

**An Apple a Day: An Exploration of Primary Care Physicians'  
Definitions of Health**

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## **Table of Contents**

Abstract	<b>1</b>
Acknowledgments	<b>2</b>
Background Literature and Theory	<b>7</b>
Theory: The Distinction between Sickness and Illness	7
Previous Attempts to Define Health: Historically and Sociologically	10
Physician’s Constructions of Health: How Doctor-Patient Relationships Impact Health	14
Successful Primary Care and the Lack of Standardized Decision-Making	16
Demographic and Geographic Factors	19
Summing Up	22
Methods	<b>23</b>
Findings	<b>28</b>
Doctors Who Work in Underserved Populations	29
Doctors that Work in Privileged Populations	38
Age of Patient Population: Different Medical Disciplines and Daily Issues	47
Insurance and Pay Structure	51
Discussion	<b>55</b>
Limitations and Further Research	60
Conclusion	<b>62</b>
Works Cited	<b>64</b>
Appendix A	<b>70</b>
Appendix B	<b>70</b>

## **Abstract**

This thesis examines how physicians define health and prioritize care, and whether or not these definitions and priorities vary given geographic location and demographics of patient population. 18 different primary care physicians, including pediatricians, adult primary care providers, and geriatricians and from different areas on the East Coast, were interviewed. They served patient populations of varying demographics, some in privileged communities and others in underserved communities. The doctors that worked in privileged communities defined health as an individual social concept, focusing on holistic evaluations of care. The doctors that worked in underserved communities focused on how larger social institutions impacted the health states of their patients. Given these social barriers, these physicians provided care practically, working to ensure the provision of basic, physical health care to their patient populations. This data exposes problems with the canonical distinction between illness and sickness, a central health definition framework in medical sociology. To expand this framework to more adequately reflect how health functions and is defined, I propose expanding the definition of 'sickness' to include holistic sickness and practical sickness.

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## **Introduction**

When I was in fourth grade, I fell rollerblading in my best friend's basement on Halloween and broke my wrist. I had never broken a bone before in my life, and I was terrified. My parents came to pick me up and found a pediatric orthopedist and pediatrician willing to open up his office for me, even though it was closed that evening. I sat with my mom, crying and scared, waiting for the results of my x-rays to come back. I had broken my bone in two places, and would be wearing a cast for multiple months. But, before getting the cast, the doctor needed to set my bone. There were no nurses in the office. There was no access to pain medication or anesthesia. He would have to set the bone without any numbing or pain management at all.

The doctor made the decision to not sugar coat anything. He did not huddle with my mom, having conversations about me without including me, and he did not tell one lie. He stood in front of me, told me everything that he was going to do, and honestly told me that it was going to hurt. A lot. I cried, and screamed, and asked if there was anything else that could be done. There was not, he confirmed. He asked me to trust him, assuring me that even though setting the bone would hurt, it would start to feel better soon after it was done. He spoke calmly, not a single tremble in his voice.

So, I laid on the exam table with my mom on top of me to keep me still. The doctor slowly counted down from three, and then set my bone exactly when he said he would. And it hurt exactly as much as he told me it would. The pain was seering and hot and terrible. And yet, I learned more about health than I had ever learned before, and felt respected, heard, and understood by my doctor. He actively showed me how he was going to make me healthier through his communication and honesty. And, I wanted to be a doctor myself.

Physicians are tasked with objectively evaluating patients and making decisions that will help them be the healthiest people they can be. They work everyday to identify, treat, and eliminate disease and discomfort in the people they serve. Specifically, primary care providers are the first line of defense in healthcare, acting as both preventative and responsive care providers. But, what is health? Where does it come from? How is it embodied and practiced and achieved? Is health truly just freedom from disease, or is there more to it? Doctors grapple with these questions every day, whether they realize it or not, and their tacit definitions of health and care shape their priorities as care providers and the health experiences of their patients.

I argue that the neighborhood a doctor works in impacts the way they define health and set their priorities when it comes to providing medical care. Specifically, socioeconomic class and race of a doctor's patient population alters the way that doctors are able to practice medicine. Doctors that serve low-income, marginalized, and underserved communities are incredibly aware of the ways in which larger social systems create barriers to providing their patients basic medical care. They feel a responsibility to find ways to navigate these barriers to provide their patients with everything they need to manage their health, concentrating on physical and strictly medical needs. They focus on the practical aspects of health while emphasizing the many social institutions and structures that deeply impact the health states of their patients. Conversely, doctors who work in more privileged areas, both in terms of class and race, see health as a more holistic and individual concept. While they are aware of some institutions that impact health, such as flawed insurance systems, they focus on the individual social networks of their patients, mental health, spiritual health, and holistic solutions. These differences are the result of patient qualities that are not explicitly medical. Given the patient population of their neighborhood, doctors operate in a different way.

This matters to consumers of healthcare who may not realize how this context impacts the care that they are receiving. The general public assumes that all doctors receive equivalent and standardized training in medical school, treating patients the same regardless of identity, situation, and other non-medical factors. They are expecting doctors to care for them with their best interests in mind, and with as little bias as possible. I find that this is not always the case. An understanding of how doctors define health and how these definitions differ given variables such as geographic location and patient pool will help patients understand their own bodies and healthiness, while also revealing important ideas about how health is valued and prioritized. Understanding how the health experience is differently understood, defined, validated, and shaped by health providers will give patients a better understanding of their health experience.

My argument exposes a way in which the current literature is failing to define health and describe the actual practice of medicine. In the canon of medical sociology, a distinction between illness, the physical, private experience of disease, and sickness, the social, public experience of disease, is a very common way to define health and position it within the social sphere. It is accepted that this distinction is not perfect, but allows for a consistent evaluation of how individuals understand disease, whether they include a social element, and whether or not they separate these two ideas completely. My data show that while this distinction is still useful, it does not fully encompass the way that physicians define health and provide medical care. It does not account for the way in which the patient population of a physician directly impacts these definitions. This distinction needs to be expanded, specifically the way that sickness is defined, in order to be useful and at all representative of the current state of medical practice.

The community that a doctor works in and their patient population changes the way they characterize health.<sup>1</sup> This variation is sometimes subtle and sometimes blatant, but is very related to how they see health integrating into the lives of their patients. Doctors who work in underserved communities see health as an integrated, yet practical, social concept, while doctors who mainly work in privileged areas see health as a holistic and individual concept. When social and political barriers do not impede access to care or limit medical autonomy, doctors individualize health, emphasize mental and spiritual health, and look at each patient as a unique and specific case. When working in underserved communities, autonomy is limited, pushing doctors to emphasize increasing access to basic health and other resources. While all doctors are still able to build relationships with their patients, the nature of these relationships are vastly different. Doctors in underserved areas feel responsible for both providing health access and advocating for their patients in the face of large social institutions, while doctors in more privileged areas focus on smaller scale variations and health determinants, emphasizing individual parts of health rather than attacking larger, problematic social systems. They are aware of the impacts that these institutions can have on the health of patients, but do not have to directly confront them or manage their varied impacts. This data exposes weak points in the current literature, prompting a reevaluation of the sickness and illness distinction that currently does not account for the differences presented in my data.

Through my work, I want to make a comment on how primary care physicians define health and whether or not these theoretical relationships are applied to their practice. I want to understand how these physicians position their definitions within the sickness and illness

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<sup>1</sup>Another aspect of the patient population that matters is patient age. I interviewed primary care providers that care for children, adults, and the elderly. Differences in terms of family involvement, patient resilience, and patient autonomy all impact the way that doctors conceptualize their jobs. This will be discussed in more detail in parts of the findings section and discussion, but I wanted to mention it now as it is an important aspect of doctor-patient relationships



framework of health and illuminate any relationship between doctors' definition of health and their priorities in distributing care and the community that they serve. My goal is not to assign value judgments to these definitions, but rather make a comment about how to reconcile these differences to create a functioning primary care system that can best serve its citizens. Discussing what parts of the definition of health should be universal and what should shift based on the community a doctor works in is not only meaningful to physicians, but an important step to take in improving patients' understandings of their own health states and health experiences.

## **Background Literature and Theory**

### Theory: The Distinction between Sickness and Illness

Few texts in medical sociology define health or healthcare explicitly, the majority actively avoiding these definitions (Thomas 2003). Regardless of how central health is to the lives of many Americans and the discipline of medical sociology, "there is no consensus on a definition for this concept among either professionals or laypersons" (Thomas 2003:15). Instead of defining health singularly or using a concrete framework, many theories rely on the idea that "what constitutes health ... depends on one's frame of reference" (Thomas 2003:15). While this may feel unsatisfying, it is true. Health, and its many facets, are deeply related to social context. Even the American Medical Association acknowledges this when discussing what constitutes basic healthcare, saying that accounting for non-medical and possibly discriminatory factors that mediate care and condition is key (American Medical Association 2022). Comprehensive definitions are increasingly complicated in the United States because the United States is not a homogeneous society, but rather a conglomeration of many diverse groups, cultures, and neighborhoods. Since "the concepts used to define and organize any system of healthcare reflect

the social organization and culture of the society in which it exists” (Thomas 2003:15) attempting to craft a unified health definition in the United States feels impossible. While a single definition may be out of reach, constructing a framework that can situate health definitions will give individuals a more representative understanding of their own health and own doctor.

One framework that is very common in medical sociology is the distinction between sickness and illness. When originally proposed, this distinction used the terms disease and illness instead of illness and sickness. In this case, disease is “an abstract, biological-medical conception of pathological abnormalities in peoples’ bodies” (Idler 1979:723) and illness is “the human experience of disease...[and] an explicitly social phenomenon with both an objective and subjective reality” (Idler 1979:723). While this distinction acknowledges the role of the physical in establishing the condition of ill health, it asserts that many of the physical changes associated with disease, “are intimately related to the person’s social context” (Idler 1979:723). This means that someone could “have a disease, yet be unaware of it” (Idler 1979:723) or someone could “feel and/or act sick without showing evidence of any objectively verifiable disease” (Idler 1979:723). This model can be incredibly useful, as it highlights health as a social phenomenon while still acknowledging how bodily difference and discomfort are very real and important experiences. Evaluating how an individual values illness or disease when defining health can reveal how they construct and prioritize the experiences of health and ill-health.

In recent literature, the terms used in this framework changed, with illness and sickness being used in place of disease and illness. Thomas articulates this framework, describing how illness is the medically relevant aspect of disease while sickness is the social experience of an illness (Thomas 2003:22). Illness is primarily an “individual, private, and usually biological aspect of the state of ill health” (Thomas 2003:23). Sickness is the social condition of ill health,

and “illness is transformed into sickness when the condition becomes publicly known through announcement by the affected party, observation by significant others, or professional diagnosis” (Thomas 2003:22). Therefore, “while illness is primarily a biological state, sickness is a social state” (Thomas 2003:23). For the purposes of this paper, the term ‘illness’ will be used when discussing the biological component of health, and the term ‘sickness’ will be used when discussing the social condition of health.

This distinction has the clear goal of directly confronting hegemonic discourses, such as the medical model. The medical model asserts that unhealthy conditions can be clearly identified by a set of biological and physical symptoms and that are treatable, improvable, objective, and temporary (Thomas 2003:17). This model assumes a strict separation of body and mind, making it difficult to validate various types of conditions, such as mental illness, which can be difficult to link to a specific biological agent (Thomas 2003:28). Furthermore, the medical model frames health as solely the absence of symptoms caused by a bodily dysfunction without emphasizing social, emotional, or cultural factors that determine health and define what bodily functions are normal. The sickness and illness distinction tries to broaden this view, allowing for multiple factors to be included in building health states and eliminating the idea that everything about health can be boiled down to solely identifiable and biological factors.

