THE HEALING EXPERIENCE

Readings on the Social Context of Health Care

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DILEMMAS IN THE DOCTOR-PATIENT RELATIONSHIP

Eliot Freidson

Eliot Freidson is among the foremost American medical sociologists. He has done pioneering research on the way doctors and patients view their situation and how those differing perceptions affect the healing experience. In this essay he describes some common types of doctor-patient interactions.

Freidson sees conflict as inherent in "the very nature of professional practice." As the science of medicine continually changes, doctors are able to apply more sophisticated methods to their diagnoses. But in any particular period of medical history, there are areas of knowledge that remain incomplete. Doctors therefore often make decisions about diagnosis and treatment under conditions of uncertainty. Patients, on the other hand, have a strong desire to understand and trust their doctors. When errors occur, that trust is jeopardized, and the patient naturally feels angry and frustrated.

There are also problems arising from more routine aspects of diagnosis and care. Doctors need to recognize patients' symptoms as the signs of an illness. The discomfort or pain experienced by the patient is often less important in making a diagnosis than other symptoms. For the patient, on the other hand, discomfort is often the primary reason for seeking a doctor's care. This disparity between the patient's need for attention to pain and the doctor's need to examine other symptoms can lead to conflict.

Freidson also provides insight into the way differences in social status between doctors and patients can affect the healing relationship. When doctors and patients are similar in status, the doctor-patient relationship is likely to be more conflicted than when doctors have higher status than their patients.

The result of such conflicts, according to Freidson, is that the doctor-patient relationship is forever changing. Doctors seek to accommodate the needs of patients.

Patients often seek out doctors or healers who can relate to their perceived needs—or turn to nonmedical forms of care. The challenge for medical personnel is to learn to accommodate the patient's social and physical needs while learning how to administer more effective care.

Almost 2500 years ago, the Hippocratic corpus presented doctors' complaints about the nonprofessional criteria that people use to select their physicians (Jones, 1943: II, 67, 281, 311), criticism of patients for insisting on "out of the way and doubtful remedies" (Jones, 1943: I, 317) or on overconventional remedies like "barley water, wine and hydromel" (Jones, 1943: II, 67) and for disobeying the doctor's orders (Jones, 1943: II, 201, 297). The physicians who have left us historical documents largely treat the patient as an obstacle, a problem of "management." From their point of view the patient is very troublesome, full of anxiety, doubt, and fear, insisting upon using his own scanty knowledge to evaluate the practitioner.

The patients who have left us documents often treat the physician as a potential danger to which one must respond cautiously and whom one must always be ready to evade. Patients have circulated stories about the occasions on which they successfully cured themselves or continued to live for a long time in defiance of medical prognoses. This sort of literature may be represented by the Roman "epigram about a doctor Marcus who touched a statue of Zeus, and although Zeus was made of stone he nevertheless died" (Pondoev, 1959: 87), and by Benvenuto Cellini's mild little story:

> I put myself once more under doctor's orders, and attended to their directions, but grew always worse. When fever fell upon me, I resolved on having recourse again to the wood: but the doctors forbade it, saying that if I took it with the fever on me, I should not have a week to live. However, I made my mind up to disobey their orders, observed the same diet as I had formerly adopted, and after drinking the decoction four days, was wholly rid of fever. . . . After fifty days my health was reestablished. (Cellini, n.d.: 128)

The struggle between physician and patient has continued into modern times. The cases recorded in Paul's volume (Paul & Miller, 1955), in the work of Saunders (1954), Clark (1959), Koos (1954), and in my own study (Freidson, 1961) have indicated that on important occasions patients do not necessarily do what they are told by physicians. They persist in diagnosing and dosing themselves and in assigning heavy weight to lay advice and their own personal dispositions. It is difficult to get them to cooperate wholly with health programs that professionals believe are for their own good (e.g., Cobb et al., 1957).

