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14.

THE SOCIAL ORGANIZATION
OF ILLNESS

IN the last chapter I discussed the variables that seem to be important for predicting the likelihood that members of a population will enter the medical consulting room. Some of the variables are similar to those predicting the likelihood that members of a population will buy a new product or adopt a new innovation.¹ In spite of that similarity, though, there are essential differences between the use of a professionally controlled service or product and the use of a commercial product—differences that stem from the status of the profession. The status of the profession allows it to shape the official recognition of need for service as well as the way that need will be organized by the service it controls. It is in this sense that the social organization of treatment may be seen to create the conditions by which the experience of being ill, the relationships one has with others when ill, and the very life of the sick person become organized. It is these conditions and these consequences that I wish to focus on in this chapter. I wish to show how, once one enters the professional domain, that domain imposes organization on the experience and manifestation of illness.

¹ For a summary of much of this material see Everett Rogers, *Diffusion of Innovation* (New York: The Free Press of Glencoe, 1962).

Medicine as an Official Institution

What is distinct about a complex civilization like ours, compared to a simple society, is the existence of special classes of men who are engaged on a full-time basis in creating knowledge, formulating laws, morals, and procedures, and applying knowledge and moral principles to concrete cases. These men formulate and administer a special corpus of social meanings that is always different in kind from the social meanings of the ordinary citizenry.² What these men do contributes to the official *social* order, and although the content of a viable official order is rarely wholly divorced from that of the average citizen, it is different. The official social order is politically and culturally dominant, reflecting the values and knowledge of the dominant classes of the society. It is not necessarily hostile to the values of everyday life, but it is nonetheless imposed on everyday life, and its imposition is supported by organized political, economic and normative forces.

In the modern postindustrial society, the practicing professions compose part of the official order and, as Parsons pointed out, are agents for social control.³ Supported by the power of the state, they have official mandate to apply their knowledge and values to the world about them. Their mandate is to define whether or not a problem exists and what the “real” character of the problem is and how it should be managed. Given the fact that they have *special* knowledge and values, it cannot fail to be that their conceptions will be different from that of the man on the street: where there are experts, there are laymen by definition. And when experts constitute a profession, their knowledge and values become part of the official order which, however enlightened, liberal, and benevolent, is nonetheless imposed on the everyday world of the layman.

Professionals are said to be schooled in some special skill that is part of civilization. Their job is to apply those skills, and in application they are likely to have some special influence by virtue of their

² See the contrast between the “great tradition” and the “little tradition” in Robert Redfield, *Peasant Society and Culture* (Chicago: University of Chicago Press, 1956).

³ See Talcott Parsons, “Propaganda and Social Control” in his *Essays in Sociological Theory, Pure and Applied* (New York: The Free Press of Glencoe, 1949), pp. 275–309.

relations with organized political power in the community and by virtue of their prestige among laymen. They are not merely experts but rather incumbents in official positions.⁴ As the state assumes more responsibility for the welfare of the layman, professionals become members of the class of caretakers, and the possibilities increase for differences between their perspective and that of laymen. Given the official status of the profession, what happens to the layman—that is, whether or not he will be recognized as “really” sick, what the sickness will be called, what treatment will be given him, how he will be required to act while ill, and what will happen to him after treatment—becomes a function of professional rather than lay decision. As functionaries who, by virtue of their professional qualifications, are granted the license to make everyday decisions related to the welfare of their clientele, they certify sick leave, sign workmen’s compensation and insurance forms, commitment forms, and eligibility forms of many kinds. Furthermore, on an everyday basis they serve as gatekeepers to special resources (the most obvious of which are hospital beds and “ethical” drugs) that cannot be used without their permission. Thus, the behavior of the physician and others in the field of health constitutes the objectification, the empirical embodiment, of certain dominant values in a society.

It is important to understand the consequences of medicine’s official status for the freedom of the patient to follow his own notions of illness and illness behavior. While the layman does exercise choice in seeking professional care, it is a considerably less free choice than in the nonprofessional marketplace. The range of choice is limited by the licensing of healers. Given that limited range, the choice tends to be more among institutions than among products or services. To quote an economist’s characterization of the medical marketplace,

The physician, not the patient, combines the components of care into a treatment. In other markets the consumer, with varying degrees of knowledge, selects the goods and services he desires from the available alternatives. In medical care,

⁴ See Eliot Freidson, *Professional Dominance* (New York: Atherton Press, forthcoming), Chapter 4.

however, the patient does not usually make his choice directly. . . . He selects a physician who then makes . . . choices for him.⁵

It is as if the housewife could choose the store she wished to patronize but not which of the articles in the store she could buy. The choice is made for her by those who run the store on the basis of their conception of what she “really” needs, which may be no articles at all, articles she does not want, or, if she is lucky, just what she wants.

Types of Practice and the Marketplace

There is, however, more leeway open to the medical consumer in the early stages of his illness than I have implied. Such leeway is available by virtue of the fact that there are various kinds of stores in the medical marketplace, some having different stock than others, and some having a different relationship to the consumer than others. Some are analogous to the small neighborhood groceries, carrying a variety of wares, open at all hours to get what business they can, and otherwise obliging to their customers; others are analogous to shops with an exclusive franchise over scarce and desirable goods. Some are embedded in the local customs and the round of life of the neighborhood; others are separate from the neighborhood, physically and culturally. When the prospective patient enters the former he is relatively free to choose the services he will get; when he chooses the latter he is likely to have to settle for what will be given him.

Let us recall where the analysis is at this point. Those who have chosen to use no practitioner have dropped out of my concern, as have those who have chosen a nonmedical practitioner. We are confronted with those who believe themselves to have an illness requiring medical consultation. Now, we may ask, what consultant do they choose, and with what consequences for the social definition of their illness and for the organization of their illness behavior? On the whole, given the inclination of lay as well as medical men to impute common and minor illness first, before deciding on an unusual and serious illness, the initial choice of medical consultants

⁵ Paul J. Feldstein, “Research on the Demand for Health Services,” *Milbank Memorial Fund Quarterly*, XLIV (1966), Part II, p. 138.

by laymen is likely to be of some kind of generalist—the consultant who handles the common and minor ills of everyday life. In nations where practice is still carried on in individual, neighborhood offices, the consultant most likely to be chosen first is the general practitioner, the internist, or the pediatrician.⁶

