From the editor
Illness, poverty and the invisible patient

A line in Ralph Ellison's "Invisible Man" that I find particularly instructive reads, "All dreamers and sleepwalkers pay the price, and even the invisible victim is responsible for the fate of all" [1]. Although this line refers to issues of race in United States, it is an equally relevant commentary on the relationship between poverty and illness. Children, men and women from low socioeconomic backgrounds are among the invisible victims of society, while the sleepwalkers and dreamers are those who—willingly or unwillingly—neglect, oppress or forget their invisible neighbors. In the increasingly complex U.S. health care system, federal budget cuts to entitlement programs such as Medicaid [2], and well-documented racial, ethnic and class disparities in health outcomes, these invisible persons are often marginalized in the health care setting. Despite the structural marginalization of those with low socioeconomic status (SES) in our society, the fate of our invisible neighbors intertwines with the lives of us all in the public health realm and beyond. Disease and insecurity, not to mention injustice, impact all of us whether we choose to acknowledge it or not.

While low SES can be defined quantitatively, characterizing poverty is a more elusive task, given its multiple determinants. Scholars vary in how they explain who the impoverished are. Furthermore, competing political and cultural interpretations of poverty and how to rectify it often hinder its alleviation. Most unfortunately, the voices and experiences of those who live in poverty are often neither heard nor heeded by society's more powerful. Thus the people living with low SES experience violence that is built into the structure of our society in the form of neglect, denial of certain human rights and inadequate access to quality public and private services, to name a few of the social pathologies that constitute structural violence.

Volumes could be written here to elucidate a more thorough and just discussion of the definitions, causes and history of poverty in America. At the very least we should be able to agree as a starting point that living in poverty imposes *vulnerabilities* on those who experience it, vulnerabilities and often chaos that leave them without the means and tools that those in higher socioeconomic brackets depend on for human flourishing: reliable social networks, various human rights, housing, food, shelter, health and the list goes on. Christie Kiefer defines poverty "not as a simple economic condition, but as a state of demoralization, where people lack all or most of the minimum ingredients we accept as the basis of a decent life" [3]. Even this definition

leaves us wanting, but from here we can begin to understand the differences between the more financially privileged and the medical patient who is poor.

The articles selected for this edition of *Virtual Mentor* demonstrate how poverty (or low SES) is related to illness in the clinical context by exposing deficiencies in the current health care system and highlighting the nuanced understanding needed to care for patients whose backgrounds challenge clinical conventions that were designed for middle- and upper-class patients. Affordability and access to health services appear to be likely candidates for blame as to why patients with low SES experience worse health outcomes than those with higher SES, but to focus on these alone is to miss the point. While central to understanding the connection between poverty and illness, access and cost are only part of the clinical puzzle. A more comprehensive look at the social determinants of health serves as a better model, not only for acute treatment of patients but also as a way for physicians to learn to advocate for patients more holistically at social and political levels.

How we understand why people are living in poverty is just as important as finding innovative ways to provide care and advocate for them. This means clinicians must understand their patients' educational and cultural backgrounds, housing, race and gender issues, and historical, political and economic disenfranchisement. We also need to appreciate the more fundamental influences on their health behaviors, such as difficulties in finding transportation to the clinic and their degree of health literacy.

At the same time, physicians must explore their own lives, upbringing and attitudes because these shape and challenge their interaction with patients of low SES. David Hilfiker, a medical doctor who works with impoverished persons writes,

> There is a belief woven intimately into our society that we live in a "meritocracy," a community where people can make whatever they want of their lives, ending up where they do largely because of their own efforts and talents… . As a culture we are deeply invested in the belief that the individual can determine his or her destiny [4].

These values shape many of us in ways that do not resonate with the experiences of those born into poverty, a place where the playing field often lacks bases, a bat and teammates to help along the way. To complicate matters, those of us with advanced educations, though we may attempt to strip down our material comforts to live among the poor, can never enter into true poverty. Even in our solidarity, we can never be true "insiders" as Hilfiker discusses; yet all is not lost.

