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CLIENT CONTROL AND MEDICAL PRACTICE¹

ELIOT FREIDSON

ABSTRACT

The interaction among colleague, practitioner, and patient is analyzed as a function of variable location in two sometimes conflicting systems—the lay referral system, which consists in a variable lay culture and a network of personal influence along which the patient travels on his way to the physician, and the professional referral system of medical culture and institutions. Two analytically extreme types of practice are distinguished on the basis of their location in each of these systems. Independent practice is located in the lay referral system and is primarily subject to client controls. Dependent practice is located well within the professional referral system and is primarily subject to colleague controls.

That the medical practitioner is typically a colleague in a structure of institutions and organizations, the patient being an essentially minor contingency, is the picture presented in the general discussions of Carr-Saunders and Wilson,² Parsons,³ Merton,⁴ and Goode,⁵ as well as in studies of medical practice by Hall,⁶ Solomon,⁷ Hyde,⁸ Peterson,⁹ and Coleman, Menzel, and Katz.¹⁰ The

¹ Revision of a paper read at the 1959 meetings of the American Sociological Society, Chicago.

² A. M. Carr-Saunders and P. A. Wilson, *The Professions* (Oxford: Clarendon Press, 1933).

³ Talcott Parsons, "The Professions and Social Structure," in his *Essays in Sociological Theory Pure and Applied* (Glencoe, Ill.: Free Press, 1949), pp. 185-99.

⁴ Robert K. Merton, "Some Preliminaries to a Sociology of Medical Education," in Robert K. Merton, George G. Reader, and Patricia L. Kendall (eds.), *The Student-Physician* (Cambridge, Mass.: Harvard University Press, 1957), pp. 73-79.

⁵ William J. Goode, "Community within a Community: The Professions," *American Sociological Review*, XXII (April, 1957), 194-200.

⁶ Oswald Hall, "The Informal Organization of the Medical Profession," *Canadian Journal of Economics and Political Science*, XII (February, 1946), 30-41; "The Stages of the Medical Career," *American Journal of Sociology*, LIII (March, 1948), 327-36; and "Types of Medical Careers," *ibid.*, LV (November, 1949), 243-53.

⁷ David N. Solomon, "Career Contingencies of Chicago Physicians" (unpublished Ph.D. Dissertation, University of Chicago, 1952).

⁸ David R. Hyde and Payson Wolff, with Anne Gross and Elliott L. Hoffman, "The American Medical Association: Power, Purpose and Politics in Organized Medicine," *Yale Law Journal*, LXIII (May, 1954), 938-1022.

nature of medical practice is seen as determined largely by the practitioner's relation to his colleagues and their institutions and by the profession's relation to the state.

But practice cannot exist without clients, and clients often have ideas about what they want that differ markedly from those supposedly held by the professionals they consult. As anthropologists have so copiously illustrated,¹¹ the client's choice is guided by norms that differ from culture to culture and even within a single complex culture.¹² And, after the client has exercised his choice

⁹ Osler L. Peterson *et al.*, "An Analytical Study of North Carolina General Practice, 1953-1954," *Journal of Medical Education*, XXXI, Part II (December, 1956), 1-165.

¹⁰ Herbert Menzel and Elihu Katz, "Social Relations and Innovation in the Medical Profession: The Epidemiology of a New Drug," *Public Opinion Quarterly*, XIX (Winter, 1955-56), 337-52; James Coleman, Elihu Katz, and Herbert Menzel, "The Diffusion of an Innovation among Physicians," *Sociometry*, XX (December, 1957), 253-70; Herbert Menzel, James Coleman, and Elihu Katz, "Dimensions of Being 'Modern' in Medical Practice," *Journal of Chronic Diseases*, IX (January, 1959), 20-40.

¹¹ E.g., Benjamin D. Paul (ed.), *Health Culture and Community* (New York: Russell Sage Foundation, 1955), and the studies cited in George M. Foster, *Problems in Intercultural Health Programs* ("Social Science Research Council Pamphlets," No. 12 [New York, 1958]).