Those everyday consultants have practices which depend for their clientele upon the individual's own choice of their services or upon other laymen referring the individual. In terms suggested in Chapter 5, they are "client-dependent practices." The very survival of the practices of such consultants tends to depend upon receiving lay referrals. And insofar as lay referrals are inevitably based on lay understandings of illness and its treatment, it follows that survival depends upon the compatibility of the diagnosis and treatment used by the practitioner with those used by laymen. The practitioner must on occasion give in to his patients' prejudices if they are to return to him and to refer other patients to him. Thus, those in such practices are likely to honor lay demands for such popular remedies as vitamin B-12 injections, copious use of antibiotics, and prescription of tranquilizers, sedatives, and stimulants. The content of their diagnostic and treatment practices, like the stock on the neighborhood grocer's shelves, reflects their position between two worlds, at the hinge where the lay system connects with the professional.⁷

The client-dependent practitioner is one who by definition depends upon laymen for the referrals and choices that provide him with his "business." In this, he is similar to the neighborhood shopkeeper. Also like the neighborhood shopkeeper, however, the practitioner always has some relations with the world outside the neighborhood—with pharmaceutical houses, medical societies, hospitals, and specialists. Insofar as the practitioner is a professional, and insofar as he requires the aid of colleagues and medical institutions to carry out his work, he participates in a *professional referral*

⁶ Much of the following stems from Eliot Freidson, *Patients' Views of Medical Practice* (New York: Russell Sage Foundation, 1961), pp. 192-207.

⁷ See the comments on the way practitioners, due to their fear of losing status and income, were overresponsive to their patients' demands for hospitalization, and for acceptable diagnoses and therapies in Raymond S. Duff and August B. Hollingshead, *Sickness and Society* (New York: Harper and Row, 1968), p. 382.

system that extends outside of the local circle of laymen on whom his practice depends. The professional system is composed of the specialists, clinics, superspecialists, university hospitals, and other institutions standing outside the referring physician's neighborhood. The first-line practitioner in a client-dependent practice refers those cases he cannot deal with effectively to other practices in the professional referral system. Those other practices have much different structural characteristics than his.

Unlike the first-line practitioner, the consultant who receives referrals from other professionals is not dependent on client choice for his professional survival. He is dependent instead on the referrals of colleagues, thus having a *colleague-dependent practice*. As such, he must be sensitive more to the needs and prejudices of professionals than of laymen, and so may be expected to employ medically approved procedures more than those with which the patient has familiarity and sympathy. However, while the patient may choose his own first-line service in the person of the first-line practitioner, once the physician he chooses confesses his failure or incapacity to cure and refers him deeper into the professional system, the patient is often able to do no more than to choose to accept what is offered him or drop out of the system entirely against the weight of medical advice. When he enters a colleague-dependent practice he has little of the influence available to him in client-dependent practice and must accept the services chosen for him. Only in such a practice does the economist's model of the professional marketplace become realized: there, one must take what another says he needs.

These two types of practice imply two gross variations in the shape of interaction in consultation. In client-dependent practice, the patient is likely to be in the position of an equal, or at least of an active participant in the process of diagnosis and management. Being in a relatively early stage of illness and not yet overcome by pain or fear, he always has before him (as the practitioner well knows) the prospect of leaving the office and, instead of coming back, of looking elsewhere for a consultant who uses more familiar notions of illness and treatment. In a colleague-dependent practice, however, the patient is likely to be in the more desperate position of a person whose own conventional remedies and consultants have failed him, with few options open to him. In the former situation

the process of treatment is far more likely to be a matter of bargaining and compromise than in the latter, where the weight of professional opinion is heavier than that of the layman. By the same token, in the former situation the choice of illness and of its management is likely to be more variable and flexible than in the latter.

The Professional Task in Consultation

I have spoken of "leverage," of "bargaining," and of "controls" in the consulting room, words which seem more compatible with the economic marketplace and the political arena than with professional consultation. This usage, however, is deliberate, for the thrust of this book is to secularize a phenomenon that has been greatly obscured by a tendency to treat it as something mysteriously apart from normal human affairs, with a mystique other affairs lack. I have emphasized the social, and therefore variable, character of the problem at issue, the ambiguity and arbitrariness of, if not the knowledge, then at least the concepts to which the knowledge is attached, and, particularly in this chapter, the extent to which the work involves a problem of social control.

While the word "control" may seem odd in medical settings where the euphemism "management" is more common, it should be clear that the word is accurate. Obviously, the physician's task is the same as that of any other occupation—to do his work in the ways his knowledge leads him to believe is correct. And, as is the same for some other occupations, his work consists in providing a service to other people. The problem is, how is that service defined and who defines it? As a profession, medicine asserts its autonomy in defining what is "appropriate," "effective," or "good" service. As a profession it claims that its mission is to provide such good service to its clientele. It is not as if the professional, like the obliging shopkeeper, can claim his merit in satisfying the customer by giving him exactly what he wants. Rather, the profession asserts what the customer's "real" wants are by virtue of its special knowledge and, as an "ethical" occupation, attempts to provide services appropriate to those wants it defines. But in order to exercise its mandate the profession must on occasion provide its clients with services they may not want. In doing so, it must in some way manipulate or exercise control over the patient. And while in the exercise of such

control the profession may not be motivated by the cynical dishonesty of the legendary salesmen who sell refrigerators to Eskimo, encyclopedias to the illiterate, and oversized suits to undersized men, at least some of the techniques of control the profession uses are likely to be shared with all other occupations that supply services or goods to others. Ethicality is not an issue. It is the demand of work which is critical.

Let us look at consultation more closely. The patient enters consultation with his own tentative definition of what ails him. Put simply, the task of the physician is (1) to determine what is "actually" wrong with the patient, and (2) to get the patient to follow his advice, including the advice that he has nothing "really" wrong with him. These two problematic tasks are usually referred to as the tasks of diagnosis and of treatment. In both cases, what is at issue is performance in a professionally defined manner—that is, the diagnosis of medically approved illnesses on the basis of information considered by medicine to be reliable, and the administration of the properly "scientific" treatment for the illness.⁸

In the case of *diagnosis*, the consultant must obtain information of the sort relevant to medicine rather than to lay cultures. Patently, given the variation in lay culture, the tasks of "taking a history"—collecting information from the patient about past illness and symptoms which may be related to his present complaint—can sometimes be rather difficult. The patient may specify diffuse rather than localized pain, for example, or may express his subjective feelings rather than analyze his symptoms from the point of view of the physician, or may fail to remember anything about the events or experiences leading up to his complaint, or may lack a recollection of whether or not he had any identifiable illnesses, adverse drug reactions, or the like in the past. In the case of *treatment*, the consultant may be confronted with other problems. The patient may disagree with his recommendations, or he may not be accustomed to organizing his life in such a way as to be able to follow instructions about adopting a systematic and self-conscious regimen—even so common a regimen as taking medication regularly, after every

⁸ See Milton Davis, "Variations in Patients' Compliance with Doctors' Advice," *American Journal of Public Health*, LVIII (1968), 274-288.

meal (if he takes three meals a day) or every four hours (if he has a watch). How can the physician cope with such problems?

