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Images of Experience: Decolonizing Medicine

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IMAGES OF EXPERIENCE: DECOLONIZING MEDICINE

by

COLLEEN HILL PATTON

(Under the Direction of Daniel Chapman)

ABSTRACT

The experiences of illness and trauma are vivid examples of a discontinuity that separates us from those that surround us. In seeking treatment, we enter a very foreign culture, regardless of how long or of how serious our injury or illness. We are disconnected from our personal and private lives and are placed within a cultural group bearing a separate set of beliefs and practices. Practitioners of medicine make up a distinct culture. This culture is formed as a site of discontinuity in a large part through the experiences of medical education from that of the experiences of the one we call patient.

The dissertation explores the current practice and institutions of American medicine and its education through the theoretical frameworks of Critical Theory, Critical Humanism, and Postcolonialism. I investigate the historical developments of the initial identity of the patient, as well as the development of the hospital as a site of patient segregation and care, coupled with the development of the institutions of medical education. Through a critical and visual narrative of my own experiences within the settings, I compare the exploration and treatment of the patient to one who is geographically colonized as those described by Edward Said in his work, *Orientalism*. As the European colonialists defined, named, and studied the Oriental, American

medicine and its education can be seen to enact very similar impacts and actions on the ill and vulnerable in our country.

INDEX WORDS: Medicine, Doctor, Institution, Physician assistant, Professionalism, Colonialism, Imperialism, Postcolonialism, Health, Narrative

IMAGES OF EXPERIENCE: DECOLONIZING MEDICINE

by

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IMAGES OF EXPERIENCE: DECOLONIZING MEDICINE

by

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Electronic Version Approved:
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DEDICATION

This dissertation is dedicated to Dr. Jerry R. Hill and Dr. Herman R. Eggers. My father and grandfather were men who shared with me a love of family and of education.

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CHAPTER 1

INTRODUCTION

Images of Experience: Decolonizing Medicine



A student told me that she had seen a young 4-month-old infant who was brought to the Emergency department by her parents. The infant was having seizures that were severe and apparently unrelated to fever or obvious disease. Laboratory results revealed a severely low sodium level in the blood stream—something very unusual for an infant in this country. The family was Hispanic and the mother reported that she had been forced to dilute the baby’s formula with water due to the costs of the formula. Thus, the child had become water-intoxicated and the sodium level dropped to such a low level that it led to the seizures.

The child was treated, the mother counseled, and the family later returned home after the child was discharged. Upon entering the emergency department, the child became a patient with seizures and the mother was the cause and at fault due to the inappropriate formula preparation. Their lives, their struggles, their apparent poverty never came into the institution. And upon their leaving, medicine and its intervention stopped at the Emergency Department door.



For a moment, imagine this mother in the Emergency department. She knew her child was very sick and she turned to the only place available to her for help. Once she entered with her child, the baby is immediately taken to a gurney, an IV is initiated, blood is drawn for laboratory studies, and medication is given in an attempt to stop the seizures.

Meanwhile, the mother is first interviewed by the nurses, followed by the hospital administrative staff, who question her regarding her “pertinent” information—name, address, date of birth, social security numbers for her and her child, as well as her insurance information. This is assuming she has insurance or a social security number. Imagine that this mother spoke little or no English. Possibly, there is an interpreter available, or perhaps someone attempts to call one in to assist her with communication. This inability to communicate, or possibly to understand what is being told to her, creates an insurmountable feeling of loss of control.

This mother knows instinctively that her child is very ill. During these periods of questioning, she is isolated from her baby—unable to see the care or treatment being provided. Later, she is brought into the treatment area. A physician or physician assistant interviews her with specific questions regarding the onset of the seizures, any past medical problems, and possible problems during the child’s delivery, with nutrition, and so on. It is at this point that it becomes apparent that there may be an issue with the formula preparation. The laboratory results return and reveal the low sodium level, prompting the discussion and questioning to resume regarding the mother’s formula preparation. The mother now realizes that the questions revolve around her, her care, and her feeding of the infant. She has done nothing more than attempt to make the can of powdered formula last as long as possible—to fill as many bottles as it could due to her poverty.

In this country, we seek help from a physician when we are ill—when our own attempts at self-care are unsuccessful. Entering the institutions and settings of medicine, we seek relief from our pain, distress, or injury. In this experience described above, the

young mother and child received medical care and the seizures stopped. The mother received counseling regarding the appropriate method of formula preparation. The seizures were due to her failure to follow directions. No effort was made to assist her in alleviating the poverty that had brought on the necessity to dilute the formula. At no time did anyone ask her what she might need in order to prevent this from happening again. At no time did the institution feel an obligation to offer anything more than identification and treatment of the low sodium level and seizures. No referral to assistance in any form was given beyond the treatment for the seizures. At best, the mother is given some coupons or samples of formula, which have been provided to the hospital by a formula company sales representative in return for a large sales contract to supply formula to the hospital nursery.

The experiences of this young mother—her struggles with poverty and the malnutrition of her infant—unfortunately are far from rare. There is an inescapable bond between the experiences of poverty and illness in this country. This experience is much, much more than that of this young infant and her mother’s struggles with poverty and desperation.

It is also the shared experience of a young student of medicine in physician assistant studies. She is a 24-year-old female who is currently on her clinical rotations in emergency medicine. She is just beginning what will be a year of learning and changing, which is expected as she begins to assume her place within the profession of medicine. She has anticipated anxiously and prepared for what she and her cohort now are face-to-face with—the patient. She is witness to this scene, but also privy to the conversations that take place at the bedside and behind the desk among the physician, the nursing staff,

respiratory therapy, and a host of other personnel that make up an Emergency department. This is the site and aspect of medicine that offers this student and others the opportunity for hands-on patient care and treatment.

Added to that is the experience of the teacher who listened to the recounting of the experience. How am I, this teacher, to teach through this experience? How often do you suppose the questions and discussions of this case focus on the mother and her lack of knowledge or awareness of the consequences of the diluted formula? How often do you suppose the questions touch on the root of the problem—the poverty? What are the realities or possibilities that I have to offer this student? This and many other experiences, like it take place daily in countless hospitals, academic teaching centers, and clinical settings.

I am the teacher in the experience above. For over 25 years of my adult life, I have been a student of, practitioner of, and educator of the practice of which we speak in the word medicine. In reading this work, there are very likely to be a multiplicity of interpretations or definitions of the word medicine. And so, I offer here a clarification of sorts, of my use of the word medicine as a major focus of this study.

If we mean simply the act of treating symptoms and injuries with methods or measures available to us, medicine as a practice of treatment dates to the dawn of man. This simply stated aspect of medicine is just that, a singular aspect of the whole that is medicine. Hippocrates is considered by most to be the father of medicine by virtue of his teaching of diseases and classifications of symptoms. The writings of Hippocrates and his successor Galen, among other Greek philosophers translated by John Coxe (1846), provide us with the following definition of medicine;

Its division is into five parts, viz.: 1. The contemplation or consideration of natural things, constituting physiology. 2. A consideration of the affections, and of a knowledge of their causes, giving rise to pathology and etiology. 3. The rationale of preserving health, or hygiene. 4. Of the observance of signs or symptoms, or semeiotics. 5. Of the mode of cure, of therapeutics. (p. 487)

In many ways, this historic definition of medicine is very accurate and is a reality of the practice of medical care today. Yet, here is another definition of medicine, or perhaps more precisely, aspects of the practice of medicine that may better describe it for my purposes:

On the one hand, medicine is defined by the social mission it is given, based on a collective movement of solidarity with other members of human society who are weakened and vulnerable by the ordeal of illness. We could call this a proof of sociality. But, on the other hand, medicine has received a mission that the person who is suffering gives to those who will care for him, and within the framework of this dialogue between a premise of trust, and unconditional care, the continuous refounding of the human social instinct is at stake. From this point of view, we could say that medicine is the activity where two human beings are placed in a situation in which they institute social behavior that makes them part of humanity. (Cadoré, 2000, p. 177)

Cadoré's statement reveals the power of trust which many would see as a foundation of the relationship between the healthcare provider and the one who is ill. The premise is one in which the role and relationship between the patient and the

provider in medicine is one of giving or submitting to one we trust while in a weakened and/or vulnerable state.

Societies of all types and in all places incorporate various roles through which tasks of daily life are completed, such as food gathering, childcare and rearing, and education. Throughout history, we see these same societies develop what sociologists term *institutions*. Rose Weitz, in her text, *The Sociology of Health, Illness, and Health Care*, tells us that the term institution describes “enduring social structures that meet basic human needs, such as the family, religion, and education” (Weitz, 2010, p. 115). When we think of medicine as an institution, we view it initially as one which society has developed to meet the basic human need for good health.

In their historical and modern existences, institutions encompass much more than a mere meeting of human needs. Poststructuralist author and historian, Michael Foucault, provides us with a vivid description of the link between power and institution in an interview with J.-J. Brocheir, as he stated:

But in thinking of the mechanisms of power, I am thinking rather of its capillary form of existence, the point where power reaches into the very grain of individuals, touches their bodies and inserts itself into their actions and attitudes, their discourses, learning processes and everyday lives....It was the instituting of this new local, capillary form of power which impelled society to eliminate certain elements such as the court and the king. The mythology of the sovereign was no longer possible once a certain kind of power was being exercised within the social body. (Foucault, 1980)

Power is now located within more modern institutions, as opposed to monarchies or sovereignties of old. It may be argued that monarchies and governments are institutions in modern form, but, what Foucault describes here, is that the basis of power is in the development of institutions, such as prisons, and for this study, hospitals.

Foucault in his text, *“The Archaeology of Knowledge & the Discourse on Language”* describes for us the institution of medicine as follows: “an institution possessing its own rules, as a group of individuals constituting the medical profession, as a body of knowledge and practice, as an authority recognized by public opinion” (Foucault, 1972, p. 41-42). Foucault describes a cyclical link between knowledge and power. His writings tell us of knowledge providing the power of institutions and regimes which in turn provide a more specialized form of knowledge entailing a higher level of power. This knowledge is seen as a form of truth which is maintained by the power of those who control the knowledge.

Within this institution, society has developed roles, such as the roles of a doctor, nurse, or patient. In occupying these roles, there are associated role expectations. Theresa El-Mehairy (1984) describes the relationship of institution and roles in medicine as:

The ways in which people who occupy these roles and are expected to act are referred to as role expectations. These expectations associated with medical roles pattern the behavior of both healers and the sick in predictable ways. The institution of medicine is the totality of roles and role-expectations related to health and illness, and includes a large number of collectivities which are systems of ‘concretely interactive specific roles’. (p. 53)

The roles within medicine as an institution, the interaction between those who occupy these roles, and the issues of how these interactions occur are a significant focus of this study. It is the encompassing of all of these roles and their expectations, as they relate to health care and illness, which form the institution of medicine. (Waitzkin & Waterman, 1974, p. 8)

Twenty-five years ago, I began my experiences with the larger institution of medicine in the role of Registered Nurse at a very small rural hospital in Appalachia. In this primary experience as a nurse, my role in medicine was focused intensely upon the human activity that Cadore described above, one in which I provided care for patients who were vulnerable and in pain. My nursing practice extended over 14 years, with practice settings ranging from rural emergency rooms, to large military medical centers, and then into rural home health nursing in Alabama.

The majority of my nursing experience was in emergency department settings where I was exposed to the role of a Physician Assistant, or PA. By definition, a physician assistant is someone who practices medicine under the supervision of a physician. As such, this practitioner is one who evaluates a patient, orders and interprets laboratory and radiological studies, participates in surgical settings, prescribes medications or treatments, and provides acute and chronic care to patients in all types of settings. Ten years ago, I made the decision to return to school and became a PA. I have practiced within this role in large metropolitan areas in family medicine, and in rural and metropolitan areas in my current specialty area of hematology/oncology.

Five years ago, my career underwent yet another transition, from that of practitioner to educator. As I began my teaching career as an assistant professor in

Physician Assistant education, I adopted yet another role. With that role, I began to see medicine through a new lens that added yet another dimension, namely a deeper understanding of how role expectations, and medicine as an institution, impact the role of the one we call patient. This is the institution of medicine into which the mother and child above entered seeking care.

When I became one of the professors in front of the students I saw the power of the educational setting and impact and direct relationship between the language and discourse of the classroom and the knowledge gained of the patient. I began to question its influence on my own image of the patient.

A much deeper understanding of curriculum became a focus of my life as I entered the Curriculum Studies doctoral program at Georgia Southern University. William Pinar in his text, "*What is Curriculum Theory?*" offers us the term *currere* as the Latin root of the word curriculum. Pinar explains, "Stated simply, *currere* seeks to understand the contribution academic studies makes to one's understanding of his or her life (and vice versa), and how both are imbricated in society, politics, and culture" (Pinar, 2004, p. 36). It is through *currere* and not a more simplistic view of curriculum that we are able to study and develop understandings of the relationship and between knowledge of ourselves and the world we inhabit. It enables us to study and grow in our understanding of the threads which weave a complicated pattern between the experience of the classroom and that of the cultures and history of the world in which it exists. Within this type of curriculum we can begin to have what Pinar calls the "construction of a public sphere, a public sphere not yet born, a future that cannot be discerned in, or even though from, the present" (Pinar, 2004, p. 37-38).

I was now teaching the language of medicine and its rituals and questioned not only the genesis of its power, but the experience of this power at the bedside. I found myself drawn to self-reflexivity and a budding realization of what Megan Boler described as “recognition of the ways in which the ‘social’ defines the ‘interior’ realm of experience” (Boler, 1999, p. 142). I reflected back to many of my own patient care experiences and settings. I began to question just how the social, cultural, and political forces had combined to form the institution and profession of medicine.

Upon entering the world of education, I became charged with teaching my students about their chosen profession. An aspect of the institution and roles of medicine is that of medicine as a profession. This term *profession* and that of *professionalism* offer us a broad view of the link between the institution of medicine and the institutions of medical education, including universities. This link is then a part of a chain, so to speak, that binds it to the roles therein and to those who learn and then practice medicine within the institution. Wider expansion of this chain brings us to the legal and judicial links between the institutions and the governance components, which entail both practice and educational issues, such as accreditation.

Author Samuel Weber (2001) provides us with a stirring description of a professional in his text, *Institution and Interpretation*, as he writes:

A professional was—and is—a specialist who lives from his work. He has undergone a lengthy period of training in a recognized institution (professional school), which certifies him as being competent in a specialized are; such competence derives from his mastery of a particular discipline, an esoteric body of useful knowledge involving systematic theory and resting on general

principles. Finally, the professional is felt to “render a service” rather than providing on ordinary commodity, and it is a service that he alone, qua professional, can supply. (p. 25)

The professions of medicine, law, and religion represent familiar representations of the description Weber provides above. Each member of these various professions combines the characteristics of service and authority gained from knowledge of their fields. Society at large rarely questions this authority and in fact places a great deal of trust and faith in those who practice these professions.

The experiences I provide here come from each aspect of the institution and profession of medicine that Weber and Foucault describe above. It is a questioning of this institution and profession, and its status of authority, to extend the impact of its practice upon those who are suffering. These experiences are reality for those within, and their experiences are a form of truth that I seek to explore. Cornell West spoke of this when he wrote, “the condition of truth...must be in tune with those who are undergoing social misery—socially induced forms of suffering” (West, 1998, p. 568). I see the truth of many experiences coming from within both the institution and the practice of medicine as a socially induced type of suffering. This is a key aspect I want to examine in this study. It is my opinion that the truth of the mother’s experience in the narrative above is very distant from the type of truth that defines conditions of health and illness within the institution of medicine. Her poverty is a form of socially induced suffering exhibited in her child’s condition. There is no definition or diagnosis of poverty-induced seizure disorder. This aspect of the child’s condition is beyond medicine’s definition of her illness.

Medicine is an institution of social control. Through the increasing use of medicalization of what have always been personal and private issues such as alcohol use and balding we now have the diseases of alcoholism and male pattern baldness. Physicians and the institution of medicine decide who is ill, what behaviors are normal, which require pharmaceutical intervention, and as we will see in the coming chapters and experiences of the patients Sarah—who is sent back out into society and Michael—who is hidden away. Weitz (2010) defines this type of social control as she writes:

When we say that medicine is an institution of social control, we are saying that medicine is a basic structure of our society that, sometimes, serves to “keep people in line” with our society’s expectations for them....Doctors act as social control agents: individuals or groups that enforce social norms, such as parents, religious leaders, and police. (p. 115)

This provides a foundation for a myriad of interpretations and aspects of the word and practice of medicine. I hope to guide the reader as I transition between these interpretations while using the terminology of the institution, practice, professionalism, and roles.

There are basic facts or realities of human existence which hold that we are all born, and that we will all experience some type of ill health, from childhood diseases to a loss of limb. Yet in America today, there exists no guarantee of a right to receive care for your illness or suffering. These issues go beyond the current practices of our Western healthcare. They are those in which individual experiences appear forcibly silenced and shut out as the patient enters the door of, or is contained within the walls of, the healthcare environment. The experience of that young mother and infant illustrate the

site of the lived experience of the ill, and medicine's blindness to the language, lived experiences, and realities of those people who our society pushes to their limits.

The experiences I have seen and have participated in reveal the many serious limitations of medicine. They are not only limitations in practice, but also limitations in medicine's focus and teachings. The context of the child's condition above and her disease are often nullified in the scientific presentation of the lectures and textbooks in medical education settings. This child's health was endangered by more than the seizure disorder that resulted from the dilution of the formula. Should the practice of medicine seek or make efforts to treat the poverty that forced the dilution as well?

Each of us, including the young infant we met in the narrative above, is born with a body that is unique. It is the house of our being, personality, and intelligence. Life is given to us, and whether through genetic alterations or through traumatic physical transformations, our bodies will change, experience illness, decay, and die.



Figure 1. Image of Birth (McCormick, 2005)

Experiences of birth followed by aging, illness, trauma, and death have been a part of human life on Earth since the beginning of our existence. Birth and death are both natural and expected events. Historically, both ends of the spectrum of life have been

experienced in and through the locus of a cultural community, regardless of the makeup of that community and culture—be it tribal, communal, or familial as in our western society.

To be born, to be ill, to experience illness, injury, trauma, disability, and death—these are words and discourse that we use to describe some of the most serious forms of our experience as human beings. These human experiences, regardless of culture, nationality, or language, become a part of our journey here on Earth. No matter how expected and natural they may be, the human experience of illness and trauma carry with them the full meaning of experience, as the German philosopher, Martin Heidegger (1971), describes below:

To undergo an experience with something, be it a thing, a person, or a god, means that this something befalls us, strikes us, comes over us, overwhelms us, and transforms us. When we talk of ‘undergoing’ an experience we mean specifically that the experience is not of our making. To undergo here means that we endure it, suffer it, receive it as it strikes us, and submit to it. (p. 57)

Experiences leave their imprint on our conscious and unconscious. Human beings develop memories and dreams, which are created by these experiences. The more profound the experience is, the deeper the imprint. Educational philosopher, John Dewey, added Alfred Lord Tennyson’s poetry to describe how these experiences weave together, as he wrote:

Every experience both takes up something from those that have gone before and modifies in some way the quality of those which came after. As the poet states it, ‘all experience is an arch wherethro’

Glens that untraveled world, whose margin fades

For ever and for ever when I move'

(Tennyson, 1903, a cited in Dewey, 1938, p. 35)

This weaving of experiences from past to present takes on a great significance when we think of those of illness and trauma. Though we may recover, we are forever changed by our experiences. We are changed by our own emotional and intellectual responses to these experiences, but also by our conscious and unconscious response to the other human beings around us. In this country, those who experience illness and physical disability are human beings from all walks of life—rich and poor, all races, and all ages. It is through these experiences that they travel to the foreign land of the hospital. It is not a journey of our own making. In truth, we each bring with us those experiences and truths that have gone before.

This weaving of experiences is what some sociologists and anthropologists consider to be the definition of culture. As Clifford Geertz (1973) writes, "Believing...that man is an animal suspended in webs of significance he himself has spun, I take culture to be those webs (p. 4). The strands of the webs that make up the world of illness make a culture of its own. As patients, the culture of medicine is one that we enter with a uniquely encoded set of behaviors, language, and expectations.

The anthropologist, Claude Lévi Strauss (1962) wrote:

What is called a 'culture' is a fragment of humanity which ...Presents significant discontinuities in relation to the rest of humanity...Accordingly, the same set of individuals may be considered to be parts of many different cultural contexts: universal, continental, national, regional, local, etc., as well as familial,

occupational, religious, political, etc. This is true as a limit; however, anthropologists usually reserve the term ‘culture’ to designate a group of discontinuities which is significant on several of these levels at the same time. (pp. 295-296)

The experiences of illness and trauma are vivid examples of a discontinuity that separates us from those that surround us. At once, we enter a very different culture, regardless of how long or serious our injury or illness. We are disconnected from our personal and private life and placed within a cultural group with beliefs and practices of its own. Practitioners of medicine form a distinct culture, which is formed as a site of discontinuity that I believe begins through the experiences of medical education.

It is not simply an emotional outcry or form of protest that I want to place into the void. I bring to this work a very deep and varied level of personal experience. The most recent of these have been in reading and studying of curriculum theory. Though I must confess I was not fully prepared for the complete unmooring that Dr. Marla Morris promised me this experience would be, I have completely embraced it and the changes it has brought to my perceptions.

Why do I write so critically of a profession of which I have long been a member? Why do I see medicine as an oppressor, as an institution of colonialism? The answer goes to the very core of my being. Physician and author, Rafael Campo, offers an eloquent example of this answer, when he wrote:

Pour in all the emotions of knowing intuitively that the way medicine is now taught and practiced is simply *wrong*, that the humane is being supplanted by the unfeeling science and uncaring economics—the incalculable distress I feel when I

hear an intern refer to her patient as “the breast cancer in room 718,” the ephemeral sadness in cutting short a visit before we can delve into my patient’s grief at the loss of her husband because I have three others waiting. (There) ... clamors the need to articulate rationally, in language not only my physician colleagues but also the likes of health administrators and policy makers can understand. (Campo, 2005, p. 1009)

I am searching for understanding as to why and how the practice and settings of medicine have evolved into such an empire, so to speak. But the impetus goes beyond this. I am seeking possibilities for change, for a realization of the seriousness of the impact medicine has upon each patient that enters. Is it social justice that I seek, or a non-violent apartheid or emancipatory process that will bring about this change? Or perhaps I may only take the bits of my life and experiences and now add my experiences of curriculum studies and attempt to understand why our practice of medicine is, as Campo put it, simply wrong. The research question at the heart of this work begins here—is medicine as we practice it a form of colonization—and if so, is change possible?

This work is a very critical exploration, as I truly believe as Campo describes above that our current practice of medicine in this country is very simply wrong. (Campo, 2005) However, I do not intend this critique of medicine to imply that there are not many men and women, physicians, nurses, and others within this institution and culture that do anything less than strive and wish to provide true care and outreach to those they encounter.

Physicians, Physician Assistants, Nurse Practitioners, and Nurses among countless other healthcare providers in this country devote time in free clinics and

traditional medical missions because they feel compelled in some way to reach out to those who need care most acutely. Others within this world seek to fight often unseen battles against poverty and disease in very individual ways. I see the realities behind this *need* as just one ramification of the ever growing divide between the culture of medicine with its “cultural penchant for reducing information to ‘bottom lines’” (Hafferty, 1998, p. 406) and the world in which the patient exists. It is in so many ways the experience of the illness and trauma which is now reduced as sociologist Frederick Hafferty tells us to a bottom line item.

What are the impacts and implications of the growing divide between the cultural worlds and experiences of the sick and that of the world of medicine? How is this divide manifested at the bedside or examination tables in countless hospitals and clinics across the United States? It is not enough to question the divide—what is needed is a study of the two worlds and the structures and institutions that seemingly buffet the lived experiences of those within them.

In this dissertation, I seek to explore the experience and culture of the institution, practice, and education of medicine. Each chapter will begin with a narrative of an experience of my own personal history within medicine. To me, these narratives bring my dissertation to life. As Michael Connelly and Jean Clandinin (1991) wrote, “The central task is evident when it is grasped that a person is both living their stories in an ongoing experiential text and telling their stories in words as they reflect upon life and explain themselves to others” (p. 128). I am in each of these stories, as nurse, as physician assistant, or as an educator. In the retelling of the stories, it is as Connelly and

Clandinin (1991) stated, I am “at once, then, engaged in living, telling, retelling, and reliving stories” (p. 128), or maybe yet, bringing that moment to life again.

In Chapter 2, I describe the theoretical frameworks and methodology that I draw upon in my study of the institutions and practice of medicine. I begin this chapter with the narrative of an elderly man, called Michael, whom I met in the nursing home. The story of my encounter and his experiences provide a view of the world of the disabled and elderly within the setting of one type of medical institution—the nursing home. Through this experience, I will offer glimpses into the historical developments of the theoretical frameworks of Critical theory, Critical Humanism and Postcolonialism. From the history to quotes from works of authors in each field, I hope to share how and why I chose these frameworks and how they in-turn informed my study.

In each of the following chapters I will offer historical background of the settings according to their focus. This will be followed by a more in-depth look at the setting and language of each area of study. These areas are the experiences of the patient and of medical education.

Again, in Chapter 3, I will begin with the narrative of a patient encounter. The story of Sarah offers us a look at the world of the hospitalized patient. In this chapter, I will investigate the historical developments of the initial identity of the patient. Additionally, I will convey the development of the hospital as a site of patient segregation and care, coupled with the development of the institutions of medicine. Through a critical and visual narrative of my own experiences, I will then compare the exploration and treatment of the patient to one who is geographically colonized, just as those of the Oriental, described by noted author, Edward Said, in his work, *Orientalism*.

As the European colonialists defined, named, and studied the Oriental, American medicine and its education can be seen to enact a very similar impact on the ill and vulnerable in our country.

In chapter 4, I begin with one of several mini-narratives of a multitude of experiences I have had within the world of medical education. Narratives of experiences with students, faculty, physicians, and educational bodies will be woven throughout this chapter. I will again study the historical development of medical education as it traveled from Europe to America and the continuing influence of that history. This will be followed by an investigation of the current settings and language of medical education and how it is linked to the issues of other curriculum theorists, such as the hidden curriculum.

My dissertation concludes with Chapter 5, which begins with the story of Diane. Her story and impact on my life occurred within an outpatient oncology clinical setting. Again, we will examine the setting of the clinic, but also the setting of her lived experience outside the clinic and the seeming inability of one setting to bridge to the other.

Each chapter and section will contain images, whether they are drawings, pictures, photographs, or video screen shots obtained from a variety of Internet sources. Each feels at home within the language of the narrative, as another dimension of the story is shared. Each brings an added dimension of reality to this work. The decision to incorporate images was made to add additional views or lenses to the critique of medicine, which is the main focus of this work. It brings into the discussion the power of

the images that medicine employs, as visual and cultural studies author, Lisa Cartwright (1995) writes:

The progress of Western scientific medicine, then, is bound up in the compounding of the physiological systems studied in a complex technological apparatus through which “experiments of destruction” are conducted. One can no longer speak of bodies or objects of knowledge without acknowledging the in-built technologies through which their health and life are regulated and disciplined. (p. 28)

I hope that the images chosen for my work add to the postcolonial and critical nature of medicine’s scientific image of the ill. I view the capacity, the ability to regulate, and the discipline of the lives of the ill and disabled as a system of colonization.

Medicine as Colonizer

American medical settings have their own language and rituals, just as those of other countries and continents. But those who travel to these settings and places do not do so willingly. They are here due to the experiences of pain and illness. As I described earlier, it is a vivid experience of the discontinuity between cultures. Exploring medicine as a system of colonialism and imperialism requires explanation before proceeding.

In this work, imperialism goes beyond the historical definition. Historically, imperialism is the expansion of economic and agricultural markets, as well as expansions of territories, by one culture or government over another. By this definition, colonialism was one aspect of imperialism that describes the political and economic subjugation and control of the indigenous cultures and peoples.

The concepts and terms of colonialism and imperialism are interconnected in many ways. Definitions of each term vary according to the experiences that they are describing. The postcolonial author, Linda Tuhiwai Smith, explores this connection and variety of meanings in her text, *Decolonizing Methodologies*. Smith's description of colonialism embodies the basis of my exploration of medicine. She writes that:

Imperialism and colonialism have been based either on their membership of and experience within colonized societies, or on their interest in understanding imperialism from the perspective of local contexts.... There is, for example, a greater and more immediate need to understand the complex ways in which people were brought within the imperial system, because its impact is still being felt, despite the apparent independence gained by former colonial territories. The reach of imperialism into 'our heads' challenges those who belong to the colonized communities to understand how this occurred, partly because we perceive a need to decolonize our minds, to recover ourselves, to claim a space in which to develop a sense of authentic humanity. (Smith, 1999, p. 23)

The impact of this study goes beyond the walls of the institutions of the practice and education of medicine. "What I want to examine is how the processes of imperialism occurred beyond the level of economic laws and political decisions, and –by predisposition, by the authority of recognizable cultural formations, by continuing consolidation within education, literature" (Said, 1994, p. 12). In many ways, the processes of medicine can be viewed as these of imperialism. They have formed "recognizable cultural formations" (Said, 1994), which I believe are continued and maintained through medical education and literature.

Ill, injured, or disabled human beings as geographical areas conquered is not meant literally; they are forced to accede to a new identity and position within the culture of the medical institution. Postcolonial author, Gayatri Chakravorty Spivak (1994), describes this process as one in which patients' "sacred geography thus becomes an interior landscape" (p. 130). Spivak speaks on the impact of colonialism on native cultures and literature. She describes the translation of Hindu religious stories and teachings and the loss of the literal meaning of the work. This occurs to patients as well. Upon our entering the clinic or hospital, we are placed, named, and objectified through the cultural practices and language of the practitioner and institution. Our individual literal meaning is equally lost in translation.

This medicalization is "imperialism without colonies" (McClintok, 1995, p. 258). The point being that colonialism does not require a land acquisition or border crossing. The institutions of medicine have amassed true colonial vestiges of power, including capital, media, governmental, and legal powers. In this country, these powers truly prevent its citizens—the ill and injured from what ought to be a basic human right—the right to healthcare.

Edward Said (1979) revealed to us in *Orientalism*,

The Oriental is depicted as something one judges (as in a court of law), something one studies and depicts (as in curriculum,), something one disciplines (as in a school or prison), something one illustrates (as in a zoological manual). The point is that in each of these cases, the Oriental is contained and represented by dominating frameworks. (p. 40)

If we take the word Oriental and replace it with the word patient, this quotation still rings with truth and implications that we need to address, critique and investigate for the possibilities of change. Said (1979) also described the patient as also a “body of knowledge” (p. 43). *Human being* no longer represents the term used in medical teachings and practice. It has become, and remains today, an *object* to be judged, studied, and illustrated within a context not of its own making.

Medicine has a very long and intricate relationship with imperialism and colonialism historically.

Medicine was a part of the ideology as well as the accountability of empire. D. Schoute once argued that when the British occupied the Dutch East Indies early in the nineteenth century they replaced the Dutch company’s narrowly ‘commercial’ medical outlook (aimed solely at keeping its European employees alive) with an ‘idealist’ vision of medicine in the service of the entire population, Indonesian and European alike. Even before the scientific breakthroughs of the late nineteenth century, imperial powers were beginning to use medicine as a demonstration of their benevolent and paternalistic intentions, as a way of winning support from a newly subject population, of balancing out the coercive features of colonial rule, and of establishing a wider imperial hegemony than could be derived from conquest alone. (Arnold, 1988, p. 16)

Over time, medicine acquired an imperialism of its own. Today, Western medicine continues to dominate and colonize not only the patients within America, but within other regions and countries, in order to explore new therapies at the risk of those deemed less than us. It is true that we utilize the poorest in other countries to perform

research for medications. Our country continues beyond the times of European colonialism to use medicine and healthcare as a method of “medical counterinsurgency operations” (Levy, 1978, p. 298). Providing care to our enemies who are wounded or captured is often methods of intelligence gathering. Yet I believe that American medicine, as an institution practiced at home, is a form of colonialism, even to those of us who reside within this country’s boundaries.

I offer this quote by James Paul (1978):

Medicine has from the beginning functioned in the service of imperialism, supporting logically the voracious search for ever wider markets and profitable deals.... We can also see how medical sciences, rather than eliminate the social roots of ill health, promotes a commodity-based disease therapy. And finally, we can better grasp the role of the doctor, not as benevolent practitioner of universal science but as purveyor of capitalist values and as enthusiastic agent of imperial rule. (p. 272)

However, the anthropologist, Clifford Geertz, reminds us that “culture is not a power, something to which social events, behaviors, institutions, or processes can be causally attributed; it is a context, something within which they can be intelligibly—that is thickly—described” (Geertz, 1973, p. 14). In his text, *The Interpretation of Cultures*, Geertz explains the importance and awareness of looking beyond generalization. A thin description is one that focuses our attention on the superficial meaning or explanation of an act, word, gesture, or custom. As an American woman, I may explain a nod as a gesture of agreement or affirming. However, a nod in a nomadic tribe in Africa would mean something very negative or dismissive.

As Geertz stated:

Although one starts any effort at thick description, beyond the obvious and superficial, from a state of general bewilderment as to what the devil is going on—trying to find one’s feet—one does not start (or ought not) intellectually empty-handed. (Geertz, 1973, p. 27)

My hope is that my varied experiences of medicine – as a student, a nurse, a physician assistant, and now an educator – provide me with an ability to go beyond bewilderment and to study and describe the experiences I have seen and what these meanings and actions may tell us about the world of the patient and medicine.

“Theoretical ideas are not created wholly anew in each study;...they are adopted from other, related studies, and refined in the process, applied to new interpretive problems” (Geertz, 1973, p. 27). In choosing to study medicine through the theoretical ideas of Critical theory, Critical humanism, and Postcolonialism—the hope is for new understandings and interpretations—a true thick description.

Medical Images



Figure 2. Image of Physician (Baron & Boseley, 2011)

In your mind, picture the image of a physician. One might suppose your image is that of a white male wearing a white coat. If we continue to think about this image, we might see him smiling, wearing or holding a stethoscope in his hands. Is he standing at the bedside in a hospital, or entering the examination room of an imaginary clinic? This image is one to which few of us would ascribe a negative connotation. In many ways, the image of the physician is influenced by modern media portrayals, including the latest pharmaceutical advertisements or results of scientific study.

Such images have done much to affirm society's belief in medicine as a caring institution. It is in many ways a formidable combination of propaganda that leads us to believe that those within maintain a level of caring and compassion for all who enter. "It also engages in propaganda, intelligence collection and socialization to the main forms of capitalist rule and domination" (Paul, 1978, p. 271). Few of us would consider challenging or questioning this image or the symbolism it represents. Yet, what is your image of the patient? What comes to mind when you imagine someone who is ill, in the hospital, or injured in the Emergency room?

When the doctor enters the hospital or examination room wearing the white coat, the reality of the doctor on the other side of the bed rail evokes the same aspects of authority and emotional responses from each of us. The power of this image is so deeply etched in our psyche that it literally "has the power to create what is real and true" (Hegel, 1993, p. 31). But is this image real or true? Is there an incredible amount of falseness in this image?

Georg Wilhelm Friedrich Hegel describes the power of this falsity as "not merely superfluous, but even injurious" (Hegel, 1993, p. 31). In his work and writings, Hegel

was describing the differences between talent and genius. Hegel's *Introductory Lectures on Aesthetics* explores the power of inspiration as a basis for artistic and literary talent and work. He describes for us the belief by many of the spiritual or God-given gifts of talent, genius, and inspiration as, "a man has not the power to endow himself simply by his own self-conscious activity" (Hegel, 1993, p. 31). Art was and is today viewed by many as "the work of a mind endowed with wholly peculiar gifts" (Hegel, 1993, p. 31). Equally, I see that many maintain a belief that great works of art are due to an endowed gift of genius. So too do we believe in a level of knowledge and genius in the one wearing the white coat. His knowledge is seen as greater than ours, as even possibly a God-given gift for healing. Yet there is an incredible amount of falseness in this image and this falsity can be, and often is, injurious.

The falseness of this image of the one wearing the white coat is one of social identity. Another view of the power of social identity, and its impact on our beliefs, is that:

Social settings establish the categories of persons likely to be encountered there. The routines of social intercourse in established settings (such as a hospital or clinic) allow us to deal with anticipated others without special attention or thought. When a stranger comes into our presence, then, first appearances are likely to enable us to anticipate his category and attributes, his "social identity"—to use a term that is better than "social status" because personal attributes such as "honesty" are involved, as well as structural ones, like "occupation".

We lean on these anticipations that we have, transforming them into normative expectations, righteously presented demands.

Typically, we do not become aware that we have made these demands or aware of what they are until an active question arises as to whether or not they will be fulfilled. It is then that we are likely to realize that all along we had been making certain assumptions as to what the individual before us ought to be. Thus, the demands we make might better be called demands made “in effect,” and the character we impute to the individual might better be seen as an imputation made in potential retrospect—a characterization “in effect,” a virtual social identity. (Goffman, 1986, p. 13)

Goffman describes the creation of a social identity through cultural encoding of attributes and assumptions we may make about the one that enters wearing the white coat. His text, however, deals primarily with the societal or cultural assumptions ascribed to those with visible physical disabilities or deformities. He uses the term *stigma* to describe the power of these specific false assumptions and their impact. In many ways, it can injure to the point of leaving scars in the form of creating the “remission society” (Frank, 1995, p. 8). Frank describes this remission society as a subculture whose members have recovered partially or even completely from their serious or chronic illness. It is a culture of those who have been permanently impacted or changed by their experiences of illness or injury within that world of medicine.

The influence of our images of people holds an immense power over our beliefs, thoughts, fears, and loves. They guide our responses to culturally ingrained differences in human beings. As Lacoue-Labarthe (1993) wrote, “the essence of Being depends, each time, on the power of human representation, on the figuring or figurative power of human representation, and any possibility of ‘disconnecting’ from (the image) is then

prohibited” (p. 19) The essence of being is within images and representations which bear their own power. Can we imagine a world of medicine without white coats and uniforms? What would it take to create this type of disconnection?

Oscar Wilde’s novel, *The Picture of Dorian Gray*, portrays a story of images and the power within them. Wilde’s Dorian Gray was a young man full of beauty, charm, innocence, romance and dreams who risked everything to maintain that image of youth and beauty. The story tells us that a well-known and well-connected artist, who saw nothing but beauty, love, and perfection in his model, painted Dorian. Covetously treasuring his youth and physical beauty, Dorian fears losing them to the point of desperation. His prayers are answered when he is able to stay young and keep his own image of youth, beauty and innocence forever; however, the cost of this immortal beauty is very high. While his physical appearance remains perfection, his sins and the corruption of his soul become depicted in the once perfect, but now hidden, portrait of Dorian. Over time, the portrait becomes a hideous site that repulses those who see it.

