Medicine As If Justice Mattered
One Doctor's Response

This is a basic talk that I then tailor when speaking to medical students about justice. I recount my own history and immersion in inner-city injustice and then ask why we—as highly privileged, affluent people—might want to work for justice and how we might do so. I gave this particular version at the annual conference of the American Association of Medical Colleges in November 2005.

I'd like to begin by suggesting that a primary question facing each one of us in this room ought to be: How do I live a *meaningful* life? We're all educated and all of us are—or soon will be—affluent … which means that we've been offered extraordinary privilege. Yet we live in a world in which privilege is divided up very unequally. In fact, the inequality—both in the US and around the world—grows with each passing year. The top 1% of the US population now owns over 40% of the wealth of the country, twice as much as twenty years ago. How do we make sense of *our* place in this grand scheme? Given that we benefit so broadly from the division of privilege while others suffer so profoundly from that same division, how do we fashion a meaningful life?

That's a personal question, so this will be in large part a personal talk, a story of my own journey in trying to fashion a meaningful life. I don't claim to have succeeded better than anyone else, but the issue has been at the center of my decision making all of my adult and professional life.

I started my medical career in 1975 as a country doctor in northeastern Minnesota. We were the only three physicians for our county's 4000 people in an area the size of Rhode Island. Our nearest specialists were 110 miles down the road. I chose that practice specifically to join a physician who was living out his belief that he had a responsibility to serve the poor. Roger's wife Barbara was a member of a band of the Ojibway tribe that lived at one end of the county, so he knew well the reality of rural poverty. Roger was more deliberate than most physicians in serving people who couldn't afford care, but his decision to include the poor in his practice was not unique. In fact, I didn't know a single physician in northeastern Minnesota—including our consultants—who refused to see patients who couldn't pay. We used the fees from those who could pay or who had insurance to subsidize the care of those who couldn't afford it, and our county hospital did the same. Making care available to everyone was simply expected. In fact, if we'd refused to see those who couldn't pay, I suspect we'd have been run out of town.

I believed deeply in our work, I had wonderful partners, the people in the community were supportive, and the surrounding wilderness environment was awe-inspiring, but at the end of seven years I was burned out by my country doctoring. Our family took a yearlong sabbatical to my wife Marja's hometown in Finland, during which I tried to make sense of the emotional realities of my Minnesota practice.

During that sabbatical year, it became clear to Marja and me that our vocations lay in the inner city of Washington where people from a small, ecumenical faith community were living and working among the very poor.

My moving to Washington was actually a pretty bizarre idea. I hadn't been able to tolerate medical practice within an idyllic, small town among people of my own class and background. I'd come to understand by then that I was very vulnerable to burnout. I disliked cities and couldn't imagine living in one. I simply can't tolerate hot, humid weather. And here I was, heading to Washington DC to work as an inner-city doctor amidst the pain of the poor!

But Marja and I knew at some inexpressible level that our lives lay with the marginalized. We didn't yet know *how* we knew that or even, really, what it meant. We were certainly aware of the religious imperative to *help* the poor, but our hope was different. We were both seeking spiritually then, and many spiritual traditions refer to life with the dispossessed as a pathway toward intimacy with God. Could building community with the poor, we wondered, bring a richer life?

For the first ten years in Washington, I worked at a small, church-related clinic. I was soon struck by how profoundly society had abandoned my patients. Even as a professional advocate, Icould turn to so few places for help.

- I was shocked to discover that people could be utterly destitute and still not eligible for Medicaid or any other form of health coverage.
- Homeless families began pouring into the clinic. According to one interview study we did, over seventy percent of the mothers had suffered physical or sexual abuse as children, yet there were no therapy services available for them as adults. Many of the mothers were addicted, yet, for practical purposes, there was no substance abuse treatment available for them, either.
- Basic education was unbelievably poor. One of my patients graduated from high school without knowing her multiplication tables. Others were functionally illiterate. And half didn't even graduate from school.

