PROFESSIONAL DOMINANCE

The Social Structure of Medical Care

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for Judy

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Foreword

In the United States today we are confronted by a number of serious social problems, not the least of which concern the character of our basic human services. In each of the broad public domains of welfare, education, law, and health there are crises of public confidence. Each in its own way is failing to accomplish its essential mission of alleviating material deprivation, instructing the young, controlling and righting criminal and civil wrongs, and healing the sick. The poor, the student, the offender and the victim, the sick —all have in some way protested the failure of the institutions responsible for them. And these protests occur at a time when the human services are absorbing an increasingly massive amount of money and manpower.

Awareness of that crisis intensified in the 1960s, and increasing energy has been invested in research designed to determine what can be done. Each of the human services has long had its own research tradition, but during the sixties each has also made a concerted effort to mobilize and use the skills of such comparatively new disciplines as sociology. Owing to these new demands, sociology itself has grown. The hitherto obscure specialties of the soci-

ology of law and medicine and the established specialties of criminology and educational sociology have taken on new vigor. In applying themselves to the task of studying the human services, however, these segments of sociology have had to choose between two different strategies.

The most common approach of sociology to practical affairs has been to make its technical skills of data collection and its special descriptive concepts available to the institutions and occupations of the human services. Such an approach has supplemented and deepened the research of those services and has provided them with more information about themselves and their tasks than they had before. It is certainly important and useful, but by its very nature it takes as given the underlying assumptions as well as the basic structure of the services it studies. If these underlying assumptions happen to be incorrect, research based on them cannot have more than limited, short-run value. Similarly, if the basic structure of those services is responsible for significant failings, merely studying and changing what goes on within the structure cannot lead to more than superficial amelioration.

A second approach is the one I shall adopt in this book. Rather than dealing with the details of the human services for their own sake—and this lack of detail is a characteristic limitation of the second approach—I shall instead attempt to stand outside the system in order to delineate one of its critical assumptions and a strategic feature of its basic structure. In doing so, I shall deal with the concept of profession, for as I shall try to show, the concept rests on assumptions about how services to laymen should be controlled and is realized by a special kind of social structure that organizes the presentation of those services. The consequences for the operation of the system of services are, I shall argue, pervasive and profound. Indeed, in the

case of health, which is the most professionalized of all the human services, the power of the concept is such that it has even influenced the way medical sociologists have studied it.

In the concrete case of health services, how is the concept of profession manifested? First, it may be noted that in matters of health the opinions of laymen are very likely to be subordinated to the opinions of professional experts. This subordination is based on the assumption that a professional has such special esoteric knowledge and humanitarian intent that he and he alone should be allowed to decide what is good for the layman. This assumption forms the ideological foundation of health and other highly professionalized human services. On this foundation is built a form of organization much different from that found in the management of ordinary commercial services and industrial enterprises. Health services are organized around professional authority, and their basic structure is constituted by the dominance of a single profession over a variety of other, subordinate occupations. I shall argue that professional dominance is the analytical key to the present inadequacy of the health services. And while I shall restrict details almost entirely to the field of health, my intent is to suggest that there are serious deficiencies in the nature of professionalism in general and that it can be shown to be responsible for problems in the other human services as well.

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Introduction: Substantive Issues in Medical Sociology

In the rather short time it has been in existence as a recognizable specialty, medical sociology has sprawled across a vast array of substantive areas without any obvious rationale for its coverage, and medical sociologists' approaches to its study have been so varied as to defy integration.[1] Indeed, while two recent books have addressed themselves to the field, both are extremely selective, omitting much of the substantive field. One limits itself largely to social aspects of disease and the social processes leading to the adoption of the sick role,[2] and the other limits itself to an analysis of the medical profession.[3] The present book is also limited to but a portion of the material included in the field. In fact, it will limit itself to a rather narrow segment of the field—specifically, that segment bearing on the way in which health services are presented to the consumer in the United States. But narrow or not, I shall argue that the organization of health services has consequences of great importance in many other areas. I shall argue, furthermore, that a truly

sophisticated and useful analysis of a concrete topic such as the organization of health services requires the use of rather general and abstract sociological concepts. Much of my exposition will in fact be devoted to elaborating these concepts rather than to describing the complex and rapidly changing data connected with the delivery of medical care in this or any other industrialized society. In elaborating these concepts I hope to contribute both to the practical problem of formulating concrete social policies for the health services and to the theoretical problem of creating a genuine sociology of medicine.

