

PART

4 Health Care Providers and Bioethics

CHAPTER 11 **The Profession of Medicine**

CHAPTER 12 **Other Mainstream and Alternative Health Care Providers**

CHAPTER 13 **Issues in Bioethics**

In this final section, we shift our perspective to health care providers. Chapter 11 provides an overview of the history of medicine as a profession and describes how the social position of doctors has changed over time. In this chapter we also explore how a person becomes a doctor, including the nature of medical education and medical culture and the steps involved in building a medical career. Finally, we look at how medical education and medical culture, as well as broader social and cultural factors, affect relationships between doctors and patients.

Although doctors typically are the first persons who come to mind when we think of health care, they form only a small percentage of all health care providers. In Chapter 12, we consider some of these other providers both within and outside the mainstream health care system, including nurses, pharmacists, midwives, and acupuncturists.

The final chapter in this part, and in this book, provides a history of bioethics as well as a sociological account of how bioethics has become institutionalized and of its impact on health care and health research. We will see how issues of power underlie ethical issues and why we need a sociological understanding of bioethics.

CHAPTER 11



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The Profession of Medicine

To become a doctor, students must spend long years studying biology, chemistry, physiology, and other subjects. In addition, students must learn the way of thinking about medicine, patients, and medical care—the worldview—that characterizes medical culture.

Michael J. Collins learned this worldview during four years as a surgical resident at the Mayo Clinic. After a particularly brutal day of surgery in which he watched a teenager die, Dr. Collins found himself emotionally traumatized, questioning the meaning of his work and the effect it had on him. Although he wished he could discuss his feelings with BJ Burke, the director of his residency program, Collins knew from experience how BJ would respond. As he wrote in his memoir,

BJ Burke was not interested in what I thought or understood. He was interested in what I did.

“If you want to learn to be sensitive and introspective,” he would say, “do it on your own time.”

I imagined myself being called into his office. As I enter the room he is seated at his desk, reading the report in front of him. He makes certain I know I am being ignored.

At length he looks at me over the top of his glasses.

“Dr. Collins, what is your job?”

“My job, sir?”

“You have a job, don’t you? You get a paycheck, don’t you?”

“Yes, sir.”

“Well, what do you do?”

“I’m a second-year orthopedic resident at the Mayo Clinic.”

“Do you want to be a third-year resident someday, Dr. Collins?”

“Yes, sir.”

“What is an orthopedic resident supposed to do?”

Where was this going? “Following orders?” I venture.

“An orthopedic resident is supposed to practice orthopedics, Doctor. He is not supposed to go around asking patients if they have ever considered the ontological implications of their fragile, mortal state.”

“I didn’t exactly—”

He jumps to his feet and points his finger at me. “We fix things. Do you understand that? We don’t analyze things. We don’t discuss things. We don’t wring our hands and cry about things. We fix them! If somebody wants to be analyzed they can see a shrink. When they come to the Department of Orthopedics at the Mayo Clinic they want only one thing: they want to be fixed.”

“Now get the hell out of here and go fix things. And I better not get any more reports of touchy-wouchy, hand-holding sessions in this department.” (Collins, 2005: 152–153)

Collins’s story illustrates two basic elements of modern-day medical culture—emotional detachment and a belief in medical intervention. In this chapter we look at how these and other aspects of medical culture and training evolved, at the consequences for both doctors and their patients, and at the history and current status of medicine as a profession.

American Medicine in the Nineteenth Century

When confronted by disquieting illness, most modern-day Americans seek care from a doctor of medicine. Little more than a century ago, however, that would not have been the case. Instead, Americans received most of their health care from family members. If they required more complicated treatment, they could choose from an array of poorly paid and typically poorly respected health care practitioners (Starr, 1982: 31–59). These included **regular** doctors, who were the forerunners of contemporary doctors. They also included such **irregular practitioners** as patent medicine makers, who sold drugs they concocted from a wide variety of ingredients; botanic eclectics, who offered herbal remedies; bonesetters, who fixed dislocated joints and fractured bones; and midwives.

Regular doctors were also known as **allopathic doctors**, or allopaths (from the Greek for “cure by opposites”), because they sometimes treated illnesses with drugs selected to produce symptoms *opposite* to those caused by the illnesses. For example, allopaths would treat patients suffering the fevers of malaria with quinine, a drug known to reduce fevers, and treat patients with failing hearts with digitalis, a drug that stimulates the heartbeat. Their main competitors were **homeopathic doctors**, or homeopaths (from the Greek for “cure by similars”). Homeopaths treated illnesses with drugs that produced symptoms *similar* to those caused by the illnesses—treating a fever with a fever-producing drug, for example. Although in retrospect the

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In the 1890s, even surgery at a major hospital such as Johns Hopkins required no advanced technologies.

homeopathic model might seem odd, it drew on the same logic as smallpox inoculation, the one successful inoculation available at that time: People who were inoculated with a small quantity of cowpox cells, and who therefore developed a mild form of cowpox, somehow became immune to the related but far more serious smallpox. Homeopaths therefore concluded that patients who received a small quantity of a drug that mimicked the symptoms of a given illness would become better able to resist that illness. At any rate, although homeopathy helped patients only through a **placebo** effect, it at least did not harm them.

That Americans before the twentieth century placed no greater trust in allopathic doctors than in any others who claimed knowledge of healing should not surprise us. Although by the nineteenth century, science—the careful testing of hypotheses in **controlled** experiments—had infiltrated the curricula of European medical schools, where many of the wealthiest or most dedicated Americans trained, it had gained barely a foothold in U.S. medical schools. Moreover, the United States licensed neither doctors nor medical schools (Ludmerer, 1985). Instead, and until about 1850, most doctors trained through apprenticeships lasting only a few months. After that date, most trained at any of the multitude of uncertified medical schools that had sprouted around the country, almost all of which were private, for-profit

institutions, unaffiliated with colleges or universities and lacking any entrance requirements beyond the ability to pay tuition (Ludmerer, 1985). Nor were standards stricter at the few university-based medical schools. For example, in 1871, Henry Jacob Bigelow, a Harvard University professor of surgery, could protest a proposal to require written graduation examinations on the grounds that more than half of Harvard's medical students were illiterate (Ludmerer, 1985: 12). Training averaged far less than a year and depended almost entirely on lectures, so that almost no students ever examined a patient, conducted an experiment, or dissected a cadaver. Any student who regularly attended the lectures received a diploma. This situation began to change significantly only in the 1890s and only in the better university schools.

Lacking scientific research or knowledge, allopathic doctors developed their ideas about health and illness either from their clinical experiences with patients or by extrapolating from abstract, untested theories. The most popular theory of illness, from the classical Greek era until the mid-1800s, traced illness to an imbalance of bodily "humors," or fluids. Doctors had learned through experience that ill persons often recovered following episodes of fever, vomiting, or diarrhea. From this, doctors deduced—in part correctly—that fever, vomiting, and diarrhea helped the body restore itself to health. Unfortunately, lacking methods for testing their theories, doctors carried these ideas too far, often inducing life-threatening fever, vomiting, purging, and bloodletting. Consider, for example, the following description of how Boston doctors in 1833 used what was known as **heroic medicine** to treat a pregnant woman who began having convulsions a month before her delivery date:

The doctors bled her of 8 ounces and gave her a purgative. The next day she again had convulsions, and they took 22 ounces of blood. After 90 minutes she had a headache, and the doctors took 18 more ounces of blood, gave emetics to cause vomiting, and put ice on her head and mustard plasters on her feet. Nearly four hours later she had another convulsion, and they took 12 ounces, and soon after, 6 more. By then she had lapsed into a deep coma, so the doctors doused her with cold water but could not revive her. Soon her cervix began to dilate, so the doctors gave ergot to induce labor. Shortly before delivery she convulsed again, and they applied ice and mustard plasters again and also gave a vomiting agent and calomel to purge her bowels. In six hours she delivered a stillborn child. After two days she regained consciousness and recovered. The doctors considered this a conservative treatment, even though they had removed two-fifths of her blood in a two-day period, for they had not artificially dilated her womb or used instruments to expedite delivery. (R. Wertz and D. Wertz, 1989: 69)

As this example suggests, because of the body's amazing ability to heal itself, even when doctors used heroic medicine, many of their patients survived. Thus, doctors could convince themselves they had cured their

patients when in reality they either had made no difference or had endangered their patients' lives.

By the second half of the nineteenth century, most doctors, responding to the public's support for irregular practitioners and fear of heroic medicine, had abandoned the most dangerous of their techniques. Yet medical treatment remained risky. Allopathic doctors' major advantage over their competitors was their ability to conduct surgery in life-threatening situations. Unfortunately, until the development of anesthesia in the 1860s, many patients died from the inherent physical trauma of surgery. In addition, many died unnecessarily from postsurgical infections. Dr. Ignaz Semmelweis had demonstrated in the 1850s that because midwives (whose tasks included washing floors and linens) had relatively clean hands, whereas doctors routinely went without washing their hands from autopsies to obstetrical examinations and from patient to patient, more childbearing women died on medical wards than on midwifery wards. Yet it took another 30 years before hand washing became standard medical practice.

Until well into the twentieth century, then, doctors could offer their patients little beyond morphine for pain relief, quinine for malarial and other fevers, digitalis for heart problems, and, after 1910, salvarsan for syphilis—each of which presented dangers as well as benefits. According to the 1975 edition of *Cecil's Textbook of Medicine*, one of the most widely used medical textbooks, only 3 percent of the treatments described in the 1927 edition of this textbook were fully effective, whereas 60 percent were harmful, of doubtful value, or offered only symptomatic relief (Beeson, 1980). Doctors' effective pharmacopeia did not grow significantly until the development of antibiotics in the 1940s.