The white coat of a physician or medical provider has incredible force as an image akin to Gray’s beauty and charm. It is an image of knowledge, virtue, influence, and power. As Wilde’s writings suggest, “With a (white coat)... anybody, even a stock-broker can gain a reputation for being civilized” (Wilde, 1890/2003, p. 8). The donning of the white coat immediately serves as a method of separation and domination of the physician over the patient. It is an image as intimidating as a king’s crown and robe. The white coat is awarded to physicians, physician assistants, and others at a ceremony with which they assume the mantle of power. The physicians have complete control over the clinical setting and exert their power to subjugate the patient.

The experiences of illness and the encounters within all clinical settings are truly similar to those Said documented in his groundbreaking work, *Orientalism*. Said developed and described multiple meanings of the term Orientalism. It is more than the academic definition of one who teaches or writes about the one called Oriental.

Taking the late eighteenth century as a very roughly defined starting point Orientalism can be discussed and analyzed as the corporate institution for dealing with the Orient—dealing with it by making statements about it, authorizing views of it, describing it, by teaching it, settling it, ruling over it: in short, Orientalism as a Western style for dominating, restructuring, and having authority over the Orient. (Said, 1979, p. 3)

Medicine can also be seen as a corporate institution for dealing with the patient. Medicine deals with, makes statements about, describes, teaches, and rules over the one called patient. Upon entering the hospital or clinic door, our name is changed to that of *the patient*. More significantly than a simple identity or altered sense of place, there is a loss of individual control and a submission to the control of medicine.

Said (1979) wrote, “The nexus of knowledge and power creating ‘the Oriental’ in a sense obliterating him as a human being” (p. 27), is the experience all too inescapable once we enter the medical institution. Upon entering hospitals and clinics, we lose all sense of self as we are placed in to the role of the ill. The physician and his institution construct our image, as the Oriental in Said’s work. Also, the individual voice is silenced by the cacophony of sounds put forth by medicine.

Entering the door of the institution of medicine entails more than a simple loss of cultural or personal identity. It is an act of surrender to the colonization that is the

practice of medicine in America today. Just as Said described the identity of the Oriental in *Orientalism*, those entering through these doors have their identity created by those who study, write about or research and describe them. He wrote:

Orientalism as a Western style for dominating, restructuring, and having authority over the Orient ... it is the whole network of interests inevitably brought to bear on ... any occasion when that peculiar entity “the Orient” is in question. (Said, 1979, p. 3)

By definition, a patient is someone “who is under medical care or treatment” (Dictionary.com unabridged, 2011). A second definition of a patient is “a person or thing that undergoes some action” (Dictionary.com unabridged, 2011). The terms *under*, or *undergoes* reveal much. If the patient is under, then the physician, nurse, or other providing the medical care or treatment is, by default, *over* the patient.

William May, in *The Patient’s Ordeal*, vividly describes the almost violent impact on the sick upon admission to the setting of medicine:

Consignment to the total institution and to the rigors of treatment there often disrupts the patient’s sense of his own body, rips him out of his ordinary community and identity, and disconnects him from the overarching order, rhythm, and meaning of his former life. (May, 1994, p. 8)

It becomes a loss of self. The illness that led the patient there becomes then a part of his or her life, his or her history and experience, possibly permanently altering their ability to resume it unchanged.

What happens when a patient enters a hospital for an illness is that they immediately surrender any claim to self. First, they must apply for and be granted entry.

Upon admission, they effectively surrender themselves to the power of the medical community, the institution of medicine, and the hospital in which it is housed. They leave outside their language, their culture, and their spirituality, and are assigned a new identity – that of the patient. The rules set and maintained by medicine are rarely questioned upon admission or entrance. We are ill, in pain, unsure, and often unaware of the many of the rules and regulations by which we are now governed. We assume the sick role and enter a world in which the language and rituals are most often extremely foreign to us. Within that world, rarely is anyone offering to explain it to us and very few of us question our experience.

The reality is that, “for the patient’s ‘bed’ to become a field of scientific investigation and the discourse is” (Foucault, 1994, p. xv) not only the setting of this experience, but the site of surrender of the colonized to the colonizer. We must see the paths that brought us here. Michael Foucault historically traced the development of the hospital and clinic from that of the home, where the family had traditionally provided a majority of the care, to that of the institutional settings. That transition led to unification of medicine and medical knowledge and was also the birth of the hospital as a site of teaching. With this change, medical knowledge became defined in “terms of frequency” (Foucault, 1994, p. 109). No longer were diseases seen in terms of individual patients and their responses, but defined in terms of occurrence and taught through repetitive exposure in what Foucault termed a “neutral domain” (Foucault, 1994).

In essence, medicine took away the individual, both in the study and practice of medicine. If we take away the individual, do we lose the knowledge of humanity? How do we begin to care for the common that is the patient, and also the individual human

being? This question is important to ponder, especially when our current medical curriculum focuses solely on the physical body, which begins in those first hours spent in cold laboratory settings dissecting cadavers—forcing the student to see the body as a thing: devoid of humanity?

Within the settings of hospitals and clinics, physicians and students of medicine move from room to room, focusing on the disease, the response to medications, or post-operative wound healing. The stories of the physicians, and the language they use, convey “pathology and disease, which began with ‘presenting’ for treatment, a listing of demographic qualities and measurements of the patient, and what was known of previous treatment” (Kuczewski, 2007, p. 410). Daily interaction between physicians, physician assistants, nurse practitioners and others invariably begins with an almost ritualistic telling of their encounter with their patient. Let me give you an example of this language.

I have a 28-year-old male who presented to the Emergency department with tachypnea, dyspnea, and slight chest pain. The patient (pt.) admits to positive cocaine use within the past 2 hours. Pt. states history of intermittent cocaine use in addition to Ecstasy frequently over the past 3 months. Vital signs are: BP 148/100, Heart rate, 168, Respirations are 26, and O2 sat is 97% on room air. EKG reveals sinus tachycardia with left ventricular hypertrophy. Chest xray reveals cardiomyopathy. An echocardiogram has been ordered to evaluate ejection fraction for probable permanent coronary damage secondary to drug abuse. I have called the hospitalist group to evaluate for probable admission.

They jot down their notes, make entries in the charts, write orders, and then take their charge sheets to their respective clinics in order to bill for each and every encounter.

Years of training and daily rounds have successfully numbed most providers to any true realization of their patient's experiences and daily life. No mention is made of any sociological or private issues that may have contributed to the reality that brought the patient to the setting—his cocaine abuse is nothing more than a medical condition brought about by his own addictive behavior. It is the patient's poor judgment to begin using the drugs that led to his addiction. His continued use of the drugs over time has led to the pathophysiology that is causing his symptoms, and led him to this setting. He will be treated for this and nothing more.

This trained distancing is “the process whereby physicians remove themselves from the particulars of patients experiences of illness” (Campo, 2005, p. 1009). Previously, ethicists and social scientists theoretically described this distancing; however, physician authors and patients have also recounted this in memoirs and pathographies (Campo, 2005, p. 1009). The great works of those in medical humanities are also seen as a battle for the soul of medicine and for those who practice it. So you may well wonder, why am I proposing to study these issues again?

It is because the concerns described within these great works and by many others have not reached far beyond the walls of the academic institutions in which they practice. The elective humanities courses and discussions appear to be easily forgotten once we enter the colonialism that is medicine as it is practiced today. In the smaller towns and community clinics, these lessons are quickly forgotten—the journals rarely read—their discourse silent. Even within the walls of academic medical teaching centers, there continues to be realities of patient existence that take place in the hospital rooms, in the outpatient clinical settings, in nursing homes, and in countless other locations.

I believe that so many aspects of American medicine can be described as colonialism. Arthur Frank describes this best, as he writes, “Just as political and economic colonialism took over geographic areas, modernist medicine claimed the body of its patient as its territory” (Frank, 1995, p. 10). The body is claimed and objectified. It is dehumanized and subsumed by medicine and those who are charged with its practice. There are no vast expanses of oceans or lands claimed by medicine, but then imagine the scope and impact medicine has within our society. From the small hospital bed, to the insurance corporation, to the pharmaceutical research facilities, the impact stretch back to our homes, to our childbirth, and to our death.

This domination extends much deeper than a simple effect on our lives, which disappears once we are discharged or released from the institutions of medicine. There is a vulnerability of illness created within our system that creates an immediate “disappearance of an orientation to the patient as a person” (Zussman, 1992, p. 29). The disease becomes the focus, while implications on the person, and on the world in which they, are too often ignored. Zussman (1992), in his text on the ethics of medical care in the intensive care ward, addresses this, as he writes:

Certainly, sociologists and historians have been quick to point out that physicians’ moral judgments are rife with class and ethnic bias and often mask what is, in effect, an agenda of social control. But moral judgments—judgments that some patients are more or less “worthy” of medical care than others, that “appropriate” treatment may demand reforming character as well as administering drugs or procedures—require at least a rudimentary knowledge of and interest in the

patient's social situation and background. Yet, at least in intensive care, both this knowledge and this interest are lacking. (pp. 29-30)

Zussman states this lack of interest quite plainly, but proceeds to describe his view of the medical care provided, in settings such as the intensive care units, as being without bias and fair. He continues that today's medicine is "less personal, but more tolerant," as medicine has been reorganized into one which treats all patients "with the same principled indifference" (Zussman, 1992, p. 29). How can one human being treat another with principled indifference? The ill, injured, and dying are among the most vulnerable of our human race, and it is these that this ethicist states medicine should treat with indifference?

Geertz (1973) depicts perfectly what I believe every theorist in any field that studies human beings strives for:

What we want and do not yet have is a developed method of describing and analyzing the meaningful structure of experience (here, the experience of persons) as it is apprehended by representative members of a particular society at a particular point in time—in a word, a scientific phenomenology of culture. (p. 364)

As Geertz writes of this phenomenology, he proceeds to describe an example in the work of Alfred Schutz, who offered us an entry point into theories of human experiences. Schultz's words speak to the heart of the joining of human and institution that I am seeking to study. Patients within medicine should never be referred to or studied as a group of "patients", just as we should avoid the description of fellowman.

Schutz offers us the term “Consociates” (Schutz, 1962, p. xxxiv) which Geertz then describes as:

Individuals who actually meet, persons who encounter one another somewhere in the course of daily life. They thus share, however briefly or superficially, not only a community of time but also space. They are ‘involved in one another’s biography’ at least minimally; they ‘grow old together’ at least momentarily, interacting directly and personally as egos, subjects, selves. (Schutz, Geertz, 1973, p. 365)

This altered view of those who encounter each other within the walls of medicine cuts forcefully through what Zussman termed “principled indifference” (Zussman, 1992, p. 29). Each patient within the intensive care unit or on the medical/surgical floors of a hospital suffers from the use of the description of patient. Each is human; the young woman with diabetes and kidney failure is vastly different from the elderly man who has lost a limb to the same condition. The young woman’s experience of her illness, her responses to medications and therapies, and the impact of her medical colonization through the practice of medicine are vastly different from those of the amputee. Yet within the walls of the institution they are considered merely a patient with a condition who will eventually improve enough to be discharged or may actually worsen and then move on to another ward or area of the hospital.

A colonial system is not a one-time event, such as a coup or a battle with winners and losers. It is, as Said describes it, “a continually repeated, institutionalized presence” (Said, 1993, p. 35). And our western culture of healthcare is, for millions of our ill, a

repeated institutionalization, forcing them into the role of patient and placing them under its control.

Upon admittance to the setting, we remove the patient from their “personal and social contexts” (Scambler & Britten, 2001, p. 55) through medicine’s scientific control. As Scambler and Britten continue, “When a doctor ... dominates or controls an encounter with a patient, this typically has the effect of absorbing and dissolving the patient’s self-understanding into” (Scambler & Britten, 2001, p. 55) the framework of the Western medical culture and colonization. “In sum, the voice of medicine has developed and retains a tendency to suppress and colonize the voice of the lifeworld” (Scambler & Britten, 2001, p. 55). Today, our culture and practice of medicine have placed the body of the ill or infirm into a mechanistic or purely scientific compilation of physiological processes. The realities of this practice have moved far beyond Zussman’s description of principled indifference to what I would call dehumanization.

“Dehumanization, which marks not only those whose humanity has been stolen, but also those who have stolen it, is a distortion of the vocation of becoming more human” (Freire, 2006, p. 44). This distortion stems from the practices, the colonization, that is medicine in this country. Our current systems of healthcare and medicine dehumanize those we care for and our participation and complicity subsequently distort our own humanity—in some cases to the point of disappearance.

CHAPTER 2

EXPERIENCES OF THEORY AND METHOD



Figure 3. Amputee in Wheelchair



I met Michael in a local nursing home, while teaching my students. I glanced into his small room with the usual blank white walls and hanging curtain between two hospital beds and bedside tables. This was his home. Yet there was nothing visible that I could see that was his. I saw no personal bedding, no personal clothes, and none of the usual items that family members or friends often bring to make these rooms homely. There were two pictures, taped to the wall; unframed. A TV provided by the nursing home sat in an alcove area, but was turned off.

He is an elderly black male, laying in one the beds closest to the open door without any emotion revealed in his face. His eyes met mine as I walked into the room and I asked him how he was doing. He said, “I guess I’m fine.” I asked him was if I

could get him anything, to which he responded, “Well, I keep asking, from time to time, if someone could get me some artificial legs, so I could get up and walk around.”

Standing beside his bed, I glanced down at the thin blanket covering him and noticed that his right leg was missing below the knee and his left leg seemed to have been amputated above the knee. I asked him if he would tell me what had happened to his legs.

He proceeded to tell me that he “wasn’t quite sure” what had happened to his right leg. He said he had “gone into the hospital when he was sick and they just took my leg off and didn’t tell me nothing.” He then said he had a “hurt left knee cap a few years later” and had gone to the doctor who had advised him that he needed to have this leg removed because “there was no way to fix it”.

As I sat beside his bed, I tried to change what felt like an incredibly awkward subject and asked Michael what he had done when he was younger. He told me he had worked at the “sugar refinery for 40 years.” He told me he had only gone to school “through the 3rd grade” and that he couldn’t read or write. He said he hadn’t “seen a check” from them in a long time, but he thought that the insurance he had was going to be paying him pretty soon.

On his bedside table was a letter from the sugar refinery addressed to Michael. It was unopened. As I stood there, I wondered if anyone came and read his mail to him. Yet, I didn’t open the letter. Somehow, I didn’t feel it was my place. To this day I regret not offering to do so. I stood there and wondered a great deal of things.

When possible, I had students spend time with Michael over the next few weeks. Though we witnessed other patients who were placed in wheelchairs, participated in

physical therapy, or were taken to the main dining area for meal, and socialization, Michael never left his bed. Though we were there for a total of ten weeks, I never saw him turned or repositioned. His retirement income was being utilized to pay for his nursing home care, as was any and all disability income and social security.

Due to his lack of formal education and his inability to read, I was forced to wonder about his ability to consent to the amputations that have led to his inability to care for and provide for himself. His physical condition with loss of limbs, and weakness with no hope of rehabilitation pales to his loss of self-determination and forced dependence on an institution for all of his basic needs.

The nursing home where Michael resides houses over 100 men and women of all races. They are living what can truly be considered an existence of other. They are no longer the husbands and wives or the fathers of mothers that they were in the daily lives of their families.

These residents awaken when the staff tells them they should, enabling routine staff shifts performance of required tasks. They dress when told, or are dressed by the staff. They are taken out of their beds, placed in wheelchairs and brought out of their rooms to be placed in the hall. Those who are able to propel themselves push with their arms or legs, wheeling from one end of the facility to another. Those who cannot do so sit and stare at the walls, so often in silence.

Ostensibly, the residents are allowed to leave the facility on trips to stores, malls, and other events. Yet, I only witnessed residents leaving these facilities for medical needs such as dialysis or scheduled doctor visits. Dietary services provides meals only at scheduled times. With very few exceptions, there are no refrigerators in the rooms for

patients to keep their own food. Some snacks are maintained at the nurses' station, which means the residents have to ask permission to obtain them.

Like most long-term care facilities, this home provided daily physical therapy, occupational therapy, and speech therapy. Eligible residents, or those who have a physician's order, are able to participate in physical therapy sessions. However, this eligibility extends only to those who are shown to be making progress and improvements in their ability to ambulate, or improve function in a limb. Once this forward progression or improvement stops, insurances, such as Medicare and Medicaid, will no longer reimburse for therapy, subsequently ending these sessions. It doesn't take a trained medical professional to realize that there is certainty of decrease or decline of any improvement if it isn't maintained by continuing therapy.

One of the saddest commentaries on therapy in nursing homes is that the activities offered and available to the residents are often very childlike in nature. Common areas and dining rooms in most nursing homes contain games that have been donated to the settings. Games I saw at this particular nursing home included Operation and Junior Monopoly. Can we imagine the possibilities of today's modern electronic games in a setting such as this? Wii and others would provide sound, physical activity, and mental stimulation while providing the social interaction that such games encourage.

At the end of the day, the residents are undressed and placed back into bed at the schedule set by the staff. Their lights are turned off and those who can fall asleep. Those who cannot, due to agitation or dementia, are given drugs to force them to sleep. In many ways, this is an attempt to keep the home quiet for those who work at night, as much as it is for those who live there.



As Mary Shelley described in the novel *Frankenstein*, “Nothing is more painful to the human mind, than ... the dead calmness of inaction and certainty which follows, and deprives the soul both of hope and fear” (Shelley, 1918/2003, p. 88).



Figure 4. Image of Nursing Home (Hihosilver13, 2007)

To survive is an incredible human instinct. A major aspect of that drive is to provide for your own food, shelter, and protection. This type of institutional life is devoid of that instinct, and a certainty that is very much a loss of hope. Where is self-will in this existence? Where are human compassion, human contact, and human interaction?

While a nursing home is just one example of a medical institutional setting, within it, we have created an “excluded population” (Rajan, 2006, p. 99). In *Biocapital*, Kaushik Rajan (2006) describes an excluded population as, “an exclusion by systems of enumeration of afflicted, treatable, and treated patients that, as integral to the rationality of such enumeration, fails to count those who, as a consequence, are left to die” (p. 99).

We have set these elderly and debilitated patients aside, and we view them as untreatable, as expendable, and as no longer fully human to be worthy of self-will and determination.

While Michael and we maintain the capability to work, to full and actively participate in the economic machine that is American capitalism we have what is called “biopolitical” (Rajan, 2006, p. 78) value. But when this ability to actively produce the goods of labor is gone, do we then become part of a population with little political impact or value? Do Michael and other members of Western society, who suffer significant disability due to any number of medical conditions, become viewed as “biopolitical regulation—the regulation, calculation, accounting for bodies, [and] decisions about who lives and who dies” (Rajan, 2006, p. 79)? Do we allow this type of institutional and biopolitical existence to continue simply because these human beings have little or no future? How do we answer these questions, or rather—do we? What type of questioning does it take to look at this type of setting with a critical lens?

I offer the following as aspects of what I see as significant components of the situation and lived experience of Michael today. He is an elderly, African-American male, poor, and with very little formal education. A prosthetic limb and the training required to teach Michael to use them would cost a great deal of money. Who and or what made the decision that this was not something to be considered? Is there sufficient medical rationale to prohibit fitting Michael and the thousands of others like him with a prosthetic limb, which raises the possibility of continued independent living?

There may be an even deeper subconscious meaning to institutionalization and alienation today. For example:

Not all expediency in our treatment of the distressed springs from gross callousness; rather, we are busily engaged in obscuring from view our own poverty: both hiding from ourselves and hiding our selves. We consign to oblivion the maimed, the disfigured, and the decrepit, because we have already condemned to oblivion a portion of ourselves. (May, 1994, p. 150)

May here is describing what may be a psychological self-protection underlying our cultural anxiety regarding aging and disability. As if quoting someone anonymously, he writes:

I have nothing for the real needs of another because what I have doesn't satisfy my own. What help could I possibly offer him? It is better to avoid him. To face him would be too depressing. He would remind me of the emptiness of my own fate. (May, 1994, p. 149)

I believe that our society has an aversion to the face and reality of aging, debility, and deformity. As a society, we choose to build environments in which we house those with these conditions—warehousing them, if you will. Yet, even within these institutions, the ability to function or to perform simple daily tasks become indicators of status; with patients like Michael falling to yet an even lower status. In one study of a specific rehabilitation setting was found a microcosm of the larger society. For instance:

The very dependent patients and those of limited sociability are dependent on others to initiate social interaction with them. Their isolation is physical and sociological, not simply a matter of personality make-up. The operating structure of the hospital and the unit contribute to imposing isolation upon them. (Roth & Eddy, 1967, p. 38)

Law and regulation consider nursing home or rehabilitation facilities to be the home of those within them. They are labeled residents and not patients for this very reason. And yet the reality for those living in this setting is far removed from homelike. A resident's isolation is directly related to their level of function, just as it is in our society. Functioning is seen as contributing to a level of independence and contribution to the world around you. However, the most severely disabled are often the lowest in terms of functionality, while simultaneously requiring the highest level of care.

Eddy and Roth (1967) describe the harsh realities of this life, such as:

Requests by patients to the ward staff to be moved or to be helped in some other way to change their activity (e.g., turning on the radio or changing the station) are discouraged by the staff, and service is frequently refused or ignored when a request is made....The physical and psychological handicaps of some of the patients severely restrict the activities they can engage in on their own. The work definitions of the ward staff exclude much of what is vitally important to the disable patient. Such a patient finds himself in a situation where some of his most important needs are nobody's business. (p. 40)

Is this not the epitome of the "colonization of the lifeworld" (Habermas, 1987, p. 386)? Jürgen Habermas (1987) developed this description of the lifeworld, as he wrote:

I can introduce here the concept of the *Lebenswelt* or lifeworld, to begin with as the correlate of processes of reaching understanding. Subjects acting communicatively always come to an understanding in the horizon of a lifeworld....This lifeworld background serves as a source of situation definitions that are presupposed by participants as unproblematic. In their interpretive

accomplishments the members of a communication community demarcate the one objective world and their intersubjectively shared social world from the subjective worlds of individuals and (other) collectives. The world-concepts and the corresponding validity claims provide the formal scaffolding with which those acting communicatively order problematic contexts of situations, that is, those requiring agreement, in their lifeworld, which is presupposed as unproblematic. (Habermas, 1984, p. 70)

Prior to admittance, an elderly or disabled person formed suppositions regarding life in a nursing home environment. This background, as Habermas discusses here, provides a sense of both context and expectations of the type of life they would have within the walls of the setting. The lifeworld of those who have significant disability, such as Michael, lose not only mobility but also a great deal of communicative ability to act within their world. The colonization of this lifeworld they now inhabit though can be seen:

By system imperatives that drive moral-practical elements out of private and political-public spheres of life. It is not the irreconcilability of cultural value spheres—or the class of life-orders rationalized in their light—that is the cause of one-sided life-styles and unsatisfied legitimation needs; their cause is the monetarization and bureaucratization of everyday practices both in the private and public spheres. (Habermas, 1987, p. 325)

If we look at the lifeworld of medicine as Habermas describes, we see it transforming citizens into clients as a response to the bureaucracy of healthcare. Through the systems of power that make up the world of medicine, human beings are patients,

residents, and customers. Staffing requirements and regulations are controlled by the State and the government owned Medicare insurance bureaucracy. The power of medicine is linked to the power of the welfare state that comprises much of the medicine and care provided to the poor, including Michael

The framing, the questioning and exploration of this and many other aspects and experiences of medicine and healthcare in America—the lived experience that is illness and disability require discussion and conversation through many voices.

Pinar’s description of curriculum as a complicated conversation has been quoted many times and is one of the more holistic descriptions of curriculum. (Pinar et al., 2004) Yet, the reality of his statement requires reflection. A complicated conversation may have many meanings to each of those who read the words and think about their import. The word *complicated*, for example, means something that is complex or difficult. By definition, it is intricate, hard, and requires effort and thought. It brings to mind images of tension, of differing opinions and their exchange. The word *conversation* stresses the importance of an exchange and, within the exchange, there is sharing, questioning, and learning. It is the ability of the individual to seek out new knowledge and to grow through dialogue with others. It is the discourse for which curriculum theorists strive, regardless of the specific framework in which they find themselves comfortable.

While complicated they may be, the conversations of curriculum since the reconceptualization of the field have not been and were never intended to be one of united ideology. There are diverse ways of to explore and to understand the world around us, and our experiences in it reach far beyond the classroom setting. These conversations bring the world into the classroom and put the classroom into the world.

While this stimulates and expands us, it confronts us with issues of struggles and realities of others' lived experiences of which we may know little. As Ken Plummer (2008) writes, "We have to live with the tensions, and awareness of them is important background for the self-reflexive social researcher" (p. 478). Awareness of tensions within the experiences that are human should be a stepping off point from which practitioners of any field.

The experiences of Michael are rife with tensions. The interaction I had with him, both as a physician assistant and as a faculty member, brought out so many issues and questions on his condition and how it had occurred. Imagine the experiences of the student who encountered him in that setting. What could be done now to change his experience? What is needed is a means that goes beyond medical intervention to a humane intervention, a change or release of the tensions of his experience. And so I wonder if I can explore it in such a way as to bring about change?

Questions of Theory

The etymology of the word theory is derived from the Greek *theorein* meaning, to contemplate, but originally, looking at or seeing. A theory, therefore, in its root meaning, may be construed as a way of seeing—but it may be argued, a particular way; it is a way of seeing one thing as if it were another. A curriculum theory, therefore, begins in the transference of meaning metaphorically from the familiar and the comprehensible to the abstract and persistently perplexing problems that arise. (Kleibard, 1982, p. 13)

This quote brings the contradictions and issues I touched on in the introduction to the world of curriculum theory. What I have seen in my experiences are images of

patient's faces, their hands, bedside tables, foley catheters, and cardiac monitors, which lead my mind from one patient to another. I hope to take these images and experiences through a combination of theoretical frameworks. Theory by definition is, as Kleibard describes it, attempting to see one thing as if it were another (Kleibard, 1982) — in this work, I attempt to see medicine as colonialism. I seek to take what is familiar and easily comprehended and provide a thicker description of the halls and practice of medicine in this country.

Critical Theory and Critical Humanism

I began this research focus early in my doctoral studies in curriculum theory. In those first days I had courses entitled *Power and Schooling*, and *Critical Readings in Curriculum*. My initial focus was intensely one of critical inquiry and critical theory, which seemed to be a very powerful framework for my study of medicine as an institution. I felt very intrigued and mentally alive as I began to truly explore the possibilities of this emancipatory frame.

The more I read, such as Michael Apple's work and the work of many current critical theorists, including David Purpel, Peter McLaren, Joe Kincheloe, and many others; the more I began to understand the power of the institution of medicine itself and how completely enmeshed are the influences of capitalism, governmental funding, pharmaceutical companies, and medicine. My instincts told me that this should be the major focus of my research. As I stated earlier, my study has an emancipatory hope that finds a voice at the heart of my thesis question—is medicine as we practice it a form of colonization—and if so, is change possible? At its core, critical theory has an

emancipatory focus of its critique. And as I explore the questions of my research, I ask the following question regarding Michael: What are the possibilities for change?

The philosopher, Karl Marx (1867/1990), wrote that capital “takes no account of the health and the length of life of the worker” (p. 381). Marx developed theories exploring the impact of capitalism on people whose work is producing the labor, and by extension, which produces the profits for the company. His foundation for this work was his belief that the system of class structures maintained by capitalism and the loss of awareness of human self-creation is severe with the growing focus on capital gain. Marx (1867) describes a link between capitalism and social production:

The historical conditions of its existence are by no means given with the mere circulation of money and commodities. It can spring into life, only when the owner of the means of production and subsistence meets in the market with the free laborer selling his labour-power. And this one historical condition compromises the world’s history. Capital therefore, announces from its first appearance a new epoch in the process of social production. (p. 189)

The laborer is a human being and the products of this labor are his labor-power. Marx (1867) continues to describe the impact of the human quality, as he writes that:

The owner of the labour-power is mortal. If then his appearance in the market is to be continuous, and continuous conversion of money into capital assumes this, the seller of labour-power must perpetuate himself, ‘in the way that every living individual perpetuates himself, by procreation’. The labour-power withdrawn from the market by wear and tear and death, must continually be replaced by, at the very least, an equal amount of fresh labour-power. (p. 191)

Michael, as a laborer for the sugar refinery, lost his labour-power with the loss of his legs. This removed him from the market of the refinery. Ostensibly, the refinery soon replaced him with someone with “fresh labour-power” (Marx, 1867, p. 191). In addition, he lost his ability to provide subsistence for himself and his family. For Michael and others of his “class” and social status, the realities of Marx theories continue to be experienced.

In addition to the impact of a capitalistic society on human labor, we see Marx’s theory of alienation offer firm footing from which to study the human experiences of illness and disability beyond the impact on health.

In estranging from man (1) nature, and (2) himself, his own active functions, his life activity, estranged labor estranges the species from man. It changes for him the life of the species into a means of individual life. First it estranges the life of the species and individual life, and secondly it makes individual life in its abstract form the purpose of the life of the species, likewise in its abstract and estranged form. Man makes his life activity itself the object of his will and of his consciousness. He has conscious life activity. It is not a determination with which he directly merges. Conscious life activity distinguishes man immediately from animal life activity. It is just because of this that he is a species-being. Or it is only because he is a species-being that he is a conscious being, i.e., that his own life is an object for him. Only because of that is his activity free activity. Estranged labor reverses the relationship, so that it is just because man is a conscious being that he makes his life activity, his essential being, a mere means to his existence. (Marx, 1959, p. 31)

It is this questioning of identity, alienation, influence, and impact of structures of power that I see as vital in looking at the existence of Michael

Critical theorist, Herbert Marcuse further explored Marx's theory of alienation. He wrote, "The concept of alienation seems to become questionable when the individuals identify themselves which is imposed upon them and... This identification is no illusion but reality" (Marcuse, 1964, p. 11). Is the self-image that Michael has today the image of his former self, or does he see himself as I see him today? If so, his is an ever-worsening process of alienation as this new identity given to Michael, and others like him, is a form of Marxist false consciousness.

I have little doubt that the conditions which led the physicians and surgeons to amputate the limbs of Michael were serious and considered potentially life threatening. Yet what were the considerations given for his future? Why no prosthetics? Why a nursing home, a form of post-human existence? What were his thoughts and questions? More importantly, did anyone ask his opinion?

In many ways, a nursing home experience can be seen as posthuman. Katherine Hayles (1999) describes posthuman as " 'post' not because it is necessarily unfree but because there is no a priori way to identify a self-will that can be clearly distinguished from an other-will" (p. 4). While a more complete explanation of posthumanism is beyond this dissertation focus, one can see how the loss of self-will is a significant component of the aged and disabled in such a setting.

It can be argued that there is no self-will—that many modern societies exist in such a system of laws, and expectations that self-will is never realized. It is a very anti-humanistic viewpoint, and anti-Marxist to deny the human capacity for self-creation. Yet

where is self-will for Michael? What possibilities are there for self-creation within the setting of the nursing home?

With the experiences of Michael, there becomes a sense of urgency to the realities of alienation and medicine. When Michael was physically able to work within the sugar refinery, he contributed as a productive member of society. His efforts and labors produced a product, enabled him to receive a portion of the sugar refinery profits, and provided his own capacity to purchase goods made by others who labored.

Many things within labor and manufacturing have changed greatly since the days Marx wrote the words above. Yet in this nursing home in 2009, I meet an elderly black man whose health or disability defines his current place in the world of capitalism and society by his inability to work. Beyond this, American medicine is vested with the power to name and quantify his disability. In doing so, medicine, in conjunction with the State, decides on his disability income and welfare income, which then returns to the nursing home for his housing.

The setting of growth for critical theory was the Frankfurt Institute for Social Research in Germany. The words and writings of Marx and Hegel—followed by those of Adorno, Antonio Gramsci and Max Horheimer—both in Germany and later in the United States provided truly groundbreaking social analysis during World War I and growing capitalism.

The Frankfurt School began at a conference initiated by Felix J. Weil. Weil was a student deeply interested in Marxism and had recently completed his doctoral studies in Frankfurt when he initiated the first meeting of what he entitled, the Erste Marsixtische Arbeitswoche (EMA; First Marxist Work Week) (Jay, 1973, p. 5). This was a very

informal gathering of men and their wives for the purpose of arriving at a “‘true or pure’ Marxism” (Weil as cited in Jay, 1973, p. 5). The more permanent institution grew from this and subsequent meetings with the support of Weil’s friends and the support of the University of Frankfurt.

During the meetings of the EMA, Weil met and befriended Friedrich Pollock, whose doctoral work and thesis were on Marx and his theory of money. In addition, Pollock had invited with him a very dear friend, Max Horkheimer. Together, these men succeeded in establishing the Institute for Social Research in 1923 at the Frankfurt University.

Max Horkheimer, who later became the director of the institute, worked with others to explore and develop the scope of critical theory. Horkheimer describes the institute’s focus on the power of critical thinking as he writes,

The individual as a rule must simply accept the basic conditions of his existence as given and strive to fulfill them; he finds his satisfaction and praise in accomplishing as well as he can the tasks connected with his place in society and in courageously doing his duty despite all the sharp criticism he may choose to exercise in particular manners. But the critical attitude of which we are speaking is wholly distrustful of the rules of conduct with which society as presently constituted provides each of its members. (Horkheimer, 2002, p. 207)

Within the institute, Horkheimer’s critical theory evolved from one that argued against the individualism to that of a strong position and philosophy, which sought to maintain an awareness of the individual within the greater work of critical theory. This evolution of critical theory is described below:

Any specific theoretical content must be constantly and ‘radically questioned,’ and the thinker must be constantly beginning anew. Critical theory does not have one doctrinal substance today, and another tomorrow. The changes in it do not mean a shift to a wholly new outlook, as long as the age itself does not radically change. The stability of the theory is due to the fact that amid all change in society the basic economic structure, the class relationship in its simplest form, and therefore the idea of supersession of these two remain identical.”

(Horkheimer, 2002, p. 234)

Here Horkheimer enforces the basic power of theory and critique and the fluidity of theoretical ideals and social constructions of power and class. To critique the larger institution of medicine as I understand it and feel it, its issues of power and class should be done through the frameworks of critical theory. The realities of medicine’s relationship and power from within its own systems are not a singular issue. There are also realities of governmental, pharmaceutical and other corporate and capitalistic realities that critical theory allows me to study. “A critical social theory is concerned in particular with issues of power and justice and the ways that the economy; matters of race, class, and gender; ideologies; discourses; education; religion and other social institutions; and cultural dynamics interact to construct a social system” (Kincheloe & McLaren, 2005, p. 307). Each of the specifics stated by Kincheloe and McLaren occur within medicine daily.

There were many issues of power, race, class, and cultural dynamics that surround the experience of Michael? The medical institution in our country extends into areas beyond the nursing home through, not only through the aspects of daily practice, but

through other settings of medicine, including the educational institutions. As we place the name of patient on Michael, medicine then classifies him, names him, and places his epidemiological information into governmental databases for tracking and possible research. Michael Apple (1995) writes, “classification of individuals, social groups, or ‘social problems’ tends to confirm and reinforce these structurally generated relations of domination” (p. 12). We classify him as disabled placing him in a position society deems dependent. As Apple (1995) explains, we have systems that have evolved and reproduced “without being consciously recognized by the people involved” (p. 12). Michael is now an elderly 79-year-old African American male with debility and disability secondary to bilateral amputations of the lower extremities.

Western medicine has a genealogy that stretches back to Western Europe in its status, class, and education. And as such it in many ways has an ideology as described by Marx and Engels. The ideas of medicine within our society have truly developed a societal false consciousness. What if our current view of medicine is as Marx described, a “camera obscura” (Marx & Engels, 1998, p. 42), a view that is truly upside down from that of reality? In *The German Ideology*, Marx wrote, “If in all ideology men and their circumstances appear upside-down as in a *camera obscura*, this phenomenon arises just as much from their historical life-process as the inversion of objects on the retina does from their physical life-process” (Marx & Engels, 1947/1998, p. 42). Have we allowed our view and perceived reality of medicine to become rationalized to the point of obscuring societal suffering, or to the point of viewing it as opposite of its experience?

Antonio Gramsci was an Italian Marxist who furthered the work of Marx. The term Marxist is used to describe someone who has read, agrees, and builds upon Marx’s theories and writings on the division of labor, society, as well as his writings on

capitalism. Gramsci took Marx's writings and further theorized the idea of hegemony.

Gramsci (1975) writes:

The intellectuals have a function in the 'hegemony' that is exercised throughout society by the dominant group and in the 'domination' over society that is embodied by the state, and this function is precisely 'organizational' or connective. The intellectuals have the function of organizing the social hegemony of a group and that group's domination of the state; in other words, they have the function of organizing the consent that comes from the prestige attached to the function in the world of production and the apparatus of coercion for those groups who do not 'consent' either actively or passively. (p. 201)

Even within the *Prison Notebooks*, which Gramsci wrote from his own cell, we see he continued in his next paragraph to describe the many questions that can arise from the description above as he specified that:

Social hegemony and state domination has various levels and among these levels some are purely manual and instrumental—carrying out orders rather than having responsibility, being an agent rather than a bureaucrat or an office, etc.; obviously, however, nothing prevents one from making this kind of distinction (nurses and doctors in a hospital, sacristans-care-takers and priests in a church, janitors and teachers in a school, etc., etc.). (Gramsci, 1975, p. 201)

Gramsci offers the physician, among clergy and teacher as a model that the "average peasant" (Gramsci, 1975, p. 201?) can aspire to become in order to raise his position to one of a gentleman to improve his position and status within the social

structure. As Gramsci hints, medical hegemony hints here is alive and well and deserves exploring.

Medicine today actively operates at the level of hegemony by ensuring multiple levels and aspects of social control. “Medical social control is defined as the ways in which medicine functions (wittingly or unwittingly) to secure adherence to social norms; specifically by using medical means or authority to minimize, eliminate or normalize deviant behavior” (Conrad, 1979, p. 1). As I continue through the later chapters, which focus on different aspects of medicine, I will explore the questions of other and even more powerful methods of social control and aspects of the hegemony of medicine which affect our behaviors and our lives.

