanding, “When they [the poor] happen to live in a deprived environment they are at a disadvantage, [and we as a society] instead of putting money into early education, we invest money in incarceration” (July 3, 2014). This doctor was very concerned with the lack of care on a larger societal level that leads to poor health outcomes. There has to be a basic level of valuing human life and seeing potential in people regardless of social position.

Poverty is also feelings about the future: “It has to do with your circumstances and future circumstances – housing, food, and health care and also social mobility. [Poverty] it is not just about basic human rights but also a dream for the future for self and your kids, I guess” (Oct. 20, 2014, Dermatology). Without an opportunity to dream of a better life there is little motivation to change circumstance or fight for change. This understanding of poverty has political implications for doctors. If doctors have the luxury to dream, what is their obligation to those that do not have that luxury? Doctors framed poverty not as an issue solely about income, but also as a person’s opportunity to meet their potential, which is a very different focus for medicine, normally focused on illness and disease.
The doctors’ understandings of poverty as multidimensional remind me of Abraham Maslow’s (1970) hierarchy of needs. Maslow’s hierarchy of need is a theory that is often used when discussing poverty. Maslow theorized that the poor are less likely to meet their potential because of the energy that is used just to survive. Those without social supports, love, and acceptance, regardless of class, are also less likely to meet their potential. When people are able to meet their potential, they then dedicate time and energy to innovation and imagining solutions to big social problems like poverty. The doctors who defined poverty as multidimensional were concerned about what comes in the way of a patient’s potential. Doctors were able to conceive of health outside of illness and disease. These doctors shared humanitarian concerns and were willing to consider other knowledge besides science knowledge to imagine solutions to problems.

**Gifted Problem Solvers**

The hierarchy of need, has implications for the poor and gives a better understanding of what obstacles come in the way of fulfilling potential. Those at the top of the need pyramid, the self-actualized, are individuals who Maslow predicted would be capable of finding solutions to big social problems like poverty. Those that do not have to struggle to survive, and that are accepted and loved, have energy to be innovative and gain insight into how helping others meet their potential makes life better for everyone. The more people are able to think innovatively, the more likely creative thought will lead to increased quality of life for all. Not all doctors experience acceptance and love, but they are economically beyond the struggle to survive. Some doctors, as Maslow might predict, do seem to understand poverty as complex, as tangible, as psychological and social. A broadened understanding of poverty seems to help doctors
Negotiating the Unknown

When asked about the definition of poverty, every physician hesitated on the answer. For some, it was a quick burst definition with apologies that poverty is much more complicated and difficult to explain. Others pondered the question and talked out loud as they constructed a definition for the first time. Doctors are well practiced at coming up with answers quickly. Montgomery (2006) writes how doctors use shortcuts called heuristics in response to unknowns, and decisions about unknowns are often “fast and frugal” (p. 35). Heuristics are experience-based judgments made quickly and efficiently, but that are prone to errors. In these moments doctors often use intuition. Montgomery goes on to write, “Physicians are trained for maximum certainty” (p. 35). This is demonstrated in this answer: “Typically, poverty is defined as a certain amount of money per household, but I do not remember what the numbers are – I have to look them up every time I need them” (August 6, 2014, Family Practice). When asked to define poverty, this question was the one in my list of thirteen that seemed to require a correct answer, and so there was struggle. For the doctors as a whole, poverty proved to be an area of uncertainty requiring intuition and personal experience to define.

The doctors were given very little time to deliberate about their answers in the interview. Some reviewed the consent information prior to our meeting and were aware that the topic of the interview was poverty, but they were unaware of exact questions in advance. The definition of poverty then becomes a helpful example of how doctors are learning about poverty through experience and intuition, and that this learning has broadened their understanding of poverty.
Understandings of poverty then fall squarely in the art of medicine as opposed to the more certain and comfortable science of medicine.

Doctors are trained for certainty in their medical education and use intuition and personal experience only when dealing with uncertainty (Montgomery, 2006). What was fascinating to me was how quickly doctors were able to think of potential solutions to the barriers for the poor in healthcare using intuition and experience. If poverty was a subject doctors did not dedicate much time to, when asked to imagine solutions, physicians were able to use their imaginations and intuition fairly easily. The doctors discussed a variety of issues that concerned them about poverty and health care, but there were two areas that were discussed more often: better understanding the cost of medical care, which are currently hidden from the doctor, and the need for community-centered care.

Cost consideration

Many of the doctors shared a concern that they were not taught in medical school how to adjust treatments based on income. In medical school students are taught the best answer, which often involves expensive medicines and expensive procedures. Knowing cost could be very helpful information in finding affordable solutions. The current system, as described by the doctors, keeps doctors clueless about cost to the patient. One doctor explained, “If I knew financial limitations when people came in and as I helped to solve the problem, I would have a better idea of resources that the patient and I can use. Just like with medical problems, I would help the patient break big issues into smaller more manageable issues” (May 22, 2014, Emergency). This same physician shared, “Rarely am I asked to solve medical problems without any money. I cannot solve readmissions problems without taking cost into consideration. To account for financial difference between patients who may create barriers to healing, there needs
to be a change in medicine to a client-focus instead of an illness-focus” (May 22, 2014, Emergency). This cost-conscious approach to medicine would require that doctors talk to patients to design medical solutions based on needs. This approach to medicine would also require partnering with patients to better understand limitations and obstacles to health. With the costs of health care continuing to rise, many doctors demanded that “medicine needs to get smarter” (May 22, 2014, Emergency).

The expense of health care has different meanings to different groups of patients. Doctors shared what they had learned from other countries: “In India, for example, doctors would not put a person on a vent because it is considered a luxury that only the very wealthy can afford” (July 11, 2014, Physiatrist). In other countries, the material reality of medicine forces doctors to involve patients in their care. The choices the patients make often improve the health for not only the individual, but also the community. One doctor discussed that if there were “more robust conversation” about the emotional, physical, and financial cost of medicine to the individual, family, and community, this conversation could really change how medicine is practiced (July 11, 2014, Physiatrist).

Some doctors did have awareness of particular costs to patients that were barriers to care. One doctor talked about how fees required just to see the doctor should be eliminated, even if a patient has insurance (July 3, 2014, Family Practice). Office visit costs, even if minimal, are a barrier to getting early care that can prevent future costly emergency and crisis care. One doctor shared her frustration with the community mental health center where she worked: “They had a sliding scale fee but everyone had to pay at least $30. This center served mainly an immigrant population but the administration did not get it that $30 might as well have been a thousand dollars. It is awful to me that the richest nation in the world cannot provide basic health care”
Another doctor shared similar concerns: “In primary care there should be no fees at point of service. When there are monetary fees associated with care, half as many patients will make an appointment to see the doctor. The problem with this approach is when you try to reduce inappropriate visits you also eliminate appropriate visits” (July 3, 2014, Family Practice). These doctors were concerned these fees were out of touch with the financial realities of the poor.

It turns out doctors are already coming up with makeshift solutions for their patients without money or insurance. One doctor talked about an underground economy that goes on unseen in the emergency room:

Doctors provide free care all the time out of frustration because deep down what you want to do as a doctor is take care of the patient. I did not go to medical school to call insurance companies and stand in the way of care. You just want to take care of people. We will call the surgeon and wink and nudge about how the patient needs an emergency surgery. In reality the person’s economic situation has made the surgery emergent, because with time comes possible complications. Disability is so much more expensive to the person and the community as a whole (June 27, 2014, Emergency).

This doctor described how doctors do their best to store medications they receive as promotional material from pharmaceutical representatives: “You do not want to think about money and have the money get in the way of the care. It is very frustrating” (June 27, 2014, Emergency). Doctors beg, borrow, and steal for the people that need it, and this practice has to be kept quiet.

Other doctors shared new and innovative ideas that could be used on a large scale. One doctor who had a degree in engineering, as well as a medical degree, shared, “Engineering students make prosthetics in third world countries that are very affordable. We do not have
access to these braces in the United States because they do not meet the rigorous requirements” (July 11, 2014, Physiatry). This doctor talked about inexpensive alternatives used in other countries as solutions that could also prove helpful in the United States. “There is an inherent bias in the United States by doctors about what they order for their patients. It is always the best, regardless of the patient’s income. Several doctors felt that treatment recommendations were rarely altered based on income unless the patient had the courage to speak up and say, ‘I can not afford that.’ Physicians are not taught about several options based on a variety of patient circumstances. Medicine does not allow for this type of flexibility” (July 11, 2014, Physiatry).

This same physician had other innovative ideas. He mentioned, “Doctors have a history of being paid for what they do to a patient, which then places a value on procedures, doctor visits and hospital stays” (July 11, 2014, Physiatry). This doctor suggested, for example, instead of treating people that already have a diagnosis of osteoporosis one person at a time, and instead target patients at a certain age with a diagnosis of fracture: “The electronic record could help to alert us to set up group meetings for at-risk patients. Instead of seeing four to six patients in a half hour each, the group could be educated on the risks of osteoporosis at the same time and this could help prevent painful and costly future fractures” (July 11, 2014, Physiatry). The idea of delivering preventive medicine to a group of patients instead of treating an illness of an individual is a very different medical model. Group education and treatment are real alternatives that could increase access to medicine and lower costs of medical treatment. All of these doctors mentioned empathized with their patients’ experiences with barriers to health care, and because of this were concerned about cost. These doctors were actively coming up with solutions to the cost problem and at times intervening and trying to provide better services to the whole community, including the poor.
Community-centered

Doctors concerned with poverty, who also consider possible solutions to the health problems of the poor, often discussed the importance of moving from an individual focus in medicine toward a community focus. Medicine has been framed as sick individuals seeking well-trained experts about medical problems, in hopes of a solution. Medicine has not been approached (traditionally) on a collective or community level, and so doctors are not practiced at approaching problems in this way. One of the physicians expressed an example of this as follows: “One of the challenges of discussing health care on a macro-level is that doctors are taught to treat people regardless of cost” (July 11, 2014, Physiatry). This doctor points out that medicine does not regularly link solutions to material reality. He explained the goal of the physician is to concentrate on the “right” answer to the problem, regardless of the patient’s situation. “Right” tends to be defined based on what can be afforded by a middle-class clientele.

