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Identifying Providers as Agents of Change for Clinical-Based Interventions by Considering Provider's Intrinsic Motivations and Capital

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IDENTIFYING PROVIDERS AS AGENTS OF CHANGE FOR CLINICAL-BASED INTERVENTIONS BY CONSIDERING PROVIDER'S INTRINSIC MOTIVATIONS AND CAPITAL
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Considering Provider's Intrinsic Motivation and Capital

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Honors Thesis

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ABSTRACT

The theory of cultural health capital factors in a patient's resources in their likelihood of accessing quality healthcare. The notion of quantifying a patient's resources when researching equitable care, inadvertently places more of a focus on patient-based interventions: policies focused on expanding a patient's resources. Yet, I push past this approach and suggest studying practitioner's capital in parallel to patients as a better predictor of quality of care. Practitioner's employ their own resources to make healthcare more equitable for underserved populations, and empowering clinicians to serve as agents of change in the patient-provider relationship takes the weight off of patients and allows practitioners to influence the quality of care patient's experience.

IDENTIFYING PROVIDERS AS AGENTS OF CHANGE FOR CLINICAL-BASED INTERVENTIONS BY CONSIDERING PROCIDER'S INTRINSIC MOTIVATIONS AND CAPITAL

INTRODUCTION

Olivia is a sixty-five-year-old nurse whose profession led her practicing medicine in the back of an ambulance headed down the Texas-Mexico border.

> I had a patient who needed to return home to Mexico but could not be disconnected from his ventilator. I told the physician I reported to that I needed to buy a ventilator. The physician did not answer, so I messaged him two more times. Finally, I sent a text that said, "I am going to get it anyway, so you might as well let me." So, I bought that ventilator. Our American ambulance took him and the ventilator to the bridge, and we met the Mexican ambulance and the patient's family. I didn't think I would ever get my ventilator back, but I did. They brought it back and cleaned it up, and we used it at least three other times. In situations like this, you have to think totally outside the box, but the whole process has to be patient-centered, and that's where people get lost in the money thing.

Providing healthcare in a border town means navigating multi-national healthcare systems. Given the circumstances, local providers' dedication to their patients is unparalleled and exhaustive; they often leave the confines of the hospital to administer care, no matter the price. Recognizing socially motivated health professionals willing to administer care outside the confines of the formal system could mean saving an uninsured resident's life. Some doctors have an inherent social motivation leading them to practice, or the dire need for healthcare in the Valley causes more doctors to practice outside the formal system. When a doctor is socially motivated in a clinical setting, they prioritize maximizing the benefit of the patient in their treatment. Often the formal standard of care omits the treatment of uninsured populations, and socially motivated doctors reject the notion that medicine should be for-profit and center their

patient's needs in their care, regardless of price. In contrast, doctors can be self-interested practitioners and practice economic determinism (Eisenberg, 1985).

Learning to identify socially motivated practitioners and placing them in clinical leadership positions allows for interventions at the clinical level rather than focusing all efforts on the patient front. In addition, using social purpose as a motivator ties a clinician back to their community and offers a more profound sense of purpose in their style of practice (Pilnick & Dingwall, 2011). Finally, the Valley's local economy offers the perfect backdrop to visualize some of these interventions. There is a dire need for socially motivated care in The Valley as its population struggles to afford equitable care.

McAllen is one city in Texas's Rio Grande Valley, nestled between the Texas-Mexico border. McAllen is amongst dozens of small cities that make up 'the Valley' a symbolic boundary illustrating the communal nature amongst the cities, sharing resources and social networks. I will use McAllen and the Valley interchangeably, as most residents do since both symbolically represent indistinguishable populations. McAllen, Texas, comprises about 143k residents, and 83% are US citizens (Data USA). The predominant Hispanic culture has been sustained for decades, as nearly 86% of the residents identify as Hispanic (Data USA). The poverty rate is higher than the national average, influencing the high rate of diabetes and obesity plaguing many residents (Data USA). The lack of state resources severely strains an already struggling system, including the rejection of Medicaid expansion, inadequate funding to sustain infrastructure for immigration, and reduced funding for public schools.

The rising cost of healthcare, coupled with the local socioeconomic demographics, influences practitioners' ability to practice medicine and, subsequently, patients' ability to afford care. Further, there is a growing demand for practitioners in the area. In addition, the Valley

continues to grow, and the high rates of comorbidities among residents are challenging to support. Many local providers were born and raised in the Valley, so they are familiar with the residents and understand the best ways to support them. For example, every participant I spoke to was bilingual; a language barrier was not typically an issue.

Nevertheless, communication between patient and provider remained a point of contention for the patients interviewed. Additionally, the high cost of care and long wait times at the doctors obstructed patients from seeking care. Hospitals and patients place heavy demands on providers, and underserved populations lead many practitioners to stay after hours and sometimes break hospital policy.

Substantial research covers patients' cultural health capital focusing on an individual's resources bettering their quality of care (Shim, 2010 & Derose & Varda, 2009 & Scott & Hofmeyer, 2007). This research helps to establish that no matter how many short-term resources a patient receives, it does not make a long-term change. For example, interventions focused on making patients more medically competent, teaching them medical jargon and communication skills still leave patients unable to afford the treatment. Giving patients short-term money and keeping them at overpriced hospitals or clinics leaves their money to dry up quickly. Hiring translators for non-English speaking patients still needs to provide equitable treatment, as their communication with the doctor still relies on the reliability of a third party. Finally, patients should not have to be taught to be good medicine consumers to receive treatment. Focusing on clinical interventions puts the ball back in the provider's court. Utilizing a provider's inherent motivation to practice as a factor in their practice will determine more about the patient-provider relationship than solely focusing on a patient's cultural health capital. This intervention will embrace a provider's influence in the patient-clinician relationship.

For example, research should focus on practitioners' motivations to practice and how it influences their clinical style. Examining the practitioner's resources or motivations coupled with the patient's cultural capital better explains the nuances of the patient-provider relationship. My interviews focused on something other than the patient-provider relationship in the examination room but on what resources both brought to the table and how it affected their relationship. To collect this data, I interviewed five patients and five clinicians. With patients, I focused on their cultural health capital, specifically what resources improved their quality of care. This line of questioning revealed that all the patients I interviewed were middle and upper-class and well-educated. Now that I had established that the patients, I interviewed had high cultural capital, it was alarming how many grievances the patients had with the local medical system. If the most well-equipped patients were still unsatisfied with the Valley's healthcare, there is more to the story.

I redirected my line of questioning with clinicians to determine what factors influence their style of care. Two of the clinicians I interviewed primarily remained practicing within the formal standard of care. While those clinicians sympathized with uninsured populations, they chose not to treat them in their private practices. The other three clinicians based their practice on ameliorating the inadequate healthcare system for uninsured residents. Some efforts included stepping out of formal care and buying medical equipment for uninsured patients, like Olivia for her Mexican patient. Other clinicians worked an extra day a week at a local clinic that provides free care for uninsured patients. By identifying which population clinicians wanted to serve, I tackled what factors influence a provider's style of care.

