Article

Urban Bioethics: A Call for the Prestige

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Abstract: Many teaching hospitals in the United States were founded on philanthropic principles and aimed to aid the urban poor and underserved. However, as times have changed, there has been a divide created between the urban poor and teaching hospitals. There is a plethora of reasons why this is the case. This paper will specifically focus on the histories of ten hospitals and medical schools and the effect that white flight, segregation, elitism, and marginalization had on healthcare institutions all over the United States. It will call for a reexamination of the values of Ivy League and Ivy Plus teaching hospitals and medical schools and for them to take an intentional look into their communities.

Keywords: minority health; bioethics; urban bioethics; hospitals; medical anthropology

Introduction

In the Christopher Nolan film, *The Prestige*, the opening monologue elaborates on the three elements of a successful magic trick—the pledge, the turn, and the prestige. The pledge is when the magician shows the audience something ordinary like a deck of card or an object. The turn is when the magician changes the object or makes it do something out of character, for example—disappear. The prestige is the last and most important element of the trick—making whatever disappeared, reappear. I will to use this format to illustrate the course that urban bioethics has taken in teaching hospitals and their respective medical schools, because the paths are very similar.[1]

Along the east coast of the United States, there are many advanced and innovative hospitals, and medical schools. These include, geographically moving northward, The Johns Hopkins University Hospital, the Johns Hopkins School of Medicine, The Hospital of the University of Pennsylvania, Pennsylvania Hospital, University of Pennsylvania Perelman School of Medicine, New York-Presbyterian Hospital, Weill Cornell Medical College, Columbia University Medical Center, Massachusetts General Hospital, Brigham and Women's Hospital, and Harvard Medical Schools. Most of the institutions listed above have historical origins in education, charity, and aiding disenfranchised people in urban communities. However, due to white flight, general marginalization of the same disenfranchised people, and the growing prestige of these hospitals with their Ivy League and Ivy Plus affiliated medical schools, the original missions of these institutions became a marker on an online interactive timeline on their websites, and not the core of what they do.

When we consider the format of *The Prestige*, the pledge was philanthropy. It was an ordinary and noble goal for hospitals when they were established. The turn is a change in purpose. Though the hospitals mentioned had a very clear and ordinary purpose, their purpose was altered through the avenues of disenfranchisement, accolades, and changes in healthcare. The prestige, however, is not here. The most important element—the element of reappearance—has not shown itself yet. To quote the film directly, "…But you wouldn't clap yet. Because making

something disappear isn't enough; you have to bring it back."[2] Urban Bioethics is not a magic trick, but the sentiment seems to be similar. This is a call for the prestige.

The Pledge

Johns Hopkins Medicine and The Johns Hopkins University were all created as a result of the philanthropy of Johns Hopkins. Starting out as a grocer, Hopkins became a multimillionaire, banker, Quaker, philanthropist, and the facilitator of the modern medical school education model.[3] In 1866, Johns Hopkins created two corporations: one for a university and the second for a hospital. This hospital was intended to be on the forefront of research and charitable healthcare.[4] In 1872, a year before his death, he officially bequeathed $7 million to be evenly distributed between the two corporations.[5] In a letter to his trustees he made his intentions very clear. "The indigent sick of this city and its environs, with regard to sex, age, or color, who may require surgical or medical treatment, and who can be received into the hospital without peril to the other inmates, and the poor of this city and state, of all races, who are stricken down by any casualty, shall be received into the hospital, without charge."[6] He also goes on to say that this particular hospital should also provide a small number of beds for patients who can afford to pay for their care—which is the opposite of the status quo today.[7] The hospital was built on 13-acres of land previously occupied by Maryland's insane asylum. Though it was not the originally desired location for Hopkins' endeavor, his trustees encouraged him to use the land because "if he [Hopkins] wanted to the help the poor, he ought to build his hospital closer to where they lived."[8]

