American Sociological Association

“Power, Inequality, and Resistance in Health Professions”

August 9, 2020

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American Sociological Association
Power, Inequality, and Resistance in Health Professions
Sunday, August 9, 2020

Transcribers: Holly Fox-Schauffner and Andrew Hansen

Alexandra H. Vinson: I see that we have some folks joining. We can't see your faces, but we're glad to have you with us. We'll get going in just a couple minutes.

Kelly Underman: In the meantime, this may take over the panel, but I'm going to share the info for where you can get the closed captioning.

Alexandra H. Vinson: Good morning, everyone. Let's get started. If you are just joining, you can find a link to live transcription in the chat box.

Speaker: This meeting is being recorded.

Alexandra H. Vinson: For the panelists, I invite you to leave your camera on or off as you choose when you're not presenting.

Good morning, everyone. Thank you for joining us today. My name is Alexandra Vinson. I'm at the University of Michigan. On behalf of Kelly Underman, I would like to welcome to our session Power, Inequality, and Resistance in Health Professions at our ASA 2020 Virtual Engagement event.

Kelly and I conceived the idea for this panel before COVID-19 hit the world. Our impetus for organizing this panel was our shared work on medical training and changing standards of medical work.

In recent decades, we've seen major transformations to healthcare work in the US. These industries exert considerable control over the healthcare industry. New professional mandates include inter professional collaboration, etc.

This has important implications for healthcare as well as how professions prepare the next generation of workers. Our panelists today examine healthcare work and medical knowledge from a range of perspectives of the expertise of trans medicine providers, medical students, etc.

They will help us see how Power, Inequality, and Resistance is taking shape in the healthcare professions today. By highlighting inequalities of trainees and patients, the goal is to increase understanding the mechanisms of different cultures that at different points in the training process contribute to inequalities in the healthcare work.

By looking at forms of resistance, we want to establish links between traditional work and healthcare professions. We want to focus on processes that maintain and challenge inequalities in professions.

As I mentioned earlier in my remarks, we designed this panel before COVID-19 created a global healthcare crisis accompanied by a second pandemic of moral injury, trauma and burnout for healthcare professionals.

Our discussion will incorporate a focus on how COVID-19 may affect the professions and professionals our panelists study. Each panelist will give a short presentation followed by a discussion and Q&A.

Feel free to use the chat or Q&A function to submit your questions.

Without further ado, I'd like to introduce our first panelist. Lauren Olsen focuses on processes by which institutions shape inequalities and how forms of knowledge are brought to bear on acknowledging these inequalities. She has won awards from the National Science Foundation, and others.

Thanks for being with us. Take it away.

Lauren D. Olsen: Thank you so much. This feels like such a treat to be here with all of you. Alexandra and Kelly, you organized an exciting session and pivoted so well to this format when we went virtual.

My research is on the incorporation of the social sciences and humanities into medical education. In my book based on this research, I make a case for conceptualizing curriculum as a fundamental and pragmatic expression of a profession's power.

This conceptual framework moves beyond medical doctors. It cuts across health professions as we think about how professionals learn to be equitable and humane.

I want to talk about so much. For now, I will rein in my focus on two consequences of present day medical school curriculum that emanate from a decisively neo liberal set of values like individualism and utility.

These curricular practices entail devaluations of responsibility from the structural level to the individual. I will briefly talk about both with the hope they spark intellectual joy and instigate conversation.

The first devolution of responsibility is in emotion. I show that the inclusion of elective humanities and a discourse around it center medical students as the sole proprietor of their own emotional well-being.

This happens through things like literature or book clubs, talent shows, and honestly a potpourri of optional offerings that result in what I call therapeutic curricular practices. Faculty and students alike describe these as cathartic, stress relieving, and fun.

That's great but the issue that I raise with this is that any structural causes of stress -- of which there are many -- they melt away as the student learns via the structure and content of their curriculum that they alone are responsible for their emotional health.

This reminds me of messaging of reopening plans. "Be resilient," they say.

Moreover, in what I think is a deftly neo liberal move, this individualizing process takes on heightened significance when they realize their emotional wellness becomes re-structuralized.

Patients and organizations, those are at stake if those students don't handle their own distress. That's the first devolution of responsibility with regard to the humanities.

The second devolution of responsibility falls within the realm of equity in the way in which the social sciences are taught. I also show that the inclusion of required social sciences on the causes and ramifications place marginalized medical students as personally responsible for identifying inequalities.

This is embodied in race-based medicine, implicit bias training, and the simultaneously massive and unknowable barriers to curricular change.

All of those comprise the structure and content of curriculum which effectively shifts the locus of responsibility and blame from these structural inequalities and the medical profession itself to individual doctors and students and also vague forces.

These both serve the vested interests of the medical profession as well as the corporations that benefit from a docile workforce. They're able to perform caring while retaining their power.

In effect, they create a neo liberal health professional, whose agency is structurally reproductive.

The sad thing is that patients will be the ones who suffer down the line. I could and would go on and on about it, but I'll end my opening remarks by saying that if we focus on kind of one aspect of curriculum in particular in context of the pandemic and protests, we could talk about what medical students are learning about race and racism and the way in which we're seeing power, inequality, and resistance manifest in the health professions today.

Thank you and I'm so excited to talk more.

Alexandra H. Vinson: We'll next be hearing from stef shuster, who is an assistant professor at Lyman Briggs College at Michigan State University. Medical uncertainty, tenuous evidence are the subjects of their book. They currently serve on the editorial boards of Gender & Society.

Take it away, stef.

stef m. shuster: Thank you so much. I am excited to be on this panel. I will speak quickly. For the next couple minutes, I want to present the broad strokes of the last content chapter of my book.

This chapter is about how providers of trans medicine negotiate uncertain expertise. It's built from my observations in healthcare conference and interviews with medical providers. I want to set the scene.