Issues of institutions and the influence of the state and capitalism were from the beginning a part of my stories and experiences, but they were not solely what I am attempting to study and explore. They are my experiences within the culture and power of medicine as institution, and they are also intimate stories of patients, physicians, students, and settings. Sociologist C. Wright Mills offers an opportunity to critically study both the aspects of the history and development of the institution, but also to maintain focus on the experience of the individual, as he writes:

In a word, continually work out and revise your views of the problems of history, the problems of biography, and the problems of social structure in which biography and history intersect. Keep your eyes open to the varieties of individuality, and to the modes of epochal change. Use what you see and what you imagine as the clues to your study of the human variety ... know that many personal troubles cannot be solved merely as troubles, but must be understood in

terms of public issues – and in terms of the problems of history, and the range of their intricate relations. Within that range the life of the individual and the making of society occur; and that within that range, the sociological imagination has its change to make a difference in the quality of human life in our time.

(Mills, 2000, p. 255)

Mills' work was strongly influenced by the writings of Marx, which is one of the foundations of critical theory. Yet, Mills offers us reminders that we cannot focus exclusively on structure and power to the point that we ignore the individual human experience of joy and suffering. And it is these experiences and the intersection of patients, students, faculty, and providers within the culture of medicine that I also wish to examine.

Combine these words and thoughts in Mills' writings with the essays of Horkheimer (2002), as he wrote, "Knowledge in this traditional sense, including every type of experience, is preserved in critical theory and practice. But in regard to the essential kind of change at which the critical theory aims, there can be no corresponding concrete perception of it until it actually comes about" (p. 220).

Again, I see my research as critical. It is a critique of the grand narrative of American medicine. It is a critique of an institution and the vast issues of power and control it wields. The purposes of this method of inquiry are to confront not only the injustices in medicine in our society, but also to understand the impact of economic and political structures and their ideologies on those individuals and communities who reside within them. And as such, it finds a home within the world of critical theory. But I wanted more from this critique than to look at the institutions and power of medicine.

The narratives are of human experience at a very personal level and yet cannot be and should not be viewed as separate and apart from the medicine. I need to look at more than the issues of power and status of those in medicine to the impact of that on the human experience.

Critical theorist Patti Lather (2004) writes that “critical inquiry as the juncture between human agency and structural constraint takes on theoretical urgency” (p. 250). This juncture that Lather describes between the human and the structure does offer a sense of urgency in the manner of exploring human liberties lost or denied.

The framework of Critical Humanism offers a very realistic means of making meaning of the juncture and the ability to bridge the frameworks of critical theory and humanism. Critical Humanist, Ken Plummer (2008) describes this framework as one that affords an “inquiry that focus(es) on human experience—that is, the structure of experience and its daily lived nature—and that acknowledge(s) the political and social role of all inquiry” (p. 480). Critical theory and critical humanism see that much of our lives, our language, and our experiences are socially constructed.

There is no specific historical appearance of critical humanism. The humanism of the Italian Renaissance is seen by some as a foundation of critical humanism. Jeff Noonan ascribes Giovanni Pico della Mirandola in his work, *The Oration of Man*. Noonan (2005) writes, “His arguments exemplify the contribution critical humanism can make to the qualitative study of society. Instead of simply accepting different cultural interpretations of the truth as given facts, Pico tried to explain them as different responses to the same problems” (p. 155). The connections and tensions between the cultures of medicine and that of the patient—both in and outside of the settings of medicine—should

be explored much in the same way. I do not want to simply accept them as fact, but attempt to look at them as responses of each individual to a common problem or setting.

Noonan traces the evolution of critical humanism from Pico through Hegel to Marx, whom he describes as “arguably the most important contributor to the development of critical humanism (although he never used the term)” (Noonan, 2005, p. 156). Marx philosophical writings and work on the human capabilities of self-creation can be seen as “a systemic elaboration on the critical humanist principle that human nature or human identity is self-creation” (Noonan, 2005). Each member of humanity is capable of self-creation, and as such we are capable of creating change in our condition and relationship with each other.

I see the writings of critical theorist, Herbert Marcuse, in his work, *One-Dimensional Man*, as another avenue and discourse through which critical theory and critical humanism intersects. While Marcuse criticized the Humanism of the Western world, many of his writings suggest to me a modern critical humanist focus. His critique of humanism is seen here in his words, “The celebration of the autonomous personality, of humanism, of tragic and romantic love appears to be the ideal of a backward stage of the development” (Marcuse, 1964, p. 56). Marcuse strongly opposed an overarching view of humanity as one whose beliefs of self and community are built and maintained through state propaganda, such as through advertising and media images.

However, Marcuse also wrote the following words for us to reflect upon our human experience and the impact of the society on the individual. He writes of the power of society to create our needs. Marcuse writes of true and false needs that are formed by political and societal powers and control. He wrote, “The distinguishing

feature of advanced industrial society is its effective suffocation of those needs which demand liberation” (Marcuse, 1964, p. 7). He describes even our need to relax, our need to maintain competitive markets are examples of false needs, while true needs are forgotten through suppression.

This description Marcuse offers in his text of the one-dimensional man—one whose self-identity is within the whole and this identity is not self-made, but provided for him by the societal controls around him. This is the type of false consciousness I see for the patient within medicine. They enter a reality that is not made by them and they simply accept it as a rule and without complaint. I see the writings of Marcuse as very humanistic as he speaks against the political or social view of the whole and the realization of the oppressive qualities of just such an influence.

There are many passionate views of medicine from those within, such as from the patients themselves, from the governmental policy makers, and from countless others. Today, medicine is viewed as science. The advances of medicine and treatments, and the search for cures for a multitude of illnesses, are vast in scope. Yet to study it deeply and truly understand the daily realities of it go far beyond a positivist, scientific manner. As Clifford Geertz (1973) said, “if you want to understand what a science is, you should look in the first instance not at its theories or its findings, and certainly not at what its apologist say about it; you should look at what the practitioners of it do” (p. 6).

Geertz was speaking of anthropology and the primary methodology of that science—ethnography. Geertz points out that this is much more than an understanding of methodology. The understanding of medicine I seek is one he may describe as a “thick description” (Geertz, 1973, p. 6). To understand what happened to Michael in the

narrative above, one truly needs a thick description. While I was not there with Michael in those initial hospitalizations through which he suffered his amputations, for many weeks over the course of two years I witnessed his current situation in the institutional setting as well as the interactions he had daily with those charged with caring for his needs. And one of my main questions for those of us who practice the science of medicine is, how much realization is there of the aftermath of our care on the individual? Did anyone take the time to evaluate his current situation and explore the impact his care would have on not have on not only the patient, but also on the family and social network within which he lives?

Todd Gitlin offers us a revealing and emotionally charged look at the works of Mills in his afterword for the latest edition of *The Sociological Imagination*. Gitlin describes Mills writing as:

A vigorous, instantly recognizable prose, he hammered home again and again the notion that people lived lives that were not only bounded by social circumstance but deeply shaped by social forces not of their own making, and that this irreducible fact had two consequences: it lent most human life a tragic aspect with a social root. (Mills, 2000, p. 237)

This continues Ken Plummer's description of critical humanism as a theory of inquiry, which at once recognizes the human experience and costs to that experience from the culture, society, and the institutions through which we travel.

The philosopher and genealogist, Michael Foucault's writings for example have also been inspiring to me. While neither critical theorist nor humanist, Foucault traces for us the development of the institution of medicine in his text, *The Birth of the Clinic*

and the many layers of power and connection with the state are invaluable as I seek to study the birth of medical colonialism. However, Foucault himself wrote in his work, *The History of Sexuality*, “The modern individual—objectified, analyzed, fixed—is a historical achievement. There is no universal person on whom power has performed its operations and knowledge, its enquiries” (Foucault, 1979, pp. 159-160).

I ask you to look again at that quote. I see a distinct divide between the words individual and universal person. It is not a universal individualism that critical humanism seeks to explore. It is the individual human being and their experiences as they are in continuous engagement with the world they live in.

Humans must be located in time and space: They are always stuffed full of their culture and history, and they must nest in a universe of contexts. Human beings are both embodied, feeling animals and creatures ... They engage in symbolic communication and are dialogic and intersubjective: There is no such thing as the solitary individual. Human lives are shaped by chance, fateful moments, epiphanies. (Plummer, 2008, pp. 486-487)

The structures and institutions in which they met daily buffet them about continuously. Yet, it is the individual who is forcibly termed “customer”, “student”, and “patient”. Their very humanness smothered by the weight of control and power of the institutions that name them.

The discourse on humanism, with emphasis on human individuality and self-actualization, may seem to sound contradictory to what I am saying in the colonialism aspect. While I believe that it would be an ideal world—one in which all individuals were truly self-creating and had the ability to freely change and mold society and culture,

the reality is that because of the forces of capitalism, the governmental control and the power of medicine itself, the patient is (although uniquely individual) too oppressed to exercise those possibilities. Medicine's impact on the individual is what reveals the impact of the colonization. It should be realized that each person in every bed is an individual with his or her own experience of the illness. But critical humanism falls short in that this vulnerable individual has lost the ability for self-actualization.

Critical humanism aims to reduce human suffering. "It must leave the solutions to definite social problems in the hands of those concretely affected by them" (Noonan, 2005, p. 157). The realities of medical colonialism, and all forms of oppression and social injustice, forcefully prohibit individuals from the ability to form effective solutions.

Critical theory or critical thinking:

Is motivated today by the effort really to transcend the tension and to abolish the opposition between the individual's purposefulness, spontaneity, and rationality and those work-process relationships on which society is built. If activity governed by reason is proper to man, then existent social practice, which forms the individual's life down to its least details, is inhuman, and this inhumanity affects everything that goes on in the society. (Horkheimer, 2002, p. 210)

The institution of medicine is that in which the social and political fallout from our current systems of government and capitalism seem to meet with such force and yet with such silence. The impoverished, the homeless, the disabled, and the mentally ill arrive daily to our clinics and hospitals, alongside the victims of racism, domestic violence, gang wars, and drug abuse. As we saw in the story of the young Hispanic

mother and that of Michael, social and physical ills come to our medical institutions seeking aid, comfort, and care. Yet, in no other public or private arena in our country, these issues are detained forcibly at the door. Only the patient, disrobed and deprived of personal identity, is treated as a mechanical object, only to be released when deemed able to resume their life in the world that remains unchanged.

Postcolonialism

Most of us have mental images of postcolonial eras and history of times past in countries distant from our own. We may visualize symbols of kings and queens extending territories across continents. But if we look closely, we see that what was once a method of conquest and acquiring territories is much more than merely an issue of land. It is an act of conquest of human beings in all of their individuality. The conquerors in their role assume control over the individuals, immediately assuming their ways and knowledge to be superior ways of existing.

Following the theoretical and emancipatory thoughts of critical theory and critical humanism, “the socially instituted division between the intellectuals and the masses can be dissolved only by the transformation of society, and that until then theoretical dissolutions of the problem are merely ideological” (Barker, Hulme, & Iverson, 1994, p. 19). There is a purpose to my critique that I hope goes beyond the ideological to the possibility of change.

I take very seriously this position from within while juxtaposed against the stance of postcolonialism. Peter Hulme (1994) describes this seemingly contradictory position as he writes, “Local knowledge in this sense of the word is situated, particular, and ‘native’. But the small narratives do not stand by themselves...they are local sentences in

the chapter of the postcolonial world” (p. 74). The narratives I offer of my experiences are local and native knowledge but within the geography of medicine may be only sentences through which pieces of this world can be shared.

The history of colonialism dates to ancient empires in Europe, yet Postcolonialism as a method or focus of social critique and study in academia dates back only to the 1970s. Most credit the work of Edward Said and his text, *Orientalism* as giving birth to the field. Great authors and works have added depth and breadth to the field. The term thus yokes a diverse range of experiences, cultures, and problems (Bahri, 1996).

This definition of postcolonial reveals the general meaning behind its use in the field of curriculum studies. Within the reconceptualization of the field of curriculum postcolonialism quickly became vital to the exploration and understanding of those we now know as Other. As Pinar (1998) stated:

We have taken the “linguistic turn,” evidenced in our field by the continuing and perhaps increasing influence of poststructuralism and postmodernism. Not unrelated to this development is the appearance of “cultural studies.” This interdisciplinary movement retains an interest in politics but is configured around postcolonialism. (p. ix)

It is this link between the political and cultural issues that I find so intriguing in postcolonialism. The ability of those in a position of power over a group of human beings is the source of oppression of any form. This then linked to the history of European control and dominance and the power of those who document the Other is then linked to so many of our cultural beliefs today—though struggle for freedom and awareness continues.

Postcolonialism now has become a firm member of what Norman Denzin terms emancipatory discourse. Alongside the indigenous focused works in the fields of critical feminism, and critical race we now have a many types of pedagogies of resistance in the area of curriculum. And as Denzin (2008) states, “Underlying each indigenist formation is a commitment to moral praxis, to issues of self-determination, empowerment, healing, love, community solidarity, respect of the earth, and respect for elders” (p. 449). The focus on and commitment to moral issues of self-determination, empowerment, and healing is vital.

The use of the prefix *post* does not mean these conditions are merely a part of the past. The effects of colonialism remain vivid today for those cultures that have lived through them. As this pertains to medicine and the positivism of most sciences, we move from the European empires to that of the West. The effects of chronic disease and trauma in many ways alter identity and human beings permanently, as we see in the experience of Michael

Said, seen as a primary author in the field, offers the following as an overview of the impact of colonialism or more specifically, Orientalism.

From its earliest modern history to the present, Orientalism as a form of thought for dealing with the foreign has typically shown the altogether regrettable tendency of any knowledge based on such hard-and-fast distinctions as “East” and “West”: to channel thought into a West or an East compartment. Because this tendency is right at the center of Orientalist theory, practice, and values found in the West, the sense of Western power over the Orient is taken for granted as having the status of scientific truth. (Said, 1979, p. 47)

The same distinction between physician and patient and between the science of medicine and the lived experience of disease can and should be explored. For it is the tendency of medicine to base its knowledge on these distinctions that have provided it with the power and status of an institution that not only knows but controls the scientific truth.

Another author in postcolonialism is Homi Bhabha. In one of his major works, *The Location of Culture*, Bhabha discusses the power of imagery. “This image of human identity and, indeed, human identify as image—both familiar frames or mirrors of selfhood that speak from deep within Western culture—are inscribed in the sign of resemblance” (Bhabha, 1994, p. 49). Bhabha speaks of the power of imagery whose meanings are provided by the culture surrounding us.

In another text edited by Bhabha he describes for us the tumult of the intersection between power, society, and identity. “The people ... represent the cutting edge between the totalizing powers of the social and the forces that signify the more specific address to the contentious, unequal interests and identities within the population” (Bhabha, 1990, p. 297). Narratives of the lives and experiences of indigenous people make real for us the risks and resilience that resides there as well.

Franz Fanon is another postcolonial author who lived the experience of the colonized. He was born to French parents in Martinique and later moved to France. He studied medicine and psychiatry and worked as a physician for the French in their colonial territory of Algeria. When the war for independence erupted, Fanon found himself treating the Algerian victims of atrocities. He went on to resign his post and moved to Tunisia where he worked actively for Algerian independence.

Fanon's life was one in which he experienced racism and a racist culture as a black man in the world of academia and medicine. Among his most famous works are *The Wretched of the Earth*, *Black Skin*, and *White Masks*. Truly indigenous are his experiences, and his texts offer us a reality otherwise unseen and unheard. His conclusion calls for strength and change as he wrote, "Man's condition, his projects, and collaboration with others on tasks that strengthen man's totality, are new issues which require genuine inspiration" (Fanon, 1963, p. 236). Fanon's work and struggles are inspirational.

The power of science as a component of colonialism is discussed by Norman Denzin (2008) as he writes, "As agents of colonial power, Western scientists discovered, extracted, appropriated, commodified, and distributed knowledge about the indigenous other" (p. 438). Denzin is speaking of the effect and power of Western science as it pertains to anthropology and studies of indigenous populations around the world. Not only does this science dictate the research fields, but they then have complete control over the dissemination of these findings and label them as fact.

So too does the world of medicine and the science thereof. Research in medicine exerts immense control over the study of disease and treatment, as well as the writing of texts used to teach students of medicine. Realities of combined corporate, pharmaceutical, and governmental influences are becoming more dominant in medical education today.

One historical event that contributed to the corporate support of educational arenas was the *University and Small Business Patent Procedures Act of 1980* and the later supplement of 1983 that included larger corporations. This law had a particular

impact in the realm of medical education as it “enabled universities to sell the patent rights to products of the research of university faculty and staff and it allowed corporations, ‘by sticking some of their dough into universities...to buy the results of university research’ ” (Weaver, 1999, pg. 142). This gave corporations the ability to utilize academic researchers as free labor to develop products for their own gain.

The areas of pharmaceutical and therapeutic research have been greatly impacted by this corporate intrusion. Researchers whose findings reflect negatively upon a drug or treatment are not published, and the funding is severed as we will see in Chapter 4.

One of the risks or limitations of postcolonialism studies is, “a risk that uncovering colonial, and postcolonial structures of domination may, in fact, unintentionally validate and consolidate such structures as well as reassert liberal values through a type of cover ethnocentrism” (Kincheloe & McLaren, 2005, p. 325). My place within this work is a very singular one. To critique and not fall into what I see as a possible mine field of attempts to maintain a balanced portrayal between what I have seen and what I wish I could see is a much more realistic assessment of risk for me in this work.

My place or position in this work is something I cannot hide—or negate easily—nor should I want to. The discourses of postcolonialism as well as other post discourses and theories deal with the relationship and impact of structures of power and society on the individual. “From an epistemological perspective, all structural, cultural, and standpoint feminisms focus on the role of power relations in shaping the politics of knowledge production, and they examine what gets counted as knowledge, and by whom, in the construction of knowledge” (Tisdell, 2008, p. 333). While Tisdell speaks of

feminist epistemology in this text, the emphasis of the work is much the same in focus. Issues of power, knowledge, and the construction of this knowledge are components of much postcolonialist work.

Many may feel that I am still in a position of power. As a member of a medical education faculty and medical profession, I must remain aware of this and remain concerned about it as an inability to maintain objectivity. It is an example of what Tisdell describes as “multiple subjectivities” (Tisdell, 2008, p. 333). My place relative to my students, other faculty members, the patients, and physicians does and must affect how I come to know it.

A study of the multiple aspects and components of medicine in all its varied definitions I explored in the introduction requires just as varied a theoretical approach. Norman Denzin followed by Joe Kincheloe and others brought to the study and work of curriculum theory the possibilities of a multiplicity of theoretical frameworks and methodologies called *bricolage*. “The bricolage is dedicated to a form of rigor that is conversant with numerous modes of meaning-making and knowledge production—modes that originate in diverse social locations” (Kincheloe & McLaren, 2005, p. 318).

A bricolage is in many ways a creation of a work, or an image composed of several singularly strong pieces and combining them into one. Denzin and Lincoln liken the bricolage to a quilt, a jazz piece, or better yet, a montage of images. (Denzin & Lincoln, 2005) The powers of the multiple components allow us to “move from the personal to the political, from the local to the historical and the cultural. These are dialogical texts. They presume an active audience” (p. 5).

One who creates a bricolage is called a bricoleur. The French term denotes someone who creates work through the use of any and all tools available to them or, as Denzin and Lincoln (2005) describes, a “Jack of all trades” (p. 4). Just as the bricolage is composed of many varied methodologies and lenses, there are multiple types of bricoleurs, including narrative, interpretive, and political. The use of a variety of methodologies to examine something is not an attempt to further validate or triangulate the research study. As Denzin and Lincoln (2005) tell us,

Objectivity can never be captured. We know a thing only through its representation....The combination of multiple methodological practices, empirical materials, perspectives, and observers in a single study is best understood, then, as a strategy that adds rigor, breadth, complexity, richness, and depth to any inquiry. (p. 5)

I am one who lives and works within the world of medicine. And through this indigenous experience, I have formed an indigenous epistemology that “[embodies] a critical politics of representation that is embedded in the rituals of indigenous communities” (Denzin, 2008, p. 449). Just as I was, in some measure, indigenous to the world of the nursing home:



I want to share with you a postscript to the story of Michael. One year later, I returned with yet another group of students to the same nursing home. As I walked through the halls of the nursing home, I saw Michael lying in a bed in a different room from where he had lived the year before and yet strikingly similar. He still lay on his back, covered in a white sheet and blue blanket in a room with the same bare walls with

the exception of two pictures. He now shared this room with two other men, in a space of approximately 160 square feet.

I went in and spoke with Michael and asked if he remember me. Though alert, he wasn't sure if he could. I asked him how he was doing and if he would like to have some students come and spend some time with him for a while. He said "that would be fine", and over the next few weeks, I continued to introduce a new group of students to Michael

In all the time we were there, I never witnessed anyone else visiting Michael. And as in the previous year, he never left his room for physical therapy, meals, or even for a wheelchair ride in the hall. Several days of our scheduled time in the nursing home passed before one of the students came to me and said that Michael wanted to know if he could get some physical therapy or even prosthetic legs.

I found myself in the position of having to explain the system of medicine, insurance, reimbursement, billing, and the limitations of it all for someone like Michael. The questions of why things are the way they are, how is this possible, and even can we change it I touched on with what I hoped would be challenges to these students—challenges to get politically active—to think about the possibilities—to put themselves, or their parents in the same situation—challenges to think in terms of criticality and with humanism.



Narrative Methodology

“Just as no man lives or dies to himself, so no experience lives and dies to itself.

Wholly independent of desire or intent, every experience lives on in further experiences” (Dewey, 1938, p. 27).

“The concrete event that is experienced by a particular person is its mooring. Curriculum is the child of culture, and the relation is as complex and reciprocal as are any that bonds the generations....We live curriculum before we describe it” (Grumet, 1999, p. 24). As Madeline Grumet describes curriculum for us, within my identities as nurse, physician assistant, educator, mother, wife, and countless roles contained within each, I have lived curriculum every day as I put on my white coat, as I enter the hospitals and clinics, as I come face to face with the patients, and now in the classroom as I face the students.

This work is an exploration of my curricular experiences of medicine in my own schooling, practice, and now teaching from the complex relations and issues of medicine. To do so, I hope to utilize a critical narrative methodology combined with a visual narrative component. The experiences revealed through words and images, reflected upon, and confessed are aspects of the life that is medicine as it is practiced in this country.

The telling and describing of many of my experiences through the frameworks above allows me to make available the stories for others to read and reflect upon. These experiences, and the emotions that are stirred from their occurrence, become a conversation that I feel the need to begin, is due to an overwhelming desire to make meaning come from them. Stacy Holman Jones described qualitative narrative and critical inquiry as movement. (Jones, 2005) One challenge she states for those who seek to do this type of inquiry is “creating texts that unfold in the intersubjective space of individual and community and that embrace tactics for both knowing and showing” (Jones, 2005, p. 767). It will not be an easy task.

Jones offers us questions I should ask myself to guide me to create a text that is for knowing and showing. Let us look at some of these questions.

How emotions are important to understanding and theorizing the relationship among self, power, and culture.... How body and voice are inseparable from mind and thought as well as how bodies and voices move and are privileged (and are restricted and marked) in very particular and political ways....How selves are constructed, disclosed, and implicated in the telling of personal narratives as well as how these narratives move in and change the contexts of their telling....How stories help us to create, interpret, and change our social, cultural, political, and personal lives. (Jones, 2005, p. 767)

Jones speaks of these questions as a means of placing ourselves within the work of narrative in order to offer movement for change. By offering stories instead of statistics, experiences instead of outcomes, narrative offers us methods that move us to think not just once, but again and again, to break through resistance.

Rather than attempt an ethnographic exploration however, I seek to place myself in the work, as a means of frank acknowledgement of my *place*. “Place is place only if accompanied by history” (Pinar, Reynolds, Slattery, & Taubman, 2004, p. 533). It is not merely my story I am trying to tell; it is as William Ayers writes, “understanding the situation from within” (Ayers in Pinar et al., 2004, p. 527) through my history. I feel a need to offer my stories, my experiences, with the hope of stirring an awakening and a sense of urgency for change.

Guenter Risse in his study on the historical development of hospitals utilized narrative to “provide an alternative mode of viewing the world and expressing elementary

human emotions and concerns distinct from official documents and texts” (Risse, 1999, p. 9). But he goes on to discuss narratives of hospital life and experiences as being in their infancy. Risse echoes similar concerns of mine as he describes hospitalization as “a journey to a foreign, exotic land, an often too common pilgrimage in which patients cross into a world of strange rites” (Risse, 1999, p. 9). Risse’s collection of letters and historic documents provide very real and personal evidence of medicine’s history. A major difference of my work, however, is through narrative of first-hand knowledge and experiences.

I will not claim to, nor would I ever attempt to, speak for these incredible human beings I have known through medicine. I cannot give them voice, as one might consider in this type of work. Their experiences are their own as are their voices. But I will attempt to convey these through a narrative of my experiences with them that I hope will evoke and share emotions. These moments have immediacy because of their emotional impact as well as the immediacy of need and awareness. As Pinar (2006) described to us, “Place and human feeling are intertwined” (Pinar et al., p. 533). Each of them has been in some way transformative.

My identity is truly “the outcome of those social practices that configure experience” (McLaren, 1995, p. 236). Here, Peter McLaren is speaking of the overall impact of the practices of any society or culture on an individual’s experience. My experiences within medicine have formed a large part of my identity in the world of medical colonialism. And my experiences through self-reflection and the study of curriculum theory are forming yet another aspect of my identity, causing changes in my form.

Education philosopher John Dewey writes, “To know the meaning of empiricism we need to understand what experience is” (Dewey, 1938, p. 25). Dewey’s writings and philosophy reminds us that not all experiences are positive ones. Not all are educative and some may actually be mis-educative in the effect any human being. Experience is beyond something that goes on inside of us, and as Dewey (1938) writes, “experience does not occur in a vacuum” (p. 40). Each experience affects that which comes after it. This is the power of experience, in that it truly shapes us as we go through life.

These same experiences shape the culture of medicine, as each experience of those within the culture can be said to affect others outwardly. Therefore, I am experiencing my work through narrative inquiry, by maintaining my place within the experience of medicine. With and without my white coat, I am a part of each place, living, interacting, seeing, and hearing people and events in each place. I must be aware of my voice, my shape, and my place in the story as I transition from myself as provider, teacher to storyteller. I am telling of myself and others and the world of medical colonialism as I interpret and understand it through my interactions within it. As Clandinin and Connelly (2000) describe it, I am not an objective inquirer studying a world that is simply less than I wish it could be, “I am complicit in this world” (p. 61). This complicity and awareness of my place is perhaps the most significant aspect of this work and may in many ways be self-implicating.

I see the aspects of the institution, practice techniques, and educational settings as places to explore. What do they reveal about the ties to both the “political and economic” (Van Maanen, 1988, p. 128) reality and colonial control in medicine. By being inside the

institution, I hope to offer my works in a very different method for others to view. Again, I read in C. Wright Mills work a call to do just that:

It is best to begin, I think, by reminding you, the beginning student, that the most admirable thinkers within the scholarly community you have chosen to join do not split their work from their lives. They seem to take both too seriously to allow such dissociation, and they want to use each for the enrichment of the other.

(Mills, 2000, p. 202)

I feel this type of separation as risking the same type of objectification of my own passions. While others' interpretations will vary from mine, a sense of the colonization of those who enter the institution of medicine will become very real, and move those who read this work. This narrative is meant to spark conversation—even if this conversation is of differing views and beliefs—the hope is that it will be complicated. As you can see, curriculum is the very complicated conversation. The conversations of curriculum since the reconceptualization of the field have not always been, and were never intended to be, one of united ideology. The multiple ways to explore and to understand the world around us, and our experiences in it, reach far beyond the classroom setting and the days of the Tylerian era of the field.

The method of *currere*—the infinitive form of curriculum—promises no quick fixes. On the contrary, this autobiographical method asks us to slow down, to remember even re-enter the past, and to meditatively imagine the future. Then, slowly and in one's own terms, one analyzes one's experience of the past and fantasies of the future in order to understand more fully, with more complexity and subtlety, one's submergence in the present. The method of *currere* is not a

matter of psychic survival, but one of subjective risk and social reconstruction, (Pinar, 2008, p. 9)

In my opinion, Pinar's work in curriculum theory serves as both foundation and cornerstone of the field. While in this text, he describes an autobiographical method, there is a similar feel to my use of narrative of my own experiences. I have slowed down or stopped to re-enter the not-so-distant past, and then use these periods as points from which I can imagine possible reconstruction of the future. I have chosen critical narrative as my primary qualitative methodology for this dissertation. It is my belief that my exploration and critique of the practice and institution of medicine would be little more than hollow words without the basis of experiences I have witnessed firsthand.

Within the field of curriculum studies there exists a great rift between those writing within critical theory and Marxist techniques and those whose works in curriculum theory are more steeped within autobiographical and narrative fields. This rift began early in the reconceptualization of curriculum theory. Martin Jay describes concerns of the early Frankfurt school philosophers regarding autobiographical work within their realm of study. For example:

Horkheimer and the other members of the Frankfurt School came to believe that the real danger lay not with those who overemphasized subjectivity and individuality, but rather with those who sought to eliminate them entirely under the banner of false totalism. (Jay, 1973, p. 53)

William Pinar in a retrospective article in the *Journal of Curriculum and Supervision* explores the creation of this rift or separation between the fields of critical theory and others within Curriculum Theory. Pinar, considered by many to be one of the

pioneers of the reconceptualization of Curriculum, describes the initial conference of curriculum scholarship that he hosted in 1973 in Rochester, New York. He describes this conference as “an effort to link the ideas of curriculum theorists to development in the political and cultural spheres, and those efforts continued, indeed became one of the major thematic of the so-called reconceptualist movement” (Pinar, 1988, p. 159). The conference in New York was the first of many, though Pinar goes on to describe the initial “internal divisions” (Pinar, 1988) which began to appear.

Pinar wrote, “In the broadest terms, the divisions were between Marxists of various orientations and interests and those of us interested less in macro-order issues and more interested in individual” (Pinar, 1988, p. 160). Pinar sought to offer venues wherein critiques of power would be alongside explorations of the lived experiences of individuals—many of whom suffered from the very institutions criticized by Apple and others. (Pinar, 1988)

In the text, *Curriculum, Toward New Identities*, William Doll Jr., provides a poignant description of this issue:

But I do wish to point out that in the esotericism of their (political theorists) debates they missed a key point, on Michael Apple (1975) made in his first essay on the hidden curriculum. There, he says, prior to his statement about the curriculum legitimating “the existing social order,” that the curriculum in its hidden form also “serves to reinforce basic rules” by positing “a network of assumptions that ...establishes the boundaries of legitimacy” (p. 99). All societies need rules; they are, again as Apple says, “the fundamental patterns which hold society together” (p. 98). However, when the legitimacy of these

rules and patterns is shrouded in mist, then indeed control becomes a ghost. Light has been shed on that ghost, even if the ghost has not been exorcised, but we have not given the attention I believe we must to the nature of and relationship between boundaries and networks. *All legitimacy, indeed all learning and knowledge occur within temporally bounded networks.* The control that lurks as the ghost in the curriculum will never be truly illuminated or exorcised until we wrestle with this fundamental fact. (Doll, 1998, p. 298)

Pinar and others sought to maintain balance, as the critical theoretical aspects of curriculum theory have been crucial to the reconceptualization of the field. “How do these two activities—on theoretical and the other methodological—support each other and serve a joint purpose? What specific research practices produce narrative research informed by a broad social critique and a politics of social change” (Chase, 2005, p. 82)? It is my belief that the two can and should co-exist. I do not believe that one can truly exist without the other. Theory is formed through experience, is it not?

However, “Narrative inquirers and Marxist-influenced scholars working in the applied social sciences often share an interest in analyzing the way large institutions dehumanize, anesthetize, and alienate the people living and working within them” (Clandinin & Rosiek, 2007, p. 47). Researchers, such as the medical anthropologist, Paul Farmer, offer first-hand experiences of scenes of the lives affected by institutions and bureaucracies.

In his text, *Pathologies of Power*, Farmer (2005) tells us:

Today, the world’s poor are the chief victims of structural violence—a violence that has thus far defied the analysis of many who seek to understand the nature

and distribution of extreme suffering. Why might this be so? One answer is that the poor are not only more likely to suffer; they are also less likely to have their suffering noticed.

The task at hand, if this silence is to be broken, is to identify the forces conspiring to promote suffering, with the understanding that these are differentially weighted in different settings. If we do this, we stand a chance of discerning the causes of extreme suffering and also the forces that put some at risk for human rights abuses, while others are shielded from risk. No honest assessment of the current state of human rights can omit an analysis of structural violence. (p. 50)

In this work by Farmer, narrative, first-hand accounts of his own experiences in Latin America and Russia are combined with in-depth critique of the structural components of issues he sees regarding health related human rights abuses. He describes his personal struggle and trepidation with decisions of how and what to write, and how to present what he witnessed. He openly states that he is not neutral in his writing and, in fact, he is “a partial witness in every sense” (Farmer, 2005, p. 26). Recalling his previous work “*The Uses of Haiti*”, in his *Pathologies* text, the structural violence as, “much more malignant in its impact—surely, structural violence damages and destroys more lives in a day than does a century’s worth of sorcery” (Farmer, 2005, p. 28). Should we not then critique the structures surrounding us as well?

As I stated earlier, my critique of the structure and institution of medicine is at its core one of critical theory in that I have much more fully realized the domination of medicine as a colonial power. However, to offer critique without narrative of my

experiences from inside the system seems empty and devoid of the honesty and realism of my lived experiences.

The primary impetus of my work and study is to critique the manners by which the institutions of medicine and healthcare in this country “physically disempower individuals and groups but also...epistemically disempower” them (Clandinin & Rosiek, 2007, p. 48). The power of the ideology of medicine is a major source of the oppression of the sick. And again, I use the term *ideology* as those Marxist theorists might; as a system or means of deflection of real understanding. Those under medicine’s control view medicine healthcare through an ideology that is I believe stems from the power of the institution itself.

“By focusing on individual experience as a source of insight, the larger social conditions that shape the narrative in which people live go unexamined” (Clandinin & Rosiek, 2007, p. 48). I believe the experience of the individual suffering from the larger social condition of medical colonization is something that must be told through the narrative of experience.

The power of narrative can be described as strikingly decolonizing:

Narrative is the specific form taken by written history to counter the permanence of vision...Narrative asserts the power of men to be born, develop, die, and the tendency of institutions and actualities to change, the likelihood that modernity and contemporaneity will finally overtake “classical” civilizations; above all, it asserts that the domination of reality by vision is no more than a will to power, a will to truth and interpretation, and not an objective condition of history.

Narrative, in short, introduces an opposing point of view, perspective,

consciousness to the unitary web of vision; it violates the serene Apollonian fictions asserted by vision. (Said, 1979, p. 240)

As Van Maanen writes, there may well be criticism of my work being nothing more than:

Akin to the complaints of missionaries and colonists who viewed the early anthropologists as godless, unpatriotic folk who care not a whit for the souls of those they studied and were content to leave the groups of their interest unchanged and no better off (perhaps worse off) by their presence. (Van Maanen, 1988, p. 130)

I also use the narrative because I care very deeply about the circumstances in which the ill, and my students, find themselves. Again, the emancipatory focus of critical theory and critical humanism is paramount to me. As Van Maanen continues his descriptions of the tellers of “critical tales,” he describes work utilizing narrative and critical theory as containing a very profound Marxist component and with regards to my inquiry—I see these stories as a true form of protest against injustice (Van Maanen, 1988, p. 30).

To critique, to question, to explore, and to begin this research without the narratives and sights, sounds, stories, and faces of those I have encountered would, in my opinion, be cold, hollow, and just another dissertation on the shelf in the library at Georgia Southern University. Without the narrative to make the critique real—change would not be possible.

Visual Narrative Methodology

Here, the action of representation consists of bringing one of these ...forms of invisibility into the place of the other...a metathesis of visibility that affects both the space represented in the picture and its nature as representation. (Foucault, 1970, p. 8)

How do I convey to you an image; a visual representation through words, through language of how I see my work in the field of curriculum studies? It is not an easy task. Foucault (1970) illustrates my quandary as he writes, “the relation of language to painting is an infinite relation. It is not that words are imperfect or that, when confronted with the visible, they prove insuperably inadequate....It is in vain that we say what we see; what we see never resides in what we say” (p. 9). I believe that by adding the visual, creating a methodology of visual narrative, will add a more vivid dimension to my study.

Through the course of my studies, I have attempted to reveal through words the stories, the histories of my experiences, and my life story as it has unfolded over the past twenty-five years of my encounters in the world of medicine. Our minds translate verbal descriptions into mental images when we read. My stories and history—these images; give my work its context.

I’ve attempted to offer verbal snap-shots of my life in the hospital as a nurse and a physician assistant, from those days when everything inside of me knew was wrong that in which I was witnessing and participating. I had no means to articulate my feelings, no method or knowledge of the forces around me. I saw graphically with sound, sights, and smells within the reality of the haves and have-nots. And the world of curriculum theory

has offered me many methods through which I can question and explore these experiences.

There are many types of representation of thoughts and ideas that go beyond words on a page. And many of these types of representation provide in many ways a different, perhaps deeper understanding of meaning. Images, whether they are photographic, or cinematographic, are just a few of the types of representation through which we can display and communicate our ideas. John Dewey (1934) in his writings expressed this when he wrote, “What is even more important is that not only is this (aesthetic) quality a significant motive in undertaking intellectual inquiry and keeping it honest, but that no intellectual activity is an integral even (is an experience), unless it is rounded out with this quality” (p. 38). Dewey felt that all intellectual endeavors must contain an aesthetic component to be worthy of the name. I have chosen to use visual imagery, while others may choose music or poetry.

Throughout my studies and the papers I have written, I feel my professors may have wondered, “What did she (witness) that we don’t get to see—pictures unused, pictures not (recorded)” (Coles, 1997, p. 161). Robert Coles’ text, *Doing Documentary Work*, explores questions surrounding documentary work and issues of theory, exploration, and responsibility. Coles (1997) wrote about the challenges of making pictures and narrative come together as he stated,

The ethical challenges that appear, it sometimes seems, from out of nowhere? Moreover, what to make of one’s interventions, as a write, as an editor of tapes or notes, as the person who picks and chooses words, crops and cuts photographs, splices constantly the tapes of a documentary film? When do selection and

arrangement and a response to narrative need, in the form of one's comments and asides become so decisive that one story...has turned into quite another. (p. 16)

Coles explores the work and images from many photographers and documentaries to pose questions about the nature of images and the study of society. The photographer Dorothea Lange's work during the depression era is one Coles chose to study. Here, he quotes Lange as stating, "I can only say that I knew I was looking at something. You know there are moments such as these when time stands still and all you do is hold your breath and hope it will wait for you" (Coles, 1997, p. 149). As I researched the images I have chosen to place within my work, I have found each of them breathtaking and I hoped others can find meaning in them. Some might suppose or believe that I intend a specific message to be conveyed, as motive for incorporating images. But it is meaning, and not message that is my intent. And as each individual sees these images, the meaning of them will for them, be individual as well.

