X
SOCIAL STRUCTURE AND DYNAMIC PROCESS: THE CASE OF MODERN MEDICAL PRACTICE[1]

WE HAVE followed a long and complicated course in working through the derivation of the major structural outlines of the social system from the action frame of reference, in the analysis of the central place of patterns of value-orientation in this structure, in the analysis of the motivational mechanisms of social process, and that of the involvement of cultural patterns other than those of value-orientation in the social system. It will perhaps help the reader to appreciate the empirical relevance of the abstract analysis we have developed if, in addition to the illustrative material which has been introduced bearing on many particular points, we attempt to bring together many if not most of the threads of the foregoing discussion in a more extensive analysis of some strategic features of an important sub-system of modern Western society.

For this purpose we have chosen modern medical practice. This field has been a subject of long-standing interest[2] on the author's part as a result of which he has a greater command of the empirical material in this field than in most others. But it also provides an excellent opportunity to illustrate some of the interrelations of the principal elements of the social system which have been reviewed in more abstract terms. A highly distinctive cultural tradition, certain parts of modern science, provides a central focus for the activities of the medical profession. We have already seen that there are important problems of the modes of institutionalization of such a cultural tradition. This institutionalization fits into the functional context of a ubiquitous practical problem in all societies, that of health, and is specially organized relative to

[1] For general comparison with this chapter the reader may be referred to L.J.Henderson, "Physician and Patient as a Social System," *New England Journal of Medicine,* Vol. 212, May 2, 1935, 819–23.

[2] The most important phase of this interest was concerned with a field study of medical practice which was carried out mainly in the Boston area several years ago. A variety of circumstances prevented the completion of that study and its publication in the intended form. Hence the opportunity has been taken for the rormulation of some of the most important of the results in the context of their relevance to the present work. Of course the earlier interpretations have been considerably modified by subsequent theoretical development and by other ex

distinctive role patterns and value-orientations in our own society. Finally, as has already been brought out briefly, the bearing of the therapeutic process on the problems of deviance and social control is such that adequate analysis of the motivational processes involved has implications reaching far beyond the particular field to throw a great deal of light on the general motivational balance of the social system.

§ THE FUNCTIONAL SETTING OF MEDICAL PRACTICE AND THE CULTURAL TRADITION

IN THE most general terms medical practice may be said to be oriented to coping with disturbances to the "health" of the individual, with "illness" or "sickness." Traditionally the principal emphasis has been on "treatment" or "therapy," that is, on dealing with cases which have already developed a pathological state, and attempting to restore them to health or normality. Recently there has been increasing emphasis on "preventive medicine," that is, controlling the conditions which produce illness. For our purposes, however, the therapeutic functional context will present sufficient problems.

A little reflection will show immediately that the problem of health is intimately involved in the functional prerequisites of the social system as defined above. Certainly by almost any definition health is included in the functional needs of the individual member of the society so that from the point of view of functioning of the social system, too low a general level of health, too high an incidence of illness, is dysfunctional. This is in the first instance because illness incapacitates for the effective performance of social roles. It could of course be that this incidence was completely uncontrollable by social action, an independently given condition of social life. But in so far as it is controllable, through rational action or otherwise, it is clear that there is a functional interest of the society in its control, broadly in the minimization of illness. As one special aspect of this, attention may be called to premature death. From a variety of points of view, the birth and rearing of a child constitute a "cost" to the society, through pregnancy, child care, socialization, formal training and many other channels. Premature death, before the individual has had the opportunity to play out his full quota of social roles, means that only a partial "retum" for this cost has been received.

All this would be true were illness purely a "natural phenomenon" in the sense that, like the vagaries of the weather, it was not, to our knowledge, reciprocally involved in the motivated interactions of human beings. In this case illness would be something which merely "happened to" people, which involved consequences which had to be dealt with and conditions which might or might not be controllable but was in no way an expression of motivated behavior.

perience, notably training in psychoanalysis. It is, however, of considerable interest that it was in connection with the earlier study of medical practice that the beginnings of the pattern variable scheme'were first worked out.

There has been fragmentary previous publication of results in three places, the paoers "The Professions and Social Structure" and "Propaganda and Social Control," *Essays,* Chapters VIII and XIII, and "Education and the Professions," *Ethics,* Vol. 47, 365–369.

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This is in fact the case for a very important part of illness, but it has become increasingly clear, by no means for all. In a variety of ways motivational factors accessible to analysis in action terms are involved in the etiology of many illnesses, and conversely, though without exact correspondence, many conditions are open to therapeutic influence through motivational channels. To take the simplest kind of case, differential exposure, to injuries or to infection, is certainly motivated, and the role of unconscious wishes to be injured or to fall ill in such cases has been clearly demonstrated. Then there is the whole range of "psycho-somatic" illness about which knowledge has been rapidly accumulating in recent years. Finally, there is the field of "mental disease," the symptoms of which occur mainly on the behavioral level. Of course somatic states which are not motivationally determined may play a larger or smaller part in any or all of them, in some like syphilitic paresis they may be overwhelmingly predominant, but over the field as a whole there can be no douot of the relevance of illness to the functional needs of the social system, in the further sense of its involvement in the motivated processes of interaction. At one time most medical opinion inclined to the "reduction" of *all* illness to a physiological and biological level in both the sense that etiology was always to be found on that level, and that only through such channels was effective therapy possible. This is certainly not the predominant medical view today. If it ever becomes possible to remove the hyphen from the term "psycho-somatic" and subsume all of "medical science" under a single conceptual scheme, it can be regarded as certain that it will not be the conceptual scheme of the biological science of the late nineteenth and early twentieth centuries. It is also certain that this conceptual scheme will prove applicable to a great deal of the range of social action in areas which extend well beyond what has conventionally been defined as the sphere of medical interests.

The fact that the relevance of illness is not confined to the non-motivated purely situational aspect of social action greatly increases its significance for the social system. It becomes not merely an "external" danger to be "warded off" but an integral part of the social equilibrium itself. Illness may be treated as one mode of response to social pressures, among other things, as one way of evading social responsibilities. But it may also, as will appear, have some possible positive functional significance.

Summing up, we may say that illness is a state of disturbance in the "normal" functioning of the total huipan individual, including both the state of the organism as a biological system and of his personal and social adjustments. It is thus partly biologically and partly socially defined. Participation in the social system is always potentially relevant to the state of illness, to its etiology and to the conditions of successful therapy, as well as to other things.

Medical practice as above defined is a "mechanism" in the social system for coping with the illnesses of its members. It involves a set of institutionalized roles which will be analyzed later. But this also involves a specialized relation to certain aspects of the general cultural tradition of modern society. Modern medical practice is organized about the application of scientific knowledge to the problems of illness and health, to the control of "disease." Science is of course a very special type of cultural phenomenon and a really highly developed scientific level in any field is rare among known cultures, with the modern West in a completely unique position. It may also be noted that scientific advance beyond the level to which the Greeks brought it is, in the medical field, a recent phenomenon, as a broad cultural stream not much more than a century old.

We have dealt at some length in Chapter VIII with science as a general feature of the cultural tradition, and with some of the conditions of its application to practical affairs. This need not be repeated here. We need only note a few points particularly relevant to the medical field. First, it should be quite clear that the treatment of illness as a problem for applied science must be considered problematical and not taken for granted as "common sense." The comparative evidence is overwhelming that illness, even a very large part of what to us is obviously somatic illness, has been interpreted in supernatural terms, and magical treatment has been considered to be the appropriate method of coping with it. In non-literate societies there is an element of empirical lore which may be regarded as proto-scientific, with respect to the treatment of fractures for instance. But the prominence of magic in this field is overwhelmingly great.

This, however, is by no means confined to non-literate cultures. The examples of traditional China and our own Middle Ages will suffice. Where other features of the cultural tradition are not favorable to the traditionalized stereotyping which we think of as characteristic of magic in the full sense, we find a great deal, and sometimes predominance, of health "superstition" in the sense of pseudo rational or pseudo scientific beliefs and practices.

In the light of these considerations it is not surprising that in a society in which scientific medicine has come to be highly institutionalized, popular orientations toward the health problem are by no means confined to the scientific level. There is much popular health superstition, as evidenced by such things as the "patent medicines," for example the widely advertised "Dr. Pierce's Golden Medical Discovery," and many traditional "home remedies." Furthermore in the health field there is a considerable fringe of what are sometimes called "cults." Some religious denominations, of which Christian Science is perhaps the most conspicuous example, include a religious approach to health as an integral part of their general doctrine. Then there is a variety of groups which offer health treatments outside the medical profession and the professions auxiliary to it like dentistry and nursing. These are apt to include complex and bewildering mixtures of scientifically verifiable elements and various grades and varieties of pseudo-science.[3]

Finally the institutionalization of science is, as the analysis of Chapter VIII would lead us to expect, far from complete within the profession itself. There are many kinds of evidence of this, but for present purposes it is sufficient to cite the strong, often bitter resistance from within the profession itself to the acceptance of what have turned out to be critically important scientific advances in their own field. One of the classic cases is the opposition of the French Academy of Medicine to Pasteur, and for some time the complete failure to appreciate the importance of his discoveries. A closely related one is the opposition of the majority of the surgeons of the day to Lister's introduction of surgical asepsis. The conception of "laudable pus" is an excellent example of a medical "superstition."

It goes without saying that there is also an important involvement of expressive symbolism in medical practice. Rather, however, than attempting to review it at this point it will be better to call attention to certain aspects of it as we go along.

§ THE SOCIAL STRUCTURE

THE immediately relevant social structures consist in the patterning of the role of the medical practitioner himself and, though to common sense it may seem superfluous to analyze it, that of the "sick person" himself. There is also a range of important impingements of both roles on other aspects of the total structure of the social system which will have to be mentioned at the appropriate points.

The role of the medical practitioner belongs to the general class of "professional" roles, a sub-class of the larger group of occupational roles. Caring for the sick is thus not an incidental activity of other roles—though for example mothers do a good deal of it—but has become functionally specialized as a full-time "job." This, of course, is by no means true of all societies. As an occupational role it is institutionalized about the technical content of the function which is given a high degree of primacy relative to other statusdeterminants. It is thus inevitable both that incumbency of the role should be achieved and that performance criteria by standards of technical competence should be prominent. Selection for it and the context of its performance are to a high degree segregated from other bases of social status and solidarities. In common with the predominant patterns of occupational roles generally in our society it is therefore in addition to its incorporation of achievement values, universalistic, functionally specific, and affectively neutral. Unlike the role of the businessman, however, it is collectivity-oriented not self-oriented.

The importance of this patterning is, in one context, strongly emphasized by its relation to the cultural tradition. One basis for the division of labor is the specialization of technical competence. The role of physician is far along the continuum of increasingly high levels of technical competence required for performance. Because of the complexity and subtlety of the knowledge and skill required and the consequent length and intensity of training, it is difficult to see how the functions could, under modern conditions, be ascribed to people occupying a prior status as one of their activities in that status, following the pattern by which, to a degree, responsibility for the health of her cnildren is ascribed to the motherstatus. There is an intrinsic connection between achieved statuses and the requirements of high technical competence, as well as universalism and competence. In addition, of course, there is pres-sure in the society to assimilate the medical role to others of similar character in the total occupational system.