¹² E.g., Earl L. Koos, *The Health of Regionville* (New York: Columbia University Press, 1954), and the excellent summary and bibliography in Ozzie G. Simmons, *Social Status and Public Health* ("Social Science Research Council Pamphlets," No. 13 [New York, 1958]).

to see a practitioner, normative or cultural differences between patient and physician qualify the relationship considerably.¹³ These characteristics, in the client, obviously are a systematic source of pressure on the practitioner. To understand medical practice, therefore, one must learn the circumstances in which the pressure is initiated and sustained, and this requires regarding the client and the practitioner in a single analytical system in which one explores the sources of strength of each.

To bring the two together, analysis must proceed on a model of society that is more common to anthropological than to sociological studies. Practice seems usefully analyzed not only as a set of practitioners interacting with each other¹⁴ but as a concrete local situation in which two systems touch to form a larger whole in which there are characteristic norms, positions, and movements. To isolate the whole, the model is not that of a society within which there are practitioners and clients,¹⁵ or of a consultation room in which there are a practitioner and a client,¹⁶ but of a system in which representatives of the medical profession practice in consultation rooms located in local communities of prospective clients. In recognizing practitioners as members of a profession, reference may be made to their organization and culture. In recognizing clients as members of a specific local community, reference may be made to their own organization and culture. In joining the two within a community, instances studied by anthropologists in which professional practitioners find it difficult to get clients can find

¹³ E.g., Lyle W. Saunders, *Cultural Differences and Medical Care* (New York: Russell Sage Foundation, 1954).

¹⁴ Hall's stress on the "inner fraternity" implies this even though he has some important things to say about clients (see Hall "Informal Organization," *op. cit.*, pp. 30-31). He is primarily concerned with how a physician obtains a clientele already organized into practices.

¹⁵ Goode (*op. cit.*) exploits this perspective.

¹⁶ Cf. Talcott Parsons, *The Social System* (Glencoe, Ill.: Free Press, 1954), pp. 428-73.

as much of a place in the analysis as instances in which professional practice is so thoroughly accepted by clients as to be almost (but never quite) routine.

It is the purpose of this paper to use such a model to organize analysis of aspects of client experience that may significantly affect medical practice and to outline a descriptive typology of such practice, the analysis being put in a sufficiently general fashion to allow application to other types of professional practice.

Characteristically, the professional practitioner claims that his skills are so esoteric that the client is in no position to evaluate them. From this stems his privilege to be somewhat removed from the market place and to accept the evaluation of his colleagues rather than of his clients.¹⁷ And this claim is one mark of his separation as a member of a professional "community."¹⁸

But, while his own "community" may be without physical locus, he must *practice* in a spatially located community among more or less organized potential clients. Thus, while he is a member of a professional "community," accepting its norms and formally dependent on its institutions, the practitioner is always a kind of stranger in the community of his practice, for his reference group is his colleagues, not his clients.

However, while the physician may share special knowledge, identity, and loyalty with his colleagues rather than with laymen, he is dependent upon laymen for his livelihood. Where he does not have the power to force them to use his services, he depends upon the free choice of prospective patients.¹⁹ But, since these prospective clients

¹⁷ See Everett C. Hughes, "Licence and Mandate," in Everett C. Hughes, *Men and Their Work* (Glencoe, Ill.: Free Press, 1958), pp. 78-87.

¹⁸ Goode, *op. cit.*, *passim*. Goode uses the term "community" in the sense of shared interests and identity. Thus all American physicians belong to the medical "community," just as all American Catholics belong to the Catholic "community." I use the term to mean locality.

¹⁹ It is not predicated here that clients choose particular practitioners—that is, that practice is

are in no position to evaluate his services as would his colleagues, and insofar as they do exercise choice, it follows that they must evaluate him by non-professional criteria and that they will interact with him on the basis of non-professional norms. Hence practice generically consists in interaction between two different, sometimes conflicting, sets of norms.

Consequently, we have two systems, the professional and the lay. In any concrete situation the two touch: the local physician may be seen as the "hinge" between a local lay system and an "outside" professional system. Structurally, the practitioner's support theoretically lies outside the community in which he practices, in the hands of his colleagues, while his prospective clientele are organized by the community itself. Culturally, the professional's referent is by definition "the great tradition" of his supralocal profession, while his prospective clientele's referent is the "little tradition" of the local community or neighborhood.²⁰ The lay tradition of the local community may, in one place or another, absorb varying amounts of the professional tradition, but by the nature of the case, as Saunders and Hewes have so persuasively argued,²¹ lay medical culture seems unlikely ever to become identical with professional medical culture.

characteristically solo, fee-for-service in nature. Choice of physician is made to some degree by clients in the United States but hardly in other countries (cf., on Israel, J. Ben-David, "The Professional Role of the Physician in Bureaucratized Medicine: A Study in Role Conflict," *Human Relations*, XI [1958], 255-74). The choice the client must make everywhere is not which doctor to see but whether to see one at all.