Beginnings of Medical Dominance

Despite the few benefits and many dangers inherent in allopathic medical care, by about 1900 doctors had eliminated most of their competitors and gained control over health care (Starr, 1982: 79–112). In this section, we will see how this change came about.

From its inception in 1847, the **American Medical Association (AMA)** had worked to restrain the practices of other health care occupations. State by state, the AMA fought to pass laws outlawing their competitors or restricting them to working only under allopathic supervision or to performing only certain techniques, such as spinal manipulation.

Most of these efforts met with little success initially, for nineteenth-century Americans considered health care an uncomplicated domestic matter, unrelated to science and not requiring complex training (Starr, 1982: 90–92). By the beginning of the twentieth century, however, as improvements in public health and in living conditions ended scourges such as cholera and typhoid, and as Americans began reaping practical dividends

from scientific advances such as electric lights and streetcars, public faith in science swelled. Increasingly, Americans defined health care as a complex matter requiring expert intervention, assumed the superiority of “scientific” medicine, and turned to allopathic doctors for care (Starr, 1982: 127–142).

Like the public, homeopaths and botanic eclectic (allopathic doctors’ two major groups of competitors) also had come to recognize the benefits of science and therefore to realize that a lack of scientific foundation would soon doom their fields. However, they still received considerable popular support. Moreover, because, like allopaths, most were white men, homeopaths and botanic eclectic generally held social statuses similar to those of allopaths. Thus homeopaths and botanic eclectic retained sufficient influence to pressure allopaths to accept them into medical schools and licensing programs, and their fields eventually faded away.

Other health care workers could bring far less power to their dealings with legislators and with allopathic doctors. Newly emerging occupations such as chiropractic (described in Chapter 12) lacked the long-standing history of popular support that had allowed homeopaths to push for incorporation with allopathy. Older occupations, meanwhile, such as midwives and herbalists, lacked the social status, power, and money needed to fight against doctors’ lobbying. Because most of these practitioners were women or minorities, they were assumed to be incompetent by both legislators and doctors (Starr, 1982: 117, 124).

The Flexner Report and Its Aftermath

These differences between allopathic doctors and other health care practitioners increased during the early years of the twentieth century. Since the 1890s, the better medical schools had begun tightening entrance requirements, stressing higher academic standards, emphasizing research and science, and offering clinical experience. These changes placed pressures on the other medical schools to do the same. Those pressures increased following publication in 1910 of the **Flexner Report** on American medical education (Ludmerer, 1985: 166–190). The report, which was written by Abraham Flexner and commissioned by the nonprofit Carnegie Foundation at the AMA’s behest, shocked the nation with its descriptions of the lax requirements and poor facilities at many medical schools. The Flexner Report increased the pressures on all medical schools to improve their programs and accelerated the process of change that was already under way. In the next few years, responding to pressure from both the public and the AMA, all U.S. jurisdictions adopted or began enforcing stringent licensing laws for medical schools (Ludmerer, 1985: 234–249). These laws hastened the closure of all proprietary and most nonprofit schools, many of which were already suffering financially from the costs of trying to meet students’ growing demand for scientific training. As a result, the number of medical schools fell from 162 in 1906 to 81 in 1922 (Starr, 1982: 118, 121).

The Flexner Report, in conjunction with the changes already under way in medical education, substantially improved the quality of health care available to the American public and paved the way for later advances in health care. However, these changes in medical education also had some more problematic results. The closure of so many schools made medicine as a field even more homogeneous. Only two of the seven medical schools for African Americans survived, and only one of the seven schools for women (Ludmerer, 1985: 248; Starr, 1982: 124). In addition, because the university schools set stricter educational prerequisites than had the defunct proprietary schools, few immigrants, minorities, and poorer whites could meet their entrance requirements. Even fewer could afford the tuition required by scientifically oriented university programs. Moreover, for the next several decades many programs openly discriminated against women, African Americans, Jews, and Catholics. So, even though the technical quality of medical care increased, fewer doctors were available who would practice in minority communities and who understood the special concerns of minority or female patients. At the same time, simply because doctors were now more homogeneously white, male, and upper class, their status grew, encouraging more hierarchical relationships between doctors and patients.

Doctors and Professional Dominance

By the 1920s, doctors had become the premiere example of a **profession** (Parsons, 1951). Although definitions of a profession vary, sociologists generally define an occupation as a profession when it is considered by most to have three characteristics:

1. The autonomy to set its own educational and licensing standards and to police its members for incompetence or malfeasance;
2. Technical, specialized knowledge, unique to the occupation and learned through extended, systematic training; and
3. Public confidence that its members follow a code of ethics and are motivated more by a desire to serve than a desire to earn a profit.

For at least the first half of the twentieth century, doctors clearly met this definition of a profession. Doctors' autonomy was evidenced in the fact that they, rather than consumers or judges, were legally responsible for deciding whether to remove the license of any doctors accused of incompetence. That doctors held highly specialized knowledge, and that they spent many years acquiring that knowledge, was well known. Finally, most Americans placed great trust in the medical field, and believed that physicians placed their patients' interests first; although trust in medicine as an institution has declined precipitously in recent years, Americans still strongly trust their own physicians and rank medicine first among occupations in prestige (Harris Poll, 2004b).

As the leading profession in the health care world, doctors enjoyed—and to some extent still enjoy—an unusually high level of **professional dominance**: freedom from control by other occupations or groups and ability to control any other occupations working in the same economic sphere. This concept has been most fully analyzed by Eliot Freidson (1970a, 1970b, 1994). As Freidson has noted, for much of the twentieth century, most doctors worked in private practice (whether solo or group), setting their own hours, fees, and other conditions of work. Those who worked in hospitals or clinics were typically supervised by other doctors, not by nonmedical administrators. Although doctors often supervised members of other occupations, the reverse has begun taking place only in the last two decades or so. Similarly, both in the past and currently, doctors often served on boards charged with judging the education and qualifications of other health care occupations, but members of other occupations played little role in setting standards for medical education and licensing. This high level of professional dominance by doctors—otherwise known as **medical dominance**—stemmed from the public's great respect for doctors' claims to a scientific knowledge base and service orientation. This respect in turn was bolstered with active lobbying by organized medicine.

The Decline of Medical Dominance

One of the most heated debates within the sociology of health and illness is the extent to which medical dominance has declined (Freidson, 1994; Light and Levine, 1988; Starr, 1982: 379–393). Foremost among those arguing that professional dominance has declined are Marie Haug, John McKinlay, and John Stoeckle. They differ, however, in where they locate the sources of this decline, with Haug (1988) focusing on changes in public sentiment and access to medical knowledge and McKinlay and Stoeckle (1989) on changes in health care financing and organization (see Key Concepts 11.1).

Changing Patient Attitudes and Deprofessionalization

In her writings, Haug has focused on how the civil rights and feminist movements of the 1960s and 1970s increased popular emphasis on rights rather than duties and on questioning rather than obeying authorities (Haug, 1988; Starr, 1982: 379–393). At the same time, Haug argues, the general rise in educational levels and in public access to medical information has helped patients to evaluate their symptoms and treatment for themselves and to challenge their doctors' diagnoses and decisions about care. These changes, coupled with growing public awareness of how unquestioning obedience to doctors sometimes can harm patients' health, helped foster both the feminist health movement and the patients' rights movement. These movements both reflected and created more egalitarian ideas about how doctors and patients should interact.

Key
Concepts 11.1

Divergent Views on Medical Dominance

THE PROFESSIONAL DOMINANCE MODEL

DECLINE OF DOMINANCE MODELS

High level of prestige
Public defers to medical judgment and feel loyalty to their doctors.

Doctors hold strong economic position.
Doctors set own working conditions.

Only doctors supervise doctors.

Doctors supervise and control other health care occupations.

Doctors act solely or largely based on their clinical judgment.

A. Deprofessionalization
Decline in public confidence and respect
Public questions medical judgment and feels little loyalty to doctors.

B. Proletarianization
Doctors become economically vulnerable and AMA power declines.
Doctors' working conditions set by corporate employers.
Doctors supervised by nonmedical administrators and review boards.
Other health care occupations gain considerable independence from medical control.
Doctors' clinical autonomy constrained by corporate or governmental guidelines.

These new popular health movements have stimulated major changes in medical practice, ranging from the sharp decrease in use of general anesthesia during childbirth to the routine use of informed consent forms before patients receive experimental drugs. More broadly, through publications such as the many editions of the best sellers *Take Care of Yourself: The Complete Illustrated Guide to Medical Self-Care* (Fries, 2004) and *Our Bodies, Ourselves* (Boston Women's Health Book Collective, 2005), these movements have encouraged consumers to take charge of their own health, to use practitioners other than doctors, and to obtain second opinions when they do go to doctors.

The rise of the Internet has added impetus to this movement, giving consumers instant access to vast numbers of others who share their concerns and to vast quantities of medical literature, including literature on alternatives to allopathic medicine. The federal government has supported this trend; its website at <http://www.healthfinder.org> was established specifically to give consumers online access to publications, clearinghouses, databases, other websites, self-help groups, government agencies, and nonprofit organizations related to both allopathic and alternative medicine.