The clinicians whose practice centered around underserved populations created safety nets protecting residents falling through the cracks of for-profit healthcare. Expanding my focus

to include the impact of a provider's intrinsic motivation as a factor influencing patient care further pushes the boundaries of cultural health capital. The logic of basing a patient's experience in healthcare on their resources guides the conception that a provider's resources likewise impact the provider-patient relationship. Lastly, extending our understanding of cultural health capital to include the impact of socially motivated clinicians offers patients a clear route to seeking affordable care and redirects the focus to clinical rather than patient-based interventions.

LITERATURE

Bourdieu introduces the idea of an individual possessing capital outside of the fiscal definition as he accounts for three forms of capital: economic, cultural, and social capital (1986 & Siisiäinen, 2003). Cultural capital refers to one's habitus, communication, education, and customs (Dubbin et al., 2013 & Bourdieu, 1977). In contrast, social capital is derived from one's relationship with their neighbor, associate, or family, one's inherent capital, in this case, is built from their social network (Bourdieu, 1986 & Siisiäinen, 2003 & Scott & Hofmeyer, 2007). Social and cultural capital are particularly salient in this paper as it develops an extended framework of the medical, sociological term cultural health capital (Dubbin et al., 2013 & Mascia, 2011). Cultural health capital is described as the applied knowledge of the medical system offering certain privileges of health care which are only attainable to patients who have the social resources to reach them (Malat, 2006). Further, culture plays a vital role in a person's approach to preserving their health (Abel, 2008 & Derose & Varda, 2009). Studying these two concepts in unison offers sociologists clues in understanding the spectrum of healthcare inequalities and potential frameworks to prevent inequitable care (Hendryx et al., 2002).

Framing varying forms of capital as potential explanations for health inequities initially introduced the modern term of cultural health capital, encompassing capital as a factor in an individual's likelihood of receiving adequate healthcare (Dubbin et al., 2013 & Wall, 1995). Cultural health capital accounts for a person's knowledge of the system: literacy of medical terminology, general education, and ability to communicate with medical professionals (Wall, 1995 & Derose & Varda, 2009). The accumulation of cultural health capital can begin in adolescence, as a child raised by two parents who are educated in medicine and have the resources to offer such care to their children pass down capital. Pairing cultural health capital theory and the life-course paradigm illustrates the time ordering, often used in healthcare research, of accumulating cultural health capital throughout one's life and effectively practicing preventive care (Missine et al., 2014).

The cumulative disadvantage theory provides a basis for understanding an individual's accumulation of capital throughout adolescence and the effects it could have on an individual's health (Missine et al., 2014 & Derose & Varda, 2009 & Hendryx et al., 2002). In this case, women who grew up attending regular visits to the dentist are more likely to seek preventive mammogram screenings in adulthood (Missine et al., 2014). Because the participant's parents instilled the importance of preventive care at a young age, and offered the resources to attain that care, the participants subsequently practiced preventative care in adulthood. Studies like these validate cultural health capital theory when conceptualizing strategies to make healthcare more equitable; this is especially salient in the US, where medical access is expensive and inaccessible (Porter, 2009).

Further, quantifying cultural health capital by accounting for the impact of patient's resources on access to care is especially necessary as Western healthcare providers and patients

are often encumbered by the demands of a corporatized healthcare system (Clarke et al., 2003 & Hendryx et al., 2002). For example, western medicine demands more from providers while providing them with fewer resources (Dubbin et al., 2013 & Clarke et al., 2003). Patients are expected to act as educated consumers when seeking good medical care rather than sick individuals seeking treatment (Dubbin et al., 2013 & Clarke et al., 2003). Building educated consumer programs is set to increase health literacy and self-efficacy to aid patients' success at the doctor's office (Dubbin et al., 2013 & Shim et al., 2010 & Schillinger et al., 2002 & Ishikawa et al., 2013). Knowledge of the healthcare system and self-efficacy represents cultural capital by Bourdieu's definition (Bourdieu, 1986 & Shim et al., 2010). Cultural skills like verbal communication competency, nonverbal interaction style, attitude, and behavior can be taught to help increase the success of a patient and provider meeting (Bourdieu, 1986 & Shim et al., 2010 & Schillinger et al., 2002 & Siisiäinen, 2003).

Preventive care in the case of increased self-efficacy amongst patients establishes the patient as the avenue to mitigate medical inequalities, yet taking a split approach to understanding the influences of both provider and doctor in data collection may influence the future proposed solution (Heritage et al., 2006 & Shim, 2014). Transitioning away from clinician-centered research to frame patients and providers instead as equal interests invigorates our understanding of the patient-provider relationship (Ishikawa et al., 2013 & Heritage et al., 2013 & Shim, 2014). Previous research focused on the provider's interest and transitioned to a focus of patients as well, yet little research framing both perspectives equally exist (Shim, 2014). Likewise, the patient-provider relationship is constantly evolving, and shifting the data collection to include both populations could reframe the clinical setting for sociologists

(Ishikawa et al., 2013 & Heritage et al., 2013 & Shim, 2014). This mode of data collection can create interventions at both the clinical and patient levels, and interventions at the clinical level.

Diversifying the populations of interest will offer a more holistic framing of the provider-patient relationship. Moreover, I identify a missing component from research that explores cultural health capital theory. Existing work only considers the patient's social and cultural capital, yet framing a doctor's capital as a factor in their practice is relevant as well. Using the logic cultural health capital theory applies to patients, the cultural and social capital a provider walks into a room with can drastically influence the outcome of the patient-clinician interaction (Pilnick & Dingwall, 2011). For example, not every physician enters medicine for the same reason or has the same goals and practices in the office (Eisenberg, 1985 & Pilnick & Dingwall, 2011). Physicians' practice patterns can range from income seekers, motivated by the style of practice and preferred patient population, maximum profit, clinical leadership, and physicians' characteristics (Eisenberg, 1985). For example, physicians who are self-motivated are likewise motivated by their style of practice, their focus is improving their capability of practicing medicine in the clinical sense: learning new techniques, keeping up to date with modern research (Einseberg, 1958). Those clinicals who are motivated by clinical leadership seek to teach other clinicians administrative care; so they would be less interested as a self-interested physicians to create a unique style of practice and would be more drawn to teaching the standard way of practice to a group of people in a position of power (Eisnberg, 1985).

Therefore, addressing every doctor as equal in intervention policies fails to factor in each doctor's independent motivations, which would offer more insight. While steps have been taken to improve the relationship between clinician and patient using patient-centered medicine,

asymmetry in care remains as the doctor's capital is not considered in conjunction with the patients. (Pilnick & Dingwall, 2011).

