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**Challenges and a super power: how medical students understand and would improve
health in neoliberal times**

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Abstract

Even though much research underscores the significance of social inequalities in illness, the health consequences of inequity tend to occupy a marginal position in medical education. Drawing on qualitative interviews with third and fourth year medical students, this paper explores how future doctors understand and would improve health in the United States. While participants with background in public health and policy understand that social inequalities shape health and access to care, many others emphasize individual behavior and motivation as central to ill health. Emphasizing health behavior aligns with biomedical understandings of disease, but also captures the hold of neoliberal values over ideas of health and illness. Focus on health behavior also provides a means of ignoring the racist roots of enduring inequity that underlies much ill health. Making inequity more visible in medical education and practice necessitates recognizing the sway of neoliberal thought over common-sense ideas of health and illness.

Keywords

sociology, health, medicine, neoliberalism, inequality, race, medical education, social determinants of health

Introduction

Research has, overwhelmingly, linked poor health with social and economic disadvantage. Inequality, as Miech et al. (2011:913) note, constitutes ‘a major cause of death in the United States’. Wealth, and higher levels of education that wealth often facilitates, entwine with better health outcomes, with unhealthy living and working conditions contributing to striking differences in health status between the wealthy and educated, and those who are less privileged (Bambra, 2016; Braveman et al., 2010; Braveman et al., 2011; Pickett and Wilkinson, 2015; Wilkinson and Pickett, 2010; Woolf and Braveman, 2011). Addressing inequality would, furthermore, improve health. As Woolf and Braveman (2011:1853-4) explain through comparing the health enhancing potential of education versus medical progress: ‘giving all US adults the mortality rate of adults with some college education would save seven lives for every life saved by biomedical advances’ (see also Woolf et al., 2007).

While medical school curricula in the United States tend to address health disparities in some form, often through outlining higher rates of disease among minorities, research indicates that ‘the curriculum rarely focuses on the forces – from individual biases and stereotypes to the myriad societal, cultural, legal, political, and medical structures – that impact health outcomes’ (Wear et al., 2017:313; Braun, 2017; Brooks, 2015; Merritt and Rougas, 2018; Metzl and Hansen, 2014; Olsen, 2019; Tsai et al., 2016). While students may be offered electives on health inequalities, ‘medical faculty rarely probe the political economy of race and racism, the cultural history of medicine, and the root causes of poor health’ (Braun, 2017:248; see also Olsen, 2019). Health disparities are often understood to rest on the more ‘downstream’ determinants of health, including health-related knowledge, attitudes and behaviors (Braveman et al., 2011:383).

With a vision focusing on more ‘upstream’ factors impacting health, Wilkinson and Pickett (2010) place *inequalities* at the heart of disparities in health (see also Bambra, 2016; Miech et al., 2011; Pickett and Wilkinson, 2015). Importantly, in the United States inequality is deeply racialized: ‘[t]oday, unjustly inherited white resources and continuing discrimination restrict access of many Americans of color to better jobs, quality education, healthy neighborhoods, quality health care, and political power’ (Feagin and Bennefield, 2014:8). Racism has fundamentally shaped the economic resources available to different

groups of people and, for example in 2016, the median wealth of white households was \$171,000, while the median wealth of Black households was \$17,100, with and Hispanic households \$20,600 (Kochhar and Cilluffo, 2017). These disparities rest on a history of racial discrimination that continues to play a central role in society, and in health and illness (Chae et al., 2011; Feagin and Bennefield, 2014; Phelan and Link, 2015). As a result of vast disparities in socioeconomic status, but also because of the enduring impact of racism (Phelan and Link, 2015:325), rates of disability, morbidity and mortality related to almost all diseases are higher among Black than white Americans (Murphy et al., 2013; Read and Gorman, 2006). Importantly, approaching disparities in health through a focus on higher rates of disease among minorities, as is common in medical school curricula (Braun, 2017; Merritt and Rougas, 2018; Tsai et al., 2016; Wear et al., 2017), risks attributing existing disparities in health to presumed inherent racial differences rather than to the enduring impact of social and economic inequity and injustice (Braun, 2017; Feagin and Bennefield, 2014; Metzl and Hansen, 2014; Tsai et al., 2016). Furthermore, research indicates that especially white medical students continue to hold beliefs about inherent biological differences between races that foster uneven access to treatment and disadvantage Black patients (Hoffman et al, 2016).