High technical competence also implies specificity of function. Such intensive devotion to expertness in matters of health and disease precludes comparable expertness in other fields. The physician is not, by virtue of his modern role, a generalized "wise man" or sage—though there is considerable folklore to that effect—but a specialist whose superiority to his fellows is confined to the specific sphere of his technical training and experience. For example one does not expect the physician as such to have better

[3] An excellent and very detailcd analysis of one of thesc border-line groups is given in the study by Walter I.Wardwell, *Social Strain and Social Adjustment in the Marginal Role of the Chiropractor,* unpublished Ph.D. dissertation, Harvard University, 1951.

judgment about foreign policy or tax legislation than any other comparably intelligent and well-educated citizen. There are of course elaborate subdivisions of specialization within the profession.

Affective neutrality is also involved in the physician's role as an applied scientist. The physician is expected to treat an objective problem in objective, scientifically justifiable terms. For example whether he likes or dislikes the particular patient as a person is supposed to be irrelevant, as indeed it is to most purely objective problems of how to handle a particular disease.

With regard to the pattern variable, self vs. collectivity-orientation, the physician's role clearly belongs to what, in our occupational system, is the "minority" group, strongly insisting on collectivity-orientation. The "ideology" of the profession lays great emphasis on the obligation of the physician to put the "welfare of the patient" above his personal interests, and regards "commercialism" as the most serious and insidious evil with which it has to contend. The line, therefore, is drawn primarily vis-à-vis "business." The "profit motive" is supposed to be drastically excluded from the medical world. This attitude is, of course, shared with the other professions, but it is perhaps more pronounced in the medical case than in any single one except perhaps the clergy.

In terms of the relation of the physician's occupational role to the total instrumental complex there is an important distinction between two types of physicians. One of the "private practitioner," the other the one who works within the context of organization. The important thing about the former is that he must not only care for sick people in a technical sense, but must take responsibility for settlement of the terms of exchange with them because of his direct dependence on them for payment for his services, and must to a high degree also provide his own facilities for carrying on his function. It is a crucially important fact that expertness in caring for the sick does not imply any special competence one way or another in the settlement of terms of exchange. It may or may not be a good social policy to have the costs of medical care, the means of payment for it and so on settled by the members of the medical profession, as individuals or through organizations, but such a policy cannot be justified on the ground that their special training gives them as physicians a technical competence in these matters which others do not have.

An increasing proportion of medical practice is now taking place in the context of organization. To a large extent this is necessitated by the technological development of medicine itself, above all the need for technical facilities beyond the reach of the individual practitioner, and the fact that treating the same case often involves the complex cooperation of several different kinds of physicians as well as of auxiliary personnel. This greatly alters the relation of the physician to the rest of the instrumental complex. He tends to be relieved of much responsibility and hence necessarily of freedom, in relation to his patients other than in his technical role. Even if a hospital executive is a physician himself he is not in the usual sense engaged in the "practice of medicine" in performing his functions any more than the president of the Miners' Union is engaged in mining coal.

As was noted, for common sense there may be some question of whether "being sick" constitutes a social role at all—isn't it simply a state of fact, a "condition"? Things are not quite so simple as this. The test is the existence of a set of institutionalized expectations and the corresponding sentiments and sanctions.

There seem to be four aspects of the institutionalized expectation system relative to the sick role. First, is the exemption from normal social role responsibilties, which of course is relative to the nature and severity of the illness. This exemption requires legitimation by and to the various alters involved and the physician often serves as a court of appeal as well as a direct legitimatizing agent. It is noteworthy that like all institutionalized patterns the legitimation of being sick enough to avoid obligations can not only be a right of the sick person but an obligation upon him. People are often resistant to admitting they are sick and it is not uncommon for others to tell them that they *ought* to stay in bed. The word generally has a moral connotation. It goes almost without saying that this legitimation has the social function of protection against "malingering."

The second closely related aspect is the institutionalized definition that the sick person cannot be expected by "pulling himself together" to get well by an act of decision or will. In this sense also he is exempted from responsibility—he is in a condition that must "be taken care of." His "condition" must be changed, not merely his "attitude." Of course the process of recovery may be spontaneous but while the illness lasts he can't "help it." This element in the definition of the state of illness is obviously crucial as a bridge to the acceptance of "help."

The third element is the definition of the state of being ill as itself undesirable with its obligation to want to "get well." The first two elements of legitimation of the sick role thus are conditional in a highly important sense. It is a relative legitimation so long as he is in this unfortunate state which both he and alter hope he can get out of as expeditiously as possible.

Finally, the fourth closely related element is the obligation—in proportion to the severity of the condition, of course—to seek *technically competent* help, namely, in the most usual case, that of a physician and to *cooperate* with him in the process of trying to get well. It is here, of course, that the role of the sick person as patient becomes articulated with that of the physician in a complementary role structure.

It is evident from the above that the role of motivational factors in illness immensely broadens the scope and increases the importance of the institutionalized role aspect of being sick. For then the problem of social control becomes much more than one of ascertaining facts and drawing lines. The privileges and exemptions of the sick role may become objects of a "secondary gain" which the patient is positively motivated, usually unconsciously, to secure or to retain. The problem, therefore, of the balance of motivations to recover, becomes of first importance. In general motivational balances of great functional significance to the social system are institutionally controlled, and it should, therefore, not be surprising that this is no exception.

A few further points may be made about the specific patterning of the sick role and its relation to social structure. It is, in the first place, a "contingent" role into which anyone, regardless of his status in other respects, may come. It is, furthermore, in the type case temporary. One may say that it is in a certain sense a "negatively achieved" role, through failure to "keep well," though, of course, positive motivations also operate, which by that very token must be motivations to deviance.

It is inherently universalistic, in that generalized objective criteria determine whether one is or is not sick, how sick, and with what kind of sickness; its focus is thus classificatory not relational. It is also functionally specific, confined to the sphere of health, and particular "complaints" and disabilities within that sphere. It is furthermore

affectively neutral in orientation in that the expected behavior, "trying to get well," is focused on an objective problem not on the cathectic significance of persons,[4] or orientations to an emotionally disturbing problem, though this may be instrumentally and otherwise involved.

The orientation of the sick role vis-à-vis the physician is also defined as collectively-oriented. It is true that the patient has a very obvious self-interest in getting well in most cases, though this point may not always be so simple. But once he has called in a physician the attitude is clearly marked, that he has assumed the obligation to cooperate with that physician in what is regarded as a common task. The obverse of the physician's obligation to be guided by the welfare of the patient is the latter's obligation to "do his part" to the best of his ability. This point is clearly brought out, for example, in the attitudes of the profession toward what is called "shopping around." By that is meant the practice of a patient "checking" the advice of one physician against that of another without telling physician A that he intends to consult physician B, or if he comes back to A that he has done so or who B is. The medical view is that if the patient is not satisfied with the advice his physician gives him he may properly do one of two things, first he may request a consultation, even naming the physician he wishes called in, but in that case it is physician A not the patient who must call B in, the patient may not see B independently, and above all not without A's knowledge. The other proper recourse is to terminate the relation with A and become "B's patient." The notable fact here is that a pattern of behavior on the part not only of the physician, but also of the patient, is expected which is in sharp contrast to perfectly legitimate behavior in a commercial relationsnip. If he is buying a car there is no objection to the customer going to a number of dealers before making up his mind, and there is no obligation for him to inform any one dealer what others he is consulting, to say nothing of approacning the Chevrolet dealer only through the Ford dealer.

The doctor-patient relationship is thus focused on these pattern elements. The patient has a need for technical services because he doesn't—nor do his lay associates, family members, etc.—"know" what is the matter or what to do about it, nor does he control the necessary facilities. The physician is a technical expert who by special trainine and experience, and by an institutionally validated status, is qualihed to "help" the patient in a situation institutionally defined as legitimate in a relative sense but as needing help. The intricacy of the social forces operating on this superficially simple sub-system of social relations will be brought out in the following analysis.

[4] This it will appear later is particularly important to the therapeutic process. It is not to be interpreted either that the cathectic significance of persons has no part in the etiology of illness or that cathexis of the physician as an object does not occur—but it is controlled.

§ THE SITUATION OF MEDICAL PRACTICE

A. *The Situation of the Patient*

THE first step is to go more in detail into the analysis of relevant aspects of the situation in which the doctor and the patient find themselves. This will provide the setting in which the importance of the broad patterning of both physician's and patient's role can be interpreted, and will enable us to identify a series of mechanisms which, in addition to the physician's deliberate application of his technical knowledge, operate to facilitate his manirest functions in the control of disease, and to promote other, latent functions which are important to the social system.

First, it must be remembered that there is an enormous range of different types of illness, and of degrees of severity. Hence a certain abstraction is inevitable in any such general account as the present one. There is also a range or different types of physician. It will, therefore, be necessary to concentrate on what can be considered certain strategic and typical features of the situation of both.

It will be convenient first to take up the salient features of the situation of the patient and his "lay" associates, particularly members of his family. These may be classified under the three headings of helplessness and need of help, technical incompetence, and emotional involvement.

By institutional definition of the sick role the sick person is helpless and therefore in need of help. If being sick is to be regarded as "deviant" as certainly in important respects it must, it is as we have noted distinguished from other deviant roles precisely by the fact that the sick person is not regarded as "responsible" for his condition, "he can't help it." He may, of course, have carelessly exposed himself to danger of accident, but then once injured he cannot, for instance, mend a fractured leg by "will power." The exhortation to "try" has importance at many peripheral points in the handling of illness, but the core definition is mat of a "condition" that either has to "right itself" or to be "acted upon," and usually the patient got into that condition through processes which are socially defined as "nothisfault."

The urgency of the need of help will vary with the severity of the disability, suffering, and risk of death or serious, lengthy or permanent disablement. It will also vary inversely with the prospect, as defined in the culture, of spontaneous recovery in terms of certainty and duration. But a sufficient proportion of cases is severe in one or more of these senses, and unlikely to recover spontaneously, at least soon enough, so that the feeling of helplessness and the need of help are very real.

The sick person is, therefore, in a state where he is suffering or disabled or both, and possibly facing risks of worsening, which is socially defined as either "not his fault" or something from which he cannot be expected to extricate himself by his own effort, or generally both. He is also likely to be anxious about his state and the future. This is a very different kind of "need" from that of a person who merely "wants" something that he can be permitted to have if he can "swing" it independently, such as a new car, or even if he "needs something," sucn as adequate food, if he can reasonably be expected to procure it

by his own efforts, as by working for it, and not being lazy or shifdess. In a special sense, the sick person is "entitled" to help.

By the same institutional definition the sick person is not, of course competent to help himself, or what he can do is, except for trivial illness, not adequate. But in our culture there is a special definition of the kind of help he needs, namely, professional, technically competent help. The nature of this help imposes a further disability or handicap upon him. He is not only generally not in a position to do what needs to be done, but he does not "know" what needs to be done or how to do it. It is not merely that he, being bedridden, cannot go down to the driig store to get what is needed, but that he would, even if well, not be qualified to do what is needed, and to judge what needs to be done. There is, that is to say, a "communication gap."

