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Charles Dickens' *Hard Times* and the academic health center: a tale of the urban working poor and the violation of a covert covenant, an American perspective.

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Abstract

Charles Dickens' novel "Hard Times" focuses on the struggles of urban workers in 19th century England. The situations of workers in 21st century America are not dissimilar thus making Dickens' commentary and characters applicable to the contemporary socioeconomic scene. The number of uninsured or underinsured poor in America is rising. Academic Health Centers (AHCs) must go beyond their traditional mission of patient care, education and research and embrace the local neighborhoods they serve. The urban location, technical expertise, and educational mission of many AHCs make them ideally suited to assist urban populations that are at great health risk. Many AHCs in the United States orginated in working class neighborhoods, such as those described by Dickens, and today are surrounded by the urban poor. An argument is made that AHCs have a moral obligation to these neighborhoods; it is an implied, or covert, covenant that they are obliged to honor.

Key words: Poverty, delivery of heath care, public health, philosophy medical, ethics, urban health.

Charles Dickens' *Hard Times* and the Academic Health Center: a tale of the urban working poor and the violation of a covert covenant, an American perspective.

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Introduction

Charles Dickens wrote *Hard Times* after visiting strike-torn Preston, England in 1854. His sentiments were with the workers and are reflected in this novel about poor urban workers and their relationships with each other and their employer. Dickens' characters could just as well have been American as British. Many modern day U.S. academic health centers (AHCs) find their origins in poor working class neighborhoods, such as those in which Dickens' characters dwelled. This is of special note because the urban working poor of the 19th century and their present day counterparts have been intermittently abandoned (depending on conditions of reimbursement and/or teaching needs) by the AHCs that "grew up" in their own backyards because of their inability to be of financial significance to these institutions.

Today's uninsured and underinsured persons in the United States exceed 43 million (Kelley, Moy, Stryer, Burstin, and Clancy, 2005). The urban working poor of

today can find access to health care to be difficult (as it was for their 19th century Dickensonian counterparts). With megamedical centers in their neighborhoods, those Americans with the least may wonder why they cannot get the most out of these modern day marvels. About 80 percent of Americans live in a city or immediately adjacent to it (Fleischman and Barondess, 2004). In East and Central Harlem, poor working class families living "in the shadow of world renowned hospitals cannot reap the benefits of these facilities because of the lack of health insurance" (Fleischman et al. 2004).

Additionally, health outcomes are affected by economic inequality (Sen, 1992). whether measured by occupation, income, or education (Anderson, Sorlie, Backlund, Johnson, and Kaplan, 1997). Although there may not be a written contract between AHCs and their local medically needy populations, there is an implication of the provision of health care that these uninsured and underinsured urban poor may have come to expect (an *implied* covenant, or contract). Thomas Hobbes (1588-1679) suggests that inference, as opposed to the written word, may indicate that a contract has been made, i.e., implicit, or in other words, *covert* (Arrington, 1998).

While the countries of the European Union struggle financially as how to continue the "umbrella" coverage for their citizenry, the United States has yet to decide if universal health care is a right, a privilege, desirable, or obtainable in any way, shape, or form. Medicare and Medicaid are available for those that are eligible, but most of the population in question is either ineligible for these services or has limited access to health care.

The characters that Dickens portrays in *Hard Times* can still be found in the industrialized societies of today. Time moves on, but the social conditions of some of society's poorest tiers do not. So how does the AHC come into play with Dickens' characters and of what covenant do we speak?

Dickens' characters and their 21st century reflections

The memorable characters in *Hard Times'* 19th century setting reflect contemporary institutions, situations, and relationships. Many of the late 20th and early 21st century participants and subgroups of concern to society and government are reflected, or can be identified, in this novel.