In the face of the wealth of research underscoring the importance of inequity in health and

illness, why does a focus on individual bodies and health behavior retain prominence in medicine and in medical education? Limited attention given to social causes of ill health resonates with a central biomedical tenet that disease is ‘an intra-corporal lesion or abnormality’ (Armstrong, 2011:802) ‘located within the anatomical frame’ (Nettleton, 2006:1168). While different medical practitioners and specialties can hold widely differing views on the causes of ill health (Berg and Mol, 1998), within the biomedical framework, curing disease tends to be understood as fixing individual bodies rather than addressing and ameliorating complex social conditions and injustice that underlie ill health.

Metzl and Hansen (2014) attribute the lack of focus on social issues and inequalities to the enormity of challenges inhering in addressing the social causes of ill health. They argue that ‘[v]ast wealth disparities undoubtedly foment feelings of learned helplessness, as gaps between rich and poor or health and illness become mortared into mortal logics of common sense’ (Metzl and Hansen, 2014:128). Even more importantly, however, ‘when structural violence – systemic institutional stigmatization and marginalization – is at issue, *we train doctors to listen to individualized stories, not to structural ones*’ (Metzl and Hansen, 2014:128 emphasis added).

This paper explores ideological factors underlying the limited attention afforded to the social causes of ill health in medical education. Following Fields (1990), I understand ideology as a subtle common sense that shapes and suffuses everyday life, but also justifies social arrangements. I draw on thematic analysis and adopt a constructionist approach ‘which examines the ways in which events, realities, meanings, experiences and so on are the effects of a range of discourses operating within society.’ (Braun and Clarke, 2006:81; Clarke and Braun 2018). In my argument, a key discourse shaping ideas of health and illness is that of neoliberalism. This paper explores how neoliberal values seep into the perceptions of health and illness among medical students. I argue that the allure of the more ‘downstream’ determinants of health lies in their alignment with neoliberal ideas of health, selfhood and the state. Approaches placing inequality at the center of disparities in health are rendered marginal not only because they misalign with biomedical understandings of disease but because they run counter to the ‘neoliberal reason’ (Brown, 2015) infusing self-perceptions and policy, as well as understandings of health and illness. Neoliberal values shaping ideas of health and illness ‘cohere around a valuing of the self-regulating, self-surveillant and autonomous self’ (Peacock et al., 2014:175; Fine and Saad-Filho, 2017). Embedded in the ideal of the self-responsible health citizen lies also a reworking of the responsibilities and the role of the state (Brown, 2015; Peck, 2010; Rose, 1999; Türken et al., 2016). A neoliberal emphasis on self-responsibility readily places

blame for ill health on individual patients, sidestepping the significance of social conditions. Simultaneously, solutions to ill health come to center on individuals *investing* in health and healthier behaviors. Importantly, in a context where disparities in health capture on-going discrimination that is based on ‘society’s white-racist roots and contemporary structural-racist realities’ (Feagin and Bennefield, 2014:7), neoliberal discourse also offers a means ‘of exporting the blame from the decisions of dominant groups onto the state and onto poor people’ (Apple, 2000:60; Saull, 2018).

That ‘neoliberal reason’ (Brown, 2015) should permeate medical education is not surprising. Unhealthy choices are readily enshrined as a primary cause of illness in the views of not only individual medical students, but in society and culture more broadly. The erasing of structural factors in health and illness that neoliberal values reinforce is, however, especially important in areas like medicine. As ‘the language of consciousness that suits the particular way in which people deal with their fellows’ (Fields, 1990:110), ideology can subtly shape the ways in which medicine is practiced and doctors approach their patients. Neoliberal ideology not only makes it easier to sidestep complex causes of illness, it also enables placing blame on those whose lives are most restricted. While medicine alone cannot produce a more equitable and healthy world, leaving the social causes of ill health to the margins of medicine risks normalizing and reinforcing an

unequal status quo. This paper makes a case for recognizing the impact of neoliberal thought on ideas of health and illness. Overlooking the influence of neoliberal values on how health is perceived limits possibilities for not only giving the health impact of inequity a more significant position in medical education, but also improving medical practice and, ultimately, health.

