Medical Care "In the Service of Humanity"

Nisha Chandra

In a Tortoiseshell: *In the following excerpt, Nisha Chandra uses the* ***conventions*** *of a speech for the imaginary opening of Princeton's medical school to craft compelling* ***analysis,*** *guided by her definition of* ***key terms****.*

Excerpt

Hello students, faculty, and friends. I am delighted to be speaking to you as the inaugural president of Princeton University Medical School, and to start working together to create a more equitable present and future for all patients. To do this, I believe that we must recognize and counteract one of the most harmful and pervasive practices within medicine: the exclusion of certain bodies from the category of "human". By this, I mean the structural devaluing of marginalized bodies – the erasure and refusal of their humanity. To decrease disparities in health, we must unpack the ways in which we continue to degrade patients of color while placing value on white patients. Which patients we spend the most time with, which patients we listen to, which patients we invest in – these questions all form part of who we think are more deserving and valuable humans. These judgements deny care to those who need it most and perpetuate disparities within healthcare. So today, I would like to talk to you all about a few of the ways in which medical practices ignore the humanity of vulnerable communities, resulting in social and physical harm. It is only in calling out this harm that we, as current and aspiring physicians, can begin to undo it by consciously ascribing equal value to all bodies.

…

I would also like to explore medicine's role in denying the humanity of marginalized communities through the lens of visibility. Sofia Samatar begins her essay "Skin Feeling" by defining the titular phrase as "What it is to be encountered as a surface, to be constantly exposed as something you are not"[1]. I want to challenge all of you to try and recognize the ways in which we encounter certain bodies simply as "surfaces". People from communities of color are often made hyper-visible – they are under constant surveillance, not as individual people, but as representatives of their race. Circulating news stories portray Black and brown people as criminals, with no indication of their personal lives or loved ones. Academic institutions put

professors of color on display: not for their achievements, but for the color of their skin. Black folks are surveilled and racially profiled by police, educators, employers, and random citizens. In all these ways and more, minority communities are made visible in our society as something they are not, as racialized surfaces. In doing so, we make their humanity invisible. We ignore the unpredictability, the desires, and the experiences that distinguish them. This concurrent hypervisibility and invisibility becomes evident within medicine when you consider how we treat patients from different walks of life. Patients from privileged backgrounds are automatically granted the freedom to have and express individual needs. However, patients from marginalized backgrounds are seen as requiring public surveillance while not deserving individual attention. In your career as a physician, I want you to consider the ways in which you and the institutions you work for construct such patients as highly visible yet highly neglected surfaces.

This paradox is apparent in our medical treatment of recently incarcerated people, who are hyper-visible members of society. You may think that the public scrutiny of these individuals exists only within the confines of prison walls. And yet, even beyond release and parole, we are constantly evaluating their level of threat to society, especially if they are a person of color. We surveil and control their decisions, refusing to let them open bank accounts or rent apartments. We make sure that their identities as "formerly incarcerated" are visible to every potential employer, that it is publicly known and salient. In doing so, we refuse to acknowledge their value and needs as human beings, including their need for healthcare. For example, there is a huge drop in HIV treatment rates as soon as people are released from prison. To stay healthy, HIV+ people need care immediately after they are released. However, a recent study found that only 5.4% of former inmates filled their antiretroviral prescriptions within 10 days of release from prison, 17.7% within 30 days, and 30% within 60 days[2]. As soon as we as medical providers are released from the legal obligation to provide someone with HIV treatment while they are in prison, we wash our hands of them. With their release, we become legally free to stop caring about their humanity and classify them as undeserving of medical care. Formerly incarcerated individuals, who are disproportionately Black and brown, are made hyper-visible to society as ongoing threats yet invisible to society as individuals.

To disrupt these categorizations, we must try to understand and address the needs of oppressed populations, such as formerly incarcerated people of color, rather than continuing to expose them as something they are not. We need to teach physicians to stop relying on labels such as "prisoner" in their judgements about who deserves medical treatment. We need to invest our time, money, personnel, and care into minority communities who have been previously

neglected, knowing that helping them achieve better health will break cycles of inequity. In the case of HIV treatment, this includes connecting former inmates to quality and compassionate medical care in their community immediately upon release. It includes tackling the systems, such as the prison industrial complex, which are responsible for patterns of illness and poverty in poor communities of color, rather than blaming the individual. We need to dissect the social forces that have made minority communities hyper-visible/invisible and learn to instead see them as people rather than as surfaces.

As the president of Princeton University Medical School, I will fight to expand medicine's definition of who is valuable and who is human. From your time in the classroom to your time in the field, you will learn about the specific ways that medicine devalues bodies of color. This involves recognizing the role of biological and cultural determinism in patient care and the harm in making certain bodies hyper-visible/invisible. You will also learn how to resist these institutional and individual reductions of humanity. To do so, you will spend time deeply listening to patients' lived experiences, entering conversations with empathy, sensitivity, and the understanding that they themselves best know the needs of their own community. You will explore how we can build sustainable medical infrastructures in the areas that need it most, providing care that is personalized, affordable, and addresses the social harms creating illness. I hope that by teaching future generations of physicians to value all bodies as equally human, we can begin to undo the social and physical harms that have created disparities in health. Thank you so much for listening to me today, and I cannot wait to begin learning right alongside you.