To place this contribution in the context of the entire field of medical sociology, however, it seems appropriate to describe the whole sprawling breadth of that field. This I shall attempt to do now, following the description by a discussion of the relation of this book to the field. Throughout, I shall attempt to deal with the substantive as well as the conceptual issues of the field. My presentation will begin with a discussion of the bearing of the idea of disease on the concepts of social control and deviance, which will pose a challenge to studies in the tradition of the sociology of knowledge. After a brief review of the problem of explanation raised by studies of the distribution of disease, extended attention will be paid to the relevance of the concept of social role to the behavior of people who are sick and those whom they consult. Discussion of the role of the healing consultant will lead to consideration of the concept of profession and such contingent questions as recruitment, the nature of professional training, practice, and interprofessional relations. This will be followed by a consideration of the hospital and like institutions in the context provided by the concept of bureaucratic organization, and, finally, a very brief consideration of health affairs and health institutions within the framework of the com-

munity. Given that context, I shall then attempt to specify the place of the study of medical care in the field of medical sociology.

The Concept of Disease

The most general question sociology may ask about medicine concerns the knowledge and ideas that surround it. A very large body of historical materials as well as a somewhat more scattered body of ethnographic reporting allows any number of questions to be investigated in considerable detail.[4] The most conventional investigations, which historians have most often performed, are addressed to the state of scientific medical knowledge in a particular historical period, the biographies of medical men, and the circumstances surrounding a particular scientific discovery. But only a handful of historians[5] has been seriously concerned with such specifically sociological questions as the determination of medical theories by prevailing religious or political philosophies of the time, the relation of the class system to the medical division of labor, the development of modern professionalism, and even the characteristic social contingencies of medical practice. It is not as if data are lacking for such analyses, for as the Wellcome Library's periodical publication indicates, there is an enormous number of primary and secondary materials available.[6] One may hope that sociologists, if not historians, may make more use of such material in the future.

Apart from historical analysis there is the somewhat different problem involving the definition of disease as such. In practice the notion of disease is at once an objective and an evaluative or moral concept.[7] It contains not only an at least substantively rational attempt at explanation of cause and specification of cure but also, if only implicitly,

an indication of responsibility for the condition. Quite obviously, if an undesirable ailment is believed to be divine punishment for sinful behavior, its occurrence has different social consequences than when it is believed to be the result of malicious human witchcraft, willful perversity, or impersonal, material forces over which no one has control. Many kinds of human complaints that we now call diseases have at one time or another been considered to be of such varied causes.

It seems fairly hopeless for the sociologist to work with the idea that there are objective disease states even though there is no doubt they exist. It is true that there are some conditions, like a distinctly broken leg, that all men everywhere would agree on. But it is also true that there are many other conditions of which we were not aware until recently, of which other people are not now aware, and of which we are not yet aware. Furthermore, "natural" states recognized everywhere to exist may or may not be treated as disease; pregnancy, for example, can be perceived as a natural and normal state or as an illness to be rejected;[8] drug habituation can be viewed as a disease or as a crime.[9] These confusions in definition occur in the idea of disease only if we insist on the objectivity of the designation. For the sociologist it is quite beside the point whether or not the designation of disease is objective, for the designation, right or wrong, real or imaginary, has social consequences in any case. Because the task of determining the "real" existence and cause of disease is left for the physician, the sociologist can study the social consequences of *imputing* disease and what kind of social concept disease is.