I hope that by placing images within my work that I can use "imagery to study specific questions and issues" (Harper, 2008, p. 187) surrounding the colonization of the patients. I see it as another method of study. These images are of "something seen" (Harper, p. 187) by artists, photographers, and even some, such as those of Jo Spence are of patients themselves. The images I have chosen to include in this work are varied in type and focus. Each of them speaks to a different focus of my work and I hope offers a specific gaze.

Medicine has developed an almost unholy reliance on imagery, but not the image of the patient. It is a reliance on medical imagery, such as radiographic studies and pathology slides, is so forceful as to literally come between the physician and patient.

Kaplan, in her study, describes researchers hearing descriptions of “how seeing the (radiologic) image seems better for learning purposes than seeing the patient directly. One physician said, ‘The system helps [overcome] the feeling of having talked to [a patient] for a half hour without getting anywhere’” (Kaplan, 1995, p. 445). With continuing and a burgeoning growth of digital imagery of the body, the patient is an afterthought, at best.

The commitment felt upon entering the practice of medicine is lost as the clinical gaze Foucault described is formed. This new gaze is formed within the classrooms as an “ambivalent space between detached recording and humane response....The clinical gaze operates in compliance with a professional code of ethics that trains its adherents in the art of personal detachment from those with whom they work” (Nichols, 1991, p. 87). The end result is a relationship between the physician and the patient that is empty—without human response and solely comprised of a disciplined and clinical encounter.

In my work as an oncology physician assistant, I have attended many meetings, called tumor boards. In these meetings, the primary oncologist or surgeon, who is in charge of the patient’s case, usually gives the initial presentation. The diagnosis and a brief history of the patient are told. Next in the presentation are slides of x-rays, CT scans or MRIs of the tumor, while descriptions of treatment that have occurred are also discussed. What follows is most often a series of slides of tissue from the pathology department, revealing the tumor at the cellular level with its naming and classification of cancer type and stage.

“The problem arising here is that the evolution of this essentially technical being that the human is exceeds the biological, although this dimension is an essential part of

the technical phenomenon itself, something like its enigma” (Stiegler, 1994, p. 50).

Medicine and technology have verbally and visually created an enigma, a riddle of life and illness; death and suffering to which is purports to solve through visually splitting the human from the being.

Elliot Eisner (2002) explores this issue as he writes:

But the act of representation is not only a re-presentation of images and ideas held in the privacy of one’s cortex. The act of representation also provides an arena in which new possibilities, new images can be discovered. The act of representation is not merely a monologue made manifest through the obedient response of a material; the material itself speaks and creates new possibilities to be discovered by a sensitive eye and a deft hand. The act of representation is an act of discovery and invention and not merely a means through which an individual’s will is imposed upon a material. (p. 239)

The technical imagery of the body should be seen as much more than an obedient response of a technological and scientific machination that separates the humanity. It should be viewed and taught as a discovery of another incredible aspect of that human being which requires a sensitive interpretation and understanding.

W. J. T. Mitchell engages us in yet a different lens, one through which we explore the world of images. In an article entitled, “*What do pictures really want,*” Mitchell describes the possibility of a humanlike consciousness of images and asks for us the question, what do pictures want? He gives to us the following “place” of images as he writes,

Vision is as important as language in mediating social relations, and it is not reducible to language, to the “sign”, or to discourse. Pictures want equal rights with language, not to be turned into language. They want neither to be leveled into a “history of images” nor elevated into a “history of art” but to be seen as complex individuals occupying multiple subject positions and identities.

(Mitchell, 1996, p. 82)

Could we not just as seriously ask ourselves “What do patients want”? Those who are ill and seeking treatment are complex and occupy many places and identities.

(Mitchell, 1996)

One such individual was the artist and photographer Jo Spence, whose life was cut short by breast cancer and subsequent leukemia. She was a photographer whose passion was to criticize modernity, and she penned her own pathography and chose to use her own personal imagery to reveal vividly to us her own colonization by medicine. She used her photography and imagery of her body to maintain and reveal to us her humanity. I see her work as postcolonial in an emancipatory effort to in some way subvert medicine’s use of technical imagery.

Linda Smith discussed this type of effort through representation as a method of decolonization in her text. She wrote:

Representation of indigenous peoples by indigenous people is about countering the dominant society’s image of indigenous peoples, their lifestyles and belief systems. It is also about proposing solutions to the real-life dilemmas that indigenous communities confront and trying to capture the complexities of being indigenous. (Smith, 1999, p. 151)

Here Smith is discussing indigenous poets, artists, and authors, but we may very well add photographers and filmmakers to this list.

The emancipatory discourse of which the ill are capable of is evidenced here in the words of Jo Spence.

Passing through the hands of the medical orthodoxy can be terrifying when you have breast cancer. I determined to document for myself what was happening to me. Not to be merely the object of their medical discourse but to be the active subject of my own investigation. Here whilst a mammogram is being done I have persuaded the radiographer to take a picture for me. She was rather unhappy about it, but felt it was preferable to my holding the camera out at arm's length and doing a self portrait. (Spence, 1988, p. 153)



Figure 5. (Spence, 1988) Jo Spence 'Mammogram'

Spence combined narrative and photographic imagery in much the same way documentary utilizes narrative as the images proceed in front of our eyes on the screen.

The power of narrative in documentary offers us an opportunity to question. Bill Nichols (1991) describes the power of imagery and narrative, which:

Raise(s) the question of representational form: how situations and events, the bodies of individuals and the exchanges between them be represented in a text so as to promote an apprehension of magnitudes discovered or revealed, perhaps even as though for the first time?... How can those often represented as Other reappropriate their own images, reestablish their own places, and reclaim their own bodies, especially when they have been routinely displaced from the position of author or authority? (p. 240)



Figure 6. Jo Spence (Spence, Dennett, 1988)

Spence here describes her thoughts on reclaiming her body,

Before I went into hospital in 1982 I decided I wanted a talisman to remind myself that I had some rights over my own body. Terry Dennett and I set up a

series of tableaux, each with a different caption written on the breast. This is the one I took with me. I felt I was entering unknown territory and wanted to create my own magic fetish to take with me. (Spence & Dennett, n.d.)

In Figure 6 above, as Spence tells us, she visually attempts a battle for self and her own individual humanness before she becomes colonized by her entrance into medicine. When Spence was diagnosed with breast cancer, she refused the traditional treatment regimen recommended to her—that of a mastectomy. Traditional medicine, and specifically her physician’s response to her refusal, led her to describe her feelings in the following manner. “I do not think I have been so lonely in my entire life as I was after I’d refused allopathic treatment for breast cancer—the mastectomy and radiotherapy” (Spence, 1995, p. 213). Can we view the work of Jo Spence and her images an act of civil disobedience? If so, what are the possibilities?

Visual imagery is far from new, from the earliest days of photography followed by film documentary, sociologists have tried to reveal what they have seen and experienced in their studies of human life in areas around the world. Utilized in this way, Douglas Harper writes, “the photographs argue that visual traces of the world adequately describe the phenomenon under question” (Harper, 2008, p. 187). These images offer a momentary look, a glimpse of the immediate. Drawn through the artist’s framing, they reveal immediacy and urge action. But it does not solely have to be images or photographs of real patients. It can be artistic forms of imagery such as Figure 6 by Gena Haskett.



Figure 7. Art of Medicine (Haskett, 2007)

The face pushing to be seen through the tissues and vessels is one that impresses me greatly. Gena Haskett offers us a glimpse of the struggle of the patient/person—to be seen and realized above and beyond the physical presence of their anatomy. The face reveals the humanity that is too often unseen and ignored.

The impact of the sterilized images of disease and pathology in medicine, and the discourse within the classroom, disembodiment the human experience of illness. Bill Nichols writes, “Individuation becomes a matter of inflecting institutional discourse with the ‘grain’ or texture of the distinctive, recurring voice. These voices—such as those (physicians)—are attached to bodies that represent not personal witness, but institutional authority in anthropomorphic form (Nichols, 1991, p. 90). Nichols goes on in his text to describe the impact the detachment brought about by revealing patients with the posturing of the victim as faceless and lacking all humanity.

Elliot Eisner wrote that, “Seeing is a selective activity shaped by the frameworks that serve as screens in our consciousness” (Eisner, 2002, p. 108). It is my belief that images such as those of Jo Spence and Gena Haskett can actually provoke questioning,

touch our minds in a way that simply reading medical text cannot. In its colonization of the patient, medicine seems to “overlook or discount the visible, palpable, bodily existence of the person-as-a-whole” (Evans, 1998, p. 16). It is a methodology I hope which will take my words beyond their mere reading and offer an added dimension.

Visual narrative is postcolonial in its continuing evolution and influence, as a method through which Spence, and others like her, reveal an emancipatory aspect of images. It is an addition to the field, and at a “time when a multitude of approaches to knowing and telling exist side by side” (Richardson, L., & St. Pierre, E. A., 2008, p. 477). Visual imagery offers evidence beyond the text with which to critique and question.

The human body of any ill person is a powerful, evocative site and case in point for all the transformations of body experiences....Moreover, although it is considered taboo not only the act of speaking about a terminal (or serious) illness, but also the act of looking at one’s deformed body, photographs finally permit us to analyze and construct different discourse for the body in pain. (Florescu, 2006, p. 283)

Shouldn’t the discourse in medicine be not only about the pathology of the disease within the body, but the unique individual illness experiences of each human being they encounter?

To understand what happens in places like ‘projects’ or ‘housing developments’ as well as in certain kinds of schools, places, which bring together people who have nothing in common and force them to live together either in mutual ignorance and incomprehension or else in latent or open conflict—with all the suffering this entails—it is not enough to explain each point of view separately.

All of them must be brought together as they are in reality, not to relativize them in an infinite number of cross-cutting images, but quite to the contrary, through simple juxtaposition, to bring out everything that results when different or antagonistic visions of the world confront each other—that is, in certain cases, the tragic consequences of making incompatible points of view confront each other, where no concession or compromise is possible because each of them is equally founded in social reason. (Bourdieu et al., 1993, p. 3)

Bourdieu et al. compiled a vast amount of first person accounts and narratives of life within France and covering urban and rural areas. These stories included those of health and illness, as experienced by the individual in their own words. Taken separately, they are each meaningful, and yet as Bourdieu et al. state above, they must be brought together. Their differences offer us a look at the various views of our world through their eyes and words.

Perhaps it is a major limitation of my study that, while the narratives are of different patients, different students, and different experiences of medicine, they are all my own. Having the unique position of crossing the borders of each place, these experiences vary sufficiently to be brought together such that “tragic consequences of making incompatible points of view confront each other” (Bourdieu et al., 1993, p. 3)

CHAPTER 3
EXPERIENCE OF THE PATIENT

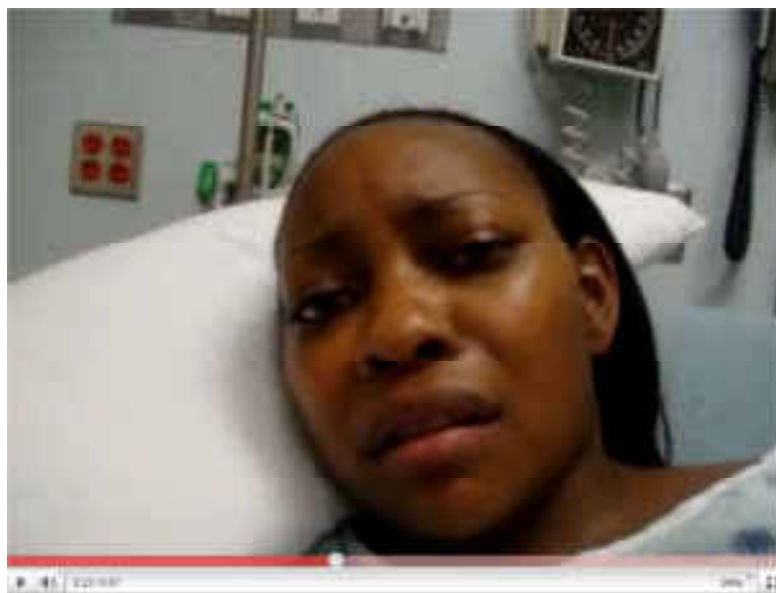


Figure 8. Sickle Cell (Xcaramel24, 2008)

In this chapter, I will explore the experience of the patient within the world of medicine through the use of narrative as a method of discourse. I begin with a patient for whom I cared and whom we will call Sarah. Sarah is unique in that I do not view any patient I encounter as typical. She made an impression on me from the moment I entered her hospital room. Over the course of the few days I knew her, her story became a part of my experience.

Clandinin and Rosiek state, “In our view, narratives are the form of representation that describes human experience as it unfolds through time” (Clandinin & Rosiek (2007, p. 40). My time with Sarah, though finite in hours, will be given a sense of the immediate as you read it. But as we will see throughout this chapter, her story will provide a point from which I hope to juxtapose the narrative of her experience in an effort

to explore both the history and development of the identity as well as place of the ill—the one medicine calls patient.



Miss S. is a 24-year-old black young woman in room 514. She gave birth to her first child one week ago by cesarean section. She returned to the hospital yesterday when her abdominal incision opened and she saw drainage from the wound. Add to this the fact that she suffers from sickle cell anemia, a genetically inherited blood disease in which red blood cells take on a shape similar to a sickle as opposed to the normally ovoid flexible red blood cells. These sickle cells can become lodged in the blood vessels at random times and throughout the body causing interruption of blood flow to the distal areas leading to lack of oxygenation and strong to severe pain. The pain of a heart attack is due to lack of oxygenation to the tissues, and sickle cell patients can feel this type of pain in any area of the body with attacks medicine terms a crisis. Infection and stress are frequently precipitating factors in the onset of sickle cell crisis.

These sickle cell crises begin in childhood and patients are treated with oxygen, fluids, and narcotic pain medication. Over the years, patients are seen often in Emergency rooms and are admitted to hospital with high frequency and need for a narcotics, labeling them as drug seekers. Whether they are truly dependent or not, they gain tolerance to the medications through repeated need and use and, in the eyes of the medical institution and staff, they are seen as abusers. What seems to disappear in these halls and fade from view is the reality that many of these people afflicted with this disease will die from organ failure due to their sickle cell disease in their 50s.

I am working as a Physician Assistant this weekend with a group of hospitalist physicians. I have been assigned this patient by one of the internists on duty. Dr. R.

advised me that “we need to get her out of here. She is not going to be happy with us because I have stopped all of her IV pain medication and she can only have PO (by mouth) meds. Don’t let her talk you into trying to give her anything stronger. She’s just a drug seeker and we’ve got to get her back home”



Medical humanities professors Delese Wear and Julia Aultman tell us, “Admitting and naming disgust for a patient is conceptually and professionally heretical for doctors—at least in the ‘outside’ world—even though these feelings and the expression of these feelings are commonplace in medical settings” (Wear & Aultman, 2007, p. 353). Sarah is couched in terms of a “drug seeker”, and as such, is to blame for her condition. This type of behavior is seen as self-inflicted and self-perpetuating. She is taking up a bed, time, and money. Those patients “whose afflictions [are] the consequence of self-abuse... [are] evaluated as less ‘worthy’ of care than those whose pathology [is] perceived as no fault of their own” (Mizrahi, Wear & Aultman, 2007, p. 356). They are blamed as the reason for their condition, as having no self-discipline, as being a burden on society and the medical system.



When I first go in to see Sarah, she is lying on the bed, alone in a room designed to hold two patients. She is alone in a bed, away from the window and just inside the door, so that all who come into the quad area outside her door are able to look in and see her lying there.

I am merely another in a seemingly endless stream of hospital persons who come into her room. I go in the room and introduce myself and ask her how she is doing. Sarah has been asked them many times in the past few days. She glances at my face and

then looks back to her body in the bed, and she states she has back pain, and leg pain. She then asks me if I can “please” give her more of her IV pain medication.

I begin to ask her more about her pain, how severe it is, where it is, the usual standard litany of the medical interview. I then ask her permission to examine her. While I am talking, she is unable to lie still, uncomfortable and moaning. I listen to her heart, lungs, and examine her abdomen, pulling back the dressing from the open C-section scar that is now being allowed to heal slowly on its own. All looks well, and then I ask her about her newborn baby.

She still doesn't look at me directly. She tells me she had a little girl, and with another question she tells me that it is her first child. I ask her who is taking care of the baby and she states that her Grandmother has the baby and is caring for it. Her affect while talking about the child has not changed from our discussion about her pain. She asks again for the pain medication and I tell her that the doctors want her to try and stay on oral medication so that she can go home sooner and see her baby. I then tell her that I will check back on her later and see how she's doing. I say that if her pain is still severe then, that I will ask if she can have another dose of the IV medications. She doesn't respond, she just continues to toss slowly in the bed.

I leave the silence of her room and go out into the quad area where the nurse's station has Sarah's chart and I proceed to write my note. The nurses in the quad area are discussing what someone is fixing for dinner that night, and in another area, a discussion is ongoing about how one nurse was treated by a doctor. Computer keys are clicking and an elderly woman in the next room is calling out for help with no response. Nurses' aides are walking down the hall in conversation about the patient they are on

their way to bathe. Dietary services come by and pick up the trays but they stay no longer than necessary. Sarah remains in silence in her bed.

I write, placing the details of my examination into the chart, focusing on her chief complaint, her description of the character and severity of the pain. I document my physical examination findings and even comment on her appearing to be uncomfortable and what I can only medically describe as a flat affect. But I make no mention of her baby and what to me is an unhealthy lack of desire to return home and care for the infant she just gave birth to. I add depression as a possible diagnosis among others and my thoughts begin to wonder about what will happen to the entire family once she is discharged home. But those thoughts have no place here and I move on to the next patient on my list.



One of the realities of American medicine is that there is a true shortage of bed space. In the hospital in which I now teach, you frequently hear a *Code K* alert over the loud speaker. The meaning behind a code K is that all beds are full and all floors are encouraged to complete pending discharges as quickly as possible. Emergency rooms are overflowing with patients waiting on beds to become available on the floors. This leads “Hospital utilization reviewers [to breathe] down doctor’s backs, questioning the necessity of keeping a patient in the hospital yet another day” (Abraham, 1993, p. 79). In America, patients are beds, numbers, coding charges, and bar codes to be moved along the conveyor belt. They are bagged and placed in the car like groceries items to go home.

Additionally, depression, isolation, and illness are everyday experiences in the hospital settings. These psychosocial issues are rarely addressed and even more rarely treated. The patient is “systematically ignored as anyone—actually anything—other than

a body” (Frank, 1995, p. 12). The inpatient settings of most hospitals address psych issues only when the behavior is suicidal, drug-induced, or psychotic.

Why would a young woman barely mention her newborn infant? Is it her pain? Is it her feeling of lack of control over her situation? She is being denied the relief she seeks through her inability to receive medication. A grandmother cares for her child, yet no other visible support or interaction is witnessed during her hospitalization.



The most I could do for Sarah was to write an order for a social service consult for the home environment upon discharge. Although forcing yet another institutional bureaucracy into her life was not the answer, it was all I could do and I felt I had to do something. I discussed my concerns with Dr. R. He listens to me and then smiles sardonically and said, “...makes you wonder why she let herself get pregnant, doesn’t it?” He began to walk away and said, “I’ll see you on the 4th floor”.



Too often in the practice of medicine, patients like Sarah are discharged with little to no follow up. The system has performed its ethical and moral duty to her by treating her acute condition, no matter how poorly, and then deciding that she is ready to go home, despite her pleas for continued help. “You are what you are because of us; when we left [or you were discharged], you reverted to your deplorable state; know that or you will know nothing” (Said, 1994, p. 35) writes Said. With Sarah’s next sickle cell crisis and admission to the hospital, she will once again be labeled as a drug seeker, and I fear no one will even think to ask her about her infant, her life, or her needs.

Despite every ounce of good intention from those who enter the practice of medicine, too often the reality can be as simply stated as this: “So you become very

efficient at not really listening to people—just getting the information you need, and ‘shutting them off’ ” (Harwood, 1984, p. 70). Who goes into medicine in order to shut people off and then out? Why are some so quick to label the sick and vulnerable with terms such as *drug-seeker*, *non-compliant*, and *frequent flyer*, without a sense that there may be something much more significant occurring in their lives which makes the label pale in comparison?

In the text *One Dimensional Man*, Marcuse described the ability for reason to become submission to what is viewed by society as a fact of life. He wrote:

The efficiency of the system blunts the individual’s recognition that it contains no facts which do not communicate the representative power of the whole. If individuals find themselves in things which shape their life, they do so, not by giving, but by accepting the law of things—not the law of physics but the law of their society. (Marcuse, 1964, p. 11)

Sarah’s response to her situation and her complete lack of control over her condition, her pain, and the circumstances which led her to it, offer us a human experience to put within Marcuse’s words.

The Setting of the Patient

The institutions and customs that exist in the present and that give rise to present social ills and dislocations did not arise overnight. They have a long history behind them. (Dewey, 1938, p. 77)

In ancient Greek and Roman empires, Conrad and Schneider (2009) tell us “disease was given supernatural explanations and ‘medicine’ was the province of priests or shamans” (p. 194). In fact, the Greek Philosopher, Hippocrates, is considered by most

to be the father of the field of medicine. Hippocrates “refused to accept supernatural explanations or treatments for disease, [and] developed a theory of ‘natural’ causes of disease and systematized all available medical knowledge” (Conrad & Schneider, 2009). Diseases were categorized and conditions were names, giving the power to name to the specialist.

Upon the advent of Christianity, most people held fast to the beliefs of the supernatural causes of illnesses, specifically that of sin. Illness and suffering were due to a real or imaginary sin that had been committed, leading to a practice of blaming the sick for their illness. Healing was attained through acts of contrition and penance, as well as through care and treatment. The disease of leprosy, for example, was believed by both Christian and Jewish faiths to be a punishment for sins. “Biblical explanations for leprosy, coupled perhaps with some awareness that leprosy was contagious, led Western societies for centuries to isolate affected individuals” (Weitz, 2010, p. 108). In return, the suffering of the leper offered, to those within the church, the power to develop conditions, settings, and rules of behavior for those afflicted. In addition, it offered those within the faiths the ability to practice a form of charity, perhaps for their own piety.

With the coming of the Middle Ages and the expansion of the Greek and Roman empires into modern Europe, these beliefs continued to be very strongly held. Physicians were also priests and ministers in their communities, giving them power over the souls, as well as the bodies. Those diagnosed with leprosy were formally and publically identified by the church in a “leper’s mass” (Weitz, 2010, p. 108), disrobed and given a “leper’s dress” (Weitz, 2010), the first patient gown. This isolation continued even into death, as

the church banned from graveyards those who succumbed to leprosy, as the association between leprosy and sin was very strong.

Dating back to the 3rd century AD, the Emperor Constantine, both a Christian and Roman, may be considered to be one of the first governmental rulers who blended church and state leadership. Constantine felt “an obligation to perform works of mercy for his suffering subjects” (Risse, 1999, p. 81). Under his rule, “shelters” (Risse, 1999) were established for those who were infirmed in some way.

In the Byzantine period, the Christian church propelled the development of a state welfare system, wherein churches established the “almshouses, hostels, orphanages, and hospitals” (Risse, 1999, p. 81). Priests and others within the church community provided care, which was primarily bathing and anointing of the sick and of those in need. This care was provided free to any who sought it.

As time progressed, a form of separation occurred. Xenodocheia and Nosokomeion were established to provide shelter and food for those in need and care for the sick, respectively. Most of these shelters, which were usually attached to and developed in conjunction with a monastery, treated patients with malnutrition and other illnesses with respite care. Risse offers that, even in this time, there were physician-clerics who practiced herbal medicinal therapeutics, while the women of the community provided the basic bathing, feeding, and clothing of the sick. (Risse, 1999)

Monastery medical care and rituals reveal very early links to medical traditions and daily rhythms, which continue today. Training of physicians in therapies and pharmacology can be traced to this time. Again, Risse (1999) offers us the following description of these early practitioners:

Monastic routines prescribed two daily visits to the sick, early in the morning and following evening prayer. The *infirmarius* usually talked with patients and asked questions, checked on the food, compounded medicinal herbs, and comforted those in need. According to Benedict's rule, 'the abbot shall take the greatest care that the sick be not neglected by the cellarers or the attendants; for he is also responsible for what is done wrongly by his disciples. (p. 100)

Physicians continue this routine practice daily in countless hospitals around the country today. Rounds begin very early in the morning in order that physicians may see their patients in the hospitals prior to beginning care in the clinical settings at 9 am. They then return in the evenings to assess their patients before going home for the night. Larger institutions and medical teaching hospitals continue to hold one physician, most often referred to as the attending, responsible for the care of all residents, interns, and medical students training under him. He may not be physically present for the rounds of those students; however, the institution maintains that he is the primary physician in charge of the care of the patient.

The historic similarities begin here, but continue through the subsequent years of the stories of the sick and the settings of their care. As I mentioned previously, the issues of the lepers, the leper houses or "lazarettos" (Risse, 1999, p. 190), continued to offer those afflicted with basic care while at the same moment offering social segregation and the beginning of payment for services received to the institution. At times, the estates and property of the afflicted would be claimed and divided throughout the institution. New admissions were often asked for a fee, or their families were asked for contributions to provide for their services. (Risse, 1999)

The outbreak of the Bubonic plague in Rome in the 1650s forced the segregation of the sick and any presumed to be sick through the use of force, barricade, and fear. Those already declared to be unclean were sent to bury, or dispose of those who died from the disease. The poor were considered to purposefully spread the contagion and were subjected to questioning and brutality. The wealthy, however, were often able to remain cloistered within their homes through the payment of bribes or other methods. (Risse, 1999)

Following the plague, the small pox contagion led to the development of pox houses in Germany and other European countries. At first thought to be a virulent form of syphilis, Small pox quickly grew to be a dreaded and deadly condition. Again, fear of contagion led to segregation of the ill from the well and both church and state alike enforced these methods in an effort to save lives. (Risse, 1999)



Figure 9. Montgomery, James Francis (n.d.) George Heriot's Hospital
Edinburgh, Scotland

Both church funded and private hospitals grew in Europe. Alongside the growth of the hospitals grew the development of teaching physicians and training of those who desired the profession. In her text, Risse describes for us in great detail the admission of one patient in Edinburgh to a local hospital in the year 1760. Janet, a 19 year old household worker presented to the infirmary on a Sunday. The day of the week was unusual due to the local Sabbath traditions of the day.

The first step Janet had to endure was the admission process, which:

Unless there was an emergency, the Infirmary required a letter of recommendation from known Edinburgh citizens or pastors from other Scottish parishes. These coveted documents were only in the possession of current voluntary contributors to the hospital...In exchange for their gifts, these men obtained the right to sponsor a specific number of patients in director proportion to the amount of the donation. (Risse, 1999, p. 232)

Again, a significant parallel can be drawn between the practices of 1760 Europe and modern Western medicine. Janet, as a working class member of her community, was deemed worthy of medical care and attention as long as she had proved herself a laborer who contributed to this community through her work. This allowed her to receive care at a private hospital as opposed to her resorting to care at an almshouse or hostel. Her employer, as Risse states, was “expected to provide the necessary help for ensuring Janet’s recovery” so that she could continue her work when she was able (Risse, 1999).

Today, in American healthcare, the same type of focus can be seen. Those members of our society who work and are able to pay for some type of insurance through a private company are asked to provide proof of this at their presentation to the setting. Private insurance is seen as a status, an ability to pay for the care received through the efforts of their labor. These patients are seen as more worthy of care than those patients who are insured by Medicare or Medicaid, the governmental welfare insurance programs. Patients, such as Sarah and others, are viewed as out of work and, therefore, not as contributing members of society.

The world of American medicine does not guarantee healthcare to its citizens despite the fact that it and other countries around the world have signed a declaration stating that it should provide just that for its citizens. In 1948, the United Nations passed a Universal Declaration of Human Rights. This declaration states that:

Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, and housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control. (United Nations, 1948)

Despite this global declaration, we can see that a patient's ability to provide some sort of proof that they or some other person or entity will be able to pay for services received in clinical and hospital settings has a history predating this United Nations declaration.

Medicare and Medicaid insurance coverage is often touted as the means whereby American citizens with disability, chronic diseases, poverty, or those who are elderly are

able to access the healthcare system. The truth, however, is that this is becoming much more of a struggle than many of us realize. In June 2010, *USA Today* and other newspapers and magazines reported the following statistics:

The American Academy of Family Physicians says 13% of respondents didn't participate in Medicare last year, up from 8% in 2008 and 6% in 2004.

The American Osteopathic Association says 15% of its members don't participate in Medicare and 19% don't accept new Medicare patients. If the cut is not reversed, it says, the numbers will double.

The American Medical Association says 17% of more than 9,000 doctors surveyed restrict the number of Medicare patients in their practice. Among primary care physicians, the rate is 31%. (Wolf, 2010)

Physicians report declining reimbursement and costs as the primary reasons for the changes. American medicine is a fee-for-services system and physicians pay for office space, staff, and supplies from monies received from patients and, primarily, from insurance companies who set payments for services rendered and reimbursed accordingly. Today, Medicare is increasingly managed in public insurance companies through funds provided by the government. The following was reported in an online blog focused on healthcare in August 2010. To include Medicaid and Medicare, *The Palm Beach Post Blog* looked at reports compiled by *Modern Healthcare* magazine, and also analyzed the percentage of incomes reported by hospital CEOs that originated from public dollars.

HCA: Richard Bracken, the CEO of the largest hospital chain in the nation, earned \$8.89 million in 2009.

(These figures included salary, bonus, restricted stock grants, and pension and deferred compensation plans reported in the company's proxy statement, Modern Healthcare said.)

About 62 percent of HCA's admissions' are paid from tax dollars, i.e., Medicare, Medicaid, and managed Medicare and Medicaid programs, the company reported to stockholders. Privately insured or uninsured patients made up the rest.

Tenet Healthcare: CEO Trevor Fetter earned \$6.8 million, including the same extras. About 47 percent of Tenet's admissions are paid with tax dollars.

And here's what the CEOs at the major insurance companies serving our area made in FY 2009.

United Health Group: CEO Stephen Hemsley made \$7.46 million in annual compensation, plus he exercised stock options worth \$98.578 million, for total compensation of more than \$106 million. (Singer, 2010)

The focus of this work is not an exposé of specific financial stakeholders in healthcare, but rather acknowledgements of the realities of the polar extremes at play every day in hospitals and medical settings around this country. Both Janet and Sarah sought care within a system where healthcare is a commodity and a source of income to the institution that provides it.

The issue of the financial profit is that it is paid at the cost of someone who is ill. In the text, "*Exploitation of Illness in Capitalist Society*" by Howard Waitzkin and Barbara Waterman we see the authors compared this concern to Marx as well. They state that:

According to Marx, the exploitation of one class of people by another is a crucial characteristic of capitalist economic systems....The sick may be broadly construed as a class of people subject to financial exploitation under capitalism and bearing numerous similarities to the working class depicted in Marx theoretical analysis. (Waitzkin & Waterman, 1974, p. 14)

As we see here with Sarah and Janet, the system of medicine expects payment in return for services and assurance of such prior to providing care for the illness or condition.

Janet goes on to be placed in a room for the next step in her admission process—the interview. She has passed the initial step of proof of class or status but now needed to be deemed eligible or needy in the eyes of medicine. Again, Risse describes this scene for us:

Her history was important for the physicians deciding whether or not she would be admitted. These encounters could be frustrating and deceptive, as prospective patients tried hard to tell doctors the “right” stories about their sufferings to ensure admission. Physicians, in turn, were on the lookout for symptoms of signs that clearly marked particular diseases, and the applicants went out of their way to provide them....The clinical test thus served as a second important screening device to separate those who, in the eyes of the admitting professionals, would probably benefit from institutional care, as opposed to the hopelessly sick or those who feigned illness. (Risse, 1999, p. 235)

Sarah and countless others today in American hospitals are faced with the same types of interview and anxious moments while waiting for medicine to grant or deny

them admission. The usual language of this decision is that the patient “meets requirements for admission”, though these requirements are never visible and is rarely provided to the patient who might deign to ask for them. Sarah, it could be said, was luckier than many. At her presentation to the hospital, the large open and purulent postoperative abdominal wound provided her with a condition that definitively proved her requirement for admission. The decision to admit her also involved a concern by the institution that the care she had received a week earlier following delivery had possibly led to the development of her infection and wound. Concerns of liability very often meet admission requirements.

Linda Smith (1999) in her text, *Decolonizing Methodologies*, describes an aspect of imperialism as one that “[provides] the means through which the concepts of what counts as human could be applied systematically as forms of classification” (p. 25). Smith draws upon Said and Fanon as she continues to explore this power of naming and classification:

The European powers had by the nineteenth century already established systems of rule and forms of social relations which governed interaction with the indigenous peoples being colonized. These relationship were gendered, hierarchical and supported by rules, some explicit and others masked or hidden. (Smith, 1999, p. 26)

I offer here yet another link between practices of medicine and colonialism. Medicine, as with both the experiences of Janet and Sarah, develops and enforces the concepts and classifications of what counts as ill, or as worthy of admission. Statements made within the admissions area include, “You do not meet the criteria for admission”, or

labeling those without insurance as “self-pay”, providing a bureaucratic label which administrative and medical personnel equate with “costing the hospital money”.

Let us return for a moment to the exploration of Risse’s story of Janet and her counterpart, Sarah Risse writes:

After the interrogation was completed and the decision to admit Janet reached ... the salaried house physician proceeded with another set of rituals. He signed a paper indicating the patient’s destination. Medical clerks, in turn, made an appropriate entry in the General Register of Patients and in a separate Admissions Book, two components of an extensive record-keeping system devised to ensure and document the hospital’s social contract with its subscribers. A list was also sent to the matron for the provision of bed clothing and linens, together with a proper diet sheet. Escorted by a nurse, Janet finally went up to the female teaching ward, a 12 bed chamber, 50 by 26 feet long and located in the west wing, now virtually a fever ward, where she would have been greeted by the other inmates. Removal of personal clothing and exchange for a hospital gown, if available followed. (Risse, 1999, p. 236)

Once the decision had been made to admit Sarah a similar documentation occurred. The medical clerks of the modern hospital confirmed her information contained within an electronic medical records database. Her name is assigned to a numeric patient identification and this number is then assigned to a room on the general medical surgery floor. Her insurance of Medicaid dictates that her room will be a semi-private room with at least one other female patient. Her identification number is placed into a bar code and printed onto a wristband and placed upon her arm. She has already

had her personal clothing removed and been placed into a hospital gown with its opening down the back, secured only by two string ties. Her belongings are itemized on another form and placed into a plastic bag. She is placed in a wheelchair and taken upstairs to her room, at which point she is transferred to her bed. The nurse arrives to begin her admission interview, instructing the patient upon certain behaviors and procedures she will be expected to submit to.

The first of these is the call bell, which Sarah has strongly advised to use if she for any reason has to get out of bed. She has been told that for her safety, she must have someone in the room with her for assistance with ambulation. The bed rails are then raised on either side of her bed.

The masked or hidden rules of the institution are such as these. A forced reliance on nursing staff for many needs is just one example of a loss of independence. There are many patients whose illnesses are so severe and debilitating that they are completely bedridden and unable to ambulate, or have pain to such an extent that they would never dream of attempting to get out of bed.

With Sarah, lying in her room, I stand outside with my supervising physician who describes her to me with very little that could be called compassion or caring, however intellectual his knowledge of her disease may be.

Bulhan (1985) offers us a description of this with a colonial focus, stating that: The doctor-patient relationship is also a dramatic microcosm of dynamics in the larger society. The doctor is white; the patient is a person of color. The doctor has power; the patient has none. The doctor acts; the patient is acted upon. The doctor is highly privileged; the patient is downtrodden. The doctor is a fighter, in

this case ostensibly against disease. The patient is only a victim now to disease and always to the colonial system. (p. 96)

Bulhan described the relationship of what most would consider the most significant form of colonialism, that of a conquerer of lands, with a major component of that colonialism through medicine. Is this description not extremely fitting to that of Sarah? Her doctor and her physician assistant are white, while she is black. Medicine has the power to grant her admission and treatment for her pain, but she has very little recourse of her own. We are privileged in many ways with our status, including our financial and societal successes; however, Sarah is poor, poorly educated, and now a single mother in the South with a debilitating disease that may someday end her life.

The walls of Sarah's hospital room is a space many of us feel is one of equanimity, one of equality of patients no matter their color or religion. Said described for us a look at the ability of this space to acquire and even elicit emotions.

The objective space of a house—its corners, corridors, cellar, rooms—is far less important than that what poetically it is endowed with, which is usually a quality with in imaginative or figurative value we can name and feel: thus a house may be haunted, or homelike, or prisonlike, or magical. So space acquires emotional and even rational sense by a kind of poetic process, whereby the vacant or anonymous reaches of distance are converted into meaning for us here. (Said, 1979, p. 55)



Figure 10. Hospital Room (Sienicki, 2005)

At first glance, a simple hospital room, oblong in shape with two nondescript mechanical beds and matching bedding may appear very different to each of us based on our own experiences or images developed from stories of others. To some, if not most, it is a cold setting. Very few of us would see it as warm or inviting. Many would view the room as a technical place, from its wall apparatuses to the technical buttons on the bed.

But each of us as individuals makes meaning from this space in our minds and thoughts and these meanings influence our emotions about this same space. Again, Said (1993) wrote, “For there is no doubt that imaginative geography and history help the mind to intensify its own sense of itself by dramatizing the distance and difference between what is close to it and what is far away” (p. 55). From within the hospital bed, you can imagine quite a vast array of geography taking place. As a young black woman in pain, how vast was the distance and difference that Sarah may feel from the white doctor in the white coat on the other side of the bed rail. Would she see him as close or

far away from her predicament? Does their difference in sex impact her feeling of difference, or of trust?

How should we address these questions? Would medical anthropologists or other curriculum scholars explore this from a critical feminism aspect, or would a critical race framework provide a much deeper grounding with which we could explore these questions? Is it a question for medical humanities?