Only a technically trained person has that qualification. And one of the most serious disabilities of the layman is that he is not qualified to judge technical qualifications, in general or in detail. Two physicians may very well give conflicting diagnoses of the same case, indeed often do. In general the layman is not qualified to choose between them. Nor is he qualified to choose the "best" physician among a panel. If he were fully rational he would have to rely on professional authority, on the advice of the professionally qualified or on institutional validation.

This disqualification is, of course, not absolute. Laymen do know something in the field, and have some objective bases of judgment. But the evidence is overwhelming that this knowledge is highly limited and that most laymen *think* they know more, and have better bases of judgment than is actually the case. For example the great majority of laymen think that *their* physician is either the best or one of the few best in his field in the community. It is manifesdy impossible for the majority of such judgments to be objectively correct. Another type of evidence is the patterning of choice of physician. A very large proportion of peopie choose their physicians on the basis of the recommendations of rriends or neighbors who "like Dr. X so much," without any sort of inquiry beyond that as to technical qualifications, even as to the medical school from which he holds a degree or the hospital at which he interned.[5] There must be some mechanisms to bridge this "gap." There must be some way of defining the situation to the patient and his family, as to what is "the matter with him" and why, what his prognosis is, what burdens will have to be assumed in recovery. There must be some mechanism for validating the "authority" of the physician, who only in special cases like the military services has any coercive sanctions at his command.

In this connection it should be noted that the burdens the physician asks his patients and their f amilies to assume on his advice are often very severe. They include suffering—you "have tb get worse before you can get better" as for instance in the case of a major surgical operation. They include risk of death, permanent or lengthy disablement, severe financial costs and various others. In terms of common sense it can always be said that the patient has the obvious interest in getting well and hence sfyould be ready to accept any measures which may prove necessary. But there is always the question, implicit or explicit, "How do I know this will do any good?" The one thing certain seems to be that the layman's answer to this cannot, in the majority of severe and complex cases, i.e., the "strategic" ones, be based primarily on his own rational understanding of the factors involved and a fully rational weighing of them. The

difference from the physician in this respect is often a matter of degree, but it is a crucially important difference of degree.

Finally, third, the situation of illness very generally presents the patient and those close to him with complex problems of emotional adjustment. It is, that is to say, a situation of strain. Even if there is no question of a "physic" factor in his condition, suffering, helplessness, disablement and the risk of death, or sometimes its certainty, constitute fundamental disturbances of the expectations by which men live. They cannot in general be emotionally "accepted" without the accompaniments of strain with which we are familiar and hence without difficult adjustments unless the patient happens to find positive satisfactions in them, in which case there is also a social problem. The significance of this emotional factor is magnified and complicated in so tar as delensive and adjustive mechanisms are deeply involved in the pathological condition itself.

The range of possible complexities in this sphere is very great. The problems are, however, structured by the nature of the situation in certain relatively definite ways. Perhaps the most definite point is that for the "normal" person illness, the more so the greater its severity, constitutes a frustration of expectancies of his normal life pattern. He is cut off from his normal spheres of activity, and many of his normal enjoyments. He is often humiliated by his incapacity to function normally. His social relationships are disrupted to a greater or a less degree. He may have to bear discomfort or pain which is hard to bear, and he may have to face serious alterations of his prospects for the future, in the extreme but by no means uncommon case the termination of his life.

For the normal person the direction of these alterations is undesirable, they are frustrations. Therefore it is to be expected that two types of reaction should be prominent, a kind of emotional "shock" at the beginning of illness, and anxiety about the future. In both cases there is reason to believe that most normal persons have an unrealistic bias in the direction of confidence that "everything will be all right," that is they are motivated to underestimate the chances of *their* falling ill, especially seriously ill (the minority of hypochondriacs is the obverse), and if they do they tend to over-estimate the chances of a quick and complete recovery. Therefore even the necessary degree of emotional acceptance of the reality is difficult. One very possible reaction is to attempt to deny illness or various aspects of it, to refuse to "give in" to it. Another may be exaggerted self-pity and whining, a complaining demand for more help than is necessary or feasible, especially for incessant personal attention. In any case this factor reinforces the others. It makes it doubly difficult for the patient to have an objective judgment about his situation and what is needed. Whether they pay explicit attention to it in any technical sense or not, what physicians do inevitably influences the emotional states of their patients, and often this may have a most important influence on the state of their cases.

In this connection perhaps a few words may be said about the relation of the medical situation to death. As was noted in Chapter VIII death, and particularly premature death, is one of the most important situations in all societies, demanding complex emotional adjustments on the part of the dying person, if the probability is known to him in advance, and on the part of the survivors, This is so important that in no society is there

[5] One physician, a suburban general practitioner, told that in several years of practice only one patient had asked him from what medical school he had graduated.

an absence of bath cultural and social structuring of ideas about death, attitudes toward it, or behavior in the presence of imminent death or its recent occurrence. Moreover the "death complex" is never purely instrumental in its patterning. It is a central focusing point for expressive symbolism.

American culture in general seems to have a strong "optimistic bias," one aspect of which is the "playing down" of death, the avoidance of too much concern with its prospect or its implications, and, when it must be faced, "getting it over with" as rapidly as possible. For example, we have relatively slight and probably decreasing emphasis on mourning. Our tendency is to "get on with living" as nearly in the usual pattern as possible. In the light of psychological knowledge and the evidence from comparative cultures it seems highly likely that this attitude is maintained only by virtue of strong disciplines which repress preoccupation with and anxiety about death. It may also mean that "grief reactions" are more frequently repressed than in other societies.

In a society normally at peace, death in most cases is preceded by illness, which links it very closely with the sick role. This is hence a point at which more or less free-floating anxieties about death have an opportunity to focus. Moreover, the physician is brought very closely into contact with death. He is often present at a death bea, and he is the first one to whom people look for structuring the situation in relation to their anxieties about the possibility or death; if the clergyman comes in it is usually later than the physician. It is striking that the medical is one of the few occupational groups which in our society have regular, expected contact with death in the course of their occupational roles, the clergyman, the undertaker, and in certain ways the police, being the other principal ones. The military in our society are a special, though sociologically extremely interesting case, because for us war is an exceptional "crisis" situation, not part of the normal life of the society.

It is to be presumed that this association with death is a very important factor in the emotional toning of the role of the physician. If he is not in general tending in our society to take the place formerly occupied by the clergy, an assertion often made, but subject to considerable qualifications, he at least has very important associations with the realm of the sacrcd. In this connection it is interesting to note that the dissection of a cadaver is included in the very first stage of formal medical training, and that it tends to be made both something of a solemn ritual, especiallv the first day, on the part of the medical school authorities, and meaical students often have quite violent emotional reactions to the experience. It may hence be concluded that dissection is not only an instrumental means to the learning of anatomy, but is a symbolic act, highly charged with affective significance. It is in a sense the initiatory rite of the physician-to-be into his intimate association with death and the dead.

Indeed, this is confirmed by the fact that historically the medical profession had to wage a long and sometimes bitter struggle to secure the right to dissect cadavers as a regular part of medical training—at one time they secretly raided cemeteries for the purpose.[6] Even today some religious bodies strongly oppose autopsies except when they are required by the law of the state where there is suspicion of foul play.

To come back to the main theme. There are two particularly important broad consequences of the features of the situation of the sick person for the problem of the

[6] Cf. Shryock, Richard Harrison, *The Development of Modern Medicine*.

institutional structuring of medical practice. One is that the combination of helplessness, lack of technical competence, and emotional disturbance make him a peculiarly vulnerable object for exploitation. It may be said that the exploitation of the helpless sick is "unthinkable." That happens to be a very strong sentiment in our society, but for the sociologist the existence of this sentiment or that of other mechanisms for the prevention of exploitation must not be taken for granted. There is in fact a very real problem of how, in such a situation, the very possible exploitation is at least minimized.[7] The other general point is the related one that the situation of the patient is such as to make a high level of rationality of judgment peculiarly difficult. He is therefore open to, and peculiarly liable to, a whole series of irr- and non-rational beliefs and practices. The world over the rational approach to health through applied science is, as we have noted, the exception rather than the rule, and in our society there is, even today, a very large volume of "superstition" and other non- or irrational beliefs and practices in the health field. This is not to say that the medical profession either has a monopoly of rational knowledge and techniques, or is free of the other type of elements, but the volume of such phenomena outside the framework of regular medical practice is a rough measure of this factor. This set of facts then makes problematical the degree to which the treatment of health problems by applied science has in fact come to be possible. It can by no means be taken for granted as the course which "reasonable men," i.e., the normal citizen of our society will "naturally" adopt.

The above discussion has been concerned primarily with the sick person himself. But in some cases, e.g., when he is an infant or is in a coma, the patient himself has nothing whatever to say about what is done to him. But short of this, the patient tends to be buttressed by tamily members and sometimes friends who are not sick. Does this not vitiate the whole argument of the above discussion? Definitely not. It may mitigate the severity of the impact of some of the features of the patient's situation, in fact, it often does. But in the first place laymen, sick or well, are no more technically competent in medical matters in one case than the other. The need of help is also just as strong because the solidarity of the family imposes a very strong pressure on the healthy members to see that the sick one gets the best possible care. It is, indeed, very common if not usual tor the pressure of family members to tip the balance in the admission of being sick enough to go to bed or call a doctor, when the patient himself would tend to stand out longer. Furthermore the emotional relationships within the family are of such a character that the illness of one of its members creates somewhat different emotional problems from the patient's own to be sure, but nevertheless often very severe ones, and sometimes more severe, or more difficult for the physician to cope with. It is not, for instance, for nothing that pediatricians habitually mean the mother, not the sick child, when they say "my patient." To anyone schooled in modern psychology the emotional significance of a child's illness for the mother in our society scarcely needs further comment. Hence we may conclude that the basic problems of the role of the patient himself are shared by the

[7] It is interesting to note that even leftist propaganda against the evils of our capitalistic society, in which exploitation is a major keynote, tends to spare the physician. The American Medical Association tends to be attacked, but in general not the ideal-typical physician. This is sienificant of the gcneral public reputation for collectivity-orientation of the medical profession.

others in his personal circle with whom the physician comes into contact in his practice. Sometimes the role of these others is to facilitate the work of the physician very significantly. But it would be rash to assert that this was true very much more often than the reverse. In any case it is quite clear that the role of family members does not invalidate the significance of the situation of the patient for the character of medical practice, as outlined above.

B. *The Situation of the Physician*

THE role of the physician centers on his responsibility for the welfare of the patient in the sense of facilitating his recovery from illness to the best of the physician's ability. In meeting this responsibility he is expected to acquire and use high technical competence in "medical science" and the techniques based upon it. The first question to ask about his situation, therefore, concerns the relation of these technical tools to the tasks he is called upon to perform and the responsibilities he is expected to live up to.

In a certain proportion of cases the doctor has what may be called a perfectly straightforward technological job. His knowledge and skill give him quite adequate tools for accomplishment of his ends, it is only necessary to exercise sufficient patience, and to work steadily and competently at the task. This would, it is true, leave the "penumbra" of emotional reactions of patients and -their families for him to deal with, and his own emotional reactions to such things as severe suffering and imminence of death might well pose certain problems of emotional adjustment to him. But with these qualifications it would be much like any other high level technical job.