That the problem continues today is somewhat paradoxical, for it seems unquestionable that the medical practitioner has reached an all-time peak of prestige and authority in the eyes of the public. The physician of today is an essentially new

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kind of professional whose scientific body of knowledge and occupational freedom are quite recent acquisitions. His knowledge is far more precise and effective than it has ever been, since for the first time in history it could be said that from "'about the year 1910 or 1912 . . . [in the United States] a random patient with a random disease consulting a doctor chosen at random stood better than a 50–50 chance of benefitting from the encounter'" (Gregg, 1956: 13). The physician has obtained unrivaled power to control his own practice and the affairs that impinge upon it, and the patient now has severely limited access to drugs for self-treatment and to nonmedical practitioners for alternative treatment. But the ancient problem continues.

THE CLASH OF PERSPECTIVES

It is my thesis that the separate worlds of experience and reference of the layman and the professional worker are always in potential conflict with each other (cf. Becker, 1953; Merton, 1957). This seems to be inherent in the very situation of professional practice. The practitioner, looking from his professional vantage point, preserves his detachment by seeing the patient as a case to which he applies the general rules and categories learned during his protracted professional training. The client, being personally involved in what happens, feels obliged to try to judge and control what is happening to him. Since he does not have the same perspective as the practitioner, he must judge what is being done to him from other than a professional point of view. While both professional worker and client are theoretically in accord with the end of their relationship—solving the client's problems—the means by which this solution is to be accomplished and the definitions of the problem itself are sources of potential difference.

The very nature of professional practice seems to stimulate the patient on occasion to be especially wary and questioning. Professional knowledge is never complete, and so diagnosis, made with the greatest of care and the best of contemporary skill, may turn out to be inappropriate for any particular case. These mistakes may occur in two basic ways (cf. Hughes, 1958: 88–101).

First of all, it is obvious that in every age, including our own, there are likely to be worthless diagnostic categories and associated treatments—sometimes merely harmless without contributing anything to cure, sometimes downright dangerous. As Shryock put it for an earlier time, "No one will ever know just what impact heroic practice [heavy bleeding and dosing with calomel] had on American vital statistics: therapy was never listed among the causes of death" (Shryock, 1960: 111). In addition, in every age, including our own, there are likely to be diseases unrecognized by contemporary diagnostic categories—as typhoid and typhus were not distinguished before 1820, as gonorrhea and syphilis were once confused, and as mental diseases are no doubt being confused today. Thus, the best, most well-intentioned contemporary knowledge may on occasion be misdirected or false and some of the patient's complaints wrongly ignored.

Second, however, is a considerably more complex source of error that flows not from knowledge so much as from the enterprise of applying knowledge to

everyday life. Insofar as knowledge consists in general and objective diagnostic categories by which the physician sorts the concrete signs and complaints confronting him, it follows that work assumes a routine character. This is the routine of classifying the flow of reality into a limited number of categories so that the individual items of that flow become reduced to mere instances of a class, each individual instance being considered the same as every other in its class.

The routine of practice not only makes varied elements of experience equivalent—it also makes them *ordinary*. This seems to be the case particularly in general medical practice. In general medical practice, while the range of complaints may indeed be unusually wide, the number of complaints falling within a rather narrow range seems to be overwhelming. In our day, for example, complaints that are categorized as upper respiratory infections are exceedingly common. Like malaria in the nineteenth century, they are so common that they are considered ordinary. And insofar as they are considered ordinary it is not legitimate for the patient to make a great fuss about the suffering they involve. His subjectively real pain is given little attention or sympathy because it is too ordinary to worry about. His likely response to this may be gauged by reading Dr. Raffel's account of the reception of his complaint of acute sinusitis (Pinner & Miller, 1952: 236–41).

What also happens is that more of reality than proves to be appropriate tends to be subsumed under the ordinary and commonly used categories. This again seems to be in the very nature of professional practice—if *most* patients have upper respiratory infections when they complain of sneezing, sounds in the head, a running nose, and fatigue, then it is probable that it is an upper respiratory infection that is involved when *one* particular person makes the complaint. It may indeed be an allergy or even approaching deafness (Pinner & Miller, 1952: 62–72), but it is not probable—that is to say, it has not commonly been the case in the past. The physician cannot do otherwise than make such assumptions, but by the statistical nature of the case he cannot do otherwise than to be sometimes wrong.