The Organization of Illness in Ambulatory Care

To accomplish his task of diagnosis and treatment the physician may adopt a variety of tactics. First, by restricting himself to a well-educated clientele, he assures himself that his patients will share most of his scientific orientation and so will follow his recommendations. Second, he may devote himself to the long-term "education" or socialization of his clientele by attempting to teach them about his conception of illness and treatment so that they will share his orientation. Third, where his clientele may not be counted on to follow his recommendations outside the consulting room (whether by lack of capacity or motivation), he may attempt to extend his practice into their homes by making home visits or by sending nurses or other paramedical personnel into patients' homes. Or he may try to adjust his practice to their habits by having longer hours, including evenings and weekends, and by locating his practice close to their homes. Fourth, he may try to bypass the patient wherever he can: instead of struggling with a history, the physician may do a thorough physical examination and then order many laboratory screening tests; instead of lecturing about the necessity for regular administration of medication throughout the day, he may administer slow-releasing injections or pills and ask the patient to return regularly for such administration. Finally, I might mention the tactic of co-opting the kin and other laymen around the patient to serve as agents of the practitioner. The patient's social environment thus becomes a therapeutic enterprise guided by professional conceptions of illness and treatment.

All of these devices leave the patient in his community, and most of them are predicated on an ambulatory pattern of care. The patient merely visits a medical setting periodically and briefly, coming from and returning to his kin, friends, and neighbors. In such a situation the physician cannot exercise precise and extensive control. Because of this, ambulatory care, when it includes an attempt to extend medical practices deep into the lay institutions of the community, has been employed primarily for illnesses which are not considered medically serious and for those which are at

once chronic and stable enough to require comparatively infrequent professional surveillance. In both cases, illness behavior becomes organized primarily by the life of the lay community.

The social behavior surrounding most cases of illness that are managed on an ambulatory basis is not organized in a very definite fashion. Most frequently, as in the case of the common cold and minor "impairments" in our time, a sick role is not adopted at all and the illness merely tempers the performance of normal roles. Less frequently, but commonly nonetheless, the patient goes through the simple and brief "sick role cycle,"⁹ involving consultation, a temporary release from some obligations, and a return to "normal." The sufferer's everyday life and his social identity are only touched by such incidents. There is, in fact, in these instances barely enough change in the sufferer's life to allow one to make useful reference to the notion of sick role.

The behavior of the sick person comes to assume a more definite pattern when he is thought to have a chronic illness requiring long-term and sustained contact with a practitioner. Such an organized pattern of behavior emerges when the behavior which is required of him is fairly complex and scheduled, and when by virtue of his belief in the treatment or by virtue of compulsion he may be relied on to conform to professional demands even when ambulatory. Such persons as the patient committed to his daily psychoanalysis, or the juvenile on probation ordered by the court to report daily for counseling in lieu of institutionalization, develop a new organization in their lives, an organization flowing from the professionally defined demands of their treatment. A woman in the later stages of pregnancy, a patient with brittle or labile diabetes, another with a decompensated heart condition, and many others can be seen to develop a round of life tempered by their own view of their illness and organized by the demands of regular professional observation and treatment of their difficulty. It is important to bear in mind that such a round of life is *not* organized by the disease and the biological incapacity it may produce but by pro-

⁹ Cf. Bernard Goldstein and Paul Dommermuth, "The Sick Role Cycle: An Approach to Medical Sociology," *Sociology and Social Research*, XLVII (1961), 1-12.

fessional conceptions of the disease and of what is needed to treat it: the disease becomes a professionally organized illness.

However, so long as the patient is ambulatory, the organization of his activities around the demands of professional treatment is never complete. He may backslide, miss an appointment, or be late; the doctor may be called away on an emergency when the patient is due; either may go on vacation, so that the regimen is interrupted. It is only by institutionalization, where a staff is always present to carry out a regimen even when the physician is absent, and where the patient is always present to be treated, that medical management and the organization of the illness become wholly predictable. And since institutionalization separates the patient from the everyday activities he carried out in the community, his behavior must become organized solely by the round imposed by the institution and its treatment of him. Such organization is strengthened greatly by the fact that institutionalization limits the effective societal response to illness to the members of the staff alone, who in turn attempt to organize the experience of and the response to the illness by the way they view the illness and by their view of the proper way to manage it. Institutionalization can effectively neutralize the societal reactions of the patient's community associates.

The Institutional Organization of Responses to Illness

Remembering that for the sociologist, medical treatment constitutes one kind of societal reaction to a type of deviance, the essential fact bearing on the organization of illness in institutions is that the staff, unlike the patient himself or his lay associates, is performing a job. For the job to be performed at all requires some administrative routine, and it requires the reduction of individual patients to administrative and treatment classes, all members in each class to be managed by much the same set of routines. If the job is to be performed to the satisfaction of the staff, procedures that minimize interference with their routine and maximize their convenience are required.

Consequently, we find that there are standard administrative courses through which a patient is likely to travel in spite of variation in his condition from others in the same treatment category.

Rosengren and DeVault¹⁰ observed that in one lying-in hospital the staff attempted to maintain a definite spatial and temporal organization of its work irrespective of individual variations in condition. In the traditional movement from admitting office, to preparation room, labor room, delivery room, recovery room, and finally the lying-in room, no step was skipped even when the patient was well past the need of it; instead, she was moved through the step more rapidly than otherwise. By the same token, the staff tolerated the expression of pain by the patient only in the delivery room, where it was considered appropriate to the "illness" and where it could be managed by anesthetic; elsewhere, it was deprecated and ridiculed. And in order to maintain the "routine" tempo of work flow established by the staff, laggard women were helped along (with forceps and other techniques) to get them to deliver on schedule. Another example of the way the staff imposes standardized organization on the course of treatment (and therefore the social course of illness) is to be found in Roth's observations of the way the staff in tuberculosis hospitals has a conception of how long it "should" take to get cured that is imposed on the clinical course of the individual's illness, organizing the progressive steps of managing the illness on the basis of the normative timetable rather than on the results of laboratory tests that may be taken to reflect the biological status of the illness "itself."¹¹ And I cannot fail to mention, finally, that mordant analysis by Roth of the circumstances in which tuberculosis was and was not treated as infectious.¹²

In the process whereby the treatment institution can impose its own organization on the social behavior connected with illness, two prominent characteristics facilitate staff control. First, the patient may be isolated from the lay community and those of his associates who are concerned with his welfare. Contact with the lay world is carefully rationed where possible. While there may be medical reasons for such isolation, it is frequently a matter of administrative

¹⁰ William R. Rosengren and Spencer DeVault, "The Sociology of Time and Space in an Obstetrical Hospital," in Eliot Freidson, ed., *The Hospital in Modern Society* (New York: The Free Press of Glencoe, 1963), pp. 266-292.