This type of distinction is common in social disciplines. Another example is the social model of disability, which distinguishes between impairment and disability (Shakespeare 2013:215). In this distinction, impairment is the physical constraints disabled people experience and disability is the social experience of being disabled (Shakespeare 2013:215). These distinctions are useful, but by no means perfect, and can be critiqued. First off, these strict distinctions often oversimplify the experience of individuals who are experiencing disease or

disability. Trying to completely separate the physical and social invalidates where these concepts overlap, ignoring the personal experiences of individuals with different levels of health. Sally French, in this case addressing the social model of disability, discusses how this feels, stating that “my experiences are compartmentalized, with someone else being the judge of which are and which are not worthy of consideration” (French 1993:19). Even given these critiques, activists and social scientists find these distinctions useful (French 1993:23). The sickness and illness distinction is a simplified way to frame health states as a social phenomena, beginning conversations about the role of oppression, power and non-medical factors in health discourses.

There are two main takeaways from this section. First, health is a social concept, and its definition varies given perspective and social situation. Second, the distinction between sickness and illness is canonical within medical sociology as a way to define health. This theoretical grounding is an important part of my argument, which is centered on how the data I collected is not completely explained by the sickness and illness distinction, as issues of power, privilege, and experience make health and its social aspect more complex than the distinction accounts for.

### Previous Attempts to Define Health: Historically and Sociologically

Historically, sociologists and medical professionals alike have used a variety of frameworks to define health and health-related concepts. As previously discussed, the medical model is one of the most widely used frameworks of health definition. This model is accepted and reinforced by the public, physicians, and many powerful institutions, including medical education and insurance. Nothing is covered by insurance without explicit symptoms and a diagnosis by a practicing doctor (Thomas 2003:18). But, given its rigidity and sole consideration for physical factors, the medical model is not representative of how health functions in a

complex social world. There are many aspects that determine health, and while physical condition is relevant, it is not the only deciding factor.

Idler (1979) highlights a variety of frameworks that attempt to account for the many non-biological factors that influence health. She lays out the distinction between disease and illness. This distinction, or one very similar to it, has remained a key distinction in medical sociology. A definition she critiques heavily is Parsons' definition of health, which is that "illness is a deviant social role" (Idler 1979:723). When individuals are free of illness, they can use their "body functions to the full extent of its capacities" (Idler 1979:726) and when ill, a person's bodily experience is limited. This definition is incomplete, as many people, including those in states of employment, bondage, or incarceration, have limited use of their bodies, and could therefore be classified as unhealthy. She also highlights work done by Zborowski that discussed how different ethnic groups handled and verbalized pain differently (Idler 1979:725). When directly addressing the medical model, Idler discusses the concept of medical legitimation as not a necessary part of the experience of illness, but rather a problematic product of the medical model itself (Idler 1979:725). Idler argues that using a variety of frameworks that account for many factors is the only way to come close to an accurate definition of health. This method has the potential to "reveal the subjective meaning of the experience of illness and healing and then recognize the knowledge of illness and healing as an important stock of knowledge that people have constructed for themselves from their cultures" (Idler 1979:730).

One framework is the health definition generated by the World Health Organization (WHO). This definition is quite simple, stating that health is "a state of complete physical, mental and social well-being" (Larson 1996:181). Even though this definition is very universal, it has been widely criticized for being too idealistic, confusing, and unrefined (Larson 1996).

Moreover, the inclusion of social well-being is ambiguous, as it is not clear whether this refers to “the environment of society or the functional status of the individuals” (Larson 1996:183) within that society. Along with these critiques, health professionals question the usefulness of this definition given that it can’t easily be operationalized (Larson 1996). The definition also feels outdated, given that “since 1948 the demography of populations and the nature of disease have changed considerably” (Huber 2011:1). The definition is in need of an update to fit the evolving social and physical determinants of health. While the WHO definition is one of the most widely known definitions of health, it lacks nuance, specificity, and is behind its time.

Patrick et al. (1973) alternatively defined health as “the immediate level of physical and mental well-being” (Patrick et al. 1973:7) along with the “probability that the condition will deteriorate, remain constant, or improve over time” (Patrick et al. 1973:7). With these ideas in mind, health conditions described by both a current well-being and a long-term prognosis were presented to both trained nurses and graduate students with no medical training. These individuals ranked the situations from 0 to 1, with 0 being death and 1 being optimal health and wellness (Patrick et al. 1973). In general, nurses and graduate students had similar ratings on the scenarios, but “the nurses gave slightly higher ratings than the students because their medical training and experience affected their values and opinions” (Patrick et al. 1973:19). This definition is easier to operationalize as it employs the concepts of current and future well-being as a way to position a health state on a sliding scale. There is a slight difference of opinion between medical professionals and citizens regarding the severity of disease states, exposing an area of miscommunication between health providers and patients.

Primary care definition has also been an important area of inquiry in medical sociology. Parker et al. (1976) attempted to create a normative definition of primary care. A group of

individuals involved in different parts of the healthcare field, including physicians, social scientists, administrators, public health nurses, and social workers, generated a series of statements they believed represented the purpose of primary care (Parker et al. 1976). After editing and categorizing these statements, expert judges, which included physicians, health providers, social scientists, and administrators prioritized and organized the total of 92 statements to create a useful definition of primary care (Parker et al. 1976). Public health nurses, social workers, and a group of health consumers were also asked to rank the statements, but they were not considered experts by researchers, therefore their opinions were not considered. This did yield a definition of primary care, which is as follows:

Primary care provides basic services, including those of an emergency nature, in a holistic fashion. It provides continuing management and coordination of all medical care services with appropriate retention and referral to other levels. It places emphasis, when feasible, on the preventive end of the preventive-curative spectrum of health care. Its services are provided equitably in a dignified, personalized, and caring manner. (Parker et al. 1976:428-429).

Most of the statements rated highest were “concerned directly with medical services and their linkages” (Parker et al. 1976:429) while the lower ranked ones concerned “increasing the patients’ capacities to assume responsibility for their own care” (Parker et al. 1976:429). Again, there were noticeable differences between the rankings of non-experts and experts in this study. Non-experts prioritized universal access to primary care more than their expert counterparts, highlighting a dissonance between primary care and the people that it serves (Parker et al. 1976).

Attempts to define health and care are not effective or incomplete. Health is a dynamic social concept, making it nearly impossible to create a universal definition. Furthermore, there is a consistent difference between the priorities of health providers and health consumers across many frameworks. Lastly, the majority of these definitions are not based in practice. While a

theoretical definition is useful, not explaining how that definition is related to the practical decisions of physicians renders the definition ineffective.

Two more recent concepts surrounding health definition, including integrative care and a patient-centered approach, move towards this. Integrated care combines behavioral health with traditional primary care. Behavioral health accounts for how behaviors such as eating habits, spiritual practice, and social interaction are related to health. Integrated behavioral health is a means for collaborative practice, accounting for health through multiple lenses (Peek et al. 2014). Researchers highlight the importance of understanding the local situation, imploring health researchers to “improve the local situation, not to produce generalizable knowledge” (Peek et al. 2014:431) by finding a lexicon that allows physicians to understand each other without eliminating the individual nature of health (Peek et al. 2014). Another means to improve practical health definition is expanding patient-centered medical homes as primary care practices, which are, “an enhanced model of primary care service delivery that is comprehensive and coordinated and provides team-based care for patients” (Hing et al. 2017:1). These practices work to include more perspectives when making medical decisions and treat patients as complex, integrated cases. Practices that adopt these values and practice suggestions recorded higher quality of care as compared to those that did not (Hing et al. 2017). These frameworks of health definition and care delivery begin to broach the important subject of doctor-patient relationships and the role of a physician in constructing the health states of their patients.

### Physician’s Constructions of Health: How Doctor-Patient Relationships Impact Health

Most health definition frameworks implicate doctors as key actors in the health experience of patients. Physicians’ actions, decisions, and assumptions about their patients have consequences. When doctors’ understandings of their patients are overly generalized, explicitly



problematic, or in direct conflict with the patient's understanding of self, there is less trust between doctors and patients, creating large gaps between the healthcare system and healthcare consumers. Many personal factors can mediate doctor-patient relationships and the successfulness of primary care provision, such as BMI, gender identity, and motherhood. Patients who felt judged by their primary care providers regarding their weight were less likely to trust their doctors (Gudzune et al. 2014). Transgender and gender non-conforming patients reported that their doctors struggled to understand and respect their gender identities, instead making assumptions and often misgendering them (Paine 2018). Many physicians construct a generalized vision of a teenage mother as someone who is lacking in critical thinking and decision-making and is unfit to raise a child (Breheny and Stephens 2007). These problematic constructions of patients are directly linked to negative health outcomes, with patients feeling less inclined to engage with their primary care providers directly, diminishing trust between provider and patient (Paine 2018 and Breheny and Stephens 2007). In many situations, negative health outcomes that are associated with specific groups, such as young mothers, are not the fault of the young mothers themselves, but rather their physicians' perceptions of them (Breheny and Stephens 2007).

These effects arise on a larger scale when doctors do not account for the unique makeup of their patient communities. Wayland and Crowder (2002) consider how applying a universal definition of 'community' when implementing community primary healthcare facilities can lead to system failure. Specifically, they focused on two primary health care facilities, one in El Alto, Bolivia and another in Rio Branco, Brazil. (Wayland and Crowder 2002). Providers projected definitions of community that did not reflect the values and communal understandings of the places they were trying to serve, leading to low engagement (Wayland and Crowder 2002). This

shows that “when policy makers define communities in ways that do not correspond to local realities, the services they provide may experience low rates of utilization and even outright rejection” (Wayland and Crowder 2002:242). This exemplifies how communal definitions that account for social context should be the objective of primary care providers and practices.

To reach this goal, doctors and patients must build trusting and positive relationships. Improving doctor-patient relationships and doctor-community relationships relies on open communication and patient-centered discourse. Ha et al. (2010) discusses how effective communication is “the heart and art of medicine” (Ha et al. 2010:38). As it currently stands, this communication is one-sided, with doctors reporting a marginally higher communication satisfaction rate than their patients (Ha et al. 2010:38). Without addressing these deficits, “divergent beliefs can affect health care through competing therapies, fear of the healthcare system, or distrust of prescribed therapies” (Ha et al. 2010:41). In order for doctors and patients to effectively communicate with each other, differences in health values need to be understood and reconciled, allowing for differing health definitions and problematic patient constructions to be discussed openly and honestly. Improving these relationships is the first step in purveying successful primary care.

### Successful Primary Care and the Lack of Standardized Decision-Making

Decision-making in primary care is not standardized. A practitioner’s personal priorities and health conceptions impact their clinical decisions and care provision. Skirbekk and Nortvedt (2010), in a study of Norwegian hospitals, found that “neither doctors nor nurses behaved impartially in their general clinical orientation regarding priorities” (Skirbekk and Nortvedt 2010:84) and that they “seemed to voice the kind of ethical particularism essential to an ethics of care, i.e., responding to the particular individual in the particular situation, rather than being

motivated by abstract and universal principles” (Skirbekk and Nortvedt 2010:84). The doctors did not see it that way, as doctors “rarely regarded their own clinical decisions as prioritizations, but rather as medically sound decision-making” (Skirbekk and Nortvedt 2010:84). Another study done in Norway found different medical values between clinicians and hospital managers (Skirbekk et al. 2017). While the differences between clinicians and managers are not central to this work, they show how the goals of healthcare distribution vary depending on perspective, priority, training, and patient exposure. Researchers found that “managers put more emphasis on production volume, whereas the clinicians emphasized quality” (Skirbekk et al. 2017:756). Within the same hospital, there are “two different rationalities compet[ing] for healthcare priority settings: one patient-centered, individualized way of attending to needs in the particular situation, and one impartialist way of comparing needs and maximizing health-related welfare across the interest of individual persons” (Skirbekk et al. 2017:757).