²⁰ The terms and image are those of Robert Redfield. See his *Peasant Society and Culture* (Chicago: University of Chicago Press, 1956), pp. 43-45, and his "A Community within Communities," *The Little Community* (Chicago: University of Chicago Press, 1955), pp. 113-51. In industrial society the "little tradition" seems less stable than in peasant society and more dependent upon the "great tradition" for its content.

²¹ L. Saunders and G. H. Hewes, "Folk Medicine and Medical Practice," *Journal of Medical Education*, XXVIII (September, 1953), 43-46.

How are the physician and his prospective clientele brought together? How is consultation initiated and sustained? Obviously, the prospective client must perceive some need for help and that it is a physician who can help him. And, if solo practice is the rule, he must determine who is a "good" practitioner. These perceptions seem to emerge from a process of interpersonal influence similar to that studied in other areas of life, a process organized by the culture and structure of the community or neighborhood through which "outside" knowledge and evaluation is strained.

In one locality,²² conceiving the need for "outside" help for a physical disorder seems to be initiated by purely personal, tentative self-diagnoses that stress the temporary character of the symptoms and to end by the prescribing of delay to see what happens. If the symptoms persist, simple home remedies such as rest, aspirin, antacids, laxatives, and change of diet will be tried. At the point of trying some remedy, however, the potential patient attracts the attention of his household, if he has not asked for attention already. Diagnosis then is shared, and new remedies may be suggested, or a visit to a physician. If a practitioner is not seen, but the symptoms continue (and in most cases the symptoms do *not* continue), the diagnostic resources of friends, neighbors, relatives, and fellow workers may be explored. This is rarely very deliberate; it takes place in daily intercourse, initiated first by inquiries about health and only afterward about the weather.

²² The following sketch stems from intensive interviews with 71 patients of a metropolitan medical group, in which they were asked to give detailed chronological accounts of the way in which they were led to seek medical care. It is not intended to describe the average experience but is a synthetic construct designed to portray the full length to which the process may go before professional practice is reached. The data suggest that, the longer the process that intervenes between first perception of difficulty and contact with a practitioner, the greater the likelihood that the symptoms are ambiguous and not unbearable: a broken leg has different consequences from a "cold" of excessive duration.

This casual exploring of diagnoses, when it is drawn out and not stopped early by the cessation of symptoms or by resort to a physician, typically takes the form of referrals through a hierarchy of authority. Discussion of symptoms and their remedies is referral as much as prescription—referral to some other layman who himself had and cured the same symptoms, to someone who was once a nurse and therefore knows about such things, to a druggist who once fixed someone up with a wonderful brown tonic, and, of course, to a marvelous doctor who treated the very same thing successfully.

Indeed, the whole process of seeking help involves a network of potential consultants, from the intimate and informal confines of the nuclear family through successively more select, distant, and authoritative laymen, until the "professional" is reached.²³ This network of consultants, which is part of the structure of the local lay community and which imposes form on the seeking of help, might be called the "lay referral structure." Taken together with the cultural understandings involved in the process, we may speak of it as the "lay referral system."

There are as many lay referral systems as there are communities, but it is possible to classify all systems by two critical variables—the degree of congruence between the culture of the clientele and that of the profession and the relative number of lay consultants who are interposed between the first perception of symptoms and the decision to see a professional. Considerations of culture have relevance to the diagnoses and prescriptions that are meaningful to the client

and to the kinds of consultants considered authoritative. Consideration of the extensiveness of the lay referral structure has relevance to the channeling and reinforcement of lay culture and to the flowing-in of "outside" communications.

These variables may be combined so as to yield four types of lay referral system, of which only two need be discussed here—first, a system in which the prospective clients participate primarily in an indigenous lay culture and in which there is a highly extended lay referral structure and, second, a system in which the prospective clients participate in a culture of maximum congruence with that of the profession in which there is a severely truncated referral structure or none at all.