THE PATIENT'S PROBLEM

These problems of diagnosis are not only problems for the doctor but also problems for the patient. All the patient knows is what he feels and what he has heard. He feels terrible, his doctor tells him that there's nothing to worry about, and a friend tells him about someone who felt the same way and dropped dead as he was leaving the consulting room with a clean bill of health. The problem for the patient is determining when the doctor is mistaken. When are subjective sensations so reliable that one should insist on special attention, and when can one reasonably allow them to be waved away as tangential, ordinary, and unimportant? The answer to this question is never definite for any individual case and indeed cannot be resolved decisively except by subsequent events. All of us know of events that have contradicted the judgment of the physician and of course many others that have contradicted the patient.

The situation of consultation thus proves to involve ambiguities that provide

grounds for doubt by the patient. Furthermore, those ambiguities are objective. Most reasonable people will agree that the doctor is sometimes wrong, whether by virtue of overlooking the signs that convert an ordinary-appearing case into a special case or by virtue of the deficiencies of the knowledge of his time. He is less often wrong now than he was a hundred years ago, but frequency is not really the problem for the individual. Even if failure occurs once in ten thousand cases, the question for the patient is whether or not it is he who is to be that one case, a question that no one can answer in advance. If the evidence of his senses and the evidence of his knowledge and that of his intimate consultants are contradicted by the physician, the patient may feel it prudent to seek another physician or simply to evade the prescriptions he has already obtained.

THE ROLE OF CONFIDENCE

If it is true that the very practice of medicine, through the process of diagnosis, is permeated with objective uncertainty of which the patient may become aware, it is at least as important to understand why patients do cooperate with doctors as to understand why they do not. One reason seems to be the ignorance of the patient—he may not be aware of or be sensitive to the contingencies of practice. Another reason seems to be the kind of situation with which the patient is confronted—whether it is a crisis situation that motivates him to be sensitive to uncertainties or a routine situation that blunts his sensitivity and attention. There is still another possible reason, however, which, if true, is more strategic than the patient's ignorance or the variable context of consultation. I refer to the special status of the professional in society that (unlike the businessman with his motto, caveat emptor) supposedly entitles him to a priori trust and confidence (Gross, 1958: 78).

The usual conception of confidence seems to be shallow and parochial. It is indeed true that under ordinary circumstances one goes to a doctor assuming that the doctor knows his business and that his judgment may be trusted, but it is no less true of the ordinary use of other services. It is a mistake to assume that the title "profession" confers a kind of expert authority on the practitioner that is greatly different from the authority of any fairly esoteric craftsman. Simmel pointed out some time ago that "our modern life is based to a much larger extent than is usually realized upon the faith in the honesty of the other. . . . We base our gravest decisions on a complex system of conceptions, most of which presuppose the confidence that we will not be betrayed" (Wolff, 1950: 313). Under normal circumstances we have confidence in a mechanic's ability to grease our car properly just as we have confidence in a physician's ability to prescribe the right drug for us and a pharmacist's ability to fill the prescription accurately. In the same fashion we have confidence in a variety of other service workers—appliance repairmen, bank clerks, carpenters, fitting-room tailors, and so on. Faith in the honest applications of specialized ability by a consultant seems to be connected not only with the use of those who are called professionals but also with the use of any kind of consultant whose work is fairly esoteric. Such confidence must exist if life is to function smoothly, routinely.

However, there seems to be a generic distinction in the way the definition of the situation of consultation varies. On the one hand, there is an unthinking and fundamentally superficial sort of confidence that is automatically attached to any routine consultation. It is manifested in uncritical cooperation with the consultant. This sort of confidence sustains the doctor-patient relationship in about the same way it sustains any consultant-client relationship. It appears to waver when the client's expectations are not fulfilled by the consultant and when the problem of consultation comes to be seen as critical (that is, nonroutine) to the patient. Questions arise when the consultant does not act as he is expected to, when the diagnosis seems implausible, when the prescription seems intolerable and unnecessary, and when "cure" is slow or imperceptible. They become pressing when the problem of consultation assumes what seem to be serious proportions. Under such circumstances what is needed to sustain the relationship is at least a different quantity if not a different quality of confidence.