These priority and decision-making differences directly impact practice and patient experience. One example of this is the provision of pain medication. In the United States, racial minorities are far more likely to be undertreated for pain, even though there has been no biological cause identified that would indicate that people of different races feel pain differently (Bonham 2001:53-56). Many patients of color correctly perceive this differential treatment as a consequence of doctors’ personal perceptions of different races, fueling mistrust of the medical system within communities of color (Bonham 2001). Medical decision-making processes are impacted by a variety of factors, including patient identity. These decisions matter given the structure of primary care in the United States.

Primary care in the United States and the United Kingdom is designed to be patients’ primary access point into the larger healthcare system. This can increase positive engagement

with healthcare, as individuals more easily build relationships with their primary care doctor, making them an approachable entry point to other health providers (Forrest 2003). This system has been incredibly successful in the United Kingdom, but has floundered in the United States (Forrest 2003). The United States healthcare system is saturated with specialists that patients want direct access to, so many have pushed for this gatekeeping system to be weakened (Forrest 2003). This is incredibly frustrating to physicians. Poplin (2004) is an internist with qualms regarding the current state of adult primary care. She pushes for internists to be more involved with coordinating care directly and dealing with complicated patients given their unique skills as primary care physicians (Poplin 2004). Seeing as both patients and physicians are frustrated with the current structure of primary care, it is clear that changes must be made.

Sawin and O'Connor (2019) argue that there is room for improvement in the U.S. healthcare system. They discuss how primary care doctors often do not understand their powerful position and their own biases when making decisions regarding their patients. They advocate for holistic and team-based primary care, along with an active effort to engage doctors in conversation about their priorities, power, and biases (Sawin and O'Connor 2019). These changes will better the integration of primary care providers into the larger healthcare system, improving primary care for both physicians and, more importantly, patients.

Doctors' decision-making processes and health priorities are not always made clear to patients, fostering mistrust and impeding the provision of quality care. This can lead to a rejection of their integration into the larger healthcare system, even though they may have the unique ability to successfully communicate with both patients and other healthcare professionals.

## Demographic and Geographic Factors

One factor that impacts doctors' work, health definition, and the experience of their patients is the demographics of their patient population. Health is not an isolated institution, and the delivery of healthcare and access to it are directly linked to privilege, power, and social structures and institutions. Wright and Perry (2010) discuss the main research themes in medical sociology, focusing on how privilege is related to medical care. They found that healthcare was disproportionately distributed across different demographic subgroups in the United States, favoring those who are privileged (Wright and Perry 2010). Furthermore, they found that social institutions directly inform medical institutions, the actions of healthcare providers, and health outcomes (Wright and Perry 2010). Medicine is a deeply integrated social structure that is influenced by existing social and political power structures. Rather than "a third logic distinct from the logic of the market and bureaucracy" (Timmermans and Oh 2010:95), as patient consumerism has risen and social structures have evolved, trust in doctors has fallen given the growth in value differences and misunderstandings between doctors and patients (Timmersmand and Oh 2010:97). Doctors have to continually adapt to the current social situation. Care is not stagnant, but entrenched in evolving social institutions.

In the United States, factors such as race, ethnicity, geography, gender, and disability status all impact access to healthcare, possibly limiting the ability of individuals to get the health care they need (National Academies of Science, Engineering, and Medicine et al. 2018). One factor that has a massive impact on healthcare status is socioeconomic status. Smith (1998) discusses how socioeconomic status is linked to healthcare access and health status. Directly, a dire health situation that requires expensive care can greatly hinder the economic success of an individual and possibly bar them from accessing medical care at all (Smith 1998:194). In

general, people of higher socioeconomic will have more access to consistent preventative care, diminishing their likelihood of having a pressing health situation in the first place. Less directly, economic issues can lead to high levels of stress that are often associated with negative medical outcomes (Smith 1998). Socioeconomic status is tightly linked to healthcare, impacting not only the utilization of and access to healthcare, but directly changing the health states of patients.

Another factor that deeply impacts health state and healthcare utilization is race and ethnicity. Race and racism have a massive impact on healthcare utilization and medical trust. There are clear racial variations in utilization of different procedures synonymous with preventative care (Embry et al. 2021). White people were more likely to get flu shots and Black and Hispanic women were more likely to get pap smear screenings (Embry et al. 2021). In general, African Americans are less likely than White Americans to utilize primary care services (Arnett et al. 2016). Years of medical abuse and repeated misleading of marginalized racial communities have caused rifts between BIPOC individuals and healthcare systems, with lack of utilization often attributed to the high rate of medical mistrust within African American and Black communities (Arnett et al. 2016). This mistrust and historical mistreatment is even greater for women of color. Women of color during the reproductive health movement often did not feel supported by their White counterparts and mainly White doctors, as the movement did not adequately address their “physical health, which for most women of color was also implicitly related to economic and racial inequalities” (Nelson 2015:199). This prompted activists to re-envision the healthcare system to directly address the intersections between health, gender, and race, as the current system was not designed with the needs of women of color in mind.

Along with the system being rooted in racism, patient race and ethnicity modulate care. As mentioned earlier, doctors’ pain perceptions of patients are greatly modulated by race, with

doctors consistently underestimating and under-treating the pain of Black and Hispanic patients (Bonham 2001). A study done in Berlin looked at how gender and ethnicity impacted doctor-patient relationships in emergency settings (Babitsch et al. 2008). Ethnicity had a large impact on many facets of healthcare interactions, finding that “service utilisation differed significantly according to sex and ethnicity” (Babitsch et al. 2008) and that “doctors’ satisfaction with the course of treatment was lower when attending Turkish patients than with German patients” (Babitsch et al. 2008). Interestingly, when controlling for communication and language barriers, these differences decrease, showing the complexity of doctor-patient relationships, and that “the inability to communicate with healthcare providers creates barriers to access, undermines trust in quality of medical care, and decreases patient compliance” (Babitsch et al. 2008). Race and ethnicity have the ability to impact patient care and modulate doctor-patient relationships and communication.

Geographic location greatly impacts the use, delivery, and site accessibility of primary care. It is difficult to access the limited number of primary care physicians in the United States. Most of them are located in urban areas as opposed to rural areas, with more nurse practitioners and physician’s assistants in rural areas (Hing and Hsiao 2014). While these individuals are still incredibly reputable and helpful providers of primary care, it is less likely for patients to build trusting relationships with them as they deal with more patients and are more likely to move locations. Geographic location also has an impact on what types of primary care delivery sites are available. While the majority of primary care and preventative care visits take place in physician offices, community health centers and outpatient departments are more common in low-income neighborhoods and utilized by poor communities and individuals who rely on public

health insurance (Hing and Uddin 2010). Geographic location influences patient ability to engage with primary care and the types of care available.

Age, of both individual patients and overall patient population, impacts health definition and can modulate doctor-patient relationships (Peck 2011). Doctor-patient interactions with older patients were more likely to be patient-centered as compared to interactions with younger patients (Peck 2011:8). This could be due to the fact that geriatricians have to understand their patients as well as possible, given that they are often tasked with making decisions for their patients about what it means to live and die comfortably (Kaufman 1997). When considering pediatrics, the behavior-based and personalized nature of pediatric care requires unique doctor-patient relationships that can be difficult to transition out of (Hart et al. 2019). Switching doctors is always difficult, but especially when moving from a pediatric doctor to a non-pediatric doctor, problems arise given patient needs and the differences between pediatric primary care and adult primary care (Hart et al. 2019). Age modulates doctor-patient relationships and the type of care that primary care patients receive.

Demographic differences will likely play a large role in modulating the health conceptions and understandings of different physicians given that they serve communities with different demographic makeups.

### Summing Up

In this background section, I have discussed my theoretical backing and important background information such as historical health definitions, primary care purposes, the impact of doctor-patient relationships on healthcare effectiveness, and the role of different geographic and demographic factors on health understanding and definition. This section not only



theoretically grounds my project, but also illuminates the literature available that supports and influences my research question.

## **Methods**

I interviewed<sup>2</sup> primary care providers, including adult primary care providers, geriatricians, and pediatricians, in Pennsylvania, New York, Connecticut, and New Jersey. While I did interview some doctors from other areas, such as Florida, I did not use these data as much as the more local interviews. Some doctors work in higher-income areas and some in lower-income areas, each serving patient populations with different demographic makeups. I contacted these doctors through internet searches, personal contacts and contacts of friends, and through spreading the word about my project in Haverford Alumni Facebook groups and message boards. My thesis advisor, a Haverford alumnus, posted in alumni groups that I do not have access to. I reached out to family and friends in local areas to get more referrals. Finding connections through already established networks increased the probability of receiving a response. I found it easier to connect with pediatric doctors as compared to adult primary care providers and geriatricians. Getting more individual contacts led to snowballing, where one doctor was able to refer me to a colleague and so on. I mainly communicated with doctors over email to schedule interviews, and held interviews in October and November of 2021.

There are a variety of reasons why interviewing is the best means of data collection to address my research question. Curating a list of questions allowed me to push doctors to verbalize their health definitions, both in terms of their explicit practice decisions and implicit

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<sup>2</sup> My research project received an IRB exemption from the Haverford Institutional Review Board for Human Subject Research. I submitted an application for this exemption on September 4, 2021, and received my exemption on September 20, 2021. In accordance with the IRB exemption, the identities and identifying information of the physicians that participated in my study were omitted.

values and constructions of their patients. These interviews addressed a wide variety of topics relating to both the individual experience of health and the larger theoretical understandings of health. Using the same interview questions for every doctor also provided standardization. While the situation, patient age group, location, patient population, age, and identities of each doctor varied greatly, each explained their experiences using the same framework. Practice observation would have been an incredibly useful research tool in terms of data collection, but was not feasible. Seeing how doctors interact with patients and pairing these interactions with their interview responses would have allowed for a much richer understanding of how doctors apply their definitions to practice and how accurate their self descriptions are. But, observing practice requires many levels of consent, both from the doctors themselves and their patients.

Furthermore, observing pediatricians during practice would have added a layer of complication since they work with minors. Given my level of resources, incorporating this type of data into my research was not possible. To make up for this, many of my interview questions are designed to make doctors talk about practice explicitly, by listing what medical issues they usually confront and how they deal with those conditions, along with asking for specific anecdotes about different types of patient interactions. While these types of questions do not completely make up for the lack of direct practice observation, I did structure my interviews understanding the need to bridge this gap with the most clarity possible.

I developed a list of interview questions regarding not only how physicians define health across multiple planes, but also how their theoretical definitions were applied or not applied to the way that they practice medicine. Furthermore, I wanted to gauge how the structure of their practice and the medical system in general constrained or liberated their decision-making. Lastly, I wanted to discuss how geographic, demographic, and environmental factors impacted a

physician's definition and understanding of health as a social concept. Some of my questions measure these ideas directly, while some only refer to them implicitly. I wanted to see how individual doctors would address these ideas in a variety of contexts. While I have a list of questions I asked in each interview, if any physician felt passionate about a specific topic, I allowed them to elaborate and asked clarifying questions as necessary.<sup>3</sup>

I tried to obtain patient demographic data from doctors and their practices directly. This proved difficult, as many practices do not keep these data, and those that did were hesitant to share. Given this, I relied on demographic information, mainly census data, on the area that the practice of each doctor was located in. Furthermore, in their interviews, doctors self-reported the demographic makeup of their patient population. Not obtaining data directly from the practice of each physician was not ideal, and this is a definite limitation of my study. That being said, self-reported data along with census demographic data about the area that each practice is located in allow me to reach my research goals in full.

It is important to keep in mind my positionality when conducting and analyzing these interviews. I am an undergraduate student interviewing physicians. By default, these individuals are placed in a position of power, and that dynamic was always present; I looked up to the doctors that I interviewed, wanting to be doing their job one day. Furthermore, gender differences impacted the interviews. As a woman, interviewing male physicians was more intimidating than interviewing female physicians. There was a greater level of comfort when interviewing female physicians because I have interacted with more female doctors and everyday patriarchal power dynamics were still present. In terms of explicit interview differences, male doctors asked far fewer clarifying questions throughout the interview while female doctors were more likely to engage with me directly, making those interviews feel more natural and effective.