300 eager medical professionals attended an annual trans health conference to learn more about how to work with this growing patient group. One attendee shared, "I have so many trans people coming into my office, and I don't know what to do." The uncertainty was palpable in her voice.

The lights dimmed for the workshop. The presenter worked in trans medicine for over 20 years. The presentation was for providers who are unsure. She said we have plenty of patients who can tell us exactly what they want. But they might have other things going on in their lives they're ignoring.

This alerts what I call a Spidey sense. When something is not quite right. In order to adequately treat someone, we're treating their whole self. Some elements might be painful, but we need to see if they're identifying they need to be treated.

The failure to recognize certain things is a red flag. The physician proceeded to present several cases exemplifying those moments that triggered her Spidey sense. She offered how she made decisions and how she identified red flags that led to her conclusion that the patient was not ready to continue hormone therapy.

Part of the discomfort these people might have stems from the fact that the scientific evidence available is often data acquired from clinical trials on cis-gender patients.

Alongside this evidence, a lot of providers don't have a lot of clinical experience working with this patient group. In the book and this chapter, I examine how providers construct expertise and use different types of evidence to frame themselves as experts.

A sociology -- suggested without expertise the status of an occupation declines and the ability for a working professional to carry out their job is called into question.

There were two distinct ways providers negotiated the roles of experts in trans medicine. The self-assured experts leveraged clinical guidelines to bolster their conviction of being experts.

These providers shifted their uncertainty onto trans people who then were expected to convince providers they were certain about pursuing gender interventions.

Self-assured experts regulated patients who don't conform. Not all medical providers are playing up their expertise. Some providers were open about their lack of expertise in this somewhat new medical field.

The second group are uncertain experts. They leaned more comfortably into the uncertainty pervasive in trans medicine. They were more willing to acknowledge their uncertainty.

Uncertain experts attempted to resist the assumptions that shape expertise by redefining the basic premise upon which expertise is built.

This can be understood as a fake it until you make it strategy. Medical providers are uncomfortable with not knowing what they're doing. They describe experience in greater discomfort.

The performance of expert becomes transformed into the reality of expertise. Confronted with all of this context, lack of evidence, little experience, providers face a considerable degree of uncertainty.

Medical evidence is a social artifact but can be weaponized when used against people and their embodied experiences with gender. All right. That's all I've got for now.

Alexandra H. Vinson: Thank you so much, stef. Our next panelist is Clare Stacey. As a medical sociologist, her work focuses on end-of-life care in the United States. She's written extensively on the paid work of home care aides and completed an edited volume on paid care work in 2015 called *Caring on the Clock.*

The current research is on hospice and palliative care in the US and documents the barriers patients and providers continue to face in the pursuit of quality end-of-life care. She's in the midst of a new project on clinical empathy on medical students.

Clare L. Stacey: I'm sharing my screen. I'm hoping this will work. Does it look okay?

Alexandra H. Vinson: Looks good.

Clare L. Stacey: Thank you so much for having me on this panel. It's exciting under these weird circumstances. I'm happy to be with all of you.

I'll talk about my book project on palliative care. I want to start by letting you know my guiding research questions. I'm interested in how palliative care providers resist, reframe, and disrupt norms associated with end-of-life care.

By norms and practices, I'm talking about interventions and curative norms in American medicine. I'm interested in the constraints palliative care provider face as they change.

Lastly, which is my focus today, how do palliative care providers achieve professional legitimacy and authority when it comes to end of life care and death?

For this project, I did interviews with providers, dying patients, families, and clergy who deal with end of life.

Just very quickly, I want to make sure we know what palliative care is. It focuses on comfort and curative care at the same time. It is not hospice care. It's largely in pain and symptom management.

[Switching Transcribers]

That includes the physicians who are doing this work, as well. They see that as their charge.

They're care coordinators and help patients identify goals of care as they face serious illness.

They focus on quality of life versus quantity of life. The field is growing as seen between 2001 and 2019. There was major growth in the field.

One remaining problem with palliative care is it's often offered to patients at the end of their lives, and it's not very comprehensive.

I'm interested in palliative care providers as they seek legitimacy. They're trying to make successful claims about their relevance, unique expertise, and boundaries with respect to end-of-life care.

Rhetorical work helps establish their professional authority.

What is some of this rhetoric? I found different claims, but I'll focus on a few here.

First, as a profession, they accept death rather than deny death. They'd argue that our American medical system is built on the denial of death.

They focus on natural death, even though palliative care works largely in acute care settings. They still focus on natural death versus medicalized death.

They're clinical experts at pain management.

They focus on the patient's agency versus system or provider imperatives. They emphasize quality of life rather than quantity of life.

Interestingly, they get tied in rhetorical knots as they justify what they do to peers and the public. Cahill says that rhetorical work can lead to rhetorical knots.

[Reading quote on screen]

I wanted to share some of the rhetorical knots that they face.

Earlier, I said that they focus on natural death. They're there to help the process go along its way. However, they get stuck in rhetorical knots. Part of their job is to administer analgesics to manage pain, mood, and dyspnea.

Speaking to families and the public perception of palliative care doctors, they are perceived as hastening death through medical interventions. They see themselves as proponents of natural death, but people view them as controlling death, often to the point of killing their loved ones.

Palliative care focuses on patient autonomy and quality of life. They face this rhetorical knot because they oppose physician-assisted death as a subfield. I can go into why that's the case, and I'm writing a paper with a graduate student about that, but there's a collision between their rhetoric and public perception experiences. They're in a weird position where they're considered harbingers of death, but they're also seen as gatekeepers of death when dealing with PAD.

Why does rhetorical work matter? It increases quality-of-life, reduces healthcare costs, can increase life expectancy, etc. I would argue that patient access to this care hinges on successful claims about the specialty's worth and value, an ongoing project for this group.

