PROFESSION OF MEDICINE

A study of the sociology of applied knowledge

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„The end for which we live is a certain kind of activity, not a quality. Character gives us qualities, but it is in our actions – what we do – that we are happy or the reverse“

Aristotle
In this book I try to show that the occupational organization of the work of one learned profession constitutes a dimension quite as distinct and fully as important as its knowledge, and that the social value of its work is as much a function of its own organization as it is of the knowledge and skill it is said to possess (xi)
PART I.

THE FORMAL ORGANIZATION OF A PROFESSION
(p 1 – 84)
PART I.

Chapter 1.
The Emergence of Medicine as a Consulting Profession
(3-23)
In all societies people diagnose sickness and adopt various methods for managing it (3). Medicine’s position today is akin to that of state religious yesterday – it has an officially approved monopoly of the right to define health and illness and to treat illness (5).

The clearest way to see some of the elements of the essential elements involved in the development of a profession having the characteristics of present-day medicine is to look closely at an instance where practitioners who diagnosed and treated illness did not constitute a stable profession, let alone a profession. Such a negative case is provided by E. E. Evans-Pritchard’s classic study of the Azande of East Africa published in 1937. He described the position of an insecure and unstable occupation lacking the prerequisites to become a profession (6).

Clearly, the witch doctor was in an insecure position. He was granted occasional individual „art“, but no special occupational „craft“ (9).
Conditions for a profession of witchcraft (9)
No matter which of these strategies is adopted, clearly one minimum condition of control is that the occupation has gained command of the exclusive competence to determine the proper content and effective method of performing some task (10).
The occupational group, then, must be the prime source of the criteria that qualify a man to work in an acceptable fashion (10).
What is also needed is general public belief in the consulting occupation´s competence, in the value of its professioned knowledge and skill. Without believe there will be little consultation (11).

Medicine and the witch doctor (11)
Official medicine, however, … became a true consulting profession in the late nineteenth century after having developed a sufficiently scientific foundation that it´s work seemed superior to that of irregular healers (12).
The development of medical technology (12)
I believe that the empirically demonstrable outcome of medical work is important to its development as a consulting profession (12).

… there is nonetheless a massive collection of evidence that rational and pragmatic material advantage plays an important even if not exclusive role in public acceptance (12).

The development of occupational organization (16)
Parallel to the development of a technically or scientifically adequate foundation of medical work was the development of a sociological foundation to create an occupation so well established in its society as to become a true consulting profession - in command of the criteria that qualify men to work at healing, of exclusive competence to determine the proper content and effective method of performing medical work, and freely consulted by those thought to need its help (17).

… that at no time in the history of medicine did he have anything like a complete monopoly over healing services, informal or formal (17).

The university-conferred title of “doctor” constituted the first stable source of distinction … (19). … licensing … uniform training … basic technical education … enforcing licensing laws … The outcome was control over the practice of healing that has never before been enjoyed by medicine (21)
Technology and Consulting Professions (21)

... that a significant monopoly could not occur until a secure and practical technology of work was developed. It is necessary, though not sufficient, for medicine because the survival of medical practice depends upon the choice of laymen to consult it. Choice to consult cannot be forced; it must be attracted ... (21)

Like the lawyer, the physician’s job is to solve the practical problems that people bring to him. He is not the custodian of a revealed dogma, whose job it is to distinguish the genuinely revealed from the spurious, ... (22).

Scholarly or learned scientific professions can gain their monopoly over work solely by the conjunction of professional association and state support. Consulting professions have to take test of practical problem solving applied by their lay clientele (22).
Chapter 2.
Political organization and professional autonomy
(23-47)
The most strategic and treasured characteristic of the profession – its autonomy – is therefore owed to its relationship to the sovereign state from which it is not ultimately autonomous (23/4).

... I shall argue that ... the state uniformly leaves in the hands of the profession control over the technological side of its work. What varies as relations with the state vary is control over the social and economic organization of work (24)

*Medicine in the United States* (25)

Medicine in the contemporary United States provides us with a fairly good example of a profession with considerable socio-economic as well as technical autonomy. Its formal organizational representative – or professional association – has been delegated many of the powers that the state elsewhere has reserved for himself, ... free of lay interference (25/6).
PART I. Chapter 2 (23-47)

Medicine in the United States (25)
... the great amount of autonomy granted to practitioners in such a system
... American Medical Association ... AMA (27).

This structure (AMA) is apparently dominated by a comparatively small
group of men who maintain power ... (28). ... characteristic general apathy
of the membership, the dead-hand method of selecting officers ... the usual
policy of the Journal of AMA not to print opinions in disagreement ... a fairly
united front is presented to the outside ... a major source of power of the
AMA ... membership may be critical to his career (28). ... the threat of ...
expulsion ... used to punish physicians ... AMA has a distinguished history
of advancing a minimum technical standards of health services ... (29) ... AMA also controls ... quality and to a degree the quantity of physicians
available to the nation (30). ... its “principles of Medical Ethics” are
predicated on a model of individual rather than cooperative forms of
practice, financed on a free-for service rather than an insured, prepaid
basis (31). There has been a great deal of objection ... to the employment
by hospitals of radiologists ... dignity of the profession was lowered (31). ... insurance ... support private over public plans (32). The basic point is the
preservation of the free entrepreneurial status of the physician (33)
PART I. Chapter 2 (23-47)

Medicine in England an Wales (34-39)
Medicine in the Soviet Union (39-43)

What seems most relevant for our purposes that … the physician … does maintain the right to diagnose and prescribe according to criteria that are rooted in medical knowledge and to have his work evaluated by colleagues, not by laymen. This is certainly the very heart of professional autonomy, …

Expertise seems to have its own leverage (43).

The State and Zones of Professional Autonomy (44-46)

The empirical examples … suggest … a logical range of variation in the organization of modern professional services. At the one extreme, … United States … the state uses the profession as its source of guidance, exercising its power, …and create a sociopolitical environment in which the profession is free from serious competition from rival practitioners and firmly in control of auxiliary workers. Within this state-protected environment, the profession has sufficient power of its own to control virtually all facets of its work without serious interference from any lay group. … including autonomy in selecting the economic terms of work, the location and social organization of work, and the technical content of work. … this comprehensive autonomy is protected by a state-supported monopoly (44)
The State and Zones of Professional Autonomy (44-46)

Nonetheless I would argue that autonomy of technique is at the core of what is unique about profession, and that … when the core autonomy is gained, at least segments of autonomy in the other zones follow after (45).

… where the claim of emergency and of possible dangerous consequences is a potent protective device (45). Granted autonomy is his technique, the professional has a number of advantages which give him a sturdy wedge into other zones of practice….the professional can argue that he cannot perform his work adequately unless … (45). … Arguing with his conceded expertise in diagnosis and treatment, he is well equipped to influence if not control many other areas of his work (46).

Autonomy over the technical character of his work, then, gives him the wherewithal by which to be a “free” profession, even though he is dependent upon the state for establishing and sustaining his autonomy (46).
PART I.

Chapter 3.
The medical division of labor
(47-70)
Medicine, after all, sought the exclusive right to practice in face of the fact that many kinds of healers were practicing (47).

Thus, the state has both made it illegal for other workers to compete with physicians and given physicians the right to direct activities of related occupations (48). … the hierarchical character of the medical division of labor (48).

*Paramedical Occupations* (48)

It is the physician’s control of the division of labor that is distinct. Those occupations falling under his control are called “paramedical” (48). The term “paramedical” refers to occupations organized around the work of healing which are ultimately controlled by physicians. Physicians control is manifested in a number of ways. First, much of the technical knowledge learned by paramedical workers … tends to be … approved by physicians. Second, … paramedical workers tend to assist rather than replace … Third, paramedical workers tend to subordinate, … at request or “order” … Finally, the prestige assigned … by the general public tends to be less … (48/9).

Therefore, the differences between “paramedical” and the “quack” do not necessarily arise from what each does or how he does it but from the relations each ahs to the dominant profession. The paramedical worker, being under “discipline”, is more easily distinguished sociologically than technologically (49).
Development of the Division of Labor (50-52)

A division of labor around the tasks of diagnosing and treating human ills has always existed in one form or another in most human societies. There has always been diagnosticians, herbalists, midwives, and nurses, even only on a part-time, amateur basis. The distinctive division of labor labelled “paramedical”, however, is relatively new and is complex only in the highly industrialized societies … (50).

With the development of the university and the guilt in European cities, then, rose a rudimentary organization of full-time health workers, organized … under the supervision of physicians and surgeons (51). There were in essence two health systems, the largest rooted in the culture of the peasant (Bauer), the most prominent in the learned traditions of Western civilization. Before the latter could become at once stable and universal, the former had to be destroyed …. In the nonindustrial countries … such division of labor does not yet exist … (51).