A doctor's instinctive motivations are unlikely to be transformed through a single seminar on patient-centered care. However, identifying socially motivated physicians and investing in their medical contributions is worth studying. Social purpose can be a motivator and, when appropriately taught, can help change some physicians' practicing styles (Janus, 2014 & Pilnick & Dingwall, 2011). Addressing a physician's motivations can positively influence their intrinsic motivations as doctors who are motivated by leadership can be placed in those sectors, and those who are socially motivated can work with patients that are not 'good consumers' of the healthcare system (Phipps-Taylor & Stephen, 2016 & Janus, 2014). Allowing doctors to master opportunities given not only their field of interest but motivational interest could elicit more structural change in medicine than simply coaching patients on how to speak to doctors (Phipps-Taylor & Stephen, 2016 & Janus, 2014 & Mascia, 2011). Thus, placing the right doctors in adjacent roles can improve health service management and increase the quality ratings of those providers (Veronesi, 2013). Veronesi's research found that linking physicians to proper roles based on their interests increased the physician's quality metrics and performance but did not improve the nurse's quality metrics when placed in comparable roles (Veronesi, 2013). Perhaps examining doctors' motivations as precursors to job opportunities would place doctors in the role best suited for themselves and their patients.

While clinicians' motivations play a significant role in their practice, so does their place of work. The role of location is also worth noting in exploring the implications of cultural health capital from the physician's perspective. Geographic location influences the populations patients serve, which ultimately influences their practice style. If the physician is working with an

underserved population their practice style shifts to a more affordable style of care, and places a greater focus on getting the funds for the patients to access care. Likewise, the hospital or clinic a doctor works as is another location that influences care. Doctors treat patients differently in private practice settings where they can only offer treatment to patients with a certain insurance, or in Emergency Rooms where they are legally obligated to offer those with life threatening illness care. The national Medicare expansion also influences location as a factor influences care as many smaller hospitals were economically incentivized to join larger hospitals to adhere to new quality metric policies (Morris, 2018 & Martin et al., 2021).

Although not every hospital administration or clinic allows doctors to practice as they please, some physicians take their moral obligation to treat their patients seriously, even if it means breaking their contract. The formal Westernized style of practicing medicine does not always work for socially motivated physicians as quality metrics push doctors to get patients out of the hospital as soon as possible while also ensuring they will not return (Raudenbush, 2020 & Martin et al., 2021 & Phipps-Taylor & Stephen, 2016). Patients who go home quickly and do not have family members to administer medication end up right back in the hospital, costing both them and the hospital twice the amount of money (Raudenbush, 2020 & Martin et al., 2021 & Phipps-Taylor & Stephen, 2016). Some doctors go above and beyond their contract to administer good healthcare, no matter the cost, even breaking some rules because they believe they are morally obligated to treat patients without insurance (Raudenbush, 2020). One physician discussed paying for a patient's prescription out of their own pocket when they could not find adequate funding for the patient; while another physician prescribed an expensive medication for an uninsured patient's family member who had the insurance to cover the medication and the intention to give it to their sibling (Raudenbush, 2020).

Location, policy, and personal motivations are three critical research areas surrounding a doctor's style of practice. When discussing cultural health capital, they should be used in unison with the patient's capital. Interventions that work toward medically educating patients lack the funding to enable patients to put their knowledge into action and pay for their treatments. Research on the doctor-patient relationship focuses on the doctor concerning the patient rather than the doctor's motivations. The concept of cultural health capital is immensely helpful in understanding patient competence, but it only tells one side of the story. In this study I want to consider both patient and provider's experiences and consider a clinical based-intervention that can improve the provider-patient relationship: capitalizing on socially motivated practitioners as a safety net for underserved populations.

METHODS

McAllen, Texas, is a smaller city located on the Texas border with Mexico. The predominant culture is Hispanic, as most residents are Mexican-American. Most families have lived in the area for generations, so it feels like every new person you meet is a mutual friend. I grew up in McAllen and am moving back in hopes of attending medical school there after undergraduate. My past is McAllen, and so is my future. Therefore, I chose this border town as my area of interest as it is not an easy place to access medical care. The poverty rate is above average, as is the rate of diabetes and obesity. The significant number of residents who are uninsured, some being refugees fleeing Latin America, are left with little resources. Having the opportunity to shadow many local doctors in recent years offered a visual understanding of the health inequities, so I decided to focus my study on a localized understanding of the practitioner-patient relationship.

I knew I wanted to interview both patients and clinicians because I was often disappointed by how little data collection was done on both populations simultaneously. I only had between October 2022 through January 2023 to collect data, so my timeline required a smaller pool of interviewees. Instead of diversifying the patients and adding another factor to the study, I focused on patients in social networks with which I was familiar. Mostly, the patients were middle to upper class and rubbed shoulders with many of the doctors I interviewed. I conducted ten in-depth interviews with patients that lasted between 30 to 60 minutes. The ages of the patients ranged from 18 to 60, and all individuals were born and raised in McAllen. I also knew of a doctor who was just appointed to a group looking to modernize the residency portion of the hospital and whom I often spoke with about health inequalities in the area. This key informant pointed me to four others to interview, and I interviewed four doctors and one nurse with ages ranging from 30 to 85.

The patients and clinicians revolved around the same social circles, and many knew each other professionally and privately. McAllen is a rather large city, but it feels like a small town as most residents remain in the area, and most families have resided there for generations. The familiarity drastically influenced the interview process as almost all interviewees were raised in the area, so they spoke freely of politics and social networks in their discourse regarding medical care access. The participants were set to narrate two different experiences, but their shared experience living in the valley led them to agree on many policy and economic issues in McAllen.

As a member of the community myself, the interviewees felt comfortable sharing solid takes on the local politics and administrators they understood we both were familiar with. Two interviews were conducted as a group as I drove to two couples' homes where both partners

were clinicians and interviewed the husband and wife together. These conversations were often the richest as the partner would add more detail to the other's story or contest the version being told. Some interviewees confessed after the meeting that they only agreed because they knew of me, as many were distrustful of the system and wary of me doing research in the area. However, citizens' respect for McAllen is apparent as they speak critically of their inequitable experience while remaining optimistic about McAllen's image in general.

Although my sample is limited to a relatively privileged population of patients, the data illustrated that even the patients with the best care access were still frustrated with the system. The patient interviews mainly revolved around the doctors already in their social circles, discussing disagreements with peers in their practice or being critical of the administration. I was initially interested in fostering a mutual dialogue between patients and clinicians regarding access to care. Instead, the patient and clinician dialogue could not be created as the two populations told very different stories. For doctors who were socially motivated to practice, their entire career revolved around the small population of uninsured patients because they put the most thought and brainstorming into helping them be treated. The experiences of both the patients and providers underscore the value of studying the social and cultural factors that influence the doctor-patient relationship.