Thank you.

Alexandra Vinson: Thank you, Clare.

I'd like to introduce LaTonya Trotter, a sociologist whose work explores the relationship between changes in the organization of medical work and the reproduction of racial, economic, and gender inequality. Her work has received awards from the American public Health Association, the American Sociological Association , etc. She's an assistant professor of sociology at Vanderbilt University and at The Center for Health Policy at Meharry Medical College.

LaTonya Trotter: Alright. Let me figure out how to share my screen.

Alexandra Vinson: Happy to troubleshoot.

LaTonya Trotter: It is not allowing me to do that.

I think I can either do it without slides -- it's not allowing me to share my screen.

Alexandra Vinson why don't I share your slides for you?

LaTonya Trotter: Alright. I'm excited to have been invited to this conversation partly because I found that focusing on resistance to be so intriguing. I try to understand how inequality gets reproduced, but I don't spend a lot of time meditating on resistance or change. I'm not alone in alighting this question.

Most scholars who study these discussions, me included, when we look for conflict we find it. There are doctors in conflict with nurses, physical therapists in conflict with chiropractors, etc. These are all useful excavations, but the focus on conflict shapes the tale. We're left with stories of who wins, loses, and why.

Why not explore the contours of resistance instead of the conflict? I'm going to talk about my own profession of nursing through the lens of resistance. We're frequently registered nurses who perform much of the work that was exclusively the right of physicians until the 1960s.

I'll answer two basic questions. What does resistance look like on the shop floor of healthcare? What can we learn about what is being resisted? What traditions of work to being interrogated?

In my book, *More than Medicine,* I focus on not just the nurse practitioner, but as they negotiate in the context of interdisciplinary healthcare teams, including physicians and social workers. My field work was a site where most patients were members of the Black community and living in poverty. They had both hurdles of poverty and racism.

The nurse practitioner is my empirical focus, but I used it as a diagnostic lever to understand the broader logic that structured the medical workplace. It is the universe of healthcare in miniature form. Where do we find resistance, and what can it tell us?

When I followed my group of nurse practitioners, I found something the pre-existing literature couldn't predict. The nurse practitioner was created to be a substitute for the [inaudible.] Any difference that was found between how an MP and physician practiced was treated as an error, something to be remediated on the part of the nurse practitioner.

In my observations, it was it difference of NP practice that became most salient in this organization. Most NPs I spent time performed and embedded that difference in their work. This difference manifested in the material work of helping patients navigate problems related to family instability and the bureaucracy of the healthcare organization to which they've turned to for care.

I argue that the expansion of the medical care factor was [inaudible.] The winnowing away of non-medical concerns is a hallmark of medical encounters. These nurse practitioners were in a space where usually only medical care work was performed. By performing it by medical encounters and demonstrating its necessary, I observed that the success of the teams rested on the care work sensibility of the nurse practitioners, which raises key questions about healthcare traditional hierarchy where the physicians' work is deemed most essential.

I argue that NPs make visible the hierarchy and rests on the neutralizing logic of gender differences. This logic devalues the feminized domain of care work and privileges the masculinized domain of medical work.

I want to end by turning to the social workers. I went to this site like all scholars looking for conflict, and I did focus on physicians. In this talk, we're focusing on resistance instead of conflict, so the social workers' work comes to the floor. If nurse practitioners are addressing coordination problems from the medical area, what does that leave for the social workers? Nothing.

When I interviewed the social workers, they complained that they couldn't do "real social work." I found their jobs seemed to be consisting on paperwork structured around medical concerns. Even in their defeat, one could find resistance, specifically resistance to normalizing a medicalized view of all patient problems. Underneath, there are specific complaints about working in a healthcare organization, which is that healthcare is where the money is, not social welfare.

When we follow this discourse of resistance, we see the state of affairs, which is that there's no money for public education, poverty programs, etc. or social welfare organizations of social workers. Yet, there's seemingly endless amounts of money to subsidize healthcare, but it's not funneled through community means. It's funneled through private hands to fund our healthcare system.

By following these forms of resistance, we can better understand what's being resisted, which isn't just interprofessional competition. It's resistant to the notion of capitalist extraction. Extraction is a labor of healthcare workers who do the essential but less valued work with whatever tools they have.

My work focuses on the NP, but in different locations, others would do this work. It's also resistance to the extraction of value from the bodies of the poor and Black, and brown folks. We're told these bodies have no value, but they have value to the entities that make money off of them.

My remarks for today are an exercise in looking for resistance. I'm not arguing that NPs or social workers are radicals, but in following their daily acts of resistance, we see the problems they face more clearly and the gender and racialized [inaudible] both in healthcare and outside of it. Thank you.

Alexandra Vinson: Thank you, LaTonya and to our wonderful panelists.
At this point, I'll turn it over to Kelly to lead the discussion.

Kelly Underman: Thank you to our panelists for the fascinating and fabulous talks. I will provide a couple comments to tie the presentations together before I move into the questions we have for discussion. Then, we'll wrap up the panel with audience Q&A. Use either the Q&A function of the webinar or chat panel if you have questions for the panelists.

Thank you for your thought-provoking talks. I want to frame our conversation and pose our questions.

There are several key themes in your work. I take these themes from the session and ASA 2020 and power and inequality.

We see the power of knowledge to shape the social world. From everyone's work like the weaponizing of uncertainty against marginalized patients and Claire's work on end-of-life care on emerging forms of expertise and how they receive professional legitimacy and Latonya's reframing of interprofessional resistance and the forms of expertise and knowledge of the social and medical world at work here.
On the subject of resistance, we see individualized forms. We see from Latonya's work and stef's work to trans activism.