In England, the country GP had been drawn into regular medical ranks. … dentistry survived fairly independently, … pharmacy … and optometry … were not fully integrated … the bone-setter … the midwife were taken over by the physician himself … laboratory technicians, rising … inside the walls of the hospital .. developed as part of the paramedical … (52).
Hierarchy in the Division of Labor (52-54)

All occupations in the system are given less prestige than the physician by society in large (52/3). Furthermore, there is a hierarchy of prestige and authority among paramedical workers, with nurses, for example, being higher than attendants and technicians. This hierarchy, too, is likely to be reflected in the social origins of the workers (53).

On the whole, the more autonomous the occupation and the greater the overlap of its work with that of physicians, the greater the potential for conflict, legal or otherwise (53).

… and physicians are not able by virtue of their numbers to perform cheaply all the traditional functions demanded of them, such conflict is common, focusing around the question of whether … non-physicians are to be allowed to offer health services independently of medical supervision (54).

Some years ago it could be visualized more or less as a pyramid, with the physician at the apex. In present-day United States, the pyramid seems to be changing into a less clear-cut structure, at the top of which is a plateau along which are arranged physicians as well as other autonomous but consulting and loosely cooperating new professions (54).
Recruitment and Training (54-57)

Training also follows a pattern whose order roughly parallels the prestige, independence, and imputed responsibility of the work. Training ranges from professional schools … at one extreme, to short, informal on-the-job training at the other (54).

Recruitment of the many low-skill positions in the paramedical division of labor seems to be a simple function of the labor market and the demand for unskilled service workers willing to do the unpleasant work. Recruitment of the higher skill positions, however, is considerably more problematic … (55).

However, the emphasis on professionalism is most often strong only during the course of training, which is where the leaders of the occupation are likely to be influential (56).

More important … is the likelihood that when paramedical students are imbued with a professional ideology emphasizing their dignity and autonomy, but begin work in settings where they are distinctly subordinate, they are in for what has been called “reality shock” (57).
Professionalism and the Case of the Nurse (57-63)

The nurse, whose leaders in the United States and abroad have with great energy sought to establish unique skills and full professional status, seems fated to remain subject to the doctor’s orders in part because her work is largely carried on in a hospital (57).

The secular nurse, like the monastic nurse, was not specially schooled in techniques of bedside care and had no clear technical relationship to the practice of hospital medical care. Furthermore, she lacked any basis for public respect ... stereotype of drunken and degraded Sairey Gamp, quite outside the respectable medical division of labor (60).

Florence Nightingale ... Crimean war ... given absolute control of a contingent of of nuns, bawdy women, and Anglican sisters ... first effort ...to strip them of any femininity ... nurses’ services were to be granted only when specifically requested by the doctors ... nuns were forbidden to engage in religious visiting. All nurses work flowed from the doctor’s orders Nursing thus was defined as a subordinate part of the technical division of labor surrounding medicine. (61) ... training school was founded. Nightingale’s trainees were placed as supervisors or matrons in hospitals so that they would be able to train those already working in hospitals (62). .. What was critical was character, ability and training (62). .. Only the personal recommendation of the training matron ... Any number of nurses could get a diploma, but only those close to highly regarded and powerful matrons could get the good jobs (62), Nightingale’s continued resistance to the idea .... was so powerful, that that registration did not occur until 1919 (63)
The Dilemmas of Nursing (63-66)
… it has become greatly concerned with finding a new, independent position in the
division of labor (63). One of the dilemmas, however, lies in the fact that its work
can no longer be controlled by the occupation itself (63) … Creating a paramedical
hierarchy within the paramedical hierarchy (65). In all, we see nursing as an
incompletely closed occupation in a state of change. The practice of traditional
nursing skills is ultimately contingent on the judgement of a superordinate
profession an o cannot constitute the basis for autonomy (66).

Paraprofessional Professionalism (66-69)
To escape subordination to medical authority, it must find some area of work over
which it can claim and maintain monopoly, but it must do so in a setting in which the
central task is healing and controlled by medicine (66). Obviously, such a statement
(of a medical technologist) is intended to give dignity and pride to a subordinate
worker (68).

Professions and Professionalism (69)
An aggressive occupation like nursing can have its own schools for training, can
control licensing boards, …, and can have its own service in hospital, in this way
giving the appearance of formal, state-supported, and departmental autonomy, but
the work which its members perform remains subject to the order of another
occupation (69)
Chapter 4.
The formal characteristics of a profession
(71-84)
Unlike other occupations, professions are deliberately granted autonomy, including the exclusive right to determine who can legitimately do its work and how the work should be done. And while no occupation can prevent employers, customers, clients, and other workers from evaluating its work, only the profession has the right to declare such “outside” evaluation illegitimate and intolerable.
The Source of Professional Status (72-73)
A profession attains and maintains its position by virtue of the protection and patronage of some elite segment of society (72). It is essential for survival that the dominant elite remain persuaded of the positive value or at least the harmlessness, of the profession’s work, so that it continues to protect it from encroachment (73). Consulting and Scholarly Professions (73-75)
Consulting and Scholarly Professions (73-75)

Nonetheless, … the consulting or practicing professions … will not assure survival because the work cannot be performed … without being in some way positively attractive to the lay clientele (74).

Unlike science and scholarship, which create and elaborate the formal knowledge of a civilization, practicing professions have the task of applying that knowledge to everyday life. Practicing professions are the links between a civilization and its daily life and as such must, unlike science and scholarship, be in some sense, joined to everyday life and the average man. Some of this linkage can be politically sustained ….but some seems to depend upon the attractiveness of the work itself to the average man (74).

… the difference between “client-dependent” and “colleague-dependent” practices are of critical importance for the way work is performed … (75)
**Profession and Paraprofession (75)**

It might be noted that paraprofessional occupations usually seek professional status by creating many of the same institutions as those which possess professional status. They create a formal standard curriculum …create or find abstract theory ..write codes of ethics …seek support for licensing … control over who is allowed to do their work … But what they persistently fail to attain is full autonomy … limited by the dominant profession (76)

**The Formal Criteria of Profession (77-82)**

… William J. Goode, allows concentration on essentially two “core characteristics” of professions … these two … are “prolonged specialized training in a body of abstract knowledge, and a collectivity or service orientation”. Among the “derived characteristics … (77).

… a process in which power and persuasive rhetoric are of greater importance than the objective character of knowledge, training and work (79). The profession’s service orientation is a public imputation it has successfully won in a process by which its leaders have persuaded society to grant and support its autonomy (82)
Formal Institutions and Professional Performance (82-84)

... my analysis shall emphasize the way professional work settings may control or fail to control deviant performance. The question of control, after all, is the obverse of the question of autonomy, for autonomy is granted the profession with the understanding that it will itself, without outside interference, regulate or control the performance of its members. Just as autonomy is the test of professional status, so is self-regulation the test of professional autonomy (84)
PART II.

THE ORGANIZATION OF PROFESSIONAL PERFORMANCE
(p 85 – 201)
PART II.

Chapter 5.
Everyday work settings of the professional
(87-108)
In the interpretation of human affairs there seem to be two distinct and persistent perspectives. There is the view generically characteristic of religionists, educationists, and psychologists – that the kind of person a man is determines how he will behave quite independently of the environment. In moral terms this view holds that the world can be changed only by first directly changing the individual – whether by a gift of grace, by instruction, or by psychotherapy. There is also the view that a man’s behavior is a function of the pressures of his environment, that his environment determines his consciousness and how he will behave independently of the kind of person he is. This view holds that the world can be changed by changing people’s environment. In the former case the strategy of analysis is to determine what kind of individual is involved in a situation – his personality, his norm or believes, his education- and how these attributes influence his behavior. In the latter case the tendency is to examine how variation in environment is associated with variation in individual behavior (87)
The most commonly suggested remedy for such behavior is reformation of the professional curriculum rather than of the circumstances of professional work … (88) Nonetheless I argue that education is a less important variable than work environment (89). Such studies as these provide evidence that quite critical elements of professional behavior – the level of technical performance, the approach to the client, “cynicism”, and ethicality – do not vary so much with the individual’s formal professional training as with the social setting in which he works after his education (98-90). … that a significant amount of behavior is situational in character – that people are constantly responding to the organized pressures of the situations they are in … and that what they do is more an outcome of the pressures of the situation they are in than of what they have earlier “internalized” (90).
Empirical Types of Practice Organization (91-98)

... medicine is practiced in an organized framework which influences the behavior of both doctors and patients (91).

The typical mode of medical practice in the United States is “solo practice”. This involves a man working by himself in an office which he secures and equips with his own capital, with patients who have freely chosen him as their personal physician and for whom he assumes responsibility.