It may be that it is this latter sort of confidence that is in the minds of those who make a special connection between professions and client confidence. Certainly it is true that three of the old, established professions deal with some of the most anxiety-laden topics of existence—the body, the soul, and human relations and property. Plumbing, internal combustion engines, and clothing are not likely to occasion as much anxiety. In this sense doctors, clergymen, and lawyers are more likely to require for their practice a special kind of confidence than are plumbers, mechanics, and fitting-room tailors. But, we may observe, it is precisely this special sort of confidence that is problematic for professions in general and medicine in particular; it is precisely this sort of confidence that does *not* flow automatically from professional status. Routine confidence is automatic but grants no special advantage to the professions. Confidence in crises, however, is demanded but not necessarily obtained by consultants with professional standing.

THE ROLE OF CULTURE

One of the things that breaks routine and thereby suspends routine confidence is an occasion in which the patient's expectations are not met. Instead of prescribing what seems to the patient to be a good sensible remedy like barley water, wine and hydromel, or penicillin, the physician suggests that the patient go on a dietary regimen or simply take aspirin. Obviously, we have in essence a clash of culture or education. The patient's culture leads him to expect what the doctor's culture does not suggest.

Cultural differences between patient and doctor have received a great deal of attention. The tenor of contemporary writings suggests that much patient-doctor conflict can be eliminated by reducing the differences between the two.

Some—particularly those writing about fairly exotic patients who cannot be expected to become "educated" quickly (Mead, 1955)—suggest that the physician should be able to get patients in to see him and to reduce conflict during consultation by adjusting himself to the patient's expectations. If, for example, his prospec-

tive patients interpret the professional attitude of detachment and impersonality to be hostile, the doctor should be prepared to behave in a less "professional" and more sociable way (Clark, 1959: 215). On the whole, the recent movement to bring social science into American medical schools seems to share this perspective: by teaching the prospective physician more about "the patient as a person," it is presumed that when he starts to practice he will be better equipped to understand, tolerate, and adjust himself to those expectations of the patient that contradict his own.

But how far can we expect the physician to adjust himself to the patient's lay (and sometimes bizarre) expectations without ceasing to practice modern medicine? There is of course a great practical difference between automatic and rigid compliance to a set of scholastic propositions and a more flexible kind of behavior, and certainly professionals would agree that the latter is likely to produce the better practitioner. But flexibility must remain within limits or it becomes irresponsible. The physician can listen closely to the patient and adjust to him only so far. If his adjustment is too great, the physician must deny the heritage of special knowledge that marks him off as a professional—in effect, he ceases to be a professional. Thus, we may say that some conflict in the physician-patient relationship may indeed be forestalled by educating physicians to be somewhat more understanding and flexible with patients, but that there is a line beyond which the physician cannot go and remain a physician. Some patients' expectations cannot be met.

It might be suggested that at the point where the physician must stop adjusting, the patient must begin. After the physician has accommodated himself to the patient as far as he can, the patient should make all further accommodation if conflict is to be forestalled without destroying medical authority. With the proper health education it is believed that the patient will understand and believe sufficiently in modern medicine to be able to approach his illness from the same perspective as the physician. Thus, *patients* are to be changed so as to conform to the expectations of the doctor.

The relation of health education to the reduction of conflict is, however, by no means clear. As one way of assessing it we might contrast the consequences of two extremes. First, we may ask, what sort of conflict exists when the patient has no health education at all—that is to say, no culturally determined expectations of the doctor. Situations like this are often found in veterinary and pediatric medicine—at least when the parent or owner of the patient does not take a surrogate sick role. Patients in both cases lack any health education. As such, they lack any of the knowledge that would lead them, when ill, to seek a physician. Unassisted, they are likely either to seek a familiar sympathetic person or, like the lion in the fable, lie helpless somewhere waiting for the chance and professionally unqualified kindness of an Androcles. If they should happen to strike upon a treatment situation, they prove incapable of indicating by any but the crudest and largely involuntary means—like a swollen paw and roars of distress—what is wrong with them. Nor can they themselves be counted upon to follow or even to submit to the treatment prescribed; indeed, it often happens that they must be physically restrained to be treated.