- Washington was an impoverished city where the physical and sexual abuse of children was much too common, yet effective child protection services, for all but the most serious cases, were virtually non-existent. If Ihad no *physical evidence* of a child having been abused (like scars or bruises), I couldn't even get a city investigator to take a look, regardless of my suspicions.
- I hadn't realized the stinginess of Welfare. DC had good benefits compared to most states. Yet a family of three received less than $500 a month, *considerably less than half* the poverty level. Since the family was then legally forbidden to receive more money from any other source, it was quite literally impossible to live on welfare without "cheating." Most welfare mothers, in fact, worked, and the rest had to get money elsewhere.

· Mothers who worked couldn't afford decent childcare. They had to take whatever was available, which was sometimes horrendous.

The picture of lazy people feeding at the public trough was a cruel joke.

At a personal level, the intractable nature of the poverty began to overwhelm me. Not only did I routinely see patients with multiple serious problems, but those problems were also accompanied by such social limitations—a "surround" of forces—that treatment seemed impossible. Homelessness, mental illness, addiction, abuse, illiteracy, single parenthood, unemployment left people without any of the usual resources for pulling their lives together. "Compliance" was almost out of the question. It frustrated me, led toward a certain hopelessness, and tapped into my tendencies toward depression. As a result, during the first couple of years, I edged closer to that common point of view that blamed my patients for their own poverty.

Soon, though, I began to see how even the sometimes destructive behavior of poor people was usually a *result* of poverty, not the other way around. I remember clearly an event—from almost twenty years ago—that marked my growing awareness.

One day Margine, a young mother, visited my office with Robert, her son of almost two years.

Robert had a minor viral illness and was understandably a little crabby. As I interviewed

Margine, Robert slipped off her lap and toddled over to the toys in the corner of the room. Soon, many of the toys lay scattered about as Robert rummaged unsuccessfully for something he might like. Suddenly Margine noticed, sprang up, and grabbed her son's arm, yanking him away from the corner, scolding, "Stop messin' with the doctor's toys. You always be gettin' into trouble." I tried to suggest gently that the toys were there to be messed with, but Margine locked her son onto her lap.

Some minutes later as I was examining Robert, I tried to get a look into his ears. Predictably, he jerked his head back and started crying. Margine's response was to shake him again, whack him on the bottom and scold, "You sit still for the doctor! You always be bad like this!"

I found myself furious with Margine. There were other indications that she might be abusing her son, and her behavior in front of me certainly supported my suspicions. But a little reflection soon convinced me that—while my anger might have been appropriate—directing it at Margine wasn't.

For Margine was at the time still fourteen. I'd been her doctor since she was eleven, and—because Margine's heroin-addicted mother was also a patient of mine—I knew about her own history as an abused child. Margine had become sexually active by the time she was eleven, and all our attempts to provide her with counseling or birth control had been futile. She had even hinted from time to time that she wouldn't mind having a child so she could have someone to love her, so she could be important in the community.

But now Margine and Robert were locked in. They lived in a neighborhood of unspeakable violence; everyone has a family member or close friend who's been killed; many inner-city children simply don't expect to live into adulthood. The school system was—is—chaos. I mentally went down the list of things that I believed everyone deserves—a loving parent, a decent education, a neighborhood relatively free of violence, decent housing. None of these had been available to Margine.

So whose "fault" was this abuse of Robert? To blame Margine was to scapegoat the victim.

While I continued to work at the clinic, three of us physicians and our families founded Christ House, a thirty-four-bed medical recovery shelter for homeless men. Our families lived on the

top two floors; our guests lived and were cared for on the bottom two floors. My son, who was six when we moved in, used those first two floors as his playground—watching television, playing board games with the guests, selling raffle tickets. The men easily accepted him as a mascot. The gentleness with which they approached my daughters and protected my son belied the usual images of homeless men on the streets.

After seven years in DC, I'd begun to see our society quite differently. Most of my patients were, in fact, no less intelligent, no less industrious, no less moral, and certainly no less desirous of a better life than anyone else. Those who did have defects in those areas usually had damn good reasons! But all my patients were black and poor, and the ladders out of the ghetto were few and far between.