¹¹ Julius A. Roth, *Timetables, Structuring the Passage of Time in Hospital Treatment and Other Careers* (Indianapolis: Bobbs-Merrill Co., 1963).

¹² Julius A. Roth, "Ritual and Magic in the Control of Contagion," *American Sociological Review*, XXII (1957), 310-314.

tive convenience, minimizing "bother" for the staff more than protecting the patient from disturbance. The social consequences are to isolate the patient from the sources of social leverage that supported him while in ambulatory consultation and that could sustain his resistance to the therapeutic routine in the institution. Second, and more important, is the tendency of the staff of all such institutions to carefully avoid giving the patient or his lay associates much information about the illness and what is supposed to be done for it. Virtually every study of patients in hospital points out how ignorant of condition, prognosis, and the medically prescribed regimen are both the patients and their relatives and how reluctant is the staff to give such information.¹³ In Davis' words, describing staff behavior toward parents of children stricken with poliomyelitis, the parents' questions were "hedged, evaded, rechannelled, or left unanswered."¹⁴

As Davis noted in his analysis, the staff's reluctance to give information is often explained as a desire to avoid an emotional scene with the parents. Sometimes, as Glaser and Strauss note in the case of the dying patient, the staff withholds information in the belief, based on "clinical experience," that it will protect the patient and his family from shock and excessive grief.¹⁵ Sometimes this reluctance to give information is explained by a genuine uncertainty, so that no really reliable information is available. However, as Davis has noted in detail, "in many illnesses . . . 'uncertainty' is to some extent feigned by the doctor for the purpose of gradually getting the patient ultimately to accept or put up with a state-of-being that initially is intolerable to him."¹⁶ Whatever the reason, however, the net effect of the withholding of information is to minimize the possibility that the patient can exercise much control over the way he is treated. If he does not know that he is supposed to have a yellow

¹³ See the detailed analysis in Duff and Hollingshead, *op. cit.*, Chapter 13.

¹⁴ Fred Davis, *Passage Through Crisis: Polio Victims and Their Families* (Indianapolis: Bobbs-Merrill Co., 1963), p. 64. For other observations on the extent to which patients are kept ignorant, see Ailon Shiloh, "Equalitarian and Hierarchical Patients," *Medical Care*, III (1965), 87-95.

¹⁵ Barney G. Glaser and Anselm L. Strauss, *Awareness of Dying* (Chicago: Aldine Publishing Co., 1965), pp. 29ff.

¹⁶ Davis, *op. cit.*, p. 67, and see Fred Davis, "Uncertainty in Medical Prognosis, Clinical and Functional," *American Journal of Sociology*, LXVI (1960), 41-47.

pill every four hours, he cannot comment on the fact that it is sometimes overlooked and insist on getting it regularly. And if he does not know that his condition normally responds to a given treatment in a week, he cannot insist on a consultation after several weeks have passed without change in condition or treatment.¹⁷

A great deal more can be said about the institutional shaping of illness, particularly in qualification of the point I have been trying to make here. Not all treatment institutions are the same, nor are all patients or treatment staffs. For example, the rehabilitation institution studied by Roth and Eddy¹⁸ had a particularly powerful influence on the course of illness behavior because its patients were largely supported by public funds and lacked effective advocates from the community outside. They rarely, therefore, "got well enough" to leave. This helplessness is somewhat tempered by the fact that in rehabilitation, tuberculosis, and other institutions, many patients have similar illnesses and are in a position to socialize and organize each other. When these conditions exist, the patients are able to develop a common conception of the way their illness should be managed and to generate the influence required to impose some of their own conceptions on the staff.¹⁹ Furthermore, institutions can be dominated by a staff ideology which specifies that the patient participate in his treatment. In fact, there are a number of patterns of interaction that reflect the degree of influence and activity allowed the patient in the course of his treatment and that express the meaning of his illness to himself and to those treating him.

Patterns of Interaction in Treatment

I have already suggested that when in treatment in a client-dependent practice, interaction will be fairly free between doctor and patient, the latter initiating and controlling some part of it.

¹⁷ See James K. Skipper, Jr., "Communication and the Hospitalized Patient," in James K. Skipper, Jr., and Robert C. Leonard, eds., *Social Interaction and Patient Care* (Philadelphia: J. B. Lippincott Co., 1965), pp. 75-77.

¹⁸ See Julius Roth and Elizabeth Eddy, *Rehabilitation for the Unwanted* (New York: Atherton Press, 1967).

¹⁹ For a very useful discussion of the implications of such characteristics, see Stanton Wheeler, "The Structure of Formally Organized Socialization Settings," in O. G. Brim, Jr., and Stanton Wheeler, *Socialization After Childhood* (New York: John Wiley & Sons, 1966), pp. 53-116.

Conversely, when in treatment in a colleague-dependent practice, interaction will likely be lesser in quantity and less free, the physician initiating and controlling the greater part of it. By the time the patient reaches the latter practice, which often involves institutionalization, he has been rendered relatively helpless and dependent, perhaps, as Goffman suggests, already demoralized by a sense of having been stripped of some part of his normal identity.²⁰ In other cases he has been rendered helpless by his failure to find help on his own or by the way his physical illness has incapacitated him.

A second element that seems to be able to predict some part of the quality of the interaction between patient and physician lies in what physicians consider to be the demands of proper treatment for a given illness. This is to say, all that doctors do is not the same and does not require the same type of interaction. Following Szasz and Hollander's typology of doctor-patient relationships²¹ but reversing the direction of analysis, we may note that under some circumstances—as in surgery and electroconvulsive therapy—the patient must be thoroughly immobilized and passive, wholly submissive to the activity of the physician. The work itself requires such minimal interaction: attendants, straps, anesthesia, and other forms of restraint are employed to enforce the requirement of submission. This model for interaction Szasz and Hollander call *activity-passivity*. In it, the patient is a passive object.