Methods

Study design

This paper draws on a longitudinal qualitative study exploring medical students' experiences of clinical training in the United States. The study sought to tease out the lived experience of clinical training. The focus was on how medical students conceptualize training, but also on the experiences and encounters that students found meaningful. Participants were seen as 'emplaced' within training environments that were, in turn, shaped 'through the convergence of an intensity of things in process, emotions, sensations, persons and narratives.' (Pink, 2011:350, 2015). As such, participants' experiences within clinical placements were seen as constituted in relation to contact with medical teams and hierarchies, patients and patients' bodies, the intense academic demands associated with medical training, and the marginal position ascribed to feeling, particularly feelings of distress, in medicine and in medical education. The study considered participants' views

of, for example, challenges in improving health as subjective, retrospective and partial, but also as sociologically interesting and meaningful (Luker, 2008).

The study focused on clinical rotations because of their central role in ‘professional socialization and moral enculturation whereby the profession transmits normative expectations for behavior and emotions to its novices’ (Jaye et al., 2010:60). The researcher was familiar with the substantial literature on health inequalities, including the reproduction of inequity in medical encounters (Lutfey et al, 2008; Phelan and Link, 2015; Spencer and Grace, 2016; van Ryn et al., 2011). That health systems can perpetuate inequity was understood as shaping the environments that students train in from the outset of the study. Within this context, conducting research with third and fourth year medical students, almost 67% of who were white and all of who were from upper or upper-middle class backgrounds, necessitated carefully formulating the interview questions focusing on inequity. Questions were phrased so that the researcher would not express direct and, more importantly, leading critique of the system that the participants were embedded in. Questions were carefully formulated also because research (Bonilla-Silva, 2015; DiAngelo, 2011) shows that especially whites can find noticing as well as discussing racial inequity and privilege challenging. Participants were asked to talk about any racism that they may have noticed during rotations. However, rather than direct questions on topics

like racism or the reproduction of inequality – questions that risked being confrontational and unproductive – participants were asked about the biggest challenges in improving health and, furthermore, how they would improve health should they have limitless resources or even a super power. This article focuses primarily on responses generated via two interview questions. First, participants were asked what they found *the biggest challenge in improving the health of the US population?* Second, participants were asked to outline what they would do *to improve the health of the US population if they had limitless power and resources*, or even a super power.

Only three participants directly connected ill health with social and economic inequality. Silences surrounding the health impact of inequity underlie this paper. Rather than blaming individual medical students for lack of insight, however, this paper turns broader cultural reasons underlying the lack of attention given to the health impact of inequity. While neoliberalism was not a concern that the study explored, theoretical accounts of neoliberalism emerged as a framework through which it was possible to make sense of the data, after data collection had concluded. In connecting individual perceptions with broader cultural values, this paper engages with the key sociological task of linking individual experience with broader social forces and values.

Participants were recruited via a combination of theoretical and snowball sampling (Luker, 2008). Five students who were about to start year three of medical school responded to a call for participants posted on a medical student mailing list. Four of these students forwarded a recruitment message and an informed consent letter to their peers.

Consequently, further 22 students contacted the researcher directly. Apart from two interviews that had to be cut short due to technical difficulties and limitations to participant availability, interviews lasted 60-90 minutes. The interviews were conducted using Skype and took place in a private setting, such as an apartment or a hospital meeting room where the participant was alone. A total of 72 qualitative in-depth interviews were conducted with 27 participants across two years. Twenty-seven medical students took part in the first interview during the first half of the first clinical year. Twenty-six took part in the second interview during the second half of the first clinical year, and nineteen participated in the third interview close to graduation during the second half of the second clinical year.

The longitudinal character of the study (Saldaña, 2003) provided a means of generating nuanced, in-depth insight into participants' experiences. Longitudinal interviews also allowed the researcher and the participants to return to examples and experiences discussed in earlier interviews. However, while the study was longitudinal in character, it did not seek to chart changing views but rather focused on generating in-depth insight into the

lived experience of training. The longitudinal nature of the study also enabled the researcher, whose interest in medical education is scholarly rather than practical, to develop understanding into the topic. The researcher's outsider status also proved important in the process of interviewing. For example, as the researcher was, rightly, seen to lack experiences of the training process, participants often provided in-depth descriptions to enable an outsider to understand their experience. Further, being an outsider made it possible for the researcher to ask questions that could have been seen as self-evident among insiders. The Institutional Review Board at the author's institution vetted and approved the study design and materials.

