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Teaching the Work of Doctoring: How the Medical Profession Adapts to Change

A dissertation submitted in partial satisfaction of the
requirements for the degree Doctor of Philosophy

in

Sociology (Science Studies)

by

Alexandra Hope Vinson

Committee in charge:

Professor John H. Evans, Chair
Professor Cathy Gere
Professor Tal Golan
Professor Martha Lampland
Professor Charles Thorpe

2015

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Chair

University of California, San Diego

2015

EPIGRAPH

Thought can live only on grounds which we adopt
in the service of a reality to which we submit.

Michael Polanyi

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A version of Chapter 5 is under review for journal publication. The dissertation author is the sole writer and investigator of this paper.

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ABSTRACT OF THE DISSERTATION

Teaching the Work of Doctoring:
How the Medical Profession Adapts to Change

by

Alexandra Hope Vinson

Doctor of Philosophy in Sociology (Science Studies)

University of California, San Diego, 2015

Professor John H. Evans, Chair

This dissertation examines how the medical profession adapts to social change by implementing reform at the medical school. The organization of the medical profession has changed rapidly over the past 60 years from a provider-driven to a buyer-driven system. Moreover, broader cultural shifts in the United States towards individualism and choice and away from traditional institutions of authority have reduced the medical profession's authority and autonomy. While medical sociology has documented how

these changes impact practicing physicians, there has been little work to study how medical students are prepared to be practitioners in this environment. In this dissertation I reorient scholarly understandings of medical education from being nearly completely student-focused to looking instead at the environment the students are embedded in and how it is intentionally designed to produce a certain type of doctor. I argue that understanding what sort of doctor the medical school seeks to produce is key to understanding how the medical profession is adapting in harmony with larger changes in society. Through ethnographic research at a highly ranked medical school in the United States, this dissertation examines the process of *epistemic boundary setting* that is at the heart of learning the practices of doctoring and collegueship central to being a physician. I show that faculty members are far more central to preclinical medical training than previously portrayed. I show how faculty members directly mediate the process of medical students taking on the physician's identity through being taught to execute the practices of doctoring and collegueship. Because the faculty members situate their rationales for practice in the larger context of health care provision and their lived experience of the changes of the past 60 years, medical education serves as a window into contemporary professional practice and a venue in which to explore current physicians' opinions of what future physicians need to know in order to be successful in practice. The findings of this dissertation contribute to scholarship in medical sociology, sociology of medical education, and interdisciplinary studies of science and technology—particularly the study of medical knowledge, epistemic cultures, and the reproduction of medical culture.

CHAPTER 1: INTRODUCTION

New approaches to American medical education have been gaining ground in the past 30 years. These include early clinical experiences, communication skills training, problem-based learning as an alternative to the lecture model, and a move away from learning medicine through the perspectives of traditional academic disciplines to learning medicine by organ system. This is thought to teach medical students a more realistic and holistic version of medicine, and one in which school knowledge is more readily translatable into clinical action. That the curriculum emphasizes early patient contact and communication skills is important to note because one of the major issues in medical education has been how to prepare students to be good practitioners in an age when patients are more like informed clients and medical practice is more like a business. These reforms raise an important question: will changing medical education lead to changes in medical practice?

This question has been raised before. Various national reforms have swept over American medical colleges for over 100 years, notably beginning with Abraham Flexner's report on American and Canadian medical education for the Carnegie Foundation in 1910. Flexner advocated for a medical education that was more scientific, and this led to medical schools either becoming more closely associated with universities, or in the case of many freestanding proprietary medical schools, being shuttered. This emphasis on the scientific basis of medical education and practice carried the profession through the Golden Age of the 1950s, but faltered as the profession was increasingly the target of outside critique that the medical profession had failed to honor its contract with society (Starr 1982). In response, other reforms were implemented in medical school.

This time reforms focused on adding medical humanities and philosophy to basic medical education in order to stave off the development of unprofessional behavior in trainees.

The history of reform in medical education is linked to changes both internal and external to the medical profession. Reform efforts reflect a profession trying to align the education of new professionals with what current practitioners judge to be important concerns. For this reason, we can use medical education as a window into contemporary professional practice. As I show, these reforms in medical education are linked to broader issues like patient agency, corporatization of medical practices, the cost of medical work, and increasing threats to physician autonomy. All of these trends are well documented in studies of the medical profession at large, but are seldom linked to the training activities of the medical school. Studying medical education has benefits beyond studying what actual medical practitioners do because in an educational environment, novice medical students are taught not only *what* to do, but *how* to do it and *why* it should be done that way. Often, explaining how and why gives the professors an occasion to reference medical history, their own training, and their sense of how medical practice has changed over the past few decades. These lived histories of professional change underpin clinical skills teaching in medical education.

Debates over patient agency, corporatization, and professional autonomy (among others) also raise a broader philosophical issue, namely who should be the party to decide what an appropriate medical intervention is? Patient autonomy advocates assert that it is the right of the patient. Physician autonomy, however, is founded on a social contract wherein the physician, drawing on professional expertise, makes the decision that s/he determines is in the patient's best interest. And increasingly over the past 40 years or so,

both government and private insurers have sought to control medical costs by controlling medical work; this idea is at the heart of managed care schemes (Hafferty & Light 1995, Light 1988).

The issue of medical education is also situated in the broader context of changing American culture. The racial/ethnic composition of the United States is changing. Americans' attitudes towards authoritative institutions have grown less favorable since the 1960s (Cockerham 2009). Political polarization has increased while public sphere debate of a number of crucial issues has thinned (Evans 2002). The rise of neoliberalism and individualism have increased the importance of choice, which is consistent with a rise in patient consumerism. Meanwhile, we have experienced rapid developments in medical and general technology. Advances in technology, such as the Internet, have to a great extent democratized both access to existing information and to the means to create and disseminate new information, particularly through blogging and social media. Advances in medical technology have allowed for miraculous rescue of life and wellbeing. However, medical technology also has a tendency to outstrip medical knowledge, leaving physicians casting about for explanations for technological output (Buchbinder & Timmermans 2011).

Ordinary Americans form their opinions about the current state of medical practice from personal experience, the received experiences of family and friends, and from public sphere outlets like news media—both large outlets like the *New York Times*' health pages or from alternative medicine or anti-medicine public figures, such as Jenna McCarthy, actress and anti-vaccination advocate. Looking at both medical skeptics and supporters, one issue is resoundingly clear—the medical profession has problems. And

for the *New York Times*, which has devoted many pages to the issue, the current state of medical training is not helping matters.

So, while an investigation of how medical education responds to changing ecologies of professional constraints is theoretically important for sociologists to undertake (a point I will examine more closely in the following chapter), it is also an issue that captures public attention. Medical students grow up to be doctors, and interacting with physicians is an experience nearly all of us will have at some point in our lives. After all, while the distribution, incidence and treatment of disease varies across demographic groups in the United States, the experience of illness itself is one of our few equalizers.

The fact that consulting a physician is such a broad response to illness lends importance to the investigation of contemporary medical training and healthcare practice. Indeed, as I will show, the two issues are inextricably linked and difficult to pull apart—the necessity of medical training exercises is justified with stories about clinical utility. Moreover, medical training is influenced heavily by what already trained physicians think is necessary for novices to know. This happens at the national level through the actions of the Association of American Medical Colleges and the Liaison Committee on Medical Education, at the medical school level through the actions of curriculum planning teams, and in the classroom as a faculty facilitator or lecturer interprets the formal curriculum through his/her own experience as a clinician.

It is physicians themselves who are considered to be experts on medical education. This comes from a few places: medicine's fraternity structure, the value placed on direct experience (the old adage "see one, do one, teach one"), and the medical

profession's enduring ability to select, train and license its own. Physicians themselves do less to shape public opinion directly, but their innovations and practices—both positive and negative—speak for themselves. Although it is now accepted that it is the medical profession's urge to claim more credit than it is due (see McKinlay & McKinlay 1977 for a discussion of the case of sanitation), no one would dispute the impact of antibiotics, brain surgery, or organ transplantation on human health and wellbeing. Likewise, we are loath to forget ethical breaches of patient consent, from testing surgical technique on enslaved women in the Confederate south (Gamble 1997), to injecting the elderly with cancer cells (Beecher 1966, Rothman 1991), or vaccine testing on minority populations (Cimons 1996 as discussed in Gamble 1997). The centrality of health and illness to human experience and the triumphs and fallibilities of physicians give discussions of medical issues the power of attention in the public sphere.

Studying medical school is therefore important because doctors are socially powerful figures to whom lay people submit themselves when they are most vulnerable--when they are ill. Medical training takes lay people and transforms them into doctors. The particular sort of doctor they become depends both on the external social position of the medical profession, as well as medical culture. These factors intersect to form the curriculum of the medical school, a plastic, shifting metric for training and evaluating doctors that reinterprets traditional elements of medical culture in light of the current conditions of medical practice.

I will show in this dissertation that the medical school is being drawn ever closer to daily professional practice through a series of curricular changes that are now common at MD training programs in the United States. These reforms seek to balance giving

students training that resembles idealized forms of medical practice with making their training resemble the pressures and complexities of actual medical practice. The goal is to help students integrate more easily into the clinical setting, rather than keeping them secluded in the lecture hall. A common way to accomplish these goals is to bring in additional clinical faculty from the local community. These clinical professors operate primarily as facilitators in small group settings and bring with them actual everyday expertise, which they seek to convey to medical students. Small group time is thus an act of translation, evaluation and selective endorsement of the idealized curriculum. This helps students figure out how to *use* their newfound skills in physical exam, history taking, motivational interviewing, and so on in everyday clinical situations. This classroom practice also animates a larger debate amongst the faculty about what makes a student a “good doctor,” the amount of resources that should be devoted to various areas of the curriculum, the value of ‘newfangled’ vs. ‘old fashioned’ pedagogical approaches, and other pedagogical topics. These new curricular additions also change what happens in other parts of medical training, as I show in my discussion of the shifting function of the anatomy lab course. In addition to clinical skills like communication practices and physical exam skills, I also attend to the professional persona of the medical student as colleague, paying particular attention to how students learn the service orientation of the physician.

Methodologically, I show that faculty members are far more central to preclinical medical training than previously portrayed. I show how faculty members directly mediate the process of medical students taking on the physician’s identity through being taught to execute the practices of doctoring and collegueship. I thus show that preclinical medical

education is more than a time to learn esoteric medical knowledge, often presented as the basis of a profession's claim to authority (Abbott 1988). This highlights theoretical issues surrounding the *use* of medical knowledge, in context, to get work done. Most broadly, I show how it is that medical students become doctors—both how they gain knowledge and skills to work with patients and how they become considered proper medical colleagues.

I am certainly not alone in my interest in studying medical students. The contemporary sociologist continues to reach back to the mid-twentieth century to understand the import of medical training. The most famous studies in this area were conducted in the 1950s, and while for many years there was a comprehensive study of medical education published roughly every decade in either the US, UK or Canada, this century has so far seen more circumscribed studies of medical education (e.g. Prentice 2012, Brosnan 2011; Holmes, Jenks & Stonington 2011).

The Student-Physician, published in 1957, is a collection of essays compiled by Merton, Reader & Kendall. Perhaps the most well known essay is Renee Fox's discussion of "training for uncertainty." This volume emphasized how medical students learned the attitudes, values and skills of medical professionals. In this perspective, the medical profession is portrayed as prestigious, socially and epistemically stable, and the path to becoming a doctor seems linear—even when fraught.

Shortly thereafter, Becker, Geer, Hughes and Strauss published *Boys in White* (1961). Unlike *The Student-Physician*, Becker and colleagues portrayed medical education as involving the same types of work management practices as other 'lesser' forms of work—an attempt to show that the division between occupational/trade and

professional work was a matter of distinction, not content. In contrast to the functionalists' neat association between values and action, Becker and colleagues reframed this classic theoretical problem as bound by situational constraint; abstract values exist only in application, and where those values do not guide appropriate or effective action, medical students adopt other values.

This debate over the relationship between values (or knowledge more broadly) and action continues to animate studies of medical education today, although the authors are remembered for the status of their contributions and general theoretical perspectives rather than the specific empirical details of their accounts. This is as good a starting place as any for my own account. In this work I build on these classic studies, particularly their insights about the need to study professions as organized and socially important forms of work. Following Knorr Cetina (1999), I conceptualize professions as having epistemic cultures that motivate their work and knowledge production in specific ways. I discuss the socialization component of this process as “epistemic boundary setting,” how medical students are taught by physicians to work within the epistemic culture as legible subjects and producers of knowledge.

While each study of medical education provides detailed descriptions of what happens during training—often including detailed descriptions of the mental/emotional lives of medical students—my work presents a critique of and a departure from this tradition. Many past studies portray medical education as insular, a protected world where medical students are taught the ways of the tribe. However, medical education today is not insular, but rather has a permeable boundary with the profession. Sociologists no longer have the luxury of treating the preclinical and clinical worlds as

separate—medical educators have been intentionally blending them together over the past few decades. It is time to draw these worlds together in both empirical work and theoretical framing. Incorporating this insight into empirical work allows me to use medical education as a window into contemporary medical practice. My approach follows faculty physicians as they deliberately link medical education and clinical practice during the first two years of medical education, traditionally called the “pre-clinical” years. These clinical faculty are subjects of a world richly documented by medical sociologists and are reengineering an institution equally richly documented by sociologists of medical education. By drawing these fields together I show how medical educators react to the contemporary climate of professional practice by implementing changes at the site of training—the medical school itself.

I am generally motivated by a perspective that places primary importance on what professionals *do* and how they explain their actions. It follows that this dissertation examines how novice professionals are *taught to do* by existing expert members. I give less attention to the inner mental states of my subjects; the social psychological interests me only insofar as it has a bearing on action. Examinations of practice lead to discussions of how people know what to do in a given situation and how they can account for their actions. An empirical situation like an educational program clearly demonstrates how sets of practices (including affective practices) are taught to novices and points toward the cultural conventionality of practice. In medical education, the curriculum (broadly conceived) contains parameters for professional subjectivity and indicates the boundaries of the system of medical knowledge. Once the parameters are established, students learn how to operate within them. That is the process of epistemic boundary setting I seek to

outline in this dissertation. As in other systems of knowledge, the combinations of practices used in everyday action are underdetermined by the formal knowledge taught in lecture courses. In their small group sessions, students learn how to *apply* formal knowledge to get their work done. My focus is on the use of artifacts like white coats and scalpels. I also examine the practices of medical language—how to talk like a doctor—and professional demeanor—how to act like a doctor. Such artifacts and practices are indicators of identity (Tabouret-Keller 1998, Rice 2010) and are employed to do ‘being a doctor’ by the medical students and their teachers. Through the combination of these practices in novel clinical situations, students craft a professional presentation of self and learn to stabilize the definition of the clinical situation.

This focus on practice reflects my stance on theories of culture, as well as my allegiance to Science and Technology Studies, wherein knowledge creation is examined through making, doing, interpreting and other acts of making visible, congealing or materializing knowledge and culture. The examples of clinical practice I present from the first two years of the curriculum may seem pat or juvenile to a physician reader, but hopefully the rationale that accompanies their teaching allows one to see why this is being taught and what it is designed to teach the student about the complicated practices that are clinical reasoning, physician-patient communication, and collegueship.

Chapter Summaries

In Chapter 2 I describe the theoretical background of the study. In Chapter 3 I describe the setting of the study, West Coast Medical School. I discuss how I gained entry there, the settings I observed and how I conducted the analysis.

Chapters 4 and 5 put the faculty members in the classroom with the students for the first time. I present two analyses of the Clinical Practice course, during which students learn professional skills like physician – patient communication, how to conduct a physical exam, ethical decision-making, team communication and other important clinical skills. In contrast to previous studies, which showed medical students adopting a “cloak of competence” (Haas & Shaffir 1977) as a social psychological reaction to their lack of knowledge, I show that professional presentation of self is explicitly taught by the faculty. In Chapter 4, I show how faculty members use the twin approaches of *coaxing* students out of their ambivalence and then *coaching* them through interactions with simulated patients. This overt attention to bedside manner reflects the rise of patient satisfaction and consumerism, which have an increasingly direct effect on patient satisfaction, physician income, and physician performance evaluations.

Chapter 5 examines one of the fundamental aspects of physician identity: authoritativeness in the clinical encounter. I show how faculty members articulate a *constrained collaborative* role for the patient in the medical encounter; this constrained collaboration helps physicians satisfy contemporary cultural expectations of patient-centered medicine, while also meeting the physician’s needs in the encounter. I show that this is possible because physicians are taught to empower patients to do what the physician wants them to do. Medical students are taught overtly about the responsibilities of the doctor and patient in the encounter and these skills are practiced in standardized patient encounters. The set of discursive techniques employed in this practice is called “closing the deal” and is related to the need to speak persuasively with patients to a health care climate in which physicians can expect resistance from patients. In combination with

Chapter 4, Chapter 5 gives an overall picture of changes in physician presentation of professional self in response to changes in patienthood.

An ethnography of medical education would be remiss not to include a chapter about students' experiences in the anatomy lab. Indeed, the cadaver is often considered to be the medical student's "first patient." In 1963, Lief & Fox found evidence that it was in the anatomy laboratory that students began to develop detached concern. This balance between detachment and sensitivity was thought to be functional for doctor-patient relations, since it allowed the physician to be both caring and preserve his/her medical judgment and objectivity. In 1988, Hafferty found that the anatomy lab was a space for students to learn to control their emotions, also with the implication that learning emotional control in the lab would have an effect on students' later interactions with patients. These studies and others portray the dissection experience as emotionally uncomfortable. However, when I entered the lab I found that students' discomfort was fleeting and that they used the space to learn to relate to one another as colleagues instead of learning to relate to the cadaver as a stand-in patient.

This finding is consistent with specific changes in the medical profession and broader American society. First, medical students today grew up in a media culture where it was much more common to witness nudity and gore. Because of this, they may have come to the anatomy lab more desensitized than their colleagues in the 1950s and 1980s. Second, an emotionally distant doctor-patient relationship is no longer considered functional for medical practice, and by extension, a cadaver is no longer a suitable first patient. As I discuss in Chapters 4 and 5, bedside manner is learned with actual patients and with patient actors, relieving the lab of its role in teaching bedside manner through

the analogic relationship of cadaver to the patient. In contrast, I found that the lab is a place where students begin to fashion their own professional identities and learn to interact with colleagues. This happens, I show, through a process of ‘surgical play,’ wherein students harness the artifacts they find in the lab and the coded language of surgery and use them to act out being surgeons as they dissect.

In Chapter 7 I return to the theme of becoming a ‘good’ physician. Whereas Chapters 4 and 5 focused on this process vis-à-vis the patient, Chapter 7 takes up the issue of being a good colleague on the wards. Medicine is a field in which one must display one’s devotion to the patient, even over one’s self. Students are presented with stories of sacrifice during their first two years of training, and the notion that patients come first is a salient tenet of physicianhood. Indeed, this service orientation is often presented as the foundation of a physician’s social contract, and the third and fourth years begin the demonstration of professional allegiance through work devotion (Blair-Loy 2003). However, one change in the profession since *Boys in White* is that doctors are no longer all boys, and even the boys are expected to have an involvement in family life. This change is expected to show up in medical education as an increased awareness of work/life balance as well as the conflict between professional allegiance and maintaining work/life balance. Although it is widely recognized that devotion to work is part of the physician’s identity, studies of professional work have not yet examined how this orientation to work is learned. I show the role faculty and peers have in communicating to rising third year students what attributes make for a good colleague on the wards. Many of these attributes resonate with devotion to work. I then show how students negotiate dedication to work with preservation of their private life once they are on the wards.

In Chapter 8 I conclude by returning to the fundamental concerns of this dissertation and look toward the future of medical education. I also address larger questions about how medical education is embracing or rejecting larger social and professional change as it educates the next generation of American physicians. I also wrap up my discussion of epistemic boundary setting and professional socialization

CHAPTER 2: LITERATURE REVIEW

One of the curious things about the study of medical education for what it can tell us about the medical profession is that it has fallen off the sociological radar. Meanwhile, the study of medical education as a process of gaining expert knowledge and professional presentation of self has persisted, but no distinct theory-building program has emerged from this collection of studies (Brosnan & Turner 2009). As it is, the Becker and colleagues (1961) and Merton and colleagues (1957) studies remain the touchstone works for sociologists of medical education. However, these works are now sorely outdated; over the intervening 60 years the medical profession has been transformed from a provider-driven, professionally coherent enterprise to one of several stakeholders in a buyer-driven medical system (Light 1988).

In this literature review I will articulate the presuppositional starting points that anchor my ethnography. I begin by reviewing the legacy of medical education research and why it fell off the radar of medical sociology. I then discuss a renaissance of interest in medical education, briefly reviewing exemplar research published after 2009. I point out that this new body of research largely does not address the concerns levied by medical sociologists in the 1980s and reiterated in Brosnan and Turner (2009) and Wear (1997), namely that sociologists of medical education should pay more attention to organizational and institutional structures. I then present some research that does take these facets of medical education into account. These studies focus mainly on the status of reforms in medical education. Educational reform has a number of functions within the medical profession, including the rhetorical value of reform, reform as reaffirming professional values, and reform in response to external pressures (Christakis 1995). One

of the lively debates within sociology of medical education has centered on whether the reforms in medical education actually led to any real change in either the educational program or the type of physician these educational programs produce.

This debate matters because it is the place in the literature where the concerns of the sociology of medical education align with those of mainstream medical sociologists—the continued social transformation of American medicine. Brosnan and Turner view medical education as “a crucible in which many of the questions central to sociology come to the foreground, involving as it does the socialization of professional groups, the interaction of institutions such as universities, hospitals, the medical profession and the state, the collaboration of different disciplinary groups, the production of knowledge and the construction of professional values” (2009:2-3). My theoretical contribution is to reunite sociology of medical education with the stream of medical sociology that focuses on the social transformation of American medicine. My substantive contribution is to show how the medical profession adapts to social and professional change by using medical education as a window into clinician subjectivity and the normative professional standards of medical practice that are taught to novices.

In this dissertation I reorient scholarly understandings of medical education from being nearly completely student-focused to looking instead at the environment the students are embedded in and how it is intentionally designed to produce a certain type of doctor. I argue that understanding what sort of doctor the medical school seeks to produce is key to understanding how the medical profession is adapting in harmony with larger changes in society. This is because curriculum reformers are also practicing physicians and many of the teachers in the school (contra Bloom 1988 & Reagan-Smith

1998) are practicing physicians. These physicians develop a curriculum that they think will produce doctors who are equipped to practice in today's clinical environment. Aligning the curriculum with everyday medical practice happens both at the curriculum development level and in implementation, as clinical professors reinterpret the formal curriculum through their own clinical experience, thereby making it realistic and providing students with actionable ways to accomplish the goals of the patient encounter. I show how students learn to participate as physicians vis-à-vis patients and as colleagues vis-à-vis other health professionals in an era of managed care. This is more than just a shift in identification from with patients to with doctors (Conrad 1988). This is about actually learning to do the work of a doctor (Atkinson 1981), a type of work that is contingent on the structure of the medical profession and its place in a dynamic social ecology of other stakeholders. In the process, I also provide a new comprehensive ethnography of medical education, which Brosnan & Turner (2009) point out is much needed.

The Legacy of Medical Education in Sociology

As discussed in the introduction, the Merton and Becker ethnographies remain the touchstone studies in the field. While these studies remain highly regarded, comprehensive investigations of medical education have receded from the sociology research agenda. I address this matter below. Concurrently, over the past few decades, medical education has emerged as a field in its own right. This is a field composed mainly of practitioners, but medical sociologists and anthropologists also cross-publish in these journals. However, some researchers find the products of inquiry in this field irksome because the empirical work mainly consists of replication studies, reflexive

examination of the researcher's own institution, or overly emphasizes cognitive approaches to learning (Light 1988, Brosnan & Turner 2009). These studies are also concerned with assessing and measuring medical student attitudes and beliefs about a fairly limited set of themes, chief among them the "fate of idealism" in medical education and the acquisition of 'unprofessional' behaviors during training.¹ Nevertheless, journals such as *Academic Medicine* and *Medical Education* have been the main venues for in-house studies of medical education and a reliable cross-publishing venue for sociologists and anthropologists of medical education. For, as Brosnan & Turner point out, the most notable recent collection of work on medical education within sociology was published in a special issue of the *Journal of Health and Social Behavior* in 1988, and these papers are still widely cited (including in this dissertation). These are the new classics. A comparable journal issue of *Culture, Medicine and Psychiatry*, published in 2011, will be reviewed below.

Why Sociology of Medical Education disappeared from Medical Sociology's Research Agenda

There are several reasons that explain why medical education receded as a priority within medical sociology. In brief: as sociologists followed the major structural changes in the organization of the medical profession as they unfolded over the past 60 years, this research agenda did not include an analysis of corresponding changes in medical education. Such a stream of analysis would have been helpful in charting the mechanisms of adaptation or resistance within the medical profession as reactions to changes in the

¹ There is also a number of accounts of medical education written by physicians themselves that focus on similar themes (Conrad 1988).

social organization of medicine. Additionally, the sociology of the professions was a primary subdiscipline that supported study of the medical profession (the medical profession was considered to be the best example of the professions and best suited for study). As Gorman and Sandefur (2011) note, this field dissolved during the latter half of the 20th century.