Stereotypically he lacks any formal connection with colleagues (91). But the phrase “solo practice” is as often used in an ideological as in a descriptive mode. It is ... a sacred cow in the medical profession of more than one century. The ideological connotation has interesting analytical implications. One of the central themes is independence – the notion of “professional autonomy” – in which a man can do as he pleases (91).
Empirical Types of Practice Organization (91-98)

STRUKTUR DER SOLO-PRAXIS

A truly autonomous free-for-service solo arrangement is inherently unstable, however: it is eventually bound to fall under the control of either patients or colleagues. In a system of free competition the physician may neither count on the loyalty of his patient (with whom he has no contract) nor on that of his colleagues (with whom he has no ties and who are competing with him). Since his colleagues are competitors, he is not likely to solicit their advice or trade information, and he certainly will not refer his patients to them. Under these circumstances he is quite isolated from his colleagues and relatively free of their control but at the same time he is very vulnerable to control by his clients. To keep them, he must give them what they want – whether tranquilizes, antibiotics or hysterectomies—or someone else will. Obviously, conscientious practice under these conditions is difficult and frustrating. It is hardly to describe it as “autonomy” (92).
Empirical Types of Practice Organization (91-98)

INFORMALLES KOLLEGIALES NETZWERK

Simple restriction of competition by banding together against the tyranny of client choice leads to the alternative tyranny of colleague choice. ... In short, present practice is not solo: it embraces a large variety of organized relationships, most of which currently emphasize colleague rather than client controls (92).

How do cooperative arrangements develop? Let us start with an ostensible “solo” free-for-service practice ... (92). ... one’s practice must be “covered” by colleagues ... A cooperative arrangement is necessary ... The need for such organization becomes even more pressing when specialization is involved ... he can send some ... to a clinic ... whose staffs presumably will not “steal” them. A rather natural and conventional solution is to work out fairly definitive reciprocal arrangements ... position to be the key “feeder” to a network of specialists ... (93) The “colleague network” described by Hall may be used as a the prototype of such an informal but well integrated arrangement ... (94) This kind of network ... is more likely to exist in localities where there is a variety of hospitals ... (95) ... most elementary type of cooperative practice ... uncomfortably vulnerable to collapse ... may break down in petty jealousies and antipathies (95/6)
PART II. Chapter 5 (87-108)

Empirical Types of Practice Organization (91-98)

FORMAL COOPERATIVE ARRANGEMENTS

1. PARTNERSHIP

The employer-physician position is particularly strong when the man he hires is not fully qualified to practice on his own … the hiring physician is very vulnerable, for each young man he introduces to his patients may take some of those patients with him when he leaves (96).

2. ASSOCIATION

The most common type of formal arrangement among peers is … the association – an arrangement whereby physicians share the expense of maintaining such common facilities as offices, equipment, assisting personal … while thy have their own patients (96).

3. SMALL LEGAL PARTNERSHIP

From the association it is a short though by no means simple step to the small legal partnership in which profits from fees as well as overhead expenses are shared. The division of pooled fees is likely to be a constant bone of contention … (96).

4. GROUP PRACTICE

“Group practice” is very often used to designate a form of association that goes beyond the scope connoted by the two-man partnership … (97). … ideological overtones … rather than emphasizing autonomy and independence, the term emphasizes “groupness” and interdependence (98).

5. BUREAUCRATIC PRACTICE

As the number of patients and doctors increases further, it seems likely that, modified somewhat by the doctor’s bargaining position, some of the technical characteristics of bureaucracy will emerge: hierarchical organization, extensive division of labor, systematic rules and procedures, and the like. In a logically ideal sense, this may be seen as a bureaucratic practice.
Medical Performance in Office Practice (98-105)

But in order to make use of empirical materials dealing with practice, we must divide all these work-settings into two types to be able to parallel the common-sense distinction between solo and group practice. The former category includes true solo and all types of informally cooperative practice (solo, colleague-network). The latter includes, from “association” on, all types of formally cooperative practice (association, small partnership, group practice, bureaucratic). By means of this distinction, we can ask how the form of work setting is related to professional performance (99).
Medical Performance in Office Practice (98-105)

TECHNICAL PERFORMANCE
Since the foremost claim of a profession is to special expertise, it follows, that the first question to ask about various forms of professional practice concerns technical performance, or the quality of service provided … cannot practice the best possible medicine without easy access to modern diagnostic and therapeutic facilities … formal cooperative arrangements … are more likely to provide the capital to buy … equipment (99).

MEDICAL KNOWLEDGE
Furthermore, the isolation of practicing physician from his colleagues is believed to be a significant element in the quality of care. … keep abreast of advances in scientific knowledge … relying less … on the … “education” of drug manufacturers … group more than solo practice seems to encourage a higher quality of care (99/100).

SPECIALIZATIONS
… care by a variety of specialists is held to be necessary… group practice facilitates frequent consultation and exchange of professional information … in group practice the fragmentation of care following upon specialization can be compensated for and … comprehensive care is more likely to ensue (100).

SUPERVISION
Finally, there is the element of supervision, the quality … to influence medical performance (100). … bureaucratic practices … encourage record keeping … provide higher quality of care (101).

CONCLUSION
In theory, then, the formal and cooperative rather than the informal and individual practice arrangements are more likely to provide good medical care. However, there are only scattered bits of evidence to support this theory (101)
Medical Performance in Office Practice (98-105)

PATIENT SATISFACTION

Patient satisfaction assumes additional importance when medicine becomes a political issue. They complain that doctors keep them waiting too long, are difficult to reach on nights and weekends, and do not give enough time to them (102). … solo program elicited more patient satisfaction than did the capitation group practice. … sense of personal interest … group practice … technically higher quality (101).

PHYSICIAN SATISFACTION

Physician satisfaction, too, may be more influenced by arrangement of work than by arrangement of payment (103). Hence, a physician in any organized scheme of practice can always find some ways to work outside, even if at some personal risk or sacrifice .. No matter what the tyranny of the patient, the solo work setting has the quality of potentially complete autonomy … autonomy perhaps more extensive than in any other profession thus exists … in solo-practice. This is what was stressed by medical students (104).
Thus far, we have discussed medical work settings as a variable quantity of professional cooperation and organization … However, this simplistic mode of analysis does not pick out some of the important analytical qualities of practice, particularly those bearing directly on the differential performance of physicians in practice. For example … the solo practitioner is not generally considered to give as good technical care as … in group practice …the specialist is reputed to give better technical care than the GP … different specialists - for example, obstetricians as opposed to pathologists – are reputed to have different “personalities” … (105/6).

How can we explain such differences? We can explain them by assuming that people select themselves … select their practices to fit their capacities (106). Quite another kind of explanation lies in the press of the situation on the individual after he has landed in a position – on the influence of the setting of work on transforming the individual who has become committed to adjusting to it … persistent and powerful demands cause the individual to behave in a certain way regardless of the personal qualities. The structural contingencies of practice … greatest significance … that influence the maintenance, raising, or lowering of the standards of ethical and technical performance … (106)
Analytical Types of Practice Organization (105-108)

COLLEAGUE STANDARDS VERSUS LAY STANDARDS

...standards of ethical and technical performance ... established and assessed by members of the profession ... may be labelled as “colleague” standards ... (106) ... contrasting them with lay standards. We may take it as axiomatic that the patient has a different perspective on health services than does the physician and that on occasion he will almost certainly ask for medication or procedures which colleagues would not approve (106/7). Opposing laymen and colleagues to each other, then, we may distinguish practices by the degree to which they are amenable to lay or colleague control (107)
Analytical Types of Practice Organization (105-108)

CLIENT-DEPENDENT PRACTICE
On one extreme is a work setting that is wholly dependent for its economic continuance on lay evaluations – client dependent practice- ... This physician ... is chosen on the basis of lay conceptions of what is needed, not by professional criteria. In order to be chose – in order to stay in practice – he must offer services of a sort that laymen themselves feel they need: he must give antibiotics for colds, vitamin injections for being “run down”, and sedatives or tranquilizers for “nerves”. ... its professional standards are likely to be comparatively low (107). ... The quack ... seems most usefully defined as a practitioner who fits this extreme ... close to this extreme ... is the independent solo neighborhood or village general practitioner (108)

COLLEAGUE-DEPENDENT PRACTICE
At the other extreme may be seen a colleague-dependent practice that does not in and by itself attract its own clientele but that instead serves the needs of other colleagues or professional organizations that do attract such clientele. It is dependent for its clientele on colleagues rather than laymen ... Here, obviously, we should expect that the degree to which it honors professional standards will be relatively great (107) ... medical specialties as pathology, anesthesiology, and radiology ... somewhat less pure ... are practices ... in hospitals, clinics, and other professional bureaucracies. Here ... organizational requirements minimize (the client’s) influence (108). ... Lead him to minimize his responsiveness to clients (108).
Analytical Types of Practice Organization (105-108)
SUMMARY
This classification of medical practice provides a foundation for understanding some of
the mechanisms involved in creating observed differences in performance among
physicians in one setting rather than another. If physicians are as individuals unusually
conscious and ethical, we … understand what practice settings can make them
comfortable … (108).
PART II.

Chapter 6.
Patterns of practice in the hospital
(109-136)
GOAL

In examining the hospital for the degree to which it is an appendage of medical practice, we first consider the range of variation in the extent to which hospital policies and procedures are controlled by the physicians who use it as a place in which to bed and treat their patients (111).