But in common with some and not other technical jobs there is in th'is case a shading off into cases with respect to which knowledge, skill and resources are not adequate, with hard, competent work, to solve the problem. There are two main aspects to this inadequacy. On the one hand there are cases, a good many of them, where the upshot of a competent diagnosis is to expose a condition which is known, in the given state of medical knowledge and technique, to be essentially uncontrollable. This is true both in the individual case and generally. Though there is a fundamental relationship between knowledge and control, this is a general and not a point-for-point relationship. Optimistic biases are very general and fundamental in human social orientations, perhaps particularly in our society and certainly in relation to healtn. It is, therefore, very common that the initial effect of a given advance in knowledge is to demonstrate the impossibility of controlling things which were thought to be readily controllable, to expose unfavorable factors in the situation which were not previously appreciated, and to show the fruidessness of control measures in which people had previously had faith.

This has been the case with many advances of medical science. For example, about in the 1870's many people, both in the medical profession and outside it, had a strong faith in the efficacy of various drugs in the treatment of pneumonia. Sir William Osler, one of the most eminent physicians of his day, undertook against strong opposition in the profession to show that this faith was not well founded. He claimed, and his claim has been scientifically validated, that there was not a single case of the use of drugs in this connection which was—apart from psychological considerations, we would now add—not either useless or positively harmful. It must of course be remembered that serum treatment, sulfa drugs and penicillin had not been discovered at that time. Hence the net

effect of Osler's "campaign" was to reduce what had been thought to be the area of rational control of disease, yet it represented definite scientific advance.[8]

The same can be true in the individual case. The patient and his family may know only that he has abdominal discomfort, has been losing weight and lacks energy. Diagnostic procedure reveals an advanced, inoperable cancer of the stomach with a hopeless prognosis. "More" is definitely known than before, but hope has been destroyed. The remarkable advances of medicine in the past two generations have significantly narrowed the range of cases of this sort. But they are very far from having eliminated them, and it seems quite definite that there is no early prospect of their elimination.

These inherent frustrations of the technical expert acquire special significance because of the magnitude and character of the interests at stake. The patient and his family have the deepest emotional involvements in what the physician can and cannot do, and in the way his diagnosis and prognosis will define the situation for them. He himself, carrying as he does responsibility for the outcome, cannot help but be exposed to important emotional strains by these facts.

The absolute limits of the physician's control—which of course are relative to the state of medical science at the time and his own assimilation of it—are not the only source of frustration and strain. Within these limits there is a very important area of uncertainty. As in so many practical situations, some of the factors bearing on this one may be well understood, but others are not. The exact relation of the known to the unknown elements cannot be determined; the unknown may operate at any time to invalidate expectations built up on analysis of the known. Sometimes it may be known *that* certain factors operate significantly, but it is unpredictable whether, when and how they will operate in the particular case. Sometimes virtually nothing is known of these factors, only that the best laid plans mysteriously go wrong. In general the line between the spontaneous forces tending to recovery—what used to be called the *vis medicatrix naturae*—and the effects of the physician's "intervention" is impossible to draw with precision in a very large proportion of cases.

The great importance of the uncertainty element is evident even if attention is confined to the physiological-biochemical levels of analysis of medical problems. In the first great era of modern scientific medicine explicit attention was almost in principle confined to this level. In the light of subsequently acquired knowledge of the psychic factor in disease, a very substantial proportion of the uncertainty factor when attention was thus narrowedmust have consisted in the impingement of psychological elements on the disease process, which at that stage were not understood at all. Taking explicit account of these, to the extent that this has so far become possible, helps to reduce the range, but again by no means eliminates it. One

of its effects, like that of all scientific advance, is to increase awareness of the vast extent of human ignorance, even in the most sophisticated fields of applied science.

The primary definition of the physician's responsibility is to "do everything possible" to forward the complete, early and painless recovery of his patients. The general effect of the existence of large factors of known impossibility and of uncertainty in the situation with which he has to cope is to impose strain upon him, to make it more difficult for him

[8] Cf. Harvey Cushing, *The Life of Sir William Osler*.

to have a "purely rational" orientation to his job than if his orientation were such as to guarantee success with competent work. This is true of his own orientation without taking account of reciprocal interactions with his patients and their intimates.

But the function of "doing everything possible" is institutionalized in terms of expectations, and these expectations are most vividly and immediately embodied, besides in the physician's own attitude system, in the attitudes of precisely this group of people. But compared to most such groups their involvement is, because of the considerations analyzed atove, peculiarly intensive, immediate, and likely to contain elements of emotional disturbance which are by definition, tendencies to deviant behavior. Hence the elements of strain on the physician by virtue of these impossibility and uncertainty components of his situation are particularly great Non- and irrational mechanisms were noted as prominent in the reactions of sick people to their situations, and those of their families. In spite of the discipline of his scientific training and competence, it would be strange if, in view of the situation, physicians as a group were altogether exempted from corresponding tendencies. In fact that magic frequently appears in situations of uncertainty is suggestive. In a later section the problem of the functional equivalents of magic in actual medical practice will be taken up briefly. However, it is clear from the above that quite apart from the operation of so-called psychic factors in the disease process itself, the strains existing on *both* sides of doctor-patient relationship are such that we must expect to find, not merely institutionalization of the roles, but special mechanisms of social control in operation.

Factors of impossibility, and uncertainty in situations where there is a strong emotional interest in success, are common in many other fields of applied science—the military field is an outstandingly important example. There are, however, certain other features of the situation of the physician which are not common to many other fields which share those so far discussed. The engineer, for example, deals primarily with non-human impersonal materials which do not have "emotional" reactions to what he does with them. But the physician deals with human beings, and does so in situations wnich often involve "intimacies," that is, in contexts which are strongly charged with emotional and expressively symbolic significance, and which are often considered peculiarly "private" to the individual himself, or to especially intimate relations with others.

One whole class of these concerns the body. For reasons which undoubtedly go very deep psychologically, certain of the sentiments relative to what Pareto called the "integrity of the individual" are focused on the "inviolability" of the body. Their structuring will vary greatly according to the society and culture. But the amounts and occasions of bodily exposure and of bodily contact are carefully regulated in all societies, and very much so in ours. To see a person naked in a context where this is not usual, and to touch and manipulate their body, is a "privilege" which calls for explanation in view of these considerations. The case of exposure and contact when the patient is of opposite sex is, it should be clearly kept in mind, only one case in a wider category, though it is a peculiany dramatic one. In our society there is no doubt that there are also very strong sentiments regulating physical contact between men, and between women as well. Furthermore, as to exposure, it may not, for instance, be "shameful" for a man to appear in public without his trousers, as it might be for a woman without either skirt or slacks, but it would certainly expose him to ridicule, and this also is certainly an expression of important sentiments. It is clear, in the light of the discussion in the last chapter, that both

the parts of the body themselves, and acts of exposure and of bodily contact are expressive symbols of highly strategic significance.

It is essential for the physician to have access to the body of his patient in order to perform his function. Indeed, some of his contacts, as in the case of a rectal or a vaginal examination, would not be permitted to any other person by most normal individuals, even to a sexual partner. Various others would be permitted only to special indmates.

Along with all this goes the problem of sentiments toward "injury" of the body. Certainly many complex anxieties center about this in many respects. It is, for example, noteworthy how many people have really severe anxieties about the insertion of a hypodermic needle even when this has become such a commonplace in our society. Obviously the problem of securing consent to surgical procedures and many types of diagnostic procedures—such as the use of a gastroscope or a bronchoscope—is not to be too easily taken for granted. The essential point in all this is that these are no simple matters of weighing a rationally understood "need" against an equally rationally assessed "cost" in the form of discomfort or inconvenience, but very complex non-and irrational reactions are inevitably involved with the typical, not only the "abnormal" patient. The fact that these elements are organized and controlled does not make them unproblematical. On the contrary, in the light of the *potentialities* or disturbance, the fact of successful control presents peculiarly important sociological problems.

Similar considerations apply to the physician's need of access to confidential information about his patient's private life. For reasons among which their place in the system of expressive symbolism is prominent, many facts which are relevant to people's problems of health fall into the realm of the private or confidential about which people are unwilling to talk to the ordinary friend or acquaintance. Some of these concern only "reticences" about himself which are not specially bound up with intimate relations to others. A man will often, ror example, hesitate to tell even his wife—even if he is on excellent terms with her—about many things which might well be of symptomatic significance to a pnysician. Others concern the privacies of intimate personal relationships, not only, but perhaps particularly those with sexual partners. Such information, however, is often essential to the performance of the physician's function. His access to it presents the same order of problems as does access to the body.

Modern developments in psychology, particularly psychoanalysis, have made us aware that in addition to resistances to access to the body, and to confidential information, anyone taking a role like that of the physician toward his patients is exposed to another sort of situational adjustment problem. That is, through processes which are mostly unconscious the physician tends to acquire various types of projective significance as a person which may not be direcdy relevant to his specifically technical functions, though they may become of the first importance in connection with psychotherapy. The generally accepted name for this phenomenon in psychiatric circles is "transference," the attribution to the physician of significances to the patient which are not "appropriate" in the realistic situation, but which derive from the psychological needs of the patient. For understandable reasons a particularly important dass of these involves the attributes of parental roles as experienced by the patient in childhood. Transference is most conspicuous in "psychiatric" cases, but there is every reason to believe that it is always a factor in doctor-patient relationships, the more so the longer their duration and

the greater the emotional importance of the health problem and hence the relation to the physician.

If all these factors be taken together it becomes clear that, in ways which are not true of most other professiosnal functions, the situation of medical practice is such as inevitably to "involve" the physician in the psychologically significant "private" affairs of his patients. Some of these may not otherwise be accessible to others in any ordinary situation, others only in the context of specifically intimate and personal relationships. What the relation or the physician's role to these other relationships is to be, is one of the principal functional problems which underly the structuring of his professional role.

If the features of the situation of the patient, the sick person, his intimates, and the physician, which have been reviewed, are taken together, they seem to present a very considerable set of complications of the functioning of medical practice on the level of human adjustment. These complications are not ordinarily taken account of in the simple common-sense view of the obviousness of the expectation that knowledge of how to cope with situations which are distressing to human beings will be applied to the limit of the availability of trained personnel and other necessary resources. They present another order of functional problems to the social system. The severity of these functional problems is such that it can confidently be expected that a whole series of specific mechanisms has developed which can be understood as "ways" of meeting the strains and overcoming the obstacles to the effective practice of scientific medicine which would exist if these mechanisms did not operate. We must now turn to the analysis of a variety of these mechanisms.

§ THE FUNCTIONAL SIGNIFICANCE OF THE INSTITUTIONAL PATTERN OF MEDICAL PRACTICE

THE analysis of this problem may be centered about the pattern variables and the particular combination of their values which characterizes the "professional" pattern in our society, namely, achievement, universalism, functional specificity, affective neutrality and collectivity-orientation, in that order.