The next question I would ask is how does she feel within this same space? Do her place and her difference have any impact upon the physician's ability to truly see her as she is—as her experience is within the space? Did mine?

Inequality, not surprisingly, is a powerful social divider, perhaps because we all tend to use differences in living standards as markers of status differences.... And when we have less to do with other kinds of people, it's harder for us to trust them. Our position in the social hierarchy affects who we see as part of the in-group and who as out-group—us and them—so affecting our ability to identify with and empathize with other people. (Wilkinson & Pickett, 2009, p. 51)

With this quote from *The Spirit Level*, we see that the difference in social class for the doctor is one that could definitely have an impact upon their relating to one another, but most significantly, this tells us that it would also affect his ability to empathize with the patient. The ability to feel a level of empathy or compassion from the physician is, to many, a prime component of the physician patient encounter. Yet, we see that a multitude of differences – race, color, and socio-economic status – can and do make a difference and have an impact.

The capacity of someone of higher socio-economic status to walk by a homeless person on the street without a glance or word offers us one example of this type of indifference. Why can I not conceive it to be possible that a neurosurgeon would invite a homeless person to dinner in their home, for instance? What is it that allows so many human beings to walk past another human being in such obvious need without any outward indication of acknowledgement or compassion? Is it revulsion, or fear of contamination or harm? I am sure most of us have heard the following statement made by someone we know, “I don’t give street beggars money, and you know they are all alcoholics or drug users — they would just spend it on booze or something”. For Sarah, it is a very similar issue. Medicine has labeled her as a drug seeker, and therefore she is no longer worthy of compassionate care or consideration.

If we return for a moment to the quote by Said, describing the impact of geography and history on issues of distance and difference, we can see that on either side of the bedrail, the geography of the patient and their history is very foreign to the practitioner. Within the setting it creates an almost palpable sense of distance between the provider standing at the bedside and the ability to know and relate to the experience of the patient that is so close and yet so far away. It is the vulnerable and submissive position of the patient to the provider that serves to compound the colonial experience within the space.

The ability of medicine through all of the centuries since those described by Risse of Janet to the experience of Sarah is the ability of medicine to surpass the realities of the past to groom what is the ideologies of medicine in the present is due in no small part to the meaning of ideology. As Geertz describes for us,

The attempt of ideologies to render otherwise incomprehensible social situations meaningful, to so construe them as to make it possible to act purposefully within them, that accounts both for the ideologies' highly figurative nature and for the intensity with which once accepted, they are held. (Geertz, 1973, p. 220)

Let me go back for a moment to the setting of Sarah. Her semi-private room is situated in what one might describe as a quad. Her room is one of four designed to contain two patients each. The doors to these rooms are closely adjacent to each other surrounding a small alcove that contains a single desk with a computer, chair, and counter with shelves to contain each patient's chart.

This type of setting as it occurs in countless hospitals, where they "treat patients in close enough proximity to each other to obviate any meaningful privacy, but at just enough distance to eliminate any meaningful contact" (Frank, 1995, p. 36). Concerns of privacy aside, patients often hear conversations between nursing staff and visitors with patients in nearby rooms. Family members and visitors coming in and out of these rooms glance into neighboring rooms out of curiosity or perhaps by chance.

One might regard this as a microscopic version of the broader panoptic settings defined for us by Michael Foucault. Prior to the development of the physical institution, Foucault places the birth of what he termed the medical or clinical gaze. Foucault's genealogy of the clinic describes for us the birthplace of the clinical gaze as occurring simultaneously with the development of the science of medicine.

The space of configuration of the disease and the space of localization of the illness in the body have been superimposed, in medical experience, for only a relatively short period of time—the period that coincides with nineteenth-century

medicine and the privileges accorded to pathological anatomy. This is the period that marks the suzerainty of the gaze, since in the time perceptual field, following the same continuities or the same breaks, experience reads at a glance the visible lesions of the organism and the coherence of the pathological forms; the illness is articulated exactly on the body, and its logical distribution is carried out at once in terms of anatomical masses. The ‘glance’ has simply to exercise its right of origin over truth. (Foucault, 1994, pp. 3-4)

Once the glance developed rights to truth, those who studied medicine and disease began to exercise these rights. The patient is “only an external fact; the medical reading must take him into account only to place him in parentheses” (Foucault, 1994, p. 8). The disease became the focus of medicine to those who studied and practiced it. To improve their study, and their gaze, the hospital became the place wherein practitioners of medicine could be classified and grouped. As I discussed earlier, they both treated the disease and housed those who were ill separate and apart from those who were not.

Thus, hospitals became institutions of medical space, removing the sick and injured from main society and placing them within a solely scientific realm. Patients are geographically distanced from their daily experiences and realities to one of medicine’s making. As stated earlier, this space is a panoptic setting. One that was built,

To permit an internal, articulated and detailed control—to render visible those who are inside it; in more general terms, an architecture that would operate to transform individuals; to act on those it shelters, to provide a hold on their conduct, to carry the effects of power rights to them, to make it possible to know them, to alter them. (Foucault, 1991, p. 172)

This is the environment that surrounds Sarah She and the other patients are constantly visible from the outside area of the floor. The nurses, physicians, laboratory, and radiology staff are able to not only view and monitor them, but also have constant access to the knowledge of their condition, medications, and behaviors contained within the patient chart, the text written of them and by those who survey them.

This type of representation of the setting of medicine is different from what I would have described to you at the beginning of my career in healthcare. I would have viewed this architectural configuration as designed with efficiency and patient safety in mind. Those who are charged with the daily care of and interaction with the patient can quickly be at the bedside in a prompt manner. They can hear the patient call out to them when they are in pain and respond appropriately. They can watch for signs of distress in verbal and nonverbal forms.

But in that time, I was focused only on my place within the setting—my responsibilities and how best I could perform my duties as given to me. I did not give much consideration at all to how it felt to be the one in the room. In my early days as a nurse, I saw my patients and their care through the lens of my place in the hierarchy of the institution.

Looking through a post-colonial lens, the image and representation of the same setting appear very different. Medical anthropologist, Bryan Good describes this change in my own personal paradigm as, “our post-colonial self-awareness and a broad loss of faith in totalizing theoretical visions” (Good, 1994, p. 25). The readings of issues such as critical theory, critical race theory, feminist authors and other scholars who critique and even challenge many totalizing grand narratives have led me to question my own place in

medicine and medicine's vision of the patient. One such aspect of this vision of the relationship between medicine and the patient is that medicine sees patient education as a primary source of extending care beyond the setting.

Educate the patient, medical journals advise clinicians, and solve the problem of noncompliance that plagues the treatment of chronic disease. Investigate public beliefs about vaccinations or risky health behaviors using the Health Belief Model, a generation of health psychologists has told us, get people to believe the right thing and our public health problems will be solved. Salvation from drugs and from preventable illness will follow from correct belief. (Good, 1994, p. 7)

Education is more than a one-way avenue of information exchange. Good (1994) later writes, "Members of societies toward which such efforts were directed are not 'empty vessels' waiting to be filled with whatever health knowledge is being advocated by health educators" (p. 26). How would Sarah describe her disease? What were her beliefs about her pain treatment? Did she believe something she had done wrong, led to her pain crisis? How did she view her new role of motherhood, and how did that change or affect the family or her place within it?

These beliefs that Good describes are significant when considering the statement made by the physician about Sarah, specifically, "Makes you wonder why she let herself get pregnant." Adding to the writings of Good, Wilkinson and Pickett employ the term *conceptions* in much the same manner that Good uses the term *beliefs*, as they describe the levels of societal issues that we might ascribe to the situation of Sarah and countless others like her. Wilkinson and Pickett (2009) state that "although we can sometimes separate out the influences of maternal age and economic circumstances in research

studies, in real life they often seem inextricably intertwined and teenage motherhood is associated with an inter-generational cycle of deprivation” (p. 121). While I do not know the exact circumstances of Sarah family and housing situation, I learned from my encounter with her, and from my discussions with her, that she became pregnant by an older male at the age of 19. They were not in any formal relationship and he never visited her at the hospital.

She was unemployed and lived with her extended family. Medical anthropologists and medical sociologists have collected volumes of data and analyses regarding the impacts of poverty, environment, education, race, gender, and community as it relates to disease occurrences and impacts. For example, Wilkinson and Pickett (2009) describe the distinction between teenage birth rates in the US and that in the UK and Japan, where “the USA has a teenage birth rate of 52.1 (per 1,000 women aged 15-19), more than four time the EU average and more than ten times higher than that of Japan, which has a rate of 4.6” (p. 123). These same statistics reveal to us that these young women are much more likely to be poor and have less education than their peers.

Sadly, this issue has yet another side to it. As Wilkinson and Pickett continue, In fact, among poor African-Americans, cumulative exposure to poverty and stress across their lifetimes compromises their health to such an extent that their babies do better if these women have their children at a young age. This idea is known as “weathering” and suggests that, for poor disadvantaged women, postponing pregnancy until later ages doesn’t actually mean that they have healthier babies. Others have shown that the children of teenage mothers are more likely to end up excluded from mainstream society, with worse physical and

emotional health and more deprivation.... But although we can sometimes separate out the influences of maternal age and economic circumstances in research studies, in real life they often seem inextricably intertwined and teenage motherhood is associated with an inter-generational cycle of deprivation.

(Wilkinson & Pickett, 2009, p. 120)

Sarah may be deemed by some to be one of the lucky ones. She has Medicaid, a government insurance program designed for the poor. It pays for health costs of those too young for Medicare, the program developed to provide healthcare coverage for the elderly and permanently disabled. Yet this health coverage also is another label, an identifier of one who may be discharged sooner from the hospital than other patients. Medicaid reimbursements for hospitalization are very small. Medicaid rates for hospital care based upon condition were determined in the 1980s. For example, a Medicaid patient with diabetes is allowed 4 days of hospitalization costs. Any complications may or may not alter this limit.

“The result is that patients who might have spent a few extra days in the hospital recuperating are now discharged ‘sicker and quicker’” (Abraham, 1993, p. 47). Not only is the grandmother caring for the newborn infant, upon discharge the continuing care and medical needs of Sarah will also fall upon the family. The burden is immense to a family already struggling with financial issues and, in this case, another mouth to feed.

Can we then also see the probability of a cycle of struggle to gain access to healthcare for both mother and child? Here, despite all of the statistics and data on the issue of poor young black women and teenage pregnancy is a living, breathing human

being seemingly caught up in this cycle and the institution of medicine questioning whether or not she is to blame for her circumstances.

More importantly, this particular young woman also suffers from a chronic and debilitating illness that will very likely take her life, but we label her seeking of healthcare and pain relief as drug seeking behavior. Is the offer of hope not the purpose of gathering the data and analyzing statistics?

The Language of the Colonizer

When I put that ... 'history' into a theoretical formulation, the familiar phrases appeared, none of them surprising, each of them applicable not only to that person but to many, many others.... When I name his 'defenses', his 'hostility', I was again consigning him (and me) to territory populated by many others.... In each one the details of an individual life are buried under the professional jargon. We residents were learning to summon up such abstractions within minutes of seeing a patient; we directed our questions so neatly that the answers triggered the confirmatory conceptualization in our heads. (Coles, 1980, p. 17)



Figure 11. Image of White Coats (Spence, 1988)

Robert Coles is describing an aspect of his own residency in psychiatry. His own story offers a glimpse into the reality of the loss of language of the patient. It is in many ways translated and altered into the language of the empire of medicine.

An example of this is best described by continuing with our look at the experience of Sarah. Here is an example of how I would document my time with her.



Sarah his a 20 year old black female who was admitted 3 days ago 7 days postoperatively secondary to sickle cell pain crisis and abdominal surgical wound dehiscence. She presented to the Emergency department after experiencing abdominal wound separation and discharge 7 days post full term delivery of her first child. She states today that her pain is continuing in her abdomen, and lower back and legs. She describes this pain as aching and at times, sharp. She states the pain is a 6-7 on a scale of 10. She has been receiving treatment with IV Dilaudid 2-3 mg every 4-6 hours prn pain. She continues to receive intravenous hydration therapy with ½ Normal saline at 75 cc/hour. She states abdominal incision pain continues and slight discharge which nursing staff report as slightly yellow and thin.

She states her appetite is fair, bowel movements are normal and she denies any nausea or vomiting. She denies fever or chills. Vaginal discharge is slight and brown in color.

She has been advised by attending hospitalist that she can no longer continue to receive IV pain medications due to possible drug seeking behaviors. She states she is concerned with this change due to her continued pain. Advised that this change is needed in order for her to return home soon and enable her to resume care of her infant.

Patient reports that her grandmother is caring for the infant. She states this is her first child and it is a girl.

Physical examination reveals a thin, young black female who appears her stated age. Patient appears uncomfortable, but in no acute distress. Patient is alert and oriented to person, place, and time.

HEENT: sclera clear, pupils are equal, round, and reactive to light and accommodation

Oral mucosa moist, posterior pharynx without exudate.

Heart: Regular rate and rhythm without murmurs, rubs, or gallops

Lungs: Clear to auscultation bilaterally, no wheezes, rales, or rhonchi noted

Abdomen: soft, abdominal incision tissue reddish, pink with slight amount of serous discharge noted. Healing continues by secondary intention. Tenderness to palpation noted in lower left quadrant, no guarding or rigidity. No masses or organomegaly noted. Bowel sounds present in all four quadrants.

Extremities: No dependent edema noted. Distal pulses are equal and present times four.

Psych: Affect flat, poor eye contact noted

Assessment/Plan:

- 1. Acute Sickle cell crisis/ Continue transition to oral pain medication and continue plans to discharge to home in 1-2 days*
- 2. Post-surgical wound dehiscence/ Continue current wound care and cleaning with saline/hibiclens solution 2 times daily and light dry dressing. Continue oral antibiotics.*

3. *Possible post-partum depression/ Consult social services for discussion of home visit to assess current situation and support.*



This example of the note I wrote for her at that time reveals a seriously altered view of this patient and one that will be read by other physicians or nurses who provide care for this patient in the days to come. As Coles writes, “Those words were written on an important paper known as a ‘chart.’ The writers were ‘supervisors,’ committing their knowledge and authority” (Coles, 1989, p. 19). Why is there so little here in this documentation or chart that even resembles her story?

“What is interrogated is not simply the image of the person, but the discursive and disciplinary place from which questions of identify are strategically and institutionally posed” (Bhabha, 1994, p. 68). The realities of her words are edited when placed within the formal language of the institution. What occurs daily in hospitals and settings of medicine is just this. It is as Bhabha continues here, a “Shifting the frame of identify from the field of vision to the space of writing” (Bhabha, 1994, p. 68). I placed my vision of her identity into words, but in translation, altered her identity. I took away Sarah hand recreated her as “patient”.

It is this aspect of daily medicine that seems to me to be such an act of colonization. Others may say it is strictly depersonalization of the patient, maintaining privacy, focusing on the facts and placing the encounter within the language of medicine is nothing more than my own professionalism in action. Is this truly just a simple matter of semantics? Or is it possible that this action is in reality a manifestation of something much more?

With Sarah and many others, I had committed and completed her colonization. I had taken her words, her language, and her story and revised, cut, edited, and deleted it until it no longer resembled anything she had said, nor did it in any way reveal what was truly going on in her life or in her hospital room.

The difference is that I had written what I knew medicine wanted to read and hear—a “cryptic, dryly condensed, and yes, all too ‘structured’ presentation, full of abbreviations, not to mention medical ... jargon” (Coles, 1989, p. 24). I had done as most physicians, physician assistants, and nurse practitioners would do, place her experiences and pain and place them in a language and method devoid of emotion or engagement.

In my charting of my encounter with Sarah, I have composed what Said described as a text about her. In other words,

A text purporting to contain knowledge about something actual and arising out of circumstances similar to the ones I have just described is not easily dismissed.

Expertise is attributed to it. The authority of academics, institutions, and governments can accrue to it, surrounding it with still greater prestige than its practical success warrants. Most important, such texts can create not only knowledge but also the very reality they appear to describe. (Said, 1979, p. 94)

Just as Said’s telling of the methods that Napoleon and de Lesseps used texts to learn of the Orient and its inhabitants, so will the notes and documentation within a medical chart provide to the medical providers the primary source of knowledge about Sarah. In their reading of her, she is silent.

Assigning the identity of patient to Sarah is akin to Said's description of the naming of the Oriental. Said (1979) wrote, "As a discipline, as a profession, as specialized language or discourse, Orientalism, is staked upon the permanence of the whole Orient, for with "the Orient" there can be no consistent, intelligible, and articulated knowledge called "Orientalism" (p. 239). Medicine as a profession then is staked upon the permanence of the whole patient. For without the patient as a static entity, the discourse and knowledge of him could be seen as inconsistent, and incapable of being articulated from one physician to another.

Medicine's view of body as machine perpetuates this static disembodiment.

Specifically:

Mechanizing the human body and defining the body-machine as the proper object of medical treatment frees technomedical practitioners from any sense of responsibility for the patient's mind or spirit. Thus, practitioners often see no need to engage with the individual who inhabits that body-machine, preferring instead to think and talk about their patient as the gallbladder in 223. (Davis-Floyd, 1992, p. 23)

Let us return again to Sarah. When I entered her room; she did not know me at all. She saw only a woman in a white coat with a stethoscope coming in to do little more than ask her questions. Questions and answers are her primary method of communication. Nurses question her regarding her eating, her bowel and bladder habits, her pain, her wound, and her IV. The physicians and I question her and we expect answers to our questions.

There are no real opportunities for conversation, no open-ended questions are asked. These questions are scripted and well-rehearsed. She is offered no realistic opportunity to do more than answer these questions. I had more than 20 other patients to see that day.

Davis-Floyd and St. John (1992) state that, during physician and patient interviews,

The doctor does most of the talking; Beckam and Frankel (1984) showed that physicians interrupted patients after a mean time of eighteen seconds, and in 69% of visits did not allow them to complete their opening statements of symptoms and problems.... Physicians' lack of interest in the patient's views, fostered during medical training, is rooted in their underlying conceptualization of the patient not as a whole person but as the object of their treatment. (p. 24)

How is caring to be accomplished within this type of setting, language, and interaction between human beings? How is compassion shown? This one patient, Sarah, is one of thousands who I have met during my years of practice. I am one person. There are hundreds of thousands of providers, and millions of human beings who enter the world of medicine for care and treatment from those providers.

The Language of the Patient

The silence of Sarah was very revealing. Her requests for pain medicine were heard by the world of medicine heard, but her need was dissuaded in response. Also, it was the silence of what she did not say that, in many ways, tells us very much about her. I question if her silence is due to a fatalism stemming from her situation in life and her current colonial situation? "There has been little rigorous study of how fatalism and

other accompaniments of poverty influence communication between doctors and patients, but at least one investigator found that doctors spend more time discussing diagnosis and treatment with well-educated people” (Abraham,1993., p. 33).

A most serious aspect of this question is that I will never know whether the silence I witnessed was due to pain, depression, fear, or fatalism. As I reflect on this one patient, out of so many I have seen, I feel a true regret for not taking the time to probe deeper into how she was feeling. Rather, I focused upon her pain and her medical condition. I sensed her reticence and yet did not attempt to breach her silence.

The language of the patient and the institution of medicine are challenged in one major way – a growing discourse within pathographies. Written not in the language of positivism or the science of pathophysiology—but written in the language of the experience.

While Sarah has yet to place pen to paper in an effort to describe her experience, one wonders what she might write, if given a chance. She and countless others with chronic illnesses are those who “lose their previously taken-for-granted continuity of life” (Charmaz, 2000, p. 280). Her life has been, and will continue to be, measured by episodes of pain crises and hospitalizations. It not only changes her self-image, but also changes the image that others have of her and her ability to fully participate in the society.

What many seriously or terminally ill patients and their families have done is begin to write narratives about their experiences in the world of disease and medicine. These are “ ‘reconstructed’ narratives (which) are not merely descriptive, but represent attempts to ‘reconstitute and repair ruptures between body, self and world by linking up

and interpreting different aspects of biography in order to realign present and past and self within society” (Scambler, 2002, p. 114). Illnesses, such as sickle cell disease and other chronic conditions, create a chasm between the life before illness and the life during and after illness. In the case of chronic illness, the life after is forever changed, as the illness is always present. Medications must be taken regularly, clinics and hospitals become frequent events, and friends and family treat you either with pity, sympathy, or in the case of HIV, trepidation or avoidance.

Pathographies are means through which the colonized patients are able to voice their efforts at recognition—“to see how the master texts need us in [their] construction ... without acknowledging that need” (Frank, 2009, p. 187). Stories told by those who have experienced or witnessed illness or trauma have become the method through which patients recapture control or better yet—free themselves from the domination of the world that is medicine.

These personal stories of illness “provide the discursive vehicles for transforming the burden of knowing into the revolutionary act of telling” (McLaren, 1995, p. 236). What makes it possible for these authors of pathography to make the conscious and then physical act of taking pen to paper? The recent growth in the number of published pathographies speaks to the growing need to share and remember their stories.

Through its development of the hospital and clinical settings, Western medicine has forced illness as separate from the rest of the patient’s life. Illness is no longer perceived to be a normal part of human existence; it is something that, only through the interceding of the physician and medicine, can be corrected. Anatole Broyard describes the illness story as a patient’s method of “recognition that his ill body is a story”

(Broyard, Frank, 1995, p. 50). This story telling is “perhaps the most fundamental act of human understanding” (McLaren, 1995, p. 236).

What makes an illness story good is the act of witness that says, implicitly or explicitly, ‘I will tell you not what you want to hear but what I know to be true because I have lived it. This truth will trouble you, but in the end, you cannot be free without it, because you know it already; your body knows it already’ (Frank, 1995, p. 63).

Pathographies reverberate with emotions, often fear, grief, love, and a sense of loss. They tell of a loss of independence, a loss of self-will and self-determination, and a loss of someone. They tell of the struggle to fight illness as told from the perspective of the one afflicted as opposed to the one wielding the technology, medicine, and scientific knowledge.

However, they are most often told after the fact, after discharge or death of the one who endured the illness. In my mind, questions arise about how different the story would be if it could be penned or heard as it was happening? Time and distance from the site of the suffering offer our minds an ability to process the memories and images differently.

These stories are often read not by physicians or medical providers, but by others who are diagnosed with a similar condition, or who are grieving the loss of a loved one who suffered a similar story. It is “a voice to an experience that medicine cannot describe” (Frank, 1995, p. 18). They provide comfort, answers, and a sense of community—an ending to the feeling of isolation.

They also vibrantly engage the readers in the political, social, ethical, and moral struggle that is most often hidden within the walls of the hospital. They engage the battle

for treatment for HIV and AIDS, or they describe the horrors of Alzheimer's dementia, while the world of medicine seeks to hide it away behind the walls of nursing homes and resident care institutions. They tell us of battles against cancers, of the insurmountable costs of treatment, and of the realities of clinical trials.

Incredible genres within pathography are those written by physicians. These stories tell of physicians who found themselves in the role of the patient after being diagnosed with an illness or after undergoing some sort of traumatic event. When medical providers find themselves suffering with illness or pain, and find themselves on the other side of the bed rail, the loss of self affects them profoundly. The stories they tell of their own experiences of being silenced, amid the voices and settings around them, forever change them and their ability to hear the stories of the patients.

Linda Garro interviewed a woman under the pseudonym of Gail, who provides for us a glimpse into the power of pathographies. In this work, Gail describes that:

We have access to different experiences, different knowledges. And there are so many of us, too. What would happen if we all knew what it really meant and we lived as if it really mattered, which it does? We could help the normal and the whitecoats both. (Garro, 1992, p. 129)

The stories of these experiences are out there for us, both the "normal and the whitecoats" (Garro, 1992) as Gail describes. They offer for us the ability to truly listen and hear the realities of experiences on the other side of the bedrail, if we take the time to read them, to hear what matters to those who cross the boundaries and enter the settings of medicine.

There is one genre judged to be missing in pathography. It is the story of someone like Sarah. While many women have penned pathographies, the missing stories are those of the poor, homeless, or more importantly, those who are refused entry to medical institutions. “We will not learn from pathography what illness or its treatment means for the very poor or marginalized, those whose encounters ...do not take place at all” (Hawkins, 1999, p. 165). Today, their voices remain silent.

I do not have a postscript for Sarah. I do not know what happened to her or her child. The ever-changing world of medicine and specialization has led to the development of a new type of practitioner, called hospitalists, who exclusively provide care for patients who are admitted to the hospital. These physicians and physician assistants provide no outpatient care at all. General practitioners and internal medicine providers utilize the hospitalist to care for their patients within the setting in order to decrease their hours and time on call. Consequently, they see the patient and care for them only upon their release. To say that this further “contributes importantly to the alienation of the chronically ill from their professional care givers” (Davis-Floyd, 1992, p. 25) is at the very least, distancing. And yet, this is an ever-growing trend in American medicine today.

Can we imagine a place in which healing is possible, where value is placed upon dialogue between humans and is viewed as importantly as the treatment of the illness? If so, I believe it must begin within the walls of medicine’s teaching institutions. In the next chapter, I will explore this aspect.

CHAPTER 4

IMAGES AND EXPERIENCES OF THE EDUCATION

No pedagogy that is truly liberating can remain distant from the oppressed by treating them as unfortunates, and by presenting for their emulation models from among the oppressors. (Freire, 2006, p. 54)



Recently, I sat in the classroom as the course director for a class in Emergency medicine. I was listening as the physician who lectured the physician assistant students described various presentations of syncope, or fainting in the Emergency room. He related to the students the story of an elderly female coming in to the ER after an episode of syncope. Though the patient had recovered at the time of the admission, she stated that her chief complaint was that she “just felt weak”. She then told the staff that she had been feeling weak for several days prior to the episode. The lecturing physician continued that this patient, in only being able to describe feeling weak, was “a very poor historian”. Her inability to describe her symptoms in his terms was her fault.

The physician was describing a frustration with the patient for her inability to provide him with more details, to enable him to more quickly make an assessment and treatment plan for her care.



Recently, I sat in a classroom of one of my colleagues. Within this classroom were 68 physician assistant students seated in stadium-like chairs and in desks facing a theatre-sized screen that display a PowerPoint presentation. To one side of the screen was a podium complete with computer, mouse, key pad, and pointer. Behind the podium and facing the students was an emergency medicine physician.

The students listened, some attentively, others less so. Laptop computers sat atop each desk, and, as students took notes, the sounds of keyboard tapping becomes a white noise to which we have grown accustomed. As I sat there, I was struck by the idea that this is what acculturation may look like.

Students who enter and study the fields of medicine and nursing often find themselves in varied settings to receive their education. These settings include classrooms, but also scientific laboratory settings with glass beakers and microscopes. Additional learning environments can be those of mock examination rooms with cameras and microphones, examination tables, desks and chairs through which simulations of various clinical encounters are experienced.



Figure 12. Student Simulated Patient Experience (Batt, 2010)

Just as varied are the students. They come to this educational setting as the sum of their own cultural contexts that I touched upon in the introduction. Despite their background or level of preparation, these students are about to become a part of yet another culture.

Medical and nursing educational social systems are another culture to which all definitions of culture can be applied. As Lévi Strauss described, the anthropological use

of the term *culture* defines a distinct group of discontinuities between one group of human beings and those who comprise the larger society. Upon entering, these students are experiencing a discontinuity through an educational institution, the significance of which they may not be fully aware. It is a culture so different that the language and settings of the laboratory and classrooms at first appear quite alien or foreign.

It has always been a very interesting phenomenon to observe as the students enter the classrooms as a David and a Brittany in their jeans and tee shirts speaking as any other college students would. Their discourse in the lounges the first few weeks are of dorms, music, friends, textbooks, schedules, and an admission of a fear of the unknown. This initial discourse does not stop, but very quickly the language and words heard in these lounges becomes one of cellular metabolism, pulmonary hypertension, and an ever growing stress level, while the fear is now kept silent.

Becker et al., in their text *Boys in White*, describes a study of those within the social cultural system of medical education. They describe the society of schools of medicine as “a complex of interwoven systems,” (Becker, Geer, Hughes, & Strauss, 2007, p. 46), cultures bound together in a multitude of manners and methods. Within the educational settings I see three systems of acculturation—that of the didactic student, that of the clinical student, and that of the faculty. These three distinct cultural systems each consists of their own role expectations and obligations. Medical education is the entry point to the social and cultural power and authority we see exhibited in the preceding chapters and experiences.

We might say that each of these distinct and yet interwoven cultural systems of acculturation that also maintain their own levels of class. Each cohort or class year attain

a level of standing within the institution. First year medical students are the lowest of the class system. They maintain their own language and their obligations are based upon their place within the larger system. Third and fourth year students are accorded a different level of class as they gain fluency with the language and participate more fully in the system of rules and responsibilities.

Medicine's claim to the status of a profession is based in large part upon its ability to persuade the public of the power of its knowledge. (Shirley & Padgett, 2006) The institution of medicine through its governing organizations and accrediting bodies maintains complete control over its educational settings from curriculum decisions to admissions. In this chapter I will take a closer look at the authoritative discourses which medicine relies upon which are then transmitted to the students. These discourses are comprised of Professionalism, Science, Technology, and Corporatization.

Professionalism, as a component of a profession such as medicine is not always easily defined. As Shirley and Padgett tell us, "Professionalism is not, in a sense, a status at all; it is a claim to a certain status, a claim that is more or less successful within a particular social context" (p. 30). Beyond this, maintaining this status requires power and privilege and the efforts of all involved to keep it. Mark Kuczewski defines medical professionalism as "the norms that guide the relationships in which physicians engage in the care of patients" (Kuczewski et al., 2003, p. 161). This would lead us to a sense that for a physician to maintain a level of professionalism in their practice they would be guided by providing the care needed by the patients.

The profession and professionalism of medicine are rooted in a cultural authority stemming from what Scambler termed a "higher knowledge" (Scambler, 2002, p. 127).

The knowledge of medicine is seen as apart and above everyday knowledge and its discourse apart from that of those outside of the domain. (p. 127) But this is the basis of professional knowledge and professionalism which gives rise to the colonizing power of medicine. As Scambler tells us, “The use of formal knowledge to order human affairs constitutes an exercise of power” (p. 127) which gives rise to medical imperialism and the modern medicalization of our daily lives.

To those within medical education today, the definition and meaning of profession and professionalism described above would appear foreign and in distinct contrast to the professionalism taught and aspired to today. This apparent disconnect between the two meanings reveal a very significant imbalance between perhaps different worlds. Or perhaps the apparent changing definition of professionalism as it relates to medicine and competing discourses reveals a layer of tensions and contradictions within medicine as an institution.

Professionalism today is but one aspect of medical education which is now touted as singularly important and as such has been designated as a required competency and outcome which must be taught and evidenced in data from medical educational settings. It is under this umbrella that ethics, bioethics and cultural diversity are taught. Professionalism in medicine then could be considered the ability to conform to the norms of the institution and these norms have now become the foundation of much of the ethics of the practice of medicine.

But the culture of medicine remains the overwhelming metastructure through which medicine and its various internal themes and discourses exist today. The discourses of professionalism, science, technology, and corporatization prevail in the

“ruling class of medicine ... made up of those individuals, groups, and organizations that hold an elite status within organized medicine, including leaders of academic medicine and medical education” (Castellani & Hafferty, 2006, p. 12). The further away from these issues and organizations one becomes—the driving concerns of these issues fade from importance and it is here in these settings and with these providers that the majority of American healthcare occurs on a day in-day out basis (p. 15).

Though these providers experienced their own medical education and training as students, time and distance and a focus on the business of medicine, hospital and clinical daily experiences, and bureaucracy very soon take their position as primary. Their daily practice is governed by the science and financial rewards of medicine and any discourse of professionalism recedes into the more pressing issues of the bottom line.

All modern practitioners of medicine in this country entered the institution as students. To begin a look at the world of medical education and the culture experienced by students and faculty, let us begin with an image from one student’s experience. As students move through these educational settings, their attitudes and perspectives undergo a significant transformation. This process is one that we will be discussing in this chapter.

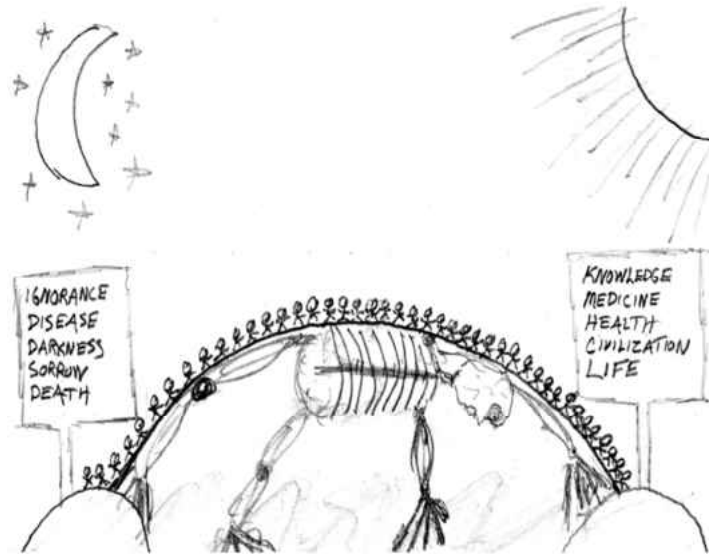


Figure 13. Image of Medical Education (Bertman, 2009)

The cadaver lab stands apart in the first years of many medical education settings. Sandra Bertman, in her medical humanities work, offers medical students facing their gross anatomy course an opportunity to depict their experiences with cadavers and illustrate how the experience impacted them or affected their medical education. This drawing astounded me in its symbolism (Figure 13). I see an image of the power of medical education as drawn by this student.

Dark and light, bridged by a skeletal corpse—ignorance and disease—bridged in the same way into knowledge and medicine, civilization and life. The drawing is simplistic in style and yet draws our gaze. We see stick figures of people walking over the corpse—students I imagine—using the body as a bridge from the evils of the world to a brighter and better land. I think we may all agree that this is an immense amount of perceived power resting upon an educational institution, as seen through this student's eyes.

As I stated in the introduction, this chapter will contain several mini-narratives, or vignettes, of experiences I have seen and heard through my years as a professor in medical educational settings, specifically physician assistant education. These experiences will be shared in this manner to offer a glimpse into multiple places and aspects of medical education—from the didactic and clinical years of training as a student to that of faculty. Narratives of experiences in state and national professional organizations and conferences will add yet another dimension to this part of the study. Images of these experiences will again add to the juxtaposition of what you may imagine medical education to be, and its realities. Our mental images of things within our world seem to vary greatly with our point of view.

In this chapter I will begin with a look at the history of medical education as it took place with the first American colonial settlements, followed by a brief link to the history of Physician Assistant education. History offers us a much deeper understanding of today. It gives us an ability to see beyond the surface realities of anything we study. The world we live in today is one which evolved through time and many of the assumptions we place faith in or act upon also developed over the course of time.

I begin with the excellent historical accounts of Risse and Foucault, followed by the history of medicine in medicine's own words—from the accounts of its own professional organizations, the American Medical Association (AMA), and the American Association of Medical Colleges, (AAMC).

I will end by exploring both the language and the settings and boundaries of medical education. I will explore a random cohort of students from admission to graduation, using narratives of memories and observations—combined with images that I

hope will provide a view from which we can walk with them from entry into didactic learning through their clinical education.

Experiences of History

From the days of the Greek and Roman Empire through the days of early Christianity, the practice and teaching of medicine was passed on from one healer to another through shared observations and experiences of patient care. It also had foundation within the worlds of the Gods and sacrifices—belief systems of their culture and society. Healing temples with baths and sacrificial areas were placed throughout the Empire. Within these temples, areas became available for those who desired to stay for a time. (Risse, 1990)

Healing methods were based upon humeral and natural remedies. Some remedies today would be considered extremely harsh and debilitating to the body, their belief that health had its basis in the body's natural abilities to recognize illness and disease and heal itself by methods of purging and release of impurities. There were early care providers in these times that "advised individuals with health problems at the marketplace or went to patients' homes" (Risse, 1999, p. 44).

The fall of Rome to Christianity brought about many changes in belief systems and practices. The temples for healing and those for worship were destroyed as places of evil worship and adoration of idols. These changes led to a major rift between those who believed that providing medical care was a primary example of charity and those who believed all illness was due to some sin or punishment from God.

As we saw in the previous chapter, the historical beginnings of hospitals and physicians came into reality followed by the development of a more formal medical

education of physicians beginning in the Enlightenment age, as Risse describes in her exploration of Janet. The hospital as a setting of patient care once developed changed little. Technology and therapeutic measures of medicine have continued to evolve rapidly, but the building and practice of the housing of medicine have changed little.

The history of medical education however focuses upon the evolution of the early apprenticeship to its growing connection to the setting of the hospital itself. I offer this distinction between the two to allow us to now follow the development of the metastructures which make up the overall institution that make up American medicine today. The history Risse provides for us, as it is very appropriate in this next exploration.

The routine was for physicians first to contact the nurses and inquire about the state of the patients, then to make rounds. Followed by a “train” of assistant physicians and students, university professors such as Cullen made their entrance at a predetermined hour—usually noon—eagerly awaited or dreaded by the patients, who greeted the procession in silence.... Although (her physician) was prone to speculate about bodily reactions, he also remained the eternal skeptic at the bedside, cautioning students to subject all their ideas and practices to empirical verification and correction. (Risse, 1999, p. 246)

How incredibly similar is this description of daily attending physician and students during the mid-seventeen hundreds to the daily routine of rounds and teaching in modern medical teaching facilities? One could take the description above and merely change the noon hour to the hours of 7 am and these same historical figures Risse describes seem to have changed very little during the last 300 years.



Figure 14. Image of Medical students and physicians on Rounds. (Davidson & Brown, 2010)

With her historical work, Risse takes us through these early days of bedside teaching to what I view as the beginning of the separation of the physician from the patient through medical education itself. The city and university of Edinburgh housed one of the first formal medical teaching institutions and as Risse describes patients were often selected based upon the learning experience that their condition provided.