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<sup>3</sup> My list of questions is available in Appendix A

Furthermore, limiting my interviews to primary care providers eliminated a faction of physicians who, due to being specialists with a more specific focus, are more likely to have a limited definition of health. The doctors I interviewed work in a very personal and relationship-focused field, and are more likely to view health as an integrated and layered concept. Any individuals who agreed to participate in my project were more likely to have integrated, socially-oriented, and complex health definitions by virtue of being open to participate.

A large proportion of doctors that I interviewed were Haverford graduates. When interviewing Haverford graduates, there was a level of comfort and understanding that was missing when interviewing other doctors. They were also aware of the type of education that Haverford provides, making them slightly more in tune to the type of work that I am doing. Still, every participant in my study knew that I was a sociology major and that I was studying health definitions in a sociological context. I did not expect this to have an impact on my interviews, but the short conversations I had with participants after stopping the recording made these impacts clear. They all expressed similar sentiments of surprise at my major, and discussed how they considered this perspective during the interview. This could have influenced their answers, pushing them to engage with the social aspect of medicine more directly than they would have if they were unaware of my major. While I do not have any data that can prove that their knowledge of my major shaded their answers, I do believe that this is necessary to keep in mind to correctly interpret these data. Their awareness that I was studying them and their answers from a sociological perspective seemed to impact the way they approached me as an interviewer.

Lastly, I must state my own research bias, an important step in doing sociological work that effectively addresses existing power structures. Sandra Harding (1992) discusses the importance of identifying bias, arguing that taking into account research bias, power, and politics

is extremely important in doing research that yields strong conclusions (Harding 1992). It is clear that “knowledge claims are always socially situated, and the failure by dominant groups critically and systematically to interrogate their advantaged social situation ... leaves their social situation a scientifically and epistemologically disadvantaged one for generating knowledge” (Harding 1992:42). Considering “research as production rather than investigation,” (Oliver 2012:30) and analyzing how perspective and biases impact this production yields stronger research.

My future career path clearly impacts my research bias. As an aspiring doctor, I have accepted the authority and professionalization of medicine. I see it as a force of good; a necessary source of healing and knowledge to the general population. Acknowledging this makes it even more paramount to address how immensely the medical profession has failed. The distribution of healthcare is limited at best, deeply unfair, stratified, and violent at most, often leaving low-income communities at incredibly high risk of adverse health outcomes. Many communities have been abused and misled by the medical community in the past, specifically communities of color. The growth of specialization and changes in healthcare systems have decreased the amount of meaningful relationships between doctors and patients and diminished the likelihood of preventative care. These various shortcomings indicate a broken system that continues to lose its direction. Understanding how patient population and location impact the constructions of healthcare’s essential terms begins to address how these failures have materialized within healthcare.

I did eighteen interviews in total. This included twelve pediatricians, six family doctors, and two geriatric primary care providers. A majority of these interviews were held over Zoom, but some were done in person or over the phone. Interviews were transcribed using Zoom auto transcription or Trint Transcription, and then loaded into Dedoose to be coded. I began my

coding process with an idea of what codes I thought would be important. These codes included illness, sickness, definition, demographic, top-down, jargon, integrative, frustration, success, holistic, patient-center, self-centered, and practical. As I coded and encountered different themes that were relevant to my theoretical inquiry, I integrated other useful codes into my scheme as well. Important codes used were illness, sickness, definition, demographic, frustration, success, holistic, patient-centered, self-centered, group focused, social, structure, location, age, busyness, change in setting, patient relationship, food, medical conditions, mental health, success, and practical. These codes covered how doctors positioned themselves in the process of health definition, their own personal understandings as a social or biological concept, and how different geographic and demographic factors impacted the way that doctors defined health and practiced.

Once data were coded, I organized important utterances and themes that related to my theoretical question and began data analysis.

## **Findings**

In the following section, I display my findings through quotes from my interviews. This is broken into four subsections. The first subsection displays the patterns in health definition and care prioritization in doctors that work in underserved communities. The next subsection displays these patterns in doctors that work in privileged communities. The third subsection discusses differences in health definition given the age of a physician's patient population, and the final subsection details the widespread frustration and outrage at medical insurance and the structure of medical care by these physicians.

## Doctors Who Work in Underserved Populations

My main findings regard how the class and race background of each physician's patient populations impacted doctors' definitions of health and care priorities. The demographics of the area that a physician's patient population is drawn from mediates the care that physician's provide to their patients and their definitions of health. I will begin by talking about doctors that serve majority underserved communities and then discuss doctors that serve more privileged communities. A legal definition of an underserved community includes, "populations underserved because of geographic location, religion, sexual orientation, gender identity, underserved racial and ethnic populations, populations underserved because of special needs," which is found in 34 U.S. Code § 12291 (Legal Information Institute 2022). When I discuss underserved communities, I am focusing on communities that face barriers to obtaining necessary healthcare services, mainly due to class (meaning that the area has a median income that is below the national average), or race (meaning that historically marginalized racial groups, primarily BIPOC individuals, makeup a majority of a community's population).

Doctors that practice in underserved populations seem to be acutely aware of how larger social institutions create barriers to adequate care for their patients. They directly confront these barriers on a daily basis and often have to focus on ensuring that their patients have access to basic facets of medical care and the treatments they need to manage their diseases, both long and short-term. The doctors included in my research who work in underserved neighborhoods are concentrated in two areas: the larger Philadelphia area and Upstate New York. Both of these communities are generally below the median household income. However, the doctors from the Philadelphia area serve majority BIPOC populations, and face issues of institutionalized racism

in medical care, while the doctors from Upstate New York serve primarily White populations. I will first discuss the Philadelphia doctors and then the Upstate New York doctors.

Two pediatricians, Dr A and Dr. B<sup>4</sup>, work in the same children's hospital located in Northern Philadelphia. Their hospital serves Philadelphia, as well as other Pennsylvania counties and neighborhoods such as Kensington and Strawberry Mansion. The Philadelphia region has a median income of \$45,972 and is about 40% Black (U.S. Census Bureau n.d.). This is far below the average median income of the country, which is about \$67,521 (U.S. Census Bureau n.d.) While the hospital serves a variety of communities, I will be using New Kensington and Strawberry Mansion as examples since these are neighborhoods that were explicitly mentioned in an interview with one of these physicians. New Kensington is a majority White community and has a median income of \$42,264 (U.S. Census Bureau n.d.). Strawberry Mansion had a median household income of \$31,679 in 2019, and is 94% Black residents (City Data n.d. and Statistical Atlas n.d.). Given these statistics, it is clear that the patient population is majority lower socioeconomic status as well as largely non-white. These demographics are supported by both of the pediatricians. When asked to describe the demographics of her patient population, Dr. A reported that, "I think we're... like the last estimate I believe was like 80% medicaid patients I believe. In my mind I'm remembering like 75% non-Caucasian. So, minorities Latinx, Black, Other, I think like 25, maybe 30% of our patients are Caucasian." Dr. B reported similarly, saying that, "based on the population that the hospital I work at serves, it is a very underserved population. It is primarily African American and Hispanic, um, and I would say primarily below the poverty line."

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<sup>4</sup> See Appendix B for a full list of pseudonyms used for doctors with a brief description of their place of work and the age group they serve. It may be useful to view this appendix while reading the findings section.



The other doctor I interviewed from the Philadelphia area is a pediatrician based at a children's hospital in West Philadelphia. I will refer to this doctor as Dr. C. West Philadelphia is about 71% Black residents, and a median household income of \$28,433 (City Data n.d.). When asked about her demographics, the self-report of the pediatrician was very similar to these statistics, saying that “I just take care of patients up to age about 19. All are children. It's about 85% African American. And the rest, I think the next step I'm not totally sure the numbers on. And about 85 to 90% I think medical assistance. And gender probably split.”

These pediatricians were very forthcoming about the social structures that create barriers to care for their patients as well as adverse health outcomes. Many of these barriers are tied to the general demographics of the neighborhoods that they serve. When asked about what matters when improving the health states of her patients, Dr. A said the following:

So in patients in general, and especially in patients like, with like lower socioeconomic status and sort of urban, underserved like my patients are, we talk a lot about things called like the social determinants of health, so all of the things that affect health that we don't necessarily think of as health right so like things like pollution, which causes like half my kids to have asthma right because there's a super increased amount of asthma and kids who live in urban environments because of the pollution, as opposed to like kids that live in like the suburbs.

The other Northern Philadelphia physician, Dr. B, discussed how her patients were institutionally disadvantaged in terms of health states, citing a study that compared different Philadelphia zip codes, in this case discussing the differences in life expectancy between Strawberry Mansion and Center City:

How the life expectancy was more than 10 years different in those two neighborhoods a couple miles away, so it is very much intertwined that where where you grow up and where you reside there's definitely health factors involved, whether it be lead exposure, whether it be more violence, less access to food, food deserts all sorts of things.

She also directly discussed how socioeconomic status is intimately linked to health states, directly noting that “particularly for my patient population, a lot of the things stem from poverty, a lot of it is food insecurity.”

Dr. C is honest about the biggest issues facing her patients. Quite simply, she states, “I mean for me, what I think has the largest impact on my population is poverty.” She is open about how working in this specific location pushed her to expand her definition of health as well as meaningful determinants of health. She discusses this growth, saying “Oh, it's been a real evolution in terms of ... it's just the profound impact that race and poverty has on people's health. You know, generations of trauma – it's really, it's really everything. For poor people it's everything.”

These physicians all discuss the different structural barriers that they battle on a day to day basis, as the healthcare system fails to sufficiently advocate for patients. The providers have to regularly account for and ask about non-medical issues that impact patient physical health compliance with medical advice, as well work to overcome these issues with their patients. Dr. A is very aware of the many impediments in the way of patient compliance, discussing issues such as, “reliable transportation – you can't expect patients to be compliant with medication if they don't have access to transportation, or like compliance with doctor's appointments.” These issues arise from social barriers that are out of individuals' control. Dr. A also expressed fear regarding her patients understanding of consent forms due to the high reading level required for medical document comprehension. She says:

The average age or average life literacy level of patients and overall in the country is supposed to be like a sixth grade reading level. But in Philadelphia, it's like a second grade reading level. The average age of consent forms across multiple hospitals is like a graduate level reading level, it was like, it was over 12th grade, it was like 16th or 17th right, something ridiculous, right?

Dr. B also discusses the variety of social and institutional factors that are impacting her patient population:

They can't afford to get healthy meals so they're eating more McDonald's so they're overweight or parents are smoking or they are exposed to a lot of violence just by the nature of the neighborhood that they have to live in and all those things affect them. Or mom can't, mom has to as a single mom and is working, can't help with their homework so they are doing bad in school, and then they feel bad and all sorts of ... it can spiral.

Dr. C discusses how her practice evolved through her time working in West Philadelphia, as she asks more questions that directly address the non-medical issues she knows impact the health of her patients. She discusses what behaviors she usually asks about during well visits, saying:

And then, of course, talking about whatever kind of medical issues are in the family, we talk a lot about what the social environment is for the child that's really important, in pediatrics, important everywhere, but I think it's particularly important in pediatrics to know, who's living at home, who is the primary caretaker, are there any kind of resource needs a family has, food insecurity or housing or whatever. There's a ... lot there's a lot of ground to cover.

These quotes also touch on the pressure these physicians feel to advocate for their patients in the face of these issues. They prioritize making sure that their basic medical needs are met for both physical health and adequately connecting with the larger medical system. An example of this is how Dr. A describes her experience with patients who needed interpreters and were unaware that they had a legal right to one, saying:

And I have to be the one to tell them like no, you are legally entitled to an interpreter. Well like how come no doctor ever told me that? It's like well, they legally have to offer, and the fact that they didn't was awful, but like now it's on you to ask, right, which is hard if you don't speak the language, how are you supposed to ask for an interpreter. Those are just like my personal pet peeves but there's hundreds of things.