PROPRIETARY HOSPITAL

At one extreme of the range is the proprietary hospital – one owned privately and run for profit. … physicians are the gate-keepers who persuade patients to be hospitalized … its policies are likely to be focused on accommodating to the needs and desires of the physicians, tempered by … the demands of the customer, economics, and other requisites of profit … the physician who brings in the most patients or the best-paying patients will have the greatest influence on policy. … policy will be dominated by the principle of laissez faire: the physicians will be free to do more or less as he pleases, medically, with little or no supervision of his medical performance (111).
Hospitals as Medical Practices (111-115)

VOLUNTARY OR COMMUNITY HOSPITAL

Such hospitals are by definition not run for profit. … compensation by private and …

public health insurance .. “charity” cases. To balance the cost of …”charity” cases, well-
paying patients were obviously desirable. The physicians who could bring such well-
paying patients … were dominant in setting hospital policy in spite of the fact that they

were neither the owners of the hospital nor committed to it by employment or capital

investment (112).

FULL-TIME-COMMUNITY HOSPITAL*

More recently … every patient is a “paying patient” …and … development of full-time, …
hospital-based practice … has been passing out of the hands of the community practitioner and into those of boards that “own” and the “administrators” who manage the day-to-day affairs of the hospital. Policy has become divided into several spheres, medical boards … and administrative staff controlling the rest. … It was likely to impose rules of its won on the physicians behavior .. Conform to religious dictates … (112/3).

MILITARY, FEDERAL, STATE, and MUNICIPAL HOSPITALS …

medical practice becomes wholly encompassed by the hospital, not standing apart from it. The most clear-cut example of this is … the military hospital, where physicians are full-fledged members of the organization … subject to discipline as other performing members … The physician´s practice lying entirely within the organization, his career is formed by his relationship to it and its personnel (113).
Hospitals as Medical Practices (111-115)

MEDICAL SCHOOLS AND TEACHING HOSPITALS

Like the university professor ... while his “practice” depends upon holding a position in the organization, his career tends to be one of high mobility, moving from one organization to another (113).

MEDICAL HOUSE STAFF

... the work of postgraduate physicians – interns and residents, or “house staff” (113/4). ... for the functioning of hospitals ... is the transience of house staff. Like students in a college, their orientation is toward obtaining what they feel they need from the institution ... in order that they may leave and begin their “real” life of practice. ... Their commitment to their hospital work ... less intense than that of the full-time staff ... the mere fact of their constant rotation or turnover may have serious consequences for the care they give patients (114).

In ... the community hospital ... the medical staff ... is not committed to the hospital in the same way as are such full-time employees as nurses. While they are part of the hospital ... it is markedly variant from that of the members of such clearly bureaucratic organizations as armies, factories, and civil service bureaus (115).
Ordering the Hospital Division of Labor (115-119)

DIVISION OF LABOR IN HOSPITALS

What groups are involved in the hospital? In my definition I stressed the centrality of medical and surgical work. But while physicians and surgeons may control the performance of such work .. They cannot do it all themselves (115/6). … it is possible to distinguish (1) physicians … (2) medical an paramedical personnel … (a) nursing and ward personal … various therapists … (b) laboratory … other technicians … (3) service workers who care for the physical plant of the hospital …managing the food, laundry … (4) clerical personnel … (5) those whose task it is to organize, supervise, and coordinate the work … the “administrators” … (6) the legal governing board of the institution … (7) the patients as clients (116).
PART II. Chapter 6 (109-136)

Ordering the Hospital Division of Labor (115-119)

MONOCRATIC MODEL OF ORGANIZATION

In the conventional industrial organization ... the workers are ... subordinate to the administration. ... the worker who performs the primary, core task of production ... is neither in control of the organization nor represented by an especially powerful superior ... a monocratic model like that analyzed by Max Weber (116/7).

COLLEGIAL MODEL OF ORGANIZATION

Recent discussions of organizations ... claim that when creative and complex work is required ... the monocratic model of organization is inappropriate. Those concerned with the role of the professional in the organization have suggested that something quite other than a monocratic form of organization is appropriate to the creative and complex work imputed to the professional – a professional organization – company of equals, or in Weber’s terms, a collegial form of organization. And, indeed in the hospitals ... there is not just one line of authority but two. Essentially, ... the physician can intervene in many areas of the hospital over which he has no formal administrative jurisdiction or authority ... (117).
Ordering the Hospital Division of Labor (115-119)

COLLEGIAL MODEL OF ORGANIZATION

…the nurse is caught between two superiors, administrative and medical. The latter, however, is not her bureaucratic superior … (117). Similarly, justifying his demands by reference to the well-being of his patient, the physician can and does give “orders” to other hospital personnel even though he is not a bureaucratically defined superior. In this way the functioning of the hospital is seen to be disrupted and broken. Lacking the clear, unilinear authority upon which Weber predicates efficiency and reliability in organizational performance (118).

MEDICAL EMERGENCY

…the physician is able to intervene in many places in the hospital and justify his intervention on the basis of a “medical emergency” … far more common in the hospital is the labelling of ambiguous events as emergencies by the doctor so as to gain the aid or resources he believes he needs … (119) … It is his ability to invoke life-threatening emergency and to claim exclusive capacity to evaluate and solve it that marks the physician off from many other experts in other organizations (119)
When does the second line of authority operate? (119-121)

EMERGENCY

In the hospital we can ... predict the likelihood of the intervention of this “second line of authority” (and the disordering of decision-making) by the degree to which the speciality of the physician involved permits the plausible and regular claim of “critical emergency” (119)

SOCIOECONOMIC INDEPENDENCE

... I would insist that much of the problem posed by the second line of authority stems ... from the combination of his sociolegal responsibility for hospital patients with the socioeconomic independence of the physician from the hospital ... the physician is in the position to escape many of the obligations of any member of a bureaucracy ... he is a relatively free agent, unrestrained by subordination to a clear organizational hierarchy (120).

Whenever the practicing physician has such personal responsibility, we will find him intervening no matter what hierarchical and functional organization of the hospital.

But the amount, content, and success of such intervention will vary with the physician’s commitment to and dependence on his position in the hospital (121).

... I would hypothesize that ... the greater the physicians commitment to his position in the hospital (Vollstelle vs Gaststatus), the greater his inclination to use the regular channels of authority and the more orderly the transmission of information and “orders” bearing on patient care (121)
Conflicting Perspectives in the Hospital (121-127)
CONFLICTING PARTIES AND THEIR RESOURCES

We usually assume that those who are administratively responsible for an organization possess the resources to make that organization pursue the officially approved goals set for it – that is, that the actual behavior in the organization will be in accord with the official view of what the organization should be doing. But frequently it is not. The classical study of a state mental hospital by Ivan Belknap showed an institution supposedly devoted to curing illness was instead devoted to maintaining a cruel custodial order among inmates, without making significant attempts at therapy (121/2).

... even when an official goal is ... pursued, it is pursued in the context of interaction between conflicting perspectives of the participants. A surgical ward ... may be run like a tight ship by the surgical captains, but not without the friction created by the resistance of patients who may want more deference, personal service, and emotional support. To understand what is actually goes on in the ward ... one must understand the perspectives of the participants, how they conflict... and what resources each has available to allow him to assert his perspectives over the others. We mention for perspectives ... patient ... nonprofessional aide ... professional nurse ... physician in charge (122)
Conflicting Perspectives in the Hospital (121-127)

THE PATIENT

... personal anxiety ... irrational character ... of patient’s behavior on the ward ... the staff is less involved in the illness ... patient less capable of arriving at the proper diagnosis ... less likely to be able to evaluate his treatment ... individual patient more concerned with his own fortunes .. staff .. Concerned with the fortunes of all patients ... balancing off the relative need ... limited time and energy ... (122).

By the nature of the situation the perspective of the patient is in conflict with that of the staff ... staff devoted to controlling behavior that disrupts the ward routine ... control such conflict by physical means (mechanical, electrical, chemical, whatever) ... by efforts at rational explanation ... pedagogy ... training ... techniques of psychotherapy (123).
Conflicting Perspectives in the Hospital (121-127)

THE PATIENT: PATIENTS ATTRIBUTES

... patient attributes ... have important bearing on what techniques of control can be exercised by staff members seeking to order their work.

a) The grossest attribute is physical incapacity: an unconscious patient obviously poses fewer problems to the staff than a conscious one ... a weak and bedridden patient ... fewer than an ambulatory.

b) Another critical attribute is the patient’s sociolegal identity: if he is a public charge by virtue of his “welfare” status, or a prisoner by virtue of legal commitment (in the case of drug addiction, tuberculosis, or psychosis), or ... labeled psychotic, senile, retarded, or otherwise deficient ... then he will have difficulty asserting his perspective ... on the ward (123).

c) ... His socioeconomic resources: if he has the money ... or the political importance ... to gain special care ... and if he has the active support of ... influential friends or relatives outside the institution, he is a special problem for management (123).

d) ... under such circumstances (patients) are likely to form their own little society which, whether it involves “living in the cracks” or “colonizing”, nonetheless becomes a source of social strength which staff must take into account (124).
Conflicting Perspectives in the Hospital (121-127)
AIDES, ORDERILES, ATTENDENTS