[I want to interrupt here to say that I'm describing African-American poverty because in Washington DC the poor I cared for were largely African American. But in telling *my* story I don't want to reinforce that destructive misconception that most poor people in our country are black, urban, ghetto dwellers. In fact, only 12% of the American poor live in black ghettos. Almost half (46.8%)
[1]
of America's poor are white; close to another quarter (23.0%)are Hispanic. Only a quarter (26.2%) are African Americans. Of all poor Americans, well less than a half live within large cities. Poverty in the United States is
not
primarily a black, urban phenomenon.]

I'd begun speaking to medical students by then and begun to articulate what had brought me to this life with the poor. It had to do with finding a meaningful life. It goes something like this:

We've become a very divided and unequal society. The vaunted US social mobility no longer exists. Millions of people now work full time and yet their families remain mired in poverty. There are structures within our society that bring me affluence and material comfort: segregation, the peculiarities of our educational institutions, low-wage jobs, corporate globalization, and so on. As a middle-class, highly educated, white male, *my* chances of material success are pretty high. Those same structures, however, leave people like Margine nothing. More and more people are defining themselves to pollsters as "have-nots." Since 1988 the number of African Americans, for instance, who call themselves "have-nots" has risen from 24 to 48 percent; the number of whites has risen from 17 to 28 percent. Even conservative columnist David Brooks has written that

[w]hen people call themselves ‘‘have-nots,’’ they are not only commenting on their current economic status. They are also commenting on their prospects. They are saying that they do not see any plausible way they are going to make it and thrive in this society. … Worst of all, [writes Brooks] this is not just perception. People without skills really do have limited prospects in the world. There really is a huge achievement gap. [2]

There are very real structures of American injustice that benefit most of us here and hurt others. Because of this extraordinary division, we who are privileged really don't *see* the conditions in which the poor live. Neither we nor the people we know well experience these conditions, so we don't understand them. These structures are not inevitable; they're not some "given." In other Western developed nations, many of them are much less powerful or have been dismantled completely. These disparities of opportunity are the result of economic, social and political
choices
that we make as a society … which we
could
make differently. We could have school systems that offered everyone an adequate education. We could have training programs to assure that everyone had a chance at well-paying jobs. We could assure that people who worked full time received enough income to support their families. We could guarantee health coverage. And so on. These aren't pie-in-the-sky programs; they exist elsewhere. As a society, we need only make decisions to create them.

So … why should this concern me … or you? Theologian Dorothee Sölle writes that when we benefit from structures that oppress others there develops within us an alienation from God, from the wider community, from our own selves. Whether we've done anything to create those structures or not, whether we *personally* contribute to the oppression of others or not, whether we're in favor of the structures or not, there develops a cynicism, a certain despair, a separation from our deeper selves that can't be bridged while the gulf between us and them remains.

We're all, ultimately, part of the same family. And though we may never realize it, the destitution of any one of us damages the soul of *every* one of us. As Martin Luther King said, "None of us is free until all of us are free."

The only healing possible, says Sölle, is to move into "solidarity" with the poor. This is quite different from *becoming* poor (which is essentially impossible for us, even if we were to seek it). It's even different from *helping* the poor. In my definition, solidarity is

seeing things from the point of view of the excluded ones … as if they were family members.

AIDS was moving into the ghetto, one more scourge among the poor. And our family, led primarily by my wife and daughter, wanted to live in closer community with those we worked with. Would it be possible to move into deeper solidarity by living in smaller community together? With help from lots of people, we founded Joseph's House, a ten-bed home and community for homeless men with AIDS. In 1990 our family moved in. We lived there for three years.

One of the three men who moved in the same day that we did was Howard Janifer. Howard was forty, and—before he learned of his HIV diagnosis—had lived on the street for seventeen years supporting his drug and alcohol habit by burglarizing homes.