The same doctor went on to say, “On the other hand, if a doctor is asked to step back and view a problem from a societal standpoint and in the best interest of the community, the question then becomes, should she treat or not treat the individual? In the present system, if a doctor approaches medicine from a societal standpoint, the doctor sets herself up to be charged with not putting the patient she is treating first” (July 11, 2014, Physiatry). Physicians are in a good position to help with societal-level decisions about healthcare, but if doctors used their expertise in this way, they would be accused of overstepping the bounds of their expertise, which is framed as recognizing and treating symptoms in individuals. The same doctor added, “You do not want a physician to be in the position of God. As it stands today, I cannot impact the decisions that impact the costs of medicine” because medical expertise is not framed as both a micro- and macro-pursuit (July 11, 2014). If cost were added to the physician’s regular concerns,
Several of the doctors discussed more directly the importance of considering the community and the individual to better address the social determinants of health problem. One doctor observed, “increasingly physicians are being asked to reconcile between the difference between public health framework and medical framework. The individual has been a main part of medical framework for many years. The public health framework is more on a community level focused on populations and standards of care. Both sides are shortsighted, in my opinion” (July 11, 2014, Family Practice). He went on to explain that the individual medical framework neglects environmental causes of health problems while the public health framework tends to think about health problems at a population level, missing the hardship of the individual.

This physician led me to a recent article by the writer and surgeon Atul Gawande (2011) in the *New Yorker*, with the title, “The Hot-Spotters.” In the article, Gawande writes about a blending of medicine and public health frameworks in Camden, New Jersey. Camden is one of the highest crime areas in the United States, is poor, and also has one of the highest per capita medical expenditures. Jeff Brenner, a family physician in this community, developed a collaborative between the hospitals in the area. The hospitals worked together to better understand the high-utilizers of the ER. It turns out these patients were not receiving primary care due to social determinants. Instead of interdisciplinary focus on individuals, Jeff Brenner’s collaborative developed comprehensive care that looked at the social determinants as a community. The interdisciplinary group worked together to lessen the social determinants of poor health outcomes (Gawande, 2011). This group was able to improve health in the community and on an individual-level using problem solving skills honed in medical training.
Another doctor explained the value of considering medicine from the perspective of “being in the same place over time” as a rural family practice physician and how this experience has helped him develop a community focus. He offered, “My patients feel comfortable telling me that they cannot afford expensive medical options. They know that I will work with them on less-costly options. In a small community there is a level of everyone knows what is going on with everyone any way. There is trust there, but also they are ashamed on a different level” (June 26, 2014, Family Practice). This doctor is aware of the interdependence between his patients and how one person’s health can influence the larger community. He understands that for his patients, “the guy down the road wants his deck finished so he is interested in the doctor helping the guy fixing the deck or else the deck is never finished” (June 26, 2014, Family Practice). This doctor has learned to broaden his skill set to include health care problem solving on a community as well as an individual level.

This doctor agreed that medicine has an obligation and ethical requirement to be involved in broader solutions to medical problems, but he was frustrated that smaller communities rarely have input into national health care reforms. He explained,

The folks here need to take care of each other or who will open the store or build the house. For example, logging is a big industry in our community and these guys are driving really heavy trucks behind me and I want them to be safe. Community-level medicine does not translate as well when you are not driving the same roads” (June 26, 2014, Family Practice).

Living in a small community motivates this doctor to make sure people are well because if they are not, the necessary functions of the town will stop. For this doctor, a lot can be learned about equality and healthcare from small town American doctors: “I could be helpful in thinking of
solutions on a local level and it is possible that these solutions could help other communities” (June 12, 2014, Family Practice). Lack of resources in small communities makes for strange partners. Solutions only come from the patient and the doctor knowing the informal resources in the community, which takes time to learn. When working with the poor it is particularly important to think about medicine on a community level, because poverty often leads to illness, and because often the treatments that will actually work involve the patient’s environment.

**Good Neighbors**

When doctors were asked about poverty they did what they are trained to do - try to solve the problem, even with a fair amount of uncertainty, and even though poverty falls outside of the science of medicine. In her book *How Doctors Think*, Kathryn Montgomery (2006) writes: "Physicians who are educated to take pleasure in solving diagnostic puzzles, working out treatment, wielding technology, and devising cures are distracted from the social and economic components of the maladies they treat” (p. 177). For the doctors who connected emotionally with the poor, class separation did not blind them to the interdependence between the classes. These doctors considered health care on a community level because they could see the connection between the health of the poor and the health of the larger society. What would happen, she imagines, if doctors approached their patients as neighbors instead of detached scientists? The neighbor analogy is intriguing but problematic. Montgomery describes doctor-neighbors as caring and non-judgmental, but also neighbors can be apathetic and critical.

The values of science and the middle class that further separate, disconnect, and detach do not come in the way of some doctors being able to empathize with the poor. Empathy and connection often provoked some physicians to action. Montgomery (2006) goes on to consider different ways that doctors could approach medicine (as neighbor) that do not distract them, but
connect them with larger social and economic health concerns. Several of the doctors interviewed suggested changes in medicine that would help the poor. Moving from a model that emphasizes the individual to a model that is community-focused could be useful in learning more about social determinants of illness, and better understanding why income disparities and discrimination influence health outcomes. Doctors concerned with poverty suggested blending public health and medicine sensibilities and learning from their patients the importance of community. In this way, it appears doctors are benefitting from considering themselves good neighbors and helpful members of the community that are concerned about the whole community. Doctors understood that knowing how to approach medicine from a community perspective would improve individual health outcomes. Doctors genuinely concerned with poverty demanded that expectations for medical leaders must change, as should approaches to medical education that include consideration of cost and approaching medical problems at the community level.

**Political Neutrality**

Doctors are supposed to remain neutral politically (List, 2008). As previously discussed, the medical value of objectivity not only impacts micro-level practice, but medicine’s role in the larger society. Doctors need to care for patients from both sides of a war, for example, regardless of what side of the war they are serving. But many doctors around the world have started to argue that it is also a doctor’s role to speak out about war atrocities (Farmer, 2003). Political neutrality is yet another space in medicine rife with contradictions. In reality, medicine has not been politically neutral. Historically, medicine has been a political force and has used its political muscle to preserve the profession (Starr, 1982). Because of the cultural techniques used to separate doctors from patients, knowledge that could come from emotional connection from
empathy is often lost. Quite remarkably, there is evidence of doctors who embrace and
acknowledge the importance of the art of medicine, who learn from emotional connection, and
who speak out against, and even intervene in, the injustice of inequality, or economic atrocities.

It is hard not to see parallels between the way medicine has used detached empathy as a
technique to preserve the doctor emotionally and how medicine, as a whole, has functioned
politically over the past hundred years. Paul Starr (1982), in his book *The Social Transformation
of American Medicine*, writes about organizations like the AMA and the AAMC engaging in
politics to preserve the status of the profession. Political capital, earned by physicians as
scientific experts, starting in the Progressive Era, was consistently used to increase physician
credibility and protect doctors as a profession. This same political capital could have been used
to reform health care to be more equal. It is very hard to tell if the values of these organizations
to maintain status and to shy away from social issues like poverty (deemed outside of medical
expertise) are passed down through medical education, strongly influenced by the leaders of
these organizations, or if the practices of detached empathy and class-distancing evident within
American medical education culture carry over to the interaction between medical associations
and the public.

**Role of Professional Organizations**

Several doctors argued that the AMA could be a helpful political tool for patient care
concerns, but historically, the association has tended to focus on preserving the medical
profession. One doctor explained, “The American Medical Association has more power than an
individual physician trying to make a change. Doctors need to be a part of the solution to poverty
in America but this will not happen through the AMA because the AMA always acts in its own
self-interest” (July 11, 2014, Physiatry) Another doctor shared a similar sentiment: “The
associations do [engage in politics] but much of it is maintaining the status quo. It is so convoluted – the agenda is there and it is clearly to maintain the status quo” (July 10, 2014, Pediatric Intensivist). Outraged, another doctor shared, “Health care is one thing that should be solved. I absolutely think that poverty should be high on the priority list for medicine. The AMA will sometimes discuss poverty concerns. Unfortunately, most conversations led by the AMA are not about the patient but the doctor’s lifestyle” (June 11, 2014, Psychiatrist). And yet another doctor was dismayed that there is very little discussion about the political realities of healthcare within the AMA. He lamented:

Well, the biggest issue, which is again a political public health issue, is how we are going to continue to pay for health care with the population not just the people that are poor. It has to do with whether or not we want universal health care. I think many doctors support universal health care. When comparing to other nations their health costs are half of what it is in the United States and the infant mortality is smaller and life expectancy is at least one year better. When you say the best care is in the United States, you have to say what about these other countries. Good care does not equal a pretty lobby. Every piece of the medical puzzle is a reflection on our attitude about health care and health care providers. The members of the AMA need to be asking, how can we provide everyone high quality and non-concierge levels of care? It will be ten years before we get something closer to universal coverage. I’ll predict it will be June 18, 2024 (June 18, 2014, Pediatric Oncologist).

Another doctor is hopeful for a change in AMA politically in the near future. He said,
I see more engagement by the AMA because of Obamacare. I think you are seeing more engagement by national organizations at the demand of their members. Doctors view themselves as a soldier of one, but it is getting harder and harder to get through their day. Doctors do not have the energy or stamina to engage politically so they are looking to their national organization to do the political work for them. Doctors are demanding new approaches to medicine because the current system is not working for them or their patients” (June 18, 2014, Internal Medicine).