The second treatment situation, discussed by most writers as *the* doctor-patient relationship, is one in which the patient's consent to accept advice and to follow it is necessary. Here, the patient "is conscious and has feelings and aspirations of his own. Since he suffers... he seeks help and is ready and willing to 'cooperate.' When he turns to the physician, he places [him]... in a position of power... The more powerful... will speak of guidance or leadership, and will expect cooperation of the other."²² The interaction is

²⁰ See Erving Goffman, "The Moral Career of the Mental Patient," in his *Asylums* (New York: Anchor Books, 1961), pp. 125–161. In the context of the succeeding discussion of interaction, it is also appropriate to cite, in the same book, pp. 321–386, "The Medical Model and Mental Hospitalization."

²¹ See Thomas S. Szasz and Mark H. Hollander, "A Contribution to the Philosophy of Medicine," *A.M.A. Archives of Internal Medicine*, XCVII (1956), 585–592.

²² *Ibid.*, pp. 586–587.

expected to follow the model of *guidance-cooperation*, the physician initiating more of the interaction than the patient. The patient is expected to do what he is told; he assumes a less passive role than if he were anesthetized but a passive role nonetheless, submissive to medical requirements.

Finally, there is the model of *mutual participation*, found where patients are able or are required to take care of themselves—as in the case of the management of some chronic illnesses like diabetes—and therefore where initiation of interaction comes close to being equal between the two. Here, "the physician does not profess to know exactly what is best for the patient. The search for this becomes the essence of the therapeutic interaction."²³ Obviously, some forms of psychotherapy fall here.

Szasz and Hollander's scheme, however, is defective logically and empirically, for their models represent a continuum of the degree to which the *patient* assumes an *active* role in interaction in treatment without being extended to the logical point where the *physician* assumes a *passive* role. Such a defect reflects the characteristically normative stance of the medical thinker: while the existence of situations where the practitioner more or less does what the patient asks him to do may not be denied, such situations are rejected out of hand as intolerably nonprofessional, nontherapeutic, and nondignified to be conceded for mere logic and dignified by the recognition of inclusion.²⁴ Logic and fact do, however, require recognition, and they dictate the suggestion of two other patterns of interaction—one in which the patient guides and the physician cooperates, and one in which the patient is active and the physician passive. It is difficult to imagine an empirical instance of the latter possibility, which requires that the physician cease being a con-

²³ *Ibid.*, p. 589.

²⁴ This lack of concern for being logically consistent and systematic is characteristic of virtually all writing about the doctor-patient relationship by medical men. Another interesting analysis of the doctor-patient relationship explores other facets to be found in nature but restricts itself to the "pathological." See F. W. Hanley and F. Grunberg, "Reflections on the Doctor-Patient Relationship," *Canadian Medical Association Journal*, LXXXVI (1962), 1022–1024, where nine "syndromes" are constructed out of three stereotypical patients and three stereotypical physicians. So long as medical writers persist in crippling their logic by normative considerations, they cannot expect serious intellectual consideration.

sultant, so we may label it "merely" a logical construct. For the former instance, however, we may find empirical examples in a fair number of the interactions in client-dependent practices, particularly where the practice is economically unstable and the clientele of high economic, political, and social status.²⁵

As I have noted, what distinguishes Szasz and Hollander's models from those I have added is the fact that they represent patterns of relations with patients that medical practitioners *wish* to establish and maintain on various occasions for various illnesses and patients. Assuming one type of interaction pattern is necessary for the therapist's work to proceed successfully, what social circumstances are prerequisite to its existence and how are they established? When the *activity-passivity* model does not automatically exist by virtue of coma or the like, some of the physician's behavior must be devoted to soothing the patient in order to get him to submit to the straps, injections, face-masks or whatever. The basic prerequisite, however, is *power* as such—sustained by the *a priori* incapacity of the patient, or by *making* the patient incapacitated. Such power is created by the fact that the individual is, let us say, unconscious and in a coma. In other instances, the exercise of power to overcome resistance when the patient is not in a coma is legitimized by the social identity imputed to the patient: he is just an infant, a cat, a retardate, a psychotic, or in some other way not fully human and responsible and so cannot be allowed to exercise his own choice to withdraw from treatment. Aside from circumstances where the patient's identity legitimizes the exercise of force, this pattern of interaction is most likely to be found where cultures diverge a great deal. There, few patients voluntarily enter medical consultation: their participation may be required by political power or may be facilitated by the incapacitating force of the disease itself.

The second pattern of interaction, *guidance-cooperation*, is essentially the one most people have in mind when they speak of the doctor-patient relationship. Obviously, its existence is contingent on a process that will bring people into interaction with the therapist in the first place, the process of seeking help that leads to the choice of utilizing one service rather than another. Here, the patient must

²⁵ See Freidson, *Patients' Views*, *op. cit.*, pp. 171–191 for historical and contemporary examples of such relationships.

exercise his own choice. Utilization is not merely something that facilitates establishing the relationship; it constitutes one-half of the battle in interaction: to actively choose to utilize a doctor in the first place requires that one in some degree concede his value and authority in advance²⁶ and that one in some degree already shares the doctor's perspective on illness and its treatment. The problem of interaction in treatment lies in the details of this acceptance, in the concrete areas in which lay and professional cultures converge. The doctor's tool for gaining acceptance is his "authority," which is not wholly binding by his incumbency in a formal legal position as expert.²⁷ Here, to the extent that the patient's culture is congruent with that of the professional, the authority of the latter is likely to be conceded in advance and reinforced in treatment by the fact that what the professional diagnoses and prescribes corresponds with what the patient expects and that communication between the two is relatively easy, so that confidence can be established when the professional must make new or unexpected demands on the patient. In this situation, what is problematic most of all is the physician's authority as such: it must be conceded before examination can begin and if treatment is to proceed. It is the *motive* for cooperation. Only secondarily problematic but problematic nonetheless is the capacity of the physician to make his desires for information and cooperation known and the capacity of the patient to understand the physician sufficiently to do as he is told. Essentially, then, faith and confidence on the part of the patient, and authority on the part of the physician, are the critical elements.

Finally, there is the pattern of *mutual participation*. Clearly, the interaction specified by this model requires characteristics on the part of the patient that facilitate communication. Communication is essential in order to determine what is to be done in therapy. Cultural congruence is thus obviously one necessary condition for such free interaction. According to Szasz and Hollander, the relationship "requires a more complex psychological and social organization."

²⁶ See Theodore Caplow, *The Sociology of Work* (Minneapolis: University of Minnesota Press, 1954), p. 114.