We see this in stef's and Clare's work on the rhetorical work that redefines death and dying through this expert work and the discussion of resistance on the shop floor. How are healthcare workers bringing resistance into the medical encounter and resisting normalizing forms of medicalization over definition of patient problems.

Let me try again. Resistance to healthcare is this way of extracting money and this financialization of inequality in these ways. So, these healthcare providers are re-substantiating value of Black and Brown bodies.

Finally, we see how inequalities are upheld. We've talked about the hierarchies in the health professional field and inequalities among patients and providers and among patient groups themselves. We see this in Lauren and stef's work around curriculum and what providers learn about patients and how these are vehicles of the reproduction of inequality.

We see in Lauren's work the ways in which marginalized students are teaching about inequality. We also see in Latonya's work about nurse practitioners do work to devalue patients in the medical encounter.

[Switching transcribers]

Given these uniting themes, I want to first raise the question that is structuring a lot of the implicit discussion in our own health professions education or sub fields and also our daily lives, which is the impact of the COVID-19 pandemic.

I want to have our panelists discuss what your findings will do to the health professions, either groups or individuals, as a result of the COVID-19 pandemic.

Lauren D. Olsen: I'm happy to take a stab at it or yield the floor to someone else if they want to jump in.

I think the pandemic and racial inequities as they took their toll and then also as brutal police violence against people of color was caught on camera, I think those moments gave medical schools another public reckoning with systemic racism.

I think in that reckoning, we're seeing potentially some changes but also a lot of a resurgence of the same types of inequalities. It's a real plus/minus situation.

With regard to what my research can comment on, one of the things I've noticed is noticing things on Twitter but also things happening as institutional changes.

Leading the charge were largely students of color and faculty of color speaking up and out against their oppressive institutions. I've been astounded by the volume and detail of anti-racism production in such a short amount of time.

One thing I want to comment on is that while it might seem like students and facility are seizing upon this moment, they have been mobilizing and working for years in what is a very emotionally taxing and uncompensated shadow economy.

Just as a brief example of what's happening in terms of institutions, at University of Washington, a group of medical students were able to remove the racial adjustment for -- pause for my terrible pronunciation of terms -- the glomerular filtration rate which measures kidney function.

This was something that occurred over two years. It was just able to happen now. The students at University of Pennsylvania School of Medicine created a long list of action items, drawing on a lot of medical student activism that has gone before them.

What I want to point out is that raises the ways in which changes are happening like the removal of the GFR, which is a really big deal. It's happening based on this emotionally taxing and uncompensated labor of actors who are already marginalized.

That is one point. The other point, which we can talk about, is that I don't know if any of you saw the #medbikini Twitter thread.

It was in response to an article about unprofessional clothing. It gained a ton of pushback from the medical education community because it was this notion that women should be able to post pictures of themselves in bikinis.

But it was largely because white women were affronted that people had pushed back on this. #medbikini received so much more attention than the anti-racism protests from a month prior. Again, it's a plus/minus situation.

Clare L. Stacey: Can I jump in? With respect to COVID and palliative care providers, it's interesting because obviously death is a topic. It's something all fields are dealing with right now, especially intensivists.

We're conversing about death in a way we haven't before be of the pandemic. Talking to respondents for my book about how they're doing, it has changed how they're doing their work because they have to often do their care outside of the ICU rooms.

They are frustrated they cannot do what they were trained to do, to be at the bedside and help people through the end of life.

It's also interesting because other providers are being forced into managing death in ways they haven't before. They are drawing on the skills of palliative care to help them. It could help to legitimate the sub field.

At the same time, could anyone do palliative care? If that is so, it undermines their claim to expertise. You have many people doing primary palliative care. And the tertiary specialists want to establish their expertise but they can't always be in the room.

I don't know what will happen, but most feel it's a good thing to have conversations about end of life. This brings into relief how we have not done well by our patients at end of life.

Kelly Underman: stef or LaTonya?

LaTonya Trotter: When thinking about Clare's observations, think about the pandemic as a moment and thinking about what kinds of professional actors are making sense of this. That is the entire story of the nurse practitioner.

The nurse practitioner was created to essentially deal with our observation that we didn't have enough physicians dealing with primary care, particularly in rural areas and for folks without insurance. A door was opened in these marginal locations that provided the data to begin legitimizing the practice.

That is happening with COVID. Where NPs have independent or autonomous practice is a state by state and organization by organization endeavor.

Often you find in these moments of chaos, the spaces where NPs work will be opened more broadly. We've seen that after the first month and a half of COVID. In states with non-autonomous practice rights for NPs they suddenly got rights in those states.

States made cases that NPs couldn't provide service autonomously, but then the door was opened. Other people will also make use of the open doors. It will be interesting to see what happens in this moment of disaster and chaos and the kinds of impacts that has on a variety of healthcare providers.

Nurse practitioners are part of the larger nursing profession. It's been interesting to watch the COVID coverage that many of the people that we've seen on media images, embodying vulnerability as a healthcare worker are often the nurses. They are the ones we've seen wearing trash bags because they don't have PPE.

It's interesting to think how invisible labor that certain providers do often turns into invisible risk in these moments. It has a way of then potentially radicalizing.

If people are doing invisible work and maybe not being compensated or recognized for it, they might find ways of thinking about the value of their work. But when this turns into invisible risk, there is an opportunity for radicalization of nursing labor in thinking about their work.

And other healthcare providers as well. We're seeing that invisible risk happening among other providers as well. Thinking about how that relates to the construction of a political identity where maybe one didn't exist prior to the pandemic.

Kelly Underman: Thank you. stef, did you want to respond? Then I'll see if anyone wants to make additional comments.

stef m. shuster: Sure. I'll add a couple of different ways of thinking.

A lot of my work is on how do providers deal with uncertainty. I feel like I'm becoming weirder the longer we're in isolation. Let me focus my thoughts.