Doctors are aware of the political potential of the AMA and are hopeful that the professions political arm will be used to change the culture of medicine to one that is more community-centered and aware of cost.

Political Engagement

Not only were doctors able to come up with creative solutions to approaching health care disparities; they were also involved in political action. Some on a small scale and some on a larger scale, but there are doctors who are involved politically, even when this goes against the grain of the medical status quo. Doctors are making sure patients are a part of agency-level decisions about health services, and they suggest care that is community-focused, using innovative ideas to cut community cost for health care. Doctors volunteer to work in poor neighborhoods and urge their health care organizations to do more for neighborhoods at a disadvantage. Doctors are sacrificing salary and status to dedicate their careers to the poor. Doctors choose to take the risk of practicing privately so that they can partner with their patients and not managed care companies. Doctors hoard promotional supplies and beg specialist to provide needed care to the uninsured. These are only some of the examples of actions the doctors I interviewed take to change health care to be more receptive and helpful to the poor.
Ethical Obligation

When asked, many doctors agreed that poverty is an ethical obligation that demands political action by physicians. Ethical obligations that insist on political engagement are very different ethical obligations than physicians are used to discussing. For example, one doctor reflected:

I think it does fall within medicine [a concern for poverty], but not only within medicine. Poverty is an ethical issue for doctors because your ability to serve patients can be critically hampered by unaddressed poverty. If you think about an ethical obligation for the poor from the narrowest sense, your efforts will not be well carried out if you are not also working to organize other physicians” (Nov 7, 2014, Infectious Disease).

This doctor discussed the need for doctors to partner in efforts surrounding poverty. Advocacy and research about social determinants of health on the part of physician are important to health. This doctor went on to say: “Doctors’ involvement in issues of poverty help to prevent the public from mistakenly thinking that poverty is an independent issue from health” (Nov 7, 2014, Infectious Disease). According to this doctor poverty policies and health policies tend to be discussed as separate issues, “For example, housing is a critical determinant of health. It is not something simply thought of as a luxury. Housing should be a basic requirement for health. It is harder to see as discretionary” (Nov 7, 2014). This doctor explained housing is an ethical priority for doctors because doctors are in a helpful position to make connections between poverty policy and health policy for the public. This doctor feels strongly that medicine must begin to embrace their ethical obligation and right some of the social wrongs that maintain poverty numbers in the United States. “I cannot defend that doctors should not be addressing poverty” (Nov 7, 2007).

He went on to say:
In the end, what research would have the greatest impact on health inequalities? We hear a lot about research and advancement that make the best off even better off. Just because someone is willing to pay for this type of research, this steers research agendas. How can doctors be a part of redesigning access to resources for patients who cannot read and do not have housing? Research is a social justice intervention. If you look at how dollars are spent by the NIH, which is a massive social investment in research, how are agendas decided on? How the NIH is being funded may be distorting the path of research. Equity should be considered ethically when designing larger macro research projects (Nov 7, 2014, Infectious Disease).

This physician is engaged politically in this issue and is a part of a bioethics program that speaks out about social determinants of health, with a mission of ending health care disparities. When asking this physician about medicine and poverty, it was clear this was an issue close to his heart. It was an issue he was in no way embarrassed to be passionate about.

Only one other doctor in the group shared this passion and has spent his career actively advocating for the poor in his practice and on a policy end. His politics and his passion for ending poverty are not hidden. He is very vocal about his belief that medicine needs to step up. When asked about how he fits his advocacy into his teaching of residents, he said,

I always weave in my experiences with activism. I try to bring up the social determinants of disease or how medicine could be better. Until recently, I was invited every year to the medical school to talk about these issues and potential solutions. The main solution I discuss is improved and expanded Medicare for everyone. I am an active member of Doctors for National Health Care and I am one of 20,000 similar doctors around the country. The nice thing about improved and expanded Medicare for all is that laws and
policies already exists. There is tremendous savings if you expand Medicare enrollment and offer everyone access. This idea is so administratively simple and the savings are huge (July 3, 2014, Family Practice).

This doctor sees the importance of medicine taking an active political role. It should not be unusual for doctors to talk about the health consequences of policies that maintain poverty, which for him also includes approaches to education and incarceration. For this doctor, medicine can and should be a part of policy fights because policies impact a community’s health. If reforms were made in health care that took costs into consideration, the money saved could be used to improve living and working conditions that would improve overall community-level health. This doctor used the example of how highways are built: “For example, think of where railings are put on the highway. The railings are put in the places where people can go off the road. Someone thinks, ‘this looks kind of dangerous and let’s put up a railing.’ These decisions are crucial to health believe it or not. The railings are there so that if a person wrecks their car, they do not also wreck themselves” (July 3, 2014, Family Practice). This doctor wants smart, young doctors learning to be brilliant problem solvers to imagine new and innovative approaches to medicine that take into consideration social issues like poverty. He explains, “I try to get young doctors to see through the inevitable. I want young doctors to understand that health outcomes could really change if poverty was reduced. If you want a healthy America do not let people stew in poverty. I do my best to teach about the connection between poverty and poor overall health outcomes to residents. The social determinants of health are more important in our clinic serving mainly the urban poor. Because of this, our residents understand and appreciate how poverty impacts their work life and their ability to do what they want to do—care for people” (July 3, 2014, Family Practice).
These two doctors are examples of what can happen when doctors empathize with their patients and that empathy results in political action. Both men have very different political approaches, but both are equally passionate and outspoken about the issue. Medicine is not politically neutral. The political clout that medicine has fought for over a hundred years can be used to shine a light on the health repercussions of poverty in the United States. The AMA has been quite influential throughout the past hundred years. Techniques of empathy and connection with patients need to balance techniques of class and science distancing for the possibility of larger-scale medical reforms with a concern for poverty. Doctors are already engaging and partnering with their patients living in poverty. Doctors are out there alone, attempting to do what feels right emotionally in a medical culture that dismisses emotions. Doctors know they are gifted problem solvers, but need medical education that fosters the abilities to come up with several cost-efficient treatment options to consider health on a community level, and an ability to lead institutional and societal cultural changes that acknowledge the injustices in the current system.

**New Leaders in Medicine**

Medical educators are looking more closely at the need to dance between connection and detachment, as a way of maintaining empathy that balances moments of fatigue with satisfaction (Hojat, 2007). There is a questioning of the detached concern model developed over a hundred years ago that continues to be preferred within professional training. Medical educators that are questioning the value of objectivity and emotional distance are still in the minority. Several doctors concerned with poverty suggested the need for a culture change in medicine that teaches doctors how to be leaders that can push for changes, not just on an individual level, but at an organization and community level.
Doctors shared experiences of trying to lead organizations in approaching medicine differently, and their attempts were met with a great deal of resistance. A handful of the doctors interviewed had attempted to change the approach of medicine within their institutions toward a community focus, and their pleas had not been met with support. One doctor explained that his family practice group is able to build programs around social determinants and is able to partner with the community because their work is kept under the radar. He explained, “We are too small to attract much attention and we do not get much recognition for the work we do. We get the spotlight solely when our organization wants to emphasize its contribution to the community” (July 11, 2014, Family Practice).

Another doctor shared his large-scale proposal to consider palliative care as a model and new approach to all areas of medicine, not just at the end of life or for those patients with life-shortening illnesses. He believed that involving the patient in treatment decisions and considering quality of life over cure not only increases patient and physician satisfaction with care, it also tends to be an approach that is more cost effective. He shared how his proposal was not well received: “There was much resistance to the idea because it asked for a partnering with the patient and at times resisting treatment on the part of the doctor. To really change the approach of medicine to a community-centered approach will take a resetting of the business of medicine and this alarms the majority of doctors” (July 11, 2014, Physiatry).

**Policy Backup**

Several other doctors described being marginalized from their physician groups for standing up for changes that would better assist the poor and that focus on the wellbeing of the community. It is not an easy road for doctors actively considering community-level medicine that takes cost into consideration. Several of these physician leaders, however, were encouraged
by the Obama Administration reforms that are shifting the health care culture away from revenue streams rewarding individual care. The Affordable Care Act has built-in monetary rewards, which force the hand of medical institutions toward providing community-level health care. The Affordable Care Act is policy that forces consideration of cost as part of the puzzle that needs to be solved by doctors:

The government now says that the hospitals readmission rates need to be reduced. The burden is on the health care team and not on the individual patient. Doctors need to know costs to help solve problems. These changes in policy force doctors to learn resources and better utilize their team. We are dumb for not involving patients in hospital-level decisions. Hospital administration needs to get smarter about reaching out to patients and to physicians to meet new government requirements” (May 22, 2014, Emergency).

These are just a few examples of doctors hopeful that the most recent policy changes in health care will shift the culture in medicine. Without a cultural shift, individual doctors are finding it hard to push on their own for changes in health care delivery to the poor. With policy backup, doctors are hopeful that their medical institutions will no longer resist reform ideas and innovative work will no longer need to be hidden away from managed care eyes.

**Conclusion**

Of the doctors interviewed who are trying to lead medicine in a different direction, most were convinced that other doctors would get involved except they feel overwhelmed by the current system. Refocusing medicine is not something an individual doctor can do alone. Medical school did not prepare doctors for negotiating medicine on an agency level or community level. Many of the doctors concerned about poverty were ill equipped to take on issues of care for the poor even if they were considering solutions to the problems they were
seeing for the poor in their community. Again, several doctors felt strongly that medicine has an obligation to start considering the needs of the poor and this ethical obligation often translated into action. For example,

Without a doubt physicians have an obligation to be leaders in discussions about poverty. Doctors are crucial in developing and suggesting solutions even on a global level about poverty. I think doctors are asked regularly to get into this fight and some doctors choose not to get involved. For example, I run a program to prevent infection and superbugs. We are running a program for antibiotic stewardship to reduce resistant infections. The truth is doctors are involved in community-level interventions that impact the poor. Should it happen more, yes” (August 25, 2014, Infectious Disease).