Charles Dickens provides representative sketches of the corporate elite, politicians and government, the small business man, the common man, and the child. Josiah Bounderby represents the industrial, corporate mentality. Thomas Gradgrind and James Harthouse, both members of Parliament, personify government and politics. Mr. Sleary, a small circus owner with asthma, represents small business and self-employment. Stephen Blackpool, a company-employed laborer who had arthritis and an alcoholic wife, represented the common working man. Lastly, there was Sissy Jupe, a foster child of Thomas Gradgrind Sr. She was cared for by the Gradgrind family after being abandoned by her father. On deeper examination of the more pertinent characters to our discussion of the urban working poor, we discover that the breadth and width of their application to the early 21st century is uncanny.

Industry was represented by Josiah Bounderby of Coketown. He was a wealthy self-made man who distrusted his workers, or "Hands". According to him, they were a bad lot altogether, never thankful, restless, never knew what they wanted, lived upon the best, insisted on mocha coffee, rejected all but the prime parts of meat and were eternally

dissatisfied and unmanageable (Dickens, 1854/2004). Bounderby's memorable attitude toward his employees is reflected by his often-repeated claim:

> "There's not a Hand in this town, Sir, man, woman, or child, but has one ultimate objective in his life. That objective is, to be fed on turtle soup and venison with a gold spoon. Now, they're not agoing, none of 'em—ever to be fed on turtle soup and venison with a gold spoon" (Dickens, 1854/2004).

While we would like to think that negotiations and attitudes between management and employees have improved, the adversarial relationship persists, and the economic hammer of a "strike" remains a weapon of labor.

A friend and acquaintance of Bounderby was Gradgrind, who represented a government attitude that seemed as pervasive then as it does today. He was " a man of realities", a man of facts and calculation. "A man who proceeds upon the principle that two and two are four, and nothing over, and who is not to be taken into allowing for anything over" (Dickens, 1854/2004). He feels that "facts" are all people need, "Plant nothing else, and root out everything else" (Dickens, 1854/2004). He determined that statistics could prove anything and everything. He brought his children up on this principle, facts only, no fancy, which contributed to their lifetime of unhappiness. To dare not to dream, but only accept the facts that are presented is what different governments, at different points in time, hope of their citizenry.

James (Jem) Harthouse represents the political stereotype that causes jocular derision even today. Harthouse,

> "...had tried life as a Cornet of Dragoons, and found it a bore; and afterwards tried it in the train of an English minister abroad, and found it a bore; and had then strolled to Jerusalem, and got bored there; and had then gone yachting about the world, and got bored everywhere" (Dickens, 1854/2004).

The argument can be made that politicians have not changed over the centuries, and by his own admission, Harthouse states, "I am not a moral sort of fellow and never make any pretensions to the character of a moral sort of fellow. I am as immoral as I need to be" (Dickens, 1854/2004).

Sleary was a small business owner (horse-rider and circus owner) who cared about his employees and their loved ones. He was "a stout man as already has been mentioned, with one fixed eye, and one loose eye, a voice (if it can be called so) like the efforts of a broken old pair of bellows, a flabby surface, and a muddled head which was never sober and never drunk" (Dickens, 1854/2004). Sleary did not like Gradgrind's belief in "the facts only". Sleary tried to teach Bounderby and Gradgrind Sr. that all people needed respite (amusement) from their work and to be respected. Mr. Sleary, who pronounced "s" as a "th" because of his inability to breathe, had advice for them,

> "People mutht be amuthed, Thquire, thomehow, they can't be alwayth a working, nor yet they can't be alwayth a learning. Make the betht of uth; not the wurtht. I've got my living out of the horthe-riding all my life, I know; but I conthider that I lay down the philothophy of the thubject when I thay to you, Thquire, make the betht of uth: not the wurtht!" (Dickens, 1854/2004).

Dickens, through the character of Sleary, indicated to the readers that he was well aware of what the common man needed. Stephen Blackpool was 40-year-old factory worker that had seen tough times,

> "Stephen looked older, but he had had a hard life. It is said that every life has its roses and thorns; there seemed, however, to have been a misadventure or mistake in Stephen's case, whereby somebody else had become possessed of his roses, and he had become possessed of the same somebody's thorns in addition to his own" (Dickens, 1854/2004).