The most fundamental basis for the necessity of a universalisticachievement and not a particularistic-ascribed structuring of the physician's role lies in the fact that modern medical practice is organized about the application of scientific knowledge by technically competent, trained personnel. A whole range of sociologically validated knowledge tends to show that the high levels of technical training and competence which this requires would not be possible in a relationship system which was structured primarily in etc.[9] It is furthermore of the first importance

[9] This is not to say that relatively high levels of technical competence cannot ever be attained or maintained in a context of particularistically ascribed role patterns. A notable example is that none of the Roman Generals who won her empire was a professional soldier in our sense. All were aristocrats to whom military activity was ascribed, and who held military command as part of a largely ascribed political career. But even Roman conquest was not applied science in quite the sense or degree that modern medicine is. Certainly no society is known with the high general level of institutionalization of very high technical competences of the applied science type in which tbey were usually structured in particularistic-ascnbed patterns.

particularistic terms or which was ascribed to incumbents of a status without the possibility of selection by performance criteria. This would drastically alter the bases of selection for the personnel of the profession, the focusing of their ambitions and loyalties and many other things. The tendency would be toward nepotism, the hereditary principle,that only this patterning is congruent with the structuring of the rest of the occupational world in modern Western society, particularly with the general world of science in the universities, and its application in other professional roles.

This last is a particularly important point. The tendency of particularistic structuring is to develop solidarities which, through contributing to the integration of the social situation *within* the solidary group, tend to do so at the cost of deepening the separations between such groups, even generating, or contributing to, antagonism and conflict.

A basic fact about science is that the structure of "pure" scientific disciplines cuts across the structure of the fields of application of science to practical affairs. The term "medical science" is thus a somewhat equivocal one, it is not the designation of a single theoretically integrated discipline, but of a field of application. Many different sciences find applications in the medical or health field, physics, chemistry, the whole gamut of biological sciences, psychology and, we can now see, sociology, though the latter is little recognized as yet. A particularistic structuring of the medical profession would almost certainly operate to emphasize and institutionalize the distinction between the medical and the non-medical even more than has actually been the case. Pasteur was initially repudiated by the medical profession in considerable part because he was not a physician but "only" a chemist—how could anything medically important come from anyone who was not a member of the "fraternity"? This repudiation of Pasteur is rightly regarded by modern physicians as a very unfortunate aberration, a refusal to recognize the "intrinsic" merits of a contribution regardless of its source. But particularistic bases of status-ascription, of solidarity, etc., *inherently* cut across the intrinsic structure of science. If they were the predominant institutional focus of the physician's role it is hard to see how the Pasteur case could fail to become the rule, which would come to be ideologically glorified in the profession as a proper protection of its "purity" against gratuitous interference by "outsiders."

The universalism of the medical role has, however, also another type of functional significance. In the light of the considerations brought forward in the last section it is clear that there is strong pressure to assimilate the physician to the nexus of personal relationships in which the patient is placed, quite apart from the specific technical content of the job he is called upon to perform. In so far as his role can be defined in unequivocally universalistic terms, this serves as a protection against such assimilation, because personal friendships, love relationships and family relationships are overwhelmingly particularistic. However, this aspect of the functional significance of universalism is closely bound up with that of functional specificity and affective neutrality. Its significance will be more advantageously discussed when the bearing of these two pattern elements has been made clear.

In its relation to technical competence, universalism is, as has been noted, linked to functional specificity. A generalized "wisdom" which is genuinely universalistic but not specialized for any particular context is conceivable, but it is certainly not the basis of the competence of the physician who is a specialized expert in a specifically defined, if broad and complicated field. But the definition of the physician's role in this respect is not

relevant only with relation to the specificity of his competence, but also of his legitimate scope of concern. Specificity of competence has primarily the function of delimiting a field so that it is relatively manageable, so that competence will not be destroyed by "spreading too thin." Specificity of the scope of concern, on the other hand, has the function of defining the relationship to patients so that it can be regulated in certain ways and certain potential alternatives of definition, which might be disruptive, can be excluded or adequately controlled.

In terms of the features of the situation discussed above, functional specificity is an important element in overcoming potential resistances to the physician, in that through it the limits of his legitimate claims on the patient are defined, and thereby anxieties about the consequences of the special privileges accorded to him are allayed. The role conforms strictly to the criterion of the burden of proof being on the side of exclusion. If the patient asks why he should answer a question his doctor puts to him, or vvhy he should submit to a given procedure, the answer is in terms of the relevance of his health problem—"if you want to get well, you have to give me the information I need to do my job," etc. If it cannot be justified by the relevance to the health problem it is "none of the doctor's business."

The obverse of permissions on the basis of positive relevance to the health problem is some sort of assurance that information or other privileges will not be used for other purposes, or that access to the body will not be used to exploit the patient, or to distort the relation in another direction, e.g., in the direction of mutual sexual attraction.

One of the most prominent mechanisms by which this is brought about is the segregation of the context of professional practice from other contexts. The doctrine of privileged communications is one of the best examples. That what the doctor learns about his patient's private affairs in the course of his duties is confidential and not to be divulged is not only one of the strongest tenets of professional ethics, but is protected by law against the claim to testify in court. Another significant example is the rule that physicians do not care for members of their own families except in essentially trivial illnesses. Not only might their emotional involvements distort their judgment, but they might well come to know things about which it is just as well for them not to know.

Even where there is both a professional and a non-professional aspect of the relationship of the physician to the same persons, there is a definite tendency to segregate the two aspects. For example one physician expressed a strong dislike of being asked for professional advice on social occasions, e.g., the lady sitting next to him at dinner asking what she should do about some illness of her child. His usual response was to ask her to come to his office and discuss it. It might be argued that his interest was in the fee, but the same thing is to be observed where no fee is involved.

One of the most conspicuous cases of the operation of segregation is where a potential sexual element enters in. For example a general practitioner whose office was in his home, and who had no office nurse or dressing room, reported that he habitually stepped out of the office to allow a female patient to get ready for a physical examination. When, as occasionally happened, the patient started to disrobe before he had time to get out of the room, he found it definitely embarrassing, though the same patient disrobed on the examining table did not embarrass him at all. The essential point is that for most men "woman in the same room undressing" usually means potential sexual relations, for the physician "woman on the examining table" means a professional job to do. Naturally,

ensuring the right behavior in each context requires a learning process and a system of control mechanisms.[10]

These examples show that segregation operates not only to maintain functional specificity, but also affective neutrality by defining situations which might potentially arouse various emotional reactions as "professional" and thereby mobilizing a system of sanctions against "inappropriate" reactions. The importance of functional specificity is to define, in situations where potential illegitimate involvements might develop, the limits of the "privileges" in the "dangerous" area which the physician may claim. The pattern of affective neutrality then defines his expected attitudes within those limits.

The case of situations which might easily arouse sexual attractions is a particularly vivid one in our society. It should be noted that breakdown of the controls insuring affective neutrality in that connection is important not only to the doctor and the patient, but would often also involve the interests of a variety of tnird parties, since each tends to be involved in erotic relations with others whose interests would in turn be affected. In other words the toleration by a husband of his wife privately seeing a doctor and the lack of jealousy of their husband's female patients on the part of the doctors' wives are important conditions of medical practice. Occasionally disturbances in this area do occur, but their relative infrequency and the quickness with which they are stigmatized as "pathological" is indicative of the effectiveness of the control system.[11]

This problem of emotional involvements is not, however, confined to the sexual aspect. It also includes likes and dislikes on another level. An eminent surgeon, for instance, was acutely aware of the emotional reaction provoked in himself by seeing a patient through a long and difficult convalescence from a severe and dangerous operation—one case was a nine-year-old boy. He said he would distrust his own judgment if he had to decide to operate a second time on such a case: He was afraid he would lean over backwards to spare the patient the suffering he knew would be involved, even in a case where he also knew the operation would probably be best for the patient in the long run. It is also important that doctors should not let their personal dislikes of particular patients be expressed in a poorer level of treatment or even positive "punishment." And doctors would scarcely be human if they did not take a dislike to some of their patients.

[10] The testimony of a considerable number of physicians interviewed is that in the early stages of medical education sexual arousal to some degree is not uncommon, but that the relevant occasions soon become "part of the day's work." Also by no means the only problem of control is the "protection" of the woman patient from the physician's "taking advantage" of her. Quite frequently it is the other way around, including the possibility of his susceptibility being used for blackmail. One of the prominent hospitals justified the policv of having a nurse present on such occasions by saying it is at least as much for the protection ol the doctor as of the patient." This nurse is graphically referred to as a "nurse-chaperone."

[11] One particular case has been reported to the author of a husband who would not allow his wife to go to a male obstetrician. The physician repordng it assumed this attitude to be pathological. But it is pertinent to note that it was not very long ago when attendance at childbirth by a male physician was not tolerated in most of Western society.

There is a good deal of folklore current in such places as the pulp magazine literatuie and burlesque stage humor about the special opportunities of the

The argument of the last few pages may be summed up in the proposition that one principal set of functional significances of the combination universalism, functional specificity, and affective neutrality, is to enable the physician to "penetrate" sufficiently into the private affairs, or the "particular nexus" of his patients to perform his function. By defining his role in this way it is possible to overcome or minimize resistances which might well otherwise prove fatal to the possibility of doing the job at all.[12]

This importance is not, however, confined to the overcoming of potential resistances. It is also evident that these pattern elements are "for the protection of the physician" in a broader sense than in the case of the "nurse-chaperone" as she is sometimes actually called. The obverse functional danger to that of refusal to admit to the sphere of private affairs is that this admission should be too thorough, that the role of the doctor should be assimilated to that of other "significant persons" in the situation of the patient, that he really should become a personal intimate, a lover, a parent, or a per- sonal enemy. All these roles are, it will be noted, defined in terms of the opposite combination of the values of the pattern-variables being discussed from that which characterizes the professional pattern.

A good many instances were collected by the author in which physicians had been put in positions where there was a "pull" to assimilate their roles to patterns of this type, particularly that of a "personal friend" of the patient. There are various complicating factors but in general it can be said that there was a marked tendency for the physician to feel uncomfortable. Asked why it was undesirable to allovv the assimilation to take place, the usual answer ran in terms of the difficulty of maintaining "objectivity" and "good judgment" in relation to the job. There is every reason to believe that there was an element of correct insight in the testimony of these doctors, none of whom incidentally was a psychiatrist or psychiatrically trained. It is, however, difficult to judge how far this is a rational appraisal of the situation and how far a rationalization of other factors of which the respondent was not explicitly aware.

The enormous recent development of psychotherapy, and increase of our knowledge of the psychological aspects or human relations relative to it, calls attention to another most important aspect of this whole situation. Through the mechanisms or transference the patient, usually without knowing what he is doing, not only has certain resistances, but he actively attempts by projection to assimilate his physician to a pattern of particularistic personal relationship to himself. He attempts to elicit the reaction which is appropriate to his own need-dispositions. Though this is most conspicuous in psychiatric cases, as noted, there can be no doubt that it is also of the greatest importance throughout the field of doctorpatient relationships.

In the first place it is necessary for the physician to be protected against this emotional pressure, because for a variety of reasons inherent in his own situation it is not possible for him to "enter in" to the kind of relationship the patient, usually unconsciously, wants.

doctor for sexual gratification. It might be that "where there is smoke there is fire." But the available evidence points to the probability that this expresses a wish-fulfillment projected on the physician's role, rather than a shrewd guess as to what actually happens.