Much like doctors are not taught directly about poverty in their medical education, they are also not taught how to be a part of their community or about the community-level ethical obligations of medicine. Doctors are engaging in problem solving better ways to approach poverty in health care and with a community focus, but this is self-motivated activity and not an expectation of medicine at large.

When I talked with the doctors about their work and their concerns about poverty, the doctors were often unable to come up with creative solutions to what they see as the problem of poverty and healthcare. Even though medical education does not spend time directly on poverty, and many of the doctors agreed that was a concern within current medical education, they were still able to draw important knowledge from their experiences with the poor in health settings to better think about the social determinants of illness. Doctors would often dismiss their solutions as anecdotal and that there needed to be hard science about the issue, but in the end there was some great thought on the matter of poverty. I was a little surprised by this result. Thinking of
solutions and how to better the connection to poor communities again illustrates that doctors use experience from their lives, and from their relationships with their patients, to better understand medicine. The knowledge that is developed through the physician’s personal experience is a comment on what can happen when doctors allow themselves to empathize with their patients’ situation (or embrace the art of medicine), despite middle-class and science ideologies that discourage connection. The poor, in reality, have never escaped physician concern over a hundred years of American medical history, even when it was unpopular to excel in the art of medicine. Discussions of poverty and the art of medicine can be found over the past hundred years in the JAMA, even at times when the topics went missing in the discussions of American medical education. The two topics are not brought up as often now as they were in 1910, but they are still part of heated arguments, usually around the adoption of new technology. Even when science became a narrow focus in medicine, there have always been doctors who value the art as much as the science of medicine. There have always been doctors who resist consideration of class as separate and disconnected. Much can be learned about medicine, and about American injustice, from doctors who resist the disconnected and detached medical culture and connect with patients on the margins, and act to try and make life just a little bit better for those at a disadvantage.
CONCLUSION

The president of the AAMC, Dr. Darrell G. Kirch, joins in the chorus of concerned medical educators about the changing diversity of the American public and the embarrassing nature of healthcare inequalities that seem inexcusable for a wealthy, modern nation like the United States. American medicine has a long history, after the Flexner Report reforms, of dazzling the public with the latest medical technology, while not “addressing some fundamental health needs in the neighborhoods” just outside the doors of the most prestigious medical schools in the U. S. (Kirch, 2010). More recently in his address to the class of 2014, “New Doctors for a New Health Care System,” Dr. Kirch declared,

> With so many innovations underway in medical education, it surprises me when I still hear some people remark that medical education has not changed since the Flexner Report in 1910. I have been pleased to witness a surge in initiatives to promote student and resident interest in global health, rural health and service to disadvantaged communities (Kirch, 2014).

Kirch, unlike AAMC presidents of the past, framed medical work with the poor as innovative. Not only is Kirch pointing out the ethical conflict of health care disparity and the moral implications of poverty to medical educators, he is also raising the status of work with the poor as a new frontier in medicine.

Kirch describes the newest medical innovations not in terms of the science of medicine like the AAMC presidents of the past, but in terms of the art of medicine. The president of the AAMC is framing innovations in medical education as a concern for the poor (rural, disadvantaged and global). Instead of encouraging the search for proof of illness and developing new treatments for disease, Kirch urges new physicians to look more closely at health care
disparity and poverty. A focus on poverty as a priority in medical education is very different from 1910 where there was no mention of poor patients at all. As is apparent in Dr. Kirch’s 2010 address, Flexner reforms are often synonymous with culturally insensitive health care. Dismissing the Flexner reforms as merely insensitive further insures the loss of important political lessons from the Progressive Era, like the use of public outrage for political gains that improved living and working conditions that decreased and ended illness like tuberculosis in the United States. Also, Flexner envisioned medicine as blending science and art of medicine. Thinking about physician personal experience and intuition as a partner to knowing scientific facts could prove helpful with current challenges in medicine.

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Dazzling Technology

Over fifty years ago, Michael Harrington (1962) urged the American public in *The Other America* to move away from thinking about poverty as a population statistic. He wrote, "My standard of comparison is not how much worse things used to be. It is how much better they could be if only we were stirred” (p. 19). Statistical technologies have not only been used to understand disease, they have also been utilized to monitor and understand the poor. Alice O’Connor (2001) writes in her book *Poverty Knowledge* that data is collected on a national level to monitor social service programs, and this data has been used to support a variety of political agendas over the past fifty years. Comparison of poverty numbers from year to year does not really change the lives of the poor. Looking at numbers leads to a particular understanding of poverty.

Statistical technologies are just one development over the past hundred years of medicine that informed the medical understanding of poverty. David Armstrong (1995) calls the technological shift after the Flexner/laboratory shift “surveillance medicine” (p. 112). Surveillance medicine is when disease and illness begin to be studied for population trends, and individuals are encouraged through the media and medical institutions to monitor and regulate their own health. Armstrong argues that statistical technologies, much like the laboratory technologies discussed in Chapter One, influenced the relationship between doctors and patients. In this shift, the patient is expected to keep up on the newest health trends, and doctors must review the newest research on medication and procedural advances, as well as statistical information, on broad trends in illness and disease.

Population study of disease and poverty further distances the public from tangible experiences with illness and poverty. Broad numbers do not explore knowledge of the everyday
experience of doctors and those living with disease, as well as those living in poverty. For writers like Harrington and Riis (1970) numbers do not get at the lived experiences of the poor, and therefore do not stir the public to action. These influential writers about poverty often mention the importance of emotional connection or empathy to bring about real economic changes for the poor. Focusing on broad numbers and self-monitoring are current practices that promote distancing and detachment. If current technology continues to separate doctors socially and psychologically from their patients, then our current health care disparities are likely to be maintained.

Statistical approaches are objective, scientific, and rational, but statistics do not get at the knowledge that is produced by direct everyday experiences with the poor by professionals, like doctors or by the experience of living poor in the United States. How will personal technology like the Fitbit® change the relationship between the doctor and the patient when technology and medical applications on phones can monitor a person’s daily activity (sleep, exercise, blood pressure, heart rate, blood sugars) and this information can be delivered and analyzed for and by the doctor without ever seeing the patient? It is likely, as in the other paradigm shifts in medical practice that this new shift will be experienced differently across classes. The middle class will be able to afford the devices and be a part of a culture participating in constant self-monitoring through technology. Personal technology will increase the importance of body awareness and how the individual fits into health trends that shift regularly based on a flood of health data and ever-emerging health products. What will this increased possibility of surveillance medicine mean for the poor?
Class Difference

Many of the doctors interviewed seemed knowledgeable about the digital divide and understood that education qualified as a basic need in American society, due to current technological advances. Without education, doctors suggested, people do not have an understanding of what keeps them healthy, and they have a hard time negotiating safety net systems and are not able to access fulfilling jobs (May 22, 2014, Hospitalist; July 21, 2014, Pediatrician). One doctor described how the safety net can keep people from poverty and help to make sure basic needs are met but that the government systems put in place to meet basic needs are often difficult to negotiate and require an ability to read, write and think critically: “Poverty has to do with how savvy people are with managing the system and accessing services that compensate for loss of income” (July 9, 2014, Physiatrist).

Education was very important to doctors in their own lives and, in general, the physicians interviewed seemed well aware of the importance of education to the current economic climate. One doctor made the observation, “I have heard that technology doubles every 18 months. Machines now do jobs once done by human beings. A machine harvests oranges. What used to take ten guys now is a machine and what happens to these jobs? What are laborers’ next jobs? Poverty will become a bigger problem because technology will continue to take over the low-wage work” (May 22, 2014, Emergency). The doctors seemed very concerned about who would be left out of the digital medical changes on the horizon. Physical labor will be a rare option so, all people will need education to participate in the current economy.

In Virginia Eubanks’s (2011) book, Digital Dead End: Fighting for Social Justice in the Information Age, she argues that “social location” has “an enormous impact” on how the poor “encounter and relate to the tools of the information revolution” (pp. 23-24). Eubanks learned
from her research that the middle class experience technology very differently, and what is seen as liberating and valuable to the middle class can often be seen by the working class and poor as yet another way to make them vulnerable to surveillance. As Eubanks points out technology is often used as a threat to the poor, and the poor are aware that they are a “test population for technologies of social control” (p. 97). Eubanks makes observations about how technology is often used against the poor to create more social constraints. Technology can often come in the way of resistance and collaboration between the classes by further separating the experience of poverty from the experience of the middle class.

Eubanks’s insights into class and digital technology parallel Mary Fissell’s (1995) writing on class and the adoption of laboratory technologies in medicine in the 1900s. The poor could often not afford the technologies that had the most health impact. Fissell writes about how the focus on laboratory science in medicine led to medical practices that denied “the poor ownership of themselves” (p. 15). In the past the poor became the research specimens, the middle class the consumers, and the wealthy the sponsors of medical advances. Class will likely play a role in the newest medical climate that relies on digital technology advances. From Eubanks’s research it is clear that the poor are more skeptical of digital advances, much like the poor of the past preferred the old ways of medicine. Based on these two writers conclusions, the poor will be helpful to data collection about health care outcomes, but will be less likely to benefit from the technological advances in medicine.

**Return of Man and Art**

Not all writers about the newest technological advances in medicine think that digital resources will further distance doctors and patients. The demands of medicine today require physicians to manage a great deal of information. Consumers of medicine are also asked to
manage the latest information on health trends. Both doctor and patient are becoming increasingly skillful at processing huge amounts of information on a daily basis. Sara Nettleton (2009) points out that networked computer systems are the newest technological shift in medicine, which she names “e-scaped medicine” (p. 636). Easy access to information is changing the relationship between doctor and patient. Sarah Nettleton updates Jewson’s (1976) observations about technological advances in medicine and how these have changed and altered the medical encounter and the concern for the patient in medicine. Nettleton writes about the return of parts of bedside medicine that were lost in the technological advances of the autopsy and the microscope.