RESULTS

Hospital Infrastructure & Medical Personnel

Patients and providers alike highlighted national boundaries to healthcare as well as heightened local obstacles. When viewing cultural health capital as a determinant of quality of care, the idea of location is less prevalent in literature framed around practitioners (Morris, 2018

& Martin et al., 2021). Depending on hospital resources, quality of care can increase across the board in terms of updated tests, modern technology, and rehabilitation centers. However, this quality of care is only accessible to those who have high cultural health capital. I noticed this when talking to patients with substantial economic income, education, and social networks. All of them spoke of the lower quality of healthcare in McAllen. They compared the long wait times and poor bedside manner they experienced more frequently in the Valley than when they went to doctor visits in San Antonio or Houston, Texas. The patients were able to compare their quality of care at home to other larger cities in Texas because they often had to leave the Valley to see specialists as the wait for an appointment with a specialist was up to 3 months in some cases. While these patients did not experience life-threatening diseases as a consequence of the quality of care in the Valley, their minor grievances were heightened for the underserved populations in the area who could not afford a visit to the doctor's office. The patient population limits the data collection as first hand experiences are described by patients with high cultural health capital, but many patients interviewed were aware that residents who lacked the cultural health capital they possessed had an even more difficult time accessing quality care. As a result of long wait times and a lack of specialists, patients may ultimately seek less healthcare due to time spent at the doctor's office, which could significantly affect local health statistics.

Andres, a fifty-five-year-old lawyer, discusses his personal grievances with the long wait times at doctor's offices. Although he has the social network to see a doctor sooner, he fears residents who do not have the same social network are forced to skip out on doctor's visits as it imposes a great strain on their schedules.

Patients lose an entire day just to see the doctor. The doctor is in a hurry because he has another 40 people in the lobby, which creates frustration. The doctors are fatigued. They are tired. The patient is frustrated

that they have been sitting there for hours waiting. I think that patients don't like to go to doctors when they have to sit for a long time. And that may cause patients to not seek treatment because of the amount of waste of time required to get attention.

Healthcare accessibility imposes a significant strain on the Valley, as comorbidities are common amongst residents. Patients in the Valley are diagnosed with diabetes and obesity at a staggering rate. One explanation could be that the high poverty rate in the area influences the residents' health. Perhaps income obstructs many residents' ability to buy fresh produce, or more time spent working means they have less time to make healthy meals at home. It is also plausible that many patients miss early signs of diabetes and obesity as they are not annually seeing their doctor for checkups because they are discouraged from attending due to long waiting times or do not have the financial means to afford regular checkups.

One local businessman, Daniel, who sits on the board of the local private hospital Doctors Hospital at Renaissance (DHR), discusses his concerns with family members waiting for appointments. Like Andres, Mateo has the social network to get his family into the doctor's office sooner, but he is concerned about residents who do not have the same luxury.

> I think there is too much work out here for the limited number of doctors, and we need a lot more doctors because if I allowed my parents and sometimes my own siblings or kids to set up an appointment, they wouldn't get in. Doctor's offices will give you an appointment four or six months later, that's just not acceptable. And so, I'm glad that I have friends within the medical profession, and I will make a call to a doctor and then ask the doctor to make a call to a specialist to see if they can get me or my family in sooner.

Social networks enable patients to seek quality care sooner than other residents. But social networks are a key factor to study amongst physicians. Physicians use their own social

network to gain more clientele, or advantage other physicians by sending them clients. The bureaucracy within medicine entails a patient seeing a primary care physician to be referred to a specialist. This step in the medical process offers primary physicians' substantial capital as they grow their social network and earn favors by selecting the specialists they refer. The specialists are at the mercy of primary care physicians and will attempt to become a part of their social network to gain business. Patients are also at the mercy of their primary care physicians as they choose specialists. This form of provider-specific social capital influences the provider-patient experiences.

Andres and Daniel were two patients who enabled their social capital to improve their experiences and their families. However, this is only the case for some residents. Long wait times are not only dangerous for patients who are seeking treatment for a life-threatening disease, but also place a financial burden on residents. Financial circumstances fluctuate for individuals and a patient can have the money set aside to afford a procedure one month, and no longer have the means to afford the same procedure months later when their long-awaited appointment is scheduled. Aside from inaccessibility in seeking timely doctor's appointments, residents also face the financial burden of having to see a primary care physician first in order to be referred to a specialist. This system costs the patients two doctor's visits, which further inhibits access to affordable care.

While the primary physician and specialist dynamic is a national conundrum, the unique nature of McAllen's hospital infrastructure further capitalizes on the relationship. DHR is the nation's largest doctor-owned hospital. When investors created the hospital, clinicians were incentivized to join since they were offered company shares. This practice leads to DHR scouting and signing some of the best clinicians in the area and outside of the Valley. It also

gave physicians unprecedented power in hospital administration. Physicians were able to join the hospital and receive shares, while continuing to work part-time in private practices. For example, Obstetricians who became hospital shareholders agreed to deliver their patient's babies at DHR, but continued seeing non-surgical cases the rest of the day in their private practice. When it comes to primary care physicians referring patients to specialists, those who are shareholders at DHR are influenced by both their economic and social capital. When those primary care physicians consider whom to refer their patients to, the obvious choice is sending them to DHR. Doctors simultaneously benefit the doctors they are referring to within their social network and are able to profit from the patient whose services yield profit for all shareholders, including themselves.

This dynamic of doctors simultaneously acting as hospital administrators and providers introduces more economic capital for the local physicians. A patient centric model of cultural health capital fails to account for instances like this, where no matter what resources a patient has, the specialist they are sent to will be based on the provider's economic and social capital instead. Although this corporatized style of medicine seems to dangerously tip the power scale in the patient-provider relationship, it is also essential to consider the quality of care. DHR provides state-of-the-art medical care as it is the hospital most invested in the area, hosting the most specialists for patients to see. It is the only hospital in the Valley with a Level 1 Trauma center. As a result, the patient almost always visits this hospital over the other smaller national hospitals in the area due to quality of care. Irene, a therapist in her forties, is married to one of the hospital shareholders. She agreed with other patients, that the quality of care she receives at DHR is incomparable to the smaller local hospitals.

> I would only go to DHR. If I were not, then I would travel outside of the area. I would go to San Antonio or Houston.