[12] It is interesting to note that the social or psychological research worker faces similar problems in his relations to people he wishes to interview or observe. The cognate features of his role have the same order of functional significance.

Above all this functional specificity which permits the physician to confine the relationship to a certain content field, indeed enjoins it on him, and affective neutrality which permits him to avoid entering into reciprocities on the emotional level, serve to bring about this protection. The upshot is that he refuses to be "drawn in" and has institutional backing in his refusals of reciprocity.[13]

But, in addition to this, our knowledge of the processes of psychotherapy reveals another important dimension of the situation. That is, the same features of the physician's role, which are so important as protection of the physician himself, are also crucially important conditions of successful psychotherapy. Psychotherapy, as we have seen, becomes necessary when the control mechanisms inherent in the reciprocities of ordinary human relationships break down. One of the most important features of neurotic behavior in this sense is of course the involvement in vicious circles, so that the social pressures which ordinarily serve to keep people "in line" and bring them back if they start to deviate, serve only to intensify the recalcitrant reaction and to drive the individual farther from satisfactory behavior. If these vicious circles are to be dealt with there must be an "Archimedean place to stand" outside the reciprocities of ordinary social intercourse. This is precisely what the patterning of the physician's role provides. Whether it is love or hate which the patient projects upon him, he fails to reciprocate in the expected terms. He remains objective and affectively neutral.[14] The patient tries to involve him in his personal affairs outside the health field and he refuses to see his patient except at the stated hours in his office, he keeps out of his sight so as to avoid opportunities for reciprocal reactions.[15] Finally, the discrepancy between the transference reactions and the realistic role of the physician provides one of the most important occasions for interpretations which can bring the patient to new levels of insight as part of the process of emotional readjustment.

An essential part of what the psychiatrist does is to apply direct knowledge of the mechanisms of neurotic behavior to the manipula- tion of his patient. Increasingly, however, psychiatrists are becoming aware of the importance of the structuring of their own roles as part of the therapeutic process. But it is quite clear that the basic structuring of the physician's role in our society *did not come about through the application of theories of the ideal situation for psychotherapy*. It was a spontaneous, unplanned development of social structure which psychiatry has been able to utilize and develop, but which originated independendy of its irifluence.

There is a most important implication of all this. Psychiatry is much more recent than organic medicine, and today constitutes only a fraction of the total of medical practice. But the continuity between them in function must be, artd historically has been, much

[13] The fact that his role is collectively-oriented, on the other hand, tends to draw him in and has to be counteracted by these other factors.

[14] "Countertransference" of course occurs, but the therapist is expected to minixnize and control it, not just "let himself go."

[15] Many specific points in the details of psychotherapeutic and psychoanalytic technique are controversial within the relevant professional groups. The present discussion is not meant to take a position on such questions as to whether it might or might not under certain circumstances be better to get the patient off the couch into a face-to-face posidon. It is meant only to call attention to certain general features of the psychotherapeutic situation.

greater than the usual explicit interpretations allow for. If the structure of the physician's role has the kind of functional significance for deliberate psychotherapy which has been outlined here, it must have some effect on the mental state of the patient whether it is used for deliberate psychotherapy or not. And there is every evidence that it does. Psychotherapy to the militantly anti-psychiatric organic physician is like theory to the militandy anti-theoretical empirical scientist. In both cases he practices it whether he knows it or wants to or not. He may indeed do it very effectively just as one can use a language well without even knowing it has a grammatical structure.[16] But the general conclusion is that a very important part of non—and prepsychiatric medical practice is in fact "unconscious psychotherapy" and that this could not be true if the institutional structure of the physician's role were not approximately what it has here been shown to be.[17]

This brings us to the last pattern element, collectivity-orientation. It is this which is distinctive of professional roles within the upper reaches of our occupational system, especially in the contrast with business. Indeed one of the author's principal motivations in embarking on a study of the medical profession lay in the desire to understand a high-level occupational role which deviated from that of the businessman who, according to certain theorists, represented the one strategically crucial type of such role in modern "capitalistic" society.[18]

It was noted above that the sick person is peculiarly vulnerable to exploitation and at the same time peculiarly handicapped in arriving at a rationally objective appraisal of his situation. In addition, the physician is a technically competent person whose competence and specific judgments and measures cannot be competently judged by the layman. The latter must therefore take these judgments and measures "on authority." But in the type case there is no system of coercive sanctions to back up this authority. All the physician can say to the patient who refuses to heed his advice is "well, it's your own funeral"—which it may be literally. All this of course is true of a situation which includes the potential resistances which have been discussed above.

[16] This has sometimes been called the "art of medicine."

[17] Two formulae are more or less current among physicians which show an inadequate understanding of the situation. One is that the doctor is the patient's "best friend." He is, in terms of willingness to help him. But a relationship of fxiendship is not confined to a functionally specific context, nor is it affectively neutral. A friend does not have the "place to stand" outside certain reciprocities. The other is current among certain psychoanalysts, "the doctor is the father." It is true that the father xole is perhara the most immediately appropriate *transference* role to a male analyst, especially if there is a considerable age differential. But when a son misbehaves a father reacts with anger and punishment, not affectively neutral "understanding." A father can also be called upon to help where a physician can legitimately refuse. It is precisely the *differences* from friendship and familial roles which are the most important levers for the psycho therapeutic process.

[18] See "the Professions and Social Structure," *Essays in Sociological Theory,* Chapter VIII, for a general analysis of the relations between business and the professions in our social structure.

These different factors seem to indicate that the situation is such that it would be particularlv difficult to implement the pattern of the business world, where eacn party to the situation is expected to be oriented to the rational pursuit of his own self-interests, and where there is an approach to the idea of "caveat emptor." In a broad sense it is surely clear that society would not tolerate the privileges which have been vested in the medical profession on such terms. The protection of the patient against the exploitation of his helplessness, his technical incompetence and his irrationality thus constitutes the most obvious functional significance of the pattern. In this whole connection it is noteworthy how strongly the main reliance for control is placed on "informal" mechanisms. The law of the state includes severe penalties for "malpractice" and medical associations have relatively elaborate disciplinary procedures, but these quite dennitely are not the principal mechanisms which operate to ensure the control of self-orientation tendencies. The significance of this will be discussed below.

Here it may be noted that the collectivity-orientation of the physician is protected by a series of symbolically significant practices which serve to differentiate him sharply from the businessman. He cannot advertise-he can only moaestly announce by his "shingle" and the use of his M.D. in telephone directories and classified sections, that he is available to provide medical service. He cannot bargain over fees with his patients-a "take it or leave it" attitude is enjoined upon him. He cannot refuse patients on the ground that they are poor "credit risks." He is given the privilege of charging according to the "sliding scale," that is, in proportion to the income of the patient or his family—a drastic difference from the usual pricing mechanism of the business world. The general picture is one of sharp segregation from the market and price practices of the business world, in ways which for the most part cut off the physician from many immediate opportunities for financial gain which are treated as legitimately open to the businessman. The motivational significance of this difference will have to be discussed below.

It is also interesting to note, following up the earlier remarks about "shopping around," that the definition in terms of collectivityorientation is expected to be reciprocal. The most usual formulation for this is that the patient is expected to "have confidence" in his physician, and if this confidence breaks down, to seek another physician.

This may be interpreted to mean that the relationship is expected to be one of mutual "trust," of the belief that the physician is trying his best to help the patient and that conversely the patient is "cooperating" with him to the best of his ability. It is significant for instance that this constitutes a reinforcement of one of the principal institutional features of the sick role, the expectation of a desire to gct well. It makes the patient, in a special sense, responsible to his physician. But more generally, it has been pointed out before that collectivity-orientation is involved in all cases of institutionalized authority, that is authority is an attribute of a status in a collectivity. In a very special and informal sense the doctor-patient relationship has to be one involving an element of authority—we often speak of "doctor's orders." This authority cannot be legitimized without reciprocal collectivity-orientation in the relationship. To the doctor's obligation to use his authority "responsibly" in the interest of the patient, corresponds the patient's obligation faithfully to accept the implications of the fact that he is "Dr. X's patient" and so long as he remains in that status must "do his part" in the common enterprise. He is free, of course, to terminate the relationship at any time. But the essential point is the sharp line which tends to be drawn between being X's patient, and no longer being in that position. In the

ideal type of commercial relationship one is not A's customer to the exclusion of other sources of supply for the same needs.

Finally, there is a most important relationship between collectivity-orientation and psychotherapy, conscious or unconscious. There are differences of opinion among psychiatrists on many subjects, but so far as the author knows, none on this point—that therapeutic success is not possible unless the patient can be brought to trust his physician. This is particularly important because it can safely be said that there is no important class of psychological disturbances which do not have, as one important component, an impairment of the capacity to trust others, essentially what, in Chapter VII, we called a sense of insecurity. This element of distrust then tends to be projected onto the physician in the transference relationship. If the role of the physician were defined in self-orientation terms it could hardly fail to invite deepening of the vicious circle, because the patient would tend to see his own neurotic definition of the situation confirmed by the institutional expectation that the physician was "out to get everything he could for himself." In this as in other contexts it is of the first importance that the institutionalized definition of the role is such as to counteract these transference tendencies of the patient, thus to set up a discrepancy between his neurotic expectations and reality which is as difficult as possible for him to avoid understanding. In view of the immense importance of what has here been called the element of unconscious psychotherapy in non-psychiatric medical practice, the element of collectivity-orientation is certainly one of the keystones of the institutional arch in this respect.

§ SOME SPECIAL PROBLEMS

A FEW special problems may now be taken up which illustrate in still other contexts connected with medical practice the usef ulness of the type of analysis which is here being employed. The ones which will each be briefly discussed here are, the part played by certain pseudo-scientific elements even within the profession itself, the predominance of informal internal controls and the resistance to outside and to formal control, and the problem of the comparative motivational patterns of the medical and business world.

We may go back to the discussion of the element of uncertainty which looms so large in medical practice. This element, and that of impossibility, the border lines between them often being indistinct, places serious strains on a well-integrated balance of need, skill, effort, and expectations of result.[19] Within this situation there is a variety of motivational factors operating to drive action in one direction, namely, "success" of the therapeutic enterprise. The physician himself is trained and expected to act, not merely to be a passive observer of what goes on. The patient and his family are also under strong emotional pressures to "get something done." There is on both sides, in Pareto's terms, a "need to manifest sentiments by external acts."

[19] Durkheim, in his classic interpretation of the nature of *anomie* in *Suicide,* was one of the first to analyze correctly the nature of the strains involved in upsetting a normal balance in the relation between effort, skill, and expectation of result. His analysis is further generalized by our treatment of the complementarity of expectations in interactive relationships and the motivational consequences of disturbances of this complementarity.

One of the best types of examples of this situation is that where a decision to perform a surgical operation is in the balance, and where, from a technical point of view, there is a genuine uncertainty element involved. The surgeon must weigh the risks of operation against the risks of delaying operation or deciding not to operate at all. In general it is clear that there tends to be a bias in favor of operating. After all the surgeon is trained to operate, he feels active, usclul, effective when he is operating. For the patient and his family, in their state of anxiety and tension also, inactivity, just waiting to see how things develop is particularly hard to bear. A decision to operate will, in such a situation, almost certainly "clear the air" and make everybody "feel better." At least "something is being done." It is also probable that American culture predisposes more to this pattern of activity than most others, and that this has much to do with our tendency to glorify the surgeon, who is indeed a kind of culture hero.