We almost didn't bring Howard into the House because he seemed a little too sick for us. During that first year we weren't quite ready to provide hospice care because we were renovating the house to accommodate more residents. We were also a little leery of taking Howard in because … well … he seemed moderately demented. We were to discover, though, that Howard's "dementia" was the product of a habit of mumbling and a strange sense of humor. And as for being "too sick," Howard lived with us for six and a half years.

He would have been an extraordinary person in any community. I first got a glimpse of that a few weeks after we moved into Joseph's House, and Howard rushed up to me breathless, "Doc, you gotta do something. This house is *wide* open. *Any*body could break in here!" Then he paused and said with a grin, "And that's a
professional
opinion." We gave him a few tools and supplies and over the next few weeks, he meticulously burglar-proofed the place for us.

Howard was a night owl. He usually stayed up until six or seven in the morning prowling the house, "protecting" it, he said. When I sometimes couldn't sleep, I'd come downstairs and find him at prayer in the living room. He said he spent about two hours every night before his homemade altar. During the other hours of the night, he cleaned the kitchen, fixed the plumbing, rewired somebody's TV to get cable, did the gardening and lawn work. He was a remarkably skilled handyman. He was very good with locks.

But Howard also requested to be called upon whenever any of the men was in his last days at the House. He'd discovered a special gift in helping a man die. Especially during the middle of the night, he'd sit for hours at a man's bedside, singing to him, reading Scripture to him, holding him, cleaning him, feeding him, whatever was necessary. Howard sometimes said that he'd destroyed his own life with drugs and alcohol. This new life belonged to God, and Howard would use it to care for others. He shaped our lives deeply. He died so suddenly we didn't even have the chance to care for him as he'd cared for others.

Howard had never said much about his background. He was the youngest of eight children from a very poor family in Washington. As a child he had to work to bring in cash for the family. At age 17 he dropped out of high school and married. His bride was twelve year old. They eventually had three children.

Howard came of age during the Vietnam War and joined the army. He was never sent overseas to participate in actual combat, but Howard's stories were full of experiences as a paratrooper and his training for fighting in the jungle … although I was never sure where his memory ended and his imagination began. After leaving the Army, however, he seemed to drop out of society. I don't know how it happened. He'd become addicted, and his addiction overcame him. He was soon separated from his wife and children, living on the streets or in prison.

He'd spent seventeen years in destitution on those streets. In the community at Joseph's House, however, Howard's remarkable giftedness became evident. It often occurred to me how much richer the world would have been if Howard had taken a different path. It's possible, of course, that if Howard had been born into the world with, say, the privileges I had as a child, he would have followed his same painful path. But the statistics are that a child born into Howard's circumstances—black and poor and living in the urban ghetto—stands a far greater chance of following Howard's path than a child born into my circumstances.

Marja and I had lived in many intentional communities, but this was by far the deepest and most intense. The issues we had to deal with—addiction, racial misunderstanding and anger, mending broken family relationships, to say nothing of the tensions of just living together—compelled us to enter deeply into one another's lives. The prospect of imminent death brings life into focus, clarifies our need for one another. With AIDS, one often dies slowly, so there's opportunity for masks to be shed on both sides, for intimacy to develop.

There's another reality that surfaces in working with the poor. And that is that the brokenness of the poor usually makes our own brokenness strikingly obvious. But in facing our own brokenness, we find ourselves on a spiritual journey. If you ask most people who've worked for any length of time with the poor why they do it, eventually you'll hear them talk about the spirit, about how their life with the poor brings them closer to the Holy. (Just to be clear, I'm not talking about religion but spirituality, the ways in which we make meaning in our lives.)

This isn't an easy subject to talk about. Brokenness is by its nature very personal. And there are so many preconceptions floating around about the nature of the spiritual journey that it's difficult to be understood, so I ask you to give me a little leeway here in telling another story.

By the time we founded Joseph's House, I was discovering that the emotional turmoil I'd experienced all my life was due, in part, to a significant organic depression. Looking back, it'd been with me at least since college. Over the years, I'd done everything I'd known to do—prolonged intensive psychotherapy, medications of various stripes, prayer, spiritual direction, aerobic exercise, sabbaticals, meditation ... you name it. I was beginning to realize that the depression would never be completely healed, that it'd always be there, sometimes crouched just beneath the surface, more often chronically interfering with everything at a low-grade level, occasionally leaping out to overwhelm me.