Patients interviewed revealed that DHR was the only hospital that provided the quality of care they required. The hospital's financial budget is significantly higher than the competing hospitals, the decisions regarding fiscal allocation are negotiated amongst physicians in administrative positions, rather than non-clinical administrators. This style of clinical leadership empowers doctors to influence clinical style at an institutional level. Doctor's power in the Valley is heightened by DHR as they have more power in what machinery is invested in and influencing the clinical style of residents taught at the hospital. While larger national hospitals are not doctors-owned and run, they have fewer clinicians in the administrative meetings making financial and clinical decisions for the hospital. Mateo, who is not only a shareholder but executive at DHR, discussed how the benefit of doctors serving as decision makers in clinical institutions is beneficial for doctor's economic and social capital, as well as the quality of care patients receive.

> When you have a doctor-owned hospital like DHR, it has a very positive effect on doctors. They can vote on what machines to buy and decide on the highest quality equipment. For example, the doctors always complained before DHR that the surgical centers for orthopedics were not on par with the heart surgery or cancer centers. So, when doctors of all those fields come tougher, they know what equipment they need and vote to purchase it instead of asking the bureaucracy and being declined.

Involving doctors in the bureaucracy of medicine could alleviate many providers' complaints regarding the inefficiency of the medical system. Doctors, in this case, have an active role in administrative duties like equipment, which modernizes the hospital in a more beneficial way than a hospital executive deciding on medical equipment without experience

using the machine. In addition, doctors serving as administrators means they spend less time negotiating with non-medical professionals and more time with their patients or improving their practice. It is unfeasible for doctor's to be completely patient centered in a for-profit medical system. Practitioners can only offer individualized care such as new medications, trials, and procedures to those who have the financial means to afford it. When practitioners attempt to provide care to uninsured patients, they are obstructed by hospital protocols, insurance codes, and the cost of pharmaceutical treatments.

Local efforts to introduce more physicians in administer roles positively influences doctor's influence within the hospital, it also increases physician's authority within the community at large. Irene, the therapist in her forties, recalls a moment when potential efforts to ameliorate the patient shortage were stalled by local practitioners.

> When investors discussed wanting to open a law school in the Valley, lawyers generally were concerned that this would create competition as lawyers came into the market and took away their business share. When the new medical school was introduced, they suffered a similar issue. Doctors were concerned that the medical school might begin to flood the market and all of a sudden, they would make less money because there would be less patients. Whether that is true or not, the reality is that the Valley needs substantially more doctors. If I go to an established city and see the doctors it is to my understanding, they wait about 10 -15 minutes. In the Valley, I will notice people sitting there for two, three, four hours before they are let in to see the doctor. And sometimes all those patients see is a nurse practitioner. So yeah, we need more doctors.

Efforts to increase the number of practitioners in the Valley have seemingly been met with resistance. This could be due in part to the heightened capital doctors have in the area, but it could also just be a symptom of the capitalist nature of medicine as profit remains front and center in decision making. The US medical system remains especially focused on hospitals'

profit margins, which not only impair provider's style of care but also the quality of care a patient receives (Dubbin et al., 2013 & Clarke et al., 2003). Mario, an ER doctor, attempted to break down his interpretations of system issues in medical care.

> I think there is so much this organization and systemic issues in healthcare this interview could take up the rest of the afternoon. Okay, first of all, there is no accountability. Mistakes every damn day. People's lives are tremendously affected. The financial ruin for some people because of what is done, and nobody is accountable. We as physicians will say, "what do we do about it?" What are the peer review committees? What are the credentialing committees? What do medical tech committees actually do? Nothing. Medicine should be about outcomes, and if your outcomes suck, then you shouldn't get paid and you should be exposed. Because if people are insisting on value-based care, what is that based on? It should be on outcomes, but there is no one checking outcomes.

Mario discusses his frustration with the bureaucratic nature of medicine and how there seems to be a general lack of accountability. Questioning which entities are in charge of accountability leads him nowhere, as he has not noticed changes or improvements in clinicians sent to those boards. He also mentions later in the interview how many of the physicians he knows have been sent to peer review communities that had reentered their practice admitting the same practices they did before that got them reported. Change is only possible when sanctions are exercised.

Ultimately, patients and physicians both agreed that location influences medical treatment. The Valley in particular lacks sufficient investment in medical infrastructure which creates a substantial obstacle to accessing care. Regardless of price, many patients are unable to see a provider due to long wait times. The local economy is largely based on DHR which is the largest hospital in the area and pays their physicians well as they also are given some shares of

the hospital. The closer a doctor is to the financial aspect of a hospital also is unique to the area and influences the quality of care patients receive.

Expanding the factors that influence cultural health capital theory could better explain a patient's experience in the exam room. Two individuals with similar cultural health capital would have drastically different healthcare experiences based on where they live or what hospital they attend. The importance of location is worth further investigating with research adjacent to cultural health capital.

Social and Cultural Health Capital Amongst Patients

Amongst the patients interviewed, all had the economic capital to see any doctor of their preference and pay for necessary medical treatments. The patients were upper and middle-class and well-connected within the community. Educated and outspoken, the patients discussed the lengths they went to attain quality health care. However, they also had many critiques of the doctors they decided not to continue seeing, citing that many had poor bedside manners and long wait times.

One patient named Thomas discusses his approach to communicating with doctors. A well-educated attorney who is well versed in medical jargon takes a proactive approach to health.

> I think the critical importance for all doctors is their bedside manners. And unfortunately, some of them have none. As a result, they do not do a good job explaining what they plan to do or how they're interpreting or analyzing the problem. Because of my background, if I am unsatisfied with answers, I will ask and continue to ask until I have a better understanding. Unlike others, perhaps I'm just not as simply satisfied with what doctors are saying. Well, if this is going to be a problem, how are we going to solve it?

What is the solution? What causes the problem? What is their opinion of that? What studies out there are available regarding this issue, and how can they get it solved.

This patient has the confidence to question his doctor and the drive to understand his health entirely. He is the quintessential 'good consumer' in healthcare as he knows what he wants and how to get it. Perhaps the doctors respect him because they know he is well-educated. Thomas suggests that because he is a lawyer, he has always received more detailed attention from his providers, who know his profession.

> I think there has always been a fear of doctors getting sued, and perhaps they may give better attention sometimes to lawyers just to make sure that they go over and above what they need to do to make sure that the person gets treated well. Now, it doesn't happen now as often because the doctors that I see are actually good friends. And as a result of that, it's the relationship we have that helps.

Initially, this patient felt his profession offered him premium care, but now he knows the doctors well enough to receive this care as a benefit of his social capital. Being an attorney, he discussed running in the same social circles as many of the city's doctors, architects, and bankers. His social network is evidently at play as his closest friends are well-educated professionals. This patient's positive experience with the healthcare system was not unique. I spoke to Rose, a patient whose husband was a shareholder with DHR, and her access to care was above and beyond any other patient I interviewed.