Physicians who are knowledgeable about the relationship between poverty and illness in a more comprehensive way will better understand why diseases such as tuberculosis and HIV/AIDS disproportionately affect the poor, for example, and can perhaps work out a more suitable treatment plan with patients who live without many social stabilities and access to services that we take for granted. Doctors who are

educated about the plight of the poor may better recognize the difficulties in treating patients at the margins of the health system who are living with chronic disease conditions, such as the substitute school janitor with chronic prostatitis who serves as the patient in the first case study in this issue. Most importantly, the burden of knowledge that comes with professional education in the social determinants of health may create a renewed or strengthened moral imperative for us all to become agents of social change in patients' lives outside and around the clinical encounter. This issue of *VM* intends to provide this burden of knowledge, knowledge that can be translated into action for justice and a more holistic approach to patient health.

Three clinical vignettes ranging from identifying pesticide poisoning in immigrant workers to the ethical dilemmas in triaging patients in the emergency room raise concerns that patients with low SES typically confront. Medical students and physicians will find the journal discussion articles useful tools for increasing their vocabulary about social determinants of health and interpreting research that suggests a relationship between SES and health outcomes. The medicine and society articles dispense important research findings on the geography of poverty and illness. This section also addresses the overcrowding in hospital emergency departments (ED) and dispels myths that the uninsured are the source of this problem while highlighting the additional attention needed to change the health care system so that patients in government entitlement programs (e.g., Medicare and Medicaid) are not "dumped" in the ED. The history of the present-day legislation against patient dumping, the Emergency Medical Treatment and Active Labor Act, is discussed in the health law section.

Complex social problems such as providing quality health care for persons of low SES and meeting them where they are in their lives demand solutions. This issue presents a host of dilemmas; while it is evident that physicians cannot solve these alone, they can play active roles, both inside and outside the confines of the clinic, to mobilize a call for change in how we as a society address poverty and the health of the invisible victims among us. Physicians can begin to network in communities to address these problems through other agencies. The Patient Navigator Act of 2005 signed into law and discussed in the policy forum is but one promise of a brighter future. Also covered in this month's policy forum is how a change in education policy can influence the health of people with low SES. Further, a medical education article explores how one medical school is bringing the care of the poor to the attention of its students.

A recent Institute of Medicine publication states, "Beyond the statistics, the suffering, disability, and death among large and growing segments of the population tear at the nation's conscience" [5]. If these problems truly tear at our conscience as clinicians and students (as they should), then we must listen to the poor and educate ourselves about the forces that shape their lives. Only then can we begin to form a more meaningful relationship with them that comprehensively seeks to promote health and human flourishing among some of the most difficult social odds imaginable. Given the rich ethical duties embedded in medicine as delineated from

the history of the profession, we must play our part in waking to the plight of the invisible impoverished patients for whom we care.

References
1. Ellison R. *Invisible Man.* New York, NY: Random House; 1980:14.
2. The Kaiser Commission on Medicaid and the Uninsured. *Deficit Reduction Act of 2005: Implications for Medicaid*. Available at: http://www.kff.org/medicaid/upload/7465.pdf. Accessed October 10, 2006.
3. Kiefer CW. *Health Work with the Poor: A Practical Guide*. New Brunswick, NJ: Rutgers University Press; 2000:78.
4. Hilfiker D. *Not All of Us Are Saints: A Doctor's Journey with the Poor*. New York, NY: Hill and Wang; 1994:152-153.
5. Thomson GE, Mitchell F, Williams MB, eds. *Examining the Health Disparities Research Plan of the National Institutes of Health: Unfinished Business.* Washington, DC: The National Academies Press, Institute of Medicine; 2006:15.

Justin M. List, MAR
MS2
Loyola University Chicago
Stritch School of Medicine

Virtual Mentor welcomes your response to recently published articles and commentaries. Send your correspondence to the *Virtual Mentor* e-mail address: virtualmentor@ama-assn.org.

The viewpoints expressed on this site are those of the authors and do not necessarily reflect the views and policies of the AMA.