Coding and analytical approach

Interviews were audio recorded and transcribed verbatim. As participants were explicitly asked about what they perceived as the biggest challenge in improving health, and what they would do to improve health, answers to these questions formed two initial and broad categories: *challenges* and *a super power*. Following thematic analysis (Braun and Clarke, 2006; Clarke and Braun 2018), the answers were manually coded to key themes. Below, I summarize themes illustrated in the data sections.

Only three participants, all with background in public health and policy, explicitly discussed social inequalities as central to ill health. Eleven participants brought up the importance of limited access to care, with seven of these participants focusing specifically on the ways in which issues such as the cost of care and lack of insurance can curtail access to care. Four brought up regulation, regulating unhealthy foods in particular, as a means of improving health. Eight participants, however, also emphasized lifestyles as what needed to change to improve health. Importantly, these participants did not explicitly frame lifestyles as shaped by economic possibilities available to people. Four participants discussed patients as lacking ‘motivation’ for healthy behavior, again, without discussing structural factors enabling or hindering healthy behaviors. Eight participants spoke about the importance of education and health literacy. While participants discussed education as a means of enabling patients navigate complex healthcare settings, education tended to be defined as educating individual patients about unhealthy behaviors without noting how health behaviors entwine with economic or structural constraints. Five participants noted culture as important in shaping health behavior, without discussing how cultural practices related to, for example, food might be connected with structural factors or histories of injustice.

Participants brought up multiple issues impacting health. In responses that combined multiple themes, for example, slipping from emphasizing the cost of care to underlining a lack of motivation, each part of an answer was associated with the relevant theme. The author undertook both coding and analysis. However, these processes were informed by discussions with colleagues who attended presentations on the paper, as well as read drafts of the paper. These discussions generated in-depth insight into theorizing the data.

Participants

The study sample was self-selected and, as such, this paper draws on perspectives from students who wanted to share their experiences with the researcher. However, to thank participants for their time, participants received a \$50 online gift card per interview. This is believed to have encouraged participation among students who may otherwise not have considered taking part. Simultaneously, the stipend was not large enough to coerce participation.

The research included roughly equal numbers of male- and female-identifying students. All participants were in their 20s. Recognizing the complexity of defining social class (Latimer and Munro, 2015; Lawler, 2005), participants' social class was ascertained in relation to participants' level of education, self-defined social class, and parental occupation.

Participants had all completed a bachelor's degree prior to entry to medical school and self-defined their social class as middle, upper middle or upper class. Parental occupations – that in order of prevalence were physician, financial consultant, teacher, attorney, engineer, professor, and small business owner – also point to participants being from middle, upper middle and upper class backgrounds. Eighteen participants were white, and five Asian or South Asian American. However, no African American or Latino/a students responded to the call for participants. The lack of African American and Latino/a participants limits the study.

Nineteen participants were asked about their educational background in the final interview. Additionally, one participant had discussed the topic earlier. Of the 20 participants from whom information on educational background was gathered, nine had undergraduate degrees in the natural sciences, including biology, biochemistry and neuroscience. Seven participants had either undergraduate or additional postgraduate training in fields such as public health, sociology, psychology or political science. Three had majored in economics or management, and two in humanities. Participants studied at five different medical schools in the United States. Twenty-five participants studied in schools located in the *South* of the United States. Furthermore, twenty-one participants studied in areas where roughly 60% of the population is African American (U.S. Census Bureau 2012).

It is important to note that patients who medical students work with during training generally come from very different backgrounds compared with students themselves: ‘a majority of students learn medicine caring for patients with significant social and economic disadvantages and with profound health problems that are far beyond easy fixes’ (Wear et al., 2017:312). While the median US household income was \$59,039 in 2016 (Semega et al., 2017), the median parental income of new medical students was at \$125,000 (Association for American Medical Colleges, 2016:2). Lack of congruence in terms of social class, but also race, applies to participants and their patients in this study also.

When citing participants, this paper will note the participant’s pseudonym and educational background. Undergraduate degrees in fields such as biochemistry, neuroscience and biology are identified with words *natural sciences*. Undergraduate or postgraduate training in areas such as public health, public policy, sociology, psychology, economics, management or political science is identified with a generic name of the field in question. For participants with humanities undergraduate degrees, I will note *humanities*. When a participant’s studies prior to medical school are not known, the word *unknown* is used.