A Lack of Comprehensive Studies of Medical Education

The Merton and Becker studies have remained remarkably salient in the half century since they were produced. One feature of the literature that explains the continued salience of the Merton and Becker ethnographies is that there have been relatively few comprehensive studies of medical education over the years (Cockerham 2009 p.233). Cockerham suggests that this is due in part to Freidson's conclusions that the work environment is a "stronger determinant of physician attitudes" than the experience of socialization in undergraduate medical education (2009:233). The ethnographies that have been conducted have been topical or of limited breadth (such as Bosk [1979] on how surgical residents learn to handle mistakes). Also, ethnographies have tended to be based on case studies and conducted too far apart to "advance a clearly identifiable and coherent sociology of medical education" (Brosnan & Turner 2009:3).

The endurance of these studies is intriguing, given the lack of critical perspective in both Merton et al. (1957) and Becker et al. (1961). Cockerham (2009) points out that their projects were dissimilar to present day medical sociology for several reasons. First, the researchers were beholden to the Cornell University and University of Kansas medical schools (respectively) for access to their research subjects. Second, the studies were conducted during the Golden Age of Medicine and many of the social relations and

structures we identify as problematic today were not considered by as many (or as powerful) voices to be a problem in the 1950s, when this research was conducted. It is with the hindsight of the Civil Rights movement, the Women's movement, the Vietnam War, and other large-scale social changes that the critical perspective on the medical profession coalesced. Third, Merton et al. (1957) and Becker et al. (1961) were attending to broader theoretical questions about the nature of professional work, which was a growing sector at mid-century and has continued expanding into the present day. Becker and colleagues were interested in the classic problem of relating values to action, a critique of functionalist approaches that assume that a value system is learned during socialization and is a stable predictor of future professional action. So, while Becker and Merton were concerned with professions and work, the features of professions that earn medical work continued sociological interest were not scholarly concerns at the time. A notable exception is Renee Fox's work on 'training for uncertainty' in Merton et al., and probably explains why her work continues to be engaged with substantively, and not merely recognized as an important precursor of work in the field.

Following the Action to the Structural Level

A second reason why medical education faded from the concern of medical sociologists was the increasing emphasis on the structural aspects of the medical profession. This is a distinct shift from Merton and Becker, who despite their differences, studied how individual medical students took up the physician's mantle.

On a structural level, the medical profession strategically gained control over medical work in the 19th and early 20th centuries, a process that included regulating through educational and licensure standards who could practice medicine (Starr 1982). In

the early 20th century, educational standards became formalized and unified through the Flexner Report (1910). Physicians also fought via the American Medical Association to control the implementation of policies that might harm the status physicians had accumulated. Examples include opposing health care reforms at several occasions (Quadagno 2004). Control is a central theme in studies of the medical profession and it is intimately linked to other issues like power and knowledge. Control is often talked about in terms of medical power, professional dominance, professional sovereignty, professional autonomy, and professional authority. Because the profession keeps changing there is a persistent warrant to continually re-examine the medical field, especially how trainees are taught to function as professionals in the contemporary practice climate.

Over the course of the 20th century, the medical profession's control began to weaken.² The profession lost crucial policy battles and was accused of violating its social contract through opportunism and profit orientation following the influx of funding guaranteed by the passage of Medicare/Medicaid legislation in 1965. The profession was also subject to the effects of broader changes in American culture, such as the rise of individualism, the increasing importance of choice as part of neoliberal ideology, and citizens' loss of trust in institutions of authority following the social upheaval of the 1960s and 1970s (Cockerham 2009). These cultural changes further weakened the medical profession's control over medical practice.

² Quadagno (2004) finds that this is due to diverging goals with the private insurance industry and calls into question the independent power of the medical profession, even during the Golden Age.

The era of managed care was formally ushered in by the Clinton administration, but was prefigured by Nixon's 1969 declaration of a "crisis in healthcare" (Ehrenreich & Ehrenreich 1970), and by the increasing emphasis on outcomes measures and cost control during the Reagan presidency. Managed care is a system of cost control measures that attempt to keep patient and employer/buyer cost low and to reduce costs for insurance companies. The specific mechanisms by which this is accomplished include payment by capitation fee (a physician receives a certain amount per month per patient, and the patient is enrolled for the physician's services) and the presence of a case manager, who is the representative of the third party payer. The case manager approves treatments and procedures prior to their provision and also pre-approves hospital stays. Physicians may be further limited in their spending ability by having to choose medications from formularies, and by periodic performance audits that examine their prescription and treatment practices. In short, managed care seeks to control medical cost by controlling medical work (Cockerham 2009, Hafferty & Light 1995), a radical departure from the provider-driven system physicians had spent the previous century crafting.

Medical sociology became more critical as the medical profession's stature began to crumble at the end of the Golden Age. Since the 1970s, the main theoretical advance of the field has been in the development of the concept of countervailing powers (Light 1991, Hartley 2002). The theory of countervailing powers accounts for the rise of other powerful stakeholders (Quadagno 2004) in healthcare and how they put pressure on the medical profession. This theory focuses on the relations between stakeholders and presents these relations as dynamic (Timmermans & Oh 2010). This is not a theory of managed care *per se*, but it emerged as sociologists shifted their attention to the

consequences of the structural reorganization of medical work and its implications for individual practitioners.

In sum, over the past 60 years there has been a general shift within medical sociology from examining the interactional level in studies of professional socialization to examining the structural level of medical practice. The impetus for this shift was the social transformation of the medical profession (Cockerham 2009). This era of Managed Care continues on today, and will not likely be displaced by the introduction of the Patient Protection and Affordable Care Act (PPACA) of 2010, since the PPACA preserves the HMO structure that does the work of managed care.

The Fragmentation of Sociology of Professions

The third reason why studies of medical education have become less prominent in the discipline is that the sociology of the professions, the arena in which studies of medical education circulated at midcentury, has slowly dissolved as a formal field (Gorman & Sandefur 2011). As Gorman and Sandefur describe, the sociology of professions at mid-century was primarily occupied with delineating the features of professions and using taxonomies to classify occupations as professions, professionalizing, or not professions. The sociology of professions was revolutionized with the introduction of Abbott's (1988) social ecology approach, which emphasized jurisdictional conflict and control of everyday work tasks (generally talked about in the medical field as "scope of practice"). He examined the relationships between professions over time by charting shifts in jurisdictional boundaries. His approach was distinguished from customary sociology of professions because it was explicitly comparative, whereas

the majority of other studies favored (and continue to favor) case studies. Although Gorman and Sandefur argue that the sociology of professions has since dissolved as an organized enterprise,³ the study of professions lives on. The authors trace work in the spirit of sociology of professions throughout several fields and organize scholarly work in terms of its attention to each of four categories of the concerns of studies of professions: expert knowledge, technical autonomy, normative orientation to the service of others, and high social status, income and other rewards (2011:278-9). As I discuss below, while work on the medical profession and medical education has continued in a fragmented way, the study of medical education for what it can tell us about the medical profession faded away with organized sociology of professions.

A Renaissance of Sociology of Medical Education?

In a 1988 special issue of the *Journal of Health and Social Behavior*, Donald Light recommended that future directions for the sociology of medical education should move from their dominant focus on the social psychological aspects of professional socialization to a focus on organizational structures of medical education. This is consonant with the move within medical sociology to focus on the structural aspects of medical practice more broadly. Instead, the sociology of medical education became somewhat dormant,⁴ but has recently reemerged.

³ Gorman and Sandefur present this as an overall positive development, as studies of professions have since been able to move beyond discussions of which occupations could be considered professions and what the stages of professionalization were.

⁴ An exception is Hafferty's work (with Franks and others) on the hidden curriculum concept, but much of this work was published in medical education, not 'regular' sociology journals. Hafferty's work is about ideology in professional education, not the type of organizational structures Light (1988) encouraged sociologists to examine.

The *Handbook of the Sociology of Medical Education* (Brosnan & Turner 2009) was helpful in drawing together many of the threads of conversation in the literature and for articulating a platform for future work. As of now, that work is still waiting to be picked up, but there have been a handful of other studies that have attended to medical education. It seems there might be a coming renaissance of sociology of medical education, as the recent papers below indicate. In this section I primarily review papers that have been published since the *Handbook* came out in 2009. This gives a snapshot of current work on medical education in sociology, anthropology and STS-related disciplines.

A dominant thread that runs through these writings is a focus on practices, which is consonant with a larger turn towards practice in sociology and STS (Schatzki, Knorr-Cetina & von Savigny 2001). One group of studies draws on Bourdieu to emphasize the cultivation of the medical habitus, with a focus on affect and embodiment, while the other focuses on the development of medical subjectivity and worldview, often from a Foucaultian perspective.

The habitus is a set of bodily dispositions that is acquired and cultivated during enculturation. Bourdieu (1984) focused on the expression of the habitus amongst members of different classes, but this insight has also been applied to medical training. Indeed, Sinclair's (1997) comprehensive ethnography gives an overview of the different dispositions that make up the medical habitus and their acquisition during medical education. Drawing on Sinclair's work, Rice (2010) examined the role of the stethoscope in physician identity, linking the use of the stethoscope in a clinical encounter to the medical habitus. This is both because it allows the physician to listen (auscultate), a

skilled practice, but also because the physicians Rice observed feared this form of physician competence would become obsolete with the development of new technologies. Another important and classic theme in sociology of medical education is learning the physician's affect. While many studies have taken up this theme (Lief & Fox 1963, Hafferty 1988, Smith & Kleinman 1989), they did not explicitly relate affect to the medical habitus. Recently, Underman (2015) studied the development of affective aspects of the medical habitus, as learned through simulated patient encounters with gynecological teaching associates. Importantly, studies of affect and embodiment remind us that knowledge is not all in our heads.

A special issue of the journal *Culture, Medicine & Psychiatry*, "Anthropologies of Clinical Training in the 21st Century," featured several articles about the process by which students acquire the practices and worldview of the medical profession, a process most of the theorists call subjectivation. Among these papers were guest commentaries about the importance of studying the process of acquiring a physician's subjectivity (DeIVecchio Good 2011), the history of medical education studies within medical anthropology (Holmes, Jenks & Stonington 2011), and fashioning an orientation towards patients and others as being a "culturally competent" physician (Shaw & Armin 2011:106). These papers move from a framework of professional socialization, which involves "instilling [in the student] the norms, values and behaviors that are accepted by the profession" (Holmes, Jenks & Stonington 2011), to an emphasis on subjectivation—both the external medical gaze discussed by Foucault (1994) and the process of self-fashioning, referred to as the "inward gaze" (2011:108). In a similar vein, Jaye, Egan & Parker (2006) show how medical school curricula function as normalizing technologies

of self that help students develop physician subjectivity. Jaye, Egan & Smith-Han (2010) show how medical students learn to fit in on the surgical ward by participating in communities of clinical practice, which contain normative standards for carrying out medical work.

Medical knowledge underpins and anchors professional subjectivity. Much has been written about how medical students learn to deal with ambiguities in medical knowledge (Fox 1957, Light 1979, Atkinson 1984, Katz 1984). There has also been research about the effects of formal, informal and hidden curricula in medical education (Hafferty & Franks 1994). Generally this research has more to say about how medical students sense contradictions in institutional priorities and what this might tell us about the development of unprofessional behavior. However, the hidden curriculum concept can also tell us about the nature of medical knowledge. Murphy (2014) examined sex education in medical school and found that there was a hidden curriculum of heteronormativity in medical education. She argued that understanding teaching about sexuality in medical education was important because whatever students learn or do not learn shapes their existing notions of sexuality and becomes the understanding of sexuality they carry with them as they do their medical work. Murphy relates this to a broader process by which heterosexuality is rendered normal and obvious and non-heterosexual identities are construed as less intelligible, less obvious, and even invisible—thereby reproducing sexual stigma as part of medical knowledge.

The bodily dispositions of the habitus and the subjective experience of practicing medicine as a professional are united in the work of Prentice (2007), who showed that the technical lessons students learn from surgeons in the operating room are embodied and

carry with them corresponding social lessons about responsibility and clinical judgment. In so doing, she draws together disparate traditions that emphasize ‘doing medicine’ and ‘being a physician.’

These studies of medical education and professional subjectivity, habitus and affect further our knowledge of what it means to be a professional. However, many of the studies do not relate their findings to the broader conditions of the medical profession in the authors’ countries. Thus, the studies do not respond to Light’s critique that sociology of medical education should look at organizational and institutional structure more closely. Brosnan (2009) notes that, in addition to few analyses of structural features of medical schools, there has also been little emphasis on faculty members’ perspectives on medical education. This dissertation is only the latest attempt to bring this area to greater prominence in medical sociology. Other scholars, discussed below, have attended to these and similar issues. Focusing on organizational and institutional structure through the actions of curricula and faculty can set us up to link developments in medical education with developments in the social organization of the profession, and by extension, changes in American society. This is because medical schools are inhabited by practicing physicians and because medical schools continually reevaluate their programs in light of professional needs.

Past the Renaissance: Increasing Attention to Organizational & Institutional Structure through Curriculum & Faculty

Jenkins (2015) and Szymczak and Bosk (2012) study how organizational constraints affect resident physicians. This is a departure from earlier studies of residents that focused on their moral development (Bosk 1979), how they distance themselves

from patients as a stress response (Mizrahi 1984) or sideline learning humanistic skills in a hospital sub-culture that emphasized coping with stress by developing a “get rid of patients” mentality (Mizrahi 1985). In her study of patient autonomy and end-of-life care, Jenkins (2015) found that residents face different constraints than senior physicians and that conflicts between institutional, professional and moral constraints can lead residents to overlook patients’ preferences in end-of-life decision-making. Szymczak & Bosk (2012) studied how residents used their time and the relationship this had to the development of their professional identity. They found that efficiency was a norm in medical practice (efficiency gained importance in the 1980s and 1990s), but that it was also a strategy residents used to manage their overwhelming workload and accomplish their labor in today’s complex health care system.

Kellogg (2011a, 2011b) also focuses on residents, but she turns her eye not to the stable institutional constraints that affect medical practice, but towards efforts to change these organizational constraints. Her specific case is work hour reform in surgical residency programs, a movement that was catalyzed by medical error—an exhausted resident slept through his pager, which led to the death of a young patient. Kellogg develops the concept of political toolkits (2011a) that accomplish the actions implied in cultural toolkits (Swidler 1986). Political toolkits contain tools like “accountability systems, staffing systems, and evaluation systems that depend on the formal authority of more powerful organization members for their introduction into particular organizations” (2011a:483). Kellogg’s work dovetails with Becker’s (1995) work on institutional inertia and provides an account of the conditions under which members of organizations are able to effect organizational change.

These studies examine the education and socialization of residents and provide much needed “conceptual updating” (Szymczak & Bosk 2012) that allows us to link the subjective experience of the trainee to the constraints of the organization s/he is embedded in. However, residents have already completed their initial medical training and are engaged in full-time practice. We also need to know what students in their first years of medical education are learning about healthcare and their professional role as a physician. This is where the initial parameters of students’ professional subjectivity are set—at the time when they are most aspirational and least experienced. Students learn about healthcare and the priorities of the medical profession from the curriculum (broadly), from their faculty members, and from pedagogical tools they are trained with. These overt teachings tell us what practicing physicians think about how they do doctoring and collegueship and what constraints they face today.

Brosnan (2011) focuses on scientific knowledge as a form of distinction between medical schools and between individual students. In a comparative study of two medical schools in the United Kingdom, Brosnan investigates the place of science in the curriculum. She examined how the place of science is shifted by efforts to produce more humanistic physicians by incorporating early clinical experience and problem-based learning into medical training and what is at stake in discussions about science in the curriculum. Likewise, Anderson’s (2008) discussion of teaching race at medical school details the resistance he encountered in leading a discussion of the social construction of race with medical students. This is an example of a common move in curriculum reform—to incorporate social and behavioral science material into the medical school curriculum. Anderson’s account of leading small discussion groups and interacting with

his colleagues from anthropology and history and the course faculty in the medical school exposes the difficulty of changing institutionalized ways of thinking, even when the organizational structure of the medical school was ostensibly open to incorporating teachers with different intellectual perspectives. This goes beyond Brosnan's analysis of the capital that comes from having a 'scientific' curriculum and points to the actual belief in scientific knowledge that makes having scientific capital matter in the first place.

Harter & Kirby (2004) show how interactions with standardized and virtual patients train students to act in accordance with the ideology of medical culture. They find that because practicing physicians write the standardized and virtual patient scripts, the cases require medical students to carry out a version of medical practice that has been influenced by the organizational constraints of managed care. For example, students learn to value efficiency because their interactions with standardized patients are timed, and they learn to balance efficiency with a competing priority—the need to value patients as people. Last, they learn aspects of biomedical ideology, such as rationally treating symptoms and valuing certainty over uncertainty.

Light (1988) pegs previous analyses as focusing too heavily on the social psychological aspects of medical training. In digging deeper he seems to be referring to analyses of individual development and micro-interactions in general, not merely social psychological analyses. The studies reviewed in the previous section demonstrate that sociology of medical education has moved on from its social psychological beginnings (Lief & Fox 1963, Haas & Shaffir 1977, 1982a, 1982b are exemplars) to emphasize embodiment, affect and subjectivation. Nevertheless, Light points in an important direction—towards organizational and institutional structures—especially as we seek to

understand how medical education changes in response to changes in the medical profession and what this tells us about how doctors are prepared to practice medicine in the current professional and American cultural climates.

The Structure of the Medical School: Reform without Change?

Some of the studies reviewed in the previous section (Kellogg 2011b, Anderson 2008) examined curriculum reforms in contemporary medical training, and point towards the organizational structures and cultures that support or hinder organizational actors who would seek to adapt medical education to the current climate of medical practice.

Reform has received a lot of attention in sociology of medical education and sociologists' publishing activities in medical education journals. Although medical practice has changed rapidly since World War II, Bloom (1988) described a situation in which medical education remained static—it did not change along with the medical profession. Yet, Bloom presented a number of calls for reform from within the medical education community.⁵ Based on the fact that these reforms did not result in substantive changes to medical education, Bloom coined the term “reform without change” and catalyzed a small research stream examining competing institutional priorities in the medical school. Bloom concluded that the main institutional concern of the medical school was research, and that the resistance to change was more than mere structural inertia, which he portrays as a passive carrying forward of existing institutional logics. He argued:

⁵ It is worth noting that Bloom seemed cautiously optimistic about Problem-based Learning as an emerging pedagogical tool in medical education. He wrote, “Yet some people believe strongly that problem-based learning brings us to the brink of a genuine revolution in medical education, similar in significance to that which occurred at the turn of the twentieth century” (1988:302).

Therefore the medical school strives to maintain the integrity of its basic educational (or socialization) function, even as, in the background, the territorial struggles among its separate [research and specialty practice] domains uses up most of the energies of its faculty and staff. This type of schizophrenic institutional character requires powerful defenses; the most popular is curriculum reform. By revising and “experimenting” with the curriculum, with all the scientific paraphernalia of experimental method and evaluation, the institution presents the semblance of rational change even while other forces actually dominate the directions of institutional process. (1988:301)

In a related editorial, Bloom again points to the “teaching and learning environment” (1995:907), a way of talking about the deep structures (Hafferty & Franks 1994, Apple & King 1977) of medical education, including institutional priorities and cultural norms. Ten years after Bloom’s initial paper, Reagan-Smith (1998) published an updated account of curriculum reform in medical education. Like Bloom, Reagan-Smith also finds that teaching is secondary to research in the medical school, which she relates to high demands for medical technology developed from the scientific research that is carried out in academic medical centers. A decade later Renee Fox wrote, “At the present historical juncture, nothing less than a deep transformation of the ethos, the social system, and the organization of the medical school is needed” to prepare medical students to meet the “impending challenges of 21st century medicine” (1999:1074). In writing this, Fox explicitly links what is happening in medical education to the conditions of the medical profession and its situation in the broader American social context.

The consensus of these papers is that reform has a primarily rhetorical value and that it perhaps brings about cosmetic change to the curriculum, but that the deep structures of medical education remain unchanged because of competing financial pressures for faculty to do research or clinical work, leaving teaching a low priority

activity. The reform without change literature asserts that it is the institutional pressure to do research and clinical care that makes reforming teaching (or even putting institutional resources toward teaching) not a possibility. Institutional inertia will tend to prevail, because the costs of innovation are too high and the existing structures function just fine (Becker 1995). But in cases where the structures themselves come under threat, institutional change becomes justifiable, even if it is still unwelcome. This can tip the balance from reform as rhetorical move to actual transformation of organizational structures. So, although the reform without change lit describes a real phenomenon, the notion itself has become a bit of a truism. It is important to remember that not all reform efforts should be dismissed as simply rhetorical or containing no real potential for change; sometimes reform efforts do address organizational structures.

Counterargument: Reform as Response to Change in the Medical Profession

It is undoubtedly true that calls for curriculum reform have symbolic purposes (Christakis 1995). However, to dismiss reform out of hand overlooks a long history of reform in medical education, beginning with Flexner's 1910 report to the Carnegie Foundation. Beginning with the Flexner Report and continuing through contemporary efforts to put into place work hour restrictions for surgical residents (Kellogg 2011b), medical training is one arena where the medical profession implements reform to adapt to social change. These calls for change in education are calls to meet the needs of a changing profession—as well as calls to remember tradition in the face of change. Therefore, reform efforts in medical education allow us to see changes in the profession and society as through a window.

For Cockerham (2009), managed care is the ultimate explanatory factor for the changes in medical education over the second half of the 20th century. He links changes in medical schools to the reduced profit margins resulting from managed care. To do this, he draws primarily on the work of medical historian Kenneth Ludmerer. Ludmerer pinpointed certain medical education trends like “more emphasis on cost-cutting decision-making, preventive care, appropriate use of diagnostic tests and effective communication with patients” as resulting from the implementation of managed care schemes within the profession (1999:348 as cited in Cockerham 2009:237).

Cockerham and I have similar perspectives and our arguments overlap. However, this dissertation will refine and move beyond Cockerham’s observations by providing primary ethnographic evidence of how one medical school intentionally changed its medical education program to keep up with changing standards of practice and with its peer institutions (other similarly ranked medical schools). Our first area of overlap is that we both note a general disconnect between medical sociology and sociology of medical education. Cockerham explains this by referring to Freidson (1970) on the primacy of the workplace for shaping professional values and practices. My critique is more detailed: the sociology of medical education portrays medical schools as insular, and does not portray education as related meaningfully to the wider profession. Cockerham historicizes the early part of this process—not only did Becker et al. and Merton et al. have research-related disincentives from adopting a critical perspective, education was not their main research concern. In addition, they studied the profession during the Golden Age of Medicine when critiquing physicians was not on sociologists’ radar because physicians had yet to experience the challenges to their professional dominance that came in the

1960s and 1970s. I provide the latter half of this historical process, which is to note that medical educators have embraced external critiques and have been steadily adapting medical education since the late 1970s.⁶

Like Cockerham, I see the direction of change as from society to the medical profession and finally to the medical school. Building on Cockerham, I observe that the mechanism by which change and stasis are achieved is that clinical faculty physicians are brought in from the community to teach medical students about everyday clinical practice, clinical experience and clinical judgment.

Faculty Members as Agents of Socialization

Why do faculty members matter? In this dissertation I show that professors intentionally design medical school curricula based on notions of what a “good” or well-prepared doctor is in today’s day and age and how they put these standards into place in the curriculum. Faculty intentionally engineer the curriculum and in doing so, “configure” (Woolgar 1990) the medical student. An emphasis on faculty and direct teaching is growing in the sociology of medical education. For example, scholars have examined how students learn both social and medical lessons from their professors as well as how to carry out procedures like surgery (Prentice 2007) or pelvic exams (Underman 2015) in the manner of a professional. While Harter and Kirby’s (2004) emphasis on linking pedagogical practices to managed care is similar to my approach, they present the interactions between students and standardized or virtual patients in a

⁶ Problem-based learning was first designed and implemented in some medical schools in 1964. For a discussion see Harter & Kirby 2004.

vacuum. Although faculty members are ostensibly present and giving feedback, the structure of the standardized/virtual patient script is the object of analysis.

I will build on this emerging attention to faculty teachers to discuss how medical education shows us how the medical profession and the society it serves are changing. In other words, what it means to carry out medical work “in the manner of a professional” changes as the social organization of the medical profession changes. This is most obvious in discussions of bedside manner. For example, while physicians at mid-century through the 1980s wanted a docile patient, now physicians today want an active patient. Following the rise in chronic disease, physicians need patients to manage their own care on a daily basis. To do doctoring now involves “activating” the patient to be a collaborator in the encounter. This is related to work in Science and Technology Studies that emphasizes studying groups based on the practices and knowledge (including ideologies and professional commonsense knowledge) that define them. My position within this theoretical perspective is outlined below.

Knowledge, Practice & Values

We need to know about medical values because we still do not have a full understanding of how values and action relate to one another. This has been the longstanding debate within sociological studies of medical education. Becker thinks that students adopt value systems to solve problems or guide their action in specific situation, whereas Merton thinks that students internalize the value systems of the culture that surrounds them. Moreover, values change over time, sometimes as the result of external constraint. So, the persistence or change of the values of the medical profession has an impact on medical culture and the self-concept of developing physicians.