Though Johns Hopkins died in 1873 and never saw anything more than the purchase of the land on which the hospital would stand,[9] many accomplishments came from the establishment of The Johns Hopkins Hospital and The Johns Hopkins University School of Medicine. John Shaw Billings of Georgetown was brought on as the hospital planner. Billings was a former surgeon himself and also an expert in public health. The Johns Hopkins Hospital was the first hospital in the United States to be equipped with central heating and Billing's attention to the sanitation details of the hospital were considered to be almost fanatical at the time.[10] The entire facility was designed to minimize the spread of diseases with a complex ventilation system as well.[11] The teaching of American medicine was also revolutionized at Hopkins facilities. The "big four" of medicine at the time were brought on to contribute to the academic environment : William Henry Welch, the pathologist; William Stewart Halsted, the surgeon; William Osler, the internist; and Howard Kelly, the gynecologist.[12] These individuals in combination with the guidance of the first president of The Johns Hopkins University, David Coit Gilman, revolutionized medicine by creating intense entrance exams for students interested in medicine, the formal residency program in the United States, prerequisites for program admissions, the implementation of four years of study for medical school, and bedside learning integrated with course work.[13]

Daniel Coit Gilman had his own ideas regarding education and they were revolutionary for the time. He was one of the first university presidents in the United States to integrate knowledge, research and scholarship. To quote from his

inaugural speech, "What are we aiming at? The encouragement of research and the advancement of individual scholars, who, by their excellence, will advance the sciences they pursue, and the society where they dwell."[14] He is viewed as a pioneer of American education.[15] This goal and ideal has not changed since the founding of the institution. The irony, however, is that even though the priority of Johns Hopkins himself was to create a hospital based on philanthropy, with his university following suit, Gilman reprioritized the goals of the institution. Gilman's focus was research and knowledge. This shift was not in itself faulty. However, the aftereffects of this decision can be seen today through the relationship Johns Hopkins Medicine has with their community. Johns Hopkins Medicine is known for many scientific and academic advances, but it is also known amongst minorities for research ethics grievances. One of the most recent incidents was during a lead-paint study overseen by Johns Hopkins University. Two negligence lawsuits were filed against the Kennedy Krieger Institute due to the danger of infecting healthy children with lead poisoning during the study.[16]

Moving northward, the Pennsylvania Hospital was founded in 1751 by Benjamin Franklin and Dr. Thomas Bond.[17] Bond was considered the "father of clinical medicine"[18] and was dedicated to building a hospital in Philadelphia to help alleviate the burdens of the mentally ill and the injured.[19] He also wanted to create a hospital specifically for the poor and ill population of Philadelphia.[20] Caring for this population was something that the city specifically struggled with, due to the sheer volume of people in the city. It had a very large population and had the fastest growing population in the original thirteen colonies.[21] Establishing the Pennsylvania Hospital was considered by Bond to be a promising solution to this problem.[22] However, the citizens of Philadelphia would not endorse the idea without the approval of Benjamin Franklin. After Bond explained his idea, Franklin sincerely approved of the idea and set about creating a petition. Its charter was granted to create a hospital to care for the "sick-poor and insane who wander the streets of Philadelphia."[23] The biblical story of the Good Samaritan was incorporated in the hospital seal to demonstrate the hospital's dedication to social responsibility and charity.[24] Many research related and scientific advances occurred at Pennsylvania Hospital, including the establishment of the first surgical amphitheater in the United States[25] and two obstetrical firsts: the first Birthing Suite in a tertiary care hospital and the first gestational carrier and egg donor programs in the Delaware Valley.[26]

To turn toward medical education in Philadelphia, the University of Pennsylvania housed the first and only medical school in the original 13 colonies. Founded by John Morgan in 1765, the educational format of the school was modeled after the United Kingdom's system.[27] A very famous and reputable staff was brought on to give direction to the hospital. Benjamin Rush was one of those individuals. He was a signer of the Declaration of Independence and was a pioneer of American psychiatry.[28] Philip Syng Physick was also another addition due to his contribution to American surgery. Both of these individuals were nicknamed the "fathers" of their prospective fields.[29] Thomas Story Kirkbride was later added as the new superintendent for the Department of the Insane[30] (which was needed due to the complex issues of the mental health population in Philadelphia).[31] Kirkbride later became one of the founding members of the now American Psychiatric Association.[32] Other famous names include, Robert Hare for chemistry, William Pepper for general medicine, and Joseph Leidy for anatomy.[33]