Below, I start with information on patient populations that participants work with, before moving onto comments that show appreciation for ‘upstream’ social determinants of health. I then outline perspectives emphasizing ‘downstream’ social determinants of health. The data sections pave way for discussion that connects ideas of health expressed by participants with neoliberal values.

Challenges and a super power

Patient populations that participants work with

Participants in this study, generally, work with patients who are much less privileged than participants themselves. According to Ben, the patients he sees are ‘[p]retty much all underserved’ (Ben, economics and management). Especially for participants whose medical schools are located in the South of the United States, the majority of patients are also non-white: ‘for the most part in the hospitals that we primarily work in, it’s African-American lower socioeconomic classes’ (Isabel, psychology).

Recognizing ‘upstream’ social determinants of health

Three participants, all with background in public health and policy, explicitly recognize the significance of ‘upstream’ social determinants of health: ‘poverty is the number one determinant of poor health in this country and the world.’ (Adam, public policy and/or

public health). Participants who appreciate the more ‘upstream’ social determinants of health see medicine alone as unable to address causes of ill health: ‘as much curative medicine as we deliver at the [Medical School] Hospital, there's *so much more* that goes around, goes into healthcare.’ (Bob, public policy and/or public health). Beth adopts a similarly wide perspective: ‘I mean, the top ten determinants of health, only one of them is healthcare and the rest are things like education and social safety nets, you know, food assistance programs.’ (Beth, public policy and/or public health). These participants understand health as entwined with structural factors and consider improving health to require action that surpasses medical care. Perspectives explicitly focusing on the ‘upstream’ social determinants of health are, however, rare with only three participants directly linking health with social and economic inequity.

Improving access and changing the system

Eleven participants note topics like limited access to care, especially due to the cost of care or lack of insurance, as significant in ill health. As such, to improve health, Chloe would ‘make going to the doctor free.’ (Chloe, natural sciences). For seven of these participants, enabling better access to care entails making changes to the healthcare system: ‘right now, money comes in when you prescribe medications...The reimbursement scheme is totally backwards’ (Carla, public policy and/or public health). Further, to improve health, ‘I’d get

rid of insurance. I just think it's horrible. And the fact that they control what you give patients' (Mary, natural sciences).

Working within a flawed system

Working within a system that some participants identify as deficient in providing care to all patients can give rise to complex and, at times, conflicting feelings. For example, the role of insurance companies and corporate interests in shaping access to care generates 'frustration' (Mary, natural sciences) but also 'a feeling of being powerless' (Sullivan, humanities). Inequity that participants encounter can also, however, give rise to anger: 'the amount of injustice that you see in medical school... there have been moments where I felt like I was actually *being burned alive by righteous anger.*' (Beth, public policy and/or public health). Beth's comment captures the emotional challenges embedded in medical training generally, but it also points to the emotional challenges related to seeing, and recognizing, the impact of inequity.

Others, however, adopt a differing approach. Asked how he feels about working in a system where money facilitates access to care, Ben explains:

'So you can get more experience if you see more patients with, with uncontrolled diabetes, which is terrible for them and terrible for the

healthcare system but it's good for you because you gain experience and you become better at whatever you're doing. So it's hard to say how you feel about it. I think that it needs improvement for patients, but in terms of for training, you don't really think about it.' (Ben, economics and management).

While for Beth, 'looking straight in the face of injustice *every day*, has been challenging... it's been sort of a formative experience.' (Beth, public policy and/or public health), Ben finds educational value of working with people with complex health needs.

From regulation to individual lifestyles

Four participants talk about regulation, the regulation of foods available to people in particular, as a means of improving health. Amar would, for example, use regulation to ensure that 'there's no junk food, there's no food that can damage people's health' (Amar, unknown). A focus on regulation often merges with an emphasis on individual behavior. While Sarah would 'make healthy foods cheap', she also notes that 'lifestyle changes would change the health of the population as a whole, more than any other specific thing would' (Sarah, natural sciences). For Chris, improving health entails getting 'people invested in their own health. And really get them to see that it's a resource' (Chris, natural sciences). Chloe would incentivize healthy behavior:

‘insurance my mom used to have, like, if she wore a pedometer and like, plugged it into a computer and like registered with her online account, she could get like, five hundred dollars back if she walks like ten thousand steps a day... a lot of people won't do it just for long-term health benefits. Like, people, like, they need to see results. They need like upfront incentive.’