This problem of the bias in favor of active intervention, of giving the benefit of the doubt to operating in surgical cases, underlies the problem of "unnecessary operations" about which there has been a good deal of discussion in medical circles. It is true that, in the situation of individual fee-for-service practice, the surgeon has a direct financial incentive to be biased in favor of operating. In the folklore of the subject, however, whatever tendency to unnecessary operations there may be, tends too immediately to be ascribed to this financial incentive. It is forgotten that there are other powerful motives operating in the same direction. In such a situation it would take far more refined research methods than have yet been applied to the problem to discriminate the effects of the two factors. One may thus be warned against glib, easy interpretations of the "obvious" motivation of a pattern of action, where it can be shown that *one* motivational factor operates in the right direction.

It is suggested that the situation of surgical practice, where the uncertainty factor is almost inevitably great, predisposes to a bias in favor of active intervention. Since the motivation for this bias tends to be strongly shared by patients and their families, its existence is obscured since there is no conspicuous group whose conscious interests are injured by it to protest But this particular version of the bias is by no means isolated. A second conspicuous phenomenon is the existence of a pattern of "fashion change," even within the medical profession as such, which, however, is far less conspicuous than the related health "faddism" current among the general public.[20]

This phenomenon is easy to observe only in temporal perspec- tive. A technical innovation in the medical field will for a time be slow in "catching on." When, however, it begins to be accepted, it will spread very rapidly and be utilized on almost everypossible occasion where an at all plausible case for it can be made. This continues until the point is reached where i't becomes "oversold" and a reaction sets in. Its use will then fall off, probably to a level below its intrinsic merits, and after a series of narrowing fluctuations it will tend to settle down to a well-established place in the professional "repertoire."

The phenomenon was perfectly described, without the slightest awareness of its sociological implications, by two surgeons writing in a medical journal, discussing a new

[20] An excellent place to study the latter is in the field of health advertising. For an analysis of one such. "fad," cf. L.J.Henderson, "Aphorisms on the Advertising of Alkalis," *Harvard Business Review,* Autumn, 1937, Vol. 16, pp. 17–23.

operative technique for the removal of the prostate gland. But the same tendency can be observed in many cases, e.g., "focal infection," the use of the sulfa drugs recently, psycho-somatic interpretations in many fields. The important point is that the "irrationar element in the belief in the efficacy of *any one* technique or diagnostic idea, which we see must be interpreted as a reaction to strain, is only temporary, but *at any given time,* there is always a group of such ideas current in the profession. By the time that rational criticism and experience have succeeded in "finding the proper level" for one, another has arisen to take its place.

The general phenomenon then is an "optimistic bias" in favor of the soundness of ideas or efficacy of procedures. Since the basic normative pattern by which such ideas are measured is that of science, there are strong pressures toward the elimination of the bias in any particular case. But as a general phenomenon it persists—it is a pseudo-scientific element in the technical competence of the medical profession which is more than simply an expression of the relative lack of scientific development of the field; it is positively motivated.

The question arises of whether it has positive functions, or as the "rationalistic" tendency of thought goes, is simply an "imperfection" to be eliminated. Comparative perspective is very helpful in answering this question. Malinowski among others has shown that magical beliefs and practices tend to cluster about situations where there is an important uncertainty factor and where there are strong emotional interests in the success of action.[21] Gardening and deepsea fishing are examples he analyzes. It is suggestive that pseudoscience is the functional equivalent of magic in the modern medical field. The health situation is a classic one of the combination of uncertainty and strong emotional interests which produce a situation of strain and is very frequently a prominent focus of magic. But the fact that the basic cultural tradition of modern medicine is science precludes outright magic, which is explicitly non-scientific, The result is a "bias."

It may be safely inferred that there is an important element of positive hmctional significance in this. The basic function of magic, according to Malinowski, is to bolster the self-confidence of actors in situations vvhere energy and skill *do* make a difference but where because of uncertainty factors, outcomes cannot be guaranteed. This fits the situation of the doctor, but in addition on the side of the patient it may be argued that *belief* in the possibility of recovery is an important factor in it. If from purely a technical point of view both the individual doctor and the general tradition are optimistically biased it ought to help, through a "ritual" demonstration of the will to recover and that there *is* a chance.[22] Of course this argument must not be pressed too far. Too many conspicuous failures of optimism to be justified by events could have a shattering effect on just this confidence. The functional needs of society call for a delicate balance in this as in many other fields.

[21] See B.Malinowski, Magic, *Science and Religion*. Kroeber, *Anthropology,* 1948 Ed., pp. 604, questions fhe universality of this relationship, but not that it exists in many cases.

[22] It may be suggested that reference to this context constitutes a significant, if not well understood undertone, in the physician's so frequent insistence that his patients should have "confidence" in him.

Modern medical practice is, as has so frequently been pointed out, overwhelmingly oriented to science. Science in turm attempts to make the state of its knowledge as clear and rationally explicit as possible. One would think that this type of pattern would run through the whole social complex of medical practice. There is a certain formal precision and clarity about the existence of a system of formal rules of behavior and formal mechanisms for their enforcement which seems to bear a certain relationship to scientific precision, so that on the basis of "cultural congruence" one might expect

a system of bureaucratic-legalistic social organization to be particularly congenial to a scientifically trained protession.

Broadly the facts do not bear out this expectation. A certain jealous guarding of their independence from outsiders might be expected from such a professional group, indeed they do tena to do so vis-à-vis the state and, ideologically at least, vis-k-vis any other potential source of "lay control."[23] But perhaps the most conspicuous fact is that even their own professional associations do not play a really important part in the control of medical practice and its potential abuses through formal channels. It is true that medical associations do have committees on ethics and disciplinary pro cedures. But it is exceedingly rare for cases to be brought into that formal disciplinary procedure. Thus the well-known reluctance of physicians to testify against other physicians in cases of malpractice, in the courts, has its parallel in the reluctance of physicians to resort to the formal disciplinary procedures of their own associations, which do not involve "wasning their dirty linen" before laymen.

It is suggested that behind this conspicuous tendency lie factors which are common throughout the occupational world, but perhaps in certain respects especially prominent here. The general tendency is to fall considerably short of living up to the full "logical" implications of the dominant culture pattern in certain crucial respects. It is suggested that this derives from the fact that it is not possible to "apply" the dominant cultural pattern literally and without restriction and not generate strains which in turn would produce responses which would be more disruptive than certain "mitigations" of the rigorous applications of the pattern itself. This deviation from the dominant pattern is what we have called an adaptive structure.

The physician is expected to act responsibly in a situation where the interests of others are very vitally affected, and in ways where it is not by any means always probable that the reaction of these others to things going wrong will be "reasonable." The resources he has available to do his job are by no means fully adequate. He inevitably makes mistakes, and his mistakes may on occasion have very serious consequences. Moreover, it may be peculiarly difficult to explain many situations where things go wrong to people not technically competent or familiar with the peculiar circumstances of medical work and whose emotions are wrought up. Even

[23] The qualification "ideologically" is necessary here. Almost all medical education, by explicit sanction of the organized profession, is now in the hands of Universities. Ultimate legal control of the university is usually in the hands of boards of trustees, not one of which is composed of a majority of medical men. Much the same is true of the government of hospitals. Yet many medical men, who never think of protesting against this situation, roundly assert that any change which will subject medical men to the authority of laymen in any respect is "in principle" intolerable.

within a medical society formal procedures necessarily abstract from the subtleties of the particular situation.

It may therefore be suggested that reliance on informal controls, even though greater formalization would be more "logical," may have its functional significance. As one physician put it, "Who is going to throw the first stone? We are all vulnefable. We have all been in situations where what we did could be made to look very bad." Formalization inevitably gives a prominent role to "technicalities" of definition. It always opens the door for the "clever lawyer" whether he be a District Attorney or merely the "prosecutor" of the medical society's own Committee on Ethics. Undoubtedly a certain amount of abuse does "get by" in the present situation which "ought not to" and would not in a well-run formal system of control. But it is at least possible that the strong reliance on informal controls helps to give the physician confidence, and a certain daring in using risky though well-advised procedures, which he would not be so ready to do in a more thoroughly bureaucratized situation.[24]

Finally, a brief discussion may be devoted to the problem of the sociological interpretations of the motivation of the physician in his professional role which can supplement the discussion of the "profit motive" in Chapter VI. Because of the prominence in their own ideology of the difference between "professionalism" and "commercialism," and the general popular tendency to think of all businessmen as "heartless egoists" and medical men as "altruists," the discussion may center on this issue. This tendency is deeply grounded in the total "ideology" of our society with its roots in the utilitarian pattern of thought. It can be shown to be quite definitely wrong in this case.

It is quite true, as has been pointed out in the discussion of the pattern of collectivity-opentation above, that the medical man is expected to place the welfare of the patient above his own selfinterest, financial or otherwise. He is also explicitly debarred, in the code of medical ethics, from a whole series of practices which are taken for granted as quite legitimate for the honest and upright businessman, such as advertising, price-competition, refusing to take patients on the ground that they are not good "credit risks," etc. Thus the physician is both debarred from a variety of immediate opportunities for financial gain which are open to the businessman, and is positively enjoined to promote the welfare of his patients, It is not these facts which are at issue, but the interpretation of their meaning for motivation and the mechanisms of social control.

It is quite possible that a selective process operates so that a career in medicine appeals to a more "service oriented" type of personality than does a career in business. But even

[24] In this connection it should be noted that some branches of medicine show a willingness to have their work exposed to professional criticism which is rarely matchedin other professions. The practice of surgery is, within the profession, essentially public, and has the further check of the pathological laboratory and the autopsy. But it is interesting that it is only professionally public, laymen are generally excluded from the operadng room. The author's observations suggest one possible factor in this. The families of padents undergoing an operation are generally emotionally "wrought up" to a high degree. The atmosphere of the operating room, on the other hand, is in generaf a "work-a-day" atmosphere, with calm technical comment and discussion, and often a good deal of joking. Much of this could not fail to appear to the emotionally disturbed relative as frivolity or callousness—the doctors don't care what happens to my wife."

if this is a factor of considerable significance it is certainly not the only or even the principal one. For the question arises, would it really be to the selfinterest of the normal physician to ignore the code of his profession and to gamer the financial rewards from advertising, from increasing his practice by undercutting the rates of his colleagues, and from excluding the bad credit risks. In general, assuming that the situation is institutionally well integrated, this would not be to his interest. For such action would impinge on both the interests and the sentiments of others in the situation. The consequences would take the form of a loss of professional standing which in turn would, if it went far enough, begin to show in quite tangible forms. Desirable connections from financial, as well as other points of view, would become more difficult to form, or be endangered, such as hospital staff appointments or referrals of patients from other physicians. A staff appointment might be terminated, or not renewed. In the extreme case there might be the threat of disciplinary action on the part of the medical society. All along there would be a jeopardizing of the easy informal "belongingness" to a group who understand each other as to proper conduct.