My work speaks back to broader ideas in sociology about uncertainty. I'm more interested in the strategies that providers use to negotiate and manage it and quell it.

We see that playing out in healthcare fields within COVID-19. If we take a case like trans medicine, which a lot of providers don't know what they're doing, they still look to familiar tools in other areas of practice to help make sense of what they should be doing or what they feel like they should be doing.

I think we see that, too. Then thinking about what Clare was suggesting, if it's like this toolkit is being drawn on but they don't have access to specialized training with which to use those tools, it's not only about delegitimizing other areas of specialization but also the mis application of ways of thinking and doing that we see playing out.

The other point to think through with COVID-19 and using the case of trans medicine to reflect on broader concerns in sociology, in some ways I think the COVID-19 crisis it has become a trojan horse for pushing through policy changes that otherwise would not have gone through.

Section 15-57 of the Affordable Care Act and the redefinition of sex and gender to erase out of existence trans protection from nondiscrimination is one small example where stakeholders used this as a moment to compel their political agenda.

I'll stop there.

Kelly Underman: I invite our panelists to speak to each other's comments. I know we're all navigating this uncertainty. The social norms are in question, but I invite you to speak back to each other or comment on each other's comments. If not, I'll ask another question.

Let me ask another question. Thank you. That was really fascinating. It's interesting you've identified these ways in which the intended and unintended consequences of a moment of crisis like COVID-19, you have expansions and resistance. Then we see political groups using the moment of crisis to shock doctrine us a bit in terms of these policy implications.

My next question is about the role of the healthcare professional groups that you studied in upholding or undermining social inequalities. Can you speak to how the professional groups both uphold and undermine social inequality in their work.

I also want you to think about the notion of complicity and inequality and how the structures that health professionals work in require them in some ways to be complicit in systems of inequality where other group membership may actively resist.

Lauren D. Olsen: I keep going first. I'm always eager to talk about this.

Medical professions uphold inequality at every step of the process from admissions to training to practice. The shared amount of time and resources to get into medical school is a massive barrier. This is something that many talk about. Alexandra is working on a project on this as well.

We can connect this to the last question. As opposed to law professions, the MCAT was one of the only professional tests that was required to be taken in person in the pandemic. There have been COVID outbreaks from students sitting in for this exam.

That is so cognitively dissonant. There are so many issues with the MCAT just holding the exam during the pandemic to begin with in terms of who can access that exam during a time like this.

That's just with admissions. My whole work is based on training and the way in which that produces inequalities as I said in my opening remarks.

This is something about my co-panelists' presentations about how healthcare professionals are practicing. And what is the more narrowly defined role of the medical professional to take what LaTonya was saying of the winnowing of what one does?

That can be expansive for nurse practitioners. Palliative care professionals have to engage in this legitimacy work. And then stef was talking about the fake it 'til you make it. It's this fascinating juxtaposition of this need for control when the circumstances are beyond the medical professional's control.

In performing that expertise or doing that narrowly defined task or in having to engage in this rhetorical work, these medical professionals as they're practicing are really reproducing inequalities for the healthcare organizations they work for.

Kelly Underman: stef, Clare?

Clare L. Stacey: In terms of inequality and palliative care, on one hand, palliative care specialists are disrupting the distinction between cognitive work and competency and affective work.

The fact they treat patients holistically, the physicians see themselves treating the spiritual needs of patients is quite radical. I think that's an interesting connection to LaTonya's work on how care work becomes this tool of inequality. It can also be used to disrupt inequality.

In that sense, there is a radicalness to palliative care. However, there is a huge blind spot around race in palliative care. It reflects the blind spot in medicine more generally.

Palliative and hospice care are underutilized by people of color. It's a question that plagues the field.

[Switching Transcribers]

They're not very reflective about that and have a long way to go. I worked with African American clergy and their perceptions of palliative care and hospice. The doctors believe it's about education, if people of color understood what palliative care was, we'd be fine.

From the focus groups, we're getting that this is about racism and experiences with racism. One respondent said that white people spend most of their existence trying to get rid of us. At the end of life, they're saying they'll help, and we're supposed to believe them? There are reasons why people are preventing these services that the subfield hasn't grappled with at all.
LaTonya Trotter: I'll answer from the case of the nurse practitioner. It's interesting or difficult to come to a particular conclusion about the role of the nurse practitioner.

One thing I found is that the performance of care work from the context of the healthcare encounter allowed patients to get many of their needs met when meeting with the nurse practitioner that they wouldn't have gotten met on average in meeting with a physician because the NPs had a more expansive view of what medical work was. However, they still had medical tools. Prior to my field work, I spent a year sitting in on nurse practitioner classes. It's probably similar to the literature on medical school. They have courses on professional development and holistic care, but the classes are about medical knowledge, the process of diagnosis, and thinking about the appropriate interventions.

The tools that they had were still individualistic tools. In the conversation of misrecognition is that there are ways in which you're filling the holes and allowing organizations to treat their "difficult patients" and how they're covering over systematic problems. They're making things visible for the healthcare encounter. In their own way, they're also re-inscribing medical problems that can be solved with a discrete set of tools, which looks different than what social workers may be empowered to do now. If you think of the history of social work, it came out of social movement, living and working with communities, and coming up with problems that might ameliorate social concerns but also fighting in the political realm. There's something uncomfortable about the relationship of the nurse practitioner in continuing to prop up the notion that these problems can be solved within healthcare encounter and de-politicizing them and thinking about what if we thought about these as political problems instead of educational or expertise problems?

stef m. shuster: With the distinctions that I made between self-assured and uncertain experts, it's not one is good and one is bad. It's about negotiating their expertise.

The uncertain experts are the group of providers who are more willing to acknowledge that they're not experts, that they feel frustrated by the system of healthcare in which they work whether it's because they describe needing more time to work with certain populations that have a particular set of vulnerabilities in healthcare. They also get frustrated with their colleagues who exhibit explicit transphobia.