Epistemic cultures (Knorr-Cetina 1999) combine knowledge and practice (“ways of doing and being” [Schatzki 1996:23] and cultivating “professional vision” [Goodwin 1994]). But values are also part of membership in an epistemic culture. Values come into play because there are right and wrong ways to carry out professional practices, and carrying out practices according to normative professional standards determines whether one is a member of the in-group or not. In a legally bounded and socially prestigious group like a profession, practice matters and the execution of practices is governed by values in addition to knowledge and professional experience.

Epistemic Socialization & Boundary Setting

Whereas most prior research has focused on clinical training, I have always been interested in the beginning phases of professional socialization. Most scholars think that the wards and clinics are where the real action is to be found, since what happens there most closely resembles the work students will do as practitioners. This has led to an overall scholarly neglect of the preclinical years. In this course of this dissertation I will show that this is an important oversight, as the students do much of their epistemic “boundary setting” during these years.

Epistemic boundary setting is a concept that describes how students acquire a system of medical knowledge that motivates, and is motivated by, their actions as junior practitioners and initiates into the profession. Crucially, these students do not accomplish epistemic boundary setting alone. They are richly embedded in the setting of their school, surrounded by peer networks, and closely guided by professors—particularly when learning clinical skills.

Understanding the process of epistemic boundary setting in contemporary medical education also helps us understand the perspectives and practical orientations of medical practitioners. This is important because, as I show, medical practitioners are drawn into the school to teach students about what clinical care is like and how to do it. This exposes students to current clinical thinking—and not always the polite, cleaned up version of clinical care that medical schools present. Focusing on these interactions allows us to see multiple things at once: the process by which students are shaped into practitioners, how the designers of the official (formal) curriculum want the students to do clinical practice, and how other faculty members tell students things are “really” done in the clinic. We can also observe in these settings how practicing physicians hold students accountable to conventional standards of practice by monitoring their affect, language use and adherence to interviewing protocols. We can also see how students’ ethical thinking and problem solving skills are shaped in the general process of clinical reasoning. During medical school, students learn to think, talk and act like doctors.

Moreover, the school itself is embedded in a wider community of teaching hospitals, community clinics, charity clinics, private practice offices, state-level medical education initiatives, professional associations, and orientations towards practitioner autonomy and discretion. In turn, through the circulation of trainees to different training sites and the standardization of education and licensing standards by the Association of American Medical Colleges and Liaison Committee on Medical Education, medical education also gains coherence on the national level. While the context each medical school is embedded in may vary in important ways (wealth of the surrounding area, dominant charity care population, school’s reputation, etc.) overarching standards seek to

ensure that a medical student's training in one corner of the nation is comparable with a student's at the opposite end.

In the course of this dissertation I will outline the concept of epistemic boundary setting and show how and where it happens during medical training. As I hinted at above, this will require more than just attending to the students. Although students are generally looked at as the raw material out of which physicians will be made (and have subsequently been the object of most medical school ethnographies), I argue that attention should be focused on those who actively design and implement the curriculum—the faculty members. In doing so, I may unwittingly reinforce the *tabula rasa* image of medical students, but the reality of professional education is that no matter what the students themselves want or what type of knowledge they possess at the beginning of medical school, they bump up against intense curricular requirements from the schools that require them to sideline their own desires and submit themselves to the educational program.

CHAPTER 3: SETTING & METHOD

This chapter will discuss my case selection, detail the various activities I have undertaken during my ethnography, and discuss my data collection and analysis methods. The institution, hospitals, and participants involved have been given pseudonyms, and the research was approved by the UC-San Diego Human Research Protections Program (IRB). This is in accordance with standards set by the Association of American Medical Colleges (AAMC) for research involving medical schools and students, and the project was supported by the administration of the undergraduate⁷ medical program.

West Coast Medical School

West Coast Medical School is located at a basic science-oriented research university in southern California. It has been consistently ranked among the top twenty medical schools in the United States by common ranking systems like the *U.S. News and World Report*. Both the school and the university it belongs to are fairly young—products of the science boom in the second half of the twentieth century. At the time I set up this study, WCMS had been working for a few years to design a new curriculum to replace what they called the old or “classic” curriculum. While the classic curriculum had reportedly been fairly radical when it was designed a few decades prior, faculty and administrators had watched as students increasingly skipped class (presumably to go surfing, I was told). Worse, students increasingly chose other comparable medical schools over enrolling at WCMS. In response, the WCMS administration brought in a

⁷ “Undergraduate” in this context refers to the degree program leading to the M.D., commonly (as in this text) referred to as “medical school.” “Graduate” medical education describes internship and residency, post-M.D. professional training that is also administered by the medical school.

new dean for the undergraduate medical education program, and began the process of restructuring the curriculum.

Following a general trend of institutional isomorphism, due both to attempts to satisfy the curricular standards set out by the Liaison Committee on Medical Education, an arm of the Association of American Medical Colleges, as well as WCMS' ongoing attempts to keep pace with its peer institutions, the curriculum resembles that of other comparable medical schools. In fact, the curriculum development team compiled best practices and curricular components from similarly ranked medical schools; several informants mentioned to me that WCMS was one of the last schools to move to this new type of curriculum.

The "new" curriculum at WCMS was described in interviews, to students, and to prospective students as an "integrated" curriculum. This curricular reorganization has two main purposes, each with distinct implications for the type of training students receive and the relation of introductory medical training with actual clinical work. First, the curriculum broke down the customary barrier between preclinical and clinical education. Traditionally, years one and two were reserved for classroom- and laboratory-based work and opportunities to engage in patient care were few. While the integrated preclinical curriculum at WCMS (years one and two) remained primarily classroom-based, it provided early clinical experiences in the form of direct apprenticeships in outpatient clinical settings and added dedicated training in a range of clinical skills. Second, as I discuss below, courses in the traditional medical disciplines were traded in for organ system-based courses (relevant disciplinary information was taught for each organ system).

In following medical students and faculty through the first years of a curriculum overhaul and new curriculum implementation, I was able to see faculty members actively reshaping medical education to better match the realities and pressures of contemporary American clinical practice. There were days when technology failed and classroom bloopers happened. For much of the first year, the faculty members described themselves as only one step ahead of the students. In some cases, the inadequacy of clinical materials exposed the artifice of the curriculum and the idealized notions of clinical practice it was intended to teach. Curricular inadequacies also created situations where the faculty facilitators fell back on (voluntarily or involuntarily) their own clinical experience—thereby (inadvertently) also executing the aim of the curriculum to connect the classroom more closely to the clinic.

Structure of the New Curriculum

The faculty built a new curriculum that slashed lecture time by over 50% (lectures were formerly 8am to 5pm most days of the week), added a robust Problem-based Learning (PBL) curriculum, and consolidated their existing short courses on clinical practice, physical exam, bedside manner and other ‘biopsychosocial’ elements of doctoring into an integrated course called Clinical Practice (CP, a pseudonym). The basic science lecture course, now much leaner, gained additional coherence as faculty members were forced to figure out what was most important for the students to be taught.

In late summer 2010, when I began following the first entering class of the new curriculum, a typical week at WCMS looked like this:

Monday: BMS lecture from 8-10am, PBL from 10am-12pm

Tuesday: BMS lecture from 8am-12pm (in year 1, often included lab time or small group sessions)

Wednesday: BMS lecture from 8-10am, CP lecture from 10am-12pm

Alternating Wednesdays: CP small group from 1-5pm

Thursday: BMS lecture from 8am-12pm (in year 1, often included lab time or small group sessions)

Friday: BMS lecture from 8-10am, PBL from 10am-12pm

This schedule, which was considered quite luxurious by the faculty, left 4 afternoons per week open for studying and other activities. In addition to the scheduled activities listed above, students were assigned two afternoons per month in an ambulatory care setting (outpatient medicine), generally in a primary care clinic. Students were also responsible for accruing elective hours over the four years and could allot their time to these on a quarterly basis and as they saw fit.

Basic & Medical Science

Whereas the previous curriculum had been composed of disciplinary courses like biochemistry, pharmacology and organ physiology, in the new curriculum students moved through organ system “blocks.” In each block, the traditional disciplines crosscut the content like “threads,” so that students in the cardiovascular block would learn anatomy, physiology, and pharmacology (etc.) of the cardiovascular system in an integrated, focused fashion. This course, which I call Basic & Medical Science (BMS), featured ‘normal’ anatomy in the first year and pathology in the second year. This is comparable to other medical programs and WCMS’s old curriculum; ‘normal’ anatomy is the foundation for learning pathology. The first year blocks included: foundations (roughly, a review of biochemistry, cell biology and genetics), cardiovascular system, pulmonary system, renal system, gastrointestinal system, musculoskeletal system, neurology, endocrinology and reproductive medicine, hematology, immunology and

microbiology. Second year blocks reviewed most of the same systems and also covered oncology. First year students had lab courses in anatomy, histology (micro-anatomy), and microbiology; small group problem-solving sessions in genetics and hematology; and a small group dedicated to reading and presenting clinical research papers. For example, in this course students read clinical trial studies of different interventions for coronary artery disease and discussed how they would draw on that information in their clinical practice. Second year students had a lab-based pathology course that was similar in format to the first year histology course.

Clinical Practice Course

Clinical Practice is a course that was introduced with the new curriculum. However, here too the curriculum is more reorganized than revolutionized; several of the components existed independently as courses in human development, doctor – patient relationship, and social and behavioral science. In the reorganized course, small group teaching took on a much more prominent role, with students participating in a Clinical Practice small group (seven or eight students with two faculty leaders in the first year, one in the second year) for their first two years of medical school. This group is the main venue for learning clinical and professional skills: how to approach ethical situations, talk appropriately to patients, and conduct oneself as a professional. Students also discuss health care systems, funding, and other issues of health care provision. It is a time for students to share concerns and experiences in a supportive environment, and to be challenged by the small group leaders whom they develop rapport with. The students also participate in standardized patient exercises (Group Objective Structured Clinical Exams) and skit-like exercises with trained patient actors, and learn to give and receive feedback

as colleagues. The overall effect of the Clinical Practice course is to make the boundary between school and work more permeable by 1) bringing community physicians to the medical school as Clinical Practice instructors and 2) creating patient care simulations and mock scenarios that students use as training exercises.

Because over half of the course hours are spent in the small group sessions, the risk of losing the uniformity of the educational experience is rather high, which was a concern for course faculty. To maintain standardization, the course director team stabilized the curriculum in several ways: the Clinical Practice lecture component served to contextualize and bring uniformity to the students' small group experiences, and the four course directors themselves gave the majority of the lectures. Additionally, the course directors laid out detailed lesson plans for the small group sessions and trained the group leaders during pre-session meetings. Lastly, the course directors provided guidelines, including scripts and character descriptions, for the simulated patient exercises.

Problem-based Learning

The second component of the Clinical Practice course is the Problem Based Learning (PBL) component. PBL sits comfortably between Basic & Medical Science and Clinical Practice, as it tries to integrate both content areas into a realistic case that groups of six to eight students work through with a faculty facilitator. PBL is a well-established teaching method, and there is robust facilitator preparation at WCMS. Cases generally last for two sessions, such that groups complete one case per week. Before the first day of each new case, all faculty facilitators came together for an hour-long briefing meeting.

Here the case was explained, questions were answered, and tips for facilitating the sessions were shared. I attended these meetings for each block of PBL I participated in.

In the classic curriculum, PBL was reserved for students at the end of medical training, namely after students had experience with patient care. Students tended to find discussing paper cases to be boring, however, in light of their actual clinical experience, so in the new curriculum PBL was replaced with more challenging multi-media material in the fourth year course and the paper case-based PBL was moved to years one and two. The PBL component in preclinical education enriches the new curriculum's focus on clinical reasoning and patient care.

Clerkships

The second two years of medical school are primarily based in the hospital. Called clerkships, students participate in these clinical rotations during the majority of their third and fourth years, with time exempted for board exam study (United States Medical Licensing Examination, Step One), residency interviews, and independent research experiences. During their third year, students take clerkships in neurology (four weeks), surgery (eight weeks), medicine⁸ (twelve weeks), psychiatry (four weeks), pediatrics (eight weeks), reproductive medicine (six weeks), clinical selectives (four weeks), and primary care (one afternoon/week, except during surgery rotation). During their fourth year, students rotate through many of the same sub-disciplines again, but they have built-in flexibility for elective training in their desired specialty. The class of 2014

⁸ Here medicine refers to the non-procedural (non-surgical) management of illness with medication-based therapy.

did not experience the fully revised clinical curriculum, although some clerkships, notably neurology, have revised their curricula for the class of 2014.

Final Phase of Training

During their fourth year, students refine their specialty choice, apply and interview for residencies and complete any remaining rotation hours and electives. Many students choose to do away rotations at worksites they are interested in applying to for residency. This means that students are no longer geographically or academically together as a cohort. However, in February, each class reconvenes at the medical school for a month of advanced PBL. This course is called “Principles to Practice,” and is designed to help students tackle complicated cases and talk through typical intern year dilemmas. The intern year is the next phase after medical school and is considered by many physicians to be the most grueling period of medical training. This course helps prepare students to succeed in intern year.

Roughly in this same time frame students have to submit their rank lists for “the match.” The match is the process whereby students are allocated residency spots. During interview season, candidates and residency programs compose rank lists and these are computed and revealed to students during March. Match Day, when the students find out where they will do their internships and residencies, is the third Friday in March. This is a ceremonial day that rivals graduation, which occurs in early June. All match envelopes in the United States are opened at the same time, 12pm Eastern Standard Time. It sometimes happens that a student does not match through this computerized process. If that happens, the student’s name is submitted to another algorithmic matching program called “the scramble.” Here, the remaining students are matched to remaining program

spots. If a student does not match in the scramble, s/he will have to spend a year doing research or clinical work to improve his/her application packet and try again in the following year's interview season. This was uncommon at WCMS, but sometimes happened in the very competitive specialties (neurosurgery, for example).

The end of undergraduate medical training is formally marked with a graduation ceremony. Students come together as a cohort for the last time at this ceremony. Degrees are conferred and awarded and students are given their charge to go forth and do good work.

WCMS Entering Class of 2010

The entering class of 2010 was the first cohort to experience the new curriculum. The gender breakdown of the class was 65 men and 60 women. 72 students came from the top three ranked University of California branches, UC Berkeley, UCLA and UCSD. Perhaps the defining characteristic of this group was that they had come to WCMS fully knowing that it was the first year of a new curriculum. Some students indicated in interviews that they thought this meant that the students in the class were more open-minded. Many of the students worried that their board scores would be weaker because of the reduced lecture hours, but the scores came back higher than expected. Some students found this humorous and explained that the students had been so worried that they had studied even harder than past cohorts just in case the curriculum could not be trusted. Because they felt jerked around by the curriculum during their first year (as I mentioned above, the faculty were often only one step ahead of the medical students, and this was common knowledge), the students adopted the collective identity of "guinea pigs."

During January of the first year, one student designed a guinea pig t-shirt, which many students purchased and wore frequently.

The guinea pig designation was simultaneously positive and negative. The students felt special to be on the front end of a new curriculum. However, they had trouble dealing with the indeterminacy of the school's requirements for them and the various snags and snafus in the execution of the first year course. This ranged from lecturers unwittingly spoiling the end of the PBL case because they did not realize that the case was meant to be a mystery, to last-minute switches in lecture topic, to large-scale fiascos in a laboratory exam. This designation was also adopted by the faculty members who used it to remind the students that they (the students) were guinea pigs. This was usually done to galvanize the students to be flexible and understanding about bumps in the road during the first year.

Data Collection & Analysis

Data collection for this project took place between December 2009 and June 2014. The Class of 2014 cohort arrived in August 2010, which marked the beginning of formal ethnographic field research. The period from December 2009 to August 2010 was used for meetings with administrators to arrange the project, attending faculty development seminars to become familiar with the faculty culture of the medical school, and for gathering archival data including publicly available descriptions of the newly developed curriculum that was set to roll out in August 2010.

I observed nearly all of the lecture, lab and small group sessions during the students' first year (2010-2011). This included lecture teaching in the Basic & Medical Science course, anatomy laboratory sessions, histology laboratory sessions, microbiology

laboratory sessions, Problem Based Learning sessions, Problem Based Learning faculty facilitator training sessions, small group problem solving sessions in genetics and hematology, small group sessions for discussing and evaluating clinical research papers, Clinical Practice sessions, Group Objective Structured Clinical Exam (GOSCE) sessions, student social events, and medical school town hall meetings. I also observed faculty committee work and facilitator training by attending curriculum planning board meetings, faculty development seminars, and PBL faculty facilitator training sessions.

During the students' second year (2011-2012) I observed two months' worth of lecture, lab and small group sessions (oncology block, neurology block, and board exam review week). I participated in the "Orientation to Clinical Rotations" week that bridged the students' second and third years and introduced them to the structure of clinical clerkships.

During the third year, I observed inpatient and outpatient Neurology (four weeks), and General Surgery/Trauma Surgery (four weeks). During the students' fourth year, many of them were away from West Coast Medical School carrying out visiting rotations at other medical schools and hospitals. Everyone reconvened in February for the capstone course, Principles to Practice, and for the Match Day festivities held in March. The students graduated from WCMS in June 2014. The approximately 25 students who decelerated, or took a year or more for research or other M.A. level study, graduated with following cohorts.

During fieldwork periods in non-clinical (school) settings, I spent an average of 20 hours/week in the field. During clinical clerkship observations, I spent an average of 72 hours/week in the field. During 2010-2011, I spent approximately 700 hours in the

field. During 2011-2012, I spent approximately 200 hours in the field. During 2012-2013 I spent approximately 576 hours in the field. During 2013-2014, I spent approximately 95 hours in the field. The grand total of time spent in the field (not including project-related meetings, social events, or time spent interviewing students, faculty and administrators) was approximately 1,571 hours.

Forms of Data

My primary data source is ethnographic field notes. I openly took field notes in classroom and small group settings, a method that helped me establish rapport with the students and faculty (my note taking became a source of much humor at times). During clinical clerkships, I took fewer field notes in the hospital, so as to be unobtrusive while the team was working with a patient. Each evening I typed these notes into a narrative account of the day's activities, trying to recount as much verbatim dialogue as possible. Field note text that appears in quotation marks was transcribed verbatim.

My second data source is semi-structured interviews with faculty members and students. I have a longitudinal sample of students who I interviewed periodically over their first three years in the program. I began with 12 students (approximately 10% of the class), lost two to attrition after the first year, but added four more at the beginning of third year. After the third year, three more students left the interview group as they left the cohort to take a research year. Seven students maintained continuity throughout the six waves of interviews. In the fourth year I replaced formal interviews with periodic informal conversations with some of the interviewees who had become close informants and I focused on informal interviews in the field. Overall, I interviewed 16 unique students, six men and 10 women. The ethnic breakdown of the interviewees was: six

White students, two students of Asian descent, one Vietnamese student, three students of Southeast Asian descent, two African American students, one biracial student (as self-identified), one student of Middle Eastern descent, and one Mexican student. In total, I collected 63 interviews (not every student was able to sit down for an interview in every wave).

I selected interviewees using a convenience sampling method in order to capture different backgrounds and pathways to medical school. I also chose students based on the rationale that I would be able to interview them about class sessions or activities I had observed them carrying out. This would help me clarify sequences of action I had recorded in my field notes and allow me to ask students for the back-story or subtext in ambiguous situations. For this reason, my sample contains participants from the Clinical Practice group and anatomy lab team I observed, as well as students from PBL sessions and clinical rotations. Because the 125 students were continually shuffled and reshuffled into different groups, I was able to observe nearly all of my interviewees in small group or clinical settings.

I also conducted interviews with key actors in preclinical education, including deans, educational specialists, lab professors, master clinical teachers, and many of the small group leaders whose sessions I observed. These interviews helped me clarify background details about the curriculum, as well as learn about the history of West Coast Medical School. These interviews were also designed to capture faculty members' thoughts on medical education, the curriculum, and themselves as teachers. I collected 15 interviews from faculty, administrators, and other relevant actors at WCMS.

The third data source is lecture podcasts from the Basic & Medical Science and Clinical Practice courses. I have transcribed selected podcasts from the Clinical Practice course for analysis in this dissertation. I will maintain the corpus of lecture podcasts (approximately 430 podcasts from years one and two) for future analysis. The CP lectures I transcribed for this dissertation come from the students' first year lectures on professionalism, the medical profession, and rudiments of patient interviewing. These transcribed sections play a role in helping explain that the faculty members are aware of the changes in the medical profession over the past 60 years and the implications these changes have for the students' role as physician.

The final source of data, which plays an overall less prominent role, is a collection of useful documents (descriptions of the curriculum, for example) that forms a small archive. These archival materials inform my understanding of the history of the medical school, the key actors involved, and the changes in the curriculum over the past several years.

Selecting Small Groups & Lecturers

One of the interesting facets of the WCMS curriculum is its emphasis on small group learning. Another was the increased centralization of each course under a course director or course director team. Both of these curricular changes present potential problems to the generalizability of my observations, as I was slotted into small groups along with the students. The groups also stayed together for several weeks (in the case of problem solving groups), an entire term (as in the case of PBL groups) or for the entirety of the first two years (the Clinical Practice group). For me to circulate more rapidly would have interrupted my ability to experience the longitudinal unfolding of the

curriculum along with the students and would have compromised the continuity of my account. For this reason, once I was placed in a group, I stuck with them until the students or facilitator switched groups.

Often my groups were chosen for me. I occasionally had some input, particularly in choosing PBL leaders, but even that was fairly rudimentary (I tried, for example, to get an even balance of men and women PBL facilitators). PBL leaders were chosen for me based on their openness to having a sociologist in the room. Even then, I still had to wait for the students to give their approval.

The most crucial placement was in the Clinical Practice course. This was the longest course with the fewest facilitators. I also rely heavily on the data I collected during these sessions to make my arguments in Chapters 4 and 5. That CP group was chosen for me because the course director and educational specialist I was working with thought that Dr. Henderson was one of the most highly qualified CP leaders and that I would see the best demonstration of how CP should be done if I was with her group. I joined Dr. Henderson and Dr. Philips' group during the second week of CP and stayed with them until the end of second year.

Method of Analysis

In order to understand how students are socialized into the medical profession during medical education, I employed a method called participant comprehension. This is a method by which the researcher 'tries to acquire as high a degree of native competence as possible and interaction is maximized without worrying about disturbing the field site' (Collins 1998). This method is a type of participant observation, and is particularly useful

for research in educational settings; by examining what actors can *do*, researchers gain an understanding of what actors *know* (Collins 2004).

In the analysis I have used an interpretive ethnographic method in which I draw on particularly evocative moments to illustrate how and why students are trained to act, talk and think in particular ways. This is in keeping with the faculty members' own understandings of what they are doing. For example, during the orientation to clinical rotations week, a faculty facilitator explained to students that the criteria on an evaluation sheet for writing a clinical note were "a way to develop your mind for medical learning. This is how we want you to think. This is how your medical reasoning gets developed." In each chapter I have tried to show the faculty member's rationale for teaching the students to act in particular ways and to show what those ways are. I take into account the faculty members' awareness of the history and public stature of the profession as a way of linking what happens inside the medical school to what happens outside of it.

My Reception at WCMS

As a researcher I primarily took on the position of a student in the organization. This was for several reasons. First, I wanted to see what it was like to experience the curriculum as a student. This led me to go beyond my concern with the purely epistemic elements of the curriculum to focus on the embodied and social experience of being a medical student (both in the classroom and the hospital/clinic). Second, I wanted to see how students regarded the faculty members. This led me to witness the lengths students went to in order to succeed in school, and also times when students exercised their peer solidarity to resist the faculty facilitator's plans to carry out the lesson during small group time. Third, sometimes I took on the position of plucky but responsible graduate student

(and occasional confidant) with faculty members. This allowed me access to faculty professional development events, faculty facilitator meetings, clinical settings, laboratory settings, and curriculum planning board committee meetings. The ease with which I arranged interviews with faculty teachers and facilitators reflected interest by the faculty in my project and in reflecting on their experience. That several of my interviewees were PhDs helped them sympathize; that all of my faculty interviewees were educators helped them invest in my examination of their investment in the students.

Those with no cause for sympathy (those not embedded as directly in the university context, such as the faculty I encountered in the hospital) saw me as harmless and as an impotent medical student analogue. Clinical faculty members are used to medical teams with a constantly changing composition and as long as I was willing to be reasonably helpful (hold doors, wheel empty gurneys) and stay out of trouble, I was welcome wherever the medical students were welcome. I consider myself tremendously lucky that people found me to be harmless, friendly, flexible and fairly boring. Some of these were attributes I cultivated in myself in the same way that I cultivated my appearance to match that of the medical students.

Around medical school faculty I played a difficult role. I had to present myself as enthusiastic, flexible, and non-threatening in order to gain entry to otherwise closed groups. Once there, I had to fade away, but then quickly establish faculty-like rapport with individual facilitators so that they would take me seriously enough to tell me the back-story about what they were doing when they were facilitating the small groups. This was successful to varying degrees, and not always in my control.