Stephen was a "Hand", a good power-weaver, a laborer in the hardest working part of Coketown. He was married to an alcoholic whom he could only intermittently locate and he was in love with a woman who at one time was a good friend of his wife.

The last of the pertinent characters to this discussion was Jupe. She represents the growing number of foster children that 21st century society has to provide for and educate. Although she could not academically keep up with her more affluent peers, she was a very perceptive "child of the streets," as are many of her counterparts in today's society.

When Sissy's teacher questioned her about the nation's prosperity, provided a very simple, but cutting response. The teacher proceeded, "Now this schoolroom is a Nation. And in this nation, there are fifty millions of money. Isn't this a prosperous nation? Girl number twenty (Sissy Jupe), isn't this a prosperous nation, and a'n't you in a thriving state?" (Dickens, 1854/2004). To which Sissy replied,

> "I couldn't know whether it was a prosperous nation or not, and whether I was in a thriving state or not, unless I knew who got the money, and whether any of it was mine" (Dickens, 1854/2004).

Her teacher, now quite frustrated, queried her again, and Sissy explains to the reader,

> "Then Mr. M'Choakumchild said he would try me again. And he said, this schoolroom is an immense town, and in it here are a million inhabitants, and only five-and-twenty are starved to death in the streets, in the course of a year. What is your remark on that proportion? And my remark was—for I couldn't think of a better one—that I thought it must be just as hard upon those who were starved, whether the others were a million, or a million million. And that was wrong too" (Dickens, 1854/2004).

Sissy's response was as correct 150 years ago as it is today, especially as it relates to health care access and health outcomes. Dickens' characters are vivid, difficult to forget, and easily identified in modern day urban America.

Covenants

Many citizens in 21st century America, more than in 19th century England, feel their government should make an effort to care for those who "have not." Much of this attitude is based on the work of Thomas Hobbes, a founder of modern philosophical thought. His ethical theory of "contractualism" survives today. Hobbes viewed the fostering of human survival and the living of a contented life as a result of moral and political obligations that arose from a contract that humans make with one another. Hobbes felt that, in theory, all humans have liberty that is unlimited, but giving up the unlimited right to behave as any one pleased was important and necessary to avoid the

unthinkable possibilities that humans can perpetrate upon one another. According to Hobbes, this basic condition of unlimited liberty needed to be surrendered to a central power. In making a contract, an obligation is created to stand by the agreement. "Here in lies the origin of morality: obligation is a bond we create through voluntary contract" (Hobbes, 1651/1996)

"Obligation is thraldome" (Hobbes, 1651/1996) according to Hobbes, but the condition of unlimited liberty is evil in that without the obligation of contract and morality life could be "solitary, poore, nasty, brutish, and short" (Hobbes, 1651/1996). Hobbes believed that obligation permitted survival and contentment. He believed that human nature could be understood without any connection to the morality of Plato or Aristotle; in that without contract between individuals there will be no prosperity or survival (Arrington, 1998).

Hobbes indicated that there are laws of nature, i.e., rules dictated by reason, that if followed, would forbid a human "to do that which is destructive of his life or taketh away by the means of pressuring the same, and to omit that by which he thinketh it may be best preserved" (Arrington, 1998). Having laws are prudent, and they place an individual under obligation as to "dos" and "don'ts". Hobbes had three laws of nature that he felt humans should follow.

"Seeking peace" was Hobbes' first law (Arrington, 1998). In other words, people need to get along. War, or any conflict that is destructive to all parties involved, must be avoided. This does not mean that we acquiesce to an opponent or to an ideal or position that is adverse to us. We have the right to defend ourselves in word and deed. However, accommodation by all parties that leaves them intact economically, socially, politically, and physically is highly desirable.