In other words, the collectivity-orientation of the professional pattern has become built into a set of institutionalized expectations of behavior and attitude. In conformity with tbe basic theorem of the institutional integration of motivation discussed in Chapter II, both self-interested and "altruistic" elements of motivation have thereby become channeled into the path of conformity with these expectations. Therefore the seeming paradox is realized that it is to a physician's self-interest to act contrary to his own self-interest—in an immediate situation, of course, not "in the long run."

The difference between the professional pattern and that of the business world in this respect, which tums primarily on the variable of self- vs. collectivity-orientation, is thus in the first instance institutional and not motivational. Whatever differences there may be from a psychological point of view between the typical motives of physicians and of businessmen, must be analyzed with this in mind, taking it as a starting point. It is a particularly vivid example of the importance of the sociological analysis of the social system f or formulation of the problem of the analysis of motivation when the generalization of the implications of that analysis is to be extended beyond the single individual to problems of significance to the social system.[25]

§ SOME THEORETICAL CONCLUSIONS

IN THE foregoing discussion we have not attempted to give anything like a full coverage of the facts relevant to the analysis of medical practice as a social system, and its place in the larger social system. We have, for example, not dealt with the processes of recruitment and training of the profession. We have not more than hinted at its very complex internal differentiations, or the large field of professional organization. Above all we have dealt only with a

[25] This problexn is somewhat further discussed in the two papers, "The Professions and Social Structure" and "The Motivation of Economic Activities," *Essays in Sociological Theory,* Chapters VIII and IX.

kind of ideal type of the situation in a way which has ignored a whole range of what, relative to the technical and ethical standards of the best of the profession, are sub-standard and deviant practices. We have, however, presented enough material to justify certain conclusions which are of central significance to the present work. Our object was not to give a complete empirical review but only the facts most directly relevant to some of our main theoretical interests.

The case selected for presentation was that of an occupational role. We are accustomed in the common sense of our culture to think of such a role in terms of the instrumental division of labor, a view which is correct and sound enough. We are accustomed to think of the incumbent of the role as "having something to sell," in this case a service, to people who have a need and know how to go about meeting that need. The place of technical competence based on scientific training is also in a broad way understood on a commonsense basis.

In common-sense terms, however, it is far from possible to give an adequate account of how these functions of purveying a service to those who need it can in fact be effectively carried out under the actual conditions of the concrete social system. We have seen that with respect to the problems of health, as to many others, the treatment of practical problems in terms of applied science is not to be taken for granted, but is subject to special conditions in the cultural and social systems. We have seen that medical practice must be a part of the general institutionalization of scientific investigation and of the application of science to practical problems, which is a characteristic feature of modern Western society.

In general in the instrumental division of labor, on the grounds we have adduced throughout this work, the institutionalization of all the roles in ways of which common sense is not at all or only very vaguely aware, is a functional requirement of the effective performance of the role. We have not taken space to demonstrate that the role of physician, simply as one of the general class of occupational roles, is institutionalized, and what this institutionalization consists in; that can be taken for granted.

We have, rather, concentrated on certain special features of the roles of both parties to the doctor-patient relationship, and their relation to certain special features of the conditions in which the per-formance of medical service takes place. There are perhaps two most general conclusions from consideration of these special features in terms of the conceptual scheme of this work. The first of these is that successful performance of those functions of medical practice, which are obvious to common sense, depends on a whole series of conditions, the necessity for which is not obvious. The second conclusion is that the ways in which both roles are institutionalized are related to aspects of the motivational balances of the social system, both in direct relation to health and in broader respects, in ways which are altogether inaccessible to common sense, and which admirably illustrate the general analysis of that motivational balance of social processes which was presented in Chapters VI and VII above.

With respect to the first context, the role of being sick as an institutionalized role may be said to constitute a set of conditions necessary to enable the physician to bring his competence to bear on the situation. It is not only that the patient has a need to be helped, but that this need is institutionally categorized, that the nature and implications of this need are socially recognized, and the kind of help, the appropriate general pattern of action in relation to the source of help, are defined. It is not only the sick person's own

condition and personal reactions to what should be done about it which are involved, but he is placed in an institutionally defined framework which mobilizes others in his situation in support of the same patterns which are imputed to him, which is such an important feature of his role. The fact that others than the patient himself often define that he is sick, or sick enough for certain measures to be taken, is significant.

On the other side of the relationship, the collectivity-orientation of the physician, and its universalism, neutrality and specificity, make it possible for the things he has to do to perform his function to be made acceptable to the patient and his family. These include validation of his professiohal authority and justification of the "privileges" he must be accorded.

A central aspect of this phase of the problem is that certain of the features of the role structure on both sides of the relationship are essential to bringing together the cultural and the situational elements of the action complex. It is possible to have a sick role, and to have treatment of illness institutionalized, where the role of therapist is not of the modern professional type. Treatment by kinsmen is a common example. But if, as in our society, the primary cultural tradition defined as relevant to health is science, it is not possible to have the role of therapist institutionalized in the same pattern terms as those of kinship. Hence in addition to the *sick* role we may distinguish the role of *yatient* as the recipient of the services of a scientifically trained *professional* physician. The definition of the sick role as that of potential patient is one of its principal characteristics in our society.

Finally, on this level we have shown that certain deviations from the ideal type of institutionalization of science and of rational action are found in the field of medical practice. These deviadons are of two types: first, a deviation from the ideal type of the institutionalized belief system in the form of the prevalence of an element of pseudo-scientific belief in the efficacy of measures, a deviation which is continuous with the wider deviations to be found among the lay public. The second type of deviation is on the level of social organization, and was illustrated by the case of the conspicuous reliance within the profession bn informal sanction systems where from a "rational" point of view formal disciplinary machinery would be more appropriate. Both of these are to be regarded as adaptive phenomena of the general type we have often spoken of.

We may express the second main conclusion by saying that the sick role, incluaing its aspect as patient, and the role of physician, both have latent functions with respect to the motivational balance of the social system which are of considerable significance. Some of the most important keys to the understanding of these latent functions are to be found in the psychiatrist's own analyses of the processes of psychotherapy, but the significance even of these for the social system is only brought out when they are seen in their more general setting in the theory of the social system. Other elements necessary to the understanding of these functions are derived from the analysis of institutional structure, in its application to these roles and their interaction, and from bringing out the common elements as between the processes of the interaction of physician and patient, and those operating in a variety of other types of situation.

The essential assumption in tbis connection is that illness is, in one of its major aspects, to be defined as a form of deviant behavior, and that the elements of motivation to deviance which are expressed in the sick role are continuous with those expressed in a variety of other channels, including types of compulsive cohformity which are not

socially defined as deviant. Because of the element of fluidity in so much of the motivation to deviance, or more generally the reactions to strain, it is possible to regard illness as belonging to a system of alternative channels for the "acting out" of such motivational elements, hence as an integral part of a larger dynamic system of motivational balance.

Seen in this perspective, both the sick role and that of the physician assume significance as mechanisms of social control, not only within the bounds of the common-sense definition of the traditional functions of the physician, but much more broadly, including intimate relations to many phenomena which are not ordinarily thought to have any connection with health.

The sick role is, as we have seen, in these terms a mechanism which in the first instance channels deviance so that the two most dangerous potentialities, namely, group formation and successful establishment of the claim to legitimacy, are avoided. The sick are tied up, not with other deviants to form a "sub-culture" of the sick, but each with a group of non-sick, his personal circle and, above all, physicians. The sick thus become a statistical status class and are deprived of the possibility of forming a solidary collectivity. Furthermore, to be sick is by definition to be in an undesirable state, so that it simply does not "make sense" to assert a claim that the way to deal with the frustrating aspects of the social system is "for everybody to get sick."

These two functions of the sick role operate even if no therapeutic influence is exerted, and their importance to the social system should not be underestimated. On this ground alone it is legitimate to question the adequacy of the common assertion that the increase in the proportion of mental illness is necessarily an index of increasing social disorganization. The fact may be provisionally granted, though because of shortcomings of the statistical information and of the fact that many conditions are now diagnosed as mental illness, which would not have been a generation ago, it might be questioned. In any case such an increase need not, as is very commonly asserted, be a direct index of increasing general social disorganization. It is quite possible that it constitutes the diversion into the sick role of elements of deviant motivation which might have been expressed in alternative roles. From the point of view of the stability of the social system the sick role may be less dangerous than some of the alternatives.

However, obviously in addition to this insulating function of the sick role, there is its reintegrative influence. The significance of this is greatly enhanced by two factors. The first is that deliberate psychotherapy is, even within the role of the physician, not an isolated phenomenon, but may be regarded as the specialization of features of that role which are present in what has sometimes been called the "art of medicine." All good medical practice therefore, we have maintained, has been and is to some degree psychotherapy. Psychotherapy as a mechanism of social control, therefore, builds on and extends what must be regarded as an "automatic" or latent set of mechanisms which have been built into the role of physician independent of an application of theories as to what psychotherapy, or social control processes, should be. Deliberate psycnotherapy is, to use a graphic metaphor, only the part of the iceberg whicn extends above the water. The considerably larger part is that below the surface of the water. Even its existence has been largely unknown to most psychiatrists, to say nothing of laymen. It consists in certain institutional features of the physician's role in its particular form of meshing with the sick role.

But even more important is the second fact, the continuity of the fundamental processes of psychotherapy with the general processes of "coping" successfully with the psychological consequences of the exposure of people to strain in social relationships. This means not only that, as just stated, the motivational materials which enter into illness are continuous with those expressed in many other forms of deviance, but also that the mechanism of control of psychotherapy is one of a much larger class of such mechanisms. In turn, a clue to what these are is provided by the element of unconscious psychotherapy we have shown to be present in the doctor-patient role relationsnip. The elements involved have been discussed with examples in the latter part of Chapter VII and need not be repeated here.

A very important set of problems arises, however, with respect to the generality of that analysis. The modern physician's role constitutes a very distinctive type of social structure. It is far too distinctive alone to form the basis for the generalizations about the relations between motivation to deviance and the mechanisms of social control which we have set forth. But we have shown that it is possible to modify our analysis of the factors involved in the motivational processes to take account of variations of role structure. In other types of roles some of the things which happen in psychotherapy are clearly not possible; thus in general parental roles are not capable of reintegrating the deviant once the vicious circle of alienation has reached the neurotic stage of elaboration. But in spite of this fact the fundamental processes involved in normal socialization and those involved in psychotherapy have crucially important elements in common, along with the obvious differences. Focusing attention on these common elements thus makes it possible to pose in a sharply meaningful way such questions as that of the significance of the existence of two parents, whereas there is normally only one psychotherapist. Similarly we have tried to show that in much magical and religious ritual, in secondary institutions, and in much of the wider institutional patterning of the social system, there are latent functions of social control, the operation of which must be understood to an important degree in the same fundamental terms as are involved in the operation of psychotherapy.

Thus the analysis of modern medical practice has not only given us a "case study" of a type of social structure which is interesting and significant in itself, and as a way of applying a theoretical paradigm for the analysis of social structure. More tnan that it has opened a "window" which can be used for the observation of balancing processes within the social system, which have generalized significance far beyond the "room" within the larger edifice of society into which this particular window opens.