(Chloe, natural sciences).

While participants like Sarah and Chloe connect behaviors like walking with the availability of, for example, sidewalks, participants do not link the availability of sidewalks, or lifestyles more broadly, with socio-economic factors.

Improving health literacy

Eight participants discuss the importance of health literacy in improving health. Health literacy is, however, discussed in differing ways. The opaque character of the healthcare system can be seen as what limits accessing care: ‘people come in and they don't even know *why* they're there... they weren't even explained properly *why* they were coming for this or what this was for’ (Vivan, management or economics). Above, lack of information given to patients restricts access to care. Stephen also emphasizes improving individual health literacy: ‘It's great to tell people to eat healthy, but unless they understand why and what's going on and are able to think about it, they won't do it’ (Stephen, natural sciences).

Choices that people make are framed primarily as matters of individual knowledge.

Patients lacking relevant knowledge, rather than inequities constraining lives, are defined as primarily responsible for unhealthy behavior.

Unhealthy 'mindsets'

Eight participants discuss unhealthy behaviors as related to motivation. In comments emphasizing motivation, the power to address ill health is located in the hands of patients themselves: '[y]ou can get off your couch, you can eat healthy things' (Sarah, natural sciences). Some participants also shift from noting issues like access to emphasizing motivation. As Isabel explains when asked about the biggest challenges in improving health:

'I think it's access to care. Especially working at [Hospital], where most of our patients don't have insurance. And I think a lot of it is changing their mindset. Because most of these people want a quick fix. And once they get medication, they do well for a few months. But then, they spend money on other things, like alcohol or smoking, stuff like that. And then they can't afford their medication anymore. And they end up right back in the hospital. So it's just this self-perpetuating cycle. So I think the biggest thing that needs change is changing the mindset of long-term changes and allocating

money toward things that actually matter instead of your desires at the moment' (Isabel, psychology).

While Isabel starts by highlighting access to care as central to improving health, she moves onto emphasizing 'mindsets'. Rather than conceptualizing behaviors as shaped by environments that people live in, she focuses on individual choices and an apparent lack of responsibility shown by those not exercising or eating healthily.

Cultures shaping health behaviors

Five participants discuss cultures playing a role in unhealthy behaviors. For Lou, improving health happens on the level of 'the basic everyday things that we do' (Lou, unknown). As she explains, 'it's a very basic thing to cut out certain items from your diet and add certain items into your diet. By saying "basic", I don't mean that it's easy, it's very hard, but it has huge impacts in your diet and your health.' (Lou, unknown). Above, Lou recognizes changing diets and eating practices as, simultaneously, 'basic' and difficult. When asked what keeps people from eating healthily, Lou explains:

'I think part of it, at least around here, is that people don't realize that all the salt and fat in, and all the vegetables that are covered in salt and fat are not as good as just vegetables... part of that is also that food is so cultural and

food around here... trying not to eat fried chicken is very difficult.’ (Lou, unknown).

Lou does not reflect on how eating practices may be rooted in economic factors or in histories of structural oppression. Rather, she sees individual lack of knowledge, as well as cultural practices around food, as what feed unhealthy eating. Placing blame on individual patients but also on cultures, again, risks sidestepping structural factors shaping behaviors. It is not unimportant that Lou’s medical school is located in an area where approximately 60% of the population is African American.

Discussion

Medical students hold a wide range of views on improving health. Participants with background in public health and policy are especially thoughtful about ‘upstream’ social determinants of health. Some participants also articulate a critique of the ways in which healthcare in the US is funded as restricting patients’ access to care and shaping how doctors can practice medicine. Appreciation for ‘upstream’ social determinants of health, and insight into the ways in which the organization and funding of healthcare can hinder access to care, generate feelings like frustration, powerlessness and anger. Many participants, however, slip from concerns related to the cost of care to underscoring individual motivation.

Healthy behaviors, clearly, matter. However, as Wilkinson and Pickett point out, gaps in mortality and morbidity ‘cannot be explained away by worse health behaviors among those lower down the social scale’ (Wilkinson and Pickett, 2010:84). What is missing from accounts of participants emphasizing ‘mindsets’ and motivation is that health behavior is entwined with possibilities available to people. Further, ‘assuming people have the freedom to make healthy choices is out of line with what many people experience as real possibilities in their everyday lives’ (Cockerham, 2005:54). Emphasizing individual choices aligns with biomedical conceptualizations of disease (Armstrong, 2011; Nettleton, 2006), but also with the individualistic ethos of western societies (Cockerham, 2005). Importantly, individualizing ill health risks erasing the impact of inequality that, in turn, rests on a history of injustice.