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By the 1870s, the University of Pennsylvania School of Medicine moved to its present location.[34] Clinical instruction had been occurring between Pennsylvania Hospital and the University of Pennsylvania School of Medicine since 1766.[35] The medical school faculty wanted to expand and encouraged the trustees to build a teaching hospital that was to be owned by the university and staffed by the faculty.[36] The Hospital of the University of Pennsylvania became the first teaching hospital to be built for a medical school.[37] University of Pennsylvania School of Medicine also was one of the first medical schools to incorporate medical specialties such as neurosurgery, ophthalmology, dermatology, and radiology. In 1997, Pennsylvania Hospital formalized its relationship with the University of Pennsylvania and merged with University of Pennsylvania Health System and Penn Medicine.[38]

To move from Philadelphia to New York, we will focus on New York-Presbyterian hospital—the teaching hospital of Weill Cornell Medicine and Columbia University Medical Center.[39] New York-Presbyterian originated as the two separate, charitable hospitals of Presbyterian Hospital and New York Hospital.[40] Samuel Bard founded New York Hospital in 1769. Bard, a physician, professor, and founder of The Medical School of King's College[41] stated during a graduation address that it was necessary that New York City saw "the need for a 'Public Hospital for the reception of the sick-poor of this government and city."[42] Bard's dedication to this cause led to King George III's chartering of the Society of the New York Hospital in the City of New York, in America.[43] Due to a fire on the building site and the American Revolutionary War, the hospital did not open until 1791.[44] However, many medical advances occurred at New York Hospital during its existence, including the first pap test to detect cervical cancer, the first hospital in the tri-state area to use a bloodless surgery program, and housing the largest burn center in the nation.[45]

Presbyterian Hospital, the second half of the New York-Presbyterian Hospital, opened in 1868.[46] James Lenox, the founder and philanthropist, owned a significant amount of land that extended from 68th Street to 74th Street and from Park Avenue to Fifth Avenue.[47] He shared the Presbyterian perspective that their denomination needed a religious, charitable presence in the New York City healthcare market to match the Catholics, the Episcopalians, and the Jewish population.[48] Lennox said that this hospital was "for the Poor of New York without Regard to Race, Creed, or Color." It was also intended to be an evangelistic tool for the Presbyterian faith. When Presbyterian Hospital opened, it housed beds for 300 patients,[49] 32 ward beds and private rooms,[50] and had advanced ventilation systems to prevent the spread of disease.[51] By 1910, Presbyterian Hospital officially partnered with Columbia University and continued to make revolutionary advancements in American medicine—including the first pediatric heart transplant.[52] In 1997, New York Hospital and Presbyterian Hospital merged to create the New York-Presbyterian Hospital System and a powerhouse for research, medical care, and education in the tri-state area.[53]

To shift focus to the medical schools affiliated with New York-Presbyterian Hospital System, Columbia University was founded 1754. Originally called King's College, it was the first University in the thirteen colonies to confer the Doctor of Medicine Degree. The original medical faculty was organized in 1767. The establishment of The College of Physicians and Surgeons was a direct response to the intentional shift in focus, that the government made in New York City, toward

medicine and the advancement of medical education.[54] Cornell University Medical College found its origins in a disagreement in the management of University Medical College of New York University and Bellevue Hospital Medical College. A legal dispute followed, leading to the cessation of faculty members from the University Medical College of New York University and Bellevue Hospital Medical College to Cornell University. With a generous donation from Colonel Oliver Hazard Payne, the medical college was founded.[55] Their relationship with New York Hospital was formalized in 1912 and their name was changed to Weill Medical College of Cornell University in 1998.[56]