The peculiarly American propensity to file malpractice suits against doctors further suggests the public's lack of confidence in doctors (although it

probably reflects even more strongly the lack of a national health care system, which can leave Americans unable to pay their medical bills if they suffer severe medical problems). A 1998 survey of obstetrician-gynecologists (the specialty with the second-highest rate of lawsuits) found that 73 percent had been sued for malpractice at least once during their careers, with an average of 2.3 lawsuits per person (American College of Obstetrician-Gynecologists, 1998). To avoid expensive lawsuits, health care institutions have worked to assert more control over the doctors who work for them. Fear of lawsuits also has encouraged doctors to change their own behaviors and to subordinate their clinical decision making in favor of **defensive medicine**—doing tests or procedures solely or primarily to reduce their risk of a malpractice suit (American College of Obstetrician-Gynecologists, 1998; Tussing and Wojtowycz, 1997). For example, one study found that, after researchers controlled for a variety of maternal, physician, clinical, and other characteristics, doctors practicing in counties with high rates of malpractice suits (in which doctors' fear of malpractice suits would likely be greater) had significantly higher than average rates of cesarean deliveries. Fear of malpractice explained 24 percent of all cesarean deliveries in the study (Tussing and Wojtowycz, 1997).

Taken together, these changes led Haug (1988) to conclude that doctors are becoming deprofessionalized, or losing the public confidence that defines professions. This concept gains credence from national polls showing that the proportion of Americans who place a “great deal of confidence in people in charge of running medicine” dropped from 73 percent in 1966 to 42 percent in 1976 and to 29 percent in 2005 (*Harris Poll*, 2005).

The Changing Structure of Medicine and Proletarianization

In contrast, whereas McKinlay and Stoeckle (1989) agree with Haug that medical dominance has declined, they instead trace that decline to changes in health care financing. They maintain that doctors have lost substantial control over the most important professional prerogatives: deciding who may enter the profession and how, setting the conditions under which a doctor works, owning one's tools and workspace, and maintaining an individual relationship with freely chosen patients. Consequently, McKinlay and Stoeckle conclude, doctors are becoming workers (or “proletarians”) rather than autonomous professionals. The authors refer to this shift as **proletarianization** and trace it to three factors: the rise of corporatization, the growth of government control, and the decline of the AMA.

The Rise of Corporatization

McKinlay and Stoeckle (1989) begin their argument by noting that before the 1960s, nonprofit or government agencies owned most hospitals and other health care institutions. With the initiation of **Medicare** and **Medicaid**,

however, the potential for profit making in health care expanded tremendously, encouraging for-profit corporations to enter the field, as we saw in Chapter 8 (Starr, 1982: 428–432). During the last three decades, investor-owned corporations have purchased or developed a growing number of health care institutions. In addition, corporations increasingly have shifted from **horizontal integration** (owning multiple institutions providing the same type of service) to **vertical integration** (owning multiple institutions providing different types of services, such as both **nursing homes** and pharmaceutical companies).

This growth of corporate medicine, or **corporatization**, occurred at a time when doctors were experiencing increasing economic vulnerability (McKinlay and Stoeckle, 1989; Starr, 1982: 446–448). Since the early 1960s, the supply of doctors has grown rapidly, more than doubling between 1970 and 1998 and far surpassing the ratio in most industrialized nations (American College of Physicians, 1998). The supply of doctors now exceeds demand in the most desirable communities and specialties. For example, among doctors who completed residencies in 1996, 56 percent of those in critical care medicine and 47 percent in anesthesiology (but only 7 percent in family practice) reported difficulty finding employment (Bodenheimer, 1999). Supply is expected to continue to increase until 2020, despite recent federal legislation to reduce funding for specialty training.

Because of the current oversupply, newly graduated doctors sometimes find the competition too great to enter private or small group practice. More and more doctors now find they must accept employment with hospitals, large group practices, **managed care organizations (MCOs)**, or other corporate institutions. Others, especially women with children, have more freely chosen corporate employment because they prefer its more relaxed lifestyle and shorter, more predictable hours. As of 1999, 41 percent of doctors worked as paid employees—about twice as many as did so 20 years earlier (Fraser, 2002).

As employees of salaried or group practices, whether by choice or necessity and whether in small groups or in corporate-owned hospitals, doctors' autonomy has diminished. Fearing that when left to their own devices, doctors will overuse available resources and drive up costs, administrators now make many decisions formerly made by individual doctors. According to McKinlay and Stoeckle (1989: 192), "doctors have slipped down to the position of middle management . . . , [while administrators are] organizing the necessary coordination for collaborative work, the work schedules of staff, the recruitment of patients to the practice, and the contacts with third-party purchasers, and are determining the fiscal rewards." In addition, administrators now may set such basic conditions of work as how many patients a doctor must see per hour.

Even those who do not work directly for corporations now often find that the only way they can get patients is to sign contracts with MCOs. These contracts limit doctors' autonomy both by controlling the fees they

may charge for their services and by scrutinizing their clinical decision making. Many MCOs expect doctors to follow **practice protocols**, which establish norms of care for particular medical conditions under particular circumstances based on careful review of clinical research (Good, 1995; Millenson, 1997). Some MCOs forbid doctors from discussing with patients any treatments the MCO does not approve, and some require doctors to get approval before admitting patients to hospitals or administering certain treatments. Over the last few years, however, doctors' dissatisfaction with such prospective review, coupled with increasing doubts about its cost-effectiveness, has encouraged MCOs to shift to more subtle means of controlling doctors.

Moreover, both within corporate institutions and under managed care contracts, the nature of the doctor-patient relationship, and thus the power of doctors within that relationship, has changed. Doctors no longer have "their" individual patients, but now must see whatever patients their employers or MCOs assign to them. Conversely, even patients who continue to have a primary caregiver feel less loyalty to that doctor because they often see whatever doctor happens to be available when they need care. In addition, as employees, doctors feel free to move around to other practices, leaving their old patients behind and destroying any bonds of loyalty—something private doctors could not afford to do.

McKinlay and Stoeckle (1989) additionally argue that doctors' power relative to other health care occupations has declined. Many health care institutions, including MCOs, now believe they can limit costs without limiting quality by hiring cheaper, allied health personnel (such as radiation technologists or nurse practitioners) to perform specialized tasks once performed by doctors. Increasingly, pharmacists and specially trained nurses have legal authority to prescribe certain drugs. Similarly, patient management now officially belongs to the health care team, in which allied specialists often have more knowledge of specialized tasks than do doctors. As a result, McKinlay and Stoeckle argue, doctors' power to control the work of ancillary personnel has declined.

The Growth of Government Control

Government regulations also now restrict doctors' professional autonomy. Because the government pays the bills generated by Medicaid and Medicare, it has a large vested interest in controlling doctors' fees and their decisions about treatment. To do so, it has established programs such as the **diagnosis-related groups (DRG)** system and the **resource-based relative value scale (RBRVS)**. The DRG system (described in Chapter 8) established preset financial limits for each diagnosis for hospital care under Medicare (and, in some states, Medicaid). Because hospitals are not reimbursed for any costs above those limits, they have a vested interest in making sure doctors stay below the limits. Consequently, hospitals may cut the wages or terminate the contracts of doctors who consistently exceed DRG limits, thus pressuring all doctors in

their employ to stay within those limits (Dolenc and Dougherty, 1985). Doctors sometimes conclude that they have only two choices: to misreport a patient's diagnosis on the DRG forms so they can justify more expensive treatments, or to ignore their clinical judgment about the treatment a patient needs so they can stay within the DRG limits.

Whereas DRGs were designed to control Medicare spending on hospital care, RBRVS was designed to control spending on doctors' bills. RBRVS is a complex formula for determining appropriate compensation under Medicare for medical care, based on estimates of how much it actually costs to provide specific services in specific geographic areas. Under this system, incomes of most specialists have declined while those of generalists (other than pediatricians, who receive no Medicare funds) have increased. Although RBRVS applies legally to Medicare only, most other public and private insurance plans also have adopted RBRVS, making it, in the words of one observer, a "de facto national fee schedule" (Sigsbee, 1997).

The Decline of the AMA

Finally, McKinlay and Stoeckle (1989) argue that doctors' professional dominance has declined because the power of the AMA has declined. Although the AMA remains one of the most powerful lobbying groups in the country, its power is now counterbalanced by that of other health care organizations. Evidence for this can be found in the spending patterns of the various political action committees (PACs)—federally recognized organizations that solicit contributions from individuals, associations, and corporations and distribute this money to candidates for election who support the PACs' political agenda. The AMA still controls a larger pool of PAC lobbying money than any other health profession, contributing \$2.3 million during the 2004 presidential elections (Center for Responsive Politics, 2005.) This sum is dwarfed, however, by the sums contributed (in total) by the PACs representing other health professions, pharmaceutical companies, health insurance companies, and hospitals, all of whose legislative interests sometimes compete with those of the AMA.

Similarly, whereas in the past the AMA and the doctors it represented had nearly free rein to set both admissions criteria and curricula of medical schools, this freedom has eroded substantially. Legal changes and social pressures stemming from the civil rights and feminist movements forced medical schools beginning in the 1960s to acknowledge the rights of women and minorities to enter medicine and of foreign-trained doctors to gain access to U.S. licensing. Ironically, over time medical schools came to value having a more diverse student population, but several court decisions have forced them to change admissions procedures in ways that could restrict minority enrollment. In addition, increased government, corporate, and foundation financing of medical training beginning in the 1960s has given these outside groups increased power to direct the nature of training, through choosing which educational programs to fund.

At the same time, the AMA has suffered internally from declining support among doctors. Whereas a half century ago most doctors belonged to the AMA, as of 2005, only 29 percent did (American Medical Association, 2005a). Instead, some doctors join more liberal organizations that often oppose the AMA, such as Physicians for Social Responsibility, and many join specialty organizations like the American College of Obstetricians and Gynecologists.

For all these reasons, then, McKinlay and Stoeckle (1989) argue that doctors are experiencing proletarianization. This conclusion is supported by the AMA's 1999 decision to end its long-standing opposition to unionizing doctors in order to increase doctors' bargaining power relative to MCOs (Greenhouse, 1999). About 40,000 doctors now belong to large, cross-occupational unions such as the American Federation of State, County and Municipal Employees.