Dr. A also works incredibly hard to connect personally with patients about their medical issues in order to boost compliance. Her community is specifically impacted by asthma. She discussed an interaction she had with a patient when teaching her to use her inhaler:

So one of the things I like to do is bring out my inhaler and show them why they have asthma. I would like explain because, like a lot of kids have never been explained, like why they have asthma or like what asthma means they just like know that they they have bad lungs or like they have asthma and then they take medicine, and it goes away, and then it comes back, right, so they've never been explained, like why it happens.

This quote illuminates how the focal point of doctor-patient relationships to Dr. A is often on basic health needs of her patients. This physician's deep awareness of social barriers to medicine as well as a strong care for her patients pushes her to focus on ensuring access and compliance to basic, necessary medical needs.

Along with impacting patient health, larger social barriers diminish patient trust in their physicians. Historical abuse of marginalized communities and structural factors that can limit access to healthcare make it more difficult for these physicians to create trusting doctor-patient relationships. This can impede the provision of treatment. An example of this is vaccination. Especially given COVID-19, vaccination has become increasingly important and politically relevant. Vaccination has historically been more resisted in marginalized communities given historical medical mistreatment of these communities. This structural, institutional, and historical context impacts medical practice of physicians in these areas. Dr. B discusses her frustrations when it comes to vaccination:

Something that comes to mind for me specifically is anti-vaccine. Like when I have parents, they don't want to vaccinate their kids, I could present them pages and pages of research, I could talk to them 'til I'm blue in the face, and sometimes they just believe what they believe and they don't want to vaccinate their children.

Dr. C also touched on issues of trust building. She candidly discussed the ways that many of the families she interacts with have issues trusting the medical system. Patient interactions in which patients and parents were comfortable in her office and open to medical recommendations constituted success. She discusses this idea, recounting when a child with complex medical problems came to her office:

I had a patient yesterday, a child, he has actually [inaudible] a lot, a lot, a lot of medical problems. In and out of the hospital quite a bit, and mom is very distrustful, and doesn't want to come in and doesn't want to do vaccines and doesn't trust any of the recommendations that the providers make to her. And so to me success yesterday was letting, was like that she didn't like, freak out and walk out and we managed to put fluoride on [the child's] teeth and get through the thing without an explosion so sometimes that's all I'm asking for in terms of success, is like something not going wrong.

These doctors modulate their practice and understand health differently given the areas that they practice and the patients they serve. They place focus on providing basic medical needs and working to overcome distrust that has historically been fostered between BIPOC individuals and the medical system. Dr. C encapsulates these ideas when discussing her definition of health explicitly. This provider very clearly deferred to physical and practical well-being and illness management, stating, "I mean certainly it's the absence of disease, the absence of illness. It is the sort of ability to do the things that promote wellness like being with loved ones, get outside, get enough sleep, eat healthy food, have some sense of optimism."

As well as interviewing doctors from different Pennsylvania areas, I interviewed two who worked in Canandaigua, New York. I will refer to these doctors as Dr. D and Dr. E. Their patient population is overwhelmingly White, with around 95% of residents identifying as Caucasian (U.S. Census Bureau n.d.). The area has a median household income of \$49,130, which is well below the average (U.S. Census Bureau n.d.). There are some differences between the themes

these doctors focus on and those that the Philadelphia area doctors focus on due to the absence of daily confrontations with issues of institutionalized racism within the medical system, including less direct emphasis being placed on rebuilding trust between BIPOC communities and the medical system. Even so, these physicians were particularly impacted by issues related to socioeconomic status.

For example, when asked about what is involved in constituting the health states of her patients, Dr. D discussed how “socioeconomic issues, access to care has to do with that a little bit too, being able to afford your medicines, being able to afford to go to the doctor, having the transportation to get to your doctor.” In this one quote, Dr. D addresses large scale issues of insurance and affording medications, as well as smaller scale social issues such as affordable and convenient transportation to and from doctors’ appointments. Dr. E continues to highlight how many non-medical factors are key to understanding their patients’ physical health, specifically highlighting how insurance companies and current medical pay structures are incredibly problematic for patients and physicians in generally underserved communities, as they often exacerbate barriers to care. She tells a harrowing story of what a patient needed to go through to get the medicine that he needed:

But because he couldn't afford his medicines, he had a heart attack, and then he became disabled and he went on public assistance and then he could get health insurance. And like that should never happen right. So that's a parable that's always stuck with me as the poor cowhand, you know, working every day, trying to provide for his children, made a lot of bad decisions right, but he had to get disabled before he could get insurance. And he shouldn't have had to get disabled, he should have been able to get his medicine before.

Given the variety of complex issues that are involved in patient health, there is a frustration with how the current pay structure in medicine does not allow for these physicians to serve their patients to the best of their ability. With complicated patients

who are impacted by a variety of personal health issues as well as inequitable social systems, maintaining patient volume often means not attending to all of these issues with as much time and detail as a physician would like. Dr. E outlines her frustration with these systems, saying, “they were like, you're not seeing enough patients, you're not seeing enough patients, and I'm like my patients are complicated, my patients are elderly, my patients are disabled, my patients have social determinants of health, and they would say you need to see more patients.”

Given these issues, these physicians are more inclined to focus on physical health. They feel an obligation to advocate and provide for their patients within a deeply unfair system. When defining health, Dr. D placed an emphasis on physical disease management, stating that, “chronic illnesses, the ... being well is having that chronic illness control, like they're staying out of the hospital, they're taking their medicine or using their medicines.” Much like the definition of Dr. C, physical health and ensuring its provision is key.

In this section, I have detailed a pattern that I observed when looking through the interview data from physicians that work in generally underserved communities, mainly in terms of socioeconomic status and racial makeup. Health institutions are unequal, and there are an overwhelming number of pressures, barriers, and roadblocks put in the way of the patient populations of these physicians as they search for medical care. These problems, which physicians in these communities confront on a daily basis, push physicians to focus on physical health and disease management as much as possible across a variety of elements, from providing care to advocating for their patients within an unfair system. Issues of inequity modulate the way that physicians in these communities define health, prioritize care decisions, and provide care to

their patients. In the next section, I detail how the doctors I interviewed that work in privileged communities define health, make care decisions, and provide care to their patients.

### Doctors that Work in Privileged Populations

Physicians that primarily worked for more privileged patient populations had a different definition of health and a different set of care priorities. As these physicians are less directly impacted by structural barriers to care, they focus on health holistically and individually. While they still see health as a social concept, they focus on individual social networks, personal connections, and social pressures such as social media and bullying. Their goal during a visit is to understand the variety of factors that impact their patients' health states, stressing mental health, spiritual health, social and familial support, and other personal struggles. While the physical aspects of health are still emphasized, there is less fear that patients will not have access to the necessary care and treatments. The data presented below supports this point.

These physicians use a holistic approach and evaluate a broad spectrum of factors when it comes to examining health. These factors are not bound to physical health alone and are very involved with the individual story of each patient. Two pediatricians that discussed this idea, Dr. F and Dr. G, worked on the Upper East Side of Manhattan. This is a neighborhood that is upper-middle class, with a median household income of \$132,264 (Census Reporter n.d.). This area is overwhelmingly White, with 73% White residents, with the next most populous racial group being 13% Asian residents (Census Reporter n.d.). The demographic descriptions of Dr. F and Dr. G lined up with the census demographics of their area, reporting a mainly White and upper-middle class population, with the majority covered by private insurance.

Dr. F emphasized forms of evaluation that are not physical. He says that he “usually just use[s] their academic reports and school performance ... unless there are, you know, physical



issues.” For Dr. F, unless there are specific and serious physical issues, other forms of evaluation take precedence.

Dr. G also defines health holistically, focusing on consistent, healthy habits across all parts of an individual’s life. As an example, she discusses how important it is to “have a healthy relationship with food and not really thinking about weight all the time, more just about healthy habits and healthy choices.” She expands this idea, bringing in many other aspects of daily life, emphasizing the importance of “getting more sleep, getting more exercise as I guess two other things. And again, you know, eating healthier whole foods, as opposed to processed foods.”

Furthermore, Dr. G explicitly discusses how health is a complex process that involves all facets of life, saying that:

Diet history, and the you know, exercising because they're all interconnected with your overall wellness right, emotional health and and and you know that and then also the opposite physical exam, then the you know lab tests that you need to do as well that can sort of have indications if things are out of whack you know whether it's their blood count, or their cholesterol and things like that, but you know I tend to think it's more than that, I mean you know, keeping keeping kids healthy and making them healthy adults, I think, is really like what's important.

Dr. G prioritizes having a well-rounded sense of what it means to keep a child healthy.

The main pressure on this physician is not advocating for her patients against an insufficient medical system, but rather accounting for their comprehensive wellbeing.

Another Upper East Side doctor, Dr. H, confirms this trend. Dr. H is an adult primary care provider for mainly older populations. He confirmed that his demographics reflect the neighborhood he practices in, meaning they are similar to the ones described above. When evaluating the health states of his patients, Dr. H uses holistic, rounded evaluators and small-scale social networks. He discusses patient interactions and his goals when building relationships, saying:

Whether it's because they would tell me that their relationship with their spouse was becoming very difficult and you know, and the stresses that they were going through in their personal life had an impact on perhaps their weight or their sleep pattern or their eating habits or something that then very much related to their health, so that beginning a conversation, you know, on a social level and on a level that would inform me of what was going on in their life, would invariably become a significant and useful piece of information later in the course of discussing their medical health.

This type of language is indicative of Dr. H's care philosophy. He values "what was going on in their life" and the individual social, mental, relational, and physical aspects that create a comprehensive understanding of the health state of each patient. He continues to discuss his priorities as a care provider, emphasizing his goal of providing total well-being on physical and non-physical levels, positioning the physician as a medical provider as well as a medical educator, saying:

Well, you know a lot of patients came in for preventive care and in many ways that was actually really, for me, the most fun because she could really hopefully make a difference by informing and educating patients and helping them in ways that would improve their overall health.

Dr. H is not just discussing the importance of providing the necessary physical health solutions at that moment for his patients, but growing relationships and providing education about comprehensive healthy lifestyles.

A pediatrician practicing in Cherry Hill, New Jersey, Dr. I, relies on holistic and individual evaluators. This area is 74.6% White with a median household income of \$105,022 (U.S. Census Bureau n.d.). Dr. I reports that the majority of her population is covered by private insurance and the demographics of her area are reflected in her practice. Dr. I discussed her care philosophy, evaluating her patients in terms of their daily lives and individual habits, saying, "with like the school-age kids, we don't have any questionnaires or anything. It's more just

talking about how school's going, and you know, are you playing sports, and so I really try to just engage them about how they're living their everyday life." She asks questions about a large range of behaviors and evaluates health across many dimensions, both physical and non-physical, through an individualized lens.

Dr. I also expresses a responsibility for issues beyond exclusively providing basic physical care. She places a large emphasis on the importance of mental health, saying, "mental health issues, depression, anxiety, that sort of thing. That's probably one of the biggest things." She also touches on modern pressures impacting health, specifically highlighting screen time and social media, commenting on how, "because these kids, as I'm sure you know, are on their phones all the time." When asked what could be done to improve the overall health of her population, she remained on this topic, saying, "I would say taking screens away from most of them. Yeah phones, iPads, all of that. It's .... I think that's social media, and I think that's one of the worst things that's impacted children's health." Given the health context and privilege of her patient population, Dr. I can widen her focus, looking at new health risks that are impacting younger generations.

Dr. J, a family doctor serving mostly older populations in Hershey, Pennsylvania, uses similarly comprehensive practices. Hershey is 82.3% White and has a median household income of \$69,688 (U.S. Census Bureau n.d.). While this doctor sees a slightly larger number of patients who are on government-sponsored insurance and are not as wealthy as others mentioned in this section, there are still differences between the responses of this doctor and those that work in exclusively underserved populations. When discussing successful visits, Dr. J highlights moments where he feels patients were able to take the lead of the visit, identify a part of their life

they wanted to improve, and find a way to see health as grounded in their own personal reality.