Health and health behavior in neoliberal times

Associating ill health with unhealthy behavior also aligns with neoliberal values such as self-responsibility and self-management (Horrocks and Johnson, 2014) and captures a shift ‘from governmental responsibility to individual responsibility’ (Brown and Baker, 2013:17). Many participants emphasize limited access to care simultaneously with defining some patients as not possessing the right kind of motivation or ‘mindset’. Patients who are

represented as not having a healthy ‘mindset’ are characterized as lacking something centrally important: a willingness to view their health and bodies as investments, and to act accordingly. Importantly, the ‘narrative of responsibility’ that is articulated by medical students risks placing blame for ill health on the shoulders of individual patients. As Brown and Baker (2013:28) point out, within a neoliberal context, ‘[i]llness comes to be seen as an outward sign of neglect of one’s corporeal self – a condition considered as shameful, dirty or irresponsible’. Unhealthy choices made by seemingly indifferent or irresponsible patients come to define understandings of character and deservedness (Sointu, 2017). At the same time, ‘self-management through choice is framed as ethical duty to the self and society’ (Skeggs, 2004:57).

A sense of moral failure on the part of patients echoes through perspectives that underscore individual ‘mindsets’ and motivation. Patients who medical students encounter, who frequently come from much less privileged backgrounds than students themselves (Wear et al., 2017), are readily characterized as unmotivated and irresponsible, but also as susceptible to immediate gratification. This emphasis on apparent failures to act in a self-responsible manner, simultaneously, hides broader social causes underlying health behaviors as well as ill health. Rather than inequity or injustice, ill health is seen to stem from ‘the (wrong) way of governing ourselves’ (Lemke, 2001:202). The apparent inability

of those with fewer means to comport themselves responsibly further marginalizes patients from underprivileged backgrounds. Not only are those in poverty ‘branded with infamy’ with regards to the visible marks poverty leaves on bodies, they are vilified further through assumptions of flawed and irresponsible character (Adair, 2010:240). Blaming those with lesser means for the disadvantages they face, simultaneously, constitutes a potent means of reminding *everyone* of the necessity of governing oneself responsibly (Adair, 2010).

Neoliberal reason and inequality

The idea of self-responsibility as ‘ethical duty’ (Skeggs, 2004:57) and a ‘precondition for ‘moral standing’’ (Schram et al., 2010:742), entwines with conceptualizing people as ‘human capital’ rather than as citizens or human beings with intrinsic value and rights (Brown, 2015). Within a neoliberal context that ‘configures human beings exhaustively as market actors’ (Brown, 2015:31), health can be framed as an investment encouraged through incentives. A sense of health as an investment, and of illness as a failure to invest appropriately, echo also through the accounts of some medical students. Importantly, understanding people as ‘human capital’ normalizes competition and etches inequality to the very center of how people relate to one another: ‘[w]hen we are figured as human capital in all that we do and in every venue, equality ceases to be our presumed natural relation to one another’ (Brown, 2015:38). Consequently, within a neoliberal context,

‘inequality becomes normal, even normative’ (Brown, 2015:38). Accounts emphasizing self-responsibility speak of this normality assigned to inequality; associating ill health with irresponsible ‘mindsets’ or indifference captures the subtle, yet powerful, normativity now enjoyed by neoliberal thought.

Why common sense thought matters

The individualizing of ill health and the ascent of self-responsibility that permeate the views of many medical students is ideological in character, offering a ‘descriptive vocabulary of day-to-day existence, through which people make rough sense of the social reality that they live and create from day to day.’ (Fields, 1990:110). As an ideology, neoliberal thought allows connecting ill health with an apparent lack of responsibility. Importantly, ideology also shapes how we relate to one another (Fields, 1990). Neoliberal thought suffuses how many medical students conceptualize their patients: as people irresponsibly seeking immediate gratification rather than as people facing enduring inequity. Research shows that non-medical factors, including ‘perceived social, cognitive, and psychological characteristics of patients’ (Lutfey et al, 2008:1398) impact medical decision-making and access to care (Phelan and Link, 2015; Spencer and Grace, 2016; van Ryn et al., 2011). As such, the ways in which neoliberal thought subtly erases social conditions and possibilities can, literally, become a matter of life and death. As an

ideology (Fields, 1990), neoliberal reason gains power through infusing common sense understandings of the causes of health and illness. It is this capacity to suffuse common sense (Brown, 2015) that facilitates the hold of neoliberal thinking on medical education and on medical students' views on improving health.