Although I hadn't realized it at the time, my depression had been a major part of the reason I'd burned out in Minnesota and left the practice there. And after I'd been in Washington for a while, the depression started breaking through again. Part of it, of course, was just the mental illness: chemical imbalance in my brain. But part of it came from working within the chaos of my patients' lives. Trying to respond to their woundedness triggered my own.

After we'd lived at Joseph's House about two-and-a-half years, the depression started to worsen ... and then became agonizing. I intensified my psychotherapy, visited my psychiatrist and adjusted medications; I cut back on my work schedule; I prayed harder. Nothing worked. The intensity mounted, and I became for the first time in my life dysfunctional. It scared me. I was peering into an abyss and I couldn't see the bottom … or the other side. I stopped work at the clinic, but I was still living at Joseph's House. I knew, though, that the pressure of trying to be present to the men in the face of my depression would be too much.

I had from time to time shared in our twice-weekly community meetings about my depression but always with a certain clinical detachment that left me pretty much in control. But this time

there was no illusion of control. I talked about the acuteness of my depression and about my fear of the chaos. I told the men I wouldn't be able to respond to them either as a doctor or as a person of responsibility in the house for a while. I asked them just to allow me to live in the house as another resident.

I stopped talking, not knowing what to expect. Right away, PeeWee spoke up. PeeWee, you should understand, had been a drug kingpin before getting AIDS, living an extraordinarily violent life. But once he had AIDS, everything fell through, and he was largely abandoned by friends and family and became destitute. Even in his debility, however, he seemed to have no other way except violence to deal with conflict. He and I had had several run-ins. His brokenness was right on the surface.

But after I described my depression at the meeting, it was PeeWee who spoke up immediately. "That's cool, Doc," he said. "We been noticin' somethin' wrong. You just take as much time as you need. We'll still be here for you."

That was it—just those few words. Over the next several minutes, each of the men responded similarly. There was no over-reaction, no soulful looks of deep understanding or pity, no embarrassment for me, no offers of help, just simple acknowledgment that I was going through a rough time and that they'd be there for me. Howard said he'd pray for me.

No, there was no miracle cure to my depression, no flash of intellectual insight, but the healing to my soul was, ultimately, incalculable. I'd acknowledged my utter brokenness, and they weren't frightened by it, embarrassed by it, disgusted with it, or even eager to cure it. Just, "That's cool, Doc. We'll be here for you."

In our society, of course, we ghettoize these men and their brothers and sisters. They're the "dope addicts," the failures, the criminals, the violent. We push them out of our sight because, I think, we're afraid of our own darkness, unwilling to look at our own vulnerability and brokenness. *They*become the repositories of all that fearfulness, hopelessness, valuelessness, meaninglessness that we can't face in ourselves.

PeeWee had been responsible for the deaths of several people in the violent drug world that he'd inhabited for so many years before coming to Joseph's House. He was one of those we so

rightly fear when we think of the inner city. He was no stranger to his own brokenness. What he offered me was unpitying acknowledgment of my vulnerability … and the awareness that some things will never be healed.

Part of the mystery is that the love and acceptance the men offered began that extraordinary process of healing in my soul. I began to understand my depression more deeply as a broken—probably *permanently* broken—part of me. My task was to learn to live with it, in some way to make friends with it. I began to realize at a profound emotional level that I was, in fact, just like each of the men in that room, limited and unable to heal myself.

We took another year's sabbatical to Finland for my emotional healing. When I returned in 1994, I knew I couldn't live in the house nor could I practice medicine anymore although I've continued to work at Joseph's House in various capacities.

I experience the life of the poor from a somewhat greater distance now. Although I still work at Joseph's House and live in the neighborhood, I'm not so personally involved with individuals on a day-to-day level. I no longer have the fresh stories to incorporate into talks like this. But something has changed me radically. I now see things from the bottom. I read the paper from the point of view of the oppressed. I think about the structures of our society, the nature of our economy, political activity all from the point of view of the victims of those structures and activities.