I presented myself as very neutral when interacting with students, partly because in the beginning I knew more about the medical school than they did, but wanted to see how they figured out what was going on and how to fit into the daily workings of the school (this included things like wandering around the building with them looking for classrooms or showing up at the wrong classrooms with them). I was reluctant to impose myself onto groups unless it was absolutely necessary, but I almost always found a welcome reception. Some groups and students were flattered to be studied, some perplexed, some apprehensive and sometimes my presence became a subject of great humor—especially when they forgot and subsequently remembered that there was a researcher in their midst. I heard later from some key informants that my neutral presentation was too neutral and that it took them until the second year to learn that I actually did have a personality.

“Getting in” with the Students

One of the classic features of participant observation, whether it is reported in the final ethnography or not, is the process of “getting in” with the group one is studying. This process of “getting in” is seen as important to gaining a deep and valid understanding of the group; when a researcher has a relationship with the researched, she is more able to engage with the research subject and learn about his/her interpretations of daily events.

One of the biggest struggles I had in the field was figuring out how to get close to the students while still remaining professional. It took about four months, but by January I had a close relationship with one key informant and two separate social groups. Several things happened that let me know I was “in” with the students: when I asked if I could

come to some of their parties, they got really excited about it; I ordered (and was encouraged to order) one of their guinea pig T-shirts; and the students began inviting me to their regular weekend brunch outings and birthday parties.

Making me make sense in the institution: “you should get an honorary MD”

The injunction to “get in” is countered by another standard piece of fieldwork advice: “don’t go native.” This admonishment, given before one enters the field, cautions the ethnographer not to lose her ethnographic eye by fully joining the new culture. In this sense, “going native” means risking one’s ability to make the familiar strange for having made the strange too familiar. It seems to be generally assumed, however, that the urge to go native comes more from the ethnographer’s side than from the native population. But what happens when people in the field site attempt to persuade the ethnographer to “go native”? In my field site, I was struck by the invitations I received to join the community and “go native” by pursuing a medical degree. I was offered a chance to actually enroll in the courses, and hardly a day went by when I did not hear jokes about how I deserved a medical degree because of my time spent in the lectures and laboratory. Resisting the pressure to “go native” in this setting was not a process of resisting my own desire to belong, but rather of resisting the powerful reconfiguring urge of the medical school—and using my awareness of this process to sharpen my analytical eye. Students’ and faculty members’ well-meaning attempt to recognize my efforts with a credential indigenous to their field was no coincidence. Rather, this is one of the most direct windows into the power of the socializing environment of medical school.

In the social world of the medical school, when one attends four years of school with the commitment that they saw me show, one graduates with an MD. The students

were putting in the time to achieve their goal, and they wanted me to be recognized for my efforts, too. So, when they said I should get an honorary MD, it was said as a sign of respect or even awe: these are people who have a basic understanding of qualitative field research, and were often surprised by the time commitment and the variety of settings I found to be “useful” data. When faculty members were surprised to see me, either because I encountered them in a new setting or when I stayed around well after the novelty had worn off—five months into the anatomy lab course, for example—I often heard them say, “You should get an honorary MD!” or “They should give you an MD for this!” Suggesting that I get an honorary MD is a specifically culturally intelligible sign of respect and their desire to recognize my hard work. This faded somewhat by the end of the second year, but was very prevalent at the beginning, and still came up during certain discussions (like those that matched up with my backgrounds in social and behavioral science).

In this type of institution it is hard to remain on the fringe, even intentionally. It should not have been a surprise, then, that the faculty of the medical school would attempt to reconfigure me in the same way as the students; their half-joke that I should get an honorary MD is a symbol of this. My adventures in the field thus highlight an often difficult to isolate aspect of professional socialization: reconfiguration of the novice into a subject intelligible by the community. It is difficult to isolate this process in the medical students for two reasons: first, they want to affiliate to the doctor status, so they do not resist the status transformation as greatly as I do, and second, they are much closer professionally to the doctors than I am, even during the first few months of medical school. An ethnographer is a less intelligible subject than a medical student, because,

although I look like a medical student—I am the same age, I am “supposed” to be there, I never seem to go away—I use the institution of the medical school differently than a medical student would. Students’ and faculty members’ attempts to make me more readable within their community is signaled by their effort to recognize my work with their credential. This phrase, “you should get an honorary MD!” toes the line between the act of symbolically recognizing my presence at the medical school and the reality of wanting me to become a doctor.

Tapping in to the Embodied Aspects of Medical Training

Lofland, Snow, Anderson and Lofland discuss participant observation as a “full-bodied” technique for data collection because it allows the researcher access to direct experience, social action, talk, archival records, and physical traces of social action (2005:86). Distinctive to participant observation is the researcher’s direct experience of a social situation: “Direct experience enables the researcher to enter more closely into the setting under investigation and may facilitate a deeper understanding of the context(s) of social action” (Lofland et al. 2005:85). Indeed, during my research, participating in an event has allowed me to deeply engage with some of the roles that I am trying to learn more about. Further, changes in my self helped me understand the depth of the changes the medical students were experiencing.

I have had my most intense participatory experiences while approximating the role of a medical student. While I had many of these experiences during the four years I spent at WCMS, the first came during participation in a faculty development seminar when we were asked to pair up and practice a teaching technique using case presentations. The faculty members in the seminar had deep experience with the case

presentation and, often, knew the ‘answers’ to the case problems. I was paired with an experienced cardiologist and asked to present a case on a young person with a particularly badly broken bone. I presented the case exactly as written, confident that the only mistake I would make was already written into the case – I was to act overzealous in my recommendation that the young patient be immediately scheduled for surgery.

I was surprised when my cardiologist partner agreed that the patient needed surgery immediately, but asked me if there was anything else that I would recommend before sending him off to the operating room. I replied that I could not think of anything else – perhaps pain medication, I replied. He asked if the patient had come in alone, and I confirmed that the patient had come without accompaniment. The cardiologist asked again how old the patient was. As I replied that the patient was twelve years old, it suddenly occurred to me that I, as the medical student, would have to alert his parents and obtain their consent before sending the patient off to surgery. I noted this, and immediately felt a physical surge of self-satisfaction at having coming to the answer myself, despite the guidance of my more experienced partner. This, for me, was a window into the experience of a medical student in the clinical setting that I had only heard hinted at before: extreme self-satisfaction (in a non-cynical way), pride, elation, and the satisfaction of approval. Without having had this experience of focused role-play during an educational seminar, I would not have begun to account for the deep emotional and bodily involvement of a medical student in his/her training.

The embodied aspects of medical training—or ethnographic participation in medical training—extend beyond the intellectual high of getting “thinking like a doctor” right. I was also frequently exhausted, simply tired to my bones. I also changed my

wardrobe, as the students (to some extent) also changed theirs. On days when the students had afternoon clinic or saw standardized patients in the mock clinic they were required to wear business casual dress and bring their white coats. On anatomy lab days, students often wore scrubs to lecture. Medical students at WCMS tended to be fit or at least slim, they were conventionally attractive, and had a conservative appearance (very few had unconventional piercings, hair colors or made unconventional fashion choices). This experience of keeping their schedule and following them during their everyday activities helped me understand a different dimension of student experience and gave me insight into how serious their commitment was and how much allegiance their training demanded of them.

CHAPTER 4: COAXING & COACHING: TEACHING MEDICAL STUDENTS TO EFFECT AN AUTHORITATIVE DEMEANOR IN PATIENT INTERACTIONS

Over the past sixty years, the American medical profession has experienced profound structural changes in the way it interacts with the public, government and corporations. Taken together, these changes align with a broad cultural shift away from trust in professions and institutions, and toward individual choice and market consumerism (Mechanic 1996, Haug and Sussman 1969). Within studies of the professions there have been several ways of describing these changes (see Light and Levine 1988). The professional dominance paradigm (Freidson 1970) and the deprofessionalization-corporatization-proletarianization perspective (McKinlay & Stoeckle 1988, McKinlay and Marceau 2002), have given way to an emphasis on countervailing powers (Hafferty and Light 1995, Light 1991) and the systems of alignments these groups can form (Hartley 2002).

Doctors' interpersonal authority is a also perennial concern of medical sociologists (Waitzkin 1989, Freidson 1988 [1970], West 1983, Mishler 2001). While sociologists have studied how physician authority is enacted during patient encounters, the process by which doctors learn to effect authoritative personas is not well understood. Understanding how doctors learn authoritativeness in their professional training provides clues to the reproduction of medical culture, and is particularly important to understand given the empirical effects of the quality of doctor-patient communication on patient satisfaction and adherence. As I discuss in this chapter and the following chapter, physicians' loss of authority is not unidirectional. Rather, physicians actively grapple with changing expectations and can creative use tools of doctoring, namely material

artifacts and communicative practices, to assert their authority in individual encounters. In other words, theorists who make a strong argument for deprofessionalization by looking only at the macro-level may be overstating the case.

The previous literature, written in an era with different pressures on the medical profession, sees learning doctor authority differently than I saw in my ethnography of WCMS. These studies focused on things like how the physician limits the patient's ability to participate in the encounter (West 1983, Mishler 2001, Katz 1984). Much less work has focused on how students *learn* to manage the clinical encounter.

Learning to be a doctor is a process with many tasks and involves learning not only medical and scientific information, but also the authoritative demeanor of the professional. One of the major obstacles to effecting this professional "presentation of self" (Goffman 1956) is the uncertainty the student feels about his/her interactions with professors, patients and the body of medical information (Fox 1957, Atkinson 1984, Fox 1980, Light 1979, Katz 1984, Haas and Shaffir 1982a, 1982b). There are several sources of uncertainty in medical education, one of which is students' awareness of their limited medical knowledge (Fox 1957). However, scholars have convincingly argued that a more immediate and compelling source of uncertainty is whether medical students will be able to pull off a convincing presentation of medical authority (Light 1979, Haas and Shaffir 1977, 1982a, 1982b). Medical students generally work under tight constraints: they are very quickly incorporated into the daily routine of medicine, confronted with a new set of cultural artifacts, and are expected to be able to perform competently – often before they have mastered the body of medical information (Haas and Shaffir 1977). Some scholars have argued that is the motive force of professional socialization; operating under severe

constraints, students adopt a “cloak of competence” that shields them from the traumatic evaluations of professors and patients alike (Haas and Shaffir 1977).

As opposed to the dominant social-psychological approach, this chapter presents a cultural analysis of the cultivation of an authoritative demeanor by medical students. Here, medical authority means being able to control the patient enough for the physician to get his/her work done. Authority is accomplished through using language and material artifacts to overcome patient resistance or create a situation where patient resistance does not happen. By looking at student-professor and student-student interactions in mock clinical exercises and group discussions of students’ performances in both mock and real clinical situations, I show that students do not come up with a professional presentation of self by themselves and that this professional presentation is not a coping mechanism or a cover for gaps in their knowledge of medical information. Rather, students are taught by their professors to use medical-cultural artifacts (the white coat, stethoscope, patient gown, and other tools of doctoring) that will aid their performance in patient interaction. Reliance on professional artifacts that all parties in the encounter agree are authoritative relieves the students’ uncertainty that their performances will not be believed, but this reliance on artifacts is learned—not automatic.

In addition to material artifacts, students learn to use language strategically in the clinical encounter. In this chapter, the discussion of language use will center on how medical students become comfortable asking intensely personal questions of strangers. They also learn to use regular language assertively and learn to trust that the assemblage of material artifacts that makes up their doctor persona will bolster their professional presentation of self and get the desired response from the patient. In the following

chapter, I show how medical students use a set of conversational devices to get the patient to agree to the doctor's plan. Both discussions center on the strategic *use* of everyday-sounding language in the clinical encounter to accomplish the physician's agenda.

My contribution to the past literature is that the students are taught how to enact medical authority, not as a cover for knowledge that they do not yet have, but as an aspect of their professional competence independent of medical information. This is necessary because physicians routinely face challenges from patients—this is consistent with the shift towards corporate medicine and patient satisfaction in American healthcare provision. It is important to fill out this story using ethnographic data so that sociologists have an updated understanding, not only of the uncertainties medical students face, but also of the lengths professors go to in their attempts to teach medical students to resolve their uncertainties and enact medical authority. What emerges is that the students engage in interactional work and negotiation with both professors and peers to learn how, for what, and when to use the language, white coat, stethoscope, patient gown and other material artifacts of the physician.

As I do in other parts of the dissertation, I begin from the standpoint that faculty members play an active role in teaching students how to interact with patients in the manner of the physician. By placing professors in interaction with medical students as the students learn how to be doctors in relation to patients, the role of professors in students' enculturation becomes accessible, in turn rendering doctor – patient communication visible as a set of interactional practices that belong to the culture of medicine. As I show in this chapter and the next, examining medical education as the process of learning how

to enact professional practices enables us to see medical authority as it is reproduced in a new generation of physicians and how what is considered appropriately authoritative in a clinical encounter changes over time.

The process of learning to properly use these professional artifacts to perform authoritative practices results in the students' epistemic boundaries being set in roughly the same epistemic 'location' as their professors.' In other words, they share the same understandings of which linguistic and affective practices are conventional to the form-of-life of the medical profession. However, this process is not without its starts and bumps. Although the students aspire to practice medicine, they express ambivalence about the need to use medical cultural artifacts and, even after they embrace the artifacts, they are uncertain that their enactments of professional authority will be taken as authoritative. I show that this prompts two responses from their professors: *coaxing* students to use artifacts as their own and *coaching* students about how to apply the artifacts to perform interactional practices when interacting with patients.

Most of the interactions recounted in this chapter are from the CP group, a small group of seven students and two faculty members that met bimonthly over the course of 18 months to engage in formal role-play exercises in the mock clinic, semi-structured role-play exercises in the classroom, physical exam learning sessions, and discussions of the elements of medical care in a bio-psycho-social system. Other examples come from CP lecture, where students are taught the skills they will practice in upcoming CP small group sessions.

Coaxing Out of Ambivalence

The material artifacts of medicine that the students learn to use in their initial phase of training are the clothing and tools of the doctor. Students also learn to use language (communicative practice) and demeanor (affective practice) in the encounter. Most students come to medical school with a familiarity with these artifacts, whether it is because they have seen doctor dramas on television, have had relationships with their own primary care providers, have shadowed or worked in medical settings, or have a family member who is a doctor. This exposure, however, does not guarantee that they will readily or smoothly be able to apply these artifacts in their interactions with patients. In this section, I show that students are initially ambivalent about taking up material artifacts and using them to enact authoritative medical practices. This ambivalence is most evident in students' negotiations with the clothing, tools and demeanor of the professional.

When students first start medical school, they have to adjust to their new identities as medical students, a process which lasts for at least the first semester:

One day in histology lab, Monica was telling a story about something that had happened to her over Thanksgiving break. She told the group that she was sitting on the airplane and reading her embryology textbook when the person sitting next to her looked over and asked her if she "was studying to be a medical doctor." She said, "Yeah, I am." She remarked to the students sitting around her, "It was kinda weird to say that." The other students listened to this story and agreed with Monica when she said that she barely even felt like a medical student, let alone a doctor. Monica continued, saying that it just felt like she was back in undergrad because all she does is study books.

However, even as students are adjusting to their new identities as medical students, their faculty facilitators engage them in exercises where they must assert a doctor's identity. But just because they are wearing a white coat does not make students think that they are

doctors; in an interview, one student reported that she just felt like she was “acting” when she wore the white coat, even in a clinical setting. During standardized patient exercises, medical students are willing to assert their identities as medical students, but are reluctant to call themselves doctors:

After soliciting Marcia’s self-evaluation, Dr. Henderson, the faculty facilitator, addressed Marcia’s self-presentation during the standardized patient exercise: Marcia had introduced herself as a medical student and kept referring to the doctor as someone else. Marcia had told the patient, “I’ll ask the doctor about that” and “the doctor will prescribe the medication for you.” Dr. Henderson told her, “You need to role-play that you’re a doctor; take on the role and run with it.”

Although the students are aware of medical artifacts, at the beginning of medical school they have different relationships to these artifacts. Some take them up readily, while others display significant ambivalence toward using the artifacts in interaction. Some students even reject the white coat and other artifacts as expressions of doctor identity and instead say that they want to just go in and talk to patients “as real people.” In one interaction, peers and a faculty facilitator discuss the purpose of artifacts as symbols in patient interaction:

As the students walked into the room, they were talking about the standardized patient exercise. Frustrated, Monica asked, “Why do they make us wear the stethoscope when we’re not even going to use it?” Victor replied, “It makes us feel all doctor-y.” And Dr. Philips, another faculty facilitator, said, “It’s a prop.” Gavin, another student, replied, “It’s so the patients will let us make them do stuff.”

Victor and Gavin were able to explain the utility of the stethoscope in both role-play (Victor) and real-practice (Gavin) situations, and throughout the ensuing role-play session were willing to use this artifact and others in their enactments of medical authority. This quote also shows that students are aware of the utility of artifacts for

getting the patients to “do stuff.” Authority can be conceptualized as being able to overcome resistance to get what one wants, and students recognize that the stethoscope can have this meaning. Later in the session:

The faculty facilitators asked for a volunteer to start the role-play exercise. Monica volunteered, but asked if she had to “put on a white coat and stethoscope [that] I’m not gonna use.” Dr. Philips said, “If it will help you get into character.” Monica replied that it would not help. In a perplexed tone Dr. Philips said, “Not even the white coat?” She replied definitively, “It won’t.” Some other students jumped in and said good-naturedly, “Put on the coat. We had a ceremony for it and everything.” Monica said, “Okay” and reluctantly put on the white coat, but not the stethoscope or the I.D. badge.

Regardless of their willingness to draw on medical artifacts during patient interaction, students like Monica initially distance themselves from the notion that they should rely on medical-cultural artifacts to do being a doctor. This distance persists even as the students negotiate the utility of these artifacts for accomplishing patient encounters. Monica’s peers also display cynical distance to the white coat because the rationale they give for why Monica should wear the coat is that they had a fancy white coat ceremony. Although she eagerly volunteers to be the first actor in the standardized patient exercise, Monica is resistant to employ artifacts in this doctoring work. She twice denies that the tools of doctoring will help her do the work of doctoring, but she is cajoled into using them. Dr. Philips, who is not a medical doctor but a clinical psychologist, does not force Monica to employ the symbols in interaction, but he acts confused when she does not want to use them.

Gavin readily employed the artifact of medical jargon, a specialized and highly visible form of medical language, when it came to be his turn in the role-play exercise. Before he talked with the mock patient, an actor who was sitting in the middle of the

room, the leaders asked Gavin to summarize the information the group had elicited from the patient thus far. In his verbal summary, Gavin replaced the patient's words with medical jargon: the patient-actor had told the previous student that his brother died of a heart attack, but Gavin told the group that the patient's brother died of an "MI" (myocardial infarction). Gavin's use of the highly precise biomedical register is one of the most obvious uses of medical language because the speaker uses words that are not part of the lay vocabulary. This use of jargon is part of the doctor's demeanor and signals one's membership in the medical community, but language also operates in more subtle ways during a doctor-patient encounter. It is in their attempts to master the uses of 'everyday'-sounding language in the clinical encounter that students face a more complicated task. I will discuss the use of medical language in the next section.

Coaching Out of Uncertainty

Language appears to be unique among the professional tools of medicine. It is by far the most complex tool and it has very complicated guidelines for its use. This is because medical language includes many types of language use: the register of biomedical jargon (technical language) that doctors use to talk to each other, the use of everyday language with patients, the translation skills to relate a patient's non-medical language to the technical register, and the conversational practices of broaching intensely personal topics with strangers, among others. Students are generally discouraged from using jargon with patients, although they are allowed to use proper anatomical terms if they think the patient will understand them or if the terms are explained in the course of the encounter. The stethoscope, white coat, patient gown, and other artifacts are adopted by the students relatively easily after the period of initial ambivalence described above,

but uncertainty about their language use and professional demeanor remains. Students' struggle to appropriately use language when talking to patients is the main prompt of coaching from the professors. The main obstacle the students face in interaction is that they do not believe that their enactments of medical authority, often via language use, will be effective. This persists long after the students have realized that they need to draw on material artifacts as additional resources for their claims to authority.

Students frequently ask their faculty facilitators how they, as experienced clinicians, would approach certain topics. Often, the facilitators reflect the question back to the group and ask the students to think about how they might start a conversation with a patient about a difficult topic such as drug use, sexual activity, alternative medicine, or depression. Students respond to this prompting in three main ways: they contribute conversational tactics (which are sometimes deemed appropriate by the professors and sometimes not), they report personal failures in conversations with patients, and they act out intentionally humorous mistakes. Each of these responses is structured by the leaders, and the leaders often interject with their own suggestions or shape the contributions to demonstrate for the students the appropriate use of language in a given situation. This coaching work helps students learn to use material artifacts and professional practices, especially the sophisticated uses of language, in their interactions with patients.

Contributions of conversational tactics

Because it is commonplace in contemporary medical education to teach students to think of patients as people situated in particular life circumstances, students worry (and are taught to worry) about how patients will respond to the doctor's requests for information.³ Medical students at WCMS are frequently taught that if they say something

offensive, accidentally belittle the patient, or make unfounded assumptions about patients, the patients will “shut down” and they won’t come back for further treatment or adhere to their current treatment plan. As I discuss in greater detail in the following chapter, this is consistent with their professors’ perceptions of and experiences with patient consumerism. This sends a conflicting message to the students: the students know that doctors must be able to command some kind of authority when asking patients for personal health information, but they are afraid of saying something inappropriate that will upset the patient and endanger the therapeutic relationship. Students thus ask for a lot of guidance in talking with patients and many conversations involve students asking how to work with a patient and respect his/her life situation, while still getting the information needed to make a biomedical diagnosis and recommend treatment. One difficult scenario students face is the hypothetical situation of handling an abusive spouse who accompanies a patient to her appointment.

The students were talking about how to get an abusive spouse out of the room. The students threw out several possible techniques, including using “female issues” as an excuse to get the spouse to leave, or lying to the spouse and telling him to “go to the front desk to take care of some payment issues.” Dr. Philips suggested that one way to bring up the issue would be to say to the patient and his/her spouse, “I just want to make sure I’m getting the full story.” Dr. Henderson contributed the following suggestion: “I need you to step out into the waiting room while I examine her.” She said, “Sometimes I put her into the gown to get him out of the room.” She went on to say that even though she doesn’t necessarily need to examine the patient, she will examine the patient, and use the time to talk with her about her relationship with her husband.

This is a particularly threatening scenario for the students and their reliance on deception indicates that they do not think that they could simply ask an abusive spouse to step into the waiting room. The faculty members, however, know that the students can assert this

authority and that it will be supported through the semiotics of the white coat, gown, and other artifacts. Although Dr. Philips and Dr. Henderson don't overtly correct the students, they do not validate the students' ideas by incorporating them into the conversation, a process referred to as non-uptake. This is a common technique in Socratic teaching methods (Mertz 2007) and allows the professors to subtly model more appropriate uses of language in the given situation. Although Dr. Henderson does not undermine Dr. Philips in front of the students, Dr. Philips is a clinical psychologist and his suggestion was somewhat overruled by Dr. Henderson in a similar instance of non-uptake. In this case, it is also notable that Dr. Henderson models a response to the situation in which she deploys another artifact, the patient gown, to bolster her bid to talk to the patient privately. She uses this example to reassure the students that their coordinated use of the patient gown, the doctor's clothing, and language use will create an authoritative demeanor that can be used in interaction to accomplish a professional task: getting a patient's relative out of the examination room without lying to the patient or giving any indication that the physician is isolating the patient to get more information about her domestic situation.

Another instance in which having a family member in the exam room could prevent the doctor from getting the necessary information about a patient is in the case of interviewing adolescent patients. Similar to the case above, the presence of a parent could limit the accuracy of the information the doctor elicits from the patient. In adolescent medicine, the adolescent is the patient and the primary object of the physician's focus.

The leaders engaged the students in a discussion about interviewing adolescent patients. These patients are special because they are often accompanied by their parents. Dr. Henderson said, "Just like with the

translator, who are you predominately talking to?” Chaz said, “The patient.” The students knew, however, that it would be advantageous to be able to interview the adolescent alone, since s/he would disclose more information if the parent weren’t there. Often, however, mentioned Dr. Henderson, if you ask the patient if s/he wants to have the parent in the room, the patient won’t feel comfortable saying no. Patrick said, “If you can get the parent out of the room without the kid having to say it...” “You’ll be winning a lot of hearts,” finished Gavin. Dr. Henderson then asked, “So, how do you get the parent out of the room?” The students didn’t have any ideas about how to do this, so Dr. Henderson told the group that she asks the patient if the parent can stay in the room; most of the time the patient says yes. Then she goes through the whole history and when she is done she asks the parent to step out while she examines the child. “And,” she told the students, “while I’m examining the child I go back through the social history” [the part of the medical history where drug and alcohol use and sexual activity are discussed]. This gives the child a chance to answer honestly and build rapport with the doctor. She said that often the parent has no problem stepping out, but if the parent looks like s/he does not want to leave, Dr. Henderson will pull the parent aside and explain that seeing the child alone will help the child to get used to building his/her own relationship with the doctor.

There is nothing out of the ordinary about what Dr. Henderson says to the adolescent patient’s mother—it is everyday language. But it is said firmly and accompanied by other traditional symbols of physician authority, like a white coat. Generally this is sufficient (similar tactics were reported in a student’s interview about his adolescent medicine rotation). The thing students have to learn is that it is okay for the doctor to tell the patient what to do and that there is a ‘doctor-like’ way to tell the patient what to do.