The Continued Strength of Medical Dominance

Not all sociologists, however, agree that medical dominance has declined significantly. Some, such as Freidson (1984, 1994), argue that even though professional dominance has declined since its high point in the middle of the twentieth century, it remains strong. As Paul Starr notes, health care corporations depend on doctors both to generate profits and to control costs (1982: 446). As a result, these corporations, which retain a vested interest in maintaining good relationships with their physician employees, continue to give doctors considerable autonomy in day-to-day clinical matters. As noted earlier, MCOs have moved away from prospective review and rarely reject doctors' treatment recommendations (Remler et al., 1997). Similarly, although corporations increasingly hire professional managers as chief executive officers of health care institutions, they often also hire doctors as medical directors to work directly under these managers, as well as in a wide range of other administrative positions. Freidson (1985, 1986) refers to this process as the restructuring of the profession of medicine into specialties organized not by clinical territory (for example, oncologists to treat cancer, pediatricians to treat children) but by functional sector: the producers who work in clinical practice, the knowledge elite who work in research or academia, and the administrative elite. Through restructuring, Freidson argues, medicine has retained control of critical areas of professional status (such as setting licensure regulations and practice standards) and thus preserved its dominance as a field, even if the autonomy of individual physicians has eroded.

Moreover, Freidson argues, although individual doctors working in specific situations have lost some professional prerogatives, the power and dominance of doctors relative to other health care occupations have remained largely intact. Freidson notes, for example, that the rhetoric of health care "teams" hides the fact that doctors have by far the most power on these teams. By the same token, the use of medical technology by ancillary occupations tells us little about the relative power of those occupations, for medical

innovations always have moved down the occupational scale over time. For example, nurses for some time have used stethoscopes and blood pressure cuffs without any increase in their power relative to doctors. Similarly, although the rise of practice protocols could decrease the autonomy of individual doctors, supporters of protocols argue that only through such self-regulation can medicine preserve public faith and, in the end, its professional autonomy (Good, 1995).

Finally, although the environment within which physicians now practice medicine has changed considerably, they retain considerable ability to manipulate and control this new environment. For example, and as mentioned earlier, many doctors now match the DRG system to their clinical decisions rather than changing their decisions to match the DRG system. Similarly, many physicians have sufficient power to ignore onerous bureaucratic directives. So, for example, hospital policies regarding how doctors should use HIV tests are only weakly correlated with doctors' behaviors (K. Montgomery, 1996). By the same token, doctors have proved surprisingly adept at maintaining their incomes because they, not consumers, largely control demand for medical services. Thus, doctors with shrinking patient pools can order more tests or treatments for their remaining patients or can expand the areas they consider suitable for medical intervention, as explained in Chapter 5's section on **medicalization**.

In addition, doctors can maintain their incomes and autonomy by performing elective procedures, in their private clinics or offices, for which patients pay out of pocket. Many doctors now heavily advertise cosmetic surgery, laser eye surgery, infertility treatment, and weight loss treatment because these procedures are both remunerative and largely free of oversight by insurance, government, or hospital bureaucrats (Sullivan, 2001). This trend partly explains why the percentage of surgeries taking place in doctors' offices rose from 5 percent in 1981 to 26 percent in 1999 (Zuger, 1999). Similarly, a small but growing number of doctors have opened "boutique" practices, in which patients pay a flat fee of several thousand dollars per year for services not covered by their insurance, including same-day appointments, heated towels, house calls, and twenty-four-hour cell phone access to their doctors (Belluck, 2002).

The continuing power of medicine as a profession is also demonstrated in the ongoing struggles, as described in Chapter 8, to place legal limits on MCOs' control over doctors. Some of the legislative proposals typically described as "patients' bills of rights" might more accurately be characterized as "doctors' bills of rights." For example, most states now legally mandate that MCOs offer women direct access to obstetrician-gynecologists rather than requiring referral from an internist or family doctor, and they allow women to use obstetrician-gynecologists as their primary care doctors. Although many women are accustomed to using obstetrician-gynecologists for primary care, logic would suggest that women would be better served by using doctors who have trained broadly in primary care rather than using doctors trained

in the surgical management of one set of bodily organs. Not surprisingly, these laws received much of their political support from obstetrician-gynecologists. More generally, by portraying themselves as fighters for patients' rights against the "evils" of MCOs, doctors have burnished their public image.

For all these reasons, although Freidson's earlier model of professional dominance certainly needs modification, it remains a useful starting point for understanding the current status of medicine as a profession.

Medical Education and Medical Values

Despite the assaults on medical dominance, becoming a doctor remains an attractive option: It offers public prestige, the emotional rewards of service, and financial rewards far greater than most other professions. Although applications to medical school declined during the 1980s, they have risen considerably since then and have stayed stable for the last decade (Barzansky and Etzel, 2005). In this section, we look at how doctors-in-training learn both medical knowledge and medical values and at the consequences of this training for both doctors and patients.

The Structure of Medical Education

Becoming a doctor is not easy. Prospective doctors first must earn a bachelor's degree and then complete four years of training at a medical school. Before they can enter practice, however, and depending on their chosen specialty, they must spend another three to eight years as **residents**. Residents are doctors who are continuing their training while working in hospitals. (The term *intern*, referring to the first year of a residency, is no longer commonly used.) As a result, most do not enter practice until age 30.

For more than 80 percent of students, going to medical school means going into debt. The average debt is \$100,000 for public medical schools and \$135,000 for private medical schools (Jolly, 2004). These amounts are in addition to undergraduate debts.

Becoming a doctor also carries tremendous time costs. Regulations adopted following the death in 1989 of a patient treated by exhausted residents now limit surgical residents to working 100 hours per week and medical residents to working "only" 80 hours per week. Even after graduation, about one-third of doctors work more than 60 hours per week (Bureau of Labor Statistics, 2004). These time pressures, coupled with the financial pressures of training, encourage novice doctors to defer marriage, children, and other personal pursuits and to choose specialties requiring less training over those they otherwise might prefer.

Due in part to financial costs, most medical students are from the middle and upper classes. On the other hand, medicine increasingly has opened to women, who now comprise half of all first-year medical students (Barzansky and Etzel, 2005). Nonwhites have not made as much progress; all minority groups other than Asians remain underrepresented in medical schools.

Learning Medical Values

During their long years of training, doctors learn both a vast quantity of technical information and a set of **medical norms**—expectations about how doctors should act, think, and feel. As this section describes, the most important of these norms are that doctors should value emotional detachment, trust clinical experience more than scientific evidence, master uncertainty, adopt a mechanistic model of the body, trust intervention more than normal bodily processes, and prefer working with rare or acute illnesses rather than with typical or chronic illnesses.

Emotional Detachment

Undoubtedly most doctors enter the profession because they want to help others. Yet perhaps the most central medical norm is to maintain emotional detachment from patients. As illustrated by the story that opens this chapter, from Michael Collins's experiences as a resident at the Mayo Clinic, medical culture values and rewards "strength" and equates emotional involvement or expression with weakness (Hafferty, 1991).

Given doctors' daily confrontations with illness, trauma, and death, some emotional detachment is a necessary coping mechanism. Sociological research suggests, however, that doctors develop emotional detachment not only as a natural response to stress but also because their superiors teach them to (Hafferty, 1991).

Professional socialization refers to the process of learning the skills, knowledge, and values of an occupation. According to sociologist and medical school professor Frederic Hafferty (1991), who spent several years observing and interviewing medical students, this socialization typically begins even before students enter medical school. At some point during their undergraduate training, most premedical students volunteer in hospitals. Through observing the behavior of hospital doctors, students quickly learn the value placed on emotional detachment. This norm can be further reinforced during admissions interviews at medical schools. Currently enrolled students often take prospective students to see the most grotesque-looking, partially dissected human cadaver available in the school's anatomy lab. Although officially they do so to display the school's laboratory facilities, their true purpose seems to be to elicit emotional reactions from prospective students. The laughter and snickers these reactions evoke in the medical students demonstrate to prospective students that such behavior is shameful while demonstrating to the current students how "tough" they have become.

The emphasis on emotional detachment is reinforced often during medical school and residencies, as faculty and students implicitly or explicitly ridicule those who display emotions and question their ability to serve as doctors (Haas and Shaffir, 1987: 85–99; Hafferty, 1991). During daily rounds of the wards, faculty members grill residents on highly technical details of patients' diagnoses and treatments. Except in family practice

residencies, however, faculty members rarely ask about even the most obviously consequential psychosocial factors. Rounds and other case presentations also teach residents to describe patients in depersonalized language. Residents learn to describe individuals as “the patient,” “the ulcer,” or “the appendectomy” rather than by name. As Renee Anspach (1997: 328) has described, using language like “the vagina and the cervix were noted to be clear” rather than “I noted that Mrs. Simpson’s vagina and cervix were clear” reinforces the impression “that biological processes can be separated from the persons who experience them.” The use of medical slang, meanwhile, which peaks during the highly stressful residency years, allows students and residents to turn their anxieties and unacceptable emotions into humor by using terms such as “crispy critters” for severe burn patients. Medical slang also enables doctors and residents to avoid emotionally distressing interactions with patients and their families by using terms that laypersons cannot understand, such as “adeno-CA” for cancer (Coombs et al., 1993).