²⁷ See Eliot Freidson, *Professional Dominance*, *op. cit.*

zation on the part of both participants. Accordingly, it is rarely appropriate for children, or for those persons who are mentally deficient, very poorly educated, or profoundly immature. On the other hand, the greater the intellectual, educational and general experiential similarity between physician and patient the more appropriate and necessary this model of therapy becomes.²⁸ However, it is not only educational and experiential similarity but also a collaborative *status* that is required. Here the patient is not to merely accept the authority of the doctor; each must accept the other as an equal in the search for a solution to the problem. Deference on the part of either patient or physician is likely to destroy such mutual participation. Thus, status congruence is necessary to the relationship in order that the interaction of each *can* be fairly equal, and the influence of the doctor on the patient will hinge essentially not on physical power or professional authority but on his capacity to *persuade* the patient of the value of his views.²⁹

These characterizations of different patterns of interaction may be used to distinguish (1) the needs of different kinds of medical work, (2) the way different kinds of illness are managed, and (3) the problems of practice that arise when the character of the lay community and particularly the lay referral system varies. (1) Veterinary medicine, pediatrics, and surgery are among those practices obviously prone to require the activity-passivity model, though the families of pets and pediatric patients are prone to interfere more than the model predicts. Internal medicine and general practice are among those prone to require the guidance-cooperation model. And verbal psychotherapy as well as rehabilitation and the treatment of the chronic diseases are all prone to need the mutual-participation model. (2) Stigmatized illnesses that spoil the identities of the sufferers are prone to be managed by the activity-passivity pattern, as are those with severe trauma, coma, and psychosis, and with patients who are extremely variant in culture or capacity: these characteristics prevent the patient *or* the physician from being socially responsive in treatment. In any single community, most "normal"

²⁸ Szasz and Hollander, *op. cit.*, p. 387.

²⁹ In this sense the influence of the expert rather than the authority of the professional is indicated.

—which is to say conditionally legitimate—illnesses are prone to be managed by the guidance-cooperation pattern; in those cases not clearly legitimized by lay culture (and so withholding authority from the physician), the mutual participation pattern is likely to be common and the pattern where the patient guides and the physician cooperates is possible. (3) I might note that the activity-passivity pattern of interaction in treatment is most likely to be found where lay culture diverges greatly from professional culture and where the status of the layman is very low compared to the professional. Where these divergences are lesser, the guidance-cooperation pattern is likely to be found, whereas where both the lay culture and status of the patient are very much like that of the professional, the mutual-participation pattern is likely to be used often.

The Conflict Underlying Interaction

In discussing interaction in treatment, I have adopted here, as elsewhere, a situational approach: I have attempted to discern whether some regularities in situations exist such that, by specifying the situation, we can predict the kinds of people likely to be in it, the kinds of illness, and the kinds and amount of interaction likely to take place. This seems to me to be an eminently useful approach, but we should not lose sight of the fact that it is merely an approach specifying regularities across arrays of individuals—statistical regularities. Furthermore, those regularities are defined as *relative*, not absolute. Nonetheless, it is unwise to assume too much regularity in the interaction in treatment settings. While the patient can be more or less excluded from assuming an active role in interaction, he can rarely be wholly excluded. He can at least, as do low-status and poorly educated patients everywhere, practice evasive techniques and act stupid in order to avoid some of what is expected of him. And while the patient can be involved in mutual participation by virtue of his similarity to the therapist, he is never wholly cooperative. Given the viewpoints of two worlds, lay and professional, in interaction, they can never be wholly synonymous. And they are always, if only latently, in conflict. Indeed, I wish to suggest that the most faithful perspective on interaction in treatment is one reflecting such conflict in standpoint, not on assuming an identity of purpose to be discovered by better education or a

disposition to cooperate sometimes hidden by misunderstanding or by failure to cooperate.³⁰

Hence, interaction in treatment should be seen as a kind of negotiation as well as a kind of conflict. This point is suggested in Balint's psychiatric sense that the patient is using his symptoms to establish a relationship with the physician³¹ but more particularly in the sense of negotiation of separate conditions and of separate perspectives and understandings. The patient is likely to want more information than the doctor is willing to give him—more precise prognoses, for example, and more precise instructions. As Roth's study indicated, just as the doctor struggles to find ways of withholding some kinds of information, so will the patient be struggling to find ways of gaining access to, or inferring such information.³² Similarly, just as the doctor has no alternative but to handle his cases conventionally (which is to say, soundly), so the patient will be struggling to determine whether or not he is the exception to conventional rules. And finally, professional healing being an organized practice, the therapist will be struggling to adjust or fit any single case to the convenience of practice (and other patients), while the patient will be struggling to gain a mode of management more specifically fitted to him as an individual irrespective of the demands of the system as a whole. These conflicts in perspective and interest are built into the interaction and are likely to be present to some degree in every situation. They are at the core of interaction, and they reflect the general structural characteristics of illness and its professional treatment as a function of the relations between two distinct worlds, ordered by professional norms.

The Institutional Organization of Being Ill

Understanding that no social structure organizes human behavior so much as directs it and poses its limits and that the indeterminacy

³⁰ For a more extended analysis of the conflict see Freidson, *Patients' Views*, *op. cit.*, pp. 171–191. And see the discussion in Carl Gersuny, "Coercion Theory and Medical Sociology," *Case Western Reserve Journal of Sociology*, II (1968), 14–20.

³¹ See Michael Balint, *The Doctor, His Patient and the Illness* (New York: International Universities Press, 1957), *passim*.

³² See Roth, *Timetables*, *op. cit.*, and Julius A. Roth, "Information and the Control of Treatment in Tuberculosis Hospitals," in Eliot Freidson, ed., *The Hospital in Modern Society*, *op. cit.*, pp. 293–318.

introduced by the conflict inherent between perspectives and the struggle for control flowing from it inevitably weaken the direct consequences of social structure for behavior and experience, we can nonetheless make useful and valid generalizations about behavior and experience from social structure alone. In the case of illness, it is necessary to remember that social structure exerts influence on illness in two ways. First, lay social structure organizes the initiation of contact between sick person and therapist: the biophysical course of the illness itself, insofar as spontaneous remission is not involved, is directly influenced by the competence of the therapist with whom the sick person is brought into contact. Second, and more importantly for my concern in this book, both lay and professional social structure organize the social state of being sick: whether or not one is "really" ill and can or must adopt a sick role; whether or not one may assume a new special social identity; whether or not one must assume the status of an object to be worked on by others; and whether or not one can ever again assume a normal identity and status in the everyday community. It is this second sense I refer to when I write of the social organization of illness.