Nettleton argues that Jewson’s “sick man,” who disappeared as laboratory science emphasized the body and the cell, begins to reappear at the shift to surveillance medicine. The sick man is no longer in bed with the doctor caring at bedside, but the patient is taking on new meaning and new emphasis. She writes,

Responsibility, and increasingly culpability for health status, lies with the person who is impelled to become aware of and act upon the wealth of health information and advice to be found not only in the health clinic, but also throughout various forms of popular media, on supermarket shelves, the internet and so on” (p. 635).

Disease and illness information, which was only in the possession of physicians, is now easily available to regular people at the end of a Google search (although it’s confusing and contradictory).

Doctors will be forced to face their “prosumer” patient who has medical knowledge acquired from a variety of media sources, or who may also be a producer of medical knowledge on the web (p. 636). One of the doctors interviewed described this new medical landscape:
“There was more respect for doctors before the internet. It was much harder to get medical information. Now it is as if my patients are giving me a quiz to see if what I say matches up to what they have researched on the web. My patients already have a diagnosis in mind when they come to see me” (July 11, 2014, Perinatologist). As the middle-class consumer expectation changes, doctors have to ponder how to relate to their patients again, as their science expertise is challenged by access to information. This technological shift, which Nettleton argues brings back an emphasis on the patient’s knowledge and meaning of illness, could require more explicit training on the art of medicine as a part of medical training. Nettleton writes, “Consequently, commentators are expressing concerns that experiential and intuitive knowledge – the ‘art of medicine’ – may be in jeopardy” (2009, p. 635). Again, with the most recent technological changes in medicine, the art of medicine is threatened.

With the newest technologies in medicine there is an opportunity to rethink the medical encounter. The ways medical educators decide to approach this opportunity will likely impact how medicine is practiced for decades. If health care disparities are the most important problem in medicine over the next twenty years, and if part of solving the problem is looking at the policy and economic causes of poverty, and how poverty contributes to overall wellbeing, doctors could be important leaders in fights for equality. Doctors are learning skills in the current medical climate, and in their work with the poor that will help them to move medicine toward cost consciousness and community level care. As Dr. Kirch says in his address to new medical students, doctors are thinking of innovative ways to address poverty and the health repercussions of poverty, but much of this work is being done quietly and in resistance to dominant medical cultures.
Shifts in What is Innovative

At the hundredth anniversary of the Flexner Report in 2010, instructors of medicine reflected back on the Flexnerian revolution, considering what was lost in the medical education reforms at the turn of the twentieth century, and how older ways of understanding illness, patients, and communities could prove helpful in the current day challenge to end healthcare disparity. For example, Dr. Charles Flexner, a physician and great nephew of Abraham Flexner was invited to speak at “The Flexner Report Centennial Symposium” in Louisville, Kentucky in 2010. Dr. Flexner reflected on what aspects of medicine were lost when university hospital medical schools became the standard after the Flexner Report.

After reviewing the discourse and writing of medical educators and practicing physicians of the Progressive Era, Charles Flexner’s current view is very similar to doctors questioning the full-scale adoption of science rigor as necessary to practicing medicine at the time of the Flexner paradigm shift marked by the 1910 report. His suggestion to bring back proprietary medical schools is I suspect, to be provocative. In my reading of Abraham Flexner’s work, I am sure he would not be pleased with his great nephew’s suggestion. There were real corruptions in the proprietary system that needed reform. I do not agree with the dividing of patient-centered and science-centered medical education. This supports a false dichotomy in medicine that the art and the science of medicine are opposites. I prefer the idea of actively noting and better understanding the art of medicine, so that the art can be explicitly taught beside the science.

Coaching Artistry

Innovative medical educators tend to be doctors who reflect on their work and continually question the dominant approach to medicine. Those medical educators that took the
time to reflect back on the reforms of the Flexner era were doing just that. What is lost in the
pursuit of the newest medical advance? Donald A. Schon (1987) has written a great deal on
applied professions and how to become a reflective practitioner. Schon writes, “Outstanding
practitioners are not said to have more professional knowledge than others but more wisdom,
talent, intuition or artistry” (p. 13). It is not a coincidence that the word “art” reappears in
discussions of wisdom and intuition. When Schon writes about how to encourage wise and
reflective practitioners he writes about the importance of coaching artistry. An emphasis on
science knowledge in medical education creates physicians that are competent in applying
science to medical situations. The artistry of medicine, however, involves questioning dominant
approaches and being creative in medical solutions by taking in information from patient, the
doctor’s own past experiences, and the needs of the community. It is difficult to coach artistry in
medicine if there are no artists or doctors encouraged to have pride in the artistic aspects of their
work. The overbearing emphasis of science over the past hundred years in medical education
may have made medical artists even more rare.

Medical education strives for competence and hopes that doctors will become wise
through experience, time, and through developing the mysterious notion of the art of medicine.
appreciations travel in the grooves laid down by his unconsciously formed habits” (p. 256). The
“grooves” of medical expertise are weighed down by cultures of middle-class sensibilities, as
well as cultures of detached science. The unconscious habits of the expert are not informed
solely by science training. Doctors’ work is informed by personal experience, but the ways
personal experience is used by doctors are not brought to consciousness in medical training.
Instead of medical education focusing on decision-making and clinical competence, Schon suggests that wise clinicians move the conversation from knowing medical facts to better understanding of the meaning of illness and excellence and innovation in medical practice. “Meaning” is very different from “facts” because meaning is uncertain and requires interpretation. Medical education that encourages the development of wisdom admits to the uncertainty in medicine. Schon repeats Socrates famous quote, “Wisdom is knowing that you know nothing.” To find meaning in illness and healing, a doctor must relate to his patient and must learn to empathize. According to Schon, rationality only gets the doctor so far in the pursuit of wisdom. It turns out that emotions not only play a role in doctors connecting and thinking of solutions to poverty, but also emotions are important to developing clinical and moral wisdom. Schon describes wisdom as a combination of the art and the science of medicine.

Wisdom is the combination of knowledge, experience, a willingness to scrutinize practice, and self-awareness about emotions. A wise practitioner sees each problem as new and recognizes there are unique elements to each medical question. This facing each new situation with an open mind is similar to Edith Stein’s (1989) understanding of embodied empathy. People capable of empathy encounter each new person as a unique experience taking in the person’s story and sensing what the person has gone through in order to better understand that person. Wisdom is the ability to have an honest conversation about the uncertainty of medicine and a sensitivity that patients need to find meaning in their life and in their decisions. In this way empathy and wisdom have a lot in common. Wisdom encourages the process of healing instead of simply providing medical expertise.
Listening to Wisdom

Several of the doctors and medical educators interviewed stressed the need for community approaches to medicine and directly addressed interdependence between the classes and the health costs of class separation. These medical educators boldly approah medical education from a community level, and have created an expectation in future doctors who medicine must be approached in a way that is sensitive to the entire community’s needs. One doctor with just such an approach to medicine said, “Medicine needs to carve out time to consider solutions to macro-level community health issues. We cannot be limited to the thought process that we take care of one patient at a time” (July, 11, 2014, Family Practice). This physician, in charge of a family practice residency program, has also started to insist that residents do home visits with social workers. Again the experience of a home visit gives the residents insight into the social determinants of health problems and has these doctors thinking about solutions from a community level. Through this education intervention, this doctor helps residents go from an abstract understanding of poverty to a tangible one.

Another doctor discussed her work encouraging a community approach to medical education:

We do not want to teach about the statistics of poverty. We want our students to understand that disparities in health care often have to do with the neighborhood. For example disparities in breast cancer outcomes between white and African American women, the differences disappear when women are given equal access to health care (June 20, 2014, Psychiatry).”

For this doctor, teaching about poverty is not merely exposing medical students to the poor. She continues, “If medical students do not learn to talk with their patients instead of talk about their
patients, they will have a limited understanding of the realities of their patients’ lives (June 20, 2014, Psychiatry).” This doctor values equally what a medical student can learn from the patient’s personal experience and scientific fact. She adds,

Medical education that includes personal experience is transformative for everyone, the patient and the medical student. What medical education needs to do is develop moments where doctors are connecting personally with their patients. Students need to learn naturally how rewarding working with poor patients can be (June 20, 2014, Psychiatry).

These doctors are showing how a community approach to medicine by medical students and residents are innovative and get at what causes disparities in health care. These two doctors are approaching medicine in a wise and empathetic way.

Encouraging wisdom is not an easy solution to the current medical education woes. Wisdom takes time, mentoring, self-awareness, and openness to scrutiny of practice. Medicine has emphasized rationality and objectivity, and to become wise, doctors will need to embrace the importance of emotion, relationship, and diverse perspectives. Wisdom will change the relationships between the doctor and the patient and the doctor and the medical team. Clinical wisdom will also need to include social analysis in medicine. Wisdom will require scrutiny, not only of individual physician practice, but also the larger medical system as part of the culture of the United States. Social analysis needs to include better understanding of health care disparities and the health consequences of income inequality as well as the political obligations of medicine about social problems like poverty.

Social Scrutiny

In the same 2014 address to medical students, Dr. Kirch discussed concerns about physician burnout, high rates of depression, and increased risks of suicide within the profession.
Kirch blames massive changes in medicine for the stress that makes medicine a setting that is hard to keep up with. According to Dr. Kirch, the perfection encouraged in medical cultures and the isolation associated with medicine contributes to the problem. Kirch also adds as stressors the increased costs of medical education, the demands of increased specialization, the requirement to keep up with rapid scientific advances, and the lack of doctors to care for the newly insured masses as a result of the Affordable Care Act. What Kirch sees as yet another major factor putting doctors at risk for burnout is “being motivated by self-interest instead of a larger mission.” Those that study compassion fatigue do find that professionals that have a strong humanitarian vision for their work tend to be more resilient and are less likely to feel the strain of the fatigue of caring, because they are at the same time benefiting from compassion satisfaction (Figley, 2002).