Kelly was asking her question and thinking about the role of health providers and upholding and potentially undermining inequalities. I think about the uncertain experts in my study and how they're actively trying to resist and undermine the ideas of expertise on one hand and trying to undercut the gatekeeping that exists in trans medicine, the rigid ways of understanding trans experience as from one to the other (binary gender).

They're trying to expand the boundaries of medical expertise and how the medical field has treated gender. They still exist in a healthcare structure that doesn't reward that way of thinking about the provision of health and development of those close relationships with patients.

For those providers, they still experience resistance in the system to the work that they're trying to do to undermine it in the first place.

I'm not suggesting that there's no room for potential change. Clearly that's not accurate. I think that for every moment that they're instituting potential structural change, they're met from different angles of health administration, colleagues, the diagnostic process, and all of it pushing back against the changes that they seek to create.

Kelly Underman: any responses to one another from our panelists to each other? If not, I have a question.

This dovetails nicely into the next question.

Thinking about the states of resistance for healthcare professions, either in organized forms of resistance, social movement types of arenas, or in everyday personal forms of resistance, what do healthcare professionals stand to lose and gain when they mobilize against the structures in which they work?

stef m. shuster: I'll change up the order.

[Laughing]

For the providers I spoke with, one of their biggest concerns was that they're going to lose their medical licenses because they're working in off-script hormone therapies and surgical interventions. They're worried about losing other patients who don't feel comfortable in the gynecologist waiting room with people who present as men in those rooms, too.

Their concerns may be unfounded, but they still feel real to them.

I've been thinking about something a lot, not only in trans medicine, but in COVID-19 world in general, is the burnout and having to manage so many different facets of their work lives and patients' lives and families and the cascading that's happening up and down the streams of healthcare.

LaTonya Trotter: I'll talk about nurse practitioners. It's interesting studying what I call a profession in flux. I have as many questions and almost no predictions.

To some extent, nurse practitioners are less powerful than the physicians at the top of the food chain, they're still higher than others on the chain, which gives them a particular stake in the status quo.

One thing I immediately found, and you don't have to find much time with nurses to see that they're revolutionary actors -- the standard is taken for granted. They work and socialize to accept that hierarchy on face value.

There are ways in which, in questioning that hierarchy, they have a lot to lose. They have some things to gain, but they have a lot to lose in terms of thinking about what happens if other kinds of providers gain access to doing the kinds of work that NPs have a lock on doing right now?

The other thing that I think is interesting is that when I was giving my remarks, I noted that nurse practitioners are nurses. That's kind of an historical fact. They first began training NPs out of their pre-existing pool of nurses. That's still the case the way it looks, but it's becoming less of a biographical fact because a lot of programs train nurse practitioners. They treat the RN portion as a quick thing to get over, and they jump into the real training of becoming a nurse practitioner.

That matters because the radical organizing and clout of nursing comes from the broader pool of nurses. There are over 3 million practicing registered nurses, a huge body of people for organizing and making change. The numbers move around, but there's no more than 200,000 nurse practitioners. There is something interesting to think about what might happen if the NP becomes a more rarefied group, separated from the larger population of nurses, and thinking that they may have even more to lose, or they might conceptualize their position as having even more of a stake.

Again, I don't want anybody listening to my talk. You can listen to my words and overstate the revolutionary potential of the nurse practitioner. I think there are pushes and pulls in a variety of locations as they become more entrenched in the system. They can become more invested in the system. It may become more profitable for them to become a rarefied group of people rather than with the nurses working in the trenches.

Lauren D. Olsen: The stakes for resistance for medical students, from my research, they range. Some students, particularly students of color who have advocated for changing the way in which race is taught in the formal curriculum, like in various lectures to the way it's facilitated in small groups -- the stakes there can be extreme like being sanctioned, noted in their file, that they're doing activism, which has a negative slant.

The stakes are also in terms of time that it takes to engage in this type of work, pushing for circular change. That's time not spent studying for incredibly important exams that allow the medical students to get placed in residencies that are more competitive.

There are also emotional and social stakes. Medical students get excluded from other types of social gatherings because even though they're talking about professional norms and what they should be learning, it's labelled as political, going back to what LaTonya said. It's something that gets derided as such.

Those are the central stakes for the students. Because medicine is so hierarchical, this is where we see this happening in another way with faculty. If they're resisting things at the circular level, their pushback is met with silence and not implemented, or they have control over their one small group that they can do something with. Or, they're given this one time slot that's right before or after students leave for a break, and they're given half a day to do it. There are other ways in which their resistance is marginalized and made to be a non-factor.

Kelly Underman: Clare, did you want to weigh in?

Clare Stacey: I don't have a lot to add. stef said it well about burnout. That's what I've seen in palliative care providers. You'd think burnout and palliative care and tied to the emotional exhaustion of caring for people at end-of-life. I've heard it's not that. It's the lack of structural support for their work. The burnout comes from building a 10 bed palliative care unit, and your hospital is sold to a Catholic hospital. Suddenly, you have no palliative care unit.

Going back to what Lauren said at the beginning is about these structural constraints on people that produce the burnout and inability to keep going.

I can't emphasize enough about the burnout I heard from providers who are trying to do things differently.

Kelly Underman: Thank you so much. This is such a fascinating conversation. I love the overlaps that we're uncovering and ways in which your work speaks to one another and answers important questions about healthcare structures.

I want to turn it over now. We have 24 minutes left. I want to open it up to audience questions.

As a reminder, if you're attending, you can use the chat function to pose questions. You can also use the Q&A function to pose questions.

I'm turning it over now because we have a Q&A question that aligns with a question I wanted to ask next. This is a nice synthesis.