The structure of the residency years largely prevents residents from emotionally investing in patients (Mizrahi, 1986). Long hours without sleep often make it impossible for residents to provide much beyond the minimum physical care necessary (Christakis and Feudtner, 1997). When combined with the norm of emotional detachment, such long hours can even encourage doctors to view their patients as foes. As Phillip Reilly (1987: 226) explains in his autobiographical account of medical training: “At 3 o’clock in the morning as I stood over [a comatose patient’s] bedside staring at his IV, he was an enemy, part of the plot to deprive me of sleep. If he died I could sleep for another hour. If he lived, I would be up all night.” According to Terry Mizrahi, who spent three years observing, interviewing, and surveying residents in internal medicine, by the end of their training, most held “attitudes towards patients ranging from apathy to antipathy” (Mizrahi, 1986: 122). These attitudes are reflected vividly in the many slang terms residents use (sometimes within earshot of patients) to describe those they dislike treating, including “trainwrecks” (seriously ill or injured patients who might not seem worth spending resources on), “scumbags” (dirty, smelly patients), and “negative wallet biopsies” (patients with neither money nor health insurance). Such terms help doctors vent frustrations regarding the difficulties of their situation and maintain needed emotional distance, but they also implicitly reinforce disparaging attitudes toward patients (Coombs et al., 1993).

Not surprisingly, given these structural factors and the resulting attitudes, the doctors Mizrahi studied sometimes appeared to care more about getting rid of patients than about providing care. The centrality of this motive to residents’ lives is evidenced by the numerous slang terms for this process. For example, a resident who has “taken a hit” (received an unwanted patient on his ward) can “buff” a patient’s record (making the patient seem ready to move on to another form of care) so that the resident can “turf” (transfer) the patient elsewhere (Coombs et al., 1993). Among those Mizrahi observed,

the desire to get rid of patients grew as residents came to realize that many patients suffer from illnesses or social problems that medicine cannot cure. Doctors reserved their most negative attitudes for such patients, as well as for those the doctors deemed morally or socially unworthy of their time. The latter include patients whose illnesses seemed linked to self-destructive behaviors; who sought treatment for minor illnesses; who were poor, non-white, female, or old; or who suffered from common illnesses that the doctors, trained in research-oriented medical schools, found uninteresting.

Clinical Experience

In addition to teaching doctors certain attitudes toward patients, medical culture also teaches, at a more abstract level, a set of attitudes toward medical care, illness, the body, and what makes humans truly human. Ironically, given that doctors' prestige rests partly on their scientific training, medical culture values clinical experience more than scientific research and knowledge (Bosk, 2003; Ludmerer, 1985; Millenson, 1997). The structure of medical training unintentionally reinforces this notion. During the first two years of medical school (the preclinical years), students take basic science courses taught by professors who hold doctorates in fields such as biochemistry or physiology. Students spend the next two years training in hospitals and clinics under professors who are themselves doctors. This division between scientific training taught by scientists in the early years and clinical training taught by doctors in the later years teaches students that scientific training is something to be endured before the "real" work of medical training begins.

Once students begin their clinical training, they also learn to base treatment decisions primarily on their personal experiences with a given treatment rather than on scientific research (Becker et al., 1961; Ludmerer, 1985: 260–271). For example, Knafl and Burkett describe the following incidents observed during surgical rounds at a hospital they studied:

After the residents finished presenting the case to the audience, one of the attendings [senior doctors who supervise residents] asked, "What 'bout doing a cup arthroplasty on him?" Morrison replied, "There's some *literature* to back it up but it's *my experience* that 'cups' just aren't that successful on young people." (1975: 399)

Similarly:

The second case is presented by Dr. Lee, a 4th-year resident. He shows slides of a 13-month-old girl whose one leg is shorter than the other. The reason for presenting the case is to discuss whether or not the leg should be surgically lengthened. In presenting the case, Dr. Lee quotes from a source in favor of such a procedure. Dr. Eddy, an attending physician, interrupts with, "I know that's what he says, but that's not the way we do it here." (1975: 399)

In this way, residents have learned to value their own intuition and idiosyncratic clinical experience over scientific research. This partially explains why

standard clinical procedure varies enormously from community to community and from doctor to doctor, producing high rates of medical error as well as rates of lumpectomies, prostatectomies, and back-pain surgery that are as much as thirty three times higher in some states than in others (Center for the Evaluative Clinical Sciences, 1996; Leape, 1994).

Recent events, however, suggest that scientific research may be growing as a value within medical training and the medical world in general. The practice protocols described earlier are part of a broader push for **evidence-based medicine**: the idea that medical care should be based on a thorough evaluation of the best available data from randomized, controlled clinical research. The trend toward evidence-based medicine reflects not only the concerns about cost control mentioned earlier but also the growing recognition that less than half of modern medical treatments—and only a small fraction of surgical procedures—have good scientific support (Naylor, 1995).

Almost all medical schools now explicitly incorporate evidence-based medicine into their curricula. But this does not mean that doctors now base their practices solely on scientific evidence rather than on their personal clinical experience (Timmermans and Berg, 2003). When doctors are working on a case, they rarely have time to obtain the latest research findings on the topic, let alone to evaluate that research fully. Instead, they often must settle for reading a single research article in a prestigious journal, or a single review article. In addition, because practice protocols cannot cover all the specific circumstances of each patient, doctors must rely on their clinical judgment rather than simply following practice protocols. Finally, medical training and practice remain hierarchical environments, in which doctors and medical students are expected to defer to their teachers, senior staff, or partners and are unlikely to challenge more senior doctors whose recommendations go against practice protocols. On the other hand, because junior doctors are increasingly turning to the research literature for answers, more senior doctors must do so as well to retain their reputations and status. In sum, evidence-based medicine has affected medical care, but has not supplanted clinical experience as a decision-making tool.

Mastering Uncertainty

One reason medical culture values clinical experience over scientific knowledge is that there is simply too much knowledge for students ever to learn it all. As a result, students can never be certain that they have diagnosed or treated a patient correctly. Moreover, because the answers to so many medical questions remain unknown, even a student who somehow learned all the available medical knowledge would still on occasion face uncertainty about diagnoses and treatments. From the start of medical school, then, students must learn how to cope emotionally with uncertainty and how to reduce uncertainty where possible (by, for example, focusing on memorizing the discrete facts most likely to show up on examinations) (M. Fox, 2000).

Students also must learn to question whether their difficulties in treating patients stem from a lack of available knowledge in the field or their own lack of familiarity with the available knowledge. Simultaneously, however, students' experiences in medical school classes and on the wards where they study also teach them that they must hide their sense of uncertainty if they are to be regarded as competent by their professors and patients (Atkinson, 1984; Light, 1979).

Mechanistic Model

Along with learning to master uncertainty, medical students also learn to consider the body analogous to a machine or factory and to consider illness analogous similar to a mechanical breakdown (E. Martin, 1987; Mishler, 1981; Osherson and AmaraSingham, 1981; Waitzkin, 1993). For example, medical textbooks routinely describe the biochemistry of cells as a "production line" for converting energy into different products, and they describe the female reproductive system as a hierarchically organized factory of signaling machines that "breaks down" at menopause (E. Martin, 1987). Similarly, medical writers typically describe **HIV disease** as a mechanical failure of the body's immune system (Sontag, 1988).

The mechanistic model of the body and illness leads naturally to a distrust of natural bodily processes. Doctors learn to always look for signs that the body is breaking down, and to view changes in the body as causes or consequences of such breakdowns. As a result, doctors typically view pregnancy and menopause as diseases, try to stop the effects of aging if possible, use drugs to control minor fevers (the body's natural process for fighting infection), and so on (e.g., Barker, 1998; E. Martin, 1987). Thus, for example, when Perri Klass (1987), a doctor and writer, became pregnant at age 26, her classmates were horrified that she did not have amniocentesis, a test designed to identify certain chromosomal abnormalities in fetuses. Yet for women in their twenties, who have extremely low rates of fetal abnormalities detectable by amniocentesis, the test more often causes miscarriage than detects abnormal fetuses. Klass's fellow students, however, had learned so well to distrust pregnancy and the natural body that they could not evaluate her situation objectively.

Intervention

As the example just given suggests, learning to distrust natural processes is intimately interwoven with learning to value medical intervention. During the preclinical years, doctors receive only minimal instruction in using tools such as nutrition, exercise, or biofeedback to prevent or treat illness; during the rest of their training, such tools are rarely—if ever—mentioned. Meanwhile, those medical specialties that rely most heavily on intervention historically have received the most prestige and financial rewards (although RBRVS is starting to change at least the financial balance). For example, surgeons (known in medical slang as "blades"), earn almost twice the median

Box 11.1 *Making a Difference: American Medical Student Association*

The American Medical Student Association (AMSA) is an independent association (not related to the AMA) of about 30,000 medical students from schools around the country. Since 1950, it has worked to improve the quality of health care and medical education, as well as to protect the welfare of medical students and residents. Recognizing some of the traditional limitations of medical education, AMSA has for some time promoted programs designed to encourage medical students to enter primary practice in underserved areas and to develop “cultural competency”: the skills needed to work effectively with persons of various ethnic groups.

With these goals in mind, AMSA (2005) has developed two model curricula. The curricula developed through this program, known as “Promoting, Reinforcing, and Improving Medical Education” (PRIME), are designed both to provide students with necessary technical and interpersonal skills and to encourage students’ idealism and commitment to working with underserved populations. The cultural

competency curriculum includes such topics as learning how other cultures interpret health and illness, how to use interpreters, and how to manage cross-cultural communication problems. The curriculum on primary practice in underserved areas teaches students to understand the underserved, their health care needs, the philosophy of primary care, and the importance of community public health work. The program also teaches communication skills for working with underserved populations. Finally, it covers practical issues such as the finances of working in underserved areas, ways to do so while repaying student loans, and the impact of managed care on primary care work.