The final city discussed here is Boston, Massachusetts with the history of Brigham and Women's Hospital, Massachusetts General Hospital, and Harvard Medical School. Brigham and Women's Hospital was formed from four separate institutions: Boston Lying In, Free Hospital for Women, Peter Bent Brigham Hospital, and Robert Brigham Hospital for Incurables.[57] Boston Lying In was founded in 1832 for "poor and deserving women" without the means to finance home medical treatment (the traditional way of obtaining medical care at the time). Its founding was financed by the Massachusetts Charitable Fire Society and the Massachusetts Humane Society with $5,000 from each institution.[58] Dr. William H. Baker founded Free Hospital for Women in 1875. He envisioned a teaching hospital for poor women with ailments specific to their sex. Immediately, it became an affiliate institution of Harvard University and grew very quickly.[59] Its namesake, Peter Bent Brigham, founded Peter Bent Brigham Hospital in 1913. A wealthy philanthropist, Brigham intended that this hospital would serve the sick in Suffolk, Massachusetts and to be a teaching hospital. They also had an alignment with Harvard, though informal for many years.[60] Robert Brigham Hospital for the Incurables was chartered in 1903 and opened in 1914. The nephew of Peter Bent Brigham, he founded the first hospital dedicated to the treatment of arthritis and rheumatic disease. This hospital specially catered to the poor in the community with arthritis.[61] In 1966, Boston Lying In and Free Hospital merged, creating Boston Hospital for Women. And in 1975, Boston Hospital for Women merged with both of the Brigham hospitals—thus leading to the creation of Brigham and Women's Hospital. By 1980, Brigham and Women's Hospital officially affiliated themselves with Harvard.[62]

The last hospital to be addressed is Massachusetts General Hospital. However, what makes this hospital intriguing is that this is the only listed hospital that was not built on charitable principles and ideas. Massachusetts General Hospital was built for the purpose of giving general care to the Boston population and creating an environment for medical education[63]—not to specifically serve the poor and indigent. One article of the *Journal of Neurosurgery* states,

> Boston was more complex than an unmixed recognition of the duty of the rich to provide for the poor. The signatories to the 1810 petition, who represented Boston's most socially prominent families, were assured of getting more for their money than simple charity. Since physicians associated with a charitable hospital practice also tended to accrue patients of a higher social standing, the hospital thus functioned not simply as a training ground for fledgling physicians, but also as a means of reinforcing the medical and social elitism already characteristic of contemporary Boston society.[64]

Massachusetts General Hospital became Harvard's first teaching hospital.[65] Reverend John Bartlett, Chaplain of the Almshouse in Boston, fundraised in the community to build this hospital.[66] It was officially open to take on patients in September 1821, but was not immediately successful. A year into its opening, there were only 12 patients out of the 83 empty beds and one individual out of the six beds reserved for the poor (due to the stereotype that elite medical care took place in the home).[67] However a significant amount of medical achievements were accomplished at the hospital: the first public demonstration of surgical anesthesia, the first replantation of a severed arm, and the identification of appendicitis.[68] The hospital as a whole also helped solidify important standards for medical education today.[69] Mentioning Massachusetts General Hospital can appear to divert from the thesis of this paper. On the contrary, it highlights how similar the institutions mentioned were and are, even though their origins were different. All of the hospitals mentioned prior to this had philanthropic origins and intentions. Massachusetts General Hospital did not. However, the landmark advances made in medicine and in education is a continuing theme for these institutions. It also contrasts the accountability that the institutions mentioned above are being held to.

Harvard Medical School itself was founded in 1782. It was not a particularly large school—it only had a "handful of students" and three faculty members.[70] Benjamin Waterhouse was the professor of the theory and practice of physic, John Warren was the professor of anatomy and surgery, and Aaron Dexter was the professor of chemistry and pharmacology. All of them were acclaimed and talented in their fields, with innovation to add to the institution.[71] However, Charles Eliot, the 21st president of Harvard University, made long lasting curricular changes that set the standard for medical schools today. Admission standards became more strict, written exams were required, higher grades were demanded, the apprenticeship program was eradicated, and a three-year-degree-program was introduced.[72] The medical school moved from Cambridge to Boston in 1810, and then moved again to Longwood Avenue in 1906—currently known as the Longwood Medical Area.[73]

The Turn

The Ivy League and Ivy Plus hospitals listed above were created with a charitable intent. They were meant to aid their newly urban communities and serve the underprivileged citizens with no discriminatory intent. They also made tremendous strides in research and science as a whole along with the medical schools they were affiliated with. These hospitals and medical schools changed history. As redundant as this theme is, a change eventually takes place. This section will address the demographic changes that American cities experienced and how this impacted the original intent of these hospitals.