Race and neoliberal thinking

While neoliberal thinking may appear race-neutral, it is deeply entwined with race (Cassano and Benz, 2019; Saull, 2018; Schram et al., 2011). The ideal neoliberal, self-responsible subject is readily, albeit implicitly, imagined as white (Saull, 2018).

Simultaneously, neoliberal values such as self-responsibility and individual choice ignore the importance of structural disadvantage and, through assigning responsibility to individuals shouldering social and economic disadvantage, perpetuate racism (Cassano and Benz, 2019). Importantly, in addition to disregarding the importance of inequity in general terms, the focus on health behavior also 'explains racial inequalities in health by autonomous choices' (Muntaner et al., 2001:665) rather than by historical and on-going injustice. While some participants emphasize health literacy, little attention is given to, for example, the '[i]ntergenerational transmissions of racial resources [that] provide whites in the United States far greater access than nonwhites to quality education' and other factors that play an important role in better health outcomes (Lewis and Manno, 2011:93). The

health enhancing power of social and economic privilege is, simultaneously, hidden from view. According to Muntaner et al. (2001:665), the manner in which racial inequality is frequently sidestepped in talk around health inequalities ‘suggests the presence of a protective self-serving bias among middle-class whites’ (see also Bonilla-Silva, 2002). A focus on health behavior and culture, furthermore, subtly enables the privileged to ‘avoid any social responsibility for the experiences of non-whites’ (Muntaner et al., 2001:665). Emphasizing individual choice, as well as the impact of cultures on people, provides a means of erasing the racist roots of the inequity that generates ill health while simultaneously defining cultures most affected by racism as inherently unhealthy. As such, silences around topics such as race and racism speak volumes of the subtle power of neoliberal reason, but also of the ways in which neoliberal thought enables paying little heed to inequity that rests on, and perpetuates, structural racism.

Conclusion

Improving health is a complex and difficult topic. Understandings of health articulated by medical students are frequently individualistic with social determinants of health relegated to the sidelines. Some participants do explicitly connect ill health with inequity.

Importantly, these participants have extensively studied areas such as public health or policy prior to medical school or in connection with their medical degrees. Many

participants, however, emphasize health behavior and motivation as central to health and illness, without reflecting on the ways in which healthy and unhealthy lifestyles entwine with socio-economic and structural factors. Furthermore, through underscoring unhealthy ‘mindsets’, participants can make moral judgments of the ill as irresponsible and unmotivated. The focus on health behavior sidelines the enduring impact of inequity, especially with regards to race. An emphasis on self-responsibility provides participants a means of bypassing the historical and present day injustice at the heart of health inequalities in the United States.

That participants who have studied public health and policy show more understanding of the ‘upstream’ social determinants of health indicates the importance of these fields, and of institutions offering students training areas like public health, in facilitating understanding into the health impact of inequity. It is, however, also important to recognize how the ‘narrative of responsibility’ (Horrocks and Johnson, 2014:178) embedded within neoliberal thought, and in contemporary culture and institutions, readily hides the impact of social disadvantage in favor of personal responsibility. That neoliberal thought uproots ill health from social conditions (Peacock et al., 2014) is especially important considering the power that future doctors are set to hold as arbiters of access to care, and to moral worth.

Further, within a neoliberal context where inequality emerges as increasingly normal (Brown, 2015), it is important to go beyond the health impact of structural inequity. Understanding into the complex causes of ill health needs to be supplemented by insight into the appeal of the ideal of self-responsibility. Noticing how values like self-responsibility facilitate ignoring the racist roots of inequity is especially important. Encouraging medical students to more fully appreciate and understand the role of inequity in ill health necessitates highlighting and challenging not only the pervasiveness but also the common sense ascribed to neoliberal thinking and values today. If we neglect the allure of neoliberal thought in how health and illness are understood, we disregard a key means of making inequity more central to medical education and practice. And through sidestepping the impact of inequity, we miss a vital opportunity for improving health.

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