The Edinburgh strategy was to select patients for a didactic, indepth management of common diseases that students were bound to encounter in their private practices. As elsewhere, this move signaled a fundamental change in the patient-physician relationship as the professional focus began to shift toward the common character of inmates' diseases rather than the individuality of the suffers. (Risse, 1999, p. 253)

Foucault (1994) in his work, *The Birth of the Clinic*, also depicts for us in words this shift in time, as he writes,

Did not the seventeenth- and eighteenth-century doctor remain ‘at a distance’ from his patient? Did he not observe him from afar, noting only the superficial, immediately visible marks and watching for phenomena, without physical contact or auscultation, guessing at the inside by external notations alone? Was not the change in medical knowledge at the end of the eighteenth century based essentially on the fact that the doctor came close to the patient, held his hand, and applied his ear to the patient’s body, that by thus changing the balance, he began to perceive what was immediately behind the visible surface, and that he was thereby led gradually ‘to pass on to the other side’, and to map the disease in the secret depths of the body? (p. 136)

At this time, the focus of medicine becomes the disease, the ability to see it as such, and the attempt to alter or cure it through external manipulation or therapies. Here we see a shift in the historical metastructures of medicine—that of the patient and the physician. Knowledge of clinical diseases and their pathophysiology slowly begins to replace the historical progression of signs and symptoms in its importance to the physician. Anatomical study and autopsy revealed the more consistent and accepted diagnosis and description of disease. The patient’s role in describing their symptoms and concerns was relegated to a secondary position behind the scientifically based findings of laboratory and later radiological study findings. Simultaneously, within the setting, we find the utilization of the patient as a primary teaching methodology and tool. Now the primary metastructures of medicine become the physician and the disease and the patient is comparably a laboratory beaker housing the specimen. Later in this work we will look closely at what is now a third metastructure of medicine—that of technology.

We must again look to our history to gain understanding of our current state of affairs. The history of medicine is extensive and crosses continents and cultures, from Chinese herbal remedies, to those of American technological measures and the globalization of medicine. While American medicine has very deep roots in European medicine, in this chapter, I will focus primarily on American or Western medicine and its formal education.

American Medicine

In the late 1600s and early 1700s, we find the first historic records of physicians who practiced in this country. These early physicians were often colonists who even in these early days held positions of power and status in their communities. Often these men were also clergy and therefore were looked upon as leaders based upon their education and community leadership responsibilities.

These early physicians were regarded as a bridge or a link between the European continent and our own, as many were secured and supported by the governments or groups who organized these early settlements. Once here, they were faced with the need to provide care for growing populations, leading them to take on apprentices, the first American residencies.

Francis Randolph Packard was a practicing physician in Philadelphia during the late 1800s and early 1900s who wrote *The History of Medicine in the United States*. It remains one of the primary general works on the subject. Packard is described as having “prized medical history for its cultural values” (Shyrock, 1950, pg. 425). The obituary goes on to state that Packard believed “that science might transform physicians into mere technicians, unless they cultivated a historical perspective on their profession and its

place in society” (Shyrock, 1950, p. 425). Perhaps Packard saw an evolution in physicians from actively engaged and participatory members of communities through a shared history to one removed or set apart. Or was his awareness of history’s ability to trace and locate the birth or growth of beliefs and assumptions the focus of his work? From the quote above, I believe he feared a lack of humanity in the world of medicine through a growing negative influence of a focus on the positivist science of medicine.

Packard describes the historic accounts and writings of the early settlers, who were accompanied by the first surgeons during their journey to America. The first settlement at Jamestown Virginia in 1607 lists a “Dr. Thomas Wooten as among the first colonists at Jamestown and speaks of him as surgeon-general of the colony.” (Packard, 1901, p. 13) These men were often secured and/or supported by the government or religious sects who were leading the settlement. They felt their duty completed when the basic health necessities of these communities had been met.

Even in the infancy of American medicine, the influence of European social and governmental control is seen. Colonial leaders looked to their monarchies to provide medical practitioners for their population’s healthcare. Letters from settlement leaders reveal requests to “find ways and means whereby they may support a minister, a schoolmaster, and...a comforter for the sick” (Packard, 1901, p. 14). Physicians during this time were frequently ministers and medical practitioners. As such, they were afforded places of honor and leadership in their communities. Whether this was by virtue of their education, or by other means, is not clear.

The doctors or surgeons of this day kept daily journals of their experiences. Early physicians painstakingly documented symptoms and mortality as a means of identifying

the illness, cause, and containment of the contagions that they encountered. These were, and remain, the basis of epidemiology.

In their writings we can see that they utilized therapies of European measure, including bloodletting and herbal poultices as primary methods of treatment. Diseases such as yellow fever, dysentery, and small pox ravaged whole communities. For instance, “In 1755 diphtheria again prevailed, and in one town in Long Island ‘two children under twelve years of age survived’ ” (Webster, Packard, 1901, p. 99). Their battles against these and other conditions were heroic in many ways.

The care of the ill was provided in the home. Early American physicians relied on family members to provide the majority of the supportive daily care of the patient. The physicians managed injuries, diseases, birth, and death by relying on this mutual support, with all members of these early settlements engaged in a struggle to survive.

The population of the new country continued to expand. Immigration from many other countries, cultures, and ethnicities led to an almost overwhelming need for physicians. By the end of the 18th century, an ever-growing number of poorly trained apprentices practicing medicine on the American frontiers. Many were charlatans who preyed on the ill and vulnerable with tonics and herbal concoctions in an attempt to make money.

There was very little opportunity for formal medical education—apprenticeships and informal education were the rule. In time, this led to serious concerns among many of the physicians over the quality of those who practiced medicine. As the new colonial settlements grew, and while European traditions continued, legal or judicial governance of the practice or practitioners of medicine was limited. In F. R. Packard’s text on the

history of medicine in the United States we find an example of the growing frustration among them in a quote from Dr. William Smith in 1758 stating:

A few physicians among us are eminent for their skill. Quacks abound like locusts in Egypt ... as the profession is under no kind of regulation.... To our shame be it remembered, we have no law to protect the lives of the King's subjects from the malpractice of pretenders. (Smith & Packard, 1901, p. 162)

With this recorded statement we have the first call from a physician for regulation and control over those who sought to enter the field. Many, of those whom Smith called quacks, were homeopaths and were labeled by other physicians as “irregular” (Conrad & Schneider, 2009, p. 195) physicians, though in truth their patient population numbers were increasing. Homeopathic medicine in this time employed natural therapeutics, while avoiding many of the more invasive procedures practiced by physicians, who were then called regulars. These regular physicians utilized the bloodletting and other surgical procedures much more frequently and felt their treatment methods superior to those more natural in nature.

Legal requirements for those seeking the education and practice of medicine in America during the early colonial periods were non-existent. In fact, the first recorded law regarding physicians, and those claiming to be, had nothing to do with education requirements, but was rather related to financial income. This first attempt at distinction from the common or “irregular” provider began with the:

‘Act for Regulating the Fees and Accounts of the Practicers of Physic’ passed by the Virginia Assembly in 1736. ‘Surgeons and apothecaries who have served an apprenticeship to those trades’ were to charge at one rate, and ‘those persons who

have studied physic in an University, and taken any degree there in' were permitted to charge at a higher rate. (Packard, 1901, p. 162)

This act placed a level of status through increased income to those physicians who had received a formal education in medicine.

I find very interesting that the first physician granted a degree of medicine from an American college was Daniel Turner, who was granted an honorary degree of “Doctor of Medicine in 1720 from Yale College” (Packard, 1901, p. 160). While Dr. Turner had given a great deal of money to the university at Yale there was no medical education department in existence at Yale during this time. Turner’s degree was awarded as a symbol of gratitude for his contributions (Packard, 1901).

The first medical degree awarded for completing a formal medical education in America was awarded in 1899 to Dr. Archer from the College of Philadelphia (Packard, 1901, p. 161). The time between that of Dr. Turner and Dr. Archer was well over 100 years.

Formal higher education in our country grew with the beginning of universities and colleges. Among these were institutions that offered degrees in medicine. Initially, most trained physicians who entered this country to practice medicine had received training in Europe. As educational opportunities in America grew, fewer sought medical education from overseas.

Where Packard’s text ends prior to the year 1901, the American Association of Medical Colleges (AAMC) continued recording events, publishing their own historical text, which describes the rise of American medicine and medical education. The title of this text—“*With One Voice: The Association of American Medical Colleges 1876-*

2002”, was written by Mark Bowles and Virginia Dawson. A history of multiple educational settings spread across the country seen as speaking in a singular voice across decades. Is there a perceived solidarity in the title—a power through majority opinion and voice?

Chronologically, this text describes the development of not only the AAMC, but also the growth of the medical profession. So let me take a few paragraphs to review this growth and development as they describe a “story told with many voices, which then as a whole represents the solidarity and powerful voice the AAMC has become” (Bowles & Dawson, 2003, p. 15). We need to examine critically the history and words written by and for those within the professional organizations of medicine. As Michael Apple wrote, “we need to understand much more thoroughly the connection between education and the ideological, political, and economic spheres of society and how the school partakes in each of them” (Apple, 2004, p. 7) I see this as a very important aspect of this study, as I see many links between the institution of medical education in this country and its role in the daily practice of medicine today, as well as the crisis that is the American healthcare system.

The period of 1876-1923 was one of growth for medical education in America. As a result of the sheer lack of physicians, medical schools in major universities were opened in places such as Philadelphia and Boston; while at the same time; private practitioners “began to establish their own commercial medical schools” (Bowles & Dawson, 2003, p. 21). These first for-profit institutions grew as the country grew. In comparison to the larger universities, these schools were often lacking in equipment and

qualified professors. Criticism began to grow among the more formally trained physicians about the quality of these medical school graduates.

As criticism grew, the desire to address it was one aspect of the formation of the American Medical Association (AMA). Bowles and Dawson cite the birth of the organization with Dr. Nathan Smith Davis as its founder (Bowles & Dawson, 2003, p. 21). Davis sat as the first president of the organization and his address at the initial annual meeting voiced this concern by stating, “the profession to which we belong ... has become corrupt, and degenerate, to the forfeiture of its social position, and with it, of the homage it formerly received spontaneously and universally” (Bowles & Dawson, 2003). With this statement, I see the declaration and acknowledgement of a position of status and class claimed by the profession for its members.

Early meetings of the AMA called for the development of educational standards and curriculum requirements among all medical schools. The early for-profit institutions curriculum and training was seen by the members of the AMA as less demanding. There was a fear in some of the more traditional and nonprofit universities of an inability to attract students when competing with schools offering an easier or less rigorous, though more expensive option. AMA president Davis described these schools as issuing “just a large diploma couched in just as unintelligible Latin” (Bowles & Dawson, 2003, p. 22).

There was not total agreement within the AMA on this issue. While Davis decried the lack of minimum standards, others such as Edward H. Clarke spoke proudly of the “independence of American medical schools from control by governmental authority” (Bowles & Dawson, 2003, p. 22). Understandably at this time in America’s history, many viewed independence as the most singularly important aspect.

By the late 1800s, there were approximately 70 schools of medicine in this country. Many of these were housed within major universities, such as Harvard and the University of Maryland. There were many more for-profit institutions, which had grown quickly across the country. The staff and facilities of these for-profit schools were often as lesser than those of the university. More importantly, they were viewed by those in more traditional educational settings as operating purely for profit, providing lesser quality education and producing graduates who were considered unqualified by the then newly formed AMA and its sister medical organization, the American Association of Medical Colleges.

Bowles and Dawson (2003) describe an initial meeting of the two groups, which was called to discuss the current state of medical education and that of the for-profit schools with their “outrageous practices” (p. 27). Practices labeled outrageous included issuing blank diplomas and selling tickets to lectures. One can understand the concern with such measures; however, other issues viewed as “irregular medicine” (Bowles & Dawson, 2003, p. 27) included teachings in homeopathy and osteopathy, which continue today to be considered outside of the mainstream by many in medical education. The members of the AAMC “voted unanimously to exclude schools that practice so-called ‘irregular medicine’” (Bowles & Dawson, 2003, p. 27). They were believed to be no more than “cults” (Bowles & Dawson, 2003).

What I see in this initial meeting is the first step by the early leaders in medicine setting themselves up as the gatekeepers to medicine and medical education, described by these exclusionary practices. As the record of the meeting continues, this is exemplified:

So the time will, or ought to come, when the schools themselves, who are in any sense irregular and who disregard the ethics, either in the spirit or the letter, will be ostracized by their fellows, and condemned by the profession at large. (Bowles & Dawson, 2003, p. 27)

A control over knowledge has occurred in both the type of education that, from this time forward, would have legitimacy, as well as those who would consider any form of medical practice that differed from this written statement. Not only would control be exerted, but also ostracism and condemnation would be the price paid to anyone who dare strayed outside the mainstream. What begins here is the birth of medical colonization. These men controlled medicine and medical education, specifically where and how it was taught, and who may be granted access to the knowledge and how they may practice it.

In his introduction to *Culture and Imperialism*, Said wrote of his concern for education and specifically universities to become a place wherein “social and political issues are actually imposed or resolved would be to remove the university’s function and turn it into an adjunct to whatever political party is in power” (Said, 1993, pg. xxvi). In the case of medicine and medical education, should we not become concerned and even vigilantly aware of those possibilities?

As Michael Apple writes, “Dominance must be worked for in order that the shocking inequalities now being built and rebuilt seem somehow legitimate” (Apple, 2004, p. xxv). Within the institution of medicine, the dominance and legitimacy began with the battle to control the educational settings and requirements. Control over the number of institutions, and the acceptance of students into these institutions were the

building blocks. In many ways, this dominance continues as very little changed. Now, over 130 years later, medicine and medical education has attained its legitimacy.

Medicine carries with it legitimacy, and very few of us question this fact. Geertz reminds us that:

The classical problem of legitimacy—how do some men come to be credited with the right to rule over others—is peculiarly acute in a country in which long-term colonial domination created a political system that was national in scope but not in complexion. For a state to do more than administer privilege and defend itself against its own population, its acts must seem continuous with the selves of those whose state it pretends it is, its citizens—to be, in some stepped-up, amplified sense, their acts. (Geertz, 1973, p. 317)

The need for healthcare is historically universal, and we look to the physician to meet that need. Legitimacy comes from the control of the knowledge and in this instance the knowledge of medical treatment, science and technology is gained by the physician. Because the need is human in the sense that this is inherent in our being human—historically those who met this need were seen as performing acts of humanitarianism—politically neutral and without bias. Yet there is a price to be paid when this legitimacy is allowed to build inequalities in the name of power and greed.

The history of medicine and medical education offer us some measure of this same legitimacy. While American medicine does not rule, it has without a doubt, a significant amount of legitimacy, as Geertz here describes. It is a right to rule, within the system over others. And who among us can doubt that its acts seem continuous with us, and its own? Do we not, as human beings, desire good health? While this need is a

human one which extends far beyond cultural boundaries, I feel it is erased by the overwhelming discourses of science, technology and professionalism.

In fact, as Annette Fay Street states, “The legitimation of medicine is a process by which medicine operates as an institution of social control reproducing the dominant ideology of healthcare in a hegemonic relationship with the state” (Street, 1992, p. 39). Medicine is far reaching in its social control. Medicine decides who is to be declared sick, disabled, and as we’ve seen in previous chapters, who is deemed worthy of admittance to the hospital, and who is able to go home and when.

The struggle for control did not end with the formation of the AAMC and the AMA. In fact, the AAMC continued to battle for limitations on the number of medical education institutions, as well as its attempt to institute curriculum standards. There were opponents of both the AAMC and AMA, who accused them of attempting to exert too much control over medical education. Arguments and battles for control also took place between these two organizations.

The AAMC began to be seen as a weaker and less stringent organization. While supposedly developing and then enforcing higher standards of educational components, the AAMC was seen as admitting institutions of lesser quality in the hopes of improving them. Parks Ritchie from the University of Minnesota College of Medicine and Surgery is quoted as saying, “it is unworthy of the membership of an association whose battle-cry is the advancement of medical education” (Bowles & Dawson, 2003, p. 32). The admission into the AAMC of various lesser quality colleges and universities led to divisions and anger between its members and those of the AMA.

In an attempt to dispel some of this anger and to undertake an independent study of American medical schools, the members of the AMA approached the Carnegie Foundation for the Advancement of Education. While ostensibly setting up an independent study, Henry Pritchett, the head of the Carnegie Foundation maintained correspondence with Dean Bevan of the AMA, which as Bowles and Dawson relate, “demonstrates that the two organizations worked hand in glove” (Bowles & Dawson, 2003, p. 37). Pritchett actually wrote a letter to Bevan which stated that when the “report comes out it is going to be ammunition in your hands” (Bowles & Dawson, 2003). In fact Pritchett added the specific warning to Bevan that they must not appear to have any direct contact so as to avoid the appearance of bias. The overall aim of the report was to force the removal of the schools of lesser quality. This independent study was in reality a method by the AMA council on education to force its demands to limit and control the number of medical education institutions.

Abraham Flexner was selected to undertake this study. Flexner personally visited each of the 155 medical schools in operation at that time. Flexner’s brother was teaching medicine at Johns Hopkins University medical school and Flexner used this institution as his “standard against which the other schools should be judged” (Bowles & Dawson, 2003, p. 37). Published in 1910, his report evaluated the number of medical schools, as well as their areas of concentration. Flexner assessed each of the schools’ enrollment, staff, entrance requirements, and teaching facilities. (Bowles & Dawson, 2003)

The report supported the view that medicine and medical education were being negatively influenced by what Flexner called, the “proliferation of proprietary schools in the Midwest” (Bowles & Dawson, 2003, p. 38). He stated, “In modern life the medical

profession is an organ differentiated by society for its own highest purpose, not a business to be exploited” (Flexner, 1910, pg. 19). This would effectively take medical education possibilities away from the rural and middle class populations, with the end result being that those students entering medicine would most likely come from the more affluent populations.

The report also continued the assault on alternative types of medicine, as Flexner reflected on the importance of scientific medicine. He stated that, “The ebbing vitality of homeopathic schools is a striking demonstration of the incompatibility of science and dogma.... Science once embraced will conquer the whole” (Flexner, 1910, p. 161). And with this statement, medicine publicly binds itself to positivism.

The resulting outcomes of Flexner’s report in the early 1900s were being increasingly felt by the 1950s; those two generations he had specifically mentioned had passed. Large cities and medical universities were providing a vastly improved medical education strongly based upon sciences, but the medical community increasingly underserved America’s rural areas. Patients with significant or critical illnesses traveled to major medical centers and teaching hospitals for care, while the majority of those living in rural areas had little to no access to primary or preventative health care.

In addition to the historical works of Risse and Bowles & Dawson, author Kenneth Ludmerer’s work, *Time to Heal* provides additional insight into the work of Flexner and the impact of his report. Ludmerer begins by quoting Flexner when he tells us, “As Flexner put it, ‘The hospital should be the laboratory of the clinical teacher, and the conditions essential to the physiologist are equally material to the teaching and research of the internist.’ For the modern medical school to do its work, it needed to

control strong teaching hospitals deeply rooted in university medicine” (Flexner as cited in Ludmerer, 1999, p. 18). To bridge the teaching sites of the hospital to those of the university was a struggle and at times a difficult one.

It took time for the hospitals to adopt medical education and research as one of their primary tenets. Early hospital administrators and boards saw patient care as their primary role and focus. Ludmerer tells us that these 19th century hospitals “vigorously protected their independence and their patients from any disruptions and inconveniences that might arise from having students set loose on the wards” (Ludmerer, 1999, p. 18).

By the late 1950s and early 1960s, there was a growing fear of physician shortages. Large university medical centers received appeals from local communities for help, including the Duke University Medical Center. During this time, Dr. Eugene Stead became the chairman of the Department of Medicine for the university. Dr. Stead, as did other physicians in similar situations, saw the crisis looming and he conceived the role of the Physician Assistant. For Stead, “The basic idea was to create a new type of care provider who would take on many of the routine and less complex aspects of health care” (Larson & Hart, 2007, p. 121). Rural and small community physicians were communicating their concerns and requests for help to the larger teaching universities. The numbers of physicians in outlying areas were strained in their attempts to meet the growing needs of the populations. Stead’s ideas and foresight defined much of the PA role as an assistant in providing primary care to patients and allowing physicians to focus on the more serious and time-consuming patient conditions. He saw them as being able to go into these communities and work alongside the physician where help was needed most.

Dr. Stead came to this point in his life with an extensive background. In 1942 he had been “forced to develop a fast track, 3-year applied medical curriculum to educate physicians at Emory University for military service during World War II” (Physician Assistant History Center, n.d.). The war was yet another drain upon the physicians across the country. Stead utilized medical students and residents to keep Grady Hospital in Atlanta Georgia capable of providing care. The insight he gained allowed him to realize that a basic knowledge base could be done in less time than the traditional medical school curriculum required. It gave him the seeds of thought through which he later developed a means to lessen the burden on physicians. He would create a physician assistant, but where would these assistants come from?

Stead developed the first physician assistant program at Duke and hand selected the recruitment of applicants. Initially, Stead had hoped to begin by training nurses in this role. He selected Thelma Ingles at a chance meeting—offering her a sabbatical year with him and under his tutelage. Ingles studied and work alongside Stead—rounding and caring for patients with him. In Natalie Holt’s work, *Confusion’s Masterpiece*, we are provided a look at the link between the two professions and the early moments of Stead’s desire to train nurses. Ingles became a staunch supporter of the new role and did all in her power to promote the role to the American Nurses Association (ANA). (Holt, 1998)

The nursing profession at this point in history had fought many years against the subservient role of the physician over the nurse. The profession, specifically the ANA, declined Stead’s offer, wanting very little to do with a role conceived as assisting physicians in yet another dependent position. Because of this initial frustration, he did not open the initial program to nurses, and though he never formally excluded women, he

did write, “During the next ten years I would like to have a hand in training men to be physician’s assistants” (Carter, n.d., p. 1).

The most significant aspect of the new role became the PA as “structured entirely as a dependent component of the doctor’s team. He has no professional existence as an independent agent” (Stead, 1970, p. 273). With this statement, we see a major aspect of the physician assistant profession. But we also see a prime example of the power of the professional organization of medicine in controlling most other healthcare provider roles and status. It is assumed that the physician assistant will be an extension of the physician only.

As Weitz (2010) tells us, “Similarly, both in the past and currently, doctors often serve on boards charged with judging the education and qualifications of other healthcare occupations, but members of other occupations played little role in setting standards for medical education and licensing” (Weitz, 2010, p. 283). This influence and power of the AMA and physicians continues today. The jurisdiction is maintained within State Medical Boards, which have as their primary role one that “will license, monitor, discipline, educate, and when appropriate, rehabilitate physicians and mid-level practitioners to assure their fitness and competence in the service of the people” (North Carolina Medical Board, n.d.).

At the time that Stead was proposing the PA role, these State boards were comprised solely of physicians. Today, the State medical boards continue to be dominated by physicians, though some State medical boards now contain one member of nursing, physician assistant, and osteopathic practitioners. Others include members of

the public with no formal connection to medicine. Their power remains the same – the right to define the roles of each practice type and educational requirements for each.

In May 1965, an Ad Hoc committee met at Duke University just prior to the opening of the new Physician Assistant Program. Based upon the committee's recommendations, on October 4, 1965, the first students began the Physician Assistant Program at Duke University. Stead chose as his first class four Navy corpsmen.

We have looked very briefly at the history of medical education in this country from the institutional aspects. But this is not where medical education begins for the students of today. The student entering medical, physician assistant, or nursing educational arenas begin their history at a very different point in time. But as we will see in this next section, for the students in the cohort of 2012, it truly began in kindergarten. As such it is an extension of all who are in education—both student and educator.

Experiences of the Student: It All Begins In Kindergarten

Robert Fulghum wrote a poem entitled “All I Really Need to Know I Learned in Kindergarten”. It contained some simple, yet touching, words on issues such as sharing; and childhood lessons, such as holding hands and cleaning up after play. Early life lessons on fair play and wonder were contained in those early classrooms according to Fulghum.

Kindergarten is merely the beginning of our educational experiences which are much more formative than Fulghum's poem describes. Educational author, Philip Jackson, in his text *Life in Classrooms*, provides for us a view of these experiences. Jackson tells us that:

School is a place where tests are failed and passed, where amusing things happen, where new insights are stumbled upon, and skills acquired. But it is also a place in which people sit, and listen, and wait, and raise their hands, and pass out paper, and stand in line, and sharpen pencils. (Jackson, 1990, p. 4)

Students in this country typically begin their education in kindergarten settings, which continues through elementary school, into middle schools, through high school, and into undergraduate colleges and universities. Through adherence to rules and standards of behavior, and evaluation methodologies, they have realized much about structures of institutions and hierarchies of power.

Jackson explains the benefits of such learning conditions. Students who are deemed successful have not only mastered material they have learned, “Yet the habits of obedience and docility engendered in the classroom have a high pay-off value in other settings” (Jackson, 1990, p. 33). These students have learned the value of good behavior to the point of ignoring their own curiosities and learning desires in order to succeed in the manner the setting and society have said that they should.

I see this as the beginning of what has been termed the hidden curriculum of medicine, but as you can see, it extends well beyond the entry laboratory course in the first year. While medical, physician assistant, and nursing educations occur at the undergraduate and graduate levels—by the time these students enter these fields they have been fully integrated into the issues of “crowds, praise, and power” (Jackson, 1990, p. 14). Most students have experienced the crowded public education classrooms settings of elementary school, middle school, and undergraduate educational settings, some with hundreds of students in one classroom.

These students have experienced praise by teachers and society as they have succeeded to a level of excellent grades and high test scores, which have enabled them to enter the extremely competitive attempts to enter these medical and nursing educational settings. They have all become intimately acquainted with the power of those settings, as they apply to schools, and undergo interviews sessions with faculty and deans, who hold in their hands, the ability to grant or deny admission.

They have experienced years of the hidden curriculum which continues today in all K-12 educational settings, where:

The tacit ways in which knowledge and behavior get constructed, outside the usual course materials and formally structured lessons. It is part of the bureaucratic and managerial “press” of the school—the combined forces by which students are introduced to comply with the dominant ideologies and social practices related to authority, behavior and morality. (McLaren, 1998, p. 183-184)

These students have learned well the lessons taught to them by our current educational system. They have learned that success is measured in a vast series of numbers, test scores, and grades. Each medical or nursing educational setting sets forth minimum standards for admission, requiring even more expensive and standardized test scores which numerically equate the sum of an individual student’s knowledge. Stretching beyond that of public or private K-12 education, total grade point averages (GPA), Medical College Admission Tests (MCAT) scores, Graduate Record Examination (GRE) scores, and others are used to evaluate each applicant’s capabilities. They are then used to judge and assess these students’ future capabilities of passing even more

nationally certification examinations, as universities must be assured that you can succeed before we offer you a chance to learn and succeed. After all, attrition, when it occurs, must be accounted for.

What is the impetus or driving influence of students who enter medicine? Is it as the student depicted in his drawing earlier in the chapter? Did he truly see his experience with the cadaver as a component of his broader medical education that could through his education bring knowledge to ignorance? The answer is not easily perceived, and in fact, it may not be answered at all. So let me begin by posing the question, what does it take to gain a seat in the classroom setting above?

Hopeful students then apply to numerous medical schools and physician assistant programs around the country hoping to be selected for the all-important interview. These interviews are held in a variety of methods and employ a wide range of techniques designed to offer the program faculty the opportunity to see the students behind the numbers. To succeed to the point of getting invited for an interview is a major hurdle in the entrance to the school.

I have been involved in many of these interviews. Interviewees are provided with tours, meetings with current students and alumni in order to see if the campus and setting and student body is one in which they feel comfortable. I watch as they arrive dressed in the appropriate “uniform,” All the gentlemen are dressed in a suit and tie. Their hair is neatly combed and facial hair is at a minimum, with the preference that they are clean shaven.

I see the women all wearing a version of the dress suit with jacket and heels. The color is the standard navy or black, as anyone wearing a bright purple or yellow will be considered to be ostentatious by many.

We conduct the interviews either one on one or small group sessions in which students are asked a variety of behavioral questions. These may include questions relating to honesty, integrity, community service and all are asked in an attempt to help with what is the most subjective part of the admission process in many programs. An example of questions employed in these interviews includes the following:

1. Tell me about a time when you saw someone being dishonest—and how did you handle that situation?
2. Describe for me a time when you put your own needs aside to help someone else.
3. What, if any problems do you see in the future for the Physician Assistant profession?
4. Tell me about the most challenging event or thing you have met in your life to this point.

We then score the interviews on a scale designed by the program and the scores are then utilized to place the student on a ranking for acceptance, wait list, or deny designation.

Faculty and /or an admissions committee meeting follows in which we sift through all of the applicants data, scores, transcripts, personal narratives, and photos. We discuss each interviewee individually if they scored high enough on the question portion of the meeting. Admission at this minute becomes a very subjective thing. A faculty member may not have like an answer or even the way the student wore their hair or their

mannerism and this small subjective concern may be the reason they are not selected for admission.

Upon gaining entry, these students begin to receive what is, in my opinion, one of the most politically charged domains of hidden curriculum in existence. They each have learned well the lessons that Michael Apple describes as the “negative value of conflict” (Apple, 1975, p. 99). They do not question or challenge assumptions they have been taught on which path to take or the roads they need to walk to get where they are today. They have checked each box, bubbled well all scantron forms for testing, appropriately completing all tasks, and have now arrived with the required pre-requisites stated on the application forms. Now they are ready and even hope to be molded into the medical or nursing model and roles. This molding is not specific to medical education—but our experiences in life and education seem to mold us as if we are clay at the potter’s wheel.

Philippe Lacoue-Labarthe was a French philosopher whose exploration on the word *mimesis*, which I feel aptly, describes the mind of one who is learning.

Memetism itself, that pure and disquieting *plasticity* which potentially authorizes the varying appropriation of all characters and all functions (all the roles), that kind of ‘typical virtuosity’ which doubtless requires a ‘subjective’ base—a ‘wax’—but without any other property than an infinite malleability: *instability* ‘itself’. (Lacoue-Labarthe, 1993, p. 115)

This plasticity and wax like state is the exact texture of students who has opened themselves to learning, to experience of any type. Any student of nursing or medicine who enters the “trenches [of] taking care of people whose lives are broken and covered

with the fallout of a culture that denigrates and ignores” (Wear, 1996, p. 108) both their own existence as students and that of the patient Delese Wear tells us.

Sociologists and medical university professor, Hafferty has studied medical education with a critical eye which focuses on the setting and impact of the hidden curriculum of medicine on the wax-like state of the students. He tells us that this powerful type of learning “is grounded in interactions that take place outside formally identified learning environments: in the elevator, the corridor, the lounge, the cafeteria, or the on-call room” (Hafferty, 1998, p. 404). In this chapter, I seek to describe experiences which reveal that the hidden curriculum exists in both the formal and informal settings.

So now imagine a young student traveling through a world of dissecting cadavers to the setting of the hospital operating room. Next he or she may encounter a young homeless family in the Emergency department and we expect them to have not only compassion but also to understand the conditions which are behind conditions of both homelessness and death.

This sojourning into death is a very early aspect of becoming a physician or physician assistant. Very early in the curriculum are the cadaver labs in which students spend hours working with cadavers, dissecting and manipulating the body as pieces and parts of some “thing” that was once a human being. Young students come into a cold laboratory setting with bodies lain on stainless steel gurneys. The cadaver’s face and head are covered and remain so until the end of the course, when the skull is opened and the brain dissected. And the student’s task, their course of study, requires that they dissect this body and become intimately familiar with each of the anatomical structures in detail. The course can last for many days or weeks. Students spend hours cutting on and

handling a body, which was at one time a being full of life. Physicians and anatomists assist them in this, both of whom expect them to deal with the lessons on anatomy of vessels and nerves as completely separate from the person who once existed in this body. This becomes one of the first tasks and experiences that will leave its mark on the students' wax.

Historically, these anatomy labs looked much as that depicted in the following painting by Thomas Eakins. One body explored in an amphitheater setting with students looking on while listening to the lecture.



Figure 15. The Gross Clinic (Eakins, 1875)

Today's anatomy lab and class looks much like the image below. One or several students are assigned to one body, which they follow through each layer of body system.



Figure 16. Medical student in cadaver lab (Bertman, 2009, p. 24)

But the impact and depth of the hidden curriculum in medical education is not only seen and felt in an academic classroom or laboratory setting. It is lived and experienced in the clinical training far removed from the academic realm and in no way observed by the administration or faculty. Clinical medical education is historically based upon modeling—an apprentice relationship between student and physician. The physician models the behaviors of the land of hospitals and clinics, knowledge, and patient understanding, with which the students becomes intimately acquainted. Yet, this modeling and molding of behaviors is through the images she or he sees set before them. It is the epitome of mimesis.

As a consequence,...only mimesis has the power of ‘converting the negative into being’ and of procuring that paradoxical pleasure, essentially ‘theoretical’...which man is capable of feeling in the representation, provided it is exact, of the unbearable, the painful, and the horrible: ‘Such is the case for example with the renderings of ...cadavers’. Only mimesis gives the possibility

of ‘tragic pleasure.’ Once they become part of the spectacle, in other words, both death and the unbearable...’can be faced.’ The spirit henceforth, far from taking fright, can take its leisure ‘sojourning’ in their proximity—even derive on occasion a certain pleasure from them,...preserve itself from its own fear (perhaps too, from the madness that threatens it and probably also from the pity the spirit feels). (Lacoue-Labarthe, 1989, p. 218-219)

The initial days in the cadaver lab, while regarded as a rite of passage, are merely the beginning of the “tragic pleasure” (Lacoue-Labarthe, p. 219) described in this passage. As time goes on, the initial shock of slicing and dissecting what was once a human being fades and the pleasure is gleaned from the discovery of the abnormal within the tissues or the organs. That becomes what is exciting. This type of excitement for the unusual becomes, for so many, the excitement felt during a code blue or a major trauma or injury in the emergency room setting.

PA Class of 2012

A group of 68 individuals collectively called the class of 2012 have begun to meet each other and are getting acquainted with their course schedules. At the end of the second week, they have their stethoscopes, otoscopes, and ophthalmoscopes.

Early in the curriculum are the anatomy and physiology courses and cadaver labs described above. Hours are spent in the classroom with students learning the intricate aspects of the human body and it’s functioning. The body is divided into organ systems, such as cardiovascular, pulmonary, and others. Each system is explored in great detail from the organ tissue, to the chemical and cellular levels of understanding, and how each works in conjunction with the other to form the body human.

Pictures, PowerPoint slideshows, and DVDs depicting virtual dissections of cadavers, are the classroom teaching methods. The laboratory teaching is comprised of cadaver dissection, where the body is manipulated as pieces and parts of some “thing” that was once a human being. Students then take their newly found knowledge of the body as an object and transfer it to the act of the physical examination on the live patient. In learning this new skill, a new language is required. As Jamie Shirley and Stephen Padgett describe, “By contrast, an alternative account calls attention to how languages function as social practices—not as names for public objects of private experiences, but as interactional events and social transactions” (Shirley & Padgett, 2006, pg. 27). This is not only a method of naming, but in this setting, it becomes the method of interaction with the patient.

After dissection, students learn to perform a physical examination. The language of the physical examination continues with this immersion in the body as a piece of machinery. Broken down into organ and body system, the students learn to inspect each area of the body, reciting as they do the aspects that they are visualizing. For instance, “I am inspecting general appearance and assessing for body habitus, color, distress, skin conditions”.

As Geertz tells us, “Our capacity to speak is surely innate; our capacity to speak English is surely cultural” (Geertz, 1973, p. 50). This learning of the medical language is another discontinuity and assimilation into the culture of medicine. The terminology of medicine becomes both the spoken and written language of this new world the students have entered. But is the new language one that further divides the student from the world of the patient’s experience?

Each new technique and step of the physical examination is then performed in staged settings with standardized patients. The standardized patients in most settings are trained in the steps and processes as well. At times they are the ones who evaluate the students and provide feedback on the performance of the skills.

Each subsequent step is mastered in the same manner. The next steps in the physical assessment skill are to auscultate, or listen with the stethoscope to certain areas of the body, such as the heart. Again, students memorize a litany of the correct assessment terms, such as, “I am auscultating for the cardiac rhythm, murmurs, rubs, or gallops.” Next they perform palpation and percussion of the area, continuing the recitation of “I am performing light palpation of all four quadrants, followed by deep palpation of these same areas while assessing my patient’s face for any signs of discomfort.”

The overt curriculum continues to build the student’s focus on the patient, and is the initial means by which the patient becomes the object, the physical assessment act performed upon a “silent body; a sort of contact prior to all discourse, free of the burdens of language, by which two living individuals are ‘trapped’ in a common, but non-reciprocal situation” (Foucault, 1994, pg. xv). The language or absence thereof in the physical examination reinforces the medicalization of the body.

Another early course in medical and physician assistant education is one in which students learn the techniques and language of the medical interview and of documentation. This course requires that the students not only learn the basic form of the language of the culture of medicine, but that they also learn the techniques that will take away and silence the patient.

Students are taught to interview the patient through technique. The term interview is a verb that belies real human emotion. The meeting of one human being with another, who is vulnerable, is stripped of its usual discourse in which one human being becomes acquainted with the other. Instead, the encounter is now taught to the student as such. The terminology of the encounter is divided into sections, much as the body, into the Chief complaint, the History of Present Illness (HPI), Past Medical History (PMH), Family History (FH), and so on.

The PA or Physician “control(s) the medical interview tightly by initiating the topics of conversation, asking the questions, limiting patients’ questions, and often deflecting patient concerns” (Conrad, 2009, p. 386). Students are taught to beware of the overly positive patient, or the one who answers yes to all of their questions. They are taught to guide the patient through the interview to reduce consumption of time, and therefore, a loss of productivity. The setting of the patient encounter is either the clinical setting or the hospital bed. At the onset it can be seen as one of control.

Students begin the history by asking the first question, “What brings you here today?” This is the attempt to elicit the chief complaint, and nothing more. The patient responds with their reason, which becomes the only sentence recorded in the medical record.

Questioning then revolves only around that chief complaint. If the patient has more than one complaint that they wish to be addressed, the student is coached to ask the patient to focus on the most pressing complaint today, and to offer another appointment to address other issues. Again, there is the constant reminder that time is money and that they do not have any to give.



A first year physician assistant student related to me a story describing a shadowing experience he had early in his education. He was shadowing a physician who was a vascular surgeon. The student was observing the follow up visit of a patient on which he had recently performed a procedure.

The patient presented for follow up as scheduled and the student was offered the ability to utilize his developing history and interview skills. He told me that he proceeded to do so and, in his performing the history, during his questioning he found that the patient had been experiencing symptoms of sweating and shortness of breath that were worsened with physical exertion. The student said, “He looked short of breath while I was talking with him. He said he had been short of breath just walking in from his car and he was sweating while I was talking with him.”