Talcott Parsons has discussed disease as one type of deviance requiring control by society.[10] As a social concept, the imputation of disease in modern society labels particular kinds of undesired or unexpected behavior as due to natural

causes for whose operation the deviant may not be held responsible and which are amenable to control by the uses of natural techniques of therapy. The behavior in question may or may not "really" be disease as scientific medicine might define it, and, in one or another historical time or place, may be defined as deviance of quite another class or may not even be recognized as deviance at all. The sociologist, then, may treat disease as a type of social deviance that has specific social consequences. Indeed, he may examine the use of the concept of disease in modern times as a social movement and as a problem in the sociology of knowledge.

Disease as Ideology

Modern times are witness to the inclusion of more behavior under the concept of disease than ever before. Just as the simple Newtonian world is being displaced by the considerably more diffuse world of modern physics, so is the simple world of Pasteur being displaced by one in which direct causal relationship between "germ" and disease is being questioned and in which notions like stress come to play mediating if not causal roles. The idea of stress, however, brings to the fore the complicated and obscure psychological and social variables that heretofore could be treated by the diagnostician as if they did not exist. Thus the naturalistic stance of medicine has moved from the biological into the psychological and social realm, coming to consider the latter as part of the "disease" addressed and legitimized by the former.

Perhaps more important than the idea of stress was the development of a medical orientation to mental disorder, much of which in medical knowledge is only obscurely connected with biophysical processes. The idea that personal and social inadequacy has rationally determinable ori-

gins amenable to purposive change or cure was, of course, not created by Freud, but it may be said that not until his work and that of his followers has its acceptance become almost a matter of orthodoxy. The growing acceptance of that idea has encouraged the inclusion of a tremendous number of social and psychological phenomena under the category of disease, phenomena which hitherto had been considered largely in moral, legal, or other terms. Expansion of the category of supposedly morally neutral, scientifically detached "disease" does not seem to have been guided solely by scientific evidence. It seems closely related to the secular, liberal, humanitarian ideology, as a number of analysts have suggested.[11]

This view of man and his ills has several important characteristics. First of all, in ascribing natural disease to many areas of human behavior which hitherto were not so regarded, it designates as pathological and amenable to scientific treatment what once was held to be a consequence of responsible personal choice or of an irrevocable state of sin or genetic inferiority. Moral arguments for social reform become displaced by "scientific" arguments. Second, it creates a rhetoric by which behavior the actor believes to be serious and responsible, even if deviant, is reduced to a mere symptom of disease for which he is not truly responsible. For example, those who hold extreme political beliefs, whether radical or ultra-conservative, have been called sick because of their beliefs, thus denying the validity of debating those beliefs on their own merits. Another result, however, is not to punish those whose behavior is deviant, but to treat them, a result that threatens the traditional functions of the courts.

Aside from the extreme cases of generally acknowledged lunacy and unpremeditated crimes of passion, for which

the argument of irresponsibility holds sway, the courts have regarded most adult behavior to be deliberate and calculating, men making choices for which they may be held responsible and punished. Laws, courts, and prisons have been predicated upon such an assumption. But the new view of man has tended to encourage the assumption that some kinds of "disease," whether of society or the individual or his immediate environment, cause crime, and that therefore the criminal should not be punished but treated. Since the courts have had the historic function of determining and assigning responsibility and retribution, one may easily understand why in one study lawyers were found to be less "enlightened" about mental illness than their peers in other occupations; their very ideology, part of their professional stance, specifies responsibility where lack of responsibility is now being claimed.[12] The resistance of people committed to an ethic of responsibility is strengthened by the inadequacy of much of the evidence supporting this view of man, but it is weakened, one might suspect, by the humanitarian quality of its sentimental appeal.