What comes in the way of empathy is much more complex and often invisible to the eye of both the educator and the educated. Medical educators are beginning to think about how to teach medical students how to learn to foster strong physical responsiveness and be empathetic toward their patients. The medical education approach of unguided exposure to poverty in the U. S. does not create empathetic situations toward the poor. I would argue that the distancing and detaching behaviors that dominate medical cultures in the United States not only come in the way of concern for the poor by medicine, but also create an emotionally stressful environment for doctors. Dr. Kirch, again in his address to students in 2014, states the importance of doctors taking care of self in order to take care of others, by repeating the famous phrase, “Physician, heal thyself.” As has been discussed throughout this investigation, denial of emotions and personal experience does not stop doctors from feeling and being impacted personally by the
suffering and injustice they witness in medicine. Kirch is wise to scrutinize the practices and policies that make medicine an emotionally dangerous pursuit.

**New Political Dawn**

My classmates and colleagues aware of my dissertation research were excited to tell me about the #WhiteCoats4BlackLives protests prompted by medical students across the country after cases of police brutality were made public after the Michael Brown and Eric Garner deaths (Workneh, 2014). Hundreds of medical students from over seventy different medical schools wore their white coats and staged a dead-in. Medical students were taking a stand, and making the claim that doctors and medical institutions needed to speak out against gun violence and racism because both are important health care issues.

Several doctors in my research discussed a change in medical student priorities, and they were witnessing shifts in both the motives to be a doctor and the types of doctors medical students want to become. From this investigation, there is evidence that there have always been political doctors, physicians concerned with injustice and taking action. It is possible that medical students are coming together more often and feeling comfortable to be more vocal about their outrage at injustice. It is possible that digital technology has helped to make the organizing of young doctors more likely (hence the # - “hashtag,” a device that catalogs keywords or phrases on the social media site Twitter and others).

The impression older doctors have about the newest generation of medical students is that they are engaged politically and concerned about larger social issues. One doctor trained in the early seventies explained,

I came from a generation of medical students that wanted to work in the black ghetto, but very few actually followed through with that mission to become engaged in the
community. The few doctors who established themselves and provided care for poor communities were very rare. These doctors, of my generation, that dedicated their lives to the poor now serve as role models to our new medical students. The current generation of medical student is much more engaged [politically] and I think that is a result of the dedication of a few doctors of my generation who stuck to the mission to serve the poor and have also become influential in medical education” (Oct. 14, 2014, Pediatric Intensivist).

It would be helpful to look back into history and see if this physician’s observation turns out to be the case.

Doctors trained in the sixties and seventies were living through major social movements that were shaking up thoughts about authority and patriarchal institutions. Medical schools were admitting women, students of color and working class students in larger numbers. Medical students at this point in American history, much like the character Basch in The House of God, were surrounded by a diverse group of classmates all questioning the status quo. Shem had his character Basch choose a connection with patients over the rewards of climbing the medical hierarchy. How many doctors also chose a different way to approach medicine and how many of them became influential medical educators? It would likely be helpful to talk to doctors trained in the sixties and seventies, and then to current medical students, to better understand what about their medical and personal experiences drives them to speak out against injustice, and to see this act as important to medicine, as important as knowing what antibiotic to prescribe. Medical education that learns from the lessons of the past while also nurturing innovation is wise medicine.
Great Doctors and Great Discoveries

Paul Farmer is a doctor inspiring young physicians today. He is also an anthropologist and a specialist in infectious disease, and works in the poorest areas of the world. Farmer is a physician human rights activist who has urged medicine to consciously partner with the poor (Saussy, 2010). Farmer encourages his audience to better understand that the poor are not only more likely to become ill due to living and working conditions, they are also more likely to be victims of structural violence. Farmer argues that because the causes of illness for the poor are social, doctors are then forced by their professional ethical code to engage politically. Structural violence cannot be treated with procedures and medications; it can only be treated with political action. Farmer writes about a hierarchy of suffering – that the poor are more likely to suffer and the wealthy less so (Farmer, 2003). This difference in suffering is hard to sense in the United States by the middle class and the elite, due to various types of social separation that have already been discussed in this analysis.

Farmer warns that relative understandings of poverty can lead to inaction (Farmer, 2003). This is concerning when many of the doctors interviewed for this analysis considered relative poverty the most important thing to keep in mind when working with the poor in the United States. Relative understandings of poverty can lead to blaming the poor for their situation instead of looking at economic and politic conditions that maintain poverty. This was true for some of the doctors interviewed who argued there is no “real” poverty in the United States because the poor are obese and have running water (June 23, 2014, Neurology; July 11, 2014, Perinatology; July 23, 2014, OB/GYN). Many physicians agreed that poverty is “different depending on where you are” (June 18, 2014, Internal Medicine). Many of the physicians interviewed for this study had a common understanding of poverty as neighborhood specific.
Several of the doctors shared experiences in developing countries either as children, in medical school, or as doctors (July 11, 2014, Physiatry; June 18, 2014, Psychiatry; June 23, 2014, Neurology; Aug. 25, 2014, Infectious Disease; June 20, 2014, Psychiatry; July 23, 2014, OB/GYN). This exposure to poverty around the world resulted in comparisons to American poverty. One doctor shared, “I lived in the Philippines as a kid. People [there] had no idea where their next meal was coming from day after day, and they had no shoes or decent clothes. In America they say they are poor, but they have running water and enough food that most are morbidly obese” (June 23, 2014, Neurology). Another doctor compared poverty in India to poverty in the U. S.: “People can be poor and have nothing to speak of. We [in the U. S.] have homeless and hungry people but it is more rare” (July 11, 2014, Physiatry). The differences in poverty around the world allowed doctors at times, to justify neglect of the poor in the U. S. and had them blaming the poor for their situation. Farmer is correct in arguing that an understanding of poverty as relative can come in the way of empathy for the poor.

An understanding of poverty as relative provoked a variety of understandings by physicians. Several doctors thought relative poverty better explained than other definitions of poverty how income disparity has health consequences in the United States. As already discussed in this analysis in Chapter Four on political neutrality, doctors gave examples of ways that the poor face constant examples of wealth as normal on television, and in consumer cultures. Poverty is rarely represented and is framed as abnormal and deviant in ways that might not be experienced in other countries. Discrimination against the poor, in wealthy countries like the United States, has health consequences. The United States also has cultures that create dependence instead of interdependence, and then dependence is constructed as deviant. Not recognizing the interdependence of illness and disease also leads to health consequences. In the
United States classes are socially separated and this separation has health consequences for all, not just the poor. From this investigation, doctors have taught me that complicated views of poverty are helpful to empathizing with the poor and seeing the social aspects of illness. That poverty is complex and contextual seems more important to understand than that poverty is simply relative. It is a hopeful sign some of the doctors interviewed understood poverty as multidimensional and complex. Empathizing with the poor and approaching illness from a community level, appear to be the stepping-stones to political engagement on the part of physicians. Either way, poverty is a problem that American medicine refuses to treat on a large scale, and the profession leadership denies the ethical obligation to engage politically to find a cure to poverty.

Paul Farmer’s status as an anthropologist is helpful. He has the tools to analyze social and cultural aspects of illness while also scrutinizing his own direct practice. The combination of the skills he has built helps him engage in wise medicine. Paul Farmer is a very outspoken and well-published physician, much like Atul Gawande whom I have mentioned multiple times within this analysis. Medicine even today tends to call attention to a few rock star physicians pioneering innovative approaches to medicine. I think this tendency in medicine to shine a light on a few good men, and the newest medical innovation, draws away from the very quiet work of resistance that likely goes on in every hospital and clinic around the world. To present these ideas as rare dismisses what feels more to me like a larger, quiet movement just below the surface of dominant medicine. I am more interested in how to nurture what is already happening in medicine to make the movement toward empathetic medicine stronger for all of our sakes not just those that are poor.
Learning from Everyday Doctors

For many physicians, an understanding of poverty, even when it is not an area that they study, is complex and nuanced. Doctors are learning from their exposure to poverty day after day, and year after year. Poverty means more to doctors than income and the number of people in a household; it is also having access to basic resources so that a person can thrive. Besides shelter, food, and hygiene, doctors also included regular education and health care as necessities in our current culture. Many mentioned love, friendship, connection, and support as necessary to thrive, and that those without connections, regardless of income, do not fare well in our society. What doctors did not mention, but which seems crucial to me, is the emotional connection of doctors to the poor.

The poor benefit from doctors who learn from their personal experiences with poverty, and from wise doctors who dedicate at least part of their practice, energy, and talent to making life better for those that are poor. Doctors are learning about poverty implicitly, and not explicitly. I can only imagine what doctors would know and what solutions that they could conjure if there was explicit education about poverty in medical training. If training in the art of medicine was partnered with the training of science in medicine, the possibility of medical solutions to inequality seems much more likely. For doctors to find meaning, and not just facts, from medical science observation, they will need to value their own personal experience and their interpretation skills. Doctors will need to actively consider how their medical observations are influenced by their worldview. Valuing intuition, emotional and connected knowing, as well as rational knowing, is important in changing practices of separation. Only if science and art are put into conversation can medicine be the ideal example of progressive education or embodied
knowledge hoped for by Abraham Flexner and Nancy Tuana. There must be changes to what is valued in medical education for medicine to be able to gain knowledge from empathy in a postmodern world.