I want to suggest that this seeing things from the point of view of the marginalized is extremely important for us who are privileged if we wish to live meaningful lives. Unless we begin to see structures and institutions from the perspective of those who suffer from them, we'll never be able to confront those structures and will find ourselves shaped by them. That alienation will begin to seep in.

We've reached a perilous state in our nation where the point of view of the poor seems irrelevant. After Katrina, there were a few moments of shock at the extent and depth of poverty, but that's already fading, and Congress is back to cutting food stamps, Medicaid, funds for the disabled, and other programs while it continues to press for tax cuts primarily benefiting the wealthy, which will, in turn, make further cuts in social programs inevitable.

The societal abandonment of the poor has its personal and psychological counterparts as well. Emotionally, we're not encouraged to explore our darkness, to find our own brokenness, to create those links with people who seem so different from ourselves. We believe that our power, indeed our sense of self, comes from our strength, not from our vulnerability, so vulnerability mustn't show. The poor—both within and without—have no voice.

Nor surprisingly, I suppose, this hardness of heart has spread also to medicine.

Medical ethics, I'd suggest, *requires* that we see the world and its problems from the point of view of those excluded from the system. The sick often become the marginalized in our society, excluded from a culture that prizes productivity and effectiveness. Unless we learn to see things from the bottom, from the point of view of the marginalized, we develop contempt for our patients. Doctors must learn to see from the victim's perspective.

And how does access to health care look from this point of view?

According to the latest study, 45 million Americans, about one out of six, have gone for at least twelve months without health insurance or other form of medical coverage. About one in every three *poor* persons has no coverage. Every other developed nation has made access to health care available to everyone. An article in yesterday's *Washington Post* reported on an international survey showing that Americans pay far more out of pocket for health care and get much less coordinated services than in other developed countries. Far more skip health care for financial reasons. When I visit Finland and talk with my friends, it's a little embarrassing: "Well, no, we haven't done it yet. We still give health care only to those who can afford it!"

As health care providers, we have a special responsibility to advocate for universal access. That is, after all, the point of intersection between our world and the needs of the poor. It's for us an *ethical* issue of the highest order. If we in medicine saw things from the point of view of the marginalized, that lack of access would be *the primary* ethical problem facing us, and each of us would feel a responsibility to help find a solution.

We must shine the same light of ethical inquiry upon the lack of access to health care as we do, say, upon the question of who can speak for the dying patient. We must see the present

lack of health care coverage as a *moral* failure of the profession.

We in the medical profession have too often lost sense of our responsibility to the very broken but also of the link to our own darkness. And without either of those, there's no moral compass.

Especially in a country with such inequality as ours, the discussion of justice for the poor belongs, among other places, in medical schools. But, too often, medical students (and most physicians) don't know about the desperation of the poor in the United States, because myth keeps affluent people from knowing the burdens under which the poor labor. We—and I'm speaking especially to medical students—have the responsibility to educate ourselves and others about that desperation, about the lack of access to care.

I began by suggesting that fashioning a meaningful life was the central question facing each of us. The huge and increasing disparities of wealth are a stain upon our society. But they also provide a potential place of meaning for us. Finding ways of including everyone in the bounty of our society is among the primary challenges facing us, and I would call you to the challenge.

(I think we have time for some questions.)

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[1] I calculated the statistics in this paragraph from Table A in: Dalaker, Joseph, U.S. Census Bureau, Current Population Reports, Series P60-214, Poverty in the United States: 2000, U.S. Government Printing Office, Washington, DC, 2001. This table can also be found at: http://www.census.gov/prod/2001pubs/p60-214.pdf .

[2] Brooks, David, "How to Reinvent the GOP," New York Times Magazine, Aug 29, 2004, http://www.nytimes.com/2004/08/29/magazine/29REPUBLICANS.html?ex=1094741300&ei=1&en=caea66d159420f11