Both curricula are based on experiential service learning, rather than on the lectures and demonstrations that dominate medical education. This structure, it is hoped, will make it easier for students to gain confidence and skills and more likely that they will incorporate what they learn into their personal values and career plans.

net income of general and family practitioners (known in medical slang as “fleas”). Similarly, medical school faculty routinely disparage general and family practitioners and discourage students from entering those fields (Block et al., 1996; Mullan, 2002). (Box 11.1 describes a program designed to change this situation.) Taken together, these forces support the **technological imperative**—the belief that technological interventions should always be used if available.

Emphasis on Acute and Rare Illnesses

As a natural corollary of valuing intervention (and a natural result of locating medical training within research-oriented universities), medical culture teaches doctors to consider **acute illness** more interesting than **chronic illness**. This is not surprising, for doctors often can perform spectacular cures for acute illnesses (such as appendicitis) but can do little for chronic illnesses (such as lupus). Similarly, medical culture teaches doctors to consider common diseases less interesting than rare ones, for the latter require complex

and well-honed diagnostic skills even if no treatments are available. In sum, during the course of their training, doctors learn to value emotional detachment more than emotional involvement or expression; trust clinical experience more than scientific knowledge; adopt a mechanistic model of the body and illness; trust intervention more than natural physiological processes; master uncertainty; and prefer working with rare or acute illnesses more than working with typical or chronic illnesses.

The Consequences of Medical Values

Although each of these values serves a purpose, each also can work against the provision of high-quality health care. Emotional detachment can lead doctors to treat patients insensitively and to overlook the emotional and social sources and consequences of illness. In addition, it can cause doctors to feel disdain for patients they consider too emotional. How much emotion a person shows, however, and how that person does so, depends partly on his or her cultural socialization. In contemporary America, women and members of certain ethnic minority groups (such as Jews and Italians) are more likely than are men and nonminorities to display emotion openly (Koopman, Eisenthal, and Stoeckle, 1984). Consequently, these groups are more likely to bear the brunt of doctors' disdain.

Meanwhile, the emphasis on clinical experience, although sometimes useful, can lead doctors to adopt treatments that have not been tested through controlled clinical trials and that lack scientific validity, such as treating ulcers (which are now known to be caused by bacteria) with a bland diet and training in stress reduction (Millenson, 1997). In addition, the desire for clinical experience sometimes encourages medical students and residents to perform procedures, from drawing blood to doing surgeries, even if they cause unnecessary pain or lack sufficient training or supervision. Medical students and doctors are most likely to do so if they can define a patient as "training material" rather than as an equal human being. This is most likely to happen when patients are female, minority, poor, elderly, or otherwise significantly different both from the doctors and from the patients on whom those doctors assume they will someday practice.

Mastering uncertainty is necessary if physicians are to retain enough confidence in their clinical decisions to survive emotionally. And presenting an image of authoritative knowledge undoubtedly increases patient confidence and stimulates a placebo effect, if nothing else. At the same time, the desire for certainty—or at least an aura of certainty—also probably contributes to authoritarian relationships with patients. This is particularly problematic when proper treatment really is uncertain. For example, doctors are particularly uncomfortable with patients whose diagnoses are unclear or whose treatment is unsuccessful. Similarly, even though for years considerable evidence indicated that neither regular mammograms to screen for breast cancer among women below age 50 nor hormone replacement therapy for those who

experience natural menopause were effective, many doctors—unwilling, perhaps, to give up their aura of certainty—continued to dismiss concerns about these practices and to strongly recommend them to their patients.

The emphasis on working with rare illnesses (coupled with the financial incentives of specialty practice) leads to a different set of problems. Most important, it fosters the oversupply of specialists and undersupply of **primary care doctors**, or **primary practitioners**—those doctors in family or general practice, internal medicine, and pediatrics who are typically the first doctors individuals see when they need medical care (Mullan, 2002; Stimmel, 1992). About two-thirds of U.S. doctors are specialists, although only about 20 percent of the problems patients bring to doctors require specialty care (Light, 1988: 308; U.S. Bureau of the Census, 2004: Table 149). Similarly, emphasizing acute illness leads doctors to consider patients with chronic illnesses uninteresting and makes, for example, orthopedic surgery a more appealing field than rheumatology (the study of arthritis and related disorders).

Other problems stem from medicine's mechanistic model of the body. This model leads doctors to rely on **reductionistic treatment**. This term refers to treatment in which doctors consider each bodily part separately from the whole—reducing it to one part—in much the way auto mechanics might replace an inefficient air filter without checking whether the faulty air filter was caused by problems in the car's fuel system. In contrast, sociologists (as well as a minority of doctors) argue for a more holistic image of how the body works and of how illness should be treated (Waitzkin, 1993). **Holistic treatment** refers to treatment that assumes all aspects of an individual's life and body are interconnected. For example, rather than performing wrist surgery on typists who have carpal tunnel syndrome, it might be better to begin by asking whether the problem could be cured by using a wrist rest while typing or changing the height of the typist's desk. And rather than simply excising a tumor when someone has cancer, perhaps doctors and other health care workers should also explore how their patients' social and environmental circumstances contributed to cancer growth and how psychological support might improve their odds of recovery.

Finally, emphasizing intervention can lead doctors to act when inaction might be best. An individual who has a cold, for example, will likely recover regardless of treatment. Often, however, doctors will prescribe antibiotics either because they psychologically need to intervene or because their patients pressure them to do something. Yet, antibiotics cannot cure colds but can cause unpleasant or even life-threatening health problems. Moreover, in the long run, and as described in Chapter 2, unnecessary treatment can foster the development of drug-resistant bacteria.

Probably all these values, and the problems they create, are stronger during medical training than afterward. Once doctors enter practice, economic pressures encourage them, willingly or unwillingly, to show at least somewhat

more sensitivity to patients' needs. In addition, those who consistently work with the same pool of patients—a situation that, as described earlier, has become less common—can develop more meaningful relationships with them. Thus, over time, doctors may recoup some of their initial, more positive, attitudes toward patients and patient care (Mizrahi, 1986). These changes cannot, however, help the millions of Americans who lack either health insurance or the ability to pay for medical care and who therefore must rely on public clinics or hospitals for their care. These patients pay the highest costs for the medical value system.

Building a Medical Career

Two of the most important decisions any new doctor must make are choosing a specialty and a type of practice. These decisions are important not only because the nature of the work itself differs across fields and practices, but also because all medical careers are *not* created equal. Rather, some specialties and practices offer considerably more status, income, and autonomy than others do. As a result, new doctors face greater competition for some residencies and jobs than others.

A new doctor's ability to enter a prestigious medical field or type of practice depends largely on **sponsorship** (Hall, 1949). Sponsorship refers to the process through which successful professionals in a given field actively help new members to establish their careers. This process is not an egalitarian one, for established members typically choose whom to sponsor based not only on **achieved statuses**, or earned qualifications such as medical school grades, but also on **ascribed statuses**, or innate characteristics such as ethnicity and gender.

Judith Lorber's longitudinal research on the careers of men and women doctors vividly shows the impact of sponsorship. For example, one young man tells how his residency supervisors sponsored him:

Dr. _____ made a conscious effort to interest me in gastroenterology, and he had the support of the chief of medicine. I found the two of them both excellent researchers and clinicians. They made it seem very exciting and interesting, and to some extent, they also wooed me just a little bit. Dr. _____ took me to a meeting in Boston in the fall of that year. They took me to the national GI [gastrointestinal] meeting in Philadelphia in May and I loved it. The meetings were excellent, very stimulating. I had a good time, and that's when I decided to go into gastroenterology. I also had them behind me pushing me and guiding me into my choice of fellowships. I was starting late to look for fellowships, and it would have been difficult, but I had the two of them assisting and making entrées. (Lorber, 1984: 34–35)

In contrast, the women Lorber studied lacked such sponsorship. Although they rarely experienced overt discrimination, they endured constant covert

Table 11.1 *Median Total Salary and Percentage of Residents Who are Female, by Specialty*

SPECIALTY	MEDIAN TOTAL SALARY*	PERCENTAGE WHO ARE FEMALE**
Obstetrics/gynecology	233,000 [†]	74
Pediatrics	153,000	68
Psychiatry	163,000	52
Family/general practice	150,000	51
Internal medicine	156,000	41
Anesthesiology	307,000	27
General surgery	255,000	25
Total	NA	41

*2002 data
**2003 data
[†]Insurance costs are significantly higher for obstetrics, and so net salaries in this field are relatively lower than these total salaries.
Source: Bureau of Labor Statistics (2004); American Medical Association (2005b).

discrimination. Their professors typically assumed that women would be happiest in traditionally female, low-status fields such as psychiatry, public health, and pediatrics. These professors therefore discouraged them from entering other fields and withheld the experience, recommendations, encouragement, and other forms of sponsorship needed to enter them. As a result, the women eventually found themselves in less prestigious and remunerative fields than did their male peers, despite approximately equal academic grades, research records, and desire to enter high-status fields. (Table 11.1 shows median total salary and the percentage of residents who are female for several medical specialties.) Meanwhile, women who do enter male-dominated fields typically face continual disadvantages; this problem was highlighted when in 1991 Dr. Frances Conley, the first female full professor of neurosurgery in the United States, resigned her tenured position at Stanford University in protest against years of discrimination.

Although little recent research is available on the topic, these same processes undoubtedly hinder the careers of those who differ from most doctors in ethnicity or class. Indeed, the many Catholic and Jewish non-profit hospitals around the country were founded early in the twentieth century because most hospitals refused to hire Catholic or Jewish doctors. Over time, religious discrimination within medicine all but disappeared, and we can hope that other social barriers eventually will fall as well.