If there is patent evidence that those who are responsible for extending the concept of natural disease to cover more and more types of social deviance are members of the liberal bourgeoisie, there is considerably less evidence about the identity of those who resist the extension. One very interesting discussion for the United States links nonhumanitarian attitudes toward crime and mental illness with the Puritan ideology.[13] An empirical study of "nonhumanism" in hospital attendants finds it correlated with "authoritarianism,"[14] which itself seems to be a working-class trait. A study of negative attitudes toward medicine as such refers to the "Protestant ethic."[15] Finally, a study of leaders of local groups opposed to the fluoridation of drinking

water suggested that their antipathy was part of a more general sense of alienation from the new scientific society.[16] There is also evidence that the poorly educated are less likely than the well educated to consider their physical and mental "problems" to be illnesses or to be serious enough to require professional medical attention.[17]

Social Elements in the Distribution and Etiology of Illness

It has been suggested that the proper interest of the physician lies in the study of what he believes to be disease, while that of the sociologist lies in the study of the behavior surrounding scientifically diagnosed disease and imputed disease. The sociologist, however, can make a contribution to the medical task by indicating some of the social correlates of disease and thereby suggesting possible elements in its etiology.

One question that has received a great deal of attention from medical people has been the distribution of illness, for knowledge of its distribution can supply hints of cause.[18] A variety of social variables has been found of significance in ordering the distribution of disease. Some illness is rare outside particular occupations because particular kinds of work bring the worker into contact with causative agents not met by others in the normal course of their lives.[19] "Black lung disease" among miners and cancer of the scrotum among chimney sweeps are obvious cases. Other illnesses are said to occur most frequently among particular ethnic and racial groups—whether the significant variable lies in diet or other peculiar customs, in general standard of living, or in genetics varies from one illness and one group to another. Still other illnesses occur most characteristically among particular economic groups, some a

result of the filth of poverty and others, like paralytic poliomyelitis, a result of the asepsis of wealth.

While it establishes connections, the epidemiological method does not by itself establish cause. In some instances there is tantalizing ambiguity in the problem of distinguishing cause from effect. In the case of chronic illness in the United States, where no national health scheme makes care available to everyone irrespective of income, it is not clear whether the environment surrounding a low socioeconomic position is the cause or the effect of chronic illness. A similar problem of explanation for a markedly different kind of illness occurs in the relation of schizophrenia to social isolation: which is the cause, which the effect? The same problem occurs in the relation of schizophrenia to urban areas and social class. Schizophrenia is especially problematic because it belongs to that class of illness which is rather inadequately defined. Even though it is one of the better defined mental illnesses in comparison to the "psychoneuroses," its essential nature and cause and the most effective method for its treatment are all very poorly understood. And while a variety of studies all seem to agree that it is, compared to neurosis, comparatively common among the working classes and rare among the middle, the exact meaning of the finding remains obscure. The genuine contribution sociologists can make to the problem is likely to lie in demonstrating how deviants, some of whom may truly be psychotic, are nonetheless socially manageable and acceptable in some settings and not others. Eaton and Weil's study of the Hutterites[20] and Freeman and Simmons' studies of the relations of various family roles to the acceptability of deviance[21] are eminent cases in point. They do not attempt to diagnose or determine the etiology of illness so much as to study how and whether illness is recognized and how responses to it are organized.

Social Class Influences on the Responses to Illness

The most common approach to the problem of explaining the way people define illness and behave when sick has been predicated upon the reasonable assumption that what they believe, know, and value influences their behavior. A very large body of sociological and anthropological information has been collected about popular knowledge of and attitudes toward health and the institutions surrounding it, particularly in the United States. The greatest proportion of that literature is grossly descriptive, seeking to determine what people know and believe and how much of it accords with modern medical aims. The most exotic findings naturally come from studies of people who are submerged in an indigenous culture and have not been intensively educated in Western medical traditions. But by and large both anthropological studies using the idea of culture and sociological surveys of "popular knowledge" in industrial societies have been singularly vague. Aside from cultural designations like Mexican, Subanun, and Mashona, there is no method by which the material is ordered save for focusing on knowledge about *particular* illnesses. Such studies are essentially catalogues, often without a classified index.