White flight greatly contributed to the demographic change in American cities. White flight is defined as "the demographic shifting of working- and middle-class white United States citizens from the urban areas of the United States to outlying suburbs and exurbs."[74] It started to occur as early as 1900 and continues today.[75] This change in demographic, combined with the effects of the Great Migration, contributed to the racial and ethnic change in the urban landscape. Areas previously inhabited by white populations became predominantly African American in a very short span of time.[76] For every black arrival, there were an estimated 2.7 white departures.[77]

White flight also had a direct correlation with segregation. As white flight increased, formal and informal jurisdictional segregation increased. [78] This dramatically effected the patient populations of urban hospitals. The best hospitals were reserved for what were unfortunately considered the best patients, alienating the blossoming urban populations. Physicians in those hospitals were also hesitant to treat patients that were not in this particular bracket. A Chicago physician who was a member of The Committee to End Discrimination in Chicago Medical Institutions in 1954 said, "Doctors are not always courageous, and they sure knew that in some of the hospitals with the ghetto approaching that it would be sacrilege to admit a black."[79] Only two of the 76 hospitals in Chicago accounted for 60 percent of black births and 77 percent of black deaths as of 1954.[80]

This was also true in the Northeast. David Barton Smith wrote in his article *Racial and Ethnic Health Disparities and the Unfinished Civil Rights Agenda*, "In many northern metropolitan areas without official Jim Crow practices, segregation, while more subtle, was also as complete. It resulted from the exclusion of black physicians from admitting privileges to historically white hospitals and the informal understanding of white physicians who did have privileges about where it was acceptable to admit their black patients."[81] For many years, there was no way to prove discriminatory treatment in hospitals or health disparities (meaning differences in access to, or availability of, facilities and services in healthcare)[82] in black communities. The National Health Interview Survey did not collect data on African-American health disparities until 1958.[83] Hospitals were later desegregated, partially due to Title IV of the Civil Rights Act of 1964, by incorporating the desegregation of hospital wings, blood supplies, and race-blind room assignments. However, this did not make everything automatically better for those who were excluded from elite healthcare. Some hospitals started to relocate or expanded into more homogenously white, suburban areas. The University of Pennsylvania Health System and New-York Presbyterian Healthcare System both have locations that could be categorized as such.[84]

There were also issues of general marginalization in healthcare. The most glaring example of this is human experimentation. During the period of slavery in the Americas, there were many instances of surgical experimentation and demonstrations on blacks. They were frequently done without anesthetic and usually left the individual marred or disfigured.[85] The Tuskegee Syphilis Experiments, which spanned from 1932 to 1972, purposefully gave countless poor, rural, African American males syphilis without telling them or giving them the medication needed to cure them—even after penicillin was invented. More than 100 subjects died.[86] The Guatemalan syphilis experiment, lasting from 1946 to 1948, ultimately affected 5,500 Guatemalan prisoners, sex workers, soldiers, children, and psychiatric patients. About 25 percent of the individuals were knowingly given syphilis, gonorrhea, or chancroid and all of them were victims of nonconsensual research.[87] There were nonconsensual whole-body radiation experiments, sponsored by the Department of Defense, done on black cancer patients from 1961 to 1970.[88] The list continues. Though this research was justified by the perceived, inherent biological differences between nonwhites and whites, it enhanced the effect of marginalization.