The indigenous, extended system, is an extreme instance in which the clientele of a community may be expected to show a high degree of resistance to using medical services. Insofar as the idea of diagnostic authority is based on assumed hereditary or divine "gift" or intrinsically personal knowledge of one's "own" health, necessary for effective treatment, professional authority is unlikely to be recognized at all. And, insofar as the cultural definitions of illness contradict those of professional culture, the referral process will not often lead to the professional practitioner. In turn, with an extended lay referral structure, lay definitions are supported by a variety of lay consultants, when the sick man looks about for help. Obviously, here the folk practitioner will be used by most, the professional practitioner being called for minor illnesses only, or, in illness considered critical, called only by the socially isolated deviate, and by the sick man desperately snatching at straws.

The opposite extreme of the indigenous extended system is found when the lay culture and the professional culture are much alike and when the lay referral system is truncated or there is none at all. Here, the prospective client is pretty much on his own, guided more or less by cultural understandings and his own experience, with few lay consultants to support or discourage his

²³ For data on the referral process and the network of consultants see E. E. Evans-Pritchard, *Witchcraft, Oracles and Magic Among the Azande* (Oxford: Clarendon Press, 1937); M. R. Yarrow, C. G. Schwartz, H. S. Murphy, and L. C. Deasy, "The Psychological Meaning of Mental Illness in the Family," *Journal of Social Issues*, XI (1955), 12-24; John A. Clausen and M. R. Yarrow, "Paths to the Mental Hospital," *Journal of Social Issues*, XI (1955), 25-32; Erving Goffman, "The Moral Career of the Mental Patient," *Psychiatry*, XXII (May, 1959), 123-42.

search for help. Since his knowledge and understandings are much like the physician's, he may take a great deal of time trying to treat himself, but nonetheless will go directly from self-treatment to a physician.

Of these extreme cases, the former is exemplified by the behavior of primitive people and the latter by the behavior of physicians or nurses when taken ill. (Paradoxically, they are notoriously "unco-operative" patients, given to diagnosing and treating themselves.) Between these two extremes, in the United States at least, members of the lower class participate in lay referral systems resembling the indigenous case, and members of the professional class tending toward the other pole, with the remaining classes, taking their places in the middle ranges of the continuum.²⁴

As Goode has noted, "Client choices are a form of social control. They determine the survival of a profession or a specialty, as well as the career success of particular professionals."²⁵ The concept of lay referral system, thus, provides a basis not only for organizing knowledge about the patient's behavior but also for understanding conditions under which he, a layman, to some extent controls professional practice. Indeed, the lay referral system illuminates the ways in which the client's choice is qualified and channeled and how the physician's sex, race, and ethnic background affect his success—though it is often said that professions rest upon achieved status.²⁶ We can see now why a practitioner may never get any clients, and why, on the other hand, he may get clients but then lose them; for the lay referral system not only channels the client's choice but also sustains it or, later on, leads him to change his mind. Interviews with urban patients reveal that the first visit to a practitioner is often tentative, a tryout. Whether

the physician's prescription will be followed or not, and whether the patient will come back, seems to rest at least partly on his retrospective assessment of the professional consultation. The client may form an opinion by himself, or, as is often the case, he may compare notes with others—indeed, he passes through the referral structure not only on his way to the physician but also on his way back, discussing the doctor's behavior, diagnosis, and prescription with his fellows, with the possible consequence that he may never go back.

One might assume that all but the most thick-skinned practitioner soon become aware of lay evaluations, whether through repeated requests of their patients for vitamins or wonder drugs or through repeated disappearances or protests following the employment of scientifically acceptable prescriptions such as calomel or bleeding. Whether their motive be to heal the patient or to survive, professionally, they will feel pressure to accept or manipulate lay expectations, whether by administering harmless placebos²⁷ or by giving up unpopular drugs.²⁸

In a relatively organized community, channels of influence and authority that exist independently of the profession may guide the patient toward or away from the physician and may more or less control not only the latter's success but, to some extent,

²⁷ The placebo might be used as an index of control by the client of the terms of practice. On rationalizing sleight-of-hand as the placebo see Evans-Pritchard, *op. cit.*, pp. 235-36.