... Such variation exists to a much lesser degree among the staff whose function it is to get done the necessary housekeeping jobs of the ward – at least as far as values and knowledge go. ... a high "custodial" orientation to the management of mental illness ... as the "custodial mental illness ideology scale" implies, their conception of mental illness is that it is so abnormal, hopeless, irrational, and dangerous as to surpass human understanding and to require close surveillance and control in the hospital (124). ... does not imply merely punitive reactions ... specific modes of "training" and otherwise helping patients. By virtue of being involved in work on the ward day and night, he is in the position to exercise some leverage over the patient, both by physical restraint, and by the age-old evasive tactics of the underdog very where – "not hearing", forgetting", and otherwise evading demands of the more powerful. This certainly gives a position of some influence on any ward. ... effectively neutralize patient demands ... The aide’s role has been powerful enough to warrant extended attention only in those institutions so underfinanced as to support at best a skeleton staff of professional workers ... and in institutions filled with patients with ailments for which there is no straight forward therapy ... (125)
Conflicting Perspectives in the Hospital (121-127)

THE NURSE; COMPLEX SYSTEM OF BARGAINING

... She is the agent of the supervising physician in carrying out treatment and patient care ... in this sense she represents the professional perspective on the ward. However, insofar as she represents the day-to-day administration of the ward, she is also concerned with the patients as a batch ... she must ... balance individual physician's orders ... against the independent demands of the patients as such and against the need to manage an aggregate of cases in an administratively acceptable way. ... The nurse serves as an adjunct of both medical and administrative authority ... she seems to be the intense focus of conflicting perspectives ... she is engaged in a considerably more complex system of bargaining. In bargaining with the physicians, one of her prime resources lies in her first-hand-knowledge and professional evaluation of what goes on in the ward ... a strategic advantage ... In bargaining with the patients, her prime strengths lies in her access to the physician ... she may serve as a troubled focus of conflicting perspectives, she also may ... hold the balance of power in determining the outcome of bargaining among patient and staff (126)
Conflicting Perspectives in the Hospital (121-127)

THE PHYSICIAN; HIERARCHY OF EXPERTISE

... his problem is to obtain conformity with his orders by the other staff ... when the physician's philosophy of treatment threatens the routine order of the ward, his approach is even less likely to be followed ... should such conflict in philosophy exist, a considerably more delicate process of manipulation and bargaining must occur for the physician to get his way ... (127).

When all is said and done, however, it is the physician's expertise that is his ultimate resource his interaction with others. ... a "hierarchy" of expertise exists independently of the administrative hierarchy in the hospital, the physician ordering and supervising those below his superior level of skill ... technical decisions are not made by vote (127).
Medical Tasks and Ward Behavior (127-131)

VARIATION BY TASK (1) SURGICAL WARD

... on e cannot discuss the hospital as a single organization. ... varied illnesses, patients, and procedures ... In special wards ... Perhaps the most marked difference in task ... between medicine and surgery ... surgical tasks ... more frequently of an emergency character ... surgeon must make his decisions quickly, and he must expect unquestioning, immediate aid ... chief resident did not delegate authority to his surgical subordinates ... social distance was much greater ... the subordinate residents, interns, and even nurses on the surgical ward were all more or less “equal” ... all followed the decisions of the chief resident ... interaction among them was fairly free and informal (128/9).

(2) MEDICAL WARD

In contrast, on the medical ward, where the medical men but not the head nurse participated in decision-making, authority to do such was delegated down the medical hierarchy. Interaction among all participants was more formal, social distance dividing each rank from the other, rather than all from the chief resident (129).
Medical Tasks and Ward Behavior (127-131)

VARIATION BY IDEOLOGY

... daily routine on ... medical and surgical wards can vary a great deal independently of the task ... The “leadership” style of a superior may stem from his qualities as a person. On any ward, a physician who shares in decision-making and minimizes his social distance from subordinates may very well be a warm, accepting person ... subscribe to a warm philosophy ... subscribe intellectually to a treatment ideology (that) defines the task as something quite different than the “mere” surgical removal ... of some troublesome condition ... behavior on the ward may vary according to the ideology as well as to the personal qualities of the workers (129/130).

... variation in interactional outcome by ideology as well as by task is perhaps more important than the “disease outcome”. ... the importance of ideology ... hospital work contrasts the behavior of the nursing staff ... whose patients are held ... not capable of improvement to ... patients believed to be curable. In the former case the task was defined in custodial terms – to run a neat and orderly ward. In the latter case the task was defined in therapeutic terms – to improve the patient’s condition ... ideology dominant ... seemed to govern ... staff behavior (130)
Patterns of Ward Care (131-134)
... it seem useful to distinguish among several patterns of performance ... in some of their wards (131)

DOMESTIC SERVICE PATTERN
This pattern involves ... of essentially housekeeping tasks – feeding, clothing, bedding, amusing, and otherwise managing the lives of the inmates ... is founded on the assumption that nothing more can (or should) be done ... than make them comfortable ... no need for a treatment staff ... protective servant to his master ... keeper of his charge ... In the underfinanced and understaffed public mental hospitals ... (131/2).

CLASSICAL HOSPITAL CARE MODEL/MEDICAL INTERVENTION PATTERN
... dominated by the medical man. The medical man is prone to see the patient’s difficulty a a transitory technical problem that can be overcome by ... some intervention ... The assumption is that the patient can be cured and discharged. But the patient is incompetent to judge what is needed ... must put himself passively into the hands of the staff, obeying them without question ... staff work is organized by the physician’s orders, initiating little itself, and primarily serving as his agent ...

Interaction between patient and staff thus takes an impersonal quality ... this pattern is most marked on surgical floors but it is also present in medicine and, in the form of “somato-therapeutic ideology”, in psychiatry. ... rehabilitation model (133)
Patterns of Ward Care (131-134)

THERAPEUTIC INTERACTION PATTERN

The pattern of therapeutic interaction is one that is commonly used ... in psychotherapy. It is also ... a pattern of organization for hospital services ... refereed to by psychiatric ideas of a “therapeutic” milieu ... rehabilitation model

... The patient must be persuaded to become an active participant ... Own motivated activity ... patient himself sometimes ... held to be a member of the “team”, though never to the extent of participating in all staff meetings. The absolute character of the authority of expertise makes itself felt even in this pattern (133/4).

Medical Performance in the Hospital (134-136)

... interaction with his colleagues is the critical variable in the control of his performance (135). ... colleague interaction is central: the more there is, the more likely medical rather than lay or individual standards will be met (136)
Chapter 7.
The test of autonomy: Professional self-regulation
(137-157)
… Its autonomy is justified and tested by its self-regulation (137).

FORMAL REVIEW INSTITUTIONS

.. The British arrangement for reviewing charges made by patients against physicians … In the United States, county medical societies (137) are supposed to review both patient and colleagues charges … they sometimes perform disciplinary functions, reviewing charges of incompetence and as well as of unethically, their activities are secret …

They lack formal screening and review procedures (138).

… physicians are highly resistant to restrictions on the independence of their decisions … clear that formal review procedures are not very common in most medical work settings … But outside of anecdote and tactfully vague official reports, there is virtually no information available on how those regulatory committees work … how much social control goes on outside of formal bodies … Indeed, I would argue that adequate informal devices of regulation are necessary … (140).
The Work Setting (140-142).

Hence, the clinic came close to being the “company of equals” that professionals consider optimal for their work: an organization in which little other than colleague control exist (141/2).

Rules (412-143)

In most models of bureaucracy the physicians had “contractual” obligations, such as the number of hours … In addition, there were intramural whose purpose it was to ensure coordination of effort: for example whether the obstetrician or the generalist …, some came from external sources, and if they conflicted with medical or organizational efficiency … tacitly agreed to ignore them … none of the rules bearing on the purely technical core of medical practice – examination, diagnosis, prescription, and treatment - may be classified as formally binding … more a policy statement than a regulation … the clinic did not specify the technical procedures to be used … being accountable to the organization for one´s time and for one´s difficulties with patients was seen to be undignified, the equivalent of being treated like a factory worker or a clerk (143).
Administrative Collection of Supervisory information (143-145).

PATIENT COMPLAINTS
Judicious tapping of the paramedical grapevine, plus inspection of the appointment books … was the only regular and continuous administrative check on performance, and it yielded information primarily about punctuality and speed of work, nothing about technical performance (144). The clinic was organized to provide regular channels for patient complaints to the administration … but few physicians would accept as valid indication of technical performance … (144).

MEDICAL RECORDS
… an accurate source of information about all physicians existed … the medical record for each patient was, in its wealth of detailed information, a bureaucratic delight … information was continuously recorded but not routinely scrutinized by anyone … was a working tool, becoming a supervisory device only when … a patient complaint, a lawsuit, an accidental observation, or the like … thus only latently supervisory … (144/5).
Colleague Collection of Supervisory Information (145-147).

The clinic administration was obviously only tangentially involved in any technical activities of the physicians. This was as it should be in the professional view of things, for only colleagues should be involved. But how far were colleagues involved? How, without routine review of the charts, could information about doctor’s technical performance be gathered? How much did colleagues know about each other (145)?