> The shareholders are dear friends of mine, including my husband. He is one of the original shareholders to start the branch. In order to be a shareholder now you have to be a doctor as the hospital is doctor owned. Before that, the legislature did not allow doctors to buy into hospitals. DHR offers premium care in my opinion, but I may be biased. For example, during COVID-19 my family and I were horseback riding in my backyard. A freak accident left me with a broken shoulder and busted ribs. My husband immediately called the head of the ER, who just so happened to be my next-door neighbor and the radiologist who

lived down the street. When I arrived the heads of each department were waiting for me outside of the ER. It was the middle of the pandemic, so the place was empty and my husband was allowed in because he has a hospital badge.

Additionally, the patients I spoke to were all highly educated and bilingual. The patients could communicate efficiently with their practitioners. When the providers did not initially offer them the required quality of care, the patients pushed back and demanded it. Isela, a twenty-eight-year-old architect, refused to settle for standard care for her doctors and described how she employed her capital to communicate with her physician.

> I have absolutely no problem questioning a doctor. I think I am very well educated and I am clearly outspoken. I am a huge advocate for myself, my family and my husband. When I think the doctors are not doing what they should be doing, or not providing me with enough time to ask follow up questions I tell them they are supposed to. I have actually no problem questioning my doctors at all.

The pattern of well-educated patients I interviewed having the confidence and communication skills to communicate their grievances with their physicians enabled them to serve as agents of change in the doctor-patient relationship. However, only some patients have the capital to employ this style of confrontation with doctors. When discussing social, economic, and cultural capital as factors of a patient's health, one clinician pointed out how important family is amongst residents' health in the Valley. Kayla, an obstetrician in her forties, initially lived in the Valley and moved to practice in Dallas; when she moved back to the Valley, she was reminded of how the predominate Hispanic culture places a great emphasis on familial ties, thus, providing her patients with a social network, unlike other patients she treated in Dallas.

I think it is helpful when patients are committed to their health. It is more helpful when their family members are as well. It enables patients to do more research on their own after meeting with me and implementing the treatment.

Social networks are a critical component of cultural health capital; instances like this show how much social capital can influence a patient's health. Capital is also worth studying as a factor influencing a practitioner's clinical style. I highlight two aspects of the Valley influencing a solid sense of community amongst certain professions. Firstly, there is a private school where all these doctors, lawyers, and engineers meet and create social circles. Secondly, the hospital's shareholder policy initially allowed non-doctors to invest, so doctors are integrated into those circles. Lastly, McAllen is not a large city, so the small-town feeling often means living next door to many of your closest friends. The predominant Hispanic culture brings residents together for traditional holidays, shared food and restaurants, and Catholic churches. These are all places where Hispanic culture is integrated as the larger culture amongst residents in the Valley. So perhaps there is a critical correlation between 'small town' feeling communities and the strength of social networks.

Expansion of Cultural Health Capital

Interviews with patients showcased cultural health capital's influence on care access. However, this thesis argues against the notion that good healthcare access is based on an individual's resources alone. Instead, focusing on the internal motivations of physicians in their style of practice as a determinant of quality of care offers a new perspective on the impact of cultural health capital. Every physician joins medicine for a different goal, and subsequently, they practice differently (Pilnick & Dingwall, 2011). For example, physicians categorized as income seekers may be more motivated to join DHR and take an active role in administration

(Eisenberg, 1985). Likewise, a doctor motivated by clinical leadership may join DHR and run the residency program or his private practice (Eisenberg, 1985).

Additionally, with the introduction of a new medical school and residency program, doctors tend to practice similarly to those they were trained with (Eisenberg, 1985 & Pilnick & Dingwall, 2011). The medical school prioritizes candidates from the Valley through an early acceptance program, so many of the graduating residents remain in the Valley and have similar practice styles. Studying doctors' training, motivation, and drive as determinants of their style of practice offers a new avenue for understanding the physician-patient relationship and why it varies substantially.

Half the physicians I spoke with centered most of their conversations around serving a predominantly underserved population. Many clinicians went above and beyond their expected role and broke hospital policies to treat their patients equitably. Raudenbush breaks down clinicians into two categories: those who follow the formal system of administering care and those who work against it (2020). I will focus on the second group of clinicians because their style of practice is socially motivated. Mary, a nurse in her late sixties, illustrated how much the high rate of poverty affects her role as a practitioner and the patient's access to treatment.

> Physicians would get frustrated. The hospital gets frustrated. And when I first started, I sat in meetings saying. I don't know why they're questioning his prescriptions; this guy has nothing. If they give him all these prescriptions, he can't fill them. So, he has to decide whether I feel my meds or feed my family. Now, you hear that thrown around a lot, but down here, it happens.

Healthcare is larger than treating an illness; patient-centered care encourages physicians to practice a tailored style of medicine. The boundaries of what is considered an illness begin to blur when doctors cannot treat a patient unless they likewise treat the social factors obstructing

the patient's health. Clinicians described how many patients had no means or family to aid their physical mobility, administer medication, or transportation to check-ups. Physicians struggle to practice patient-centered care in a system designed to capitalize on both patient and practitioner. While clinicians spend hours negotiating with insurance companies to prescribe an affordable dose to their patients, patients scramble to account for the cost.

However, this nurse understood the boundaries of care her patients endure and often spoke up in meetings explaining to her supervisors that they would have to find private funding for this patient or he would not be able to provide adequate care. Her role as a nurse in a room full of doctors likewise highlights the power dynamics instituted by the medical bureaucracy. There is always a board to refer a question to, and often she would have to hear back from her supervisors when she requested additional financial assistance for her patients.

Nevertheless, DHR was built to mitigate the health crisis in the Valley. The national hospitals in the Valley invested little as this branch was not their primary source of income. So, DHR's motivation and the goal of many doctors is to provide care, even if it is not within the confines of medicine. Treating a patient often means treating their extenuating circumstances. Mary revealed a private contribution DHR made to a deserving family.

> A couple was losing their apartment because the husband cared for his dying child while the mother cared for their newborn. He could not get a job, and his sick time at work was up. Upon notice of eviction, the foundation paid their back month and the next several months.

This foundation that donated to the family was composed of providers who had likely treated this patient and recommended selecting them for assistance. In this case, their motivation to practice medicine escapes the confines of the patient-provided exam room interaction. It expands the clinician's role of treating the root of their patient's ailment. None of the other interviewees who worked for the other national hospitals discussed financial

contributions. However, those doctors did not access administrative roles as the DHR doctors did. This same family who received the donation would have had a different experience at a national hospital regardless of their cultural health capital. It took socially motivated doctors to improve their quality of care.

Additionally, handpicking socially motivated clinicians to participate in clinical leadership provides patients better care. For example, one doctor in his early eighties,r spoke of his concerns regarding medicine's corporatized nature. As a result, he actively worked against this practice to improve his patient's quality of care. I would consider him to be a socially motivated physician as he ultimately left the for-profit care system partly to provide free care to patients at a non-profit clinic.