Doctors do not, for example, strong-arm patients or threaten them.

When the Clinical Practice small group discusses tactics for soliciting delicate information from or negotiating with patients, the professors invite students’ ideas. When the students contribute conversational tactics that the professors do not find valid (i.e. lying), they decline to take the suggestion into the conversation and instead supply their own guidelines for handling the situation.

Contributing their own ideas and then hearing the professors' examples and stories is the main way in which students learn to authoritatively manage patient interactions. There are, however, two additional ways in which students learn communication tactics for patient encounters. Both of these revolve around failure to correctly use medical language. Making a mistake is an important way to show that one recognizes the use and utility of a symbol or rule (Winch 1958). Mistakes (and their correction) show the boundaries of conventional practice and help students set their epistemic boundaries—what is considered knowledge and what the strategies are for appropriately acquiring and using knowledge. Students use their own interpersonal foibles to help them establish the boundaries of appropriate communicative practice. The two ways in which students do this is by reporting failures in actual or mock-clinic patient interactions, and by intentionally making mistakes in informal discussions of communication (often to great comedic effect).

Failures

As students progress through their first year of medical school, they are gradually allowed to take on more responsibility at their outpatient clinic apprenticeships. Often this means that students are sent in to a patient's exam room to take a preliminary medical history while the supervising doctor is finishing up with the previous patient. Students draw on their experiences at the clinic during their CP class discussions. During a discussion of the chancy nature of asking a patient about his/her sexual activity, Gavin reported the following conversational failure:

I asked her, "Are you sexually active?" And she said, "No, not right now. My husband is deployed." And I said, "But are you sexually active right now?" And as soon as I said it, I thought, "I am such a dick." I just wanted

to know if she was sexually active not with her husband around...see, I stumbled over it just now. It's so hard. Luckily she was nice about it.

In Gavin's case, he did not know how to use the language of patient history-taking to properly obtain the information he was seeking. In other cases, students know the proper thing to say—as taught to them by their professors—but they still have trouble saying it.

For example, during one session the students were assigned to work as a group with a standardized patient actor who came to their classroom for the scenario. The students knew that their task was to get the patient to talk about his spirituality, but they did not know what else to expect. Talking with the patient proved to be difficult, because the patient answered most of the students' questions by saying that he was either “angry at God” or “just sad.” The students took turns sitting in the middle of a circle of chairs and talking with the patient one-on-one. The student and the professors had the ability to time-in and time-out of the scenario, often taking suggestions from the group when the student seemed to hit a wall. In one such time-out, it became clear that the students needed to follow up the patient's statements about being sad by asking him if he was depressed:

The students talked with the professors about how to ask a patient if s/he is depressed. The leaders assured the students that they could plainly ask a patient whether s/he was depressed. Victor said, “This is the time for us to learn to start saying these things” (asking a patient about depression or suicidal ideation). Marcia countered, “It's hard to be fluid” when on the spot. At the urging of the group, Victor tried his hand at talking with the patient and took the empty chair across from the patient. After talking so confidently about asking patients if they are depressed, however, he stumbled over the suicide-related questions when talking with the patient.

This instance shows that even as students start to develop an awareness of the appropriate course of action in a conversation with a patient, they are not always confident that they

can actually broach the topic with the patient. This points to a larger concern in the professional socialization of medical students: professional socialization involves not only reconfiguring one's relationship to the medical community, but also to the non-medical community. In this case, reconfiguring their relationship to the non-medical community means that the students have to learn to ask highly personal questions of strangers. These questions would be inappropriate for anyone else to ask, but they are necessary for the doctor to ask—to not ask a visibly depressed patient if he was depressed or suicidal would be negligent. The skill of asking these questions not only relies on applying language to ask the appropriate questions, but also relying on other medical artifacts to stabilize the definition of the situation to make asking these questions legitimate in the first place. Although the artifacts do not seem to be actively employed in the above example, they set the stage to make the encounter look like a medical encounter between the doctor and the patient. It is the white coat, stethoscope and badge that distinguishes the doctor from the patient. Medical artifacts can serve this purpose because they help stabilize the definition of the situation in the medical encounter and imply the physician and patient as concomitant roles.

Nevertheless, students sometimes make mistakes in this process, and one type of mistake they tend to make is trying to rely on biomedical information as a symbol to be applied and used in patient interaction. Their professors do not reinforce the use of science as a resource for authority and students are not allowed to draw on biomedical information as a resource for authority in a patient encounter. Professors teach the students that the material artifacts and communicative practices they have are enough—students do not need to rely on borrowed authority from scientific studies or lab results.

For example, one of the students' problem-based learning cases concerned a teenage athlete who injured the nerves in his shoulder during a football game. In the scenario, the team doctor suspects that the athlete has been using steroids to improve his performance so that he can get a college scholarship. This suspicion is confirmed by the athlete's mother, who asks the doctor to talk to her son about steroid use during his follow-up appointment, but asks the doctor not to say that she found used syringes and empty bottles of steroids in her son's closet.

The faculty facilitator, Dr. Edwards, said to the group, "He's coming to your office on Monday. How do you talk to him?" Marcia groaned, "It would be easier if you had taken a urine sample, then you have proof—because if you ask him, he's probably going to deny it." Dr. Edwards asked, "Would you 'out' the mom?" Bianca said she thought that was a bad idea. Hannah said it would be better to stress the athlete's changes in weight over the last year and to emphasize the shared relationship, since the doctor has known the patient for a while.

Dr. Edwards does not take up Marcia's attempt to rely on medical information when trying to get information about the patient. This is a subtle way that Dr. Edwards teaches the group that scientific information is not an appropriate resource to draw on in this scenario; test results are extrinsic to the direct communication between the doctor and patient. In a way she is also clueing the students into the fact that doctors still command a lot of cultural authority on an individual level, despite the deprofessionalization that has occurred on the professions level. When they assemble enough material artifacts and communicative practices to be believable doctors, they can expect that the patient will grant them authority. The trick in CP is learning what combinations are appropriate, or believably doctor-like. In an additional example from a CP small group session, Chaz volunteered to play a "difficult patient" and the other students had to work together to get

Chaz to realize, first, that he is at risk for diabetes and second, get him to make a plan to change his diet and exercise habits.

At first Marcia tried to use scientific information (glucose transporters) to explain the pathology of diabetes and the Monica tried to use scientific work (research studies) to get the Chaz to take the correlations between obesity and diabetes seriously. Dr. Henderson cut this off fairly quickly and told the students, “If people are in denial, you have to confront them with reality.” She went on to ask Chaz if he wanted to be alive to see his grandchildren graduate from high school and used this to get him to take weight loss more seriously.

When students employ scientific information in a mock patient exercise, it is often cut off by professors or not taken up in professors’ explanations. Such unintentional failures are instructive because students begin to learn the appropriate applications of artifacts; mistakes are often fruitful ways to learn rules.

The second type of failure is intentional and often humorous. Failure of this sort pokes fun at those who would violate the boundaries of conventional practice in a patient encounter. It also offers a window into seeing how the medical-cultural artifacts hang together as a coherent cultural resource.

Dr. Henderson asked Marcia how she would bring up the issue of drug and alcohol use with an adolescent patient. Marcia, playing the doctor, repeated the phrase Dr. Henderson had earlier used: “Lots of kids experiment with drugs and alcohol. Do you know anyone who does that?” To Dr. Henderson she said, “It sounds so lame when I say it! It sounds better when you say it.” Chaz joked in a creepy voice, “I used to smoke weed...do you ever smoke weed?” The group laughed at his performance of the out of touch adult’s stereotypical failure at building rapport with teenagers. Marcia continued with her presentation and mentioned the suggestions she had read for how to ask teenagers about their sexual activity. She mentioned that they sounded “unnatural” and told the group that one of the lines was, “Tell me about your sex life.” Dr. Philips commented that it sounded “pretty ‘70s,” and implied that using that phrase would make a doctor seem out of touch. Chaz again joked in the same creepy voice, “I used to have sex...do you have sex?” The group laughed heartily.

By evoking the image of an out of touch doctor broaching an awkward subject with a teenager, Chaz playfully tests the boundaries of appropriate medical language use. Chaz and Marcia's interpretations of the suggested question-asking techniques show that the appropriate words, said with the wrong demeanor, can be as ineffective in eliciting information as an inappropriate question. While humorous, these failures serve to construct boundaries between appropriate and inappropriate uses of medical language when talking to patients.

The professors coach the students in appropriately using the clothing, tools, demeanor and language of the professional as authoritative interactional practices by reinforcing their appropriate choices and deflecting their inappropriate choices. The students demonstrate their growing knowledge of the contours of the body of professional practices by making intentional, and often comical, mistakes. Through coaxing and coaching the students, the professors lead the students out of ambivalence and uncertainty and into more confident enactments of an authoritative physician persona.

In this chapter I set out to show how professors teach students to develop practices from the cultural resources of the medical profession and how to use these practices to enact professional authority. Understanding the material and symbolic resources the physicians draw on to accomplish their work gives us clues into how physicians manage patients during the encounter. These practices appear to be acquired as a coherent set because the professors are reluctant to let the students engage in the conversational practices of doctoring without also wearing the white coat and the stethoscope. Moreover, conversational practices are dependent on affect—questions

should be asked with a particular demeanor. Finally, an important aspect of the coherence of the system of artifacts is that it is attributed in part by the patient. This is something that students are aware of, and which occasionally makes them uncomfortable. For example, as one student remarked to another during a histology laboratory session, he wished his clinic patients were not so complacent, because it was clear that he did not know what he was doing. This student gave the impression that the patients' patience actually highlighted his failures to do procedures quickly or correctly on the first try. Although the patients ultimately aid the medical students by stabilizing the definition of the situation in the medical encounter, students find this to be unnerving when they cannot figure out how to elicit the patient's concerns or get the patients to follow desired actions.

By far the most difficult task of the medical encounter is mastering language use. Some of the uses of language, such as the use of jargon, are fairly easy to master and are rapidly taken up by students. Jargon is an indicator of membership in the profession because it is the type of language doctors use to talk with each other about patients and the students learn it quickly because they aspire to be recognized as members of the medical community by other more senior members. But there are more subtle differences between lay-lay and lay-doctor communication that the students have to master. This means that students are not allowed to use jargon with patients. They must learn to use everyday-sounding language in new ways, like asking highly personal questions of strangers. When students feel frustrated by this new use of language, they say that they're just going to talk to patients "like real people." By this, the students mean that they will approach a doctor-patient encounter as if it were a lay encounter between peers or new

acquaintances. Their plan to talk to patients as “real people,” however, quickly butts up against the interactional constraints of the patient encounter. Not only do patients expect a certain type of presentation from the doctor, students quickly discover that they have a limited amount of time and a pressing need to gather highly precise information.

An analysis of role-play settings in medical education shows that professors overtly teach students how to use medical-cultural artifacts in their interactions with patients; properly harnessing and applying these artifacts is how medical students accomplish enactments of authority. As they become doctors, medical students must negotiate new relations to non-medical people. This involves using new artifacts: a white coat, clipboard, stethoscope, patient gown, as well as mastering new communicative and affective practices: not interrupting, moving to an interview style instead of a conversation, learning how to ask questions that only doctors ask, learning how to move an interview in a desired direction, and working under time constraints. Initially students show ambivalence towards the clothing and tools of the professional and wonder if these artifacts are truly essential for doing the work of the doctor. Students also experience an uncertainty about enacting medical authority that persists even after they have learned to rely on the artifacts in patient interactions. Professors coax and coach the students, teaching them through examples and stories how to appropriately use the artifacts of medical culture.

In the following chapter I will discuss further uses of language in the clinical encounter, linking language use to increased patient consumerism, cultural expectations of patient participation, and changes in the nature of disease that draw physicians into new ways of collaborating with patients

CHAPTER 5: CLOSING THE DEAL: PHYSICIAN AUTHORITY IN AN AGE OF PATIENT EMPOWERMENT

As health care has shifted from a seller's to a buyer's market, patients have increased consumer power (Conrad 2005, Ebeling 2011), increased access to information technologies (Lemire, Sicotte and Paré 2008), and engage in health social movements and activism (Brown and Zavetoski 2004). But beyond consumer power and legal rights is a growing expectation that patients should be treated as partners in their care and participate in decision-making about their treatments and prognoses; indeed this is held as an ideal in health care (Andreassen and Trondsen 2010). This cultural trend is referred to by many names, including patient-centered medicine (Bardes 2012), patient autonomy (Conrad 1987), and patient empowerment (Roberts 1999). In order to link this trend to its heritage in health social movements, I refer to all of these related concepts as patient empowerment, and the use of patient empowerment techniques in doctor – patient interaction as the “discourse of patient empowerment.”

Patient empowerment as a clinical priority represents a stark contrast to earlier models of physician – patient interaction, such as the paternalistic model, in which ‘the physician acts as the patient’s guardian, articulating and implementing what is best for the patient’ (Emanuel and Emanuel 1992:2221, McKinlay and Mareceau 2002). Salmon and Hall (2004) have recommended that patient empowerment be more closely examined, particularly from the patient’s perspective. Others, such as Fox, Ward and O’Rourke (2005) and Henwood, Wyatt, Hart and Smith (2003) have undertaken this. What remains underexamined, however, is “how physicians define patient empowerment,

what they like/dislike about empowered patients, [and] how patient empowerment affects their jobs” (Roberts 1999:90), as well as how physicians deploy patient empowerment techniques—and to what ends (Roter 2000, Aujoulat, D’Hoore & Deccache 2007). A rejection of medical paternalism in favor of individual choice is a hallmark of neoliberal culture. So, doctors have to make patients feel like they are making choices about their care. As I show, this must be combined with the physician’s agenda in the medical encounter.

Understanding how doctor – patient interaction happens in the contemporary health care context has implications for theories of professions that imply that physicians are being steadily deprofessionalized (McKinlay and Marceau 2002), as well as for theories that imply that patient consumerism is entrenched and unstoppable (Mol 2008). It also points to a central tension in patient care: the physician, by virtue of his or her training has *real expertise* in clinical medicine (Collins and Evans 2007) and must find a way to persuade patients of this. I argue that medical professionals are using a new means, a discourse composed of patient-centered communication techniques, to meet a classic end, patient compliance. Discourse, in this case, operates on the microsocial level as the medical profession’s own countervailing power in response to patient consumerism and deprofessionalization.

Studies of the Medical Profession

Analyses of the U.S. medical profession vary by their attention to the effects of structural or cultural factors on the profession’s stature, by their attention to the macro- or microsocial level of analysis; and by their focus on professional autonomy versus professional authority. In the following section I present trends and continuities in the

study of professions in order to highlight a lacuna where these three angles of analysis overlap: few studies focus on microlevel cultural understandings of physician authority, and none from a countervailing powers perspective, which has been dominated by professions-level structural approaches.

Physician professional dominance results from a combination of structural and cultural force, the last stop of which is physicians' legal control over direct patient care and medical work (Light and Levine 1988). Analyses of cultural forces focus on the culture of medicine and meaning of medicine in the broader social context—the status of medicine's professional authority. In particular, such analyses stress the American public's loss of trust in the medical profession (Mechanic 1996), health social movements (Brown and Zavetoski 2004), patient consumerism (Ebeling 2011, Bury and Taylor 2008), and medicalization (Conrad 1992, Conrad 2005). Professional autonomy aligns broadly with the structural aspects of the medical profession and its relations to other professions; deprofessionalization and countervailing powers theories therefore pay most attention to structural aspects of the profession and how individual stakeholders' control over their work is constrained by other parties.

Countervailing Powers

The countervailing powers framework sets the health care system into motion by situating moves and bids for power by the medical profession, government, and other stakeholders in a political-economic framework. This is in direct contrast to the professional dominance and deprofessionalization frameworks, which are 'unidirectional concepts that do not capture the dynamic engagement of health professionals with other parties in the health care field' (Timmermans and Oh 2010:51(S)). Thus, much like

Abbott's (1988) social ecology of professions, the countervailing powers concept provides a dynamic way of conceptualizing the relationships between healthcare stakeholders. For each stakeholder, "the degree of dominance consists of one's ability to override, suppress, or render irrelevant challenges by other parties, either behind closed doors or in public" (Light 1991:505). Examples of countervailing power are often structural and include changes in the funding and organization of health care, and the rise of non-physician health professionals (Light and Levine 1988). Overall, the macrosociological approach to professional dynamics is important for charting the players in the game, but leaves few links to the microsocial level.

Research on how professional dynamics are reflected in the everyday work of rank and file physicians has been largely restricted to structural forces, such as pressure to provide efficient care (a hallmark of corporatization) appearing as "teaching for efficiency" among residents (Szymczak and Bosk 2012). Others have discussed cultural forces, such as physician and medical student perception of changing patient trust and physician authority (Pescosolido, Tuch and Martin 2001). However, one area of research that has sustained a focus on microsocial, interactional-level analyses is sociolinguistics. Early studies in this area tended to reinforce the professional dominance paradigm by showing how physicians used subtle markers of authority to control the direction of conversation in patient encounters (West 1983) with only occasional resistance from patients, which was characterized as unusual or remarkable (Mishler 2001).

More recently, studies have shown doctors to use discursive techniques to secure patient agreement to a treatment plan (Anspach 1993, Dixon-Woods 2001) or constrain patient participation in treatment decision-making (Robertson, Moir, Skelton, Dowell and

Cowan 2011). Conversation analysis studies have also examined active and passive forms of patient resistance and doctors' attempts to secure agreement to treatment plans before shifting to the closure phase of the encounter (Stivers 2006). However, no one has yet shown how these techniques are actively taught in medical school and examined the implications this has for understanding the perpetuation of physician authority in contemporary medical practice. This is important because in actual practice, the researcher must often deduce why a doctor does what he/she does when talking to a patient. In medical education, the how and the why of doctor – patient communication are explained together, because the students do not yet know how to talk to patients as doctors. This also clues us in to a mechanism of the reproduction of physician authority; students do not have to develop *ad hoc* strategies for getting work done in the encounter. The strategies are taught to them by their clinical professors.

In chapter 4 I discussed the process by which students get used to their role on the other side of the medical encounter and how they learn to do this doctoring work properly, including how they use language and artifacts to get patients to undertake desired courses of action, such as leaving the room. In this chapter I continue my focus on medical language. Medical language has long been a tool to get patients to do what the physician wants (see West 1983, Mishler 2001). But whereas language used to be used to limit patient participation in the encounter, today it is used strategically to get patients to participate.

Patient Empowerment Discourse

Patient empowerment has diverse origins in fields such as health social movements, feminist consciousness-raising, patient education, and social work (Starkey

2003). It is a corrective project that seeks to mitigate a perceived disparity in interpersonal power in the medical encounter, commonly through the use of communication techniques like patient-initiated question-asking (Roter, Stashefsky-Margalit and Rudd 2001). In this sense, patient empowerment is similar to patient-centered medicine and shared decision-making. While there is a noted deficit in standard definitions of patient empowerment (Roberts 1999, Aujoulat, d'Hoore and Deccache 2007), most include the central tenet that patients should participate in making decisions about their treatment and care. Indeed, patient empowerment is widely held as an ideal in medical care (Andreassen & Trondsen 2010), and has been embraced, albeit to varying extents, in medical education.

However, some researchers have also noted that patient empowerment techniques are used strategically by physicians, leading researchers to characterize the very notion of patient empowerment itself as a contemporary route of medical paternalism. Haug and Sussman (1969), for example, discuss the co-optation of the 'client revolt' by medical professionals and describe organizational methods to quell patient resistance, such as patient councils or patient representatives to medical boards. This, they write, is a way for the medical profession to "socialize the dissidents into the special organizational knowledge of the inner professional circles" while retaining control of the esoteric knowledge that justifies physician autonomy (1969:158).

Although evidence that doctors strategically use language to meet instrumental ends is present, there has been less work on how physicians *learn* to employ discursive techniques in their interactions with patients. Such an analysis would enable one to see physicians' interactional ability in formation, a process that takes place in medical school.

Understanding how medical students learn to interact with patients is significant because they are often taught these skills by practicing physicians. The physicians are currently practicing doctors in the community and are familiar with the differences in medical practice today from how medical practice took place when they were being trained. These physicians have had to adjust to changing practice structures, medical technology, and patient preferences during their careers. Their teaching is therefore informed by their experience as practitioners. In educational settings, physicians explain how to talk to patients, often at the same time explaining the rationales for these discursive techniques—how using these techniques will allow students to achieve their goals of accomplishing their work in a timely manner, actually achieving results with patients, and retaining patients’ business. As they reason through different actual and hypothetical patient scenarios, the physicians expose their impressions of the profession and patients and how these inform their actions in consultations.

In this chapter I present discourse use as a bid for countervailing power that operates on the interactional level during the physician – patient encounter and is learned during medical school courses on doctor – patient interaction. I characterize the nature of doctor – patient interaction by examining the backstage (Goffman 1956) of medical training. Here, the rationales for communicative techniques are clearer, since they are articulated in the process of training. In line with noted historical trends of anti-paternalism, patient consumerism and health social movements, as well as teachers’ characterizations of the medical school curriculum, I use the term “discourse of patient empowerment” to describe the communication techniques I observed during medical student training sessions. Discourse can be both a sign of authority and a way of

exercising authority in interaction. Discourse allows one to “name and frame” medical problems (Brown 1995, Conrad 2005), it represents institutionalized ways of speaking and thinking that are learned through enculturation into the institution (Collins 2010), and discursive techniques allow for the exercise of power between people (Foucault 1982).

During medical school, students learn their professors’ perceptions of the stature of the medical profession, restrictions under which they work, their sense of the profession’s history, explanations for the way things operate in the profession, and the way they encode these perceptions into their everyday actions with patients. In the course of the analysis I do not attempt to present faculty members’ motivations (an internal cognitive state I have no access to). Rather, I present professors’ perceptions of historical trends and the constraints these have on daily professional practice and possibilities that exist for ‘old’ ways of doctoring to persist in spite of these constraints. Professors readily reference these perceptions in lectures and small group settings. Based on my findings that medical students are taught to use language authoritatively in the interest of patient compliance, I present this as a microsocial, cultural bid to reassert medical dominance on an interactional level that is shaped by broader cultural standards for the exercise of authority. To support my claims that the medical profession has adopted and creatively repurposed empowerment discourses to keep up with changing cultural notions of authority, I take into account the faculty members’ stated awareness of the history and public stature of the profession as a way of linking what happens inside the medical school to what happens outside of it.

In this chapter I present a classic tension in patient care. Physicians feel a sincere desire to help the patient, and often believe they have remedies that will ameliorate the

patient's condition. However, the physician must square these interventions with the desires of the patient, which have been increasingly marked by consumerism and Internet-aided acquisition of medical knowledge. The Clinical Practice course was marked by this tension. It was also marked by less patient-centered concerns, such as how to complete consultations in a timely manner, how to deal with difficult patients or challenges to their expertise. Overall, I found that the faculty members had embraced the critique of medical paternalism that is embedded in the patient empowerment movement, but had difficulty reconciling the need to give patient-centered care with the fact that they found informed or consumerist patients to be time-consuming and challenging. In professional terms, the communicative strategies I present below and the rationales that underpin them represent a bid for medical professionals' own countervailing power—a way to resist perceived patient consumerism. Instead, medical students are taught to enroll the patient into the doctor's proposed plan. In an era of chronic disease management, this is important because the doctor needs the patient to carry out the day-to-day management of his/her own condition in the way the doctor wants him/her to.

In the following sections I present the issue of contemporary U.S. physician – patient communication training in three steps. First, I present physicians' awareness that the classical paternalism of the Golden Age is no longer a tenable interactional strategy for physicians. Second, I present a practical problem: how the physician experiences his/her objective to give medically competent patient care as being in conflict with the agendas of informed and agentic patients' own objectives for their care. Importantly, the physician's authoritative resources are constrained by the cultural context of contemporary health care. This context results in a customer service orientation becoming

part of physician professionalism, but is also frustrating to physicians. Third, I present the solution to this problem: “closing the deal,” which is a set of discursive practices that occurs during the end-phase of the medical encounter and is trained using simulated patient care scenarios. These practices follow the disclosure of test results or a diagnosis and help the physician and patient negotiate a treatment plan.

New Context: Historical Constraints on the Physician – Patient Relationship

Medical educators have internalized the critique of the medical paternalism that has become standard in the literature, and they have materialized this critique in professional skills training curricula for medical students. Amongst Clinical Practice faculty members, therefore, is a broad awareness that physicians can no longer talk to patients as they did in the 1950s—students are introduced to this era of American medicine as unprofessional by today’s standards by Dr. Horner, a key member of the Clinical Practice teaching team:

Ok, respect for families, respect for patients and families. This is another key principle of professionalism, is demonstrating respect. Ok? This is what I’m talking about with this sort of peer relationship you have with patients now, not this sort of autocratic, condescending, paternalistic kind of thing that we used to have. You know, when I was in medical school. [...] I don’t have to agree with everything they say, but I have to respect it. [...] In 1950 in the United States, I think it was something like 90+ percent of physicians would not tell their patients they had cancer. In this country—in 1950. Ok? That would be totally unprofessional today.

Dr. Horner models for the students a tension that he experiences as a physician between disagreeing with the patient and respecting the patient. He distinguishes the way he relates to patients today from the way he learned to relate to them when he was a medical student, and gives a sense of how the broader cultural context of health care provision is present in the local encounter.