The student presented his history to the physician, who proceeded to go into the exam room and repeat the history and examine the patient. No questions were asked about the symptoms of shortness of breath or of sweating. The questions the physician asked related solely to the procedure that had been performed on a vessel in the lower extremity. The student said that the physical examination of the extremity revealed normal healing and nothing indicating infection or concern and that the physician had seemed pleased with the result. The patient was released with request for him to follow up with his primary care physician.

The student then told me he had questioned the physician about this. He said, “I told him about what the patient had said to me and that I was concerned that he might be having a problem with his breathing or his heart. The doctor told me that he only had 10 minutes to see each of this patients and that he had to focus on just the post-op follow up

concerns. He said that the patient would have to follow up with his primary physician, and that he would handle it.”



As Waitzkin and Waterman (1974) tell us:

Physicians themselves can directly affect the demand for their services. In general, patients rely on their doctors' advice in deciding the frequency of their appointments. Physicians also enhance the demand for their colleagues' services by advising referrals and consultations, which patients usually feel bound to pursue. These sources of “derived demand”—that is, demand directly created by the producers of health services—increase the profits available for individual physicians. (p. 12)

Here the student is provided an early lesson in fee-for-services healthcare. In outpatient settings, common practices include triple booking of appointment times, limiting the patient complaint to one issue at a time, and charging patients for missed appointments. This experience provides an example of the type of behaviors students may encounter in the first months of their education.

After the chief complaint has been assessed, the student is taught to begin to explore possible causes of the complaint. Students are taught to ask, “how long have you had this?”; “has it gotten worse?”; does anything make it better?”; focusing solely on the one complaint. Then they look for the social issues that may be to blame or that are influencing the complaint. Does the patient drink, smoke, or use illicit drugs? Are they overweight? Are they promiscuous? What is their sexual orientation? These questions are taught to students very early, as patients and their lifestyles are frequently to blame for their illnesses. Students are never taught to ask, “Are you poor?” Or, “Do you have

any concerns about the costs of your care?” These issues are the social issues which most practitioners shy away from.

This is discussed again in those out of the classroom or hallway corridors in medical institutions. Students often feel they should not ask because the monetary aspect of a patient’s ability to pay should not influence their relationship with the patient. Providers often attempt to reassure the patient that this has no bearing on their care when concern over payment of fees enters the conversation. The reality is quite different.

Laboratory tests are ordered based upon the type of insurance or lack thereof. If the insurance company will not pay for a test then the physician will avoid it—often against their clinical judgment. A prescription for the more expensive medication will be changed to the less expensive and perhaps less effective medication when financial concerns are present. All of this is done in the name of human concern and caring—but why is it necessary to begin with?

The next step in learning the patient encounter is to document the visit. We name their world. The language of medicine continues through this technical documentation of its language to objectify or, in some instances, to erase the individual entirely. “Rarely do doctors reveal their assumptions about patients when talking to them; it is in talking and writing to other doctors about patients that cultural assumptions, beliefs, and values are displayed more directly” (Conrad, 2009, p. 287). Regardless of the possibilities of the emotional or psychological impact of the interaction between them, the fact that two human beings have just discussed what could be a life-changing event is written in concise and terse language.

This documentation of each patient encounter, each daily progress note in the hospital chart is written or dictated solely in the language of medicine and “in most instances (the patients) are neither able nor allowed to read (them); the chart becomes the official story of the illness” (Frank, 1995, p. 5). It becomes the only version of the patient’s story and illness that matters. As Frank states, “the physician becomes the spokesperson for the disease” (Frank, p. 6). Their words are erased and, as we saw with Sarah and of my documentation of her encounter in Chapter 3, replaced by those of the provider.

Author Graham Pechey offers us a postcolonial link between this erasure of the patient within words as he describes writing the history of South African citizens. We might see the patient’s story of illness as being “forcibly written into someone else’s narrative” (Pechey, 1994, p. 153). South African citizens are “anything but postcolonial” (Pechey, 1994). I believe that patients such as Michael and Sarah are more vibrantly human than one could see by reading the words in their medical charts would reveal. This act of placing the patient into words that are not theirs continues the objectification of the human being that began in the cadaver lab. Students are taught to translate the patient’s story into medical terminology and language, documenting each area of the history and physical examination steps. This process is taught not only for the sole purpose of recording the encounter, but also students are taught that this is how they get paid.

Documenting and subsequent coding of the details of the visit are utilized by medical institutions to bill the insurance companies. A medical encounter that involves a simple ankle sprain, which contains a few history and physical examination steps, is coded and billed at a lower level than that of a patient who presents with chest pain.

In my setting, students are repeatedly taught that they must document all aspects of the encounter they perform in order to “make money for their boss” who is, by nature of the profession, a physician. They are cautioned about fraud, but also cautioned not to “under code” a visit simply out of “pity” for a patient’s inability to pay. In lectures that instruct student how to code each aspect of the encounter, the consequences of under-coding a visit and the penalties for fraud, if caught by Medicare and Medicaid, are sternly described.

Each system the practitioner inquires about is tallied and increases the amount billed or charged. Asking a patient if they are nauseated or experiencing diarrhea counts as a review of the gastrointestinal system. In a routine or simple patient visit, two to three body or organ systems may be inquired about. While an admission or visit due to serious illness will frequently require a review of as many as nine to ten systems. These are documented and the visit is coded and charged based upon the number of systems about which are inquired.

Each body system examined in the physical examination is tallied and coded in the same manner. A simple examination of the ears, throat, and lymph nodes counts as one system called the HENT, or head, ears, nose and throat. Auscultation of the heart is one, the lungs are another, and the abdomen a third system to be tallied and adds to the billable components of the visit.

If a practitioner spends a large amount of time providing counseling, this too becomes a billable component of the visit. One simply documents this as “Greater than 50% of the visit, approximately 15 minutes devoted to providing patient counseling.” This then allows the provider the ability to code the visit at a higher reimbursable charge.

The colonization of the patient through the loss of their voice and their loss of identity, as resultant from our medical education institutions and practices, is continually perpetuated by teaching students to objectify the patient and their voice. “Post-colonialism in its most generalized form is the demand to speak rather than being spoken for and to represent oneself rather than being represented or, in the worse cases, rather than being effaced entirely” (Frank, 1995, p. 13). We are teaching students how to speak for and represent the patients, and we are teaching students to truly make the patient encounter a colonial experience.

Images of Textbooks

What seems unexceptionably good sense to these writers is that it is a fallacy to assume that the swarming, unpredictable, and problematic mess in which human beings live can be understood on the basis of what books—texts—say; to apply what one learns out of a book literally to reality is to ask folly or ruin.... It seems a common human failing to prefer the schematic authority of a text to the disorientations of direct encounters with the human. But is this failing constantly present, or are there circumstances that, more than others, make the textual attitude likely to prevail? (Said, 1979, p. 93)

The first years of medical education seemingly drowns students in a sea of textbooks. I see this as an engrained trait of all students, gleaned from years of K-12 education and nights of repetitious hours of memorization of facts taken from the pages. Years of primary and secondary education, followed by undergraduate education have led medical students to feel comfortable with this style of learning. These texts in medicine depict graphic images of cells, tissues, organs, nerves, but rarely are faces of these bodies

revealed. Texts are to be believed, valued, revered, and possess unquestionable authority. Just as Said wrote, these students have grown to prefer this type of authority.

Somewhere in these pages is contained everything they feel they must learn in order to pass that all important test to prove mastery of the material. The *patient* is esoteric in its pages. If we use the experience of sickle cell anemia I will offer an excerpt from *Harrison's Principles of Internal Medicine's* (Benz, 2005) description of the patient's symptoms which it terms as clinical manifestations:

Intermittent episodes of vasocclusion in connective and musculoskeletal structures produce painful ischemia manifested by acute pain and tenderness, fever, tachycardia, and anxiety. These recurrent episodes, called painful crises, are the most common clinical manifestations. Their frequency and severity vary greatly. Pain can develop almost anywhere in the body and may last from a few hours to 2 weeks. Repeated crisis requiring hospitalization (>3 per year) correlate with reduced survival in adult life, suggesting that these episodes are associated with chronic end-organ damage. (p. 596)

But the facts to be memorized are the symptoms associated with the condition. The *patient* is not something the student imagines or visualizes within the reading. The task is to memorize the common symptoms in order to make the correct diagnosis and pass the next test.

As stated earlier, the initial skills and instruction that students receive is that of how to take a patient's history. Jack Coulehan (2003) tells us:

That talking with the patient is the single most important element of diagnosis and the key to effective therapy. *Harrison's Textbook of Medicine* makes this point in

its first few pages, before devoting the next two thousand pages exclusively to organ systems and biochemistry. (p. 91)

In medicine there is always the need to study not only the diseases and their cause, but to develop as one textbook describes it, an approach to the patient. Let me give you an example of one such textbook paragraph regarding the recommended approach to a patient developing kidney failure.

Once it has been established that GFR is reduced, the physician must decide if this represents acute or chronic renal injury. The clinical situation, history, and laboratory data often make this an easy distinction. However, the laboratory abnormalities, characteristic of chronic renal failure, including anemia, hypocalcemia, and hyperphosphatemia, are often also present in patients presenting with acute renal failure. (Denker & Bremmer, 2008, p. 270)

Where is the human being in the approach to the patient above? Just as the quote from Said in the beginning of this section tells us, I can't imagine how distant a student of medicine would become after years of this type of reality, which indeed can lead us to folly or disengagement from the world in which our patients live.

Let me contrast this with a true story of kidney disease, poignantly portrayed about a man named Robert and written by Laurie Kay Abraham in her text, *Mamma might be better off dead: The failure of health care in urban America*. Abraham (1993) writes,

Why Robert waited until he was in such crisis to seek medical care is not entirely clear.... None of his short-term, minimum-wage jobs provided medical insurance to pay for diagnostic kidney studies, or medications, or follow-up visits to the

doctor, and he was not consistently enrolled in Medicaid, which has very limited coverage for single adults, anyhow.

This is what Robert recalls: “I wasn’t thinking there wasn’t that much wrong. I thought whatever it was might clear up on its own. They told me I had something on my kidney, but nobody told me to come back.”

Then, too, people who can barely afford food and shelter may not think they have much to gain from spending scarce dollars for doctors’ visits. “For someone who is poor, healthcare is not the highest priority,” Dr. Conway said, an observation offered repeatedly by doctors and nurses who work with poor patients. (p. 31)

Abraham tells us that Robert’s kidney disease was detected initially in a routine employment physical when his urine revealed abnormal protein levels. The detection of the disease through the laboratory evaluation was not enough to ensure the early intervention which was not mentioned in the textbook’s approach to the patient we saw earlier.

For our cohort we have been following, the study of kidney conditions completes their classroom education. And so it is, armed with months or years of medical knowledge, handouts, textbooks, notes, and all of the information which classroom and laboratory instruction can provide—the class of 2011 enters the setting of clinical education. They enter the world and meet the patient with knowledge of texts and science but in a setting still formulated by the institution. The struggle now becomes one of understand how that textual knowledge becomes the means by which they interact with the human being in the bed.

PA Class of 2011

A 23-year-old female student was sitting in the classroom with several other students during a required return to campus scheduled between each of their clinical rotations. This specific session was one in which students were encouraged to discuss their clinical experiences to provide opportunity to share with each other some of patient care experiences which had made an impact upon them.

The student described being in the operating room with the other operating room personnel, including the anesthesiologist, OR nurses and scrub tech. The student stated that the staff having completed the sterile technique and prep for the procedure were standing around the operating room with the patient lying on the table draped and ready for the surgery.

The door opened and the surgeon walked in and said, “All right, let’s cut the fat f... open”. Everyone in the room heard him say these words, including the patient, who was not yet under anesthesia.



Wear (1996) describes a critical component of clinical education as she writes, “since there is no single consensus on the best manner of doctoring, you pick up your style by trying to emulate the doctors you admire” (p. 87). Mimesis is just such an imitation. For the young student from Texas who told me the story, the thought that she might imitate the behavior she has witnessed is something I cannot imagine. Yet, I am witnessing her cohort as they navigate their way through their first five clinical rotations. They come back to me at the end of each rotation and I would allow them some “safe” time to decompress, to share some of their stories. Nothing is formally done here, other than offering them a chance to tell me about what they have seen, done, and heard.

What is incredible to me is that they began these rotations armed with over a year worth of science, pathophysiology, and pharmacology. Every few weeks, I “become voyeur once again through my student’s accounts of what they see daily in hospitals” (Wear, 1996, p. 107). The more that I do this and reflect on my role and place within their education, the more trepidation I have about my role. I wonder if there are other stories that students shy away from sharing out of fear of reprisals I may bring upon the physician who has just given them a grade. I wonder if they truly believe; as one may imagine that they must continue the silence they have maintained on these rotations. Do they assume that I, as a medical professional, would want them to keep buried that deeply hidden part of the curriculum that is medicine?

What do I do with these narratives I hear from the students? I am in no real position to act upon what I hear. The hierarchy of medicine places me in a subordinate position. Do I report what I hear? Do I place the student in the position of defending themselves against the physician who has offered them a clinical experience but who also has given them a grade on that experience?

It is an unspoken form of education, but one that is all too real. Clinical education is almost exclusively experiential. John Dewey cautioned us all on the pitfalls of overreliance on this type of education.

The belief that all genuine education comes about through experience does not mean that all experiences are genuinely or equally educative. Experience and education cannot be directly equated to each other. For some experiences are mis-educative. Any experience is mis-educative that has the effect of arresting or distorting the growth of further experience. An experience may be such as to

engender callousness; it may produce a lack of sensitivity and of responsiveness.

Then the possibilities of having richer experiences in the future are restricted.

(Dewey, 1938, p. 25-26)

It is not difficult to imagine the impact of the young student's experience above as engendering callousness, or at the very least, a lack of responsiveness to any subsequent learning from this surgeon in the operating room.

During the second year of physician assistant education, or during the third and fourth years of medical school, students participate in what are colloquially called clinical rotations. These rotations are the foundations of the apprentice-like experiences that make up their clinical education. Each student is placed within a setting that provides a variety of experiences.

The educational program in which the students are attending dictates the setting type. The accrediting bodies through which the specific university is under further dictate these. Generally, Rotation sequences provide students with a broad exposure to primary settings of Internal medicine, Primary care, Surgery, Obstetrics and Gynecology, and Emergency Medicine. Variations of these, from inpatient settings to outpatient clinical experiences, vary depending upon the institutions.

Students are provided a supervising physician or attending that is charged with oversight of their learning. Smaller hospitals may provide one on one teaching while other larger academic settings provide an attending that oversees a group of residents in the daily charge of student teaching.

As we have seen earlier, medicine maintains a language of its own, medical terminology and the development of it is an important aspect of the profession. But the

language of residencies and clinical rotations for the student also includes terms that many see as wielding a level of power and abuse. “Pimping” is one such term that is used to describe the physician’s questioning of the student regarding the patients’ case history, or treatment plan. I, in part of my complicity have warned my students that they will be “pimped” by their preceptors and this can be brutal if the attending is intent of passing on his feelings of humiliation suffered when he was in medical school.



Figure 17. The Agnew Clinic (Unknown, 1889)



A student related to me that, in the operating room and early in the procedure, he was asked a question, or “pimped,” by the surgeon. The student said, “Yeah, Dr. L. pimped me good today”. He said he had answered the question to the best of his ability and received the following response from the surgeon. “Don’t ever talk again in my OR—you know nothing but stupid answers.”

The student had come to my office to discuss the incident and I had very little to offer him in the way of assistance. This type of interaction is a harsh reality of medical education. Despite the fact that it is well known and decried in many formal curriculum

discussions—it continues. When I related the incident to my colleagues the response was almost repetitious with the many “that’s just how it is” statements made.



Pimping occurs most often after a student has completed their interview or history taking and physical examination of the patient in the room. They leave the room and then advise their preceptor of their findings. Physicians and other preceptors then question the student regarding their findings. They frequently interrupt the student and make statements such as “What about the palpation of the liver,” or “Did you ask them if they were taking their medicine daily?” If a student forgot a portion of the examination or history, they return to the room to correct the error.

Pimping occurs on not only the procedures or examination steps student perform, but also on the knowledge of medications and pathophysiology regarding the patients’ condition. It is a type of teaching and learning that varies greatly from one physician to another. In many ways, it was seen as a required component of the fraternity of medicine—a type of hazing that, when a student survives and succeeds, they emerge as a member of a group of brothers.

I speak here in very male or even patriarchal terminology, which will seem to many as a sexist view. Many of the examples of doctor and student interactions I have provided have occurred with male physicians. This has not been consciously done. While the face of medicine is greatly changing, just over 50% of medical school applicants are female and the realities of the medical educational setting are still one in which the professors and preceptors are male and a culture of the “old boy’s club” is still very much alive.

Other medical terminology that students learn on rotations, passed on to them from attendings and preceptors, are words such as DBI, or Dirt Bag Index. These terms are medical slang and components of the hidden curriculum specific to medicine. DBI is defined as the number of tattoos multiplied by the number of missing teeth to give an estimate of the number of days since the patient last bathed. Another term is GOMER, an acronym for Get Out of My Emergency Room, which is used to describe a patient who does not have a life-threatening illness. All of these terms utilized in the hospital settings by those who are there to care.

Many of the students have already become very jaded and bitter after only 4 months in over 40 different and separate clinical sites and settings. One student rotating in the pediatric clinic returned to voice anger at a young mother whose 16 day old infant had developed a fever and needed hospitalization. The child's mother did not seem to understand the seriousness of the condition and stated she had no time to have a child admitted because they had a funeral to attend that day. My student was outraged at this mother's lack of understanding—yet at no time did I hear her mention concern for this mother's loss by asking further about the funeral, or other issues going on in the life of that family.

Another student having just completed a rotation in the Emergency department and had come away with disgust and disdain for the middle-aged black woman who sought care in the emergency room, “because they know we can't turn them away and its free”. She vented to me and to her classmates that this woman actually brought five children to the ER to be seen, though none of them had a serious illness. Her anger was at this woman, who had no insurance or employment, simply because she was seeking

healthcare for her family. But where was my student's frustration at the political, social, economic, and cultural realities of her life which had placed her patient in this dehumanized role?

This exemplifies the battle waged between the formal and hidden curriculum of medicine.

If the formal curriculum doesn't deal with them directly, these cultural beliefs take up residence in the hushed (but oddly informally sanctioned) corridor talk among students and residents, in the shorthand jargon they use to categorize particular kinds of patients, or in their way of making sense of patients unlike themselves. (Wear, 2006, p. 93-94)

I hope that these concerns illustrate how physicians and medicine are very little changed in our society today from the religious physicians of early Christianity. The blaming of the patient for their conditions and behaviors are a reality today. Each behavior deemed to be a risk becomes an immoral or perhaps sinful act in the eyes of medicine. It is as if we never left those days and times where illness and sickness were viewed to be due to a sinful act, either by acts of commission or omission.

Many within the profession now think that anyone who has a heart attack must have lived the life of gluttony and sloth.... We seem to view raising a cheeseburger to one's lips as the moral equivalent of holding a gun to one's head. (Marantz, 1990, p. 1186)

The issues go much deeper than this and with much more of a personal and private nature. The still lingering fear of and discrimination towards those who are infected with HIV is a prime example. Those with the virus, no matter what their sexual

orientation, are immediately assumed by many both in and outside of medicine to have committed the sin of promiscuity, if not homosexuality. If their infection was not due to sexual activity, then it must come from illegal drug use.

If we become obese and develop a chronic illness possibly linked to the obesity, it is due to pure gluttony and sloth. Laziness and an inability to control our eating habits are viewed as the cause, as well as an inability to heed warnings, no matter how dire. These are realities of attitudes of medicine. We can see evidence of them in the stories of the surgeon with the patient who was “fat in her head”, and in those of Sarah

Issues of race, class, and sexuality are other such issues that continue to be touched upon in the formal curriculum while often more fully developed in the hidden curriculum.

Learning to recognize and respond to cultural features that affect clinical care—one common definition of cultural competency, and indeed professionalism—does not address, much less attempt to erase, the hidden faces of racism, classism, xenophobia, or any other believe system that can operate concurrently even as students acquire culturally-specific knowledge and skills. (Wear, 2006, p. 87)

In academic medical education, the awareness of bias, racism, and classism remains one which is hard to broach, and so often harder to teach.



In my own attempt at cultural awareness, I was teaching a course to the physician assistant students on medical interviews with respect and awareness of cultural and racial differences. I had recently been very moved by a documentary on young African-American teenagers, entitled “A Girl Like Me” directed by Kiri Davis. I was so looking

forward to sharing it with the students, but I also thought it might be just as moving to share with the other faculty.

During a curriculum faculty meeting I had asked for time on the agenda to share some of the film—to include the segment in which Kiri had repeated the historic Doll study performed by Kenneth and Mamie Clark in the 1940s. The faculty approved of my decision to share the film with the class, but afterwards I was approached by a colleague of mine who stated, “You know that stuff like that is just put out to us by the black community to keep their issues in the media. I grew up poor, and look at me. I had to same opportunities that they had, I went to school, I joined the Army, and I made something of myself. They had the same opportunities for success as I did.”

This was my first foray into attempting a humanities approach with my students and with the faculty. Unfortunately, a belief in meritocracy is alive and well within both worlds. When I showed the students the film, a student raised her hand to ask me “Professor isn’t this staged?”



The Experience of the Faculty

There are inspiring faculty among all of these disciplines and I do not intend for this section to appear overly critical of the field. It is one in which the players are caught up in the struggle for what our corporate influenced higher educational institutions have become. Their language and roles are often defined for them and historically shaped and played out in medical universities across the country.

There is a professional socialization which for these men and women occurred during their own medical education. This is often what they themselves pass on to the students they later encounter in the lecture halls and hospital corridors.

The culture, language, and hierarchy and traditions of the medical institution is as we will see—the site of teaching medical colonialism.



Not too long ago, I attended an annual meeting of the Physician Assistant Education Association (PAEA). These meetings are designed to provide faculty development and a platform for presenting research data and education on current issues within the field.

PAEA is the national organization of physician assistant programs and educators in the United States as well as Canada, the United Kingdom, and Australia. This is not a public forum, but a conference whose attendees are all actively involved in physician assistant education in some way. The number of programs in the US has now grown from Stead's founding program at Duke to over 140 programs across the country.

I remember sitting in one spotlight presentation, where the formal presentation had ended and an open discussion session had begun. A faculty member from another PA program was sharing the experience of providing his students with an outreach program into the homeless community in his city.

The faculty member described how his students were offered an ability to provide a minimal health screening to homeless people who stayed under a raised transit system in an inner city area. The students provided blankets, coffee, and performed health assessments in an attempt to identify needs and assess the presence of emergent conditions that may require assistance and transportation to the local hospital. He described how motivated his students were to participate and how the setting provided more awareness of public and societal health issues for the homeless in the urban areas.

When he finished describing the experience to the group, a long time professor in PA education turned to him and said, “So how do you assess outcomes in that situation? We are all about outcomes these days and just how do you assess the students before and after the experience to document your outcomes?”

Outcomes, data, and analysis of this data are the primary focus of all PA programs as the overwhelming pressure to maintain accreditation singularly rests on such statistics. It becomes strikingly apparent to me as I attend more of these meetings that the struggle for an individual program is to stay alive by nothing more than statistically analyzing data proving outcomes and competencies.

One session after another is devoted to methods and means of acquiring the data, documenting the data, and meeting the standards. Predicting outcomes and providing measures and strategies to ensure that the student you interview for admission will succeed in graduation from the program, but more importantly the all-important test—the national Physician Assistant National Certification Examination or PANCE. Programs across the country tout their board pass rates in percentages to show that the education they provide will the knowledge required to pass this exam and enter the profession.

Educators are not alone at these meetings. We are joined by a number of textbook company and the ever-present pharmaceutical corporation representatives. Each conference contains entire afternoons and evenings devoted to allowing attendees to be treated to a luncheon and drinks provided by these corporations. These gatherings are held in large meeting rooms. The rooms are surrounded completely with booths and

tables with billboard sized posters and display touting the latest medications and therapies being used in practice settings and taught in the classrooms.

We are each provided with a bag of some type for the primary purpose of picking up the latest pens, notepads, coffee cups, and package insert materials describing the corporate logo, name, and new medication indications and dosages. From one table to another we stroll while we eat, and drink, and listen to each representative discuss the latest study and data proving their medication is the most effective and causes the least side effects.

What is missing here? Where is the session on improving the learning environment and relationship with the student? Where is the patient? What about this conference provides a means to build the relationship between the two?



Competency and outcomes are so much the focus that I feel we so often forget exactly what it is we are teaching and why. Did these students learn from this experience about “the other”? Despite what many may feel are downsides to service learning and community service in general, isn’t it possible that these students gained an informal education and knowledge that will affect the way they practice medicine in the future?

Today’s changes in the education and profession of medicine are fluid and yet continue to be linked to institutions and powers of the state. Where authors McKinlay and Marceau see an important shift in the link between American medicine and the state, I see the possibility of increased issues of power and control. The state is most often viewed as the government or an institution which develops and enforces laws and maintains protection of its citizens. In this sense, the authors view the state as less

supportive of medicine as the shifts occur in the healthcare reform legislation as well as support for physician interests.

McKinlay and Marceau state the shift has occurred in the fact that, "...the state appears to have lost some of its ability, or willingness, to act on behalf of and protect the profession's interest" (McKinlay & Marceau, 2009, p. 216). McKinlay and Marceau describe this shift as due to what they describe as a growing allegiance of the state to the private sector. But if we look at their description of the "Marxist perspective," we see a view of "the state as partisan—maintaining the class system by either subordinating certain groups (e.g., racial and ethnic minorities and women) or dissipating class conflict" (McKinlay & Marceau, 2009, p. 216). But what I see here is that whether it is by the state's remaining partisan to the profession of medicine, or by a new allegiance to the corporations and private insurers, the American government still has great influence on the system of institutional health care.

The government continues to allow the medical profession legitimacy and power through the monopoly of the practice of healthcare, the control of its education requirements, as well as the societal status and function of the profession as a whole. In fact, the government can control how much or how little of this system is run by free market principles.

Curriculum

Wear (2006) describes medical curriculum in the medical teaching university as follows:

In medical education, curriculum work is tethered almost exclusively to the nuts-and-bolts objectives-content-instruction-evaluation paradigm.... Thus, little

critical inquiry generally occurs into the social effects of curriculum on medical students, particularly the formal curriculum. When we wring our hands about a medical student's negative attitude (pick one: a sense of entitlement, lack of compassion, cynicism), we rarely look to the curriculum we've constructed ourselves—the content of lectures, seminars, syllabi, or case studies; the organization of basic science and clinical knowledge; evaluation methods—for sources of such attitudes. (p. 29)

As we saw in the historical background of medical education in this country, the oversight and governance of medical education is primarily through the AAMC and the AAGME. These organizations are, like many others, comprised of ranks and categories of people who operate within the organizational structure and through governmental rules and procedures. These procedures tend to be arrived at by consensus and are maintained by collective agreement.

Curriculum revision or changes are seemingly overwhelming at times. Each course goal and objective is scrutinized to ensure they meet an appropriate accreditation standard and then are assessed through an evaluation instrument and the data compiled and analyzed in an effort to prove that the course instruction is valid.

Becker et al. offer a description of just how the impact of the governing institution of medicine and therefore the faculty impacts the experiences of the student. They write, Medical schools are, even more than other kinds of schools, organized in an “authoritarian” fashion: The faculty and administration have a tremendous amount of power over the students and, in principle, can control student activities

very tightly and cause students to act in whatever fashion they (the faculty) want.
(Becker et al., 2007, p. 48)

Through the auspices of the AAMA, AAMC, and the AAMGE, the curricula continue to this day to be very similar in length and content regardless of the institution one chooses to enter. Having completed four years of undergraduate education, students enter the graduate level medical education settings, then complete two years of basic medical science education followed by two years of exposure to the clinical specialties of medicine, psychiatry, and others as I discussed earlier.

The difference between medical school and physician assistant education is the didactic and clinical exposure are most often 1 year each in length. This is very similar in many ways to the educational curriculum of an advance practice nurse, or Nurse Practitioner.

All medical schools train students and provide educational experiences in conjunction with hospitals and outpatient clinical settings. The majority of medical schools are as Flexner recommended, are aligned with a major university. This is not as true with regard to physician assistant education, as today we see several small for-profit institutions offering education and graduate degrees for physician assistants.

Becker et al. (2007) tell us of the types of faculty which students encounter in the medical university settings, whether medical school or physician assistant, as they write, All teachers of medicine are specialist; more and more of them have their whole career in academic medical institutions. None is a rural general practitioner; few ever have been. These tensions and relations vary by state, region, and ownership of the school. State schools have to be especially sensitive to the local and state

professional organizations; the latter may be listened to by the state legislators of their districts. Some state schools, ours (The University of Kansas Medical School) among them, exert great influence over the standards of medical practice in their regions and promote and conduct active programs of postgraduate education for practitioners. (p. 51)

Without mentioning the specific institutions of which I have been trained, or have served as faculty, I will agree that the description above is accurately portraying the settings I have experienced. I will say that my own personal experiences and settings have varied from that of the upper mid-West, to the Deep South, mid-Atlantic areas, and others. The significance of what Becker et al. tell us here is the relationship and dependency between the university, hospitals, and state legislative organizations can be quite formidable and tenuous.

Today, we see a growing influence of business and corporations within major universities. If we look for the genesis of corporate influences in academia and higher education itself, we need to look to the 1980s when some significant events occurred which made investing in education very attractive to the corporate world. "First, U.S. federal funding of higher education, so ample in the preceding two decades was cut considerably during the Reagan administration and included reductions in the funding of federal grant-giving agencies" (Weaver, 1999, p. 142). In her article "*Point. Click. Matriculate:*"(1) *Corporate Influence in the University and the Academic Library*, Joyce Weaver cites further historical events which made it very attractive for corporations to contribute to academic institutions. "The 1981 Tax Recovery Act made monetary largesse to higher education more attractive to corporations by 'increasing the tax

deductions for ‘donations’ made to universities” (Soley as cited in Weaver, p. 142). We could say this became quite a positive development for both business and educational institutions.

The University and Small Business Patent Procedures Act of 1980, and the later supplement of 1983 which included larger corporations, contributed to the corporate support of educational arenas. This law had a particular impact in the realm of medical education as it “enabled universities to sell the patent rights to products of the research of university faculty and staff and it allowed corporations, ‘by sticking some of their dough into universities...to buy the results of university research’ ” (Soley as cited in Weaver, 1999, p. 142). Weaver goes on to add that some of the corporations participating in this type of funding often do so even though their funding comes from government dollars. This act basically gave corporations the ability to utilize academic researchers as free labor to develop products for their own gain.

In their response to these events, universities and their administrators began the practices that John McMurty (1991) describes as “searching for ways to justify education that will motivate ...corporate sponsors to provide more adequate financing” (p. 210). Academia and higher education are viewed as a means of remaining competitive in the world market. As McMurty (1991) states in his article on Education and the Market Model, “this subordination to an external system of rule with very different and even opposed goals to education is already very far advanced” (p. 209).

One could go on with the evidence of this overall pattern of education administrators, pressured by corporate executives, and threatened with ever further cuts in real income from government, increasingly taking up the demand

that public education be redesigned to serve as knowledge producers for private corporations in international economic competition. What was traditionally education's by-product function is now proclaimed as its ultimate goal.

(McMurty, 1991, pg. 210)

This has resulted in a slow but dramatic change in higher education and campuses across the country. Faculty and administrators now focus on education as yet another product to be sold and students as consumers to be pleased and in some instances, catered to. In yet another article discussing corporate influence in academia, Gail Cannella and Lisa Miller (2008) describe the impact on faculty as "they are placed in positions in which student satisfaction is the only measure, resulting in major incentives to 'go easy' on the 'customers' regarding amount of work and grades" (p. 33). This is not the type of environment or relationship between faculty and student that occurs when one is struggling to teach and the other to learn a difficult or complex issues. (Cannella & Miller, 2008)

The effect on faculty and curriculum at medical universities is increasingly evident at the administration level. Weaver cites a US News and World Report as she writes, "The presidents of more than one half of the 50 institutions listed on US News and World Report's dubious rankings of leading universities serve on corporate boards" (Kniffin as cited in Weaver, 1999, p. 143).

Corporations also endow program chairs and professorships. Is this relationship a possible threat to academic freedom and integrity? How much control might a program chair attempt to exert over his faculty and research if a huge pharmaceutical firm pays for his position? If this is a medical program, the impact could be very serious. An example

of this, published in the Chronicle of Higher Education, tells of two researchers in medical education settings who were “fired from academic positions after they published findings that angered their corporate sponsors” (Mangan, 1999, p. 14). The professors discussed in the Mangan’s article dealing with corporate influence in medical research both taught at different institutions, yet suffered a similar fate.

Historic and forward thinking academic scholars sought to ensure their freedom. What we now call tenure formally began in 1915 with the creation of the American Association of University Professors (AAUP) by Arthur Lovejoy and John Dewey and others. “The AAUP’s purpose in putting forward the construct of academic freedom was to create a legal space so that faculty could explore controversial ideas without fear of arbitrary firings and to create a position for which they were experts, rather than leaving the decisions with boards of trustees, donors, and regents” (Cannella & Miller, 2008, p. 29).

The freedom of faculty to teach and maintain responsibility for curriculum and research with an unrestricted sense of inquiry I see as crucial to the professorship. Those who teach future health care providers are entrusted and charged with inspiring critical thinking. Should medical educators not have control over pedagogy and the freedom to explore new ideas in these areas without fear of reprimand or reprisals?

An example of such a reprisal lies in the story of Betty Dong. Dong, a clinical pharmacist was working at the University of California San Francisco (UCSF). She had received a grant from Boots Company to research the drug Synthroid (a common hypothyroid medication) comparing it to the generic alternatives. “When the research

failed to establish Synthroid's superiority, Boots blocked Dong's publishing her work and criticized her study publicly" (Jensen, 1999, p. 13).

A more disturbing trend is beginning to occur now at graduate medical universities. This trend involves the funding of residencies by pharmaceutical companies in some specialty areas. While the stated rationale for this is to encourage and increase the number of physicians and mid-level providers in specialty areas such as dermatology and rheumatology, the risks of much more than a simple conflict of interest are there. In a letter to the editor of the Journal of American Medical Association (JAMA), Dr. Orin Goldblum and Dr. Michael Franzblau voice their concern by stating, "Unrestricted grants may not be unencumbered and might create feelings of reciprocity. He also wondered whether this type of funding was a new way for pharmaceutical companies to influence physician behavior" (Goldblum & Franzblau, 2006, p. 2845).

The answer to that question is yes. Stanford University says it counters these possible influences by teaching their young residents about ethics. (Keuhn, 2005, p. 1580) Yet, prominent figures such as Drummond Rennie MD, the deputy editor of JAMA, write, "To say that this has nothing to do with advertising and influence is absurd" (Keuhn, p. 1580).

Pharmaceutical companies in truth bear a heavy burden of guilt here in corporate influences in medical education. But not only residencies are affected. Curriculum and research itself are dictated by the corporation that is funding the research. Few young physicians entering the research arena are free to choose their field of study while in school. And many are signing over all rights to the products of their efforts; a huge boom for the corporation funding the study.

There has also been a major paradigm shift in medical education in the past decade to become competency based. This type of teach by numbers effort to assess a practitioners knowledge of medicine and the ability to interact with a patient at the bedside is the highest example of irony in my opinion. Yet the struggle to have all education evaluable by some measurement of outcomes and minimum standards is again being brought to teaching hospitals and universities by those same forces that are bringing NCLB into elementary schools. We have discussed earlier the issues of attempting to teach competencies, but taking another look at it here with this quote from Klass reinforces some of the issues.

It is relatively meaningless to state that an individual can take a history. The statement only gains meaning when critical aspects of the situation in which the history is taken are specified (e.g., the setting, the nature of the patient, and the nature of the patient's problem). (Klass, 2000, p. 483)

I do understand there is real and valid criticism regarding the pressure on university faculty to perform research in some areas of higher education. There are those however, who feel that the “too exclusive focus on research is harming teaching” (Readings, 1996, p. 125). Faculty senates, hiring, and promotion now not only hinge almost solely upon one’s ability to perform research, but also on their ability to secure large amounts of funding for the study and, therefore, for the department in which it is being done.

I recently attended a faculty senate meeting where I teach. The faculty senate is a gathering of the faculty members from the various departments which make up the College. The agenda dealt in large part with the introduction of new faculty for the

medical school and schools of public health and health sciences. Without fail, each professor in the medical school introduced themselves by stating their latest research study and amount of funding they had received. No mention was made of their teaching, their methods of promoting critical thinking or even their impact upon the lives of their patients. In fact, not one of the twenty-odd professors mentioned clinical practice at all.

Becker et al. discuss the amount of education provided by tenured faculty of professors and that of residents in the clinical year. They interviewed residents in the University of Kansas Medical School to rank the importance of their teaching responsibilities compared to that of administration and their own learning. “Without exception, they ranked teaching last....It is likely, on the basis of our general knowledge of many-leveled hierarchies, that they would be more concerned with their own ambitions and pleasing their superiors than with supervising their subordinates” (Becker et al., year?, pg. 355-56). Residents do provide a large clinical teaching role in any academic medical setting to include teaching physician assistant students in their clinical year. Though they may consider teaching to be their least important duty—they are often much more effective teachers than a hurried attending.

Medical education is quickly becoming a world of specialty educators just as medical practice has experience. Classroom instruction in anatomy is in many areas taught by anatomists, biology by biologists, and pharmacology by pharmacists with terminal degrees. This has quickly led to multiples months of classroom education with professors who are completely removed from the care of patients. I feel this extends the divide between the students and the world of healthcare in which they will find themselves in the clinical year.

With the distance growing between those who instruct and the world of the patient the concern becomes one that takes on another colonial aspect to explore. Those within medical education we might say are natives to the world and culture of medicine. And as we stated earlier, the students who enter to learn become immersed within this new culture and language. Said provides a description from which we see a different type of link between the two. In *Orientalism*, Said details the work of Richard Burton. Said describes Burton,

As a traveler, Burton was a real adventurer; as a scholar, he could hold his own with any academic Orientalist in Europe; as a character, he was fully aware of the necessity of combat between himself and the uniformed teachers who ran Europe and European knowledge with such precise anonymity and scientific firmness.