Patient-Doctor Relationships

From the beginnings of Western medicine, medical culture has stressed a paternalistic value system in which only doctors, and not patients or their families, are presumed capable of making decisions about what is best for a patient (Katz, 1984); this chapter's ethical debate on truth telling in health care (Box 11.2) gives an example of such a situation. Often, this paternalism is reinforced by patients who prefer to let their doctors make all decisions; indeed, at least part of doctors' efficacy comes simply from patients' faith in doctors' ability to heal. Paternalism is also reinforced by the structure of medical practice, in which doctors by their own (probably optimistic) estimates spend an average of only 18 minutes per patient per office visit (Mechanic, 2001b). As a result, doctors often do not have the time to inform patients fully or to assess patients' needs or desires.

Unfortunately, doctors' inclination to make decisions for patients is sometimes bolstered by doctors' racist, sexist, or classist ideas. Doctors are exposed to and sometimes adopt the same stereotypical ideas about minorities, women, and lower-class persons common among the rest of society, believing, for example, that African Americans are unintelligent, women flighty, and lower-class persons lazy. Doctors who hold such ideas sometimes make decisions for patients belonging to these groups, rather than involving the patients in the decisions, because these doctors believe it is easier and less time-consuming to do so. For example, medical residents in obstetrics and gynecology interviewed by Diana Scully (1994) made such comments as "I don't like women that think they know more than the doctor and who complain about things that they shouldn't be complaining about" and "I think the main thing is that the patient understands what I say, listens to what I say, does what I say, believes what I say." Similarly, "I don't care for the patient that gives you a fight every time you try to give them a drug. I don't care for the patient that disagrees with me" (Scully, 1994: 92).

Finally, doctors' inclination to make decisions for patients can be reinforced when cultural barriers make it difficult for doctors to gain patients' cooperation or to understand patients' beliefs or wishes. Those cultural differences are probably greatest when Western-born doctors treat immigrants from non-Western societies. In these circumstances, even the smallest gestures unintentionally can create misunderstanding and ill will. For example, in her observations of Hmong patients who had immigrated from Laos and their American doctors, Anne Fadiman found that

when doctors conferred with a Hmong family, it was tempting to address the reassuringly Americanized teenaged girl who wore lipstick and spoke English rather than the old man who squatted silently in the corner. Yet failing to work within the traditional Hmong hierarchy, in which males ranked higher than females and old people higher than young ones, not only insulted the entire family but also yielded confused results, since the crucial questions had not been directed toward those who had the power to make the decisions. Doctors could also appear

Box 11.2 Ethical Debate: Truth Telling in Health Care

Jeffrey Monk, an unmarried, 26-year-old accountant, goes to see Dr. Fisher because of recurrent headaches that have made it difficult for him to concentrate at work. Jeffrey generally enjoys good physical health, although he has experienced bouts of severe depression since his mother died a few months ago.

Dr. Fisher runs a series of tests and soon discovers that Jeffrey has an inoperable brain tumor, which will probably kill him within the year. Because no treatments are available, telling Jeffrey of his diagnosis would seem to serve little purpose at this point. Jeffrey has no dependents, so he need not make a will or other financial arrangements immediately. Moreover, telling him might cause his health to deteriorate more rapidly, spark another depressive episode, or even lead him to commit suicide. Anyway, Dr. Fisher believes, few patients truly want to know they have a fatal illness. He therefore merely tells Jeffrey that the headaches are not serious and prescribes a placebo, counting on the fact that placebos significantly reduce patient symptoms in about 30 percent of cases.

Do doctors have an obligation to tell their patients the truth? Answering this question requires us to look at several significant ethical issues. The most central ethical issues in this case are autonomy versus paternalism. According to the principle of autonomy, each rational individual is assumed capable of making his or her own choices if given sufficient information, and each health care worker has the obligation to provide that information. Consequently, each individual has the right to decide what is in his or her own best interest and to act upon those decisions without

coercion from others. Counterbalancing this is the principle of personal paternalism—the idea that some individuals (in this case, doctors) have the expertise needed to decide what is in the best interest of other individuals.

Evaluating this situation requires us to weigh the benefits of disclosure against those of dissembling. Will hiding his diagnosis from Jeffrey protect him from depression or suicide, or will the anxiety caused by not knowing the meaning of his symptoms increase his emotional problems? Is suicide necessarily against Jeffrey's best interest? Is it best for a doctor to give a patient a placebo, which may offer some physical and emotional relief, or to let the patient know the truth, so the patient may make his or her own choices—from seeking unconventional treatments or a second opinion to choosing how to spend his last months? The final question, then, is can doctors know what is in their patients' best interest, and when if ever should they be given the authority to act on those judgments?

Sociological Questions

1. What social views and values about medicine, society, and the body are reflected in this debate? Whose views are these?
2. Which social groups are in conflict over this issue? Whose interests are served by the different sides of this issue?
3. Which of these groups has more power to enforce its view? What kinds of power do they have?
4. What are the intended consequences of the various policies under consideration? What are the unintended social, economic, political, and health consequences of these policies?

disrespectful if they tried to maintain friendly eye contact (which was considered invasive), touched the head of an adult without permission (grossly insulting), or beckoned with a crooked finger (appropriate only for animals). (1997: 65)

In these circumstances, doctors sometimes conclude that collaboration with patients is impossible and that paternalistic decision making is their only alternative.

Nevertheless, doctors only rarely have complete control over treatment decisions and interactions with patients. As Thomas Szasz and Marc Hollander (1956) explain, three **models of doctor-patient interactions** exist. Only in the first model, **activity-passivity**, is the doctor totally active and the patient totally passive. Emergency surgery performed on an unconscious patient would fall into this category, as would drugging a psychiatric patient against his or her will. In the second and most common model, **guidance-cooperation**, the doctor offers guidance to a cooperative but clearly submissive patient, such as one suffering from a cold. In the third model, **mutual participation**, both doctor and patient participate equally. This model occurs most often with chronic illnesses such as diabetes or multiple sclerosis, in which much of doctors' work consists of helping patients discover what works best for them.

Eliot Freidson (1970a) has looked at the power dynamics underlying these different models. Doctors' power is greatest in two situations: (1) when patients are completely incapacitated by coma, stroke, or the like; and (2) when doctors have sufficiently greater cultural authority than their patients so as to argue convincingly that they can most accurately judge patients' best interests, whether that patient is a Jehovah's Witness who refuses a blood transfusion, a pregnant woman who refuses a cesarean section, or someone labeled mentally ill who opposes hospitalization. Doctors' power also increases when they work in group practice rather than in solo practice. Because doctors in group practice obtain most of their business through referrals from colleagues or MCO contracts rather than from satisfied patients, they need not worry as much as other doctors about losing income if they assert their power and alienate patients. Finally, doctors' power is higher when interacting with patients who do not share the doctors' language, culture, and social status. In sum, doctors' power depends on their cultural authority, economic independence, cultural differences from patients, and assumed social superiority to patients. As this suggests, and given the demographic composition of contemporary medicine, doctors are most likely to adopt egalitarian interaction patterns with those they consider their equals: white, nonelderly, male, and middle- or upper-class patients (Street, 1991).

To explore *how* doctors maintain dominance during their meetings with patients, researchers have conducted detailed analyses of conversation patterns between doctors and patients (S. Fisher, 1986; Katz, 1984; Waitzkin, 1991; West, 1984). Conversations between doctors and patients typically

Box 11.3 ***“Hi, Lucille, This Is Dr. Gold!”***
by Lucille G. Natkins

I’m going in for a dilation and curettage (D&C) next week. But even as I worry about carcinomas and five-year survival rates, an incident from my last D&C keeps popping into my mind.

That operation occurred after I hadn’t seen a gynecologist in years. On my internist’s recommendation I saw a physician whom I’ll call Dr. James Gold, diplomate, American Board of Obstetrics and Gynecology; fellow, American College of Surgeons; and associate attending physician at a large teaching hospital. It turned out that he was a contemporary, that he lived in my neighborhood, and that his children and mine were classmates. He’d gone to medical school with one of my friends and interned with another. No one would have worried about inviting us to the same dinner party.

One visit and several phone calls later—all conducted on a cordial “Dr. Gold” and “Mrs. Natkins” basis—surgery was scheduled and soon afterward I was wheeled into the operating room. As my vision blurred and my legs numbed, a voice cut through the anesthetic haze. “Hi, Lucille, this is Dr. Gold!” Stupor

turned to rage. “You expletive, that’s not the way it goes! It goes ‘Hi, Lucille, this is Jim’ or ‘Hi, Mrs. Natkins, this is Dr. Gold.’”

All soundless. I was out of it, zonked. The next thing I remember was a female voice saying, “Wake up, Lucille, the operation’s over. Wake up, Lucille.” Damn, I thought, not again.

The biopsy findings were negative. I was free to stop worrying about gynecological malignancies, but “Hi, Lucille” wouldn’t leave me. There are more dignified positions in life than lying naked and horizontal, legs spread-eagle, while half a dozen strangers shove their fists into what was once (wisely) called “one’s private parts.” But that indignity was unavoidable. What, though, was the purpose of “Hi, Lucille, this is Dr. Gold” from someone who would have been Jim had we met socially, or “Wake up, Lucille” from someone who was ensuring my waking by slapping my face? What purpose other than to underscore my lack of dignity and helplessness?