Marginalization also shows in the stereotypes created by diseases. For example, the stereotyped four H's of HIV/AIDS were hemophiliacs, homosexuals, heroin addicts, and Haitians.[89] Most of these terms are considered derogatory today and

have developed very negative connotations. These are groups believed to be at a greater risk of contracting the HIV/AIDS virus. Four out of the five H's are usually members of urban populations. These stigmas, though they arose at the start of the AIDS epidemic, have followed these groups for years. This naturally puts these individuals on the outer echelons of society. The effects of these stigmas were long lasting. Socially, it also made these individuals more likely to live on the outside of traditional Western medicine for fear of social shaming.

Of course, the response to this could always be that these events all occurred a long time ago—why should it matter now? However, the roots of communication for many marginalized people are in oral tradition and passing information through word of mouth.[90] This is still how many communities communicate amongst themselves and the accounts of inhumane experimentation and social shaming still permeate the narrative. If one went further and connected this to the idea of a research hospital (especially if the individual did not know everything that a research hospital does) the very thought can be so negative-by-association that the institution cannot remain unmarred.

The growing prestige of hospitals also contributed to the widening divide between elite healthcare and the new urban demographic. Each of the hospitals and medical schools listed above made significant advances in medicine. These advances contributed to the prestige of the hospitals and the clientele they attracted. Not only did it attract a prestigious clientele, it attracted physicians as well. The Ivy League and Ivy Plus institutions affiliated with the hospitals therefore cultivated these physicians, feeding them into the historic and elite hospitals. As stated earlier, clientele who were historically considered elite moved into the suburbs. Even though the demographic of the urban areas changed and the mission of these institutions remained the same, the clientele did not change; they just came from a different part of the community or—perhaps more accurately—a completely different community.

The Prestige

Bioethics is the ethics of biology and everything related to it. It is a way for us to create new moral ideas and philosophies in the face of a constantly changing world of technology. However, at its core, it is a way to connect science with humanity. Urban bioethics was specifically defined by Jeffrey Blustein, and Alan Fleischman in 2004 as follows: "Urban bioethics is an area of inquiry within the discipline of bioethics that focuses on ethical issues, problems, and conflicts relating to medicine, science, health care, and the environment that typically arise in urban settings."[91] Blustein and Fleischman go on to explain that urban bioethics is supposed to challenge traditional bioethics in two ways. First, it should challenge traditional bioethics by evaluating value concerns, health disparities, and public health within the context of cultural and ethnic diversity. Second, it should expand its focus on autonomy to include the values and interests of family, community and society.[92]

Bluestein and Fleischman's perspective takes into consideration the unique needs of cities and their populations and differentiates them from suburban or rural needs. Even though being in good health is a general value that surpasses geography, different regions have different needs. For example, residents of urban environments tend to have larger disparities in socioeconomic status.[93] There are

also higher rates of crime and/or violence and a greater occurrence of psychological stressors on their residents.[94] Air quality is usually worse in urban areas, and that can contribute to diseases such as asthma.[95] However, residents of rural environments have different health issues. Rural residents tend to smoke more and be more sedentary than suburban residents. They are also more likely to struggle with obesity.[96] Primary care physicians and other healthcare facilities tend to be farther away from rural areas, thus requiring especially longer travel times to receive care.[97] This implies that bioethical nuances of these communities are different as well. Even though the bioethical principles of autonomy, beneficence, nonmaleficence, and justice are the core values of most individuals, geographic health challenges can change the lens through which they are perceived.

As discussed earlier, the original purpose of teaching and research hospitals were to aid the urban population in some way, with a specific emphasis on the poor and marginalized. This, according to the definition above, was a facet of what urban bioethics was supposed to be. However, somewhere along the road, urban bioethics became stagnant. Urban bioethics did not accommodate its changing urban population. Even though the demographics of cities change, due to segregation, white flight, and the growing prestige of the hospitals and institutions attached to them, the healthcare systems did not accommodate the changes.