> I live in this area, so I am so passionate. When I say stuff, I am told to be quiet. Just be quiet because nobody wants to hear. I just don't think, even now, everything is becoming corporatized. Okay? The hometown doc type is done. Medicine is sold out, it sold itself out to venture capitalists years ago. And this is where we are at. That's the reality, and we have to deal with it.

Hospital infrastructure actively works against doctors like him, whose reason for joining medicine was socially motivated. He wanted to make a difference in his community and was met with new administrative roadblocks each time. Hospital bureaucracy is one of the reasons doctors lose faith in the system and in themselves to practice medicine equitably. The corporate nature of medicine is the greatest weakness of the argument that doctors can influence change in their practice. When doctors are restrained by hospital policy and do not have the means to cover patients' expenses, the patient's cultural health capital is necessary to access quality care. The capital of the practitioner and patient both weigh into the success of their interaction. The idea of cultural health capital includes the physician's resources solely, and I suggest including

a practitioner's cultural capital in parallel to their patients will reveal more about the factors influencing quality of care.

Clinicians further detailed the bureaucratic obstacles to providing individualized care when prompted to discuss patient-centered care. Finally, Mario the ER practitioner, frustrated by demanding administrators and patients, explained his side.

> Everybody's on a timeline, how the hospitals are on the timeline, consumers are on the timeline. So, I mean, your quality metrics, your patient satisfaction metrics, everything is going to be impacted by that. From the hospital's perspective, they get penalized by having patient's too long, and the consumer's perspective is they want to stay as long as possible for fear of getting worse. They tell me not to send them home. And then they demand I treat them now. I have surgeries and other patients. Sometimes people forget this is a hospital, not a Ritz Carlton.

Many health professionals echoed the notion of working on a strict timeline. Lucia, a practitioner whose focus is working with residents at DHR, struggled to account for the patient's and hospital's needs simultaneously. Often meeting with patients of a certain class meant they demanded more from her, like the ones interviewed. When in reality she had to focus her time on the underserved patients who had no one else to turn to. Lucia's response to challenging situations like the one above is acting as a social worker and passionately explaining the situation to her patients. Lucia believes this approach kept him practicing patient-centered medicine without disrupting the hospital policies.

> There is a piece of being a doctor that includes being a social worker. You know what? That is part of the art for me. I'm talking to a 46-year-old who only had weeks to live, okay? She tells me that she doesn't want to die. Instead of explaining the financial reasons for transferring her to a nursing home from the hospital, I said I was here to help. I'm here to pick you up. I'm here for your children, I know what they are going through. It is horrible because she knows she is dying, but I need to give that sense of comfort. It makes me feel better too. I have always been that way, that's why I became a doctor. My patients always come first.

Lucia found her purpose and pursued her social desire to help in the way she practices. Lucia serves as the necessary standard in clinical practice, but many of the residents she trains behave differently. Working in clinical leadership revealed how different young residents' motivations are and how drastically it impacts their medical practice, especially their bedside manner. She focused on delivering bad news to patients and supporting them through it, a skill she does not find new residents gaining easily.

> And if I have to get into a difficult conversation with patients, but the fact that they're dying, I'm going to do it with compassion and I'm going to do it gently. But at the same time, I'm not going to leave them alone. I don't shy away from that. I see that more younger residents are coming through. Communication is not what it used to be, right? Like the trainees, the residents, I mean, some of them have the worst manners you could ever imagine. So, I can't even imagine how they are with patients. Medicine is becoming a little bit too clinical in the sense that there's so much work to be done and residents just yell ordering tests they don't even know the implications of. Compassion is not as present in a lot of the younger residents. I think we're losing a lot.

Lucia is concerned that so much medical training is done away from patients, and younger generations spend less time online with people. She finds it more challenging to work with her residents in recent years, and likely suggests the corporatized nature of medicine also eliminates another 'human level' from medicine. More time is spent considering if the next step falls within regulation rather than what is best for the patient.

DISCUSSION

Interviews with doctors in McAllen, Texas, suggest that the medical institution they work for influences their practice. How medical institutions operate either limits or empowers practitioners' clinical style (Morris, 2018 & Martin et al., 2021). Breaking down practitioners into three categories, motivated by practice style, socially motivated, and clinical leadership, helps illustrate how DHR heightens practitioners' power in the Valley and its impact on

equitable healthcare. Among physicians motivated by practice style, physicians discussed the relief they felt discussing what equipment to buy with a group of doctors rather than business people. They suggested, along with a few patients, that this purchasing system at DHR increased the quality of care. Practitioners motivated by clinical style focus on improving their craft and modernizing their scientific approach to medicine (Pilnick & Dingwall, 2011). Doctors focused on improving that craft benefit from also being hospital shareholders. However, modern tests and equipment are a cost the hospital has to make up with steeper costs elsewhere. Therefore, upgrading the hospital could cost the patient more to access care at this hospital.

Doctors motivated by clinical leadership can lead in this unique medical institution in multiple ways. They can lead financial meetings, surgical teams, and residency programs. A doctor I interviewed led one of the residency programs. Her concerns were resolved around the need for more humanity in medicine and how new residents spent less time with their patients and more time ordering around other staff. Her position as a chief in the residency programs allows her to change the culture among residents and influence how they treat their patients. She discussed taking extra time with students on how to handle discussions about grief with patients and addressing socioeconomic factors effectively that make it more difficult for patients to access care. Capital influences her leadership in two ways. First, as a long-time resident of the Valley, she is exposed to underserved populations at a greater rate than most physicians nationwide. The predominant Hispanic culture is also keen on family stepping up to care for sick family members and neighbors helping each other out. She discussed how most of her patients have a support system and did not notice them when completing her residency outside of the Valley. Therefore, the culture in the Valley influences how she practices medicine, and in

place of leadership, she cultivates this mindset in young practitioners who grew up in different areas.

Lastly, the socially motivated physicians can profit off the for-profit system at DHR by capitalizing on their social networks and economic capital to fund new avenues to provide equitable care. Well past their seventies, the physicians and nurses work at DHR three days a week and volunteer at the Hope Clinic twice a week. The practitioners started the Hope Clinic as a reaction to the party leaving the for-profit care system, they held grievances with. Both practitioners felt guilty offering only a select few the quality care they provided at DHR, so they opened a clinic to offer free care to uninsured residents regardless of the cost. In order to do this, the practitioners employed their social network of other doctors at DHR to join them and volunteer at the Hope Clinic through rotations. Additionally, both practitioners are nearing retirement, have saved up enough capital to afford this system of administering care, and have friends who can also afford to invest substantially in the clinic.