In complex societies a very useful and popular mode of classifying behavior is offered by the idea of social class. However, it too requires more differentiation before its value can be fully exploited. Empirical studies have used as indices of social class, occupation, education, and income, individually or in combination. In addition to such elements there is also involved the element of class culture—the general style or pattern of thinking and behaving char-

acteristic of some stratified segment of society, including patterns of distance and deference in relations between strata. Each element may have distinctly different bearing on responses to illness, but each tends to be confounded with the other under the term "social class." In the United States, class culture, level of education and information, and economic ability to pay for care are all prone to be confused; few studies have been able to distinguish clearly and instructively between economic opportunity and culturally and educationally motivated responses to illness. In countries where the class structure is relatively marked and traditional and its range wide, even with economic accessibility and level of information held constant, the mere pattern of deference holding between ranks and the position of the physician in the dominant classes may influence the inclination to seek care and the nature of the interaction between practitioner and patient.

The Organization of Responses to Illness

Careful sorting of the variables qualifying what people generally believe, know, and do about illness is necessary and useful as a way of understanding the social and cultural elements they bring to the process of being sick. But knowing the aggregation of elements brought to the process does not provide us with a way of organizing them. One way of organizing them is to recognize that the perception of and response to illness takes place over a course of time and that one can see it as a kind of career or cycle.[22] At the very least "illness behavior"[23] is problem solving in character, and we can speak of the various stages of perceiving a problem and the various attempts at solution. Recognition of this allows us to classify people's belief, knowledge, and

custom by the priority of their introduction into the problem-solving process and by their bearing on estimating the period of time required for solution (or cure) and on the degree of recovery possible or expected. An additional source of organization lies in the fact that people who are ill are supposed to behave in ways appropriate to being ill. This is to say, being ill involves assuming a social role. Indeed, the concept of role seems to be the most important means by which we can develop a solid structure for our understanding of the behavior surrounding illness.

Talcott Parsons has given us a fairly refined delineation of the sick role.[24] He sees in the sick role one way by which deviant behavior and the response of others to that behavior can be organized. Biological disease may, of course, fall into the category of illness, as may forms of deviance with no apparent biological origin. The person defined as sick is relieved of everyday responsibilities, but he is also expected to take the proper steps in seeking competent help so as to be able to be cured and returned to normalcy. Defined as it is, the sick role is obviously a device for accommodating the behavior of others to the sick person and also for preventing the ill from withdrawing from society. Furthermore, it is a device for putting the ill in touch with therapeutic agents who can cure his deviance.

The nature of Parsons' contribution is of first importance, but the value of its substance is severely limited. The most casual observation indicates that what Parsons describes as the sick role has little relevance to much of the behavior surrounding illness. Some illness is not considered serious enough to warrant more than a slight reduction of everyday activity. Other illness is defined as incurable, to be adjusted to as such. Much illness never reaches the stage of formal consultation with a professional. Parsons' sick role obviously applies to only a small part of the process of seeking a cure

for illness. Its limited reference to only some stages of the process of seeking help may be in part a necessary deficiency, however, for the earlier stages of illness, at which professional help is not yet prescribed and sought, are considerably less definite and thus more difficult to conceptualize with clarity.

A perhaps more serious deficiency in the idea of the sick role is its apparent inapplicability to populations other than those inclined to share professional values of universalism, achievement, and the like. From the approval with which it is used by both French and German writers, one might gather that Parsons' definition makes sense to middle-class Europeans as well as Americans. But working-class, peasant, and native populations, at least some of which are not inclined to use the professional consultant, are still left out. For them, being sick in a socially acceptable way does not hinge upon professional legitimation or even necessarily on special consultation with anyone.

What is needed is, in essence, specification of a set of roles corresponding to important and potentially final organized stages of the process of seeking help. This set of roles must include both permanent legitimate roles (like that of the "sickly" person, the handicapped, the mentally retarded),[25] temporary legitimate roles (such as "indispositions," female or otherwise); Parsons' sick role (which requires for its legitimation the pursuit of professional help), and both temporary and permanent roles to which moral stigma is attached even after the illness is to all intents and purposes "cured" (the mentally ill being the most outstanding case in point). Mental illness and drug addiction, as well as to a somewhat lesser degree mental deficiency, epilepsy, leprosy, tuberculosis, and venereal disease, are analytically interesting here precisely because many people cannot quite adopt a purely neutral "disease" orientation