The organization of professional institutions shapes both the status of illness and the organization of the process of assuming that status. As I have noted several times, for most people being ill is an isolated experience, limited in time and in social significance. However, in our day more and more illness becomes long-term. The label of deviance-as-illness has been extended into many new areas of social behavior by health professionals without at the same time being accompanied by effective methods of cure that can dissolve the status of illness quickly and permanently. In addition, the virtual elimination of the acute communicable diseases in our society has left many people alive long enough to experience the traditional chronic diseases, which are also not easily curable. Furthermore, these illnesses, being professional creations in the former case, and a traditional part of the professional domain in the latter, come to be organized by the network of professional institutions engaged in seeking them out, labeling, and managing them. Being ill becomes a long-term experience, frequently of some therapeutic ambiguity, and almost always of an increasingly definite social status as it is led through professional agencies. Its shape and content tend to

become a function of the organization of the professional services through which the sufferer passes. Such organization has increasingly come to be extended down into the lay community and, insofar as it is formal organization, comes to impose more and more definite order on the process of being sick.

At an earlier time it may have been that the physician's office and the hospital he uses for acutely ill patients could represent by themselves the essential institutions of healing. At that time, most illness was at best only loosely organized by the scattered entrepreneurial practices of individual physicians. This is no longer true in societies such as ours. As I have pointed out in Chapter 2, there is now an enormous complex of independent, competing, overlapping, and linked institutions devoted to the identification, referral, and management of illness. Their representatives are located throughout the lay community, not only in the person of the first-line physician, but also in such everyday persons as the minister,³³ the school teacher, the personnel manager, and even the policeman.³⁴ Beyond these immediate representatives of the official order stands the variety of diagnostic and treatment agencies to which tentatively labeled cases of illness or impairment are referred. From the school, for example, come referrals to such practitioners as the dentist, ophthalmologist, otolaryngologist, and the orthopedist, and to such institutions as the psychological clinic, the speech clinic, the social agency, and many others.³⁵ The referral is not of the same informal quality as those of lay associates; it is frequently an official referral, of which records are kept and with which compliance is not necessarily voluntary. Furthermore, it is based on professional and institutional criteria of deviance, not necessarily on those of the

³³ See Elaine Cumming and Charles Harrington, "Clergyman as Counselor," *American Journal of Sociology*, LXIX (1963), 234-243. For an indication of the extent to which the clergyman may serve as a referral agent, see Charles Kadushin, "Social Distance Between Client and Professional," *American Journal of Sociology*, LXVII (1962), 517-531.

³⁴ See Elaine Cumming et al., "Policeman as Philosopher, Guide and Friend," *Social Problems*, XII (1965), 276-286, and Egon Bittner, "Police Discretion in Apprehending the Mentally Ill," *Social Problems*, XIV (1967), 278-292.

³⁵ Very little is known about the total system of health, education, and welfare agencies, and, most particularly, about their interrelationships. For a recent (and rare) attempt to characterize it empirically, see Elaine Cumming, *Systems of Social Regulation* (New York: Atherton Press, 1968).

lay community. And it is often independent of the desires of the individual or his lay associates. Such a referral mirrors the fact that the individual's official even if not community identity has been changed from "normal" to "problematic": it is intended to find a more precise label to attach officially to what has been singled out as problematic by the referrers and to prescribe the subsequent course of its official management.

While they may be specialized, initial referrals from official community institutions tend to be to fairly open diagnostic units. They are open in that they function to catch, attract, or receive a variety of tentatively labeled deviants; and they are diagnostic in that they begin to discriminate among them, setting them on different management routes. Here is where the discrimination between the malingerer and the "really" sick occurs; where a troublesome child is set on the road to being delinquent, feeble-minded, emotionally disturbed, brain-damaged, or whatever; where the "hard-of-hearing" become "really" deaf, and the "very nearsighted" become legally blind.³⁶ At such open diagnostic units the clientele is fairly heterogeneous and disorganized, but at the point of official diagnosis it becomes differentiated: some are returned to the community; some are sent to other diagnostic units; and others are kept to be treated or referred deeper into the treatment system connected with the diagnostic unit. In the case of those who are kept, diagnostic label and prescription become solidified and pressure is exerted on the incumbent of the deviant role to accept and cooperate with treatment by behaving "sensibly." If he is left in the community, the treatment agency may work with family, school, employer, and other everyday institutions in order to attempt to carve out a special deviant role in the social space surrounding the individual, a role reflecting the meaning of his illness and the regimen urged on him for his treatment. But if he is institutionalized, he can do no more than play his new deviant role, choosing only to play it badly or well. In concert with those others who have also been sorted into his diagnostic category, whether by all being institutionalized together under the same circumstances or by all seeking each other

³⁶ For an excellent, detailed picture of the role of agencies in defining and organizing the social role of blindness, see Robert A. Scott, *The Making of Blind Men* (New York: Russell Sage Foundation, 1969).

out for mutual support in a community of which they no longer feel themselves to be a normal part, he comes to take on a new identity, systematically playing an officially created deviant role.

From these comments it would follow that the more formal and rigid the social structure through which the person may be led or pushed, the more definite the social organization of his illness. In ambulatory care the social behavior and experience of the sick person can never be wholly or even mostly controlled by professional notions of illness and treatment. In contrast, when the sick person is institutionalized, the experience of being ill becomes far more amenable to organization by staff demands, for the person tends to lose his social and physical mobility, to be isolated from his lay associates, to be cut off from the information he would need in order to assume an active role in the management of his illness, and to be fitted into administrative routines organized to permit the staff to work in ways they consider effective and convenient. In fact, only when he is institutionalized can the sick person be restricted to performing only one role—that of the patient. In the community he almost always performs other roles along with that of the patient. Those other roles are left at the door on admission to a domiciliary institution and, save for visiting hours, the patient role comes to absorb all the person's efforts, day and night, waking and sleeping, in work and in play.

Since it is the institution that creates and organizes that patient role, we can use the structure of the institution itself to represent the way being sick becomes organized, experienced, and expressed by the individual who is in it. As Sudnow put it, "The categories of hospital life, e.g., 'life,' 'illness,' 'patient,' 'dying,' 'death,' or whatever, are to be seen as *constituted by the practices of hospital personnel* as they engage in their daily routinized interactions within an organization milieu."³⁷ By the same token we can use the organization of the whole complex of professional agencies leading up to institutionalization to represent the social organization of the career of becoming a sick person. And so it is that a profession and the institutions it dominates may be seen to collaborate with nature in

³⁷ David Sudnow, *Passing On, The Social Organization of Dying* (Englewood Cliffs, New Jersey: Prentice-Hall, 1967), p. 8.

creating and shaping the character of what its work is designed to manage.