(Said, 1979, p. 194)

Said tells us of Burton's self-conception of one who learned the language, and became a member of the communities through his travels. Burton became fluent and disguised himself as an Indian Muslim physician. (Said, 1979) He immersed himself in the culture through his knowledge of the world of the Oriental. Yet as Said stated, Burton's knowledge of the Orient remains one

Yet what is never far from the surface of Burton's prose is another sense it radiates, a sense of assertion and domination over all the complexities of Oriental life... For even in Burton's prose we are never directly given the Orient; everything about it is presented to us by way of Burton's knowledgeable (and often prurient) interventions, which remind us repeatedly how he had taken over

the management of Oriental life for the purposes of his narrative. (Said, 1979, pg. 196)

Again, we could replace the word Orient with the word patient almost synonymously. Though the lectures and materials on diseases and conditions are seemingly exhaustively covered, the patient remains objectified and distant from the classrooms. The patient becomes as Said describes Burton's oriental, "a domain of actual scholarly rule" (Said, 1979, p. 197). It becomes a thing to be learned and a knowledge to be acquired—not a person to be known.

Perhaps if we remember that the study of human experience usually has an ethical, to say nothing of a political, consequence in either the best or worst sense, we will not be indifferent to what we do as scholars. And what better norm for the scholar than human freedom and knowledge? (Said, 1979, p. 327)

Every description of clinical presentation, disease states, and treatment guideline are offered to the student with the nondescript *patient* somewhere in the periphery of the instruction. Occasional anecdotal narratives are added just as the physician who described the elderly woman as a poor historian I shared earlier in this chapter.

Academic and clinical medical faculties are most often trained physicians and physician assistants themselves. They were educated within the same systems of traditions, hierarchy, rules, and practices. To teach within these settings you must be a practitioner of medicine. The comparison of Burton to an educator within medicine is similar with regards to the fluency of language, and immersion within the culture.



I decided one day to bring into the classroom a woman who had just recently been diagnosed with her third recurrence of breast cancer. She very graciously agreed

to my request to come into the class and share with the students her own story which I have never seen in a textbook on breast cancer.

She began by telling the students about her initial diagnosis and its impact on her husband and her two sons. She told them of one of her chemotherapy side effects leading to her loss of taste, and how she struggled to eat food which had no taste at all. She went on to talk about one of her son's change in behavior at school due to her diagnosis of the first recurrence of cancer. There was some give and take in the discussion with students asking questions about her relationship with her physician and PA.

They were interested in hearing her describe her feelings about her providers, did she feel they listened to her, and other questions relating to an aspect of the doctor patient interactions which I had never thought to include in my classroom lectures—nor did it appear in their text.

In my own teaching of physician assistant students in hematology and oncology lectures I have found myself struggling with humanizing the patient. Witnessing patients in oncology I saw the toll the treatments can exact on the patients. I also saw moving love stories between family members as well as husbands and wives. I felt myself keenly aware of the patient at the periphery of the classroom lecture.



I realized at that moment that in preparing my lectures, in the putting together of power point slides, handouts, and diagrams that I had not thought to ask my students what they wanted to know or learn.

CHAPTER 5

CONCLUSION

Diane was a 41-year-old African American woman that I met four years ago. She had just been diagnosed with Stage IV non-small cell lung cancer. A Stage IV designation indicates that the disease has already spread to other areas of her body and in her case, it was inoperable.

When I met her she was in the outpatient clinic where she had been referred for an initial consultation with the oncologist to discuss her condition and develop a treatment plan for chemotherapy. Diane was a very funny and sarcastic thin young woman with a great laugh and a smile that revealed several missing teeth. She had an air of determination and self-reliance, which was easily apparent. Her social history revealed that she had dropped out of high school, was unemployed, and living on welfare support. Due to these and other issues, she was completely estranged from her mother and family. She had no insurance. She had never qualified for Medicaid as she had never been significantly ill before. She had no car and relied on public transportation completely.

The discussion in the examination room between the oncologist, I, and she was a sober one. Chemotherapy and possibly radiation therapy were discussed and recommended. This course of action would offer her the possibility of prolonged life, though the possibility of a cure was very small. She decided to proceed with the treatments and was scheduled to return for chemotherapy the following week.

Her next stop in our office was to sit down with the office manager to discuss the costs of her care. The costs for treatment of lung cancer can reach as much as tens of

thousands of dollars per person with advanced disease and possible disease progression. Patients who are destitute often begin treatment for cancer and later document their resulting debt and poverty with the Welfare offices in order to qualify for Medicaid. They then are responsible for a minimal co-pay amount of three to five dollars per visit for their care.

Diane began her treatments the next week. The chemotherapy room in the outpatient office where I worked was large and open with many windows to let in natural light. Vinyl recliners in a semi-circle were the chairs patients sat in to receive their chemo. Some treatments lasted only 30 minutes while others could last several hours to complete. Warm blankets were always available, as were snacks. Patients could bring in food, or even order food to be delivered.

Some may read this description of the setting and be amazed at such an apparent, almost blatant violation of the privacy rules and regulations. However, the goal was for the patients to be able to share their experiences, to share their stories and those of their families, in an effort to help them through what for most is the most fearful time of their lives. So all patients received their treatment together with nurses and aides as well as doctors all coming in and out while they watched television or read, talked, or just slept through their care.

Diane arrived that first day and took her place in one of the recliners. One of the chemotherapy nurses and I went over to ask her how she was feeling. We discussed together what she could expect that morning and what medications and chemotherapies we would be using. The chemotherapy nurse discussed with her in detail the possible side effects of the treatments, to include hair loss, nausea, and loss of appetite, decreased

white blood cell counts, and our ability to manage these toxicities if they occurred. We asked her if she had any questions and then offered her the form for her signature stating that she was giving us permission to treat her. The signature line contained the words, Patient Name.

Diane began her chemotherapy treatment and in doing so became a part of the semicircle of recliners and the patients who were in them. She had an infectious laugh and wit that brought her character into the room.

Her chemotherapy lasted several hours and she had little money and would eat from the snacks and drinks available during her treatments. Without her own car, she often waited quite a while for the county maintained transportation to come and take her home.

After several weeks of treatment, Diane began to suffer from toxicities and side effects of her chemotherapy, to the point where she required hospitalization for a time. I continued to see her on rounds in the hospital and oversaw parts of her care with my physicians until she could be released.

She was very weak and in need of assistance when she went home, so the hospital social services and discharge coordinators put in place a home nursing and care arrangement. What became striking was the telephone call we received in the office from the home health services the day after she was discharged.

The home health nurse reported that Diane lived in one room on the second story of a building down town. She had no bathroom and no running water in this room. She relied on a bathroom and washroom downstairs in someone else's apartment. She had

no ability to keep food refrigerated or to cook her own meals. The building was in such disrepair that the home nursing company felt it was too unsafe for them to enter.

What followed this phone call were many more calls which led to the physician I worked for placing the most crucial call of all—to Diane’s mother. More calls followed and a conference in our office arranged with Diane and her mother. The results of which was that Diane accepted her mother’s offer to move into her home and continue with home health nursing and follow up care for her symptoms and condition.

Diane was never able to resume her chemotherapy. Within a few weeks she returned to the hospital. I continued to see her daily on rounds and the chemotherapy nurses took turns visiting her and bringing her food and things she requested. Diane died a short time later.



“Traveler, there is no road. The road is made as one walks” (Machodo, as cited in Macedo & Freire, 2005, p. xxiv). The quote from Paulo Friere’s text, *Teachers as Cultural Workers*, is one that means a great deal to me personally and offers us much to contemplate here at the end of this work. We have no road before us... And in many aspects we have explored here this statement is true. I have touched on problems, explored difficulties, and described realities that trouble the path we are on. But another reality also exists in this quote—we can walk and therefore make our own road into the future.

There are countless Dianes in the world today. Millions of Americans live in poverty and suffer disease and illness, homelessness and disability. The consequences of their lived experiences are real. It is now up to us to decide how to move forward—if

change is possible—and if so how. We must create and build a new medicine whose focus is on the lived experiences of the ill. Medicine must be able to see and work beyond the doors of the institution into the world in which the issues of poverty and social concern become the cause of disease and disability. The dynamics surrounding, connecting, and separating Diane and the world of medicine are also real. It is the colonial dynamics which name and form her experience within medicine that concern me most.

When I began this dissertation, I set out to explore medicine through the lens of colonialism. I have stated my desire is emancipatory in many ways and that I hope to bring about change. But I must admit that I have no road on which to guide us.

Now, at the end of the histories and stories contained within this study, I hope that I have as Caputo writes, perhaps brought my readers to:

Not to a conclusion which gives comfort but to a thunderstorm, not to a closure but to a dis-closure, an openness toward what cannot be encompassed, where we lose our breath and are stopped in our tracks, at least momentarily, for it always belongs to our condition to remain on our way. (Caputo, 1987, p. 214)

I feel in many ways that I have sought not to provide the thunderstorm, but to at least create a disclosure, as Caputo describes in this work. Each time I have sat down to this work, I realize that I may not be able to arrive at what many would call a conclusion. Even now, I do not feel that this was what I intended when I began.

Is medical education solely responsible for the colonizing impact of medicine on the patient? Truly, it is little more than a symptom of the larger issues of our own American views of class, poverty, and social compassion. Medicine as an institution and

through its practices responds to the symptoms of the disease, but did not necessarily create the disease. Its focus is assuredly narrowed and self-perpetuates many of the colonial aspects of medicine. T. S. Elliot's words remind us that we should not look to education as a means of directing or reforming the culture of medicine. He wrote:

There is also the danger that education—which indeed comes under the influence of politics—will take upon itself the reformation and direction of culture, instead of keeping to its place as one of the activities through which a culture realizes itself.... We must not train them merely to receive the culture of the past, for that would be to regard the culture of the past as final. (Eliot, 1948, p. 108)

American education is under the complete control of the government, politics, and corporations. Since the days of Sputnik, the race to force the education of future generations of scientists and other globally competitive workers has been driven by American leaders. Evidence of the ramifications of this are seen every day in classrooms operating under the No Child Left Behind Act (NCLB).

It is truly a direction of culture as Eliot describes above. One in which the driving forces are those of economic gain at all costs. Marla Morris (2011) offers questions we in education should ask ourselves. "If this is the case, if we really do stand at a crossroads of meaning, what kind of meaning are we making with our students" (p. 123)? Is medical education's emphasis on the disease organism and its treatment offering students an ability to truly make meaning of or understanding the experience of illness?

The practice of medicine is learned within the institution of medicine. As Said writes, colonialism is "domination of a people...with a degree of economic exploitation and denial of human rights". And in America, healthcare is not a right. That statement

alone speaks volumes as to the level of domination and colonialism exerted on the “natives” of this land of ours. By continuing to deny—no matter the reasoning—healthcare as a right to the citizens of this country, our current healthcare system will remain in a position of domination just as any other colonial empire.

What will it take to change this? What type of struggle for change is necessary to enable any one of us in this country to enter a hospital and receive treatment based solely upon the fact that we are ill and in need of medical care?

One of the main tenets of Critical Humanism is that each of us as human beings is a self-creation. We are each capable of becoming what we envision. As Noonan (2008) wrote: “The value of this principle for research is that it concentrates attention on the general capabilities that enable people to build and rebuild their social worlds” (p. 156). Through critical humanism we can work to effect change by raising the awareness and possibilities of human action. (Noonan, 2008) If this work can and does stimulate action that leads those who teach and work within healthcare to bring about changed actions then I believe we can all walk together and build a new road, as the poem describes.

In seeking to view the possibilities for change in the future, I want to return again to the idea of culture:

It may be the cultural particularities of people—in their oddities—that some of the most instructive revelations of what it is to be generically human are to be found; and the main contribution of the science of anthropology to the construction—or reconstruction—of a concept of man may then lie in showing us how to find them. (Geertz, 1973, p. 43)

Could it be that the main contribution of medicine someday may be the reconstruction of the concept of the patient? Perhaps we should not teach the concept of patient as a body with an illness or disease organism. Perhaps we should instead teach the concept of a fellow human being experiencing an alteration in their ability to live their lives as they normally would due to an illness.

Our definition and understanding of men and women, of the patient cannot and I feel should not be reduced to what Geertz called the “lowest-common-denominator view of humanity” (Geertz, 1972, pg. 43). As Geertz tells us, in sociology and anthropological studies of cultures there is a perceived need for generalization and universal understandings of men and cultures. His concern is explained as he offers a disease analogy as he compared an anthropologist’s belief in the universality of a cultural phenomenon to that of the knowledge of human genetics that we can gain from a single disease known as sickle-cell anemia (Geertz, 1972).

Our understanding of the genetic influence of sickle-cell anemia provides us the ability to trace its genealogy through the family and predict the possibility of a future child being born with the disease. The knowledge and understanding of the disease in medical education I feel provides the foundations for many of the assumptions that are then transferred to our approach to the individual patient. The cellular configuration in sickle-cell disease is a generalized finding, but the individual’s experience of the disease is far from universal. But the most forceful generalization in medicine is the need to provide the common denominator terminology of the word patient to every person who seeks and needs medical care and treatment.

There is a great deal of hidden power in the ability to name. Contemplate how much thought and consideration goes into the naming of a child for instance. These naming of the patients whose stories I have narrated in this work were with a required level of anonymity due to privacy issues. However, I could not in good conscious label them as medicine would, the patient in room 431, or the sickle cell in 234. Thus, I offered pseudonyms so their identity would remain hidden but their humanity could be left intact.

The character of medicine, just as the character of men and women are formed through our cultural formulations of them. Again, returning to Geertz (1972), we read:

There are, at least beyond infancy, no neat social experiences of any importance in human life. Everything is tinged with imposed significance, and fellowmen, like social groups, moral obligations, political institutions, or ecological conditions are apprehended only through a screen of significant symbols which are the vehicles of their objectification, a screen that is therefore very far from being neutral with respect to their “real” nature. Consociates, contemporaries, predecessors, and successors are as much made as born. (pg. 367)

If consociates and successors are made—then changing the symbols which lead us to objectify the patient offers us hope. We must become fully aware of these symbols and their significance and affects in our daily practice of medicine. We have the ability, and the responsibility, to change the cultural definition of the word patient, which is naming the human being we see in the hospital bed, or examination room.

The reality of the experience of colonization is contained not only in the identity of the patient, but also in the power to identify illness itself and disability. In the act of naming the patient it we find what is a forced identity is in many ways. As Said writes,

“In short, the construction of identity is bound up with the disposition of power and powerlessness in each society” (Said, 1979, p. 332). I feel the ability to decolonize American medicine will require a change in the balance of this power.

The ability of science and medicine to name and study disease causing organisms and develop treatment measures and methods is not the source of the power which colonizes. This power stems from the ability to provide or withhold this knowledge for the purpose of financial gain. As we saw early on in the works of Foucault, there is power in the belief that science is the most important aspect of power. And there is power in the naming and labeling of the experience of illness and the identities of those who are ill. It is the construction of the very identity of patient and of the physician itself—the powerless and the powerful defined by their identities.

Since beginning this work, the questions in my mind all seem to begin with “why” and “what if”. Why it is that healthcare in this country is not a right? What if the experience of Diane and her illness could have been completely without the issue of poverty and healthcare cost?

When the oncologist I was working with took the moment to call Diane’s mother, he was acting out of the compassion of one human being to another. His act had little to do with providing her a chemotherapy treatment for her disease. It had very little to do with any courses or lectures he had attended during his years of training. The phone call did not exist on any therapeutic guideline flow chart for cancer regimens and modalities. The step he took in making that phone call offered a chance for Diane to receive basic care, meal preparation, basic house cleaning, daily visits from nursing assistants for

bathing and a multitude of other basics to include fewer things for her to worry about as she became more ill.

In every emergency room, hospital floor, and outpatient clinic—there are patients whose disease or conditions are often the least of their worries. They are reaching out to another human being and one of the few ways available to them, if it is at all available. Just as we saw in the first narrative of the mother and infant with seizures, the impact of the world outside of the hospital is so often the most serious of contributing factors or as medicine may call it, a pre-existing condition.

Medicine has among its members, some of the brightest and most intelligent minds in the world. What would happen if they collectively turned their focus and subsequently their research dollars to the questions of hunger, poverty, and homelessness? Those within public health work to identify these issues among many others as factors which contribute to and impact the practice of medicine in this country. Isn't it possible that more research and action turned to these issues would result in critical changes? It is possible that we could see momentous changes in the well-being of this country's citizens.

Scambler provides us with a possible paradigm within which this focus could begin to be explored. If we take the view that a deprivation of healthcare access is a loss, then we can look at its impact as:

The loss model emphasizes an individual's state of heightened susceptibility to illness due to (socially structured) biographical circumstances indicative of 'loss'. The positive impact of social support on health is often cited. Treatment, in this vein, tends to focus on strengthening those resources which act as social

support.... The risks to health and longevity are seen as graded by social strata, as in the long tradition of health inequalities research. Treatment consists in societal rather than individual measures, although these may include calls for ‘demedicalization’ ... and ‘deprofessionalization’. (Scambler, 2002, p. 25)

This could require an actual change in the focus of medicine from the competency of professionalism to perhaps one of deprofessionalization as a first step. By this I do not propose a discrediting of the practice of medicine nor do I mean to imply that there is no value in all of the effort placed into improving the practice of medicine by focusing on professionalism. As we saw earlier in this chapter, professionalization by definition is to acquire or attain status through specialized education, knowledge and membership in an organization then perhaps deprofessionalization is the better aspiration. Perhaps the most emancipatory act would be to redefine professionalization as Hafferty describes it, “Professionalism implies obligation and commitment, and both entities are better viewed as residing within individuals than within organizations” (Hafferty, 2000, p. 29). Then it would have very little to do with status obtained through education or institutions, but could become a very humanistic quality.

I do not make this statement of possibility and change lightly, nor do I intend to purport that this possibility for change is the only manner in which to make all the wrongs in the world of illness disappear. But I firmly believe that change is urgently needed and it must begin within medicine itself and those who practice it. We must all become actively and fully engaged in this work if decolonization is to become a reality.

The most urgent change necessary is that America must emphatically believe and support the belief that health care is a right for all of its citizens. Healthcare as a right

must be granted equal status with education, freedom of speech, and freedom of religion. Our country as a major member of the United Nations has signed the Declaration of Human Rights and in doing so has stated that we have the belief that our citizens should expect this. And yet we remain the only industrialized nation in the world to deny this right. Simply saying this will not make it so, as many before me have said it. But if we are to be serious about healthcare reform, equality, and access it will necessitate a major shift in ideology within the world of medicine.

Rather than a right, Healthcare has become one of the largest American businesses today. “The expansion of medical facilities and health-related industries is not unlike the imperialism of capitalist monopolies” (Waitzkin & Waterman, 1974, pg. 35). Health and health-related companies continue to expand in major cities and areas of the country because they have legitimacy through maintaining the ideology of service similar to other colonial systems. (Waitzkin & Waterman, 1974) European colonists felt they were bringing services to those they colonized. Franz Fanon’s medical service in Algeria is one example. Colonial empires saw the natives as without knowledge, a religion, or medical treatment that they alone were privy to. In much the same way, our medical institutions see patients as without knowledge. This dehumanization of the patient has been an important prerequisite to turning Healthcare into a commodity. It is a service which is bought and sold and it provides this service to an unlimited supply of demand. As a component of our capitalistic society, our institution of medicine colonializes and exploits those who are ill and vulnerable.

Medicine as an institution has become one of social metastructures through which misuses of power have been allowed to maintain injustices, exploitation, and

dehumanization of those who are ill. (Goldsen, 1964) The realities are right in front of us as the American society. We spend more money per capita on healthcare than any other nation in the world. And yet, we have a shorter life expectancy than many countries deemed far less privileged or affluent. These statements are and have been front-page news in the most recent battle for national healthcare reform.

Again, I say that the call for change must come from within. We cannot continue to look to others with power, such as the politicians or organizations to speak for the interests of the vulnerable. We must live up to the teachings of Hippocrates “to do no harm” (Hippocrates, 400 BC/2004) and speak with and for those who are in need and suffering. In that same national battle I just mentioned, the AMA was among those fighting against healthcare reform in an effort primarily to maintain their bottom line—to prevent cuts in Medicare reimbursement. According to an article in the Washington Post in 2009, we see that the AMA spent “a total of \$8.2 million on lobbying through June of this year” (Eggen, 2009).

As universities adopt the ideology of the corporation and become subordinated to the needs of capital they are less concerned about how they might educate students in the ideology and practice of governance, the political importance of democratic values and the necessity of using knowledge to address the challenge of public life, focusing instead on increasing profits and market values, identities, and social relations. (Giroux as cited in Jaschik, 2007, p. 4)

The AMA as a major lobbying organization on Capitol Hill has formally opposed the latest movement toward a single-payer insurance funded by the government. The formal statement placed before the senate finance read as follows:

The A.M.A. does not believe that creating a public health insurance option for non-disabled individuals under age 65 is the best way to expand health insurance coverage and lower costs. The introduction of a new public plan threatens to restrict patient choice by driving out private insurers, which currently provide coverage for nearly 70 percent of Americans. (Pear, 2009)

When physicians are surveyed outside of the AMA the results to the question of single-payer national health insurance receives a very different answer. Percentages ranging over 50% of physicians surveyed in various poles reveal a disconnect between that of the professional organization and those physicians not necessarily aligned with them. (Mount Sinai Medical Center Press Release, 2010) The reasons for this are not as humanitarian as we might wish them to be.

An online article by Roger Bybee (2008) stated the primary concerns of these physicians to be the overwhelming bureaucracy of private insurers and the constant decrease of reimbursements leading physicians to feel they would feel relief from dealing with multiple corporate entities to a single-payer or national insurance organization for all patients. As Bybee stated, “Doctors are experiencing an extreme and relatively sudden loss of control at the hands of insurers and hospital networks, while being snowed under by paperwork and bureaucratic battles with insurance companies over authorizations and payments” (Bybee, 2008).

I won't pretend to have the answers to the enormity of the situation facing some in our own country and others, but as David Purpel tells us, we may not finish the tasks of reducing pain and suffering due to issues of social injustice, “but neither are we free to take no part in it” (Purpel, 1999, p. 107). It is this sense obligation which motivates me

to continue in this endeavor. And I believe if we take the theoretical framework of postcolonialism to an action of decolonization of the patients, our own citizens, there is a chance for change.

Pechey offers us a link between this erasure of the patient within the words as he describes his concern of the term postcolonial as if it in effect tells us that the condition is confined, or in the past with the terminology of “post”. Pechey (1994) tells us:

The postcolonial condition is the perspective one enters when one has resolved that paradox, relished that irony of history, and moved on.... It is rather a dispersal, a moving field of possibilities which everywhere carry within them the mutually entailing, intimately cohabiting negative and positive charges of both power and resistance. (pg. 153)

There are seemingly insurmountable issues in existence every day within the world of medicine which occur hundreds of times over at the bedside and examination tables in this country. In my most passionate moments in writing this dissertation, I feel as if the teaching of medicine must begin to see the world of American healthcare as one that begins and exists in the lived experiences of our patients.

Medicine should see itself as humanistic as opposed to scientific in every aspect of the institution. The overwhelming and still growing belief that science is the foundation on which medicine should be built must be changed. The science of medicine in developing interventions and treatments is without doubt impacting the health of those who are ill. But the combine discourses of science and corporatization exceeding the discourse of humanism have exacted a serious cost to the practice of medicine.

Ivan Illich (1977) discussed the realities of the scientific ideology in his text, *“Limits to Medicine: Medical Nemesis, the Expropriation of Health”*. Illich wrote, “By turning from art to science, the body of physicians has lost the traits of a guild of craftsmen applying rules established to guide the masters of a practical art for the benefit of actual sick persons. It has become an orthodox apparatus of bureaucratic administrators who apply scientific principles and methods to whole categories of medical cases. In other words, the clinic has turned into a laboratory. By claiming predictable outcomes without considering the human performance of the healing person and his integration in his own social group, the modern physician has assumed the traditional posture of the quack. (Illich, 1977, p. 253)

Far too often the physician or provider performs the ritual performance of the interview, the history taking followed by the physical examination. Based upon data acquired from these steps perhaps followed by data from laboratory tests or radiological studies a diagnosis is arrived at and treatment is provided based upon the latest evidence-based medicine and scientific study. This all occurs in the usual 10-15 minute appointment which at 1 pm is often triple booked. Therefore leaving the physician little time for the provider to remember that this is an encounter based upon trust, and human qualities which include the nature of the human being and an art of caring.

Physician and medical educator, Gregory Doran provides us with a powerful glimpse into the entrenchment of scientism as opposed to a humanistic focus of medical education. In this article he reminds us that this lost art of medicine as a social encounter is a process of dehumanization. Doran tells us “that the dehumanizing process occurs in

medicine is obvious (one has only to spend time as a patient in a large busy hospital to realize this) (Doran, 1983, p. 1832). How have we arrived here? Are those who practice medicine colonized as well by the ideology of science and the institution of medicine? Do we suffer from a belief that we truly lack the power to change the system? Are there those within who feel as I have felt—that other members of the culture are not interested in such human feelings? (Doran, 1983)

The drive of those within medical academia to pursue funding for the next drug or surgical device and technique are of prime importance to far too many. Compare their funding with that of grants or funding requests for bedside practice measures. A 2009 National Institutes of Health American Recovery & Reinvestment Act funding report reveals a grant amount for Health and Science research totaling over 389 million dollars. Grant funding for Research and Research Infrastructure totaled over 625 million dollars. The 2009 funding for research in Health Disparities Intervention totaled just over 300 thousand dollars. (National Institutes of Health, 2009) The practice of medicine is an act of providing more than treatment, it is providing care far beyond the level of an intervention.

Science has blinded us within medicine to the lived experience of those who are ill and injured. We have as James Paul (1978) writes, “thus obscuring the broader health-destroying effects of the social order it supports” (p. 272). The institutions of medicine too often ignore the social and environmental causes of disease and in many ways overmedicalize society.

This continued inability of medicine to research and study the impact of social issues—the world outside of the hospital door—is frankly a form of neglect. (Lewis,

2006). According to studies performed by Public Health organization such as the World Health Organization we know that poverty and social injustice are the major contributors to disease and illness and that remains the reality in America today despite of scientific efforts and prowess.

What would be possible if the millions of dollars spent lobbying against the latest plan for national healthcare could, in turn, be spent for a national health system which guarantees the right to healthcare to all regardless of race, age, or even citizenship?

I look again at Samuel Weber's text, *Institution and Interpretation* as he discusses the issues of government vs. private control of medicine. We have worked for too long in the opposite direction. Cuts have been and are being made in programs with an eye to reducing the budget. The political mood in America seems to become more and more one of *robbing Peter to pay Paul* as the old saying states. There is a belief that in placing the program in a private corporation for profit that we are saving the taxpayers money. When in fact this results in the taxpayers being forced to pay even higher costs to provide these same corporations a larger bottom line. The fiscal effort needed to fund a national healthcare system would be one of the most significant this country has undertaken.

Today's efforts in medical educational institutions and accrediting bodies to improve the act of caring at the bedside by focusing on improving professionalism in fledgling physicians and others is merely a stepping stone in the right direction. These students reside in a world that still maintains a formidable hierarchical system of structure and power.

This change will require a shift in the very culture of medicine as an institution.

As a question spoken to the cosmos, I have asked myself how we can continue to not see the need for change in this country. How can we not hear the thunderous impact of the whispers in the emergency and intensive care waiting rooms as families struggle to grasp the enormity of the cost for treatment of an injured loved one?

I know that others hear these same struggles every day. I have heard the patient in the examination room in my oncology office that admits very reluctantly to me that she has not been able to take her medication to prevent a recurrence of her breast cancer because she cannot afford the \$200 per month fee and still afford to buy groceries. I have heard the elderly woman in tears because she cannot afford the newly developed inhaler medication for her husband with chronic lung disease because it is beyond the limits of what his Medicare will pay for this month. The gentleman in the emergency room experiencing a heart attack that looked up at me and said, "I'm not sure I can pay for this" becomes another voice in the chorus pleading for change.

Dr. Daniel Chapman (2010) in the introduction to his edited text, *Examining Social Theory: Crossing borders/reflecting back*, reminds me that these questions are among many without answers. He wrote:

No one seems to have a "right" answer; rather, all of our answers are influenced by our cultural, historical, and social context.

"Right" answers are often not thoroughly scrutinized because they are self-serving, or emotionally satisfying. On the other hand, propositions that counter the status quo undergo careful examination because they cause emotional dissonance. (p. xv)

If the answers are influenced by our cultural and social contexts then I feel the best place to begin to look for answers would be by placing our questions of healthcare and the practice of medicine within the contexts of the larger culture and society in which we all live. I do not claim to have all of the answers, nor do I claim to have the right answer. But to offer a look at medicine from a perspective of colonialism—combined here with the images we have seen—I hope will perhaps ask the question in a new or different way which might lead to possibilities for change.

The continued growth of increased medical costs range today to an obscene level when contrasted against the background of the lives of the young mother and child in the introduction, alongside Michael, Sarah, and Diane. The growing number and trend of physicians who provide concierge services for their patients who are willing to pay up to 1500 dollars per year for increased accessibility to those patients is in my opinion another symptom of the capitalistic nature of American healthcare today—and one which should be stopped.

A form of national health insurance combined with decreased or subsidized medical and nursing education I offer as possible measures with which to begin. I agree with the proposals put forth by Waitzkin and Waterman as they offered,

First, industries manufacturing products such as drugs and medical equipment should be nationalized. In fact, nationalization of the medical-industrial complex appears to be the only reasonable means by which patients will no longer bear the excess costs of illness. Second, private insurance companies should be permitted no role in health care. Instead, all members of society should pay for healthcare through a progressive taxation structure. Through this mechanism, economic

constraints would cease to be a disincentive for low-income patients' seeking care on a regular basis-rather than only in times of acute illness. Likewise, added profits to the insurance industry would no longer comprise a major portion of patient's health expenses. (Waitzkin & Waterman, 1977, p. 109)

In addition to these measures, medical and nursing education could be subsidized in order for students' debt-to-income ratios to lessen. Other suggestions put forth by the work of Waitzkin & Waterman have been echoed in other later studies comparing our system of healthcare with that of other industrialized nations such as Great Britain, and Germany.

The nation of Cuba offers a form of socialized medicine and practice which I have seen first-hand and one we might do well to study for its positives. Their system of medicine places the primary importance on family and preventive medicine.

Most health care is delivered by family physicians. Family doctors are responsible for a defined community and they typically live above (or near) the small consultorios located in the neighborhood they serve. The family physician we visited cared for some 800 people in the five blocks surrounding her consultorio. During the mornings she saw patients in the clinic; in the afternoon she did home visits. (Anderson, 2008)

This type of focus on primary or public health combining the physician home visits with that of a more traditional US version of the outpatient setting offers much to the lives of the communities surrounding these clinics. There are some medical centers in urban settings in America who offer physician home visits on a limited basis. Mt. Sinai hospital and teaching university in New York is one of the more well known.

The Cuban healthcare system also extends its services to many poor and impoverished countries—Haiti being the one that I am more familiar with having seen this work in action personally. Cuba requires its and newest graduates to perform international practice in poor countries.

The story of Cuba's health care ambitions is largely hidden from the people of the United States, where politics left over from the Cold War maintain an embargo on information and understanding. But it is increasingly well-known in the poorest communities of Latin America, the Caribbean, and parts of Africa where Cuban and Cuban-trained doctors are practicing. (van Gelder, 2007)

I witnessed the work of a young Cuban family practice physician and pediatrician on my own medical trip to Haiti. These physicians were sent to Haiti after completion of their medical training to work and serve in small communities where there were no physicians at all. These two provided healthcare at no cost to those Haitians living in the area. Facilities were incredibly poor, power in the hospitals was generator provided if at all and running water was nonexistent in the facility.

These physicians were also encouraged through scholarships provided by the Havana based Latin-American based medical school to assess young Haitians who might wish to receive medical education themselves. If selected, these young natives of Haiti would receive their medical training in Cuba and then in return for this education return to their native country to serve their populations and communities. (van Gelder) The same type of offerings and relationships exist between Cuba and Africa, and other Latin American countries.

American students who are unable to afford medical school in this country attend the Latin American School of Medicine in Cuba. Once they have completed their training, they then return to the US to practice in the poor and underserved areas of this country. (Eisner, 2009)

America has made their own efforts in this regards. The federal program funded for rural and underserved areas in the country, AHEC (Area Health Education Center), operates in each State to seek out and encourage young health professionals of all types to serve in these communities. The physicians, physician assistants and nurse practitioners are provided with student loan repayment amounts annually for each year they serve in the rural or urban underserved areas.

These efforts succeed for some, but many communities see the physicians and other healthcare providers leave their areas and communities once their commitment and/or loan reimbursement needs are met. They often leave for the larger salaries and larger hospitals in the more medically affluent areas of the country.

If we take a moment to look at other industrialized and democratic countries who have in place a nationalized forms of healthcare for all citizens we see Germany, Canada, and Great Britain. German healthcare utilizes a form of socialized medicine with what is called a social insurance. They are called sickness funds and costs are shared in geographical areas between employers and employees earning 75,000 dollars or more annually. Because it is based upon income, the cost are maintained at around 15% of the total. Hospital physicians are paid by salary while ambulatory care providers are paid an annual fee for each patient in their practice regardless of the number of visits. (Weitz, 2010)

The German government maintains control of the number of physicians practicing at any time. Forced retirement ages of 68 is combined with a prohibition of physicians practicing in what are termed overserved areas. German life expectancy now surpasses that of Americans and their infant mortality rates are at 3.8 percent—one of the lowest in the world.

Great Britain provides care through their National Health Service. This national coverage is paid through a general taxation, and the taxation amount is based upon income. Physicians are employees of the National Health Service and are paid a salary. The counterparts to our family practice physicians are called general practitioners and they work as contractors for the government. They are paid a set fee based upon the number of patients in their practice and also upon their specific services provided within the practice setting. These physicians are provided extra compensation for offering care to the poor and elderly patients in their areas. English citizens do not receive hospital or physician bills, nor do they pay for routine prescriptions. (Weitz, 2010)

Issues such as access are realities of this system and there are waits for elective procedures and non-acute care at times. However, there is never a delay for emergency procedures or care. And as in Germany, life expectancy and infant mortality rates are better than they are in the US. (Weitz, 2010)

It is the commitment of these and other countries to ensure access to healthcare to all of its citizens regardless of their ability to pay which is in striking contrast to that of our own country. But financial costs of healthcare are not the only aspect of our system of medicine that I feel must change—albeit a crucial one. They refuse to exploit the healthcare of their citizens for profit.

Sam Durrant (2004), a contemporary critic in his text *Postcolonial Narrative and the Work of Mourning*, wrote, “Post-colonialism as a praxis is grounded in an appeal to an ethical universal entailing a simple respect for human suffering and a fundamental revolt against it” (p. 3). As these narratives of patient experiences reveal, the suffering of so many of the ill who enter the institution of medicine is not only a reality for them while inside the walls of the setting. It exists and so often develops from a type of suffering which makes up their experiences outside these walls and I feel we should and must revolt against it.

And so I would offer as the first step a major shift in focus in our medical practice and medical education to see and engage with the humaneness of those who are ill. If we are truly to become post-colonial in medicine, we must begin here with Durrant in both developing a respect for their suffering alongside a revolt to change our current practices from those within.

I feel we should begin with the students of today. The creation of the discourses of humanism and critical inquiry into the world outside of the institution should be the focus of medicine’s curriculum and research. The words of Hafferty tell us, “Until we come to accept that medical training is, at root, a process of moral enculturation and that medical schools function as moral communities the reform that is needed—the reform that the public deserves—will remain both elusive and enigmatic” (Hafferty, 1998, p. 406). We cannot hope to make this change in the institution or empire of medicine without beginning with the cohort of 2013.

The shift I envision is monumental to say the least. It will require that those in medicine lose their appetite for profit and research grants for technology and procedures

to those of the social issues and the causes of too many of the diseases today. The terminology of the texts and evidence-based medicine can and should be rewritten to include faces and names of patients who are living with the diseases studied. Medicine should no longer be seen as a profession which emphasizes “high tech, high cost interventions at the expense of humane primary care, social justice, and democratic inquiry” (Lewis, 2006, p. 159). I feel we must decolonize medicine.

The physician and anthropologist Paul Farmer in his text, *Pathologies of Power* (2005) forwarns us that, we are at an “impasse in which many of us caregivers now find ourselves: selling our wares and services only to those who can afford them, rather than making sure that they reach those who need them most” (p. 138). No matter your definition of human rights abuses—the continued denial of healthcare as a right to all American citizens in my opinion is just that.

I feel we can no longer remain in the position of power and status accorded medicine today as long as it comes at the expense of those who are ill and most vulnerable. We must no longer have the ability and power to name those we call patient and write them into a world we have created to contain them. We must begin to see a practice of medicine as one in which one human being with a need is met by another human being, a true consociate, who can meet that need through seeing beyond a chief complaint.

Again, I have few illusions as to the scale of effort which would be required to undertake a complete change in focus of our current healthcare system because it requires first a change in longstanding politics, and yes-culture. And I deeply believe that it must begin with those of us within the culture as rebellion often does. As Paul Farmer tells us,

those of us who practice medicine, and those who teach others to do so must begin by taking the first steps to “resocialize their understanding of who becomes sick and why, and of who has access to healthcare and why” (Farmer, 2005, p. 138). It begins here.

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APPENDIX

DEFINITION OF TERMS

For the purposes of this paper, the following terms are defined.

Ambulatory care. This is the term utilized for care provided in an outpatient or clinical setting.

American Medical Association. This is the primary professional association for medical physicians.

Chronic Illness. This term is utilized to refer to an illness which develops gradually or one which will continue for several months and possibly until the patient dies. Diabetes, End-Stage Renal disease, and Multiple sclerosis are diseases which are classified as chronic illnesses.

Compliance. This is a term used to indicate a patient or individual doing as instructed by a health care provider.

Deprofessionalization. This is a process in which an occupational or professional group lose the confidence of the society and therefore are no longer viewed as a profession.

Epidemiology. The study of disease distribution within a specified population.

Fee for service: The practice of physician reimbursement based upon services provided as opposed to a salary.

Imperialism. An unequal cultural and economic relationship based upon domination and subordination.

Institution. A structure within society which developed and dedicated to meeting needs within society, such as education, healthcare, and religion.

Physician. A person licensed to practice medicine.

Physician Assistant. A person licensed to practice medicine under the supervision of a physician.

Postcolonialism. A discourse and theory dealing with the legacy and analysis of colonialism.

Registered Nurses. Individuals who have received educational training and licensure to practice nursing.

World Health Organization. A United Nations organization which oversees the documentation of health problems and seeks to improve health around the globe.