He described one of these encounters, saying:

The main behavior change that she decided to work on, which I would never have guessed in a million years but she offered up, was that she always enjoyed writing poetry and writing stories and that you'd love to get back into that. And when she started talking about that she just lit up right, you know it was just clearly evident, this was something that she really had valued in the past, so we came up with a plan for her to kind of change your behavior to get back to writing.

This type of care was only possible because of the holistic approach of Dr. J. He allowed the patient to guide the visit, wanting her to highlight non-physical and individual ways that she could improve her health, finding a recommendation that he would not have come to otherwise.

A pediatrician from Guilford, Connecticut, Dr. K, also practices holistic evaluation. This area is 92% White with a median household income of \$111,870 (U.S. Census Bureau n.d.).

When describing his own demographics, this doctor states that,

We reflect our local community. We are, Shoreline is predominantly White. But, we have a fairly interesting, diverse mix because we take both military insurance and Medicaid. We get a fair amount of folks from other parts of the, you know, shoreline, that are a little bit more urban, a little bit less White. But it is still predominantly White. Probably 95% Caucasian and maybe 5% some level of, you know, BIPOC but it is hard to know.

It is clear that this pediatrician is mainly working with a privileged patient population, both in terms of race and socioeconomic status. When discussing his care philosophy, this doctor is clear that his focus is on holistic wellness more than solely physical health, saying that “Um, as you get older it's kind of, you know, it's balancing all of those things. Are they thriving, are they happy? I tend to focus on happiness, wellness, I think, rather than health.” He continues, discussing this concept of wellness and highlights the importance of happiness, saying, “I think it's about wellness. Are you happy? And It is very hard to be happy if you are in pain, or if you

feel, you know, you have overwhelming angst about things. So, I think, you know, you can have a chronic illness and be in good health, as long as it is managed well.” While this doctor is talking about managing physical disease, all the treatments necessary to manage these diseases are available to this patient population. Providing access to the necessary care is not in question, so while managing the disease is still important, once it is identified, Dr. K concentrates on promoting happiness and rounded wellness.

These doctors still include an important social element when discussing health. Doctors in privileged communities focus on individual social networks rather than larger social institutions. When asked about what actions can be taken to improve the health of his patients, Dr. F, an Upper East Side pediatrician, discussed stressors that come from school and other social networks, commenting that:

I think that the school system here is way too intense for kids and really leads to more psychosocial issues than anything else in their life. You know the high pressure, high intensity, need to do a college education in high school, is, I mean I really believe it robs kids of their childhood.

He continues to expand on this idea both in terms of school stress and larger mental health issues, quoting studies that have “shown that kids in upper middle class environments with school stress and sports pressures and so on, will often have the same metabolic responses to it that cause the same diseases later on, so it's not just bad stress, good stress can also do it.” Dr. F is illuminating how social stressors specific to his patients have the ability to produce negative health outcomes later in life.

Another pediatrician from the New York area, Dr. L, places focus on smaller social networks. Dr. L mainly works in a private practice on the Upper West Side, but does spend one day a week in Scarsdale. In 2019, the Upper West Side’s population was 68.7% White, 14% Hispanic, 10.1% Asian, and 4.7% Black (Furman Center n.d.). The median household income for

this neighborhood was \$139,070 in 2019 (Furman Center n.d.). Scarsdale has similar demographics, with a population that is 79.3% White and very wealthy, with a median household income of over \$250,000 as reported by the census (U.S. Census Bureau n.d.). While this physician does spend some time working in a public children's hospital, where she describes the population as underserved, the majority of her time is spent in privileged communities.

Dr. L explicitly talks about social pressures that most directly face her patients, bringing up two examples. First, when talking about middle-school girls, she talks about school environments, saying, "the social environment definitely you know, like you see so many somatic complaints. In middle school, girls are the worst. You know, we have multiple middle school girls who have so many somatic complaints." She directly links physical problems of her patients to their daily social stressors. Next, she discusses the parents of her patients, especially mothers raising young children, and comments on the problematic expectations that are set around motherhood. When asking how to improve the health of her patients, she says:

I guess the social pressures, what I would say is this, the social pressures that people feel. Like breastfeeding is the perfect example. How many times I have to tell a mother.....so when you're in residency it's like breastfeed you have to breastfeed you have to breastfeed. And what you realize is not everybody wants to breastfeed and you know, instead of breast milk best, fed is best. That sort of changed over time and, you know, there's a lot of pressure, I would say, on the Upper West Side to breastfeed.

The issues that Dr. L are discussing, while ingrained in problematic social norms, do not deny her patients the basic health care that they need. Rather, they put mental and physical stress on her patients as individuals.

Dr. K, the Guildford pediatrician, discusses how involved he is with the personal and social lives of the families he serves. He discusses a specific patient situation in detail, saying,

I had a family where, you know, they had a really complicated home situation, I don't want to reveal too much. They came in after having their babies, they had multiple. You know, I think over a three-month period they went through the midst of a near split to being, you know, life partners that have stayed together throughout the children's lives. So, the father passed away from cancer. It was a sad story when all was said and done, but they were there for each other and I think a lot of that happened because we worked together to sort of help solve what were very large issues. That to me is pretty satisfying. Which I know sounds more like social work than medicine.

This story is incredibly telling. Dr. K clearly knows his patients and their families very well, and they trust him enough to confide in him about family problems. He felt proud of his ability to act as a mediator and social worker for this family, giving the parents a chance to live together as partners not only for the sake of the child, but also to improve their own happiness. In this case, his stress is not about how the lack of a strong parental relationship could impact the ability of the child to access care, but rather how a positive parent relationship could improve the home environment and social health of the child in question.

Given the privileged backgrounds of the patients these physicians are usually seeing, they place less explicit emphasis on basic and physical health needs because they and their patient populations have many direct connections to the larger healthcare system. Dr. F discusses how there are easy connections between his practice, his patients, and other parts of the medical system. He discusses two of his patients who he identified as needing extra help, saying:

It didn't take much to, you know, evaluate the kids and realize that both of them had autistic spectrum disorder. And I, you know, got them into, I have luckily over the years been well connected with one of the major treatment centers in New York, so I called, got them both into the treatment center. They are now around 14 years old, the one kid, the one twin is in all honors classes in school. And the second twin is, you know, still needs a buncha help, but it is really pretty high functioning at this stage, so you know, there was one where if she'd sort of kept going wherever she was, by the time the intervention came in and may not have been as effective.

Even given the pressing medical issues of these patients, it was quite easy for Dr. F to provide care for his patients.

All of these doctors have the ability to focus on their patients as holistic individuals, deeply value mental health and stress, and address a wide variety of modern issues that impact health. Even so, they are aware of larger social structures that impact medical access. The Guilford pediatrician, Dr. K, commented on this, saying, “I’m very, what’s the word I’m looking for, I have a very limited view because I practice on the shoreline in a suburban setting where there is really not a limit on access to care for almost 100% of our population. There are some folks, even in New Haven where, you know, it’s a more urban population, or Hartford.” Other doctors within this group made similar comments about the state of medicine, many advocating for socialized medicine and health insurance, for the dismantling of current pay structures in medical business, and against the exploitative power of pharmaceutical companies. Even so, their reflections on their daily practice do not reflect the presence of these structural, institutional, and larger social problems. This is because they do not face them. They do not feel the pressure to single-handedly ensure the compliance of their patients to whatever necessary medical regimen. They are able to branch out to other forms of health that they feel closely impact their patients. Their daily care priorities and their health definitions are rooted in individualism and holisticness.

All doctors that I interviewed, regardless of patient population, care deeply about their patients, work incredibly hard, and are doing everything possible to provide the best available care. Due to different demographics and a flawed medical system, the best way to provide the best care possible differs between privileged and underserved communities.



### Age of Patient Population: Different Medical Disciplines and Daily Issues

The age of the patient population of each primary care provider impacted their goals in patient care and definitions of health. This is because their daily patient interactions, common problems, and medical disciplines are different, and therefore shape their priorities differently. While they are all under the umbrella of primary care, their experiences impact the way they define their own jobs and health as a concept.

One family doctor that mainly serves adult populations from Macedon, New York, Dr. M, is representative of the way that doctors who serve this age group discuss age as it relates to their patient population. This physician is incredibly data-driven and focused on disease management, both in terms of physical and mental health. He lists the main issues that patients come to see him for, naming “preventative care, well visits, and management of long-term risk factors such as hypertension and hyperlipidemia, diabetes.” When asked about what tests are key to well visits, Dr. M talks about data-driven tests, saying:

But if you're talking to a standard well visit, as far as tests run, it really comes down to basic blood work, so if you, for specifics, I do metabolic panels, blood counts, and liquid panels. And a general brief physical exam compared to past, you know, generations of physicians who have done more like exhausted physical exams that might not be evidence based any longer.

While these types of tests are important for all primary care physicians, doctors serving adults place extra emphasis on them. He even goes so far as to discredit the usefulness of a physical exam, something many pediatricians rely on. When discussing mental health, he also relies on more medically and data-motivated classifications, saying:

I like to make people aware of the diagnosis codes that are used. So they know that these things come with the word disorder on them-adjustment disorder, major depressive disorder, anxiety disorders - and I always tried to tell patients some things I say that I don't see you as disordered, these are the terminologies that

have been used forever for mental health now and I always talk about normalizing mental health symptoms without minimizing them.

Given that Dr. M is a family doctor, he does have some experience with children, and talks about the differences between children and adults. He says that “kids are almost always straightforward and adults are more unpredictable.” In this sense, he is referring to how the disease management and health needs of adults can change more frequently, as children usually have less chronic needs. Furthermore, Dr. M talks about age substantially less than pediatricians and geriatricians normally do. Adult care providers have less of a sense of age as explicitly impacting care provision. This differs from pediatricians, who often talk about how the age of their patient populations has a direct impact on the ways they provide care and evaluate health.

When discussing the general outlook of pediatricians, I will be quoting a pediatrician that works in Delaware County, PA, Dr. N. Her discussion of age is representative of how pediatricians discuss age. Pediatricians see their patients incredibly often given the nature of pediatric care. Dr. N discusses this, saying, “I see them way too often. Until they're about three years old, and I see them yearly. Okay right and and of course that's a difficult question to answer, because the first year and a half a child is in daycare or going to school, for the first time they tend to get a new illness every two weeks.” In this case, she not only touches on the fact that pediatricians see their patients frequently in terms of well visits, but also that the increased incidence of acute infection as opposed to long-term disease management changes the way that pediatricians and patients interact.

Given the increased presence of patients in their offices, pediatricians talk about relationship building as the key to positive primary care. They discuss the complexity of these relationships openly, especially given the role that the entire family unit plays in pediatrics. Dr. N

talks about navigating complicated relationships between patient, parents, and physician. She describes difficult moments where patients want to talk with her without their parents, saying:

Can I talk to [Dr. N] by myself and the parents are like, 'What do you mean,' but some of them really trust me and they step out. And all they wanted to do was say I had a good day in school. They like to have nothing to tell me they just wanted to spend my time with me. It's very cool. I see that as well as interactive.

Dr. N continues to describe how it can be difficult to manage family relationships, talking about how it is important to her that her patients, "identify someone that they feel safe with that if someone does something that they're uncomfortable with they would tell that one person. Parents are usually flabbergasted that they're not that person." She also explicitly identifies the role of the whole family in pediatrics, saying, "in pediatrics, sometimes helping the kids means helping their parents. Right so it's not just a kid thing, it's adults and kids." These types of family relationships are uncommon in adult primary care.