²⁸ "This helplessness of regular physicians, coupled with popular distaste for bleeding and vile medicines, goes far to explain the success enjoyed by large groups of irregular practitioners. . . . A not uncommon shingle advertisement in those early years was: Dr. John Doe; No Calomel" (Thomas Neville Bonner, *Medicine in Chicago, 1850-1950* [Madison, Wis.: American History Research Center, 1957], p. 12). When doctors began to do less dosing in the late eighteenth and early nineteenth centuries, the public went out and bought its own medicine (Richard Harrison Shryock, *The Development of Modern Medicine* [New York: Alfred A. Knopf, 1947], pp. 248 ff.).

²⁴ See the review of studies in Simmons, *op. cit.*

²⁵ *Op. cit.*, p. 198.

²⁶ E.g., Talcott Parsons, "The Professions," *op. cit.*, pp. 189 and 193; note the qualification on p. 197.

also his professional technique and manner;²⁹ in short, the lay referral system is a major contingency of medical practice. Practice in an indigenous extended system must adjust itself to the system in order to exist: when involving patients who are themselves professionals, it may make fewer adjustments.

The above discussion of the lay referral system should be taken to show that, in being *relatively* free, the medical profession should not be mistaken for being *absolutely* free from control by patients. Indeed, we may classify various kinds of professional practice on the basis of relative freedom from client control. But, to do so, we must examine sources of professional freedom that lie not in a complaisant clientele but in the nature of professional organization itself.

Enough has been written about the privileged position that the organized power of the state grants the practitioner. (Indeed, this support by power located outside the community is often crucial to practice in "underdeveloped" countries where the prospective patients do not have a high opinion of modern physicians.) At the same time, political support sets severe limitations on competition,³⁰ both by prosecuting irregular "folk" or "quack" practice and by allowing restriction of the number of professional practitioners, two measures which greatly contribute to the stability and independence of the professional role.

Beyond these measures, however, we must note an additional important source of strength: insofar as there are two "traditions" and two structures in a community, the lay referral system is one, and what we might call the "professional referral system"

is the other. The professional referral system is a structure or network of relationships with colleagues that often extends beyond the local community and tends to converge upon professionally controlled organizations such as hospital and medical schools. Professional prestige and power radiate out from the latter and diminish with distance from them. The authoritative source of professional culture—that is, medical knowledge—also lies in these organizations, partly created by them and partly flowing to them from the outside.

The farther this professional referral system is penetrated, the more free it is of any particular local community of patients. A layman seeking help finds that, the farther within it he goes, the fewer choices can he make and the less can he control what is done to him. Indeed, it is not unknown for the "client" to be a petitioner, asking to be chosen: the organizations and practitioners who stand well within the professional referral system may or may not "take the case," according to their judgment of its interest.

This fundamental symmetry, in which the client chooses his professional services when they are in the lay referral system and in which the physician chooses the patient to whom to give his services when he is in the professional referral system, demonstrates additional circumstances of the seeking of help. When he first feels ill, the patient thinks he is competent to judge whether he is actually ill and what general class of illness it is. On this basis he treats

²⁹ Cf. the devices used in China and in Europe to avoid offending the patient's sense of modesty—Howard Dittrick, "Chinese Medical Dolls," *Bulletin of the History of Medicine*, XXVI (September-October, 1952), 422-29; Julius Friedenwald and Samuel Morrison, "The History of the Enema with Some Notes on Related Procedures," *Bulletin of the History of Medicine*, VIII (January, 1940), 68-114, and *ibid.*, February, 1940, pp. 239-76. On modern practice, articles in *Medical Economics* provide evidence.

³⁰ To cite a dramatic instance of earlier competition: two tenth-century physicians who were competing for the favor of a king ended by poisoning each other at the king's dinner table. The one who knew the antidotes obtained the king's patronage (L. C. MacKinney, "Tenth Century Medicine as Seen in the *Historia* of Richter of Rheims," *Bulletin of the History of Medicine*, II [August, 1934], 367-68). The veracity of this is questioned in P. O. Kristeller, "The School of Salerno," *Bulletin of the History of Medicine*, XVII (February, 1945), 143-44, but as the historian Louis Gottschalk once said, "Se non è vero è ben trovato." For modern times Hall's observations on the "individualistic career" are relevant.

himself. Failure of his initial prescriptions leads him into the lay referral structure, and the failure of other lay prescriptions leads him to the physician. Upon this preliminary career of failures the practical authority of the physician rests, though it must be remembered that the client may still think he knows what is wrong with him.