Later in the lecture he explained how the doctor – patient interaction is related to patient satisfaction and compliance:

This relationship is critical to everything you do in medicine. And these are just a bunch of detailed, specific proofs of that thesis, ok? So there's no question that the way you relate to patients is related to patient satisfaction, which we, just so you know, we get measured on, individually and as a practice, every quarter, ok? [...] But the point is that patient satisfaction's important. Patients are more likely to actually do what you say if they had a reasonable interaction with you, ok? You can be brilliant and develop the best plan in the world and if the patient wads it up and pitches it in the garbage can on the way to the front door of the office, you know, all your brains are for naught 'cause you didn't sort of *make the deal* with the patient. I mean, you know, you're there as a collaborator, you're not there to say, you know, "well, here's the orders [*affects gruff, stodgy tone of voice*], here's what you should do." They're more likely to stay with you, you know, which is the goal.

Here Dr. Horner distinguishes again what he is teaching the students from traditional 1950s paternalism, as exemplified by his gruff rendering of "here's the orders." He highlights the role of "making the deal" with the patient as the alternative to giving patients orders, and tells the students that properly making the deal will make patients more likely to continue their care with the physician. Dr. Horner makes it clear that patients today are different from those in the 1950s and that the physician's behavior must change accordingly in order to preserve the doctor – patient relationship. Although the excerpts are drawn from one lecture, they echo the general tenor of interactions between students and faculty members I observed at WCMS.

Problem: Balancing the Need to Accomplish Work Tasks with the Need to Retain Clients

Physicians experience the increase in patients' countervailing power as a practical problem. Patient consumerism is not merely a request for a desired treatment; it is

increasingly common for patients to research their conditions before meeting the physician. These patients leverage their lay expertise and create a situation in which the physician must reassert his/her credentialed expertise. Furthermore, the sense that a physician (through careless conversation) could lose a patient to follow-up or another physician's second opinion looms large. This awareness promotes customer service-like behavior and subtle persuasion amongst physicians, and is taught overtly as a strategic form of patient-centered communication in medical school. As Dr. Kavinch, another lecturer, explains:

As soon as I will start telling you what to do, go ahead, exercise, pay the membership, buy the Nike shoes and you will be fine, or, stop eating this crap and start eating right—or else! You will become very defensive; it's a normal human response. So, every time you talk to a patient, and even if you believe that this medication, this particular medication is particularly important and useful for this patient, if you just tell the patient, take the medication, [do] it right, do it exactly the way I told you—or else. I can guarantee you that the patient will never follow through. The patient will become very defensive, very resistant, and most likely will change the doctor. [Emphasis mine]

Dr. Kavinch presents the consequences of using “here's the orders” paternalism in this example—if patients do not want to accept the treatment and the doctor is unable to explain it in a way that makes sense to the patient or conveys the gravity of the situation, the patient will become defensive, resistant, and may change doctors. As Dr. Horner also highlighted in the previous section, the goal of a doctor – patient interaction is to get the patient to stay with the doctor. This both acknowledges consumerism, in that the patient has a choice to stay with the doctor or not, and acknowledges the reality that a patient might not take the treatment at all. The goal of the Clinical Practice course is to achieve both of these objectives, clinical and professional.

In CP lecturers, lecturers articulate the difference between the physician's role and the patient's role in the encounter. For example, Dr. Zelisk, one of the course directors, explains it in this way:

So, a patient comes in with a problem. And you need to gather information, but there's two different agendas you need to consider when you're gathering that information. Down the illness framework is the patient's agenda. Their agenda is their ideas, their concerns, their expectations, their feelings, their thoughts, and the effects that their illness is having on their life. And the disease framework, what we're focused on are the symptoms, the signs, the laboratory tests and the underlying pathophysiology because we want to come up with what's called the differential diagnosis, which is our possibilities for explaining what's going on with them. And somehow we need to accomplish both of these things at the same time, so that we can integrate our agenda and their agenda and come up with a shared plan for how we're going to attack their problem.

She presents a role for the patient that is constrained to strictly non-medical aspects of their condition. So, while patients should participate and, as Dr. Kavinch explains, the doctor should not just dole out orders, the role for the patient is one of *constrained collaboration*.

Problems can arise, then, when patients come in to the doctor with their own ideas about what is wrong with them. As Dr. Horner explains, these patients can be challenging for the doctor because they may have incomplete or incorrect ideas about what is making them ill:

Well, when your patient comes in with a web printout sheet with, you know, articles and they're instantly aware and informed about their medical care, I say that with tongue in cheek, you know, this becomes a little bit more of a challenge to manage. Okay? Because they don't have the knowledge. You know? Because if all you needed was, you know, a wad of printouts, why would we charge you 30,000 dollars a year and have you come to medical school for four years? You know. So, there has to be some give and take with the patient—they bring some information,

some preferences, things like that, and you bring the knowledge that you have and you make sort of a shared decision.

As Dr. Horner and Dr. Zelisk explain, negotiations about treatment proceed when the patient brings his/her preferences and some information, while the doctor brings the medical knowledge. This attitude towards the division of information contribution in the physician – patient encounter is not unique to Dr. Horner and Dr. Zelisk; in fact, it is echoed in other statements on patient-centered medicine, such as Delbanco (1992) and Barry and Edgman-Levitan (2012). The struggle to integrate the imperative to do patient-centered medicine with their conception of doctors as having primary expertise over health and treatment characterizes the Clinical Practice course and colors the lessons the students learn there.

Examples from lecture teaching such as these establish the terms of the doctor – patient relationship and give the students expectations for how consultations will proceed. It is in their small groups that students encounter specific patients (in the form of skits or standardized patient actors) and have a chance to try out the techniques their instructors demonstrate.

Solution: ‘Closing the Deal’ in Standardized Patient Exercises

In the Clinical Practice lectures at WCMS students learn what effective and professional doctor – patient communication is, how to carry it out and why it is important. Students also gain a sense of the historical context of doctor – patient communication. However, Dr. Horner is careful to explain it is not enough that the physician possess medical knowledge. The physician must also make the deal with the patient. Evidence from Stivers’ (2006) work points to the fact that while patients see the

role of giving diagnosis as within the physician's realm of expertise, treatment planning is a shared domain and therefore open to negotiation. Indeed, the standardized patient exercises at West Coast Medical School reflected this clinical reality, and students were taught to accommodate patient participation in treatment negotiation. "Closing the deal" is the final stage of the medical encounter and can be accomplished through implementation of specific conversational techniques that compose the discourse of empowerment. Students review and practice these communication techniques in their small group sessions.

Standardized Patients

Standardized patients, actors who follow a script to help the students learn communication techniques, are an important part of contemporary medical training (Ainsworth, Rogers, Markus, Dorsey, Blackwell and Petrusa 1991).¹ Students at WCMS are trained to talk as doctors during standardized patient exercises in the small group component of the Clinical Practice course. Many exercises occur in a mock clinic setting and are used as an assessment of students' clinical skills, but others, like the one I highlight below, are faculty-mediated group training exercises where students take turns interacting with the patient. These sessions can be paused by one of the faculty members to make corrections in technique. This scenario is very similar in form to the patient with depression encountered in the previous chapter.

The curriculum directors construct and mediate the standardized patient's performance through actor training and a script. In this setting, standardized patients function as a technology whereby medical educators train students to interact authoritatively with patients, and to expect the outcome of normal patient interactions to

be patient acquiescence. This is because standardized patient encounters are organized in such a way that they do not end until the medical student, playing doctor, has figured out a way to get even resistant patients to buy in to the doctor's treatment plan.

In the following account of a Clinical Practice session, the students worked with a standardized patient-actor, "Mary Smith," to negotiate her use of an at-home glucose monitor to confirm the doctor's preliminary diagnosis of diabetes. In this exercise, the students were given two tasks: disclose to the patient that she had most likely had diabetes, and to convince her to take home a glucose monitor and to check her blood sugar for two weeks. This exercise simulates a follow-up medical encounter, with an unexpected disclosure of new information (she had previously come in to be treated for a urinary tract infection). The tricky part for the students is persuading Ms. Smith to carry out what she perceives to be a troublesome self-monitoring program, especially since it was given in the instructions for the scenario that the diabetes test results were not definitive.

Closing the Deal

"Let's review our techniques," said Dr. Whitney Henderson, one Clinical Practice leader. "What do you need to take into consideration before you give information?" The students replied that it would be important to find out the patient's knowledge level before beginning to educate him/her about the diagnosis and treatment. Dr. Henderson reviewed the "Ask-Tell-Ask" technique that the students had been taught in their Clinical Practice lecture. "Remember," Dr. Henderson told them with a knowing twinkle in her eye, "it's not 'Tell-Ask-Tell.'" This was a sly reminder to avoid the same type of "here's the orders" paternalism that Dr. Horner characterized as unprofessional during Clinical

Practice lecture. Dr. Henderson elaborated on what “Ask-Tell-Ask” means in practice: “Ask them where they’re coming from, tell them something, ask them if they got it.” Dr. Henderson also reminded the students of a similar technique: “Chunk and Check,” where doctors give patients chunks of information about their condition or treatment and then check the patient’s understanding of what s/he has just been told. “Ask-Tell-Ask” is oriented around a physician’s question, thereby preserving the authoritative question-answer-question cycle observed by Mishler (2001). “Chunk and Check” is used to assess whether the patient understands the doctor’s recommendations. Both of these techniques serve to direct and orient the patient to the physician’s priorities in the treatment decision-making process.

A few minutes later, Mary Smith entered the seminar room and took a seat at the table. Victor, whom Dr. Henderson had appointed to go first, was responsible for delivering the news to Ms. Smith that she likely had diabetes. After he had tried the interaction, other students picked up where he had left off and began to move to the main event of the encounter: convincing Ms. Smith to self-monitor her blood sugar levels at home for two weeks. Chaz and Monica each had a go at talking with the patient. During each of the encounters, Ms. Smith grew increasingly tense; while the test results had not shown that she definitely had diabetes, each student was nevertheless trying to get her to take on the inconvenient task of glucose self-monitoring.

Dr. Henderson stopped Monica partway through her stint as doctor. Dr. Henderson pointed out to the group that the patient was frequently frowning and “giving [Monica] a lot of body language.” Body language here serves as a gestural analogue to the passive resistance noted in Stivers (2006). Dr. Henderson said to Monica, “I want you

to name the emotion. Now, ‘overwhelmed’ is not an emotion. Fear is an emotion, anger is an emotion.” “Naming the emotion” is a technique that students at WCMS are taught to use as an opener to a difficult conversation about a patient’s feelings. Naming the emotion is nearly always formulated as a statement—“that must be really scary for you”—that sums up the emotion the patient seems to be expressing in the consultation. The students are taught that by saying the emotion first, the doctor can open the door for the patient to elaborate on his or her feelings. The reason why this is important is that these feelings may relate to the obstacle that is blocking the patient’s desire or ability to carry out the doctor’s treatment plan. Dr. Henderson prompted Monica to address the concerns that Ms. Smith raised: she had a lot to do between taking care of her children and running her household and was worried about incorporating glucose monitoring into her already stressful life.

By naming the emotion, Monica was able to get Ms. Smith to ‘tell her story’—another technique students learned in Clinical Practice lecture. In telling her story, Ms. Smith discloses her obstacles to glucose self-monitoring. Once Monica knew the obstacles (family pressures), she and the other students were able to work with Ms. Smith to convince her that it would not be difficult or time-consuming to carry out the monitoring. The “ask” in these scenarios is generally something like, “do you think you could do that” or “do you think that would work for you?” The goal is to get buy-in by proposing something that the doctor wants and that the patient is actually prepared to do. Dr. Horner explained a version of this technique in a CP lecture:

You can advise. You can sort of say, you’re the information person.
 You’re not the *you should do this* person. You’re the information person.
 People who generally [are] overweight, they’ve got a higher frequency of

developing diabetes. People who have diabetes lose their feet. You know? You can deliver messages. You need to agree with patients and roll with them, and sort of roll with where they want to be. Collaborative goal setting—it's not *here's what you need to do* and then you're non-compliant or non-adherent at the next visit. You need to roll with them. You need to assist. If they say, well, I hate sweating when I exercise. Okaaay, what do you hate about sweating? You know, you work with them to figure out what the barrier is. A fan might work, who knows? And you need to follow-up. You need to not just say, Lose 20 lbs. One of the *best* notes I ever saw was an orthopedics clinic at Harbor up the road in LA. [Short laughter] Patient came back to see me, needed a spine operation or something, and [laughing] she said, they refused to operate on me. I looked at the note and it said *lose weight, return 6 months*. [Student laughter] Orthopod really discharged his responsibility perfectly.

Motivational interviewing—help patients be ready, willing and able to enact a self-management plan. This is what you're going to practice this afternoon. It's patient-centered and empathic. The patient sets the agenda. Now, patients don't *always* set the agenda. If they roll in at 280, we have an agenda—whether their agenda is, my elbow hurts or not, we have an agenda. But it has to be, you know, patient centered and you have to sort of understand where they are using the skills we just talked about. So, motivation to change is elicited from the patient, not imposed from without. So, less advice, less psycho-education, more of, well, how is it being 40 lbs overweight for you? How's that working? [Laughter] That's like, [the] current phrase. How's that doing for you?

In this paragraph, Dr. Horner again proposes a constrained collaborative role for the patient in the encounter. It is clear that patient-centeredness is valued in the encounter, but it is not as important as making sure that the patient receives the care that the physician thinks is necessary. At the end of this section is another version of the question Dr. Henderson asked Chaz, documented in the previous chapter, when he was playing an overweight patient at risk for diabetes.

Collaboration between the healthcare team and the patient. You need to support the patient's own ways of doing things, things that they can do, their expertise, their autonomy. You need to roll with resistance. Sometimes the resistance to change that we suggest is the way we suggest it. *Lose weight*. You're not getting any surgery out of *me* unless you lose

weight. That's not exactly designed to produce a receptive patient who wants to change their behavior.

You need to enhance readiness through resolving ambivalence—what are the pros and cons, I mean, I hate to sweat, but I hate being 40 lbs overweight. You have to have the patient do a balance sheet and sort of figure that stuff out. These are all tools you can do in 2, 3 minutes in the office. So, you need to enhance the patient's ability to do change. You point out things that they've been successful at before, and you have them work from those.

Enhancing a patient's ability to change through resolving ambivalence is one of the tactics the students were trying with Ms. Smith in the CP exercise. They were working to convince her that using a glucose monitor a few times a day really was not all that bad and that it would generate useful information about whether she had diabetes.

Dr. Horner continued:

So you have 6 tools in the thing we sent you. Assess the state of change—are they, do they need education about why this is not healthy? Do they really not *know* that this behavior's not healthy. Or what about this behavior is contributing to their other problems that they're taking *pills* for and spending *money* on and trying to *fix*! Even though they're pouring gasoline on the fire at the other end. You need to do the pros and cons thing—what would be the pros of staying the way you are, what are the cons? [...] You know, you can do this ask-tell-ask that Sharon Zelisk is going to teach you a lot more about in the spring in terms of sharing information with patients, and you need to assess the conviction and the confidence in patients. So, if you set up a plan that you're going to work with the patient on, then you say, how confident are you that you can do this grand plan that I just sort of helped you construct? And then the patient says, oh, a 2 out of 10. Well, is that dead on arrival? Is that going to be the prescription that sort of gets [tossed] into the can on the way out the door? Why not give them something that they say, I think I can do that on an 8 out of 10 scale? So, you've got to do that kind of assessment of their confidence and how important you think this is. Aw, I don't think it's going to make a difference. You think someone's going to change behavior if they don't think it's going to make a difference?

Dr. Horner continued on to demonstrate how to make the “ask” to close the deal in a patient encounter—how to get the patient to agree to the treatment plan. He also

demonstrated what not to do when trying to get the patient to commit to behavioral change.

Agenda-setting, action plans, this is specifically what you're going to do this afternoon. So we're giving you the template that *we invented* in our *EMR* to do this in the office with patients. So, when I go in there, instead of lapsing into my usual physicianoid patient psycho-education gig, Ah, you know, you really need to stop eating at in and out burger, you really need to *WALK* every day—don't you think you could *WALK* 30 minutes every day [said through gritted teeth], I mean, you know, let's make a plan: walk 30 minutes every day. I've done a good job, a note, I've got the plan down, patient [makes a sound that indicates that the patient is not really on board with the plan]. So, you've developed this little thing that allows you to do this kind of action plan developing about, what do you want to do [directed to patient]. So, you do the hardest thing in the world for a physician [to do]—shut up! So, you say to the patient, okay, you've talked to me about not liking being overweight and you're worried about developing more diabetes. Or diabetes like your Aunt Mary had. So, what do you want to do about it? [Pause] Well, maybe I could walk a little. What do you mean by that? Well, when I go to work I have to park the car. Maybe I could park it sort of at the far end of the parking lot. Good, I like that, that's cool. How long does it take you to walk all the way into the building? 5 minutes. Okay. Work with the patient, roll with the patient. What are the things that might be a barrier? Well, I'm frequently late for work. Well, that would probably make you want to park closer, right? Yeah, that's true. Well, how could you make sure you have enough time to walk the extra five minutes to the building? Well, maybe I could get up earlier. Okay? So, you know, you go through this with them [student laughter] and it doesn't take very long but it's responsive sharing and constructing, it's not you rattling off a bunch of goddamn things they're supposed to do. Okay?

In addition to linking up the conversational techniques with what they are designed to do, this excerpt provides another example of the fruitlessness of simple patient education. Dr. Horner is clear that there has to be actual patient buy-in for the doctor's recommendation to take hold. Dr. Horner works to resolve obstacles and ambivalence the patient has about behavioral change just like Dr. Henderson coached the students to do in the encounter with Ms. Smith.

Similar to closing the deal with a patient who does not want a certain treatment is dissuading a patient who is asking for an inappropriate treatment. In another Clinical Practice session, the students were taught to dissuade a patient who wants an MRI scan. The professors set the terms of the encounter in the instructions to the students: in this case, an MRI would be medically inappropriate and too expensive to responsibly order without due cause.

After discussing how they might approach a situation such as this, Dr. Henderson went to the board and began to write a list. She said, “A bunch of you acknowledged and validated feelings.” Chaz said, “we named the emotion.” Dr. Henderson continued, “You’re emphasising your advocacy, that you’re their advocate. So, what’s your next step in someone who’s asked for something inappropriate?” She wrote on the board, “Educate.” She continued, “So, you’re educating about their condition, but aren’t you also educating them about their expectations?” She wrote, “Negotiate,” “Time Frames” and “Alternatives” on the board. She said, “You know, I like what Monica said—my license is on the line.” [*The leader had earlier introduced this rationale and was reinforcing Monica’s repetition of it.*] Later Monica asked, “Are you going to lose a lot of patients if you’re just like, “sorry...”? Dr. Henderson replied, “If you do this [educate your patients] well, you have fewer problems. [...] Monica said, “My ideal patient is one who’s going to respect that I’m a well-educated health professional. I don’t really want to deal with the rest of them.” [*Sympathetic and genuine laughter from all but Chaz, including Dr. Henderson. Then Dr. Henderson moved the conversation along without further comment.*]

Scenarios about a patient coming to the doctor with a diagnosis or treatment in mind are how the students often encounter patient consumerism. Part of their role as a doctor, Dr. Henderson teaches the group, is educating the patient—both about what a proper treatment might be, as well as educating the patient about his/her expectations of medical care. Several further communication strategies are presented in this excerpt, including using the doctor’s legal obligation to only give appropriate medical care (“my license is on the line”). Negotiation, Alternatives and Time Frames are other techniques reserved

for resistant patients. When a patient simply will not agree, then the students are taught to say something like, “Alright, let’s keep trying your method for another 2 months. If you’re not better by then, we’ll try my way.”

When medical students carry out mock patient encounters, the exercise does not end until the students have worked out how to close the deal, and their professors scaffold this process by offering conversational techniques and tricks. By making closing the deal both a responsibility of the physician and a condition for a student’s successful completion of a patient exercise, medical professors teach that authoritative communication is inherent to doing being a doctor. Although these communication techniques are patient-centered—in that they are specific to each patient’s circumstances and elicit the patient’s experiences and feelings—the doctor’s plan remains primary. Using the discourse of empowerment helps physicians reconcile the sometimes-contradictory goals of patient-centered and doctor-centered medicine.

The theoretical analysis put forth in this chapter examines physician – patient interaction courses in medical education in order to understand how changes in professional dynamics on the macrosocial level affect the daily practice of rank and file physicians. Empirically, it investigates the strategic use of communication techniques by physicians to help them secure patient compliance. Most work on countervailing powers has focused on structural aspects at the professions level of analysis. However, in spite of changing professional dynamics, individual physicians continue to accomplish routine work tasks; thus, it is important to understand the microsocial expression of changing professional conditions, as well. Because the medical school is populated with practicing

physicians, it becomes a reliable window into contemporary physician practices of patient management.

During the Clinical Practice course at West Coast Medical School students are taught by their professors, who are practicing physicians themselves, that an exercise of authority is necessary to get their work done. But at the same time, students are taught that classical medical paternalism is no longer a tenable interactional strategy. The central practical problem that these students face, then, is how to accomplish their work as providers within the narrowed range of expressions of authority they are permitted to use. This dovetails with the process, explained in the previous chapter, by which students reconfigure their relationship to the lay community/patients. As I show, medical students are taught to secure patient compliance by using discrete conversational techniques: validating a patient's emotions, setting a patient's expectations, ensuring the patient understands the physician's version of the problem, securing the patient's agreement to the physician's treatment plan. The use of these techniques aids physicians as they negotiate treatment objectives with patients.

Thus, although students are taught ostensibly patient-centered techniques—elicit and validate patients' feelings, interact with the patient as a collaborator—during lectures, the rationales for these approaches were often marked by doctor-centeredness. The prime example of this is Dr. Horner's tongue-in-cheek mocking of patients who research their symptoms before visiting the doctor. This cynicism seems to be rooted in frustration physicians face as they administer care in a context where just saying "here's the orders" will no longer suffice. Even when the doctor has sincere collaborative intent, the role for the patient's collaboration is still constrained to his/her preferences, values,

and so on. These practicing professionals make clear that there are multiple functions of these communication techniques that physicians can manipulate to achieve their goals in the encounter. These communication techniques create a feeling of patient-centeredness while also allowing the physician to achieve his/her goals in the encounter. Often, in practice, shared decision-making means eliciting a patient's preferences to assist the patient in choosing between fixed choices in a plan made and set by the physician.

I have linked the communication practices used by physicians I observed to the values of the patient empowerment movement, and named this the discourse of empowerment. Because physicians are resourceful in their adaptations to the changing cultural environment of medical practice (see Timmermans & Oh 2010), they have appropriated this discourse from health social movements and patient education. In professional terms, the use of patient empowerment discourse in the interest of patient compliance is a new expression of the exercise of physician authority, and represents a mechanism by which the medical profession resists the countervailing power of patient consumerism and exerts professional dominance with its own form of countervailing power: a discourse of empowerment that does double duty to satisfy both patients' and physicians' needs in the encounter. In short, the discourse of empowerment helps physicians achieve their goals in the encounter while preserving the standards of patient-centeredness.

Medical students at WCMS are taught to talk with patients by practicing physicians, and the primary way that this teaching is accomplished is through discussions of simulated patient care scenarios. Because the scenarios are modeled on real life patient encounters and facilitated by practicing physician professors, they provide realistic

understandings of what practicing physicians think about patients and how patients are perceived to act during the medical encounter. These types of teaching situations provide access to the clinical judgment and professional self-image of the contemporary physician. Further, the structure of standardized patient exercises in medical education trains medical students to enter practice with the expectation that consultations will go their way. The teaching of doctor – patient communication therefore functions as one venue in which to observe the cultural reproduction of physician authority and how it changes over time.

Studying the cultural reproduction of physician authority on an interactional level has implications for understanding the status of the American medical profession as a whole. The last decades have seen an ongoing debate within American medical sociology over the extent and nature of physician deprofessionalization. Indeed, this debate remains unsettled (for a discussion see Timmermans & Oh 2010). This debate primarily discusses structural factors, particularly the reorganization of healthcare provision and funding through managed care and third party payers, as well as the increased regulation of individual physician conduct by hospital and healthcare network administration.

But while recent studies emphasize other stakeholders that resist medical professional dominance, without a further elaboration and focus on physician counter-resistance, countervailing powers becomes merely a new form of the deprofessionalisation argument. Indeed, despite the macro- and meso-level changes ushered in by managed care schemes, physicians still retain primary authority over diagnosis and other practices that lie within the jurisdiction of their profession. As I have shown, physicians are able to leverage existing cultural resources, such as the emphasis

on patient-centered medicine, as a micro-level form of countervailing power against patient consumerism. Physician resistance to countervailing powers can be observed on the microsocial level; through discourse physicians make bids for countervailing power of their own.

Empowerment is a process by which a professional gives power over to the patient—empowers him or her—but empowerment happens with a specific goal in mind: to take one's medication, to monitor one's glucose. In this chapter I have shown how medical students are taught that by using a set of conversational techniques, the physician makes the plan and then 'empowers' the patient to follow the plan. Patients want to get better, feel less pain, or have their normal life back, and the implicit assumption is that the patient is willing to do it in the doctor's way. This makes intuitive sense: the doctor, after all, "knows best," but what is the nature of empowerment in this situation?