REFERRAL RELATIONS

First of all, referral relations must obviously be involved … for one doctor to be in a position to observe another… a clear relationship between the capacity to rate a colleague and the general referral relationship (146) more ignorance about the abilities of colleagues was reported by internists and pediatricians about each other, than by specialists about generalists and vice-versa (147).

… that what one man knows about another is … a function of the division of labor, but that the visibility of performance granted by the division of labor is not holistic but fragmentary (146) … younger men were generally more critical in their evaluations than older men … and that long-tenured men were generally rated higher … differences in assessment … occurred according to variation in the type of work being referred … men did not seem to gossip much about each other´s experience with colleagues. This means that there was nothing to compensate for the limited and fragmented distribution of information … (147)
Transmission of Supervisory Information (147-149).

It should be clear that neither the administration nor the collegium observed both the doctor’s organization of effort and the technical quality of that effort (147) … obviously, the colleague group could not behave as a collectivity as long as these bits of information were scattered discretely through its ranks. They must in some way share the information by pooling it (148) … In unusual cases, a sufficiently large number of observations had been stored in the memories of a sufficient number of physicians to allow a coalescence of opinion. Arriving at a critical mass of discontent with an individual seemed to be necessary before physicians would begin complaining about him to each other and the administration. One physician might make a rather neutral but probing remark to a second about a third …
PART II. Chapter 6 (109-136)

Negative Sanctions (149-151)

TALKING-TO

Slowly and selectively, some information about misbehavior did come to light. How was it handled? When physicians were asked what they would do about an offending colleague, the usual response was: Nothing”. Asked, what they would do if the offence were repeated … they answered: “I´d talk to him”. “Talking-to” was … the most ubiquitous sanction in the clinic and was used by both colleagues and administration as virtually the only means of sanction … talking-to seemed to involve various blends of instruction, friendly persuasion, shaming, and threat …(149).

The incidence of talking-to varied with social distance … more likely in his own department … and to a peer or junior more than to a senior man …

Talking-to were also graded according to severity .. The mildest (and by far most common) talking-to was a simple man-to-man affair … might enlist the aid of other talkers .. Might be talked to by the Medical Director or a formal committee of colleagues (149).

What is interesting about talking-to in the clinic is that it was the only institutionalized punishment short of dismissal. There were no intermediate forms of punishment. And since dismissal was almost impossible … talking-to was virtually the only sanction available (149).
Negative Sanctions (149-151)

DISMISSAL

Only the most gross and shocking deficiencies would do. The practical impossibility of dismissing a tenured physician was thus inevitable (150).

BUREAUCRATIZED REWARDS

Talking-to was the … the only practical form of negative sanction in the clinic. Aside from this, there were only rewards to motivate the physicians. Most of those rewards were bureaucratized so as to operate automatically, independently of the physician’s deportment … as system of automatic increments, vacation with pay, bonus increments for obtained specialty board certification, at a certain age a man could buy his way out of making night and weekend emergency calls … These rewards were rights of which an offender could not be deprived … and individual could be “punished” by being “passed over” in their assignment (150)

PRIVILEGE SYSTEM

The set of discretionary rewards might be called a privilege system: special tokens … which have not been codified and bureaucratically guaranteed … extra money for supervising the laboratory, handling … patient complaints … serving as a special consultant … supervising a research program (150). Others were more symbolic in character … represent the organization to a group of distinguished visitors .. Travel at clinic expense … take a leave of absence … the most strategic privileges played upon the physician’s self-image (151).
Negative Sanctions (149-151)

TECHNIQUE OF PERSONAL EXCLUSION

... offended colleagues used the technique of personal exclusion. They attempted to bar a man from working with them individually or with their own patients, but they did not attempt to bar him from working with or on the patients of others. This is similar to the principal method of control used in solo practice. The offender is not referred patients ... his advice is not sought ... and he is not called in to look at an interesting or particular case ... not included in the system of exchanging favors that is so important and common in professional work ... It is important to note that all these methods of exclusion are practiced by individuals: They are not actions of the collegium ... They punish him only insofar as he is sensitive to the good opinion for these particular individuals who exclude him (151).
Characteristics of the Process (151-153)

... elements ... of the process by which control was exercised in this company of equals were fairly bureaucratic ... (151). The process ... had several characteristics. First ... the system of control was not ... collective or hierarchical in its operation ... it was inclined to operate like the economist’s free market ... Second, the process worked slowly ... Finally, the process had a characteristic vulnerability ... the system was quite helpless in the face of a man who did not depend on the esteem and trust of his colleagues ... all that can be done is to seal him off and try to minimize whatever damage he is believed to do (153).
Regulation in other Settings (153-156)

Goss distinguished two types of supervisory control exercised along the hierarchy (153).

ADMINISTRATIVE DECISIONS

… administrative decisions that allocate and schedule the work a man will do … a superior tells the practicing physician when and where to work, how much to work, and with whom. These decisions and “orders” were accepted without question … These administrative “orders” established the pacing and tempo of practice … but did not bear on the practice as such (154).

SUPERVISORY SUGGESTIONS ABOUT CARE

The superior did have the right … to give advice about the handling of cases to the subordinates responsible for them … this was done so rarely as to be atypical … giving of advice rather than orders … no obligation to follow it … “considered it their duty to take supervisory suggestions about patients in their account … but they also felt obliged to examine such suggestions critically … and to follow them only if they appeared in the patient’s best interests according to their own professional judgement” (Goss) … Since it is he who takes personal responsibility for the outcome, it was his decision that was accepted as final so long as he could justify rejecting the advice (154/5).

UNSOLICITATED ADVICE

… unsolicited advice is not likely to be offered unless a sufficiently senior and noncompeting man felt fatherly, or unless a man wanted to insult another, for unsolicited advice violates ordinary medical etiquette … in the laissez faire system of private, solo practice we are likely to find the least conscious and systematic regulation of behavior (156).
Observability, Leverage, and Norms (156-157)

… with the way the individual physician’s behavior can be controlled by his colleagues … The assumption has been that observability of performance is a structural prerequisite for regulation … the controls that were exercised were less than what the given degree of observability allowed … Clearly the structural limits on control imposed by observability and dependence in different work settings were not enough to explain or predict the controls actually applied. That is, they do not seem to explain the source of variation in the absolute level of performance … the nature of the variables which can explain the source of variation. These variables are normative in character, not structural … (157)
Chapter 8.
The clinical mentality
(158-184)
INTRODUCTION

I asserted that when deviant performance occurred it was not always to, not often communicated to others, and rarely subject to regulation. Such finding points to the limitations a “pure” as well as a formal organizational or structural analysis: It requires that I turn my attention to the norms or values of the individuals who are working in the organized settings, for when these settings permit regulatory behavior, and when that behavior does not occur … I assume that the values of the participants figure in discouraging self-regulation (158).

In Parsons’ terms, the profession’s role is supposed to be “collectivity orientated” rather than “self-orientated” … Parsons also notes other norms … “performance criteria by standards of technical competence” … “achievement values, universalistic, functionally specific, and affectively neutral” (Parsons, the Social System) … not even restricted to professionals alone … (158/9) … the normative segment of the formal organization of professions, expressed by codes of ethics, public statements … and the like. They are quite distinct, analytically and empirically, from the actual norms of individual professionals … not necessarily the operative norms of performance. In this chapter I … sketch the norms that seem to play an important part in the work of physicians … (160)
Professional Responsibility (161-162)

INFORMAL CONTROL: BOYCOTT and LOSS OF REPUTATION

The hypothesized profession-wide “sense of responsibility” … is manifested almost wholly in standards for training and admission to practice, without any active, formal mechanism for assuring that standards are maintained in practice (161).

However, Carr-Saunders and Wilson as well as Parsons suggest that discipline is indeed carried out, but on a more informal basis by means of colleague boycotts or loss of professional reputation among colleagues. Such informal control does not … prevent an offender from working; instead it merely keeps away from him the patients of those who think little of him … Clearly we must elaborate in more detail the peculiar character of this “sense of responsibility” (162).
The Nature of Medical Work (162-164)

PROBLEM-SOLVING vs SCIENCE
What is the work of the profession? It is the attempted solution of the concrete problems of individuals. … it is by its nature applied rather than theoretical … it is markedly different from the work of a scientist. At best, the practicing physician may use general principles to deal with concrete problems … its focus is on the practical solution of concrete problems, it is obligatory to carry on even when it lacks a scientific foundation for its activities: it is orientated towards intervention irrespective of the existence of reliable knowledge. The practitioner is more comfortable in doing something – being, as Dowling suggested, inclined to fear doing nothing - and so is lead to use drugs and other procedures more than might be indicated by academic (and scientific) standards (163).