Hobbes' second law, "lay down the right of nature", also applies. Here Hobbes indicates that we should lay down our right "to do anything" if others are willing to do the same. The rule "requires each of us to be satisfied with as much liberty toward other human beings as we are willing to allow them with respect to ourselves" (Arrington, 1998). When we give up liberty (or portions there of) we can "renounce this right or transfer it to someone else" (Arrington, 1998). This right is "transferred" when we do not care who receives the benefit. Whether a right is renounced or transferred, a promise or commitment is made, thus an obligation is made (by us). Hobbes considers this obligation that is created by "laying down the right of nature" as the origin of morality (Arrington, 1998). Nature does not require commitment, i.e., one can do whatever he or she pleases (there is no morality in nature). Any commitment to an ideal, a situation, etc., incurs an obligation on my part. Thus, there is justice in my promise of commitment and injustice in my breaching of a promise of commitment (Arrington, 1998).

This second law leads to the concept of contract, or covenants. When people renounce or transfer the "right of nature" a contract, or covenant, is made. Covenants may "not be explicitly conveyed and acknowledged by words. The sign or indication of a contract may be by inference, and be implicit, or *covert*" (Arrington, 1998*)*. Hobbes claims that, "generally a signe by Inference of any Contract is whatsoever sufficiently argues the will of the Contractor" (Hobbes, 1651/1996).

Hobbes' third law regards the performance of covenants. If a covenant is made, it is important that, "men performe their Covenants made: without which, Covenants are in

vain, and but Empty words, and the Right of all men to all things remaining, wee are still in the condition of Warre (Hobbes, 1651/1996).

The concept of "inference" or "covertness", regarding Hobbes' second law, and the obligation of performance regarding the third law are very important. The citizens of the United States have come to expect good and available health care. The growing number of uninsured and underinsured may have limited access to prompt and adequate state of the art health care. The provision of health care is a covenant that the urban poor had hoped and have expected the AHCs to uphold since the late 19th century. The "right" at stake here is the right of the medically needy to "transfer" their need (per Hobbes' theory) for health care to an AHC. Even though the urban AHCs have found themselves in difficult situations intermittently throughout the last 125 years (sometimes at the very margins of financial viability), the medically needy, nonetheless, have by inference expected AHCs to accept this condition, the "transfer" of need. This expectation exists because the AHCs are (1) in the neighborhood and (2) have historically accepted patients who have meager financial means, thereby allowing the argument that a covenant of mutual trust (*implied*, thus *covert* according to Hobbes) has been made by the AHC with the communities surrounding its' AHC. Having implied a covenant as to the provision of health care there follows the requirement of the performance of the obligation (Hobbes' third law). According to Hobbes, "the definition of injustice is no other than the not Performance of a Covenant" (Hobbes, 1651/1996). If an AHC is just, it will abide by its covenants. The question arises as to whether the AHCs recognize or have any idea as to any covert covenant to which they may be obligated.

The Academic Health Center

Eli Ginzberg's excellent treatise, *Teaching Hospitals and the Urban Poor*, provides an enlightening historical review (Ginzberg, 2000). Many well-known AHCs established themselves in the 19th century. These centers were a union of teaching hospitals with medical schools established through philanthropy (Ginzberg, 2000). They provided care to those in the neighborhood that were ill, specifically to those urban residents affected by the intermittent epidemics that plagued population centers. The vast majority of these patients were poor. The acute care hospital was not used by the middle and upper classes until the very late 19th and early 20th centuries (Ginzberg, 2000).

Medical schools of the late 19th and early 20th centuries depended upon their affiliated hospitals to admit enough charity patients so that the medical students and residents could have enough teaching material. Most of these hospitals operated at about the "break even point" and they had to be careful as to the number of non-paying patients they admitted. This was to the detriment of the poor, including the aged. This early historical parceling of medical services, to those unable to pay for their health care, was an initial act of abandonment of the medically needy by the AHCs in their neighborhoods. However, the AHCs of the time were receiving no government assistance of consequence and were indeed living on the precipice of insolvency (Ginzberg, 2000).

In the 1960's, the financial situation of AHCs changed with the advent of Medicare. With Medicare in place, AHCs no longer had to admit high numbers of non-paying "charity" patients to meet their teaching needs. The poor elderly were now "paying" patients who could be accessed for educational purposes (Ginzberg, 2000).