Dr. Henderson explicitly distinguished what she taught the students from the type of medical paternalism that was common in the Golden Age of Medicine. She said to the students, "This is you, working with another human being who has a life and opinions. This is not the paternalistic, 'don't worry about it honey, just take this pill and come back and see me in a couple months.'" Yet there is a persistent cultural expectation within the medical profession that physicians should be authoritative in their interactions with patients because they have the most relevant expertise in the situation. Medical students learn overtly and implicitly from the beginning of their training that they are the agent in charge of the medical encounter both for making medical decision and that they have the responsibility to close the deal with the patient. Understanding the discourse of empowerment as a new form of medical paternalism—one that is particularly suited to

the healthcare and wider American cultural environment today—contrasts with structural-level narratives of diminishing professional authority and contributes to a theory of the micro-level reproduction of medical authority as a set of interactional practices.

A version of Chapter 5 is under review for journal publication. The dissertation author is the sole writer and investigator of this paper.

CHAPTER 6: PLAYING SURGEON: THE ANATOMY LAB REVISITED

In this chapter and the following one, I shift from examining how teachers help students become doctors vis-à-vis patients to how the teachers cultivate students as colleagues. This chapter is a pivot point because it contains a little bit of both learning to be a doctor and learning to be a colleague.

Cadaver dissection is one of the canonical rites of passage that marks the medical student's status transition from layperson to doctor. The cadaver experience is significant to the medical community because it is the first setting in which the medical student takes on the role of the doctor, a role that is implied by the cadaver, lying supine on a metal table, in the position of a patient. The image of the cadaver as "first patient" is highly nostalgic and represents an era in United States medical education when students had little experience with death or patients' bodies; the cadaver was often the only patient-like body they had access to until their third year hospital rotations began. For this reason, the gross anatomy course has been primarily investigated for the implications for bedside manner when the first patient is a cadaver.

Gross anatomy is the study of anatomical structures visible to the naked eye, as contrasted with histology, the study of micro-anatomical structure (arrangements of cells). Gross anatomy involves cadaveric dissection, learning with plastic models and already dissected cadaveric specimens, and referring to anatomical atlases and x-ray films to learn bodily structures. For a long time, what made the cadaver experience stand out was that what happened in the lab happened nowhere else during the first two years of medical school: intimate access to a human body. In contemporary medical education,

however, the primacy of the cadaver as first patient has been destabilized by other “first patients” in the medical curriculum: standardized patient actors, living patients with anatomical anomalies, and actual clinic patients. In addition, medical students, by virtue of being members of broader American culture, come to medical school with more knowledge of naked, ill, dead, and grotesque bodies—this they have gained from television and other media. In short, medical students today, unlike those in the past, do not rely on their cadaver for patient contact, nor do they enter the lab as unfamiliar with death as their medical forebears, who have been studied by medical sociologists since the 1950s. This chapter explores departures from the traditional functions of the anatomy lab and examines what *does* happen in the lab.

Whereas anatomists and physicians have a poetic and agentic image of the cadaver as a gift of knowledge to students, sociologists have taken a different tack; although some take the cadaver experience and students’ reactions to it at face value, many look for the consequences for medical practice that are implied when the esteemed “first patient” is a dead one. In a previous era of medicine, sociologists concluded that dissection taught students to control their emotions in front of patients, to be able to handle death, and to control their emotions in front of their peers (Hafferty 1988, Lief & Fox 1963, Smith & Kleinman 1989). In 1963 Lief & Fox published what has become the dominant way of understanding the cadaver experience. They found that one of the outcomes of medical students doing dissection was the development of “detached concern,” a dispassionate demeanor that students effect to maintain emotional control over themselves and their patients so that they can be effective, yet compassionate, caregivers in emotionally heightened situations. Much of a doctor’s persona is wrapped

up in his/her ability to remain calm in front of the patient during trying situations; moreover, the asymmetry of an active medical student and a silent (here, a dead) patient is related to the asymmetry of the doctor-patient relationship, which was at its height when Lief & Fox were in the field.

A similar focus on psychosocial aspects of socialization was taken up by Hafferty (1988) in his well-known study of “cadaver stories,” urban legends told by medical students that feature strong protagonists, weak victims, and heinous and unsanctioned uses of cadavers and cadaver parts. In his work, the encounter with the cadaver has two dimensions: it is reflective of the relationship the student will have with patients, and it is thought to be a harrowing, even traumatic, encounter with death and dying. Hafferty could only speculate about what the cadaver stories might mean for the students later when they would become practicing clinicians, but the implication was that if students were socialized in the lab to understand cadavers as medical tools, they would find it easier to restrict what was happening to their patients to the same emotionally neutral domain.

In contrast, Becker and colleagues (1961) took the same matter of fact perspective that they used to understand medical education in general and applied it to the anatomy lab. While they reported initial student anxiety about dissecting cadavers, Becker et al. took the students at face value when they reported utilitarian and neutral feelings about dissection after the initial anxiety passed. In a related paper, Becker & Geer (1958) found that the cadaver experience is important because dealing with a cadaver lets medical students feel membership in the profession as they begin to deal with the unpleasantness of a doctor’s duty to his patient.

Recently, Lempp (2005) concluded that the focus on emotional socialization in the lab has been too narrow. She found that cadaver labs allow students to practice clinical skills and learn valuable anatomical knowledge, and that a narrow understanding of anatomy as “emotionally grueling” should be reconsidered in light of her students’ positive experiences. Sinclair (1997) concluded that cadavers grant students medical status because they take on the role of patient that legitimates the students acting like doctors. Furthermore, because medically qualified “demonstrators” (TAs and faculty) are present in the lab, students have a chance to talk with them about medicine in general, and thus feel more a part of the professional community. He further found that certain practices in the lab mimicked those from the wards, specifically things that would orient students to the status and hierarchy of clinical teams, like being “put on the spot” during mock rounds.

The Anatomy Lab Revisited

Because the lab has traditionally been a place to learn emotional control in the face of death, there are powerful historical warrants for revisiting the lab. My observations took place in a traditional anatomy environment and are comparable with descriptions in past studies (Becker, Geer, Hughes & Strauss 1961, Lief & Fox 1963, Hafferty 1988, Sinclair 1997). Because the space of the anatomy lab I encountered was so similar to anatomy laboratories I had read about in the literature, I expected to find some of the things other researchers had found before. When I went to the lab, however, the things past researchers had observed—the development of detached concern, cadaver stories, and a preoccupation with emotional control—were not salient. I also did not observe the type of intense teaching and close student-teacher relationships that Lempp

(2005) noted or the types of hospital-esque question and answer practices and “rounds” that Sinclair (1997) observed.

In order to explain my finding that the anatomy lab setting appears very similar to others noted in the literature, yet the students seemed to have different experiences in the course, I will look to historical changes in the American medical profession and society. If the anatomy lab, like other parts of medical education, is a window into medical culture and broader society, then what I saw happening in the lab might indicate that the medical students were already desensitized to the notion of dissection before they come to medical school. While the historical events shaping the practice of medicine also shape the type of doctors students become, it is important to remember that students join the medical world from the lay world and that they do not check their experiences at the door. Students today come to medical school with more exposure to the body—bodies have become more visible in the media, For example, medical practice, including anatomy and related disciplines like surgery, anatomical pathology, and forensics, has been demystified through medical and forensics television dramas (Davin 2003, Goodman 2007). Further, casual nudity and pornography have increased students’ familiarity with the body, although older bodies, such as those donated for dissection, may still be somewhat foreign. Popular museum exhibits such as BodyWorlds present plastinated organs and whole bodies for popular consumption, and one of the major functions of this exhibit is to show people what is under the surface of the skin.

Thus, it is reasonable to presume that cadavers today are experienced differently by medical students because of their pre-medical media exposure. This historical change has theoretical repercussions for the validity of past analyses of the cadaver lab

experience, many of which are implicitly premised on the fact that the experience will be traumatic, even if (as in the case of Becker et al. 1961) their findings include no evidence of this. Second, warm bedside manner has become more important to the doctor-patient relationship since the 1950s. It is no longer culturally acceptable for a physician to remain emotionally detached from a patient (although it of course still happens). As I have shown in other chapters, the medical school has taken an active role in training medical students in doctor—patient communication, partly in response to mounting complaints about poor bedside manner.

Classic accounts of the anatomy lab experience describe it as a time when the student learns to take on a particular type of relationship to the cadaver—dispassionate, emotionally controlled—and speculates that the distance he or she gains from the cadaver will be reflected in his or her future relationships with patients. But I found that medical students no longer develop their primary relationship to their future patients when they interact with their cadavers. Despite the ubiquity of the first patient discourse, the cadaver is no longer the sole “first patient” medical students encounter. Instead, students today learn to relate to patients using live patient-actors, or standardized patients. In this setting they learn to be representatives of the profession in the eyes of the public. What happens in the lab today, then? I found that instead of using the cadaver to learn about their identity with respect to patients, the students actually harness the infrastructure and material trappings of the lab setting to play with potential future identities as surgeons and colleagues. Since students no longer use the dissection course to learn about detached concern or adjust to death, they use the time to develop other skills they think they will need.

Faculty members and anatomy demonstrators figure largely in both Sinclair & Lempp's analyses, and are important for mediating the lab experience so that it feels like a clinical setting. The mediation they provide is to make the lab setting resemble a hospital setting by encouraging clinical reasoning (Lempp 2005) and structuring learning using the same type of question and answer structure as is used on rounds in the hospital ward (Sinclair 1997). However, as I will show, most mundane work time in the lab is not faculty-mediated, and students work through the dissection assignments with only their teammates for company. So, although some studies focus on the role of faculty members in learning colleague relations, there is also a lot of "free play." During this time, as I demonstrate, students learn colleague relations from stereotyped notions of surgical practice.

Recent work has discussed the relationship between anatomy teaching and surgical training (Prentice 2012, Prentice 2007). This approach links with a larger literature on surgery (Bosk 1979, Hirschauer 1991, Katz 1981, Doyle & Roen 2008). These approaches are oriented to the embodied practices of surgeons (Prentice 2007) and the rituals of the operating room (Katz 1981). As I show below, evidence of these rituals can be seen in students' surgical play in the lab and are aspirational because the sartorial and linguistic trappings of surgery are culturally prominent and prestigious within medicine. As in other chapters, language use is important in the lab. Whereas medical students are all but prohibited from using jargon in front of patients, there are no patients in the lab and students can use jargon freely. The anatomy lab actually has two coexisting systems of jargon, which I will discuss below. The lab environment itself supports the students' "surgical play" because it is stocked with surgical artifacts.

Focusing on the material setting of the lab allows us to see that the lab as a place imbued with social relations that are brought to life through play. But unlike earlier analyses would lead us to expect, students are not primarily playing doctor—patient roles. In fact, they are playing doctor – doctor roles. I will show that the anatomy lab offers a space for learning to situate oneself as a member of the profession and craft one’s collegial presentation of self. As I explain, in the anatomy lab, students learn to situate themselves in the profession of medicine through play-acting and teamwork in a quasi-surgical setting. This is facilitated by their unmediated access to the body of the cadaver, the ready availability of surgical tools, the acceptability of high-status medical jargon, and the general spatial and material homologies between an anatomy lab and an operating room.

What is it like to be in an anatomy lab?

Before the course began, students were sorted into teams of five or six students based on their height. This is because the tables were set to different heights so that students could peer into the cadaver for long periods of time without injuring their backs. There were two large rooms with cadavers, which became known as the “tall room” and the “short room” because of the team-height organizational system. On the first day of the course, I joined the team of one of my same-height primary informants. Our group stayed together for the duration of the course, approximately five months, and we worked together in the lab for an average of four hours per week. Each session followed a similar rhythm: students, dressed in scrubs, would troop down to the lab, don plastic aprons and latex gloves, uncover their cadavers, and work through the lab manual’s instructions for that day. Occasionally we watched videos that demonstrated dissection technique, but the

majority of the time was spent unmediated, carrying out dissection with scalpels, forceps (which look like large tweezers), hands and scissors.

During each lab session I was a non-dissecting participant observer and member of my team. Because the dissection tables were placed so closely together, I was also able to observe the activities of and participate in conversations with students at the neighboring five tables, as well as watch from a distance what was happening across the room. I participated in discussions, dressed in scrubs, and did everything the students did, but I did not dissect. This was one of the conditions for my observation, since the bodies in the lab were specifically donated to the school, and the body donors had only consented for medical students to dissect them—not wayward sociologists. My immersion in the lab environment gave me the freedom to ask questions of the students and faculty, and to become a member of the team; I, too, was given a hard time by my teammates for missing the occasional lab session.

Lab space as liminal place

The material setting of the lab can be described as one *liminal place* where the status transformation from neophyte to provisional member of the medical community takes place. As conceptualized by Gieryn (2000), a place is “a compilation of things or objects at some particular spot in the universe” that, in addition to its materiality, is “also interpreted, narrated, perceived, felt, understood, and imagined” (p. 465). Liminal places are between established social structures and in them conventional social forces are suspended so that initiates can leave behind one social identity and undergo the status transformation that will allow them to take on another role in their community (Turner 1964). Liminal places are locations of identity work, but this identity work is often

guided—many initiates undergo formal instruction in the traditions and origins of their community, for example. In the liminal place of the lab, medical student initiates have room to play with the new identities they are taking on. Faculty members are generally aware that students exploit homologies between anatomical dissection and surgery, but the extent to which faculty members support this (pedagogically or practically) is mixed, as I will discuss below.

One of the things that makes the anatomy lab a liminal space is its spatial separation from other school activities. Generally, across medical schools, access to the anatomy lab is restricted to those currently taking the dissection course in order to protect the cadaveric remains.⁹ Visitors are not allowed, and the door is locked and only accessible with keycard or access code. At WCMS, the anatomy lab is hidden away in the basement of an older laboratory building. The paths to reach it are circuitous—even seeming to magically appear—and the routes were not clearly explained to the students. This led to some confusion on the first day of the lab course:

Today was the first day of anatomy lab. When we left the auditorium after two hours of biochemistry lecture, we didn't know where we were supposed to go, what we were supposed to do, what we were supposed to wear, and when we were expected to be in the lab. Luckily some of us remembered that the lab was in the basement. We tramped down the stairs to the lower level, but immediately hit a dead end: a small entryway with one armed security door and an elevator. We were about to go back upstairs when one student told us that he knew the way because he had done the med school prep course over the summer and they had worked in the labs. He called the elevator, pressed the “basement right” button, the other set of doors opened and we walked through the elevator like a secret passage to the other side. The basement hallways were a labyrinth, and we wound around until we found the locker room. We changed into scrubs and clipped on our nametags and began to look for the lab. I overheard the

⁹ Cadaveric remains are valuable and may be stolen and sold for profit, a source of scandal for a similar medical school.

students saying that they didn't know what to do, that they were confused and that they wished they'd been given more information.

Initial Emotional Reactions

As reviewed above, the dominant impression for most studies since the 1950s was that lab course was an emotionally difficult experience for the students. Despite the increase of media exposure to bodies and gore, it would be unrealistic to assert that the medical students didn't experience any apprehension about dissection. As is evident in the following excerpt from my field notes, there was quite a bit of apprehension on the first day of dissection:

Speaking over a dinky home karaoke microphone, the professor told us that we could go ahead and uncover the cadavers. Our cadaver was an elderly woman, thin but not emaciated, and very petite. The students immediately remarked, both to themselves and to me, she "just doesn't look like a real person." This was understandable, as the cadaver had stiff looking, pale skin. Her face was covered, and remained covered for the entirety of the course, with a black plastic bag.

The students in my group looked at the cadaver and talked. They never stopped talking, but it was space filling logistical talk (finding the printout of the labs, getting the tempera paints set up for the lab exercise, and so on). No one touched the cadaver and no one seemed to want to be the first one. After a minute or so, they needed to get started. Still, no one wanted to be the first one to touch the cadaver. One of the guys tried to guide another guy's hand to the cadaver's arm. They gently played around, and the student being 'guided' to touch refused, but didn't act repulsed. One of the women announced, "okay, I'm touching, I'm touching" and she put the tip of her finger down on the cadaver's arm. Then the first student touched the cadaver and told his friend, "it feels just like you!" His friend replied, laughing, "don't say that!" That seemed to break the ice and the students all began touching the cadaver.

However, lab activity quickly became mundane and the students seemed to be fairly desensitized to many aspects of dissection. However, some continued to find the idea of it unsettling. This did not appear to be something that was a constant worry, but rather

something I elicited in interviews outside of the lab. Similar to courses at other medical schools, some ‘humanistic’ touches have been incorporated into the anatomy experience, specifically a body-painting exercise on the first day that was designed to help students become comfortable with the cadaver and to align external anatomical landmarks with internal anatomical structures by drawing on the cadavers with tempera paint.

Some of the things that happen to the cadaver in the course of the dissection class can rightfully be called mutilation. The best example of this is major cuts to the skeleton, which are necessary at different points in the course. However, students no longer use a saw to cut their own cadavers through the midsection to expose the pelvis, as was common practice in the past (see the discussion of Michael Crichton in Dyer & Thorndike 2000). This is done for them by the faculty when it comes time to dissect these otherwise inaccessible structures. The most brutal mutilation of the body the medical students were personally required to carry out was to remove the front of the ribcage (the chest plate) with a large pair of garden shears.

Once the initial adjustment period ended, lab activity became for the most part mundane and students began to attend to other salient features of the lab in addition to the cadaver.

Learning Bedside Manner Elsewhere

As I have discussed, the wide-ranging curricular changes at WCMS amounted to a reorganization of the first two years of medical education. The most visible change was the reorganization of the curriculum from discipline-based to organ system-based courses, the second was the emphasis on early patient contact. Both of these changes greatly impacted the gross anatomy course and what the students learned there. First,

when the curriculum was organized around organ systems, anatomy, a classical discipline of medicine, became redistributed across each organ system “block”—as an outcome of this change, there was less anatomy material per organ system test (since it had to share space with physiology). Second, curricular time was taken away from the lab and redistributed to lectures and other learning exercises. Third, while the anatomy faculty remained masters of their domain, the space of the lab, they had to answer to the course directors of each organ block for everything else. In the process of the curriculum change, the first and second year anatomy courses overlapped for several weeks, putting significant strain on the faculty, TAs and space of the lab. Last, adding standardized patients appears to undercut the significance of the cadaver as the first patient, delivering a symbolic blow to the anatomy faculty. The rationale of the medical school administration was that West Coast Medical School had taken specific steps to shore up its curriculum to match not only that of other medical schools’, but also to more closely match the types of situations the patients will be in during early practice, including learning how to work with participatory patients. The school tends to produce about 3x more Medicine doctors than Surgeons; it is unclear if this is a cause or effect of the place of anatomy in the curriculum, but the anatomy faculty remembered more favorable years during our interviews.

I came to discover that although it hadn’t appeared to, the lab had in fact shifted in concert with the rest of the curriculum—although not by choice. Seeing how pervasive the shift in the curriculum was—it was able to penetrate one of the most traditional, conservative, salient and protected environments of the medical school—the cadaver lab,

gave me insight into the various ways that the medical school curriculum is constantly shifting to adapt to the environment of daily professional practice.

The different ‘doctoring work’ of dissection & standardized patient exercises

The cadaver is no longer the first patient a medical student encounters. Instead, the “first patient” is now a standardized patient actor that the students encounter in a general practice setting—a one-on-one consultation where the focus is on forming a relationship with the patient and getting him/her to do what the doctor wants to do. The bedside manner of the physician that was originally noted as learned in the anatomy lab has migrated to these types of patient encounters. This follows from the larger trends in patient consumerism and empowerment discussed in the previous chapters. Now, students do different forms of doctoring work in these two distinct settings.

In standardized patient exercises, students must wear a white coat and an ID-badge, they must adhere to a general template for history taking and talk in terms intelligible to the patient, they are closely surveilled by the faculty instructor, and they rarely touch the body of the patient. In the standardized patient encounters I observed, as recounted in chapter 4, students were hesitant to wear the white coat and take on the identity of doctor. In contrast to the standardized patient exercise, students in the anatomy lab do not shy away from taking up clothing, language and practices that announce themselves as physicians. They are not as hesitant to wear scrubs in public as they are to wear their white coats. There is never a struggle to get them to wear scrubs to do dissection, as there can be a struggle to get students to wear a white coat and a badge during standardized patient exercises. Talking with patients—even patient actors—is difficult because they can talk back and every patient encounter is an evaluative exercise.

Further, physicians now have to speak plainly with patients, and medical training reflects this. Cadavers do not talk back and the dissection *per se* is not evaluated, only the students' anatomical knowledge is tested. Moreover, although the students sometimes relate to the cadaver on a personal level, it is not cast in oppositional terms to relating to the cadaver as a patient. This differs markedly from standardized patient exercises, where students lament their inability or state their unwillingness to talk like doctors and announce that they just want to talk to the patients "like real people."

Hirschauer (1991) described the "gestalt switch" anesthesiologists cause in the patient, taking him/her from waking to sleeping. He notes how the discourse of the operating room and the activities that take place there abruptly shift as soon as the patient has gone to sleep--the patients are no longer "talked with," but "talked about" (1991, p. 288). In our lab, this was the dominant mode. When patients are not awake, surgeons are free to use collegial language to talk to one another—this is the use of medical jargon. Students rapidly assimilate to medical jargon in all areas of their medical training, but they are permitted to use it in very few settings. It is desirable to use jargon because it is a very obvious way to talk "like a doctor." The anatomy lab *qua* operating room allows them to use high-status jargon in a setting resembling patient care, and this stands in stark contrast to standardized patient exercises, where they must communicate with patients on the patients' lay terms.

Although they develop the vast majority of their clinical skills in the Clinical Practice course, students do learn a little bit about bedside manner with their cadavers. For example, students display a basic orientation of care towards the cadaver—many were careful to clean up the remnants of dissected tissue at the end of each day, and some

even wiped down the tables. This sometimes explicitly invoked the personhood of the patient—saying things like, “hey, let’s clean her up and leave her nice.” Students also used one of their extra cotton sheets to drape across the cadaver’s genitals, in much the same manner as a patient would be draped to protect his/her modesty. (This also served to protect the students’ modesty.) Bedside manner was also from time to time demonstrated by the lead professor, who occasionally patted the cadaver on the shoulder and made a comment directed to it. However, this was not always the case, as the same professor also used the cadaver’s forehead as a flat surface upon which to rest a dissected heart during an impromptu teaching session. So, the semiotics of the cadaver as patient were uneven, but occasionally the cadaver as patient became salient. This does not change the fact that the primary model of a patient in this training program was a live person.

A first patient who is a cadaver does not offer opportunities to learn and practice the complex communication skills that are essential to the practice of contemporary medicine, and medical faculty also maintain that these communication skills cannot be learned during the clinical phase of medical school alone, as they formerly were. Not only are the communicative techniques of patient management sophisticated, the medical school wants to retain control over teaching these skills—they teach the most conservative and most professionally sanctioned versions of doctor-patient communication. In the lab, however, students can practice their doctor – doctor communication skills.

The language of anatomy vs. the language of surgery

Another salient issue in the lab is the language of anatomy. As I mentioned, there are two sets of jargon operative in the lab. One is surgical eponyms, used by surgeons,

and the other is ‘proper’ anatomical terms, used by anatomists. The anatomy faculty members at West Coast Medical School are dedicated to “stamping out” the use of eponymous terms, anatomical features that are named after the person who discovered them. They say that this is because the eponyms do not have an easily discernible meaning to those not initiated into the culture of surgery, so they want the students in their general education to use Latinate and Grecian anatomical terms—those found in the volumes of the *Nomina Anatomica*. The Latinate and Grecian terms tend to be literal descriptions of features, for example, the *locus ceruleus* (dark blue place) in the brainstem, or features named for their proximity to other anatomical regions or features (i.e. peritoneal pouch). As one of the faculty members explained the situation to me:

Surgeons love eponyms. [The other anatomy professor] and I believe that one of the reasons doctors and surgeons particularly love eponyms is because it’s sort of a code. It’s a way of—I don’t know what it is, but it’s a sort of a code for communication that is sort of closed to the general public and even closed to maybe even other doctors who are not so much in the anatomical surgical disciplines.

By using eponyms in lab, students could associate even more closely with the professional prestige of surgeons, but the faculty does not want them to talk this way. This shows that the faculty members are aware of the homology between the cadaver and the surgical patient, but that they also have an active stake in changing the discourse of anatomy and surgery more broadly. Nevertheless, the anatomy faculty’s efforts are limited by the social context the students will encounter during third and fourth year surgical training:

...we recognize [eponyms are] in wide usage so we don’t want our students to be caught flat-footed by not knowing the name, but the pouch of Douglas, everyone calls it the peritoneal pouch. It’s a certain region. [...Or] it’s like Fallopian tube, I don’t know. It’s probably...it may be as

benign as a habit that just won't go away. One surgeon says it to another. Surgery is so hierarchical that you would never have a fourth year medical student holding a retractor correcting their *doctor professor* when he's doing a Whipple and telling him "no, it's not the Pouch of Douglas, it's the peritoneal pouch." *You mean the peritoneal pouch, esteemed doctor?* There's a pecking order, especially in surgery that makes change very difficult. Change comes slowly to some disciplines, surgery especially.