INDIVIDUALS vs AVERAGE, TAKING OF RISKS
Furthermore, medical practice is typically occupied with the problems of individuals rather than of aggregates or statistical units … individual variability poses a constant problem … necessity for personal firsthand examination of every individual case and the difficulty of disposition on some formal, abstract scientific basis … taking of risks in the course of intervention (164)
The Nature of Medical Work (162-164)

CHARACTERISTICS OF MEDICAL WORK ENCOURAGE LIMITED SENSE OF RESPONSIBILITY

... the actual amount of such risk and opinionated judgement can vary a great deal. What does not vary is the fact that the work is applied, involving intervention irrespective of available knowledge, and revolving around experience with individual, therefore somewhat variable, cases. These characteristics of everyday medical work, I wish to suggest, are responsible for the development of norms or attitudes that encourage a very special, limited sense of responsibility (164).

And they encourage emphasis on the primacy of firsthand clinical experience rather than scientific laws or general rules ... exaggerating the acceptability of varying opinions ... sustaining well-intentioned resistance to forsaking one´s own practices in the face of others´ disapproval ... They seem to form the foundation for norms discouraging general collegial control of individual physician behavior (164).
PART II. Chapter 7 (158-184)

Medical Responsibility and Clinical Experience in Training (164-168)

... students solved their problem by adopting to their own needs two values that were strongly emphasized by the staff of the medical schools. These were the values of medical responsibility and clinical experience (165).

MEDICAL RESPONSIBILITY

Basically, the term “responsibility” refers to the “archetypical feature of medical practice: the physician who holds his patient’s fate in his hands and on whom the patient’s life or death depend ... (Howard S. Becker, 1961). This responsibility is personal and direct, in that it belongs to the physician who is working directly with the patient. It is consequential in that it requires the physician to take the blame for bad results. The idea was impressed on the student by his teachers in many ways .. "getting into trouble" ... hierarchy ... ordered by differential access to such responsibility ... highest were free to do the most complicated procedures ... (165).

CLINICAL EXPERIENCE

"Clinical experience" refers to "actual experience in dealing with patients and disease ... even though it substitutes for scientifically verified knowledge ... legitimate a choice of procedures ... used to rule out use of some procedures which have been scientifically established" .. inadequacy of "book" and scientific knowledge in the face of the practical contingencies and complexities of the individual case ... "the only counter-argument that can prevail is ... by someone who can claim greater experience in the area discussed" (166).
The Clinical Mind (168-172)

... the practitioner has a different view of his work than the theoretician or investigator ... he has a different way of looking at the world (168).

NOT KNOWLEDGE BUT ACTION

First, the aim of the practitioner is not knowledge but action. Successful actions preferred, but action with very little chance for success is to be preferred over no action at all .. spurious assumption that doing something is better than doing nothing ... tendency to prefer action (168)

PHYSICIAN AS PLACEBO REACTOR

Second, the practitioner is likely to have to believe in what he is doing in order to practice - to believe that what he does does good rather than harm ... He is himself a placebo reactor who is developing faith in his remedies and so modifying his behavior towards the patient ... likely to manifest a certain believe in the value of his actions than to manifest skeptical detachment ... (168).

PRACTITIONER AS CRUDE PRAGMATIST

Third, perhaps because of his action orientation, perhaps because of the complexity and variety of the concrete, the practitioner is a fairly crude pragmatist. He is prone to rely on apparent "results" rather than on theory, and he is prone to tinker if he does not seem to be getting "results" by conventional means (169).

PERSONAL EXPERIENCE

... is prone ... to trust his own accumulation of personal, first hand experience in preference to abstract principles or "book knowledge" ... "dangers of intellectualization and book learning are stressed" "gut response", certain subjectivism in his approach (169).

UNCERTAINTY

... the practitioner is very prone to emphasize the idea of indeterminacy or uncertainty, not the idea of regularity or of lawful, scientific behavior ... it does provide the practitioner with the psychological ground from which to justify his pragmatic emphasis of firsthand experience (169)
CLINICAL RATIONALITY
The rationality is particularized and technical; it is a method for sorting the enormous mass of concrete detail confronting him in his individual cases. ... the clinical rationality is not a tool for exploration or discovery of general principles, as is the scientific method, but only a tool for sorting out the interconnections of perceived and hypothesized facts (171). ... "clinical experience" is frequently personal mythology based on one or two incidents, or on stories by colleagues (172).

CLINICAL MENTALITY
It follows from this discussion of the clinical mentality that individualism is a dominant element in orientation and behavior. Each man builds up his own world of clinical experience and assumes personal ... virtually individual, responsibility for the way he manages his cases in that world (172).
Professional Status and Values (172-178)

IDEOLOGICAL AMBIVALENCE

Prospective physicians: Being predominantly from the bourgeoisie, the professional emphasizes independence, social and economic individualism, and class dignity in his status. ... prospective physicians valued highly the "opportunity to work with people rather than things", and the "opportunity to be helpful to others." ... emphasizing the desirability of earning a great deal of money and obtain social status and prestige ... did not place high value on the opportunity to be creative and original or "to use my special abilities or aptitudes" ... There is ... a curious ideological ambivalence in the premedical student ... (172/3). ... "intellectual stimulation" was emphasized rather little (173).

ENTREPRENEURISM AND INDEPENDENCE

Practitioners in the country: ... the entrepreneurial dimension in the physicians values ... (176) ... bourgeois values of independence ... incompatible with the technical requirements for the practice of medicine (177).
Professional Status and Values (172-178)

SERVICE ORIENTATION (178)
...service or collectivity orientation ... does not seem ... a very prominent value .. is addressed to helping individuals rather than to serving society ... (178).

PRACTICAL KNOWLEDGE (178)
Second, physicians have some intellectual investment ... everyday practitioners having less than others ... emphasizing instead practical knowledge and action INCOME AND PRESTIGE (178)

Third, physicians emphasize the value of independence and prestige connected with their occupation ...

INDEPENDENCE AND AUTONOMY (178)
And finally, everyday practitioners more than others emphasize the value of independence and autonomy ...

UNDERSTANDING THE RESPONSE TO CRITICISM (178)
These values ... stem from the social background of the practitioner more than from his work, reflecting both the values of his bourgeois origins and the special intent of his career choice. The work of medicine is something else. ... a will to believe in the value of one’s own actions and a belief in the inadequacy of general knowledge ... these two sets of values, one stemming from social background and aspiration, the other from the demands of the work itself, together allow us to understand the practitioner’s response to having others look critically at his performance of medical work.
Criticism and Criticizing (178-180)

PROFOUND AMBIVALENCE
The physician’s attitudes are marked by a profound ambivalence. On the one side he is has a more than ordinary sense of uncertainty and vulnerability; on the other, he has a sense of virtue and pride, if not superiority. This ambivalence is expressed by sensitivity to criticism by others (180).

SELF-CRITICISM
... "it could have happened to anyone!" ... Self-criticism is more likely to be observable than other forms of criticism ... cathartic benefit of confession while avoiding the price of penance (179).

CRITICISM
While self-criticism is acceptable, criticism by others is not ... (179) A professional does not lower himself by snooping into the affairs of other colleagues and expects his colleagues to respect the privacy of his affairs (180).
Personal and Communal Responsibility (180-183)

... the proof of professionalism comes when bad performance is recognized by practitioners: on perceiving errors or incompetence, what do they do? (180).

INCONTROVERTIBLE MISBEHAVIOR

There is first of all the very special and comparatively rare case of incontrovertible misbehavior ... unambiguously outrageous offence .... drunken surgeon ... addict who makes off with too many narcotics ... there is considerable reluctance to expert controls ... allowing the man to resign rather than by outright expulsion ... in gross cases a man is likely to be expelled from the company of his present colleagues but not from his profession ... Professional handling of such cases is marked by ambivalence and pain ... his colleagues settle for what their very individualism would see as their first duty - keeping their own nest clean. He is encouraged to resign from their company, but he is not expelled from the profession (181) ...

The physician is likely to take personal responsibility for his own work and not to be concerned with the work of colleagues unless it has direct bearing on his own. This is why he feels he need not stoop into affairs of others (182).
If a practitioner is dissatisfied with another’s work, and talking to him does not lead to desirable changes of behavior, he is not likely to move to ruin the other’s life. All he will do is protect his own personal responsibility. This is done not by any direct effort at control, but by avoidance, by what ... Carr-Saunders and Wilson called the boycott. But it is an individual or at most a special colleague-group boycott, not a profession-wide boycott ... he avoids having to assume responsibility for the culprit’s actions ... while at the same time he avoids having to assume responsibility for the culprit’s professional life (182).

The personal boycott is ... the most analytically important mechanism of control to be found among physicians and other professionals. It is important, because it allows us to understand how one man can be personally ethical and conscious and another not, yet both exist within the same profession without causing any great tension or conflict between the two. It expresses both the ethical success and failure of the profession, representing as it does the peculiar outcome of the professional’s way of looking at his work, himself, and his responsibility (183).
Variations in Professional Values (183-184)

... particularistic standards ... play a pontifical, functionally diffuse role ... stress the symbolic and material perquisites of his official status ... more than the intrinsic rewards of his expertise ... less likely than the scholar or researcher to manifest the whole set of "professional values" described by Parsons ... in science and scholarship ... the obligation to publish keeps one’s work public and under the scrutiny ... of colleagues. But to the consulting practitioner his work and its evaluation are seen almost as a form of private property (184).