This movement through the lay referral system is predicated upon the client's conception of what he needs. The practitioner standing at the apex of the lay referral system is the last consultant chosen on the basis of those lay conceptions.³¹ When that chosen practitioner cannot himself handle the problem, it becomes *his* function, not that of the patient or his lay consultants, to refer to another practitioner. At this point the professional referral system is entered. Choice, and therefore positive control, is now taken out of the hands of the client and comes to rest in the hands of the practitioner, and the use of professional services is no longer predicated on the client's lay understandings—indeed, the client may be given services for which he did not ask, whose rationale is beyond him. Obviously, the patient by now is relatively helpless, divorced from his lay supports.

From the point of view of the physician, position in the process of referrals is also of importance. If he is the first practitioner seen in the lay referral structure, and if he sends no cases further on, he is subjected only to the lay evaluation of his patients as they pass back through the hands of their lay consultants after they leave him. If he refers a case to another practitioner, however, his professional behavior becomes subject to the evaluation of the consultant. In turn, when the patient leaves the consultant, he often passes back to the referring practitioner, so in this sense the professional con-

sultant is subjected to the evaluation of the referring physician. Thus the physician who subsists on patients referred by colleagues is almost always subject to evaluation and control by his colleagues, while the practitioner who attracts patients himself and need not refer them to others is subject primarily to evaluation and control at the hands of his patients.

These observations suggest two extreme types of practice, differing in the relation of practice to the lay and to the professional referral systems. At one extreme is a practice that can operate independently of colleagues, its existence predicated on attracting its own lay clientele.³² In order to do so, this "independent practice" must offer services for which those in a lay referral system themselves feel the need. In reality, of course, it will be conditioned both by the existence of competitors and by the particular lay system in which it finds itself, but on the whole, one should expect it to be incapable of succeeding unless conducted in close accord with lay expectations. To survive without colleagues, it must be located within a lay referral system and, as such, is *least* able to resist control by clients, and *most* able to resist control by colleagues.

At the other extreme is postulated a "dependent practice" that does not in and by itself attract its own clientele but, instead, serves the needs of other practices, individual or organizational. The lay clientele with whom the practice must sometimes deal does not choose the service involved: a professional colleague or organization decides that a client needs the services of a professional in a dependent practice and transmits the client to him: the colleague or organization, alone, in many cases are told the results of the consultation. Obviously, by definition, dependent practice could not exist in a lay referral system. To survive without self-selected clients, it must be in a professional referral system where clients are so helpless that they may be merely transmitted. As

³¹ The actual specialty of the practitioner's standing in the lay referral system varies; certainly, the general practitioner is almost always within it. Often pediatricians, gynecologists, internists, and ophthalmologists are to be found within it, particularly in communities of the professional classes; pathologists, anesthesiologists, and radiologists are unlikely ever to be within it.

³² See my paper, "Specialties without Roots: The Utilization of New Services," *Human Organization*, Vol. XVIII (Fall, 1959).

such, dependent practice is *most* able to resist control by clients and *least* able to resist control by colleagues.

The logical extreme of independent practice does not seem fully applicable to any professional practice, if only because a professional practitioner is trained outside the lay community before he enters it to practice and because his license to practice ultimately depends upon his colleagues "outside" and may be revoked. The "quack" seems to fit this logical extreme, for not only does he not require outside certification but, as Hughes defined him, he is one "who continues through time to please his customers but not his colleagues."³³ He, like the folk practitioner, is a consultant relatively high in the structure of lay referrals, with no connection with an outside professional referral system.

Close to this extreme in the United States is the independent neighborhood or village practice (usually general in nature) that Hall calls "individualistic,"³⁴ with, at best, loose co-operative ties to colleagues and to loosely organized points in the professional referral system. All else being equal in this situation of minimal observability by colleagues and maximum dependence on the lay referral system, we should expect to find the least sensitivity to formal professional standards³⁵ and the greatest sensitivity to the local lay standards.³⁶ This differential sensitivity should show up best where the lay referral system is indigenous and extended.