**Doctors Cannot Do This Alone**

In Dr. Kirch’s address to the AAMC in 2010, he discussed his hope that the Obama Administration would heal an injured health care system with a push for insuring more people. His hopes were dashed by the midterm elections, and the winning rhetoric that villainized health care reforms. Facing a lack of action on the part of government, Dr. Kirch’s attempted to stir his physician audience to action: “…we cannot be passive observers watching what the government does or does not do. Now, more than ever, we need to respond; we need to take action. I believe our response is going to define academic medicine for years to come (p. 1).” Kirch references the success of the Flexner Report to push for needed change. Dr. Kirch admits, quite courageously, the dependence of the current medical system on paying customers and the neglect of those without resources who are often perceived as hurting the financial health of medical institutions. The financial incentive in medicine is to treat high volumes of sick, preferably insured patients instead of promoting wellness for all, and for too long the “tyranny of the urgent” has preempted medicine taking bold actions to end the health results of inequality (p. 7). Doctor Kirch goes on to say, “This is a time when we need to show real courage. Actions like these will require us to deal with dynamic tension, even outright conflict, on many fronts (p. 7).” Kirch sees the flaws in the current medical culture and the need for doctors to become a political voice against injustice because injustice is costly.

Dr. Kirch looks to the Flexnerian Revolution for ways to be politically successful. According to Dr. Kirch, the academic medical centers, which are a result of the Flexner reforms,
could be the best place to explore redesigning American healthcare. Dr. Kirch states the number one priority in this redesign is a medical education culture change away from individualism and toward collaboration, with the mission of preventive and population health. Medical schools now have a lot of resources, which is what Flexner was really fighting for in 1910, but those resources are not used wisely. Dr. Kirch ended his presentation (The Journey of Medical Education: 1910-2110) at the Flexner Report Centennial Symposium (2010) by urging his colleagues to use Flexner as an example of courage; he remarks, “Transformational change is wrenching at best. Culture change is wrenching.” Dr. Kirch predicted in his 2010 address that if Abraham Flexner, the writer of this famous report, was still alive today, he would be amazed by the changes in medical education. Abraham Flexner was optimistic that science would solve illness quickly and that the inequality of the health system being set in place in 1910 would only need to be temporary.

Dr. Kirch’s hope for reforms in medical education that meet the emerging needs of the public and the needs of the new physician are inspired in part by the Flexner anniversary as is evident in his speeches throughout the past five years. In his presentation at The Flexner Report Centennial Symposium (2010) he stated, “I think we are due for transformational change in our country focused on healthcare.” Dr. Kirch not only sees the need for change in medical education to better address the current healthcare system concerns but also the importance of health to American culture and the importance of American physician leadership in improving the quality of life for the American public and the globe. The medical education culture constructed in part by the Flexnerian Revolution cannot be sustained, according to Dr. Kirch. For him, it is crucial that physicians play an active role politically if any transformative change in the U. S. is to
occur. Therefore, political engagement will need to be a purposeful part of future medical education.

**Future Consideration**

When medical education shifted to science training and a middle-class pursuit for middle-class clients, class and science cultures influenced class dynamics and medical practice. The art of medicine was used rhetorically to cover all aspects of medical practice that fell outside of science. The older knowledge from bedside medicine began to be dismissed as not important to medicine. The care of the poor also fell outside of these changes. The poor were helpful as human specimens in the medical education laboratory, but their lives and their stories were no longer relevant. The doctors who cared for the poor also became less relevant to medical practice.

To writers like Harrington, the poor in the United States have been made invisible through social separation and labels like “dependent” that have allowed the poor to be stigmatized as unhealthy and non-productive citizens. Evidence of the invisibility of the poor comes from doctors shocked at seeing poverty for the first time in medical school. Doctors also gave insight into their own middle-class values through their personal choices in medicine and how they approached class contradictions like obesity in the poor. Doctors have middle-class expectations of all their patients without recognizing these expectations, and instead focus on treating all patients the same as just and ethical medical practice. Doctors are, however, influenced by ideologies of independence and discipline that they learned from middle-class cultures.

The Flexner Report brought changes to medical education that created education practices that have been passed down for a hundred years as necessary tradition, but the report
was only part of the story. The Progressive Era was also a time when there was an increased demand for science and medical innovation due to successes in the prevention of deadly infectious diseases of the time, namely tuberculosis. These innovations were possible due to the microscope. Medical education reforms of the time were also in response to public skepticism of the market, which was by many as a corrupting force. There were organized efforts made by the public, medical associations, and government to keep medical education outside of market competition. Public outrage led to regulation, and standards emerged to protect the public’s health, making the collaboration between doctors and the government stronger.

We are currently in a time of increased medical technology and the relationship between medicine and the government is shifting toward more regulation, due to the increased cost of healthcare that is impacting the overall economic health of the United States. Whereas the middle class of the Progressive Era would be outraged by today’s healthcare disparities as coming in the way of democracy, there is very little organized public concern for the situation of the poor. There are doctors learning from their experiences with the poor that are gaining skills and knowledge from their medical encounters with poverty. Doctors who empathize with the poor are also involved in solving problems with them on ways to get past barriers, including the cost of medicine. Investigating more closely how doctors are able to resist dominant medical cultures of distancing and detachment, to fight for changes that might end health care disparity, is important to future study and understanding of the role of medicine in American society.

Skills for The Future

Abraham Maslow (1970) is helpful theoretically to just such an investigation because he saw psychological norms and pathologies as hopeless places for study. Maslow instead chose to look at people that were innovative and helpful to the larger society, in spite of being surrounded
by the profound illnesses caused by capitalism. He named these people the self-actualized. Studying the self-actualized that happen to be physicians could be helpful in better understanding how power and discrimination work. One such doctor explained the current fate of the empathetic doctor:

I see it in my residents those that are highly empathetic toward the poor, and they get angry with their fellow doctors: ‘Why are not they more like me?’ These residents work too slowly trying desperately to impact the effects of health care disparity one person at a time. Their work begins to be criticized because you cannot fix poverty one person at a time and it just looks like you are slow and incompetent (July 3, 2014, Family Practice). This doctor agreed that knowing how to engage politically to work on a macro-level, on issues like poverty, is crucial for the wellbeing of these empathetic physicians as well as their patients.

Doctors need advocacy skills on micro-, mezzo-, and macro-levels to work on health problems like poverty. This doctor went on to say,

You could create a grid and on one side of the grid place empathy at one extreme and no empathy at the other, then on the other side of the grid place self-sacrifice and greed. How a doctor falls on this grid would predict a person’s political behavior. Those high in empathy and high in self-sacrifice are more likely to be provoked to political action” (July 3, 2014, Family Practice).

This doctor talked about being an activist and how social change takes time and tenacity. Improving the human condition as a goal in medicine takes a lifetime of work. When this physician talks about self-sacrifice and a lifetime of dedication, I am reminded that vision and compassion satisfaction from this work can offset the fatigue of activism. This doctor talked enthusiastically about his work as an activist, but also discussed the invaluable experience of
meeting up with other doctors with a similar vision. Doctors with concerns about the poor seem isolated, from my observations and time with them in my research process. Helping these doctors connect with each other and with other professionals concerned about health care disparity could further nurture advocacy work on the part of doctors.

**Silent Outrage**

My understanding of human potential and how the poor fit into it comes from Abraham Maslow’s (1970) work in *Motivation and Personality*. I see a connection between Maslow’s view on human potential and Hardt and Negri’s imagining of the multitude in *Multitude: War and Democracy in the Age of Empire* (2004). Very simply, the multitude are all those “resisting the power of empire” (Browning, 2011, p. 91). The multitude is made up of skilled workers formed in the crucible of the tech-savvy global market who use their skills to push for equality. The multitude is “the global resistance movement, which is composed of a multiplicity of forces of discontent” (Browning, 2011, p. 18). These diverse forces use the skills built in the global economy to dismantle oppression. Hardt and Negri’s (2004) conception of the multitude working unannounced and in a variety of ways to bring equality relies on technology as the key to liberation. This is a utopian idea very similar to Marx’s hope in working class revolt. I must agree with Browning that the conception of the multitude does not take into account the “controls exerted by capital on the experiences of labour and social interaction under the conditions of capitalism” (Browning, 2011, p. 77). The multitude is needed, within the global market, to be creative in the information age, and this group is encouraged to use these skills of creativity as part of their work. These same skills, fostered by the market, will also be used by the multitude to lead us all to common goals against imperialism and toward justice and equality. The multitude sounds very much like Maslow’s self-actualized.
The self-actualized and the multitude seek growth, and realize that chances of continued growth are more likely when we help to create a community that nurtures growth for all. Maslow and Hardt and Negri see collaboration between the poor, working, and middle classes as essential to any major social change. Maslow and Hardt and Negri envision a better future where equality and justice become a concern for the majority of people through connection, and not through an obsession on individual productivity. Cooperation and advocacy across classes will become commonplace and necessary for global change. Although I am very skeptical of this utopian view of the future by these scholars, I still find their theories provocative. Again, to empathize, doctors have to encounter the personal stories of their patients or be in the neighborhoods and homes of their patients, to alter their understanding of poverty from an abstract one to a tangible one. A tangible understanding of poverty seems crucial to doctors thinking about large-scale solutions to poverty.

Where I tend to agree with Hardt and Negri (2004) is in the possibility of solutions fostered by the creativity required of the multitude in the global economy. Practice in creative problem-solving in the workplace could translate to successful social change (p. 91). “Through quiet resistance,” Hardt and Negri write, “the world will be transformed by the multitude in unforeseen, open and democratic ways” (p. 141). Finding what is in common across class through “creativity, love and truth will underpin alternatives to empire and capital (p. 141).” Alternatives to oppression will “come from below rather than being determined by the Party or science” (Hardt and Negri, 2004, p. 142). Those doctors who see the value in their patients’ stories and that work with their patients to reach their potential are a part of the multitude. Their blending of the art and the science of medicine is resistance. The skills that they develop working with the poor are skills that could prove helpful to solutions to larger social ills.
Presently within medical education, there is a great deal of argument surrounding the measurement of students’ competence in a variety of areas. As Huddle and Heudebert (2007) explain in their article, “Taking Apart the Art: The Risk of Anatomizing Clinical Competence,” a “physician’s feel for the territory in which the patient’s problem fits” is vital to practice and difficult to measure (p. 539). Some medical educators worry that focusing on skills that can be easily measured de-emphasizes higher levels of competence that require skills that are more difficult to measure. Many medical educators argue that proper evaluation of students must be quantitative. Other medical educators worry that quantitative measures focus only on a student’s ability to do a history and physical, or to order the right labs and imaging techniques. These same educators worry that the examples used to quantitatively measure competence are too “straightforward,” so that the student can come up with a “correct” diagnosis with some ease.