Additionally, Medicare helped cover the hospitals' capital costs, indirect and direct costs associated with residency and fellowship programs, and even allowed room rates to be raised. Money also was made available from the federal government for research and faculty salaries thereby allowing part-time professors (usually the best teachers), who needed their private practice to supplement their charity care, to be employed by the AHC full-time to teach and do research. This affected the urban working poor:

> "The sizable state as well as federal funding being made available to voluntary and public hospitals under Medicare and Medicaid took much pressure off the leading urban voluntary teaching hospitals to continue to admit uninsured or underinsured patients. With a reasonably clear conscious, the staffs of some AHCs and other leading teaching hospitals referred such patients to public institutions whose primary mission was to care for the uninsured and the poor. The urban poor continued to seek care at an AHC emergency room or clinic; because many states required all hospitals to operate an emergency room on a round-the-clock basis, to care for all who sought treatment and to admit those who were seriously ill" (Ginzberg, 2000).

The AHCs of the twentieth century that prospered in many of America's urban neighborhoods disengaged themselves from the working poor with the advent of Medicare. This was another instance of abandonment. In other words, the urban working poor and the underprivileged elderly were in the traditional "charity" group, but in the 1960s, the elderly were carved out, leaving only the working poor as part of this group.

Another question that may be asked is, what about Medicaid? This is a nationwide program that is sponsored by the federal government and is operated and administered by individual state governments. There are broad federal guidelines as to who is eligible, but the states decide who is eligible; the duration, amount and scope of services provided; provider payment rates; and methods of administering the program. Medicaid will provide health care for certain low-income individuals, but it does not provide health services to all low-income people in every state. It is the largest source of funding for medical and health-related service for people with limited income. It is technically referred to as Title XIX Benefits. The main problems with Medicaid are two fold, (1) physicians do not like to accept Medicaid because it reimburses them at a significantly lower rate, and (2) the majority of those living at or under the federal poverty line are not eligible for Medicaid (Guyer, Broadus, and Dude, 2000 and Pezzin and Kasper, 2002). The fortresses of academia, which are visible from the backyards of the urban working poor and could, in fact, give care to these workers, have broken the covert covenant (see Covenants below) the implication that AHCs would care for them.

An early 21st century analysis

There is little doubt that socioeconomic status affects health status and that race affects economic status (Fleischman et al.). While *Hard Times* confronts socioeconomic status, it does not address race and only hints at ethnicity and regionalism. However, in the 21st century there is also no doubt that race affects health (Cooper and David, 1986 and Massey and Denton, 1989). Therefore, if race can determine socioeconomic status and level of education, then it can affect employment possibilities, which will reflect

upon a worker's ability to obtain adequate, or any, health insurance (Fleischman et al. 2004.).

AHCs cannot be expected to shoulder the brunt of the health needs of urban America without financial assistance. Such help must come from the local, state and federal governments. Unfortunately, such an outlay needs more than a moral will, it needs a political will that is increasingly difficult to muster in the face of extended conflicts, such as Iraq and Afghanistan, and the continued trade deficit and national debt of the United States.

In regard to the moral and political will of society, the moral responsibility of the AHC must be addressed. Dickens expresses the force of morality throughout *Hard Times*. A Kantian backdrop exists in this Dickens novel in regard to this force of morality, "It rules us absolutely and necessarily; we feel its power even when we are most defying it. It is not one consideration to be balanced against others, but rather a compelling dictate that can be ignored, but never refuted" (Scruton, 2001). In *Hard Times,* some characters ignore the force of morality, but it lingers without refute; the reader hears it, feels it, and smells it although it is only ink on pages.

The same can be said of AHCs and their surrounding neighborhoods. The backdrop of the urban health plight does not fade away; it comes to the foreground. This is an irresistible moral force. AHCs, when deciding on an action as an end (whether to more vigorously engage in provision of health care to the medically needy, for example), will be constrained to act only on that principle that they can at the same time "will" as a universal law (Scruton, 2001). This is a restatement of Kant's categorical imperative, which Dickens weaves into his works, knowingly or otherwise. Furthermore, a principle that can be "willed" by AHCs into a universal law is health care access for those neighborhoods that are, literally, in their shadows.