It is patent that there are shortcomings in working with patients with no

health education at all, but are there any virtues? One is that while the patient may be incapable of illuminating his complaint due to his lack of education, he is also incapable of obscuring it by irrelevancies and misinformation or compounding it by imaginative anticipation. Another is that he has no expectations about treatment, so that once the consultant establishes control there is no contradiction of his authority. Another is that simply by reason of the fact that the patient cannot cooperate it is permissible to use physical restraint, a very convenient device for practice that cannot be used on people who theoretically can but will not cooperate. And finally, apocryphal but worth citing nonetheless, the ignorant client, once won over, may, like Androcles' lion, show undying gratitude and devotion to his healer. If this is true, it is no mean virtue.

However, the virtues of the completely ignorant patient may seem small in the face of the shortcomings. After all, patients who are educated in health affairs will have the knowledge to allow them to recognize symptoms so as to come in to see the doctor in time, to give a useful history, and to cooperate intelligently with treatment. Surely people with the most health education will be more cooperative and will not struggle with the doctor.

It does not seem to be so simple. The physician is the one with the greatest possible health education, but there are good grounds for believing that he is not a very cooperative patient at all. The physician is reputed to be given to a great deal of self-diagnosis and treatment. This follows in part from his advanced health education, which makes him feel competent to diagnose himself "scientifically," and in part, like his susceptibility to drug addiction, from his privileged access to the medication that his self-diagnosis calls for. And when, after the long delay caused by self-diagnosis and treatment, the physician does seek the aid of another, he is reputed to be an argumentative and uncooperative patient incapable of repressing his own opinions in favor of those of his consultant. This too seems to follow from his very health education, for it gives him a "scientific" position in which to stand and counter that of his consultant, and it gives him a clear insight into the uncertainties of practice such that he may feel strongly justified in holding to his own opinion.

This view of physicians as patients is supported only by the plausibility of what is essentially gossip. It is made substantially more credible, however, when we look at the behavior of well-educated middle-class patients. Fairly well versed in modern medicine, they can on occasion cooperate beautifully with the physician, but on occasion they are also quite active in evaluating the physician on the basis of their own knowledge and shopping around for diagnoses or prescriptions consonant with their knowledge. They are more confident and cooperative on a routine basis, perhaps, but they are also more confident of their own ability to judge the physician and dispose themselves accordingly.

Whether health education resolves or encourages conflict in the doctor-patient relationship, then, seems to depend upon the situation. Where the well-educated, acculturated patient's expectations are being met (and they are more likely to be met by a physician than are those of worse-educated patients), his cooperation can be full and intelligent by virtue of the correspondence between his conceptions and those of the doctor. But by the nature of the case, so much of di-

agnosis and particularly treatment being a matter of opinion even within the profession itself, the patient's expectations will on occasion be violated: here his education is more likely to encourage conflict than to resolve it, for it allows the conflict to be justified by the same authoritative norms as those of the physician himself. A worse-educated patient may be far more manageable.

THE ROLE OF LATENT STATUS

Thus far, the only clear way by which professional authority seems able to sustain itself consistently appears to lie in an at least partial compromise of the *content* of the authority—by taking patients' expectations into account and adjusting practice to them. At the point of adjustment to the patient beyond which professional authority must be sacrificed, however, an additional nonmedical element may work to control the patient without compromise. In political affairs we would call it power; in professional affairs we lack an adequate term but might call it ability to intimidate. This mode of resolving conflict flows not from the expert status of the physician but from the relation of his status in the community to that of his patient.

In the consulting room the physician may be said to have the manifest status of expert consultant and the latent status (cf. Gouldner, 1957) of his prestige in the lay community. His latent status has no necessary relationship to his technical qualification to be an expert but obviously impinges upon his relation to his patients. Indeed, latent status seems crucial for sustaining the force of manifest or professional status, for while many occupations possess expert knowledge, few have been able to control the terms of their work. The established professions, however, have obtained both the political power requisite for controlling the sociolegal framework of practice and the social prestige for controlling the client in consultation. Both the power of the profession and the prestige of the practitioner are quite separate from the "authority" inherent in technical expertness. They seem to be critical conditions for reducing doctor-patient conflict *without* compromising expert knowledge. However, even when professional power and technical expertness are high, the relative prestige of the practitioner varies. It is not a constant. It has varied through history; within any particular society it varies from one practitioner to another; within any particular practice it can vary from one patient to another. What are the consequences of variation in relative latent status for the doctor-patient relationship?