Of course there could be many questions to counter the premise of this paper. Is this really a historical issue? Why should an institution be tied to its original principles? Shouldn't institutions have the flexibility to grow and change as the times grow and change? There are also questions regarding the sincerity of the intentions to help the poor and indigent. Were these hospitals built with the intention of exploiting the poor? Was it done to purposefully experiment on them because no one would notice or care? However, these are not the most important questions. The most important question is this: If any institution in a community takes resources from that same community—should they be obligated to give back to it? When these institutions were founded, the answer was a resounding "Yes." However, somewhere in the history of these institutions, the "Yes" has become more of a complacent "Eh."

Many of hospitals listed above are involved in philanthropic work and make efforts to reach into their communities. However, the occasional community day or free clinic is not enough to change the negative stigmas that the current urban population has regarding healthcare. This will require a greater compassion from the healthcare system and consistent training in cultural competency, to enable the physicians and administrators of these institutions have a greater understanding of the values of their respective urban communities. We have to create an environment where leveling with the communities in which we work is the norm and not the extra mile. It is not good enough to build glittering buildings in areas and forget to look out our windows to see who walks below. It is not good enough to conveniently focus on accommodating the previous urban population. It is a new day and we have to look to who and what is in front of us. In light of the protests against racial profiling and police brutality, gun violence, the current presidential election, and the Affordable Care Act, it is time to move healthcare in this direction. This call, however, is not to trivialize the business aspect of running a hospital. Healthcare costs continue to rise as technology has increased and medicine has advanced. The hospitals described here were also founded, before widespread medical insurance was available, to aid the cost of healthcare. Creating environments

for discovery and elite education are to be commended; however, there is more that can—and must—be done to accommodate the current urban population and meet the intentions of the founders of these prestigious hospitals. Innovation and philanthropy are not mutually exclusive.

To reference the introduction, the most important aspect of the magic trick is the prestige. No one claps until the prestige occurs because anyone can make something disappear. It is futile to wait for applause before the object reappears—one needs the prestige to truly make an impact. The rediscovery of urban bioethics is a call for the prestige. If elite healthcare wants to go from just facilitating interest to creating applause, they have to bring back what has disappeared. The call should be to bring back urban bioethics and reimplement the original purpose of these institutions. It should also be incorporated into the education of the respective medical schools. The urban population is holding their breath, waiting for the prestige.

Notes

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7. See note 6.
8. What Hopkins Built, and Where; available at http://www.hopkinsmedicine.org/about/history/history2.html (last accessed 16 Nov 2017).
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19. Pennsylvania Hospital History: Historical Timeline—Dr. Thomas Bond; available at http://www.uphs.upenn.edu/paharc/timeline/1751/tline2.html (last accessed 16 Nov 2017).
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21. See note 20, Pennsylvania Hospital History.

22. See note 20, Pennsylvania Hospital History.
23. Pennsylvania Hospital History: Historical Timeline—1751–1800; available at http://www.uphs. upenn.edu/paharc/timeline/1751/ (last accessed 16 Nov 2017).
24. See note 23, Pennsylvania Hospital History.
25. Pennsylvania Hospital History: Virtual Tour—Surgical Amphitheatre; available at http://www. uphs.upenn.edu/paharc/tour/tour5.html (last accessed 16 Nov 2017).
26. Pennsylvania Hospital History: Historical Timeline—1951-Today; available at http://www.uphs. upenn.edu/paharc/timeline/1951/index.html (last accessed 16 Nov 2017).
27. School of Medicine: A Brief History, University of Pennsylvania University Archives; available at http://www.archives.upenn.edu/histy/features/schools/med.html (last accessed 16 Nov 2017).
28. Pennsylvania Hospital History: Historical Timeline—1751–1800, *supra* at note 23.
29. Pennsylvania Hospital History: Historical Timeline—1801–1850; available at http://www.uphs. upenn.edu/paharc/timeline/1801/ (last accessed 16 Nov 2017).
30. See note 29, Pennsylvania Hospital History.
31. Pennsylvania Hospital History: Historical Timeline—1751–1800, *supra* at note 28.
32. Pennsylvania Hospital History: Historical Timeline—1801–1850, *supra* at note 29.
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42. Cornell University Medical College (Weill Medical College of Cornell University), *supra* note 40.
43. See note 42, Cornell University Medical College.
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