The Montefiore Medical Center and the Johns Hopkins University have acknowledged this deficiency in their response to this covert covenant (Foreman, 2004 and Fox, Morphord, Fine and Gibbons, 2004). Furthermore, AHCs are now recognizing that the congestion of the urban environment underscores the concentration of risk, "The effects of socioeconomic status on health are amplified because risk factors associated with low socioeconomic status tend to cluster within individuals, families, and communities," which is why some claim that social causation is the main explanation for health care disparity in the disadvantaged (Fiscella and Williams, 2004). This disadvantage cuts across all "stages of the life cycle and across environments" (Fiscella et al. 2004).

This circles us back to the dialectic that AHCs and *neighborhood* responsibility go hand in hand (a covenant). Stephen Foreman, M.D., president of the Montefiore Medical Center, Bronx, NY (teaching hospital for the Albert Einstein College of Medicine) calls on "academic medical centers that serve urban communities to go beyond the traditional mission of patient care, teaching, and research by accepting responsibility to build community-based care systems that are capable of improving the health of underserved populations within their reach" (Foreman, 2004).

Foreman claims this call for AHCs to be socially responsible is more than 50 years old (McNulty, Scheps, and Knapp, 1970 and Lewis and Scheps, 1983). Foreman further states that there is an, "implicit social contract that requires AMCs (Academic Medical Centers), in exchange for large amounts of public financial support, to accept

responsibility for addressing many of society's pressing problems, including the complex conditions that undermine many inner-city neighborhoods" (Foreman, 2004).

In view of AHCs continued worry about revenue streams, Dr. Foreman presents evidence that building a community based system that is served by the neighborhood AHC is not only morally right, but strategically correct (Foreman, 2004). Supporting the local working population, if properly organized, could lead to increased government funding, private support, and substantial political capital for future endeavors. With such forward thinking, medical institutions will be properly positioned economically, socially, and politically for successful forays into universal health insurance or other subsidy support when such opportunities present themselves.

The Montefiore Medical Center approach is echoed by the Johns Hopkins Urban Research Institute. John Hopkins University is another AHC that is situated in a poor neighborhood (East Baltimore, MD). The establishment of this institute was a response by Johns Hopkins University to "improve the health and well-being of the residents of East Baltimore and to promote evidence-based interventions to solve urban health problems nation-wide" (Fox et al. 2004). The university acknowledged that the residents living in proximity to their institution lived in inferior conditions, had inferior health indices, and had the worst health conditions of any group in the United States (Fox et al.). Therefore, they too have accepted the social responsibility to intervene through the work of this institute.

AHCs are targeted in this dialectic because of their (1) urban locations, (2) expertise (subspecialty, research, and otherwise), and (3) educational mission (training of physicians, nurses, researchers, and allied health providers). The urban environment presents quite a challenge. A.R. Fleischman's comments on urban health being used as a framing paradigm, or urban health construct, are perceptive as they regard medical education (Fleischman et al. 2004). In *Urban Health: A Look Out Our Windows,* he states that this urban health construct has been of use in social science, health services research, and epidemiology,

> "...but its utility and importance in medical education are relatively underdeveloped. Teaching about urban health in medical education not only examines the special health problems of the urban poor, but it also allows a particularly sharp view of the convergence of clinical and public health perspectives and highlights for students important aspects of cultural sensitivity and social responsibility" (Fleishman et al. 2004).

When I take "a look out our windows" from the literary perspective and glance back 150 years, I see Charles Dickens looking out his window with pen in hand observing how "England's lower classes were experiencing poverty, disease, poor education, and overwork" (Dickens, 1854/2004). Karen Odden's introduction to *Hard Times* allows us to look through Dickens' eyes at the England he was viewing (Dickens, 1854/2004). What is remarkable is that much of what Dickens saw and penned in 19th century England seems to persist in early 21st century America. It is noteworthy that the urban health paradigms that are being addressed today seem to have found their preliminary construction in many of Dickens' works, especially *Hard Times*. This may be lost on those urban health researchers who do not, or cannot, avail themselves to the pronounced, though sometimes cryptic, examples of medicine and public health in literature.