When the physician has had a lower standing than his patient, "more on a footing with the servants" (Eliot, n.d.: 91), he is likely to have to be either complaisant or nimble or both to preserve the relationship. This necessity is clearest in instances in which social standing is accompanied by absolute power and in which the severest result could ensue from failure. For example: "Astragasilde, Queen of France, on her death bed had begged her husband, Gontrano, to throw her doctor out the window immediately after her death, which was done with the greatest punctuality. . . . In the fifteenth century, John XXII burned an unsuccessful physician at Florence and, on this Pope's death, his friends flayed the surgeon who had failed to keep him alive" (Riesman, 1935: 365). Under such circumstances the dif-

ficulties of practice according to strictly professional standards must be very great indeed—beyond fear of severe punishment for failure, considerable frustration could be caused by the way a patient of relatively high standing could effectively refuse to cooperate, as the difficulties of Dr. Henry Atkins, physician to Charles, duke of Albany, indicated (Keevil, 1954).

Even today it seems plausible to think that physicians of eminent and powerful men have a trying practice and that their behavior in the presence of superordinate patients will differ considerably from their behavior in the presence of "charity" patients in a hospital outpatient clinic (cf. Turner, 1959: 211). Indeed, Hollingshead and Redlich observed that upper-class

> patients and their families make more demands of psychiatrists than other patients. . . . These patients and their families usually view the physician as middle class. In such relationships the psychiatrist is not in a position to exert social power; he is lucky if he is able to rely on professional techniques successfully. All too often he has to carry out complicated maneuvers vis-à-vis a critical, demanding, sometimes informed, and sometimes very uninformed "VIP." Some VIP's push the physician into the role of lackey or comforter, and some psychiatrists fall into such a role. (Hollingshead & Redlich, 1958: 353)

Obviously, where the relative latent status of the physician is below that of the patient, he is not in a very good position to obtain cooperation. Overt or covert conflict seems likely to ensue.

On the other side we have a situation in which the physician has considerably higher standing than his patient. The most extreme example illustrating this is found in the case of James IV, king of Scotland, who practiced on his subjects. Here, while the physician's behavior might be qualified by his sense of paternalistic or professional responsibility, we should expect that his standing is sufficiently intimidating to the patient that, while the patient is in his hands, he will be in a position to impose the full weight of his professional knowledge. However, in response to his lack of control over his own fate, the patient seems to be inclined to adopt the defense of evasiveness. He may avoid coming in to see the physician in the first place—King James, as a matter of fact, paid his patients a fee to get them into his consulting room—or he may play dumb, listen politely while in the consulting room, and, once outside, ignore the physician's advice. Evasive techniques seem to be very common in instances where the physician is in a position to intimidate his patients. As Simmons has observed: "The deference doctors receive as upper-status persons can easily be mistaken for voluntary respect and confidence. This error could prevent perception of substantial resentments and resistances of patients" (Simmons, 1958: 22).

I have argued that objective differences in perspective between physician and patient and uncertainties inherent in the routine application of knowledge to human affairs make for incipient conflict between patient and physician. Conflict occurs especially when the patient, on the basis of his own lay perspective, tries in

some way to control what the physician does to him. It is more likely to occur when the patient defines his illness as potentially critical than when he sees it as minor and ordinary.

There seem to be three ways by which conflict may be forestalled, but each is problematic. The doctor may accommodate to the demands of the patient, but if he should do so extensively he ceases to be the doctor. The patient may be educated in health affairs so as to be more in agreement with the doctor, but education also equips him to be more self-confident and self-assertive in evaluating the doctor's work and seeking to control it. Finally, the physician may attain such relatively high social standing as to gain an extraprofessional source of leverage for controlling the patient, but the patient tends to answer by only superficial cooperation and covert evasiveness.