Moving toward the position of dependent practice is what Hall called the "colleague practice," in close connection with a well-organized "inner fraternity" of colleagues and rigidly organized service institutions.³⁷ This practice tends to revolve around specialties, which in itself makes for location outside particular neighborhoods or villages,

³³ Hughes, *op. cit.*, p. 98.

³⁴ See Hall, "Types of Medical Career," *op. cit.*, pp. 249-52, and Solomon, *op. cit.*, chaps. vi and vii on physicians connected with Group II hospitals.

³⁵ This, rather than medical education, might be an important determinant of the findings in Peterson *et al.*; *op. cit.*

and therefore reduces the possibility of organized control by the clients.

Finally, the closest to the extreme of dependent practice is a type that overlaps somewhat with the "colleague practice" but that seems sufficiently significant to consider separately. It might be called "organizational practice." Found in hospitals, clinics, and other professional bureaucracies,³⁸ it involves maximal restriction on the client's choice of individuals or services: clients are referred by other practitioners to the organization, or, if they are seeking help on their own, they exercise choice only in selecting the organization itself, functionaries of which then screen them and refer them to a practitioner. Here, practice is dependent upon organizational auspices and equipment. The client's efforts at control are most likely to take the form of evasion. The events of the referral process being systematically recorded and scrutinized, and ordered by

³⁶ As examples of the effect of clients' prejudices on success and location see Josephine J. Williams, "Patients and Prejudice: Attitudes toward Women Physicians," *American Journal of Sociology*, LI (January, 1946), 283-87; and Stanley Lieberman, "Ethnic Groups and the Practice of Medicine," *American Sociological Review*, XXIII (October, 1958), 542-49. For the effect of the type of legal practice on participation in community affairs see Walter I. Wardwell and Arthur L. Wood, "The Extra-Professional Role of the Lawyer," *American Journal of Sociology*, LXI (January, 1956), 304-7; Arthur Lewis Wood, "Informal Relations in the Practice of Criminal Law," *American Journal of Sociology*, LXII (July, 1956), 48-55.

³⁷ See Hall, "Types of Medical Careers," *op. cit.*, pp. 246-49; see also Solomon, *op. cit.*, chaps. vi and vii, on physicians connected with Group I hospitals. In "colleague practice" it seems that the colleagues' racial or ethnic prejudice determines success, not the clients'.

³⁸ This term is defined in Dennis C. McElrath, "Prepaid Group Medical Practice: A Comparative Analysis of Organizations and Perspectives" (unpublished Ph.D. dissertation, Yale University, 1958); its problems are analyzed in Mary E. W. Goss, "Physicians in Bureaucracy: A Case Study of Professional Pressures on Organizational Roles" (unpublished Ph.D. dissertation, Columbia University, 1959). See also Ben-David, *op. cit.* Unfortunately for our present purposes, none of these studies paid much attention to the role of the client.

hierarchical supervision, the practitioner is highly vulnerable to his colleagues' evaluations: we should expect him to be most sensitive to professional standards and controls and least sensitive to the expectations of his patient.

This paper has stressed two notions—that variation in the culture and organization of patients and in the location of medical practice in the community is decisive in the introducing and sustaining of practice and in the technical and interpersonal modes of procedure in established practice. These closely interrelated notions were derived by conceiving of practice in relation to organized lay communities as well as to organized professional systems and by following the prospective patient through the two referral systems. The outcome emphasized was the relative extent to which control lay in the client's or in the practitioner's hands.

Likewise any analysis in which one must hold much of reality in abeyance, this has produced a certain amount of exaggeration. Where practice is already established, as op-

posed to where it is struggling to establish itself, much of what goes on is routine and conflict between the patient and the physician is rarely open but is masked by evasion and depends upon the practitioner's justified assumption that incompatible clientele will stay away or can be discouraged easily. Within this routine, such breaks and irritations as do exist are, of course, strategic areas to study, but the very routine, with the stable set of selected patients it implies, when compared from place to place, practice to practice, should reveal the compromises necessary to establish and maintain practice in the face of varying lay systems and varying positions in the lay and professional systems. Thus, the abstractly conceived professional role as described by such writers as Parsons may be qualified—indeed, sometimes, compromised—by the cultural and structural conditions in which it must be played.

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