The question in chat is:

"This moment of crisis has shed a light on the entrenched belief of people as commodity. All institutions, including the health institution, have social structures where money is concentrated in a few hands. How can the medical community change the concept of humans as tools for increased profit to humans having a medical right?"

LaTonya Trotter: I can get things started.
From my perspective, the view is simple, which is there's no provider-based solution or expertise-based solution. It's a political solution.

That's one thing that's been the most interesting in watching the pandemic. It's watching healthcare providers enter the political space. They're doing it as advocates for patients, but they're doing that in political space.

I don't think there's another way of doing it. If you're going to transform a structure, you can't do that by tweaking the structure. I think about the parallels for those working in academia, both panelists and attendees -- we're in a moment right now where our educational institutions are doing something similar. They're making an economic calculation of who to bring back, in person or not, etc.

As faculty on the inside, there are limitations for how much work we can do within the faculty committee, sending the email to the provost, or answering survey questions. The only way to get institutions to reorient their values is through protest. You can't do it on a Council.

I spoke first because my answer is simple.

That's important, too, because when we have professional identities, we think part of what it means to be professional is to be neutral. I think we sometimes misunderstand that neutrality is a political position. When healthcare providers maintain their neutrality, they're providing the best care to people, that that's also a political stance. I think in reorienting themselves and thinking about other kinds of political stances they could make is the only way to do that. If I put my own political ideas out there, I think there's no way the market can fix this.

The market creates commodities. That's the only thing it does. It creates and assigns values to commodities. The only way to make that not happen is remove healthcare from that particular space.

Lauren D. Olsen: I completely agree with LaTonya. I like to think that there's hope in that, through some curricular change so doctors can unlearn some things they've learned and realize what's at stake and what they would need to do. Maybe that's too idealistic for me.

The curricular changes often feel like band-aids on massive wounds that are just bleeding out.

[Switching transcribers]

Kelly Underman: Clare?

Clare L. Stacey: I don't have anything to add.

Kelly Underman: stef?

stef m. shuster: I'm still thinking about it. Rather than everyone sitting and watching me think, it's okay to move to another question. [Laughter]

Alexandra H. Vinson: Let's look at the audience Q&A. I have a question about the field of public health, particularly in light of the current pandemic. Your insightful presentations and comments highlight how medical providers relate to medical facilities and infrastructure. How do medical care providers relate to public health? Has this field become a profession of its own? Has the rhetorical frame led to suppressed talk of inequalities? Who would like to kick off?

LaTonya Trotter: You've got me all riled up! [Laughter]

It does connect in some ways to my previous set of comments. Public health is its own professional category. There are public health experts and practitioners who think of their work as facilitating the public's health as opposed to individual health.

We've seen systematic defunding of public health. One of my big observations is that there is plenty of money. We have to watch that it's being funneled to some places versus others. We've seen money funneled to privatized healthcare and not following to other places.

Just as you've seen the devaluation of social welfare programs, it's also public health because there is no money to be made from it. There are no private hands through which it can be funneled.

If we removed the question of health from a sphere of commodification, there will be a reopening to reassess where the locations are where we can profitably use the money from the citizenry because that's what public money is. It's not the government's money.

Thinking about where our collective money should be going and thinking about the ways in which we could revitalize public health. Historically, that's been the thing that has moved us forward. We often think it's about the medical interventions, but it's really clean water, air, vaccinations, etc., that raises the collective health.

If we could re-prioritize that, I think we will see a radical re-shifting in the distribution of health in the country.

Clare L. Stacey: There are also some interesting cases of when medical professionals intersect with public health and work together.

In palliative care, there is a movement to frame the American way of death as a public health crisis. Some people in palliative care are not interested in that. But there are active collaborations between palliative care associations and a national project to have families sit down and talk about end-of-life wishes. When they end up in situations to make decisions, they're more informed.

The American Association of Hospice and Palliative Medicine has helped push that as a public health approach. It's outside my expertise where that has happened elsewhere, but there are interesting cases where medical professionals work alongside public health.

Lauren D. Olsen: I will give a historical wrinkle to the question of how public health and medicine have been interacting. In the 1920s, there were a lot of deliberate conversations about how public health and medical education should or should not be done together.

There were decisions made to keep them actively divorced. That's one thing.

The other thing is to think about how public health knowledge has changed over time. What comes to mind particularly is in the 1950s and '60s, we see a behaviorist turn with a lot of social scientific knowledge. Our entire field is complicit in this.

A lot of public health knowledge that was being produced starting at this time started moving away from thinking about systems. There were a couple decades of production of knowledge around thinking about behavioral level issues.

It really wasn't until Kamara Jones was the chair of the Public Health Association. Maybe that was in 2015. She had to actively call racism a public health issue.

There were several years where a lot of the public health knowledge being produced was very individualizing, which dovetailed with those biomedical orientations. That is one thing that has also happened with welfare programming, too.

Thinking not of poverty as a social problem that stems from capitalism but thinking of it as this means tested individual level type of phenomenon.

Alexandra H. Vinson: Thank you. Would anyone like to respond back to that? stef, would you like to weigh in?

stef m. shuster: I've been thinking a lot because of the particular place where I work, which is a STEM residential college. I work with a lot of pre-medical students.

One thing in my classes we talk about is the responsibility of the scientific and medical community to the public and vice versa. I wish I had taught that class last semester.

What caught me off guard in watching news reporting when COVID-19 was playing out in the United States is that suddenly these journalists were like, "There's racism in the healthcare system! This is a breaking story!"

I was having a lot of mixed feelings. On one hand, I want the public to engage in this conversation. Yet I was thinking about how public health and the public don't always speak to each other. It's this novel insight that systematic racism continues in healthcare.

I don't know if that necessarily answers the question, but it is worth thinking through how public is public health. What does that look like? How does that change based on whatever is happening in our given social environment?