For medical educators worried about teaching the art of medicine, it is more important that the student be able to respond to uncertainty and contextual changes and these skills are not as easily measured. There might be multiple right answers. An emphasis on measurement “obscures the creative and constructive activity of the practitioner” (Huddle & Heudebert, 2007, p. 539). This creative and constructive activity is seen as the art of medicine and thus appears immeasurable. This is just one example of arguments that go on continually within medicine that debate the limitations of science. Labeling the unknown as an art begins many divides between valued knowledge (perceived as more certain), “science” and less valued knowledge (perceived as uncertain) “art,” that repeat as medical science advances. Medicine is an art because it involves uncertainty and involves interaction between people that is unpredictable and highly complex.
Medicine cannot fully escape the sociocultural influences that impact the practitioner or patients. Because of this, doctors need “a broad scope and base of knowledge” that not only comes from science and numbers, but also from experience and intuition (Malterud, 2001, p. 398). When a doctor is good at the art of medicine, it comes from experience, from encountering a variety of situations and a variety of people (Malterud, 2001). Those that defend the art of medicine consider it something that cannot be investigated or “visualized, articulated, documented or researched;” it is a part of medical practice that is very difficult to find words to describe (Malterud, 2001, p. 398). Malterud argues that only qualitative methods can get at questions around the art of medicine. This investigation is just one of many that should look more closely at what is being discussed as the art of medicine and how this art is important to just medical practice.

In the discussion about the newest technologies in medicine and the benefits of these technologies, it is important to remember that modern advances are not felt in the same way across class. The newest shifts in technology are pressing doctors to become a new kind of expert, which includes a return to the older ways of medicine. Instead of science as the answer to all health problems, there is renewed discussion about the artistry and wisdom that comes from personal experience, emotions, and the intuition of doctors. Medical education leaders are changing the tone in medicine and are considering the possibility of putting medical minds to the problem of poverty. Medicine on a macro-level that is concerned with global poverty will require doctors who are skilled at both political intervention and treatment. Doctors are gaining skills and knowledge about the poor that have not been investigated, thoroughly because the knowledge comes from the art and not the science of medicine. For those concerned with poverty, doctors will be helpful resources and partners in the fight for more equality.
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FOOTNOTES

1 There were several events honoring the 100th anniversary of the Flexner Report: The Flexner Report Centennial Symposium May 4, 2010 Louisville, KY; Ackerman Symposium on Medicine & Culture: The Flexner Centennial: A 100 years of Medical Education Reform Harvard Medical School April 15-16, 2010; Dedicated Journal to Flexner reflection, Academic Medicine (2010). February 85 (2); Joint conference between AAMC and AMA “Exploring New Horizons for Medical Education” Sept 20-22 Washington D. C.

2 Simon Flexner worked for a pharmacist for many years and saved money to go to a proprietary medical school. During this time a person could go to medical school without a high school diploma. Simon became a well-known physician by working for a university medical school – he was a talented chemist and helped to make several minor medical discoveries. Michael Nevins (2010) points out that Simon would have never become a doctor after his brother’s reforms were put in place.

3 The AMA and the AAMC had a joint conference in 2010 rethinking the impact of the Flexner Report. This conference led to a dedicated edition of Academic Medicine dedicated to rethinking reforms in medical education. Harvard and the medical systems in Louisville, Kentucky also had conferences on the subject. Jewish Hospital and University of Louisville School of Medicine. (2010). The Flexner Report Centennial Symposium: Transcripts. Louisville: Jewish Hospital and University of Louisville School of Medicine.

4 Andrew Carnegie’s philosophy can also be seen in Flexner’s views. Andrew Carnegie wrote about the social obligations of wealth in two published essays: “Wealth” and “The Best Fields for Philanthropy.” Carnegie rationalized the need for wealth but at the same time hoped to “strengthening the ties of brotherhood that they may still bind together the rich and poor in harmonious relationship (Wheatley, 1988, p. 21).” Carnegie urged the wealthy men of his time to consider the importance of using their wealth to benefit the larger community. The U. S. was also the home of the new rich, those not from royalty but from hard work. Figures like Andrew Carnegie that had come from modest means explained that wealth was ideal because the wealthy would improve the world for the rich and in turn this would improve life for all (Painter, p. 94).

5 When looking at the AAMC annual meetings, women doctors are mentioned frequently with respect and the female members often contributed feedback to the conversations about
education reform. Women physicians were also published in JAMA. There was a presence of women physicians in medical education and in medical work with the poor.

6 Dewey and Flexner both graduated from Johns Hopkins.

7 In the book *The Problem of Medical Knowledge*, David Armstrong in his essay “The Doctor-Patient Relationship: 1930-1980” reviews British medical journals from this time period and there is no mention of patients and patient experience in the 1920s. JAMA did have many mentions of patient experience during the Progressive Era, so this lack of patient acknowledgement had not yet become standard, although was becoming normal within discussions between medical educators at the time. This jump to patient as object seemed to be adopted much more readily within the medical education ranks.

8 Jewson and Foucault are writing about England and France and these countries moved to hospital medicine sooner. In the U. S. hospitals were strictly for the poor leading up to the Flexner reforms. Hospital doctors in France and England were held in high esteem, while American doctors in hospitals were much lower in status. The well-respected doctors in America served the wealthy in private practice and did charity work on the side. Grave robbing in poor neighborhoods was a common way to supply medical schools with bodies.

9 Poor hospitals also gave rise to various factions of social services to the poor in the Progressive Era like settlement houses and charitable organizations.

10 American doctors like Benjamin Rush also approached medicine as a science. The technologies available to doctors were limited. Doctors believed that the body was made up of humors that when not balanced would cause illness. They believed this from scientific deduction and aggressive treatments like bleeding and purging. Flexner was hardly the first talk of science in medicine.
APPENDIX A:

Experience of Medical Education and Poverty: An Analysis of Physician Oral Histories
Heather Sloane

There are many things that led me to this topic: one was my experience here at Carle as a part of my responsibilities on the bioethics committee I had the opportunity to talk with medical students on several occasions in their medicine and society class. They seemed very interested in my experiences with poor patients and spoke openly about not feeling prepared for working with the poor.

I am in the inductive part of my research – asking doctors to talk about their experience and thoughts on this topic to see if there are themes and commonalities across interviews.

As discussed in the consent, your name will not be included in my writing and your information will be protected with no identifying information. Your participation is voluntary.

1. Where did you receive your medical education (medical school/internship/residency)? When did you get your medical education and what was going on at the time that was important to you and your classmates/fellow interns/fellow residents?

2. Why did you go to medical school? What led you to medicine? What did it mean to your family that you became a doctor? How did you choose what area of medicine you wanted to practice?

3. What was positive about your medical education? What is your fondest memory of your medical education? What was most valuable about your medical education? How has medical education changed for the better, if at all? How did your experience in medical school/internship residency prepare you for your current practice?

4. What were the negative of your medical education? What was the biggest conflict for you in your medical education/internship and residency? What did your medical education not prepare you for that is important to your everyday medical practice? What reforms would you like to see in medical education? What trends in medical education do you find upsetting?

5. How do you define/understand poverty? Who is poor to you and how do you think your views on poverty compare to the general public’s views on poverty?

6. What was your exposure to poverty and illness prior to medical school?

7. Can you describe your work with the poor during your medical education?
8. Do you feel your medical education prepared you for working with the poor? In what ways?

9. How much of your current practice involves impoverished clients? What is this experience like?

10. Does poverty contribute to illness? In what ways?

11. What is the relationship between medicine and poverty? Do you think this is how most doctors feel - how do other’s feel differently?

12. Do you feel there is an ethical obligation to the poor that is unique to medicine? If yes, in what way? Do you think your perspective is similar to most doctors? How do others feel?

13. Who do you consider an excellent doctor and why? Do you have any suggestions of doctors that might be interested in being interviewed for this project?
Thank you for your submission of Revision materials for this project. The Bowling Green State University Human Subjects Review Board has APPROVED your submission. This approval is based on an appropriate risk/benefit ratio and a project design wherein the risks have been minimized. All research must be conducted in accordance with this approved submission.

The final approved version of the consent document(s) is available as a published Board Document in the Review Details page. You must use the approved version of the consent document when obtaining consent from participants. Informed consent must continue throughout the project via a dialogue between the researcher and research participant. Federal regulations require that each participant receives a copy of the consent document.

Please note that you are responsible to conduct the study as approved by the HSRB. If you seek to make any changes in your project activities or procedures, those modifications must be approved by this committee prior to initiation. Please use the modification request form for this procedure.

You have been approved to enroll 20 participants. If you wish to enroll additional participants you must seek approval from the HSRB.

All UNANTICIPATED PROBLEMS involving risks to subjects or others and SERIOUS and UNEXPECTED adverse events must be reported promptly to this office. All NON-COMPLIANCE issues or COMPLAINTS regarding this project must also be reported promptly to this office.

This approval expires on December 16, 2014. You will receive a continuing review notice before your project expires. If you wish to continue your work after the expiration date, your documentation for continuing review must be received with sufficient time for review and continued approval before the expiration date.

Good luck with your work. If you have any questions, please contact the Office of Research Compliance at 419-372-7716 or hsr@bgsu.edu. Please include your project title and reference number in all correspondence regarding this project.
This letter has been electronically signed in accordance with all applicable regulations, and a copy is retained within Bowling Green State University Human Subjects Review Board's records.