Pediatricians talk about health and priorities through a less data-focused lens. They evaluate the well-being and safety of their patients rather than collecting data regarding prevention and long-term health management. When reporting what questions she asks during well visits, Dr. N is less specific than most adult practitioners, saying, "there is definitely no one question that I asked, other than how are you doing and what brought you to my office today." In pediatrics, health is evaluated in a behaviorally-grounded way, with Dr. N saying, "when kids are healthy and happy they come in, they chat with you, you ask them questions they answer appropriately, they're making good eye contact with you." Pediatrics is influenced by age, family relationships, and guided by behavior, as compared to adult primary care which is guided by medical data.

When moving into geriatrics, there is an interesting blend between pediatric and adult philosophies. Within geriatrics, long-term disease management is central. As a geriatrician based

in Providence, Dr. O, states, “maybe it's somewhat self-serving to say that my view of successful aging includes, but is not limited to, coping skills. Even in the face of extraordinary physical assaults, and by assault I don't mean to get mugged, I mean disease.” In this quote, Dr. O is alluding to the importance of finding coping mechanisms for older people as they manage disease. In addition, issues of social interaction reinsert themselves into the realm of primary care. The connection of younger people to aging complicates the medical field, as this physician recounts, saying “ageism is rampant among, it isn't just the gen x's and y's and z's and when we get to z will we start on the Greek Alphabet I don't know, whatever it is. It's not just the youngest people in our society who are not only terrified, not only vilifying older people and aging, but terrified of it.” This type of social impact on the field leads to a combination of both behavioral evaluation and data-based evaluation of patients. When asked about what issues were the most prevalent in his patient population, Dr. O first says, “I think, after Alzheimer's disease, I will put not a disease, but a societal problem, which is isolation and loneliness of older people,” then adding, “So, if number two is that then number three, there's competition between cardiovascular disease and ageism.” These conditions are a combination of physical ailments as well as behavioral and social problems, prompting the care priorities of geriatricians to be an interesting mix of the data-driven evaluation of adult primary care providers and the behavioral and social evaluation of pediatricians.

Another complication of geriatric care is the reentrance of the family unit into the medical decision-making process. As patients get older, the family unit, whether this be children or partners, becomes more involved with medical decisions. Like pediatricians, geriatricians must learn to manage these complex relationships and take care of full families. Dr. O discusses how important the family unit is in geriatric health, saying, “passion for their wellbeing, devotion

at an individual and family level to doing right, do the right thing, deeply caring, I mean you know we have this myth in America that at 65 they give it to their children who put them in a nursing home. And that's just not true.” He takes on the narrative that families remove themselves from this process, actively saying that they are passionate about being involved. This passion can lead to many difficult situations, including when a parent has a neurodegenerative disease that damages their memory of their family, to issues of pride, and complex class relations, as it is possible, unlike in pediatrics, that the education, socioeconomic status, and geographic location of the patient and of their family members are vastly different. This geriatrician touches on this phenomenon, discussing how his patient population is, “mostly White. Mostly previously middle income and now poor and often with highly educated children.” These types of differences in background between patients and their families can lead to difficult dynamics that primary care providers must manage in order to provide care. Given the complexities that come with serving older patient populations, the care priorities of geriatricians are a combination of the outlooks of pediatricians and adult primary care providers, as well as an added element of dealing with families of multiple demographic backgrounds.

### Insurance and Pay Structure

When looking through the interviews, one incredibly common thread that emerged is widespread frustration with insurance companies and the current medical pay structure. Almost all doctors I interviewed, regardless of location of practice or demographic breakdown of patients, advocated for at least some change to the current structure of medical insurance in the United States, many advocating for socialized medicine.

Insurance companies and drug costs were discussed at length by many doctors as direct limitations to providing care. Doctors felt constrained in their ability to do their jobs because of

the confusing and lacking coverage of medical insurance. Dr. N responded immediately when asked about constraints, expressing her frustration with insurance companies, saying, “absolutely by insurance companies. Yes, I'd like to prescribe this medicine, but no, we don't want you to, and if you prescribe it your patient has to pay \$400 for that. And if you prescribe we dock your pay. I think that insurance companies are the bane of my existence, and I would love to do without them.” Dr. H, a primary care provider who works on the Upper East Side of New York City, also criticized insurance structure, saying, “there are constraints that are imposed by insurance companies today. In many respects they impose restraints in terms of what medications that a patient can receive.” Dr. A commented on how limiting and limited insurance can be, saying the following when asked about constraints:

The other big one is insurance. 100% of the time insurance is stupid and awful. Yes, and like won't cover glasses, insurance will, thank you, like medicaid and medicare don't cover eyeglasses. Like what medicare like F, is when you start like there's like ABC or like the main ones, and then like D through like X or whatever.

The restrictions existed within multiple realms of healthcare, with Dr. M commenting on how “cost is a constant barrier to people seeking mental health care,” and that insurance companies do not cover enough when it comes to mental health treatment.

Furthermore, pharmaceutical companies constrain as well, with Dr. K saying that “I mean I think honestly, actually probably the best answer to solving the US health crisis would be to make it, you know, make pharmaceutical robbery a thing of the past,” highlighting not only how drug companies and insurance structures can be limiting, but also calling out these companies for using their power to make money instead of prioritizing patients.

Primary care providers see changing the insurance structure as key to improving the larger medical system. Dr. H believes insurance needs to be changed to improve healthcare,

stating that, “you have to remove barriers to healthcare and remove barriers to good health. So the barriers to healthcare, the biggest barrier today, I think, is lack of adequate insurance.” The issues with insurance coverage and structure are so prominent within primary care that many doctors wind up actively advocating for changes within the insurance system. Dr. E says:

Most people in primary care believe in socialized medicine. And so do I. Nobody should have to ... someone today said, she was crying, she said, my husband has diabetes medicine that costs \$700 for three months worth, and they're retired, and she goes, so he's not going to take it.

Many get directly involved in political initiatives and support specific programs that are aimed at bettering the provision of insurance as it stands. For example, Dr. O, a geriatrician, discusses the Program of All-Inclusive Medical Care, or PACE, saying that, “What the PACE program does is it takes in for care older adults, Medicare eligible and also Medicaid eligible, either by poverty or disability, and combines those two funding streams to be used, with some discretion by the PACE program, to meet the needs of the individual.” He also openly discusses supporting the program both as a physician and financially. He says that “when I was in government and in the late 90s, I gave that program and the woman who ran [PACE] \$2 million for an information system, for a then contemporary information system, because they were doing such a fabulous job without an information system, and they needed one.” Doctors are not only frustrated with the current insurance system, but they are actively trying to change it.

Pay structure is also a major frustration of many physicians. A pediatrician from Wilmington, Dr. P, remarked on how physicians are often pushed towards specializing instead of remaining in general health fields, saying that:

You have, even within general pediatrics you have inpatient specialists and that's also happening with internal medicine also. Part of that, unfortunately, is because of how we're paid. You know it's in that pay structures have changed it's sort of made it that people primarily are in the outpatient world. For them to stop their

day and run over and take care of patients in the inpatient setting it's actually..... it hurts them financially.

Specializing, rather than remaining within general primary care, is not incentivized in terms of financial compensation. Other physicians continued to struggle with the corporate side of medicine that emphasizes profitability and volume rather than patient care. A pediatrician from Hershey, PA, Dr. Q, stated that:

I really feel medicine is becoming a business. It's very corporate oriented. We have a huge overlay. Administrative personnel who we never see, in fact, are not even on the campus or in a building that is a mile's distance. That impacts a lot about what you can do, particularly involving the electronic medical record, which was very difficult for me, I never really got adjusted to it.

In this quote, Dr. Q not only discusses the corporate structure of medicine, but frustrations with the growing use of electronic medical records to allow for easier connection with administrative personnel. Other physicians have discussed frustration with electronic medical record systems as well, such as Dr. J, the other Hershey doctor, who immediately deferred to the electronic medical records when asked about constraints, saying, “the electronic health record is probably the biggest challenge and barrier. There is a lot of documentation, a lot of clicking that has to be done, and these are all based on sort of regulatory reasons and billing reasons.” This is a frustration not only with the electronic medical records as a day-to-day annoyance, but rather the use of them to communicate with administrative actors and insurance companies that are not connected with everyday patient care.

When looking through many of the doctors’ descriptions of their connection to administrative systems, pay structures, pharmaceutical companies, and insurance agencies, the frustration is widespread. Issues with constraining their daily practice decisions and not allowing for optimal patient care are everywhere and seem insurmountable. The fact that these doctors,



regardless of their patient population, length of time in medicine, or current location, all found many issues with the structure of corporate medicine and insurance, calls into question the current way that healthcare policy is managed in the United States. If doctors are advocating for an increase in socialized healthcare with complete coverage as a way to maximize patient care, it is in our best interest to listen to them.

## **Discussion**

What is abundantly clear, and not at all surprising, is that the definition of health is not constant among physicians. Some thought of health as optimization, making the best of the social and physical situation at hand. Others discussed health as coping, giving patients the necessary strategies and treatments to manage and enhance their health state. Others looked at health as adapting to the environment, some as a combination of all of these things, and others as something completely different. All the physicians I interviewed discussed health through a variety of lenses, both social and physical, at a much higher rate than I predicted. This bodes well for primary care users. Primary care physicians have the responsibility of bridging the gap between patients and the healthcare system at large, and their ability to understand and evaluate health on multiple levels shows their commitment to doing their jobs as well as possible. However, the primary care system at large continues to struggle, with low engagement, especially in underserved communities, and complicated doctor-patient relationships. Given the general well-rounded nature of the health definitions and patient constructions of the physicians who I interviewed, this feels surprising.

While all physicians had health definitions that accounted for multiple aspects of health, this did not match up with their descriptions of care priorities. Physicians who served more

privileged communities, both in terms of higher socioeconomic status and at times majority White communities, looked at health socially, but individually. They focused on mental health, spiritual health, personal connections, and holistic care. While some of their answers demonstrated a clear awareness of the way that larger social institutions impact health and wellness, they primarily attend to the personal social, familial, and physical networks of their patients. They position health as an individual and holistic problem. In contrast, physicians that serve primarily underserved populations discuss health as a larger social problem, confronted by institutionalized health disparities that deeply impact their patients on a daily basis. They focus on doing whatever it takes to provide all necessary, basic, and physical health services to patients in spite of the social barriers in the way. Their understanding of health is deeply socio-political and completely practical, motivated by doing everything possible to ensure their patients have the necessary resources to manage their illnesses and acute physical health.

For doctors who serve underserved communities, their pressure is twofold: they not only have to fight explicit structural barriers, such as insurance complications and high drug costs, but they also have to deal with implicit ways that larger social and political institutions make care provision more difficult. It can be harder to build trust with patients and have honest conversations about different treatments, such as vaccination. When physicians have younger patients who are in low-income families, constant parental or guardian presence is not guaranteed due to limited childcare resources, and ensuring that patients adhere to treatment is harder. There is constant pressure to explain and purvey health care advice in every sense, from explaining how to use an inhaler, to explaining that interpreters are legally required to any patients who are not fluent English speakers, to finding ways to get patients access to basic needs, such as education and food. Again, these problems do not result from fully physical

causes, are not the result of patient pushback nor physician negligence. They are the result of lacking health policies and problematic insurance structures that do not adequately support underserved patient populations.

Doctors that are not subjected to these pressures on a daily basis focus their time on patients as individual beings that are embedded in complex, personal social networks. They talk about screen time, friendship, school pressure, social media, parental relationships, mental health, spiritual well-being, and individual conditions. Their patients have access to the health resources they need, allowing physicians to focus on holistic remedies, emphasizing well-rounded personal relationships. All doctors care deeply about their patients, want to build relationships with them, and do everything in their power to help their patients be as healthy as possible. But, class and race impact the ways that physicians care for patients and what factors of health are prioritized.