Alexandra H. Vinson: Thank you. Fascinating responses to a really important issue of who is participating in public health and who it is for.

We have another question that will take us down a different path. With both medical care and medical education occurring virtually during the pandemic such telemedicine and online learning, should we resist these powers in medicine or are we hopeful of new forms of resistance emerging? Is there already evidence of new forms of resistance? Lauren?

Lauren D. Olsen: LaTonya said earlier about the ways in which people being placed in more positions of risk or the way in which things are disrupted can cause potential for resistance.

I do think there are spaces. The telemedicine thing is really interesting. I do think that could expand the ways in which coverage could be given to more people. But it could also be premised on other inequalities such as Internet access.

It also introduces this whole new thing, which I'm very acutely nervous about with teaching, which is these technologies and what they will be used for. How do you have a safe conversation with your provider that's recorded or potentially recorded?

I think there are opportunities for there to be positive change, but there are also opportunities for new consequences we haven't thought of.

Alexandra H. Vinson: Thank you. stef, would you like to join?

stef m. shuster: Sure. One thing I've been thinking about recently is when we think of progress and how it's often cast as this linear progression. But we actually see it's a series of moving forward and sideways and backwards and in different directions.

Maybe this echoes what Lauren said. Maybe I'll reframe the question a bit. Instead of thinking about virtual spaces for healthcare delivery as progress or not progress, it just raises new questions and potential spillover effects of pockets of inequality and also potential for change.

That's all.

LaTonya Trotter: I can't really comment on medical education or physician education. But it's interesting to note that a lot of nurse practitioner training programs have already moved online.

It's hard to define a shortage, but more people want to get into nurse practitioner programs than there are actually nurse practitioner granting institutions. Often these schools leverage online education. They've been doing this for a very long time.

It's not clear to me that that has impacted anything more or less revolutionary in terms of thinking of how NPs practice. One of my observations and thinking about education versus the shop floor is that I honestly think it's the shop floor that ends up being much more formative in terms of thinking about how people actually practice.

Maybe I'm jaundiced. When I think of them adding more stuff to the MCAT, it's like, "Boy, let's add more classes premed students have to have and make them work even harder," thinking that will change the fundamental nature of institutions.

Physicians only have 6 minutes to spend with patients. It's just a factor. We have to see what comes of it and how it happens.

Alexandra H. Vinson: Clare, any thoughts?

Clare L. Stacey: It's an interesting empirical question. I can't speak to it. I finished 30 interviews on Zoom with medical students. They love talking to me on Zoom.

For this generation of medical students going through this experience, they may be comfortable with this technology. It's probably a train that has left the station.

But as far as the implications, I don't know. There is really interesting work to be done on this.

Alexandra H. Vinson: Thank you. Maybe I'll take my co-organizer's prerogative to add that I am beginning to look at medical practice by medical students and by practitioners and finding initially that the telemedicine amongst people who have reliable access and are comfortable using the portal modalities destabilizes the interaction in some way and makes it more casual.

I've been hearing about people taking their telemedicine appointments from under the covers of their bed. It's a different flavor in some of the encounters. I'm excited to look more into it.

Kelly Underman: In light of the structures of time, we have time for one last question. This is coming from the chat. From the healthcare workers I've spoken to during the pandemic, I've heard extensive critiques of administrators of hospitals being blamed for lack of PPE and how this puts others in jeopardy.

In blaming the administrators, doctors may be shifting the responsibility for inequalities. How would you put administrators into the larger conversation? Any thoughts? Maybe this links up into our question about capitalism and for-profit healthcare in some ways.

LaTonya Trotter: There might be something to the idea of placing the blame on another set of actors. I think administrators would point the blame to the incentive structure in which they are working.

That is another way of saying if you fired all of the administrators and hired new ones, you would have the same result. There is something about the position in which they sit as opposed to the individual people inhabiting those moments.

It's probably politically useful to shine a light on administrators. That is a way of taking the focus from outside the exam room and it is at least higher up in the structural chain of influence. There can be something useful about that politically.

But analytically speaking, I think that really keeps pointing us up to the larger incentive structure in which the decisions that people make within that incentive structure seem maybe not great but could be the best decisions in that system of constraint. We have to continue having conversations about reshaping those constraints.

[Switching Transcribers]

Lauren D. Olsen: I can't comment from my research, but I read *Healthcare off the Books* where healthcare providers are working in very low resourced hospitals. Admin are constantly constraining what they can do. They develop informal strategies that might be described as illegal or against what their professional code of conduct is or against what the hospital allows them to do, everything from keeping a stockpile of medications to give patients to giving them money to fill things to writing "blank scripts." Patients can write their name and get that medicine. They engage in informal strategies to subvert this structure.

stef m. shuster: We're really close. I guess we're out of time. I'll say something quick.

Lauren was thinking about how providers on the ground can engage in strategic workarounds. Maybe the way we often think through relationships between the individual and structure that we see a lot -- in my own silence in my head, I'm thinking about the role of administrators. Maybe that is another area that we ought to look more closely at.

We've known that hospital administration is ballooning. The number of units and micro units within hospital administration are ballooning. Maybe they face a particular set of strategies to work on. That's something to think about moving forward.

Alexandra Vinson: Thank you. Clare, would you share any last words?

Clare Stacey: I'm fine. Thank you.

Alexandra Vinson: Wonderful. With that, I'll close our panel. Thank you for a wonderful discussion and bringing tailored presentations for our discussion today. You made it a valuable opportunity to connect and synthesize work across multiple perspectives in the health professions, which isn't always something that we get to do when we come together. So, thank you very much.

Thank you to Kelly Underman, my co-organizer. We'll wish you well.

If you'd like to continue the conversation, we'll be on Twitter.

[Panelists signing off]