Author Commentary

Nisha Chandra

I wrote this essay for Professor Ruha Benjamin's class, Political Bodies: The Social Anatomy of Power & Difference, in which we explored how racism impacts the body itself and the avenues of resistance we can take to disrupt these cycles of harm. For our midterm paper, we were asked to write a speech from the perspective of the inaugural president of Princeton University Medical School on Opening Day, using two concepts from class and two current issues that exemplify those concepts.

When I sat down to consider what the president of a medical school might want to convey to an incoming class of students, I kept coming back to something Professor Benjamin had said at the beginning of the semester – that "some people have to petition to be let into the category of 'human'". I decided to frame my paper around this idea, that even though they are often unspoken, we are constantly creating and reinforcing racialized definitions of who is more valuable and who is more human. If I was speaking to medical students, I would want them to understand the ways in which these judgements continue to exist in medical practices and how we can begin to undo them.

Because mass incarceration is such a glaring example of racial dehumanization, I wanted to explore a population whose second-class treatment was linked to this system but who many incoming medical students may not have deeply considered before – formerly incarcerated people. I first researched the ways that our society judges formerly incarcerated people as "less than", which is an extensive list. Because I was speaking to students who would soon be immersed in our health care system, I focused on our failure to connect HIV+ people to medical services upon their release from prison. In trying to explain to a medical school audience what our degrading treatment of formerly incarcerated people might say about how we operate as a society, I tied this example to the concept of hypervisibility/invisibility. The label of "former prisoner", and especially "Black/brown former prisoner", acts as a permanent, hyper-visible marker that is synonymous with dangerous and undeserving. However, this community's humanity and individuality are constantly made invisible, and therefore easier for us to ignore.

In writing this speech from the perspective of the president of a medical school, I wanted to fully recognize the role that myself and the institutions I've been part of have played in erasing the humanity of marginalized patient populations. I used "we" as the subject throughout

the essay, making it clear that racism within medicine is not a passive occurrence, but rather is continuously practiced by those of us within the system, including everyone at the event. This also means that such dehumanization is something we as medical faculty and students can and must undo. To initiate this undoing, I explained the school's plan to help students understand the role of racism in creating ill health and the need to place equal value on all patients. I wanted to set a precedent on the school's Opening Day, showing everyone that Princeton University Medical School will not shy away from acknowledging medicine's neglect of people of color. But I also wanted to write a speech that would empower the students, showing them that no matter how entrenched these issues are, I have no doubt that they can all make an impact.

Editor Commentary

Alice McGuinness

Writing for not only a reader, but also a listener, is a hefty task. Nisha's paper, a speech for the opening of Princeton's medical school, deftly integrates the **conventions** of a speech with the **analysis** of an academic paper. In academic writing and beyond, **conventions** refer to the accepted standards of certain elements of a work– grammatical person, specialized language, the use of active versus passive voice. From its introductory line, Nisha's speech follows the **conventions** of an address by using the first person and second person. The paper calls the imaginary listeners to action while illustrating the urgency and implication of today's medical professionals.

Another important **convention** of a memorable speech is a unifying theme. Nisha skillfully defines the **key terms** "hyper-visible" and "invisible" and uses them to frame her speech. They are a lens through which she discusses the medical treatment of formerly incarcerated people. The use of these **key terms** also makes Nisha's **structure,** or line of reasoning, easy to follow, especially in the format of spoken word. The paper's ideas develop over its course, building the contradiction of how medical treatment simultaneously renders people both "highly visible yet highly neglected." She refers to a secondary **source** to help define her terms, and with this background in mind, transitions to a real-world demonstration.

Nisha's choice of **evidence** and skillful **analysis** are both persuasive and compelling. The paper introduces the issue of the lack of HIV treatment for formerly incarcerated people as intimately tied to its **key terms**. Nisha cites statistics that are not only cogent, but easily digestible in the form of a speech. She emphasizes that this is an issue that future medical providers may not think about. Nisha then uses this example to show how physicians can begin to disrupt these systems, establishing her expectations for the medical school. In this way, Nisha addresses the **global motive**, imploring future students to actively work against medical racism and underscoring her argument's broader implications to the reader.

Nisha's paper exemplifies the beauty of the Writing Program lexicon: even in genres that we might think of as unconventional to academic writing, there are common threads that relate elements of any composition. This shared vocabulary ensures consistency and accessibility, across topics, disciplines, and genres.

Works Cited

1. Samatar, S. Skin Feeling. *The New Inquiry* https://thenewinquiry.com/skin-feeling/ (2015).

2. Baillargeon, J. *et al.* Accessing Antiretroviral Therapy Following Release From Prison. *JAMA J. Am. Med. Assoc.* 301, 848–857 (2009).

Bios

Nisha Chandra ’21 concentrated in Molecular Biology and received a certificate in Gender and Sexuality Studies. At Princeton, she volunteered with the educational nonprofits Hatch Tutors and Matriculate and was the captain of the club squash team. She is now working as an AmeriCorps member at a community health center in the Bronx and will attend medical school later this year. She wrote this paper as a senior.

Alice McGuinness ‘24 concentrates in the History department with certificates in Gender and Sexuality Studies and South Asian Studies. In addition to her work for Tortoise, she is a Project Leader for El Centro ESL, a Peer Representative, and a UN Women Fellow. She wrote this commentary as a sophomore.