There is clear evidence of differences in care provision and health definition from doctors that depend on non-medical factors, such as race and class. But, these pivotal differences are not captured by the sickness and illness distinction. It could be argued by medical sociologists who have relied on this distinction in the past that the distinction can still evaluate these definitions in terms of 'how much' a doctor considers the concept of sickness or the concept of illness in their definition of health. But, that is not applicable given the differences observed. The patient populations of physicians did not impact to what degree they considered health a social concept, but *how* they considered health a social concept. Health is either influenced by large social structures and political institutions, or by the social networks and personal connections of each individual patient. Medical sociology, and its canonical use of the sickness and illness

distinction, is far too limiting, failing to fully account for the way that the definitions of physicians function and the ways that care is provided.

Given that the sickness and illness distinction is one of most utilized and common forms of health definition within medical sociology, filling this gap is crucial. The true feelings and perspectives of physicians are not represented. While the physician perspective is not the whole story, they are deeply embedded in how health is understood and purveyed. Having a framework that accurately characterizes physician definitions must be a priority for medical sociologists, not only in terms of expanding the field to be more representative, but also providing patients and non-physicians a clearer understanding of the priorities and health conceptions of their doctors.

Clearly, this framework needs to be expanded. The focus should be put on expanding the term 'sickness.' While 'illness' as it currently stands still leaves some gaps, the main differences in physician definition exist given the social context of medicine. Illness, in one way or another, is included and prioritized by physicians across all interviews. I propose improving the sickness and illness framework by creating a new distinction that is specific to sickness: practical sickness and holistic sickness. Practical sickness is a conception of health that is deeply entwined with larger social institutions and structural barriers to care. Given these barriers, physicians have to focus more on the provision of basic health needs and ensuring illness management is in place for their patients. In this case, the goal of health providers is to manage disease and handle health issues despite the situation. Holistic sickness is a conception of health focused on small scale social connections and networks. While health, in this sense, is clearly impacted by factors that are not purely physical, there are fewer barriers to physical care, allowing for more attention on other factions of health as a whole concept, including spiritual health, mental health, and healthy relationships with others. Holistic sickness, rather than being

about management, is about optimization. It is about making the best of the situation in all aspects of life and health.

While this distinction is by no means perfect, it expands the sickness and illness framework to illustrate the variety of ways social dynamics impact health and the direct and destructive impacts of our current health system. Doctors are by no means perfect. They are sometimes unaware of their patient's identities, self-centered, and closed off to the larger problems facing their patients. But, they have been dealt a tough hand, and the current state of our healthcare system and its structure makes it difficult for doctors, in a variety of contexts, to prioritize patients as whole individuals and build meaningful relationships.<sup>5</sup> Specifying the illness–sickness distinction allows for a definition that is more representative of how care is being provided to patients. While there is still work to be done, the current definition is clearly insufficient, and expanding the possible categories is paramount to creating a more inclusive and well-rounded understanding of health for policy makers, doctors, and patients alike.

The differences in health definition I found address both larger structural problems with medicine as well as dissecting the role that personal social networks have on the health state of each individual. Updating current methods of defining health is an important step forward, as it forces doctors and policy makers alike to look at the problems that have been created in the healthcare system honestly and fully, leading to a higher chance of building useful solutions that

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<sup>5</sup> As detailed in the results section, age has an impact on how doctors discuss health. While this finding is incredibly interesting, it is based on the differences between the disciplines of serving adults or older people and serving children. Different ages face different health problems, and the nature of these problems impacts the content of patient visits as well as priorities in terms of providing healthcare. The connections of each physician to the family unit is incredibly dependent on age, as well as how much they focus on data-driven evaluation as opposed to behavior-driven evaluation. Furthermore, the transition into geriatrics leads to a melding of the philosophies of pediatric and adult primary care providers, as the family unit becomes reinserted into the health process, but in a different way. In order to make more productive statements about how the age of patients impact health definition, my interview pool of geriatricians must be expanded. I will discuss this further in my research limitations section.

can maximize positive patient care, good doctor-patient relationships, and lessen the amount of people that feel alienated and left behind by the medical and primary care systems.

### Limitations and Further Research

My research addresses a small part of a much larger issue within medical sociology, which is how health is defined, constituted, and constructed. There is much more research that could and should be done to not only improve the field, but to improve the way that doctors do their jobs and patients receive care. There are many limitations to my research, including my timeframe, the lack of specialists in my interviews, the small sample size, the limited geographic scope, and the lack of patient input. While my work is still useful, it is only scratching the surface, and it is important to consider these limitations in the future to expand upon this research and improve it.

To improve my own research methods, I would pair my interviews with practice observation of each physician that participated. While I ask the physicians about their practice, direct observation will always be better than verbal reports. In-person observation lends itself to direct comparison between physicians' descriptions of their practice and the realities of their practice. This observation would have allowed for more direct analysis of how physicians apply their theoretical definitions to their practice decisions.

Furthermore, it is clear that patient voices are missing from this work. Conducting similar interviews with patients to see how they define and understand health would lead to an understanding of what is important to patients, which would improve patient care. The medical field should be designed with the wants, needs, and priorities of patients in mind, and knowing how patients define and construct health is a key step to accomplishing this goal. In terms of growing the field of medical sociology, understanding patient definition of health would reveal

how patients position themselves within the process of constructing health as a social or physical concept. Furthermore, direct comparison between a healthcare provider's definition of health and their patient's definition of health would depict any connections and disconnections between these two entities. Are patients and their doctors on the same page, and how effectively are they communicating their needs and ideas to one another? Starting with patient voices is the most important and clear cut way to expand upon this research.

Including specialists in these interviews would provide a new perspective within the healthcare field. Focusing on general practitioners that serve a variety of age groups was intentional. I wanted to focus on doctors that did not have a singular focus and were more likely to have long-lasting relationships with their patients. That being said, specialists have become increasingly present in the medical process, and understanding how they conceptualize health is incredibly important to the medical field, both practically and within medical sociology.

COVID-19 has rocked the medical sphere. A medical event of this size has not happened for years, and many physicians saw their jobs change very radically and very rapidly. Assessing how doctors who went through swift changes during the pandemic adjusted their definitions of health and understanding of their profession would make a temporally relevant comment on how specific experience impacts health definition.

While age was not the main subject of my argument, it is an important variable to focus on in future studies. The age of each doctors' patient populations impacted their answers and health definitions. Children are very resilient, and their pediatricians often identified how they knew that their patients would get better in spite of them. They focused on a variety of health evaluators, including how their patients acted in visits and their grades, and had to navigate complex family relationships. Adult practitioners are often more data-driven, deal with family

relationships less, and are more concerned with long-term disease management given the needs of their patients. The geriatricians interviewed had an interesting combination of the philosophies of pediatricians and adult primary care providers. While disease management is central, the family reenters the equation, albeit in a different way, and non-data driven and life-prolonging measures of health, such as happiness and comfort, begin to regain importance.

Studying the complex dynamics between geriatricians, their patients, and the families of their patients has the potential to illuminate how the competing social identities of people involved in the medical process impacts a doctor's conception of their job and decision-making. In this case, it is possible for the family and the patient to have very different class backgrounds. The children may be more highly educated, or have less money, or live in a different neighborhood. The interactions that doctors have from day to day are not just limited to the community in which they practice. Seeing how this type of diversity in interaction impacts a doctor's outlook has the potential to make powerful claims about how specific interactions with people of a variety of social backgrounds impact doctors.

## **Conclusion**

The patient populations of primary care physicians impact the way that they define health and prioritize care. The daily problems and patient population of each doctor influences their understanding of their jobs, and therefore their provision of care. These differences are not captured in the current literature in medical sociology regarding health definition. The central distinction of sickness and illness is not adequate. Specifically, the concept of sickness needs to be expanded. I propose the use of holistic sickness, a social health based on personal and individual social networks, and practical sickness, a social health focused on larger social



structures that create barriers to physical health. This addition maintains the simple and approachable elements of the distinction that make it useful while expanding it enough to make it more representative of how health is purveyed and experienced. While this is only one step towards creating a more representative and useful health definition, I believe that advancing this distinction has the ability to improve both the medical and sociological fields and provide patients and physicians with a more complete picture of their own health experiences.

At the beginning of this thesis, I told a story about when I broke my arm as a kid and how a doctor helped me fix it. I told this story not just because he illuminated a new aspect of physical health, the idea that pain cannot always be avoided, but rather that he was one of the few physicians, authority figures even, that treated me as I saw myself. He spoke to me like he respected me, and continued to keep me informed and engaged as the process went forward. He answered my questions in ways that I could understand without leaving out all scientific significance. He asked me for my trust, he did not assume it. He met me where I was at, and showed me that health and care are not about blindly trusting physical recommendations, but feeling heard and seen given who you are, where you are in your life, and the many intersecting problems that create your current health state. Of course, as a young privileged child whose biggest problem at the time was not being able to go trick-or-treating that night, this story is a very insignificant and small-scale example of the impact of integrative and representative health definitions and practices. We are not yet at a place where every doctor-patient relationship has the ability to be as overarching and positive. Hopefully, if we start looking at the way that health definitions and prioritizations are forced to vary given different social factors, we can start moving in the right direction.

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## Appendix A

### Interview Questions<sup>6</sup>

1. How many years have you been practicing, where do you primarily practice?
2. How long have you been practicing at your current location?
3. How many patients do you have? How often do you see them?
4. How many patients do you see per week?
5. How much time do you spend, on average, with your patients?
6. Are the majority of your patients covered by health insurance? Is it primarily public or private insurance?
7. Do you have any anonymous demographic data on your patients that I could access?<sup>7</sup>
8. What is the structure of your specific practice? Does that impact your work or place any constraints on you in terms of decision-making processes?
9. Have you ever worked anywhere different? If so, how was that experience different?
10. What are the most common things that patients come in for? (Top Three Issues)
11. How do you usually describe these issues to your patients? Is there any language that you usually use?
12. What behaviors do you usually ask about?
13. What tests do you usually run and why?
14. Could you describe a patient interaction you thought was successful?
15. Could you describe a patient interaction you thought was unsuccessful?
16. Why did you want to work with the age group that you work with?
17. How does the age group you serve impact the way that you do your job?
18. How do you know when your patients are healthy?
19. What could be done to make them healthier, if anything at all?
20. How is the environment related to health, both physical and social?
21. What matters the most when providing healthcare and making medical decisions?
22. Are there any ways that you feel limited or constrained when making medical decisions?
23. What have you learned about health and wellness during your time working here?
24. Are there different types of health?
25. What is your definition of health?

## Appendix B

### Doctor Pseudonyms

Dr. A: North Philadelphia, Pennsylvania: Pediatrician

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<sup>6</sup> I asked all of these questions to each of the doctors that I interviewed. There were a few interviews in which, due to time constraints, a few questions were skipped. I marked down which interviews these were. Also, questions 12 and 13 were often combined.

<sup>7</sup> Often, doctors were unable to provide me with such data for administrative reasons. In this case, the doctors would self-report this data to me based on their experience



Dr. B: North Philadelphia, Pennsylvania: Pediatrician  
Dr. C: West Philadelphia, Pennsylvania: Pediatrician  
Dr. D: Canandaigua, New York: Family Doctor  
Dr. E: Canandaigua, New York: Family Doctor  
Dr. F: Upper East Side, New York: Pediatrician  
Dr. G: Upper East Side, New York: Pediatrician  
Dr. H: Upper East Side, New York: Adult Primary Care Provider  
Dr. I: Cherry Hill, New Jersey: Pediatrician  
Dr. J: Hershey, Pennsylvania: Adult Primary Care Provider  
Dr. K: Guilford, Connecticut: Pediatrician  
Dr. L: Upper West Side, New York: Pediatrician  
Dr. M: Macedon, New York: Family Doctor  
Dr. N: Delaware County, Pennsylvania: Pediatrician  
Dr. O: Providence, Rhode Island: Geriatrician  
Dr. P: Wilmington, Delaware: Pediatrician  
Dr. Q: Hershey, Pennsylvania: Pediatrician