Conclusion

Five years after writing *Hard Times* Dickens wrote a *Tale of Two Cities* and his often quoted opening lines are applicable to the early 21st century,

> "It was the best of times, it was the worst of times, it was an age of wisdom, it was an age of foolishness, it was the epoch of belief, it was the epoch of incredulity, it was the season of Light, it was the season of Darkness…we had everything before us, we were all going directly to Heaven, we were all going direct the other way--in short, the period was *so far like the present day* (Karen Odden's emphasis), that some of its noisiest authorities insisted on its being received, for good or evil, in the superlative degree of comparison only" (Dickens, 1854/2004).

AHCs are uniquely situated and qualified for the task at hand. AHCs should take the moral responsibility for their communities' health. It is the right and proper thing to do. They should endeavor to acquire the capital necessary for the task, put in place the proper educational components, engage in community outreach, and, generally, provide for the common good (health). They must lead the way. The covert covenant made long ago still remains unfulfilled.

References

Anderson, A.T., Sorlie, P., Backlund, E., Johnson, N., & Kaplan, G.A. (1997). Mortality effect of community socioeconomic status. *Epidemiology, 8,* 42-47.

Arrington, R.L. (1998). *Western Ethics*. Oxford: Blackwell Publishers.

Cooper, R.S., & David, R. (1986). The biological concept or race and its application to public health and epidemiology. *Journal of Health Politics, Policy and Law, 11,* 97-116.

Dickens, C. *Hard Times.* (2004). New York: Barnes & Noble Classics.

Fiscella, K., & Williams, D.R. (2004). Health disparities based on socioeconomic inequities: implications for urban health care. *Academic Medicine, 12,* 1139-1147.

Fleischman, A.R., & Barondess, J.A. (2004). Urban health: A look out our window. *Academic Medicine, 12,* 1130-1132.

Foreman, S. (2004). Montefiore Medical Center in Bronx, New York: improving health in an urban community. *Academic Medicine, 12,* 1154-1161.

Fox, C.E., Morphord, T.G., Fine, A., & Gibbons, M.C. (2004). The Johns Hopkins Urban Health Initiative: a collaborative response to urban issues. *Academic Medicine, 12,* 1169-1174.

Ginzberg, E. (2000). *Teaching Hospitals and the Urban Poor*. New Haven: Yale University Press.

Guyer, J., Broadus, M., & Dude, A. (2002). Millions of mothers lack health insurance coverage in the United States. Most uninsured mothers lack access to employer-based coverage and to publicly subsidized insurance. *International Journal of Health Services, 32,* 89-106.

Hobbes, T. *Leviathan*. (1996). Cambridge: Cambridge University Press.

Kelley, E., Moy, E., Stryer, D., Burstin, H., & Clancy, C. (2005). The national health care quality and disparities report: an overview. *Medical Care, 43,* 13-18.

Lewis, I.J., Scheps, C.G. (1983). *The Sick Citadel: The American Academic Medical Center and the Public Interest*. Cambridge: Oelgschlager, Gunn & Hain.

Massey, D.S., & Denton, N.A. (1989). Hypersegregation in U.S. metropolitan areas: black and Hispanic segregation along five dimensions. *Demographics, 26,* 373-391.

McNulty, M.F., Scheps, C.G., & Knapp, R.M. (1970). The role of the teaching hospital in community service. *Journal of Medical Education, 45,* 403-410.

Pezzin, L.E., & Kasper, J.D. (2002). Medicaid enrollment among elderly Medicare beneficiaries: individual determinants, effects on state policy, and impact on service use. *Health Services Research, 37,* 827-847.

Scruton, R. (2001). *Kant: A Very Short Introduction.* Oxford: Oxford University Press.

Sen, A. (1992). *Inequities examined*. Oxford: Oxford University Press