“Hi, Lucille” was still rankling months later when my 80-year-old mother-in-law was hospitalized. Overwhelmed by crippling arthritis and

follow a pattern in which the doctor opens a topic with a question, the patient responds, and the doctor signals that the topic is closed (Mishler, 1990). The doctor can then raise the next topic or ask further questions for clarification and repeat the cycle. In either event, the doctor maintains control over the direction and length of the conversation. For example, a patient might come to a doctor complaining of various problems. The doctor will ask for further details about only some of those problems, typically ignoring how factors in patients’ lives might cause health problems or how health problems might cause other problems in patients’ lives. The doctor also can ask questions about problems the patient had not mentioned but the doctor expects to find, thereby defining certain problems but not others as relevant. In addition, doctors control conversations by asking

a host of other problems, she asked the nurse, whose name pin read "T. Bass," to "please get my slippers from the bedroom." "Whatever are you talking about, Bertha," snapped T. Bass, who was, perhaps, all of 30 years old. "You're in the hospital, not your house." My mother-in-law stiffened and blanched. Reality therapy with a bludgeon.

I became a first-name freak, asking friends and colleagues who addressed them by first name without expecting reciprocity and, conversely, whom they addressed by first name while expecting to be called Mr. Price or Dr. Wand. No surprises in this survey. Inferiors are called by first name: children, menial workers, the elderly, and women.

I wrote to the hospital where my mother-in-law had been a patient, noting that the hospital system that was reducing an 80-year-old woman to a child was robbing her of the will and determination she needed to ensure her recovery. The administrator replied that he could not understand my charges of abuse. I wrote to a widely syndicated medical columnist, asking why his replies to women began

"Dear Amy" and to men "Dear Mr. Hall." No answer. . . .

I chose a new gynecologist. But not by using physician referrals and checking medical directories as I would have before, when I thought I was sophisticated. "Is your gynecologist a nice person?" I asked friends. "Are you treated with dignity and consideration? Called by your first name or your last?" Another survey with few surprises. Not many women answered "yes," "yes," and "last name."

But some did. (And, yes, my new gynecologist is board-certified, as nearly everyone in a metropolitan area seems to be these days.) So far, so good, but next Friday both of us will have to pass our big tests in the operating room. Will I have malignant cells on my pelvic wall? Will he resist the temptation to say "Hi, Lucille" when I'm flat on my back and going down for the count?

Health and self-respect, I've learned, are both necessities.

Source: *Journal of the American Medical Association*, May 7, 1982, 247(17): 2415. © Copyright 1982, American Medical Association. Reprinted with permission.

closed-ended rather than open-ended questions, thus making it difficult for patients to raise new topics. Doctors also can reinforce their dominance by the simple tactic of referring to the patient by first name, but expecting the patient to refer to them by their title ("Dr. Smith"), as Box 11.3 illustrates.

Other techniques also enable doctors to control interactions with patients (S. Fisher, 1986; Katz, 1984; Waitzkin, 1991; West, 1984). Doctors interrupt patients far more often than patients interrupt doctors, cutting off discussions and questions the doctors consider irrelevant or uncomfortable. They give general rather than specific answers to patients' questions, give information only when directly asked, or use euphemisms (such as "tumor" instead of "cancer") that leave patients confused about their situations. As a result, patients lack the information they need to challenge doctors' actions

or make their own decisions. This in turn can create both stress and distrust when patients conclude that their doctors have withheld information.

Conclusion

Between 1850 and 1950, allopathic medicine attained and then enjoyed unprecedented autonomy and dominance, becoming the premiere example of a profession. In its battles for status with its many nineteenth-century rivals, allopathic medicine benefited from the public's growing respect for scientific knowledge and from the increase over time in the field's scientific foundations. It also benefited from the public's assumption that because allopathic doctors were disproportionately upper-class white men, they must be more competent than the minorities, women, and poorer persons who dominated competing health care fields.

Since the 1950s, however, doctors' social status has declined and their control over working conditions, relationships with patients, and finances has diminished. Yet doctors continue to have far more autonomy and dominance than do professionals in most other occupations, especially within the health care field. This continued professional dominance—and the continued internecine warfare between medicine and other health care occupations—affects all of us as consumers of health care because it sets the stage on which attempts to improve the health care system must occur.

Doctors' professional socialization, too, affects all of us as consumers. In its current form, this process is lengthy, arduous, and expensive, making it difficult if not impossible for many otherwise qualified persons to become doctors and encouraging those who do become doctors to become emotionally hardened or financially driven. To these **unintended negative consequences** of medical training must be added the problems caused by a medical culture that emphasizes emotional detachment, clinical experience, intervention, mastering uncertainty, and acute and rare illnesses rather than common and chronic illnesses.

As consumers of health care, we all benefit from the extensive training doctors receive. Those benefits, however, must be weighed against the costs we pay when our doctors also learn ways of interacting with patients and thinking about illness that can encourage overly aggressive, scientifically unjustified, or simply discourteous treatment. Only by directly confronting the nature of medical culture can we hope to change medical training and make future doctors better able to meet their patients' needs.

Currently, pressures to change medical culture and doctor-patient relationships are coming from within as well as outside the medical field. Many doctors now believe that the rise in malpractice suits largely reflects patients' disenchantment with their relationships with doctors rather than problems in the quality of care. As a result, medical journals often publish articles instructing doctors to reduce their malpractice risk by improving their relationships with patients (Annandale, 1989).

Deeply felt personal beliefs, and not just economic self-interest, have driven other doctors to work for changes in the system. Such beliefs have led to the founding of organizations such as Physicians for a National Health Plan and the American Holistic Medical Association. Similarly, the American College of Physicians, the professional organization for doctors in internal medicine, derives its strength partly from the growing number of doctors who favor its more humanistic approach to medical care.

Finally, throughout the United States, medical students and professors are working to implement innovative programs for integrating more humanistic perspectives into the medical curriculum. At Harvard Medical School, for example, students now must take a three-year course specifically designed to improve relationships with patients and to humanize medical care (Tosteson, Adelstein, and Carver, 1994). Beginning with role-playing and discussing their personal experiences of illness, students are reminded what it is like to experience illness and health care. Subsequently, students learn how to interview patients, with the emphasis on listening to patients and understanding the psychosocial circumstances in which individuals experience illness. In this way, students can learn from the beginning of their training to see health care from patients' perspectives.

Similarly, **cultural competence** is now a commonly cited goal of medical education. Cultural competence refers to the ability of health care providers to understand at least basic elements of others' cultures and thus to provide medical care in ways that better meet clients' emotional as well as physical needs. Cultural competence has been promoted as a means of increasing clients' willingness to seek medical care and satisfaction with care, and consequently as a means of improving health outcomes. Both the American Psychiatric Association and the American Academy of Family Physicians have officially endorsed including cultural competence in medical training. As of 2002, 38 percent of medical students participated in overseas programs designed to increase their understanding of other cultures, but most medical schools provided only three or fewer class sessions devoted to the topic (Champaneria and Axtell, 2004). Little data are available so far about the effectiveness of this training, but the hope is that in the long run, these programs may restructure medical culture and doctor-patient relationships.

Suggested Readings

Alvord, Lori Arviso, and Elizabeth Cohen Van Pelt. 1999. *The Scalpel and the Silver Bear*. New York: Bantam. Alvord writes of her experiences as the first female Navajo surgeon, of what she has learned from working with Navajo patients, and of what Navajo healing traditions have to offer all of us. A fascinating book.

Conley, Frances K. 1998. *Walking Out On the Boys*. New York: Farrar Straus and Giroux. Conley, the first female full professor of neurosurgery in the

United States, describes in this memoir the shocking discrimination still encountered by women in surgical training and practice.

Rothman, Ellen Lerner. 1999. *White Coat: Becoming a Doctor at Harvard Medical School*. New York: William Morrow. Rothman tells of her experiences in Harvard's revamped medical school program.

Watts, David. 2005. *Bedside Manners: One Doctor's Reflections on the Oddly Intimate Encounters Between Patient and Healer*. New York: Three Rivers Press. In this book of short essays, poet, NPR commentator, and doctor David Watts beautifully describes medicine, and the doctor-patient relationship, at its best.

Getting Involved

American Civil Liberties Union. 132 W. 43rd Street, New York, NY 10004. (212) 944-9800. www.aclu.org. Among other things, works for the civil rights of mental patients.

American Medical Students Association. 1902 Association Drive, Reston, VA 20191. (703) 620-6600. www.amsa.org. Among other things, seeks to make medical education more humanistic. Open to premedical as well as medical students.

Review Questions

What was the difference between *allopathic* and *homeopathic* doctors?

What was medical training like in 1850?

What could a doctor offer his patients in 1850? in 1900?

What does it mean to say that an occupation is a *profession*?

How did doctors achieve professional dominance? What factors have reduced doctors' professional dominance?

What are the major medical norms, how do doctors learn them, and how do they affect patient-doctor relationships?

What is cultural competence, and why is it important?

Internet Exercises

1. To find out how social class affects individuals' perceived health status, first locate the website for the University of California's Survey Documentation and Analysis (SDA) Archive. This archive contains data from several national random surveys. Enter the SDA archive, and then click on the GSS Cumulative Datafile, 1972–2002, full analysis. Find the "Select an Action" section, and then click the button for "Frequencies or Crosstabulations." Next, click on "Start." A form with several blank spaces will appear on your screen. For row variable, type *conmedic*. For column

variable, type *class*. Click on the boxes to the left of “Column Percentaging,” “Statistics,” and “Question Text.” Then click the button to “Run the Table.” Repeat, using first sex and then health as column variables. Which groups have the least confidence in the people running the institution of medicine? Which variables have the most impact?

2. Go to the website for the Center for Responsive Politics (www.opensecrets.org) and see what you can learn about how medical organizations and other health care industry groups are working to affect elections and health-related laws in the United States. You might look for information on managed care legislation, tobacco control, or gun control.