Illness and Knowledge

In this part of my book I made a number of points about the nature of the knowledge and the practice, or the nature of the content of the work, of the profession. I pointed out first that the aim guiding medical work—the alleviation of illness—includes two distinct sets of knowledge. Most obvious is knowledge of the source of the illness and of the likelihood of its alleviation by one set of treatment activities rather than another. This is usually considered to be "the" knowledge of the profession. Less obvious is the knowledge surrounding the identification of illness as a form of social deviance. There, on an evaluative or moral rather than purely neutral, descriptive foundation, the profession picks out some state or characteristic and designates it as the kind of undesirable state which is called illness. I pointed out that the generically sociological task of analyzing illness lies in determining the course of those evaluations, their variety, and their consequences for social life. Addressing myself to that task I indicated that the important consequential meanings connected with contemporary notions of illness are those excusing the individual of any immediate responsibility for becoming ill, those specifying the gravity or seriousness of the illness and, finally, those evaluating the legitimacy of the illness. As those socially diagnostic meanings vary, so do the consequences for the personal life of the individual vary: on the crudest level, he may be punished or indulged in therapy, he may be expected to perform his normal social roles, or instead to adopt a new and special deviant role; more explicitly, he may be expected to take on new obligations while forsaking most normal privileges, or allowed to take on new privileges while forsaking old obligations.

These social meanings delineating how people considered ill are expected to behave are created by lay as well as by professional people, the two frequently differing from each other in the kinds of meaning to be assigned to given symptoms and signs, and therefore in the way each would respond to a deviant. Laymen, for example, are likely to hold an individual responsible for behavior which physicians are likely to consider illness and to manage by

punishment where physicians are more likely to manage by treatment. On the other hand, many laymen are likely to ignore and therefore not respond at all to some things which physicians are likely to consider illness and seek to treat. Clearly, unlike medicine with its interest in biological constants, this kind of sociological analysis provided no fixed criteria for evaluating "illness": as a social meaning, illness and its consequences vary as the social characteristics and knowledge of the evaluator vary. Only by adopting one group's perspective can some stability of "diagnosis" be gained. The perspective of the medical profession is of course authoritative in our time, but since most of what is considered illness is managed on a voluntary basis, understanding the perspective of the layman is crucial to understanding how the profession obtains the laymen on whom it works. The work of such a consulting profession cannot be seen accurately from the professional perspective alone: it must be seen as the product of lay and professional perspectives in interaction.

Having explored in Part II the characteristic "mentality" of the practitioner as it bears on autonomy and the organization of his work, in this part I turned to what seemed to me to be the characteristics of the practitioner's relationship to the content of his work, or his knowledge. I pointed out first that the profession of medicine has, over the past century, come to be increasingly influential in defining deviance as illness, even at the expense of legal and religious definitions. And I indicated that medical definitions of deviance have come to be adopted even where there is no reliable evidence that biophysical variables "cause" the deviance and that medical treatment is any more efficacious than any other kind of management. Medicine's expanding jurisdiction over various forms of deviance was seen to be linked with humanitarian movements outside of medicine as well as with the natural tendency of the profession to itself interpret more and more of the world in the light of its own commitment to the idea of disease. Indeed, medicine was seen to be committed to "discovering" illnesses, and was characterized, with some qualification, as following the decision-rule of seeing and diagnosing illness rather than health. In this sense, by virtue of its occupational perspective, medicine always looks for and sees more illness than the lay world. As I pointed out in some

detail, what the individual practitioner perceives as illness arises out of the special selection of cases which the particular location and organization of his practice presents to his experience. His commitment to his sense of effectiveness in treating the illness he sees is sustained by the uncontrolled role of his own placebo reactions in clinical practice. Such subjective reactions in clinical practice seem to support and sustain the varied opinions and schools to be found in modern medicine, particularly for those "illnesses" for which present scientific knowledge is insufficiently precise and reliable.

As I noted in my discussion of medical knowledge, a critical determinant of much of what the practitioner *can* know lies in the cases he comes into contact with. Since most cases he sees must bring themselves into the purview of the practitioner, it follows that the layman's inclination to label deviance as illness and therefore to seek medical care is a strategic element in producing medical knowledge, at least so long as the profession is not empowered to examine and treat laymen without their consent. The layman's perception of pain, his interpretation of various sensations and signs, and his faith in medical men as appropriate therapists—all of which are culturally variable—as well as the structure of the lay system in which he participates play a critical role in determining whether or not he will enter consultation and, of course, contribute to the clinical experience of the practitioner. But while lay culture and society may be critical for leading the individual into professional treatment, once the patient is in treatment the professional and his institutions seek, naturally enough, to treat him by professional rather than lay meanings.

In essence, the process of treatment and care may be seen as a process which attempts to lead the patient to behave in the ways considered appropriate to the illness which has been diagnosed, a process often called "management" by professionals. Such management is of course based on the professional's conception of the illness and its treatment and constitutes the professional's notion of the proper way of dealing with the patient so as to best apply his knowledge of treatment. It is also a reflection of the administrative requirement of treatment imposed both by the organization of the institution and by the technological demands of treatment. Profes-

sional management generally functions to remove from the patient his identity as an adult, self-determining person, and to press him to serve the moral and social identity implied by the illness which is diagnosed. Within its own institutions, protected by its organized autonomy, the profession has developed knowledge of its own and, by virtue of being a consulting profession, a capacity of its own to shape the behavior and experience of the layman independently of the lay community. In those institutions, the profession does not merely treat a biological state by biochemical or physical techniques: it also organizes the social identity of the layman into being a patient. Thus, in applying its knowledge, the profession cannot avoid making social as well as "purely medical" decisions about the people it deals with.

Illness and the Profession

This conclusion brings my book full circle. I began the book by exploring the circumstances that led to the development of a profession, as well as those that sustain the profession today. I then discussed in some detail how the everyday work of the profession is organized, and some of the ideological and organizational characteristics of the profession which sustain the way by which everyday work is carried on. I turned to the object of the profession's work—illness. Focusing on illness as a social meaning rather than as a biological state, I tried to specify the various social meanings connected with the idea, and the role of the profession in determining which of the various meanings come to be attached to deviance. And finally, I tried to show how the experience of being ill is shaped by lay social life and its relation to professional institutions. In pursuing that problem I was led back to the organization of the profession—its practice and the institutions it dominates. I am led, in fact, to the point of suggesting that when an occupation arises to serve some need or demand on the part of the lay community, and subsequently succeeds in becoming a profession, it gains the autonomy to become at least in part self-sustaining, equipped to turn back and shape, even create that need anew, defining, selecting, and organizing the way it is expressed in social life. This is perhaps the most important consequence for society in granting an

occupation professional status. But how desirable is that consequence? Is it in the public interest for society to allow the profession the autonomy to define both need and problem and to control their management? In Part IV, concluding this book, I shall try to suggest answers to that question.