When discussing starting the Hope Clinic with Olivia, the nurse we met in the introduction, she discussed how her age influences her and her husband's ability to practice as socially motivated practitioners. When Olivia was deciding whether or not to break hospital policy and buy her patient a ventilator, she decided her patient had more to lose than she did. Her social network included her husband, a significant shareholder at DHR, and other doctors who would advise against her department punishing her. Additionally, when she started the Hope Clinic and pushed back against the for-profit healthcare system, she felt that in her retirement years, she had the confidence to employ the clinical system she had always wanted to practice. Age is a factor worth investing alongside cultural capital when considering what

influences socially motivated practitioners to break the norm in medical practice and go against the formalized system of providing care.

CONCLUSION

As a student of both sociology and medicine, I had different reasons for studying the patient-practitioner relationship. Through studying sociology, I recognized the clear power imbalance between patients and providers. I wanted to interview both populations to learn how to be a more socially aware future doctor. Additionally, I wanted to create a dialogue between patients and physicians and serve as a liaison helping both sides come to some agreements. However, I quickly realized patients and physicians were not fighting against each other; they were simultaneously struggling to coincide in a system so focused on cost.

I established four broad takeaways from analyzing the data. Number one, practitioners' motivations and clinical styles are intrinsically linked. For example, socially motivated doctors will practice differently than those motivated by clinical leadership. A socially motivated doctor is more likely to break the norm of formalized care and treat an uninsured patient, even if it does not align with hospital policy. On the other hand, a physician motivated by clinical style would be less likely to break hospital policy as they prioritize modeling proper formalized care as a role model for other doctors rather than breaking the rules for a singular patient. Secondly, proper clinical leadership can foster a socially centered style of care. Isela, the practitioner who led residents, focused on personalizing care for her patients and fostering a sense of humanity when practicing medicine. Her experience growing up in an area with many uninsured patients influenced her care style. Now that she is in a clinical leadership position, she can influence

young residents to focus on individualized care to benefit every patient, not just the insured ones.

Thirdly, clinical based interventions place less of an emphasis on making patients good consumers and empowering practitioners to serve as agents of change in the patient-practitioner relationship. Focusing on the provider's resources allows new methods of research to support further clinical-based interventions. Fourth, I realized that practitioners and patients are not working against each other; they are pushing back against a system prioritizing profit over patient outcomes.

I learned how much resources impact a person's access to care by interviewing well-educated and wealthy patients whose concerns with medicine relied mainly on other residents' access, not their own. Speaking with providers, I realized that most of their day, even when being 'patient-centered,' was not spent with their patients. Instead, the providers spent their days pushing against for-profit hospital policies. Some providers left the confines of formalized care and provided treatment on the border in one case.

The mutual evil that patients and providers both despised were insurance companies, as privatized insurance coverage left patients unable to afford treatment and physicians unable to provide it. After collecting sufficient data, patients and providers most often focused on the obstacles of formalized care. For example, insurance companies, hospital policies, and cost. So, I decided on instead shifting the framework of cultural capital from focusing on patient-based interventions to provider centered interventions because I felt most research focused primarily on improving access to care though patients.

In clinical settings, patient-based care is a practitioner-based intervention. Clinicians are taught to individualize care for each patient, no matter what resources they bring. Unfortunately,

patient-centered care is not always executed correctly; doctors' clinical practice varies substantially based on their personal motivations, residency instruction, own biases, and personal resources. Additionally, hospital bureaucracy obstructs many doctors interviewed from performing patient-centered care since the cost is of the utmost importance for administration.

I want to push back against the narrative of cultural health capital that places unintentional blame on a patient for not having the adequate resources to be seen as a good consumer of medicine. Further, I reject the notion that doctors will treat patients similarly according to their cultural health capital. Every doctor practice medicine differently. Even in my small sample of five clinicians, I could broadly categorize three as socially motivated. However, among those socially motivated physicians, each pushed the boundaries of formalized care differently.

Practitioner-based intervention still fails to account for medical policy's obstacles, but the more socially motivated doctors grow, the louder the demand for change within the system. Focusing on clinical interventions does not chastise how doctors practice medicine. Instead, it empowers socially motivated clinicians to join clinical leadership positions and alter how future practitioners' practice. Unfortunately, not all doctors are equally as motivated to help underprivileged communities, and we cannot change their human nature and willingness to work outside their structured role as practitioners. Nevertheless, we can identify practitioners who focus on underserved populations and cultivate their outlook on medicine in future doctors. Those clinical leaders may only speak to a couple of young doctors in a room, but starting this chain of empowerment for clinicians to make a change can further patient-centered care.

Further, another application of this research involves designing an education intervention at the undergraduate level that teaches young medical students about patient care

instead, focusing on socioeconomic factors that obstruct patients' access to care and paths to alleviate those obstacles for patients as future practitioners. Engaging young students with medical training outside of the typical chemistry and biology classes could attract a student to be more socially motivated and ultimately increase the quality of care underserved populations receive.

Motivations and clinical style of care are intrinsically linked. Alternatively, one's motivation coupled with good, compassionate teaching will lead to a socially centered style of care. Either way, learning to identify the types of students who are socially motivated could improve future patients' quality of care. Furthermore, interventions focused on cultivating socially focused practices will create more equitable health care practices. Unfortunately, corporatized medicine places substantial roadblocks to practicing this style of medicine, but the right doctors in clinical leadership can ameliorate the adverse effects of corporatized for-profit medicine.

Cultural health capital is patients' ability to access quality care based on their resources (Malat, 2006). Bourdieu describes cultural capital in many ways. My research suggests that studying the cultural health capital of both the patient and the provider in parallel will better determine the quality of care the patient receives (Bourdieu, 1986). Additionally, research has focused on a physician's intrinsic motivations; I propose furthering this framework by engaging with literature like Raudenbush, who focuses on a practitioner's motivation as an indicator of clinical practice style (Phipps-Taylor & Stephen, 2016 & Janus, 2014 & Raudenbush, 2020). Coupling the framework that focuses on a practitioner's intrinsic motivation with future research regarding the impact of their capital as indicators of their practice style is worth investigating.

        This research was limited in the time I had to collect this data, which only allowed me to

undergo ten in-depth interviews. Additionally, the research focuses on McAllen, Texas, which

has a unique medical infrastructure discussed in this paper. The hospital is doctor owned, which

places a greater emphasis on the practitioner's power in the healthcare system. I suggest future

research employ the framework I have described, studying both patient and practitioner's

cultural capital in parallel in different cities nationwide. Every practitioner practice medicine

differently; sometimes, uninsured patients luckily arrive at the right doctor's office whose

socially motivated style of administering care offers them quality healthcare at a fraction of the

cost. Future studies asking practitioners if they consider themselves socially motivated and how

willing they are to leave the formalized confines of administering care would give a better

understanding of how many socially motivated practitioners exist and how we can capitalize on

their style of practicing medicine in providing access to quality healthcare for underserved

populations.

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