In the light of these dilemmas it might be asked how it is that medical practice can even persist, let alone grow as much as it has over the past fifty years. Pain and desire for its relief are the basic motives of the patient, and they are not diminished by any of the elements of contradiction in the doctor-patient relationship. The prospective patient will not stop seeking help, but the way these dilemmas are managed will figure in what he seeks help for, when he seeks help, the way in which he seeks help, whom he seeks help from, and how he will behave in consultation. How some of the dilemmas are managed, of course, also involves the physician—his willingness and ability to accommodate to the patient, and the presence of situations in which he must accommodate if he is to keep his practice. They are reflected in the way he tries to deal with the patient. Thus, the doctor-patient relationship is not a constant, as Parsons (1951) seems to imply, but obviously a variable. As I have tried to show elsewhere, systematic differences in the doctor-patient relationship such as Szasz and Hollander (1956) discuss may be seen to flow from historical and situational variability in the strength and content of struggling lay and professional systems.

REFERENCES

BECKER, H. S. 1953. Some contingencies of the professional dance musician's career. *Human Organization* 12:22–26.

CELLINI, B. N.d. *The autobiography of Benvenuto Cellini.* Trans. John A. Symonds. New York: Modern Library.

CLARK, M. 1959. *Health in the Mexican-American community.* Berkeley: University of California Press.

COBB, S., S. KING, and E. CHEN. 1957. Differences between respondents and nonrespondents in a morbidity survey involving clinical examination. *Journal of Chronic Diseases* 6:95–108.

COHEN, J. M., trans. 1957. *The life of Saint Theresa.* Harmondsworth: Penguin Books.

ELIOT, G. N.d. *Middlemarch: A study of provincial life.* New York: A. L. Burt.

FREIDSON, E. 1961. *Patients' views of medical practice.* New York: Russell Sage Foundation.

GOULDNER, A. W. 1957. Cosmopolitans and locals: Toward an analysis of latent social roles—I. *Administrative Science Quarterly* 2:281–86.

GREGG, A. 1956. *Challenges to contemporary medicine.* New York: Columbia University Press.

GROSS, E. 1958. *Work and society.* New York: Thomas Y. Crowell.

HOLLINGSHEAD, A. B., and F. C. REDLICH. 1958. *Social class and mental illness.* New York: John Wiley & Sons.

HUGHES, E. C. 1958. *Men and their work.* New York: Free Press.
JONES, W. H. S., trans. 1943. *Hippocrates.* London: William Heinemann.
KEEVIL, J. J. 1954. The illness of Charles, duke of Albany (Charles I), from 1600 to 1612: An historical case of rickets. *Journal of the History of Medicine and Allied Sciences* 9:410–14.
KOOS, E. L. 1954. *The health of Regionville.* New York: Columbia University Press.
MEAD, M., ed. 1955. *Cultural patterns and technical change.* New York: International Documents Service (UNESCO), Columbia University Press.
MERTON, R. K. 1957. The role-set: Problems in sociological theory. *British Journal of Sociology* 8:106–20.
PARSONS, T. 1951. *The social system.* Glencoe, Ill.: Free Press.
PAUL, B. D., and W. B. MILLER, eds. 1955. *Health, culture and community.* New York: Russell Sage Foundation.
PINNER, M., and B. F. MILLER, eds. 1952. *When doctors are patients.* New York: W. W. Norton.
PONDOEV, G. S. 1959. *Notes of a Soviet doctor.* New York: Consultants Bureau.
RIESMAN, D. 1935. *The story of medicine in the Middle Ages.* New York: Paul B. Hoeber.
SAUNDERS, L. W. 1954. *Cultural differences and medical care.* New York: Russell Sage Foundation.
SHRYOCK, R. H. 1960. *Medicine and society in America.* New York: New York University Press.
SIMMONS, O. G. 1958. Social status and public health. Social Science Research Council Pamphlets, no. 13. New York: Social Science Research Council.
SZASZ, T. S., and M. H. HOLLANDER. 1956. A contribution to the philosophy of medicine. *A.M.A. Archives of Internal Medicine* 97:585–92.
TURNER, E. S. 1959. *Call the doctor.* New York: St. Martin's Press.
WOLFF, K. H., ed. and trans. 1950. *The sociology of George Simmel.* Glencoe, Ill.: Free Press.