... values connected with the regulation of performance will vary by the kind of work performed and by the lay values of its performers. Supervision and regulation ... are more likely to be participated in by those who do not work with a lay clientele ... work settings maximize or minimize the observability of work ... (184)
PART II.

Chapter 9.
Profession as organization - Formal and informal
(185-201)
**Introduction (185-188)**

FORMAL CHARACTERISTICS (SUM OF PART I OF BOOK)

In part I of this book I dealt with the formal characteristics of the profession of medicine ... its ultimate control over its own work ... smoothed by such cosmetics as a code of ethics ... (185). Thus, a professional may remain a professional when he is socially subordinate to someone who does not belong to his profession so long as he is not technically subordinate ... a profession is established by the analysis of the relation of occupations to each other in a social structure ... defining a profession structurally, as a position in a division of labor ... (187). Thus, the formal status of a profession reflects what Hughes called its license and mandate to control its work, granted by society. This is what is unique and central to the notion of profession. The profession´s position in society does not necessarily ... reflect a distinctive and especially superior skill, theoretical learning, or ethical behavior on the part of all or most members of the occupation (187) ... What the status reflects is society´s belief that the occupation has such attributes and society´s belief in the dignity and importance of its work (187). ... Thus, we ask what it is that persuades society to grant professional status. Codes of ethics may persuade ... systematic theory may persuade ... formal institutional attributes of occupations ... emphasis of the status of autonomy in a division of labor must be added (188).
In part II of this book I moved from the formal status of the profession in society ... to the varied in which individual members of the profession work and which themselves, by their organization, encourage or discourage physicians to perform their work in particular ways (188). ... In short, I moved from the official claims of and for the profession to the everyday performance of its members. Consonant with the situational approach I use in this book ... distinguish a number of types of work settings for their bearing on performance ... Office-setting: client-dependent practice ... colleague-dependent practice ... I predicted systematic variation in the quality of work performance ... by reference to the structured pressures that an organized work setting contains (189).

Hospital: allows (the physician) to exert remarkable influence on the operation of the hospital, an influence only in part based on his expertise ... I concluded that in ambulatory more than in organized group settings, observation and regulation are minimized ... large measure of permissiveness ... exclude the offender from the concrete setting ... but not to exclude him from performing similarly in other settings on other patients (190).

Rejecting the value of the general norms usually ... connected with professionalism, I sketched out the values which seem to arise from the contingencies of consulting, or clinical work ... leads to an exaggerated sense of limited personal responsibility ... The outcome of such an ideographic mentality is reluctance to criticize or to be criticized by another (191).
Linking Performance with Organization (191-192)

BOYCOTT AS INFORMAL ORGANIZATION OF THE PROFESSION

My discussion of medical norm and the regulation of professional performance has been ... a discussion of the reality of professional work compared to the hopes and claims of official spokesmen of the profession. Analytically, the two are not yet connected into a coherent system (191). The link ... lies in the personal boycott. The mechanism of the personal boycott, while expression professional norms, also has specific interactional and organizational consequences for the ordering of relationships among concrete individuals and institutions ... it might be called the informal organization of the profession. ...

Specifying the formal organization of medicine allows us to understand what structured uniformity there is in medical performance ... (192). Specifying the informal organization of medicine allows us to understand the sources of structured variation in medical performance, largely by reference to the interaction of practitioners organized by specific settings (192).
The Creation of Informal Organization (192-194)

TYPES OF MEDICAL CAREER

... Oswald Hall was able to distinguish three types of medical career by the kind of relation a young medical graduate had to a senior men already in practices: (1) an "individualistic career", in which a young man struggles for his own clientele independently of others; (2) a "friendly career", in which a man is helped by and helps a few colleagues who are close friends; and a "colleague career", in which a young man works under the patronage of highly successful older men who control hospital appointments and access to the most desirable clientele (192).
Part II. Chapter 8 (185-201)

The Creation of Informal Organization (192-194)

Colleague Career / Inner Fraternity

... "inner fraternity" of physicians, standing at the peak of success ... and controlling access by others to that success. If a young physician looks promising (in part by having the right religious and social background, in part by his proper demeanor, in part by the ability perceived in him), he is offered demanding positions at the bottom of hierarchy. ... work hard for the prestige ... intrinsic interest in the position ... promise for better days ... he is gradually doled out better positions and patients, his movement to the top slowly and carefully nourished by his superiors ... If he becomes impatient, he is dropped from the system and sustains no such interaction ... (193).

Sponsorship

"The inner fraternity ... has one dominant method of functioning. Its basic activity is referred to here as "sponsorship" ... that established members of the inner fraternity actively intervene in the career lines of newcomers ... Sponsorship has a dual purpose. It facilitates the career of those selected and relegates those not so selected to a position where they compete under decidedly disadvantageous terms". And what is sponsorship? It is the precise opposite of avoidance and the personal boycott (193).
The Creation of Informal Organization (192-194)
NEGATIVE ASPECTS OF PATRONAGE
What happens to those who do not get the approval of the inner fraternity, to whom patronage is not given, or from whom it is withdrawn? (193). ... even outside the inner fraternity there must be fairly sable, organized colleague groups ... there can be numerous "fraternities" in a single community, and there are certainly numerous "fraternities" in the profession as a whole ... these colleague groups are built by the mechanism of patronage and boycott; and, by the very consequences of the mechanisms themselves, they must be fairly well segregated from each other (194).
Characteristics of Informal Organization (194-197)

LOGICALLY IDEALIZED CONSEQUENCES

Let us try to visualize logically the structural consequences of the mechanism of boycott by hypothesizing a heuristic free-market situation in which individual practitioners are free to select the work ... and the colleagues with whom they divide their labor ... assuming that these fraternities, circles, or networks are created on the basis of common standards .... deviants may be excluded from one but will find another ... (194) ... it is a segregation process that leads to and maintains such networks, and since the individual’s behavior is less controlled by such process than classified and assigned to a collectivity of like people ... we can see how within a single profession ... organized variations in professional performance can develop and stabilize (195).
Characteristics of Informal Organization (194-197)

ASPECTS OF REALITY
The picture I have presented is fairly abstract and logically idealized ... Several aspects of reality must certainly qualify its operation (195).

PROCESS OF BEING SORTED (195)
First, ... entrance into practice .. is continuous over time ..individuals are always in the process of being sorted ... reduces the homogeneity of any colleague group ....

SOME SORT THEMSELVES (195)
... homogeneity is increased by ... sorting takes place without ... avoidance to operate ... some sort themselves so accurately or humbly that they never have to be excluded by others ...

SOME CANNOT BE EXPELLED (195)
... stable organization of practice precludes .. operation of ...individual choice and selection. ... for example ... senior people with the historical right to membership even though they have relaxed their standards ... instead they are merely sealed off, encapsulated, and perhaps neutralized ... these men violate homogeneity ...

CIRCUMSTANCES ALLOWING MORE RAPID SORTING (195/6)
... some circumstances allow more rapid evaluation and sorting ...: a colleague group formed around a division of labor, in which each man can see ... the other´s work, is likely to sort itself out more quickly than a group that goes beyond cooperative social and economic relations ...

SORTING BY BOYCOTT IS SLOWLY AND ERRATIC (196)
... personal boycott is not invoked promiscuously ... sorting by boycott to be slowly and erratic
The mechanism of personal boycott, therefore, paradoxically operates to place offenders beyond further professionally acceptable controls, and the informal organization of internally homogeneous networks ...sustains if not reinforces the differences in standards among networks (197/8)


**Profession as Organization (200-201)**

**SUMMARY OF PART I AND II OF BOOK**

In the first two parts of the book I have been treating a profession as an organization of workers first and as a set of ideas and knowledge only second. In this I adopted more the approach of Karl Mannheim than of Max Weber, taking social organization as the central fact for analysis (200). ... Organization was found on a number of levels of both abstraction and reality ...

**DIVISION OF LABOR (200)**

I specified ... organization established by the relatively persistent relationships among various occupations ... division of labor ... ordered by the technical interdependence or overlap of their work .. and by the authority some have over the others ...

**FORMAL ORGANIZATION OF THE PROFESSION (200)**

... there is that organization of official spokesmen which has legal identity ... its negotiation with the sovereign state ... establishing ... the advantages of the occupation ...

**WORK SETTINGS (201)**

... there is variety of settings in which the ... profession works ... represent the reality ... the proving grounds for the formal profession’s ... ethicality and competence ...

**INFORMAL ORGANIZATION (201)**

... the organization which I have called informal ... sorting and shifting of colleague relations ...

In fact, being the organization of men with various qualities and standards of performance into self-sustaining and self-segregated groups, it explicitly contradicts the official fictions that all licensed men are qualified to work and that all formally qualified men work equally competently and ethically.
PART III.

THE SOCIAL CONSTRUCTION OF ILLNESS
(p 203 – 331)
Chapter 10.
Illness as social deviance
(205-223)
Introduction (205-207)
... (205).