The anatomy faculty cannot enforce their no-eponym policy because of lasting preferences for eponyms among surgeons and their desire to not let their students get caught "flat footed" or violate the hierarchy of medicine by correcting a higher-up. The practice and culture of surgery filters down into the lab, and students use this type of language in their communications with each other. The type of language students use in the lab matters. Language acts such as using jargon are acts of identity (Tabouret-Keller 1998), and by using surgical eponyms in the lab, students support their aspirational, identity-based surgical play.

Playing Surgeon

Material artifacts in the lab

In addition to language use, many things about the material setting of the lab resemble an operating room, and students exploit this homology in their play. But there are aspects of the lab that distinguish it from the operating room and help keep the space from being too realistic. One of these is the unmistakable sensory environment of the lab; it has a distinctive smell that betrays the difference between an anatomy lab and an operating room. Nevertheless, the lab is a good enough substitute for the operating room. It "works" for two reasons. The first is its liminality, as discussed above. The second reason is that it is stocked with useful artifacts that the students can repurpose during their surgical play. The first of these is the cadaver, who does not resemble a live patient,

but can more easily take on attributes of the type of anesthetized patient one would find in an operating room than it could the attributes of a living patient. Other salient artifacts include masks, scrubs, gloves, tools and assistants:

On the way back into the room, students started getting masks, which had been laid out on the counter, and putting them on. A few had gotten masks before the video, and those who hadn't mostly got them afterwards. (After donning a mask, most of the students were also wearing scrubs and name badges, and all of them were wearing plastic aprons and gloves). One of the women students, who had just taken a turn dissecting, told me, "Now I feel like a surgeon; people are doing things for me." This was because another one of the students had fetched her a mask and tied it onto her face while she was dissecting (she couldn't have done it for herself because her hands were busy, but also because she was gloved up). What was funny and went without comment from the instructors, but with some teasing among the students, was that at least half of the students had put their masks on inside out (with the blue part facing outward and the white part facing inward). Those who were wearing their masks backwards brushed off the teasing, saying things like, "dude, who cares?"

This is an example of leveraging high status clothing, which, like language use, is a way that the students mark themselves as doctors. They are further marked as doctors when other colleagues do something for them, like tie on a mask or gown. Ironically, many of the students get it wrong—they wear their masks inside out. Further evidence for the primarily symbolic use of the masks is that they don't keep the smell of formaldehyde out, which is what the students originally thought they would be useful for. The masks protect the students from splashing fluids and bone shards, although these are transient threats.

Cadavers no longer need to be suitable stand-ins for living patients, since there are plenty of models of these in other parts of the curriculum, but they are useful surgical patients—especially when surrounded with other artifacts from the operating room. The anatomy laboratory is stocked with the equipment needed to carry out realistic surgical

play: scalpels, masks, gloves, and plastic aprons. Students themselves come in scrubs and close-toed shoes, just as they would in the operating room. When they join a crowded neighboring table to watch one of the professors teach or demonstrate dissection, they wedge their way in using a technique they call “surgeon elbows.” As they employ these objects and practices in the activities of the anatomy lab, they are playing with surgeon identity.

There is a division of labor within teams that somewhat mimics the division of labor in the operating room—some students mainly “cut” while others monitored the instructions or refer to the anatomical atlas. The division of labor in the cadaver lab tended to follow surgical interest (those who were more interested in surgery or working with their hands did the dissection, those who weren’t read from the anatomical atlas or the lab manual, and those who were supremely disengaged could be found off at the computer looking up material or studying—this was uncommon).

Change the setting, change the type of play

Because it resembles an operating room, the lab setting is crucial for allowing the students to feel that they are authentically playing surgeon. If you change the lab, as it was changed during the Neurology course (from stainless steel dissection tables to working with models, prosections, and samples while sitting at miniature tables), the students no longer feel like surgeons—they report feeling like children:

The tables and chairs that replaced the anatomy tables were child-sized and I immediately felt like I was in an elementary school classroom. [...] Bonnie commented that this lab set-up reminded her of kindergarten. Ken said that it was like elementary school. [...] Another woman came over and we worked with the model eyeball. After that, we joined the table next to us to work on the anatomy of the ear. A TA led the review and

used a model ear that was comically large—as long and wide as his torso. One of the students remarked, “I feel like I’m at science camp.”

The surgical tables, gloves, scrubs and cadavers matter for making the students feel like doctors—the material setting of the lab enables their surgical identity play, and the significance of the setting is highlighted by the way students instead compare themselves to children when the setting is altered.

One important note is that much student time and conduct in the lab is unmediated by the faculty members present there. Students’ work is guided by the lab manual, but their off-task surgical play is largely their own. Although students are not expected to develop actual surgical competencies in the lab, they are expected to learn anatomical features and structures. They are pointedly told that cadaveric dissection enables surgery by providing knowledge about anatomical structures, but that the tissue itself is so different from living tissue that students should not mistake it for surgery. Because anatomists think of surgery and dissection as distinct and discourage parallels, the clinical play I observed, which drew significant and strong parallels between dissection and surgery, is independent of the faculty and demonstrators and dependent on the students’ unmediated access to the body. Also, it is play—the realism of the actual feel of the tissue or the vitality of the patient is not as relevant as what the students are doing amongst each other.

The professional importance of surgical play

Insofar as moral errors are reprimanded more harshly than technical errors among surgeons (Bosk 1979), it could be that beginning the moral training of surgery in a setting where technical skill is not a matter of life and death is one important way that the

anatomy lab experience prepares students for future surgical work. Perhaps it is as Prentice (2012) describes—the cadaver approximates the patient so as to allow the training of social surgical skills in the approximated social matrix of the operating room. As opposed to the case of surgical simulators, where technical skills can be practiced in the absence of the operating room’s social milieu (Prentice 2012), cadavers offer opportunities to practice social skills of surgery (although not as many technical skills). In the lab at West Coast Medical School, building a technical skill set relevant to surgery is not the primary purpose of dissection—students learn anatomical dissection technique, which differs slightly in ways they don’t always like to acknowledge, such as frequently using the fingers to ‘blunt dissect’ tissue.

It is the relationship between the medical student and his or her potential future self as a surgeon (and future self as a third year surgery clerk) that is played out in the anatomy lab. Drawing from stereotypical images of surgeons informed by media and medical experience, and supported by the surgical artifacts in the lab, students try on surgeon identity. This is one of the most accessible medical identities because it is so marked by clothing, language use, and hierarchy. It is a marker of their novice status in the medical profession that students assimilate to this culturally dominant model of physician identity; it is this dominance that makes surgery both desirable and accessible. When the students play surgeon in their dissecting teams, they are imagining themselves as surgeons and treating their peers as their colleagues, in line with their impressions of how things work in an actual operating room. Taking the material setting of the anatomy laboratory into account helps to draw out the different aspects of this play—the anatomy

lab is much more than the psychosocial reckoning with death and patienthood it was previously thought to be.

What, then, is left behind in the anatomy lab in the wake of new patient models being added to medical training? The anatomy lab presents an unusual relationship to the patient—a dead patient, silent in the way that patients rarely still are—except for in surgical situations. Thus, although, as I have shown in Chapters 4 and 5, the more obvious analytical traction is in analyzing the students' interactions with standardized patient actors and how this reflects the medical community's understandings of contemporary patients, what is “left behind” in the anatomy lab is also compelling.

So, while the cadaver in the place of the patient legitimates the self-fashioning and play that happens in the anatomy lab, the lab is not a space where students learn to relate to patients. Instead, due to curricular revisions following from broader changes in medical practice, students learn how to interact with their patients on a new “first patient,” a standardized patient actor—this is the training setting for the professional persona of the doctor vis-à-vis the patient. The fact that students are now socialized to act as doctors in situations featuring two different sorts of patients, a ‘medical’ first patient and a ‘surgical’ first patient, is an indication of a larger trend in medical education: that of shoring up medical education to match the environment of professional practice. In the setting of the medical first patient, this involved inserting the medical first patient, in the form of a standardized patient actor, into the curriculum. This patient can be thought to represent the medical community's vision of who contemporary patients are: empowered, consumerist, informed—patients with a voice. The curriculum change indicates how, when patients and other conditions external to medicine change, the medical profession

adapts to keep up. Medical professionals institute many of these changes at the level of the medical school, even though the interventions themselves likely began as *ad hoc* responses to patients by individual clinicians.

Just as medical students need training in how to craft their public professional demeanors by interacting with patient actors, they also need time to imagine and play with medical artifacts and identities, get used to the segregation they feel from the lay world, and interact with physicians in a purely professional context. This is what the cadaver lab experience offers by virtue of its status as a liminal place—a place in between, where social roles are altered (Turner 1964) and where cultural norms, identities and memories are narrated as part of the “normative landscape” (Gieryn 2000). In the next chapter, students will move from playing with received notions of collegueship to learning how to actually do “being a colleague” on the wards.

CHAPTER 7: CULTIVATING WORK DEVOTEES

The physician profession is marked by a devotion to work, and this extends to American professions in general. Physician orientation to work has specific attributes, like overt service orientation and the need to prove one's allegiance to the profession and to one's colleagues. Also, like other specialized forms of professional work, it involves a lengthy and intensive period of postgraduate training during which the trainees are segregated from their lay communities and transformed into professionals. In light of these issues, this chapter addresses how trainees gain their specific orientation to doing medical work. In this chapter I draw on observations and interview data to ask: how do novices become socialized into work cultures, particularly cultures that prize devotion to work? I show that the work culture students are socialized into prizes devotion to colleagues. Medical students do not just work for patients, but for the interns, residents and attendings on their teams.

How has the nature of collegueship changed over time? Since the 1950s, the number of women medical students has increased dramatically; in 2015, women are nearly at parity with men. This is a far cry from the world of medicine described in *Boys in White*. At that time, the number of women was so small that that they were excluded from the study. These changes within medicine mirror broader demographic changes in the American professional labor force. For Becker and colleagues, the warrant for studying the making of doctors was related to the overall growth of the professional sector at mid-century. Professional work continues to be a large sector in the labor market

today. In this sense, the original warrant still holds, but the theme deserves reinvestigation because of the changed demographics of the medical student population.

Sociology of Professions & the Nature of Work

In other parts of sociology, dedication to work has been theorized as a schema of work devotion. There has been a concerted effort over the past several decades to understand the nature of work. This has often resulted in drawing distinctions between and transitions to different types of work, such as manual labor versus knowledge-based work or professions versus other occupations. While the effort to create a taxonomy of the features of professions vis-à-vis other forms of work was popular in the 1940s and 1950s, this approach was largely discarded in favor of examining common features of work (the Chicago School approach, for a discussion see Becker et al. 1961). There is a continued focus on elite workers in the literature, however, which is generally justified by the power and status they hold (Kahn 2012) as well as a sense that this work is a more extreme case and therefore a better forum in which to observe phenomena like work/non-work conflict (Blair-Loy 2004). In addition, the classical professions, like medicine, still think of themselves as special forms of work and there is a need to take professionals' self-proclaimed work identity into account.

Work on organizational cultures examines organizational processes that structure work and worker identity. Work devotion is a schema "that defines the career as a calling or vocation that deserves single-minded allegiance and gives meaning and purpose to life" (Blair-Loy 2003, p.2). This cultural schema provides ways of doing and being a suitable worker against which workers are judged and judge themselves (Blair-Loy 2004). The literature on work devotion generally examines how workers negotiate the

conflict between work devotion and family devotion. Each type of devotion has its own schema, which invests work or family with certain meanings for the worker and helps the worker decide where to spend his/her time. Both work and family devotion schemas are cultural and moral constructions that are influenced by other elements of culture, particularly gender schemas like biological essentialism, the belief that men and women have certain “natures” that they can affirm through career and/or parenting choices (Cech 2013). Devotion schemas portray work and family devotion as irreconcilable and many workers experience the tension between these schemas in their everyday lives, as evidenced by the popularity of the issue in the news media. Although workers can fashion ways to have both work and family, often by remaining devoted to work and hiring out domestic duties, women continue to experience more conflict between gender and work schemas than men do (Blair-Loy 2001) and often take on more of the housework, the so-called “second shift” (Hochschild & Machung 2003 [1989]).

However, unlike researchers of the professions, theorists of work devotion typically do not focus on the cultivation of work devotees. In a parallel stream of research, literature on professions has historically focused on outlining the characteristics of professions, some of which—like having a service orientation towards one’s clients and considering the profession a calling—resonate with concepts like work devotion. Using the medical profession as an example, this chapter describes the cultivation of work devotion in medical students as they enter their third year clinical rotations.

Professional Socialization in Medical Education

Work devotion *per se* is not currently a topic of study within medical sociology. Medical sociology generally favors organizational arguments (i.e. hospital labor needs)

and epistemic/knowledge arguments (i.e. medical students need to experience treating a wide range of conditions so they can recognize them in future patients). Social psychological work in medical sociology focuses primarily on coping mechanisms for dealing with the volume of work and learning the trainees have to accomplish (e.g. Haas & Shaffir 1977, Mizrahi 1985). However, there is a general acknowledgement that medical lessons are also social lessons (Prentice 2007, Bosk 1979) and quite a lot of work has been done on processes of professional socialization. One part of enculturation into the profession is taking up a physician's identity, which includes adopting professional dispositions. During this process, students learn ideologies about work and presentation of self that reflect what medical professionals think make for good performance as a medical student and future physician. In this chapter I will show that these dispositions are expressed by medical students through linguistic and affective practices in order to convey devotedness to work and the medical profession.

Instead of examining differential work devotion, gendered aspects of work devotion, or consequences of low/high work devotion, I examine the cultural cultivation of work devotion. There is a functional aspect of the cultivation of work devotion in medical students: the students are taught that one aspect of being a good physician (being "professional") is understanding that patients come first across the career, not just during training. In addition, by virtue of their subordinate status, medical students learn strong messages about their place in the medical team and what the collegial duties of the third year medical student are. This is reinforced in anecdotes by professors, both formal, like in lectures and informally, like watching physicians step out of meetings to answer pages or give personal anecdotes during small group teaching. In other words, because the

students are developing a disposition that they will use and are expected to use throughout their career, we can call this an example of socialization, not merely a constraint of training. So, my contribution is twofold: first, I update the understanding of the cultural aspects of medical education that cultivate work devotion in medical students (produce work devotees). Training imposes epistemic, affective and material constraints on trainees. There are social penalties for not being devoted, but there is also resistance to the pressure to be devoted. Second, understanding how the work devotion schema is cultivated in neophytes during professional socialization will contribute to developing the theory of work devotion.

In the following sections I focus on the orientation to clinical rotations week and students' experiences as third year students on the wards. During this period of medical schooling students learn to think of themselves as having a job. They learn to devote themselves to their team and their patients, drawing their work and non-work lives into sharper conflict than ever before in their education. Students' work activity and work presence is regulated by the team and students gradually learn how to negotiate their subordinate status and take care of themselves by learning the conversational practice of asking to "go home." This form of "managing from below" is prefigured in the preclinical years as students seek to manage how much work they are required to do in the classroom setting. Likewise, messages about being a devoted physician do not suddenly pop up during the orientation to clinical rotations week—they exist throughout the curriculum, most notably in the CP lecture course.

Becoming a 'work devotee'

As students get absorbed into the ways of doing and being in the medical school, they become separated from non-medical ways of doing and being. The separation from the lay world manifests itself in a shift in the importance of relationships—students no longer spend as much time with the friends they had before medical school. This is for several reasons: they often move away from home for medical school, they have so much work that they are mostly alone studying, they don't have much time for the types of hobbies and activities they did before medical school, and most of their primary friends during medical school are other medical students. The other medical students themselves don't have much free time and often study alone.

While research suggests that flexibility can reduce work-nonwork interference (see Schieman et al 2009:970), what is actually important in the initial years of medical school is keeping all of the students in a cohort (in effect, an intentionally inflexible system). This can be accomplished because the medical school works like a total institution (Goffman 1961). The walls that separate students from the rest of their lives and keep them in the school and integrated with their classmates are immaterial, but are constructed out of schedule constraints and attendance requirements, as well as the sheer amount of work students must complete in order to pass their courses. The curriculum is time-consuming and deviance from the group program is discouraged.¹⁰ Students are not the architects of the borders separating their work and family life. Preparation for the “all or nothing” workplace (Stone & Hernandez 2013) that characterizes clerkship and residency training is thus trained into the students in the first two years of medical school.

¹⁰ Students must receive special permission to miss class activities for family events like weddings or personal care events like counseling appointments.

Also in keeping with what total institutions theory would expect, if students begin to fail, they are not immediately or willingly released from the institution; instead, they are given extra faculty and dean-level attention as individual students away from the herd.

During this initial phase of education, students also encounter messages about professional work, particularly in their CP lectures. Early in the students' first year, Dr. Horner talked about working until all of the patients are taken care of, which he links to altruism and professional responsibility:

So, I'm a Boomer, right? I work 80 hours a week—it's like, of course, that's what I'm doing, that's par for the course, it's expected. New generation, not so much. But what this talks about in terms of placing patients' needs—your question is, where's the limit on this, placing patients' needs over one's own. And here's how I would describe the limit to you. You can decide how many shifts a week you're going to work and when you're all done. You can decide how many hours you're going to have your office open, you can decide how many times you're going to cover the OR, you know, in your group. You can decide how many weekends you're going to work, that's fine. That's your rationing from a distance. You've decided that's your work envelope. Within that envelope, stuff's going to happen. Stuff's going to leak over and it's going to interfere with things you want to get to, places you want to go, things you want to do. Your stuff. Altruism is making sure that the patient gets served before your stuff gets served. Okay? So, I was supposed to be at a very important event yesterday from three to five [o'clock], welcoming a new chair. I wanted to be there, I moved my schedule to try to accommodate it, it didn't quite work out. As you know, medicine never stays in the box you try to put it in. So, the last three patients, you know, took a lot longer than I thought they would and I missed the whole damn thing. So, I was sitting there, seeing the clock tick. I could make part of it, I could still get there. I'll be 10 minutes, I'll be 30 minutes late. And then I said, "Screw it, this is what I have to do. I have to take care of these people, they're on my schedule, I said I would be here, I'm going to be here. This is my job. Okay? And that goes with going to dinner with your significant other, that goes for all kinds of things. So, within the box that you choose to work, doesn't mean you have to work 80 hours a week, but within that box your responsibility as a professional is to take care of the patient.

Dr. Horner acknowledges generational differences in how much physicians want to work, possibly gesturing to the increased importance of work/life balance for younger physicians, but emphasizes that the professional service orientation is independent of how much time a physician wants to work. Good doctors make sure their patients are taken care of before they take care of themselves.

18 months later, when the students reach the “orientation to clinical rotations” week, they find similar messages about the priority of patients repeated. Another of the CP course directors, Dr. Jensen, spoke to the students about the difference between coursework in the first two years and life on the wards:

Your world is going to be different, you’re moving into a phase where you are going to be a clinical professional. This is a job. If you weren’t a morning person, you are now. The earlier you get to the hospital, the more time you have to get to know your patients and find your way.

One of the course directors for the Primary Care Clerkship, who spoke later during the orientation to clinical rotations week also drew a contrast between the first two years and the second two years:

In the first and second year, the focus is really on the student. In third year, that will start to shift. The patient will become the primary person, focus and responsibility. It really pains me to say this, but patient care comes before student learning. But if you keep your eyes open, you’ll learn. These are real patients with real diseases, and education at the patient’s expense is not okay.

The Primary Care Clerkship is similar to the Ambulatory Care Apprenticeship the students participated in during the first two years (one afternoon in clinic every other week). The course director echoed Dr. Horner’s comments during the first year CP lecture when he told the students later in his lecture:

Your learning is important, but more important is taking care of the patients that come into the office. The idea is about four hours in the office—sometimes you'll leave late [...] this is normal, this is normal for doctors. Stay until the patients are taken care of.

Starting from the beginning of medical school, students are overtly told that it is a normal part of the physician's job to stay until all of the patients are taken care of. But being a physician also involves being a colleague. While the students are acquainted with the doctor – patient relationship from all of their CP education and standardized patient encounters, they are less familiar with colleague interactions. They play out team membership in the anatomy lab, experience a one-on-one relationship with their clinical preceptor at their Ambulatory Care Apprenticeship, and are familiar with teamwork in the classroom, but they have a lot to learn about what it takes to be a good colleague on the wards. Orientation to clinical rotations week is designed to teach the students what to do and how to act so that they are welcome and productive members of their teams.

Teamwork in Medicine

Like responsibility towards patients, students also learn about teamwork from very early on in their education. During the CP course, Dr. Horner explained why the curriculum had so much small group time built into it:

You will work in teams. The day of the individual, solo doc is *gone*. It's gone even in a small community of 3,000 people where you're the only doc! Because you would find the job impossible on day two if you had to do it all yourself. [...] Requirements for functional teams—you're learning this in your small groups. This is why *all* of medical education is moving towards small groups. Why are we doing that? It costs more money, it takes more facilitator faculty, it's a pain in the ass to organize—we do it because you're going to be *working* in teams and you need to know how to behave and perform, cooperate, collaborate in teams and that's why medical educators put you in teams to learn medicine.

When medical students get to the orientation to clinical rotations, they learn what their role will be on the hospital team. Unlike the PBL and CP small groups, students are not peers with the other members of the team. In fact, they are at the bottom of the social and knowledge hierarchy. In order to manage this subordinate status, faculty and rising fourth year students use the orientation to clinical rotations week to tell the students about their role as “third years” on the team.

The ‘work’ of work devotion

Before medical students enter the hospital for their third year (MS3) clinical rotations, they are given a lot of coaching about how to act by the professors of the medical school. During the preparation for their clinical training, students receive instruction on what their role in the medical team is and what the expectations for their behavior will be. This involves overt discussion of desirable professional disposition and the affective and linguistic practices used to convey these dispositions. “Doing” these dispositions communicates the values a medical student holds with respect to work. But whether medical students actually hold these values is irrelevant, as long as they can effect the practices that convey them. The ‘work’ of work devotion is simultaneously emotional labor and actual medical labor.

In doing the work of work devotion, students must manage their affect and presentation of self to maintain a motivated and enthusiastic persona. They must adhere to the team hierarchy. They must be punctual, clean and well-dressed. They must be collegial and professional. By expressing these desirable dispositions, students demonstrate allegiance to the profession—an understanding of what is most important (patient care) and an understanding of their role in the team. As I explain in the final

section, devotion, deference and teamwork are neatly united in the practice of securing permission to go home from work after each shift. This is also where work/non-work conflict becomes most obvious, as students explained in interviews.

Desirable Dispositions in the Third Year Medical Student

In this section I first discuss certain desirable dispositions as affective mandates for third and fourth year medical students. I then explain the structure of a medical team and the general flow of the clinical day, contrasting the medical student's role with the roles of other team members. The work students do on clinical teams is related to their acquisition of expertise in practicing medicine (coming up with a diagnosis, taking histories, writing patient notes, etc), but they also learn important professional values that are linked to central parts of the ethos of medicine and professionalism. The desirable dispositions students are told during the orientation to clinical rotations that they should display on the wards are: engagement, punctuality and cleanliness, professionalism, collegiality, flexibility, and deference. Dispositions are not self-evident, however. They must be expressed through affective, practical and linguistic means. So, students are not only told which dispositions are important, but how to express them.

During a lecture entitled "Advice from the Experts," Dr. Haskell, the course director for the orientation to clinical rotations course, presented feedback she had gathered from interns and residents about what attributes made for good medical student performance on the wards. Although I will go through several of these dispositions individually below, seeing them as Dr. Haskell presented them to the students gives a better idea of how these are presented not in isolation, but as a package of desirable traits:

What do residents look for when evaluating students? On the slide stood: Enthusiasm, effort, clarity of thought, affability and raw knowledge. Dr. Haskell made a point to point out to the students that raw knowledge was important to the residents, but not as important as the other factors—she told the students they were listed in rank order. Dr. Haskell told the students it was important to be a self-motivated learner and to be able to take in feedback and make changes. The next slide was a list of good qualities for third year students: enthusiastic, team player, hardworking, inquisitive, respectful, good social skills, trustworthy, always ready to do more, and incorporates feedback.

Enthusiasm and Engagement

The single most desirable trait in a third year medical student is enthusiasm. This is conveyed to the students multiple times during the orientation to clinical rotations week. From the very beginning of the week, enthusiasm is linked to membership in the team. Dr. Jensen explained: “You are a member of the team. You will feel good if you are helpful and enthusiastic. If you are less enthusiastic, they will be less interested in helping you.” Enthusiasm is also linked to being perceived as engaged and hardworking. As Dr. Jensen explained later in the lecture, “Students who are more involved and enthusiastic get to see things and get positive feedback. Everything you do will fit into how you are perceived.” On one of his PowerPoint slides was written, “Ask frequently: how can I help? (and mean it!)” Enthusiasm is also linked to getting to learn more and more interesting things on the wards.

Enthusiasm is one of the outward affective practices whereby a student can express the disposition of engagement. Asking another team member how s/he could be helpful is a linguistic practice for expressing engagement. “And mean it!” is a signal that the words must be said with the proper demeanor—the question must sound authentic. Even better is when the student really does mean what s/he says. However, as Dr. Haskell

quipped in a session later that week, “sometimes that enthusiasm may have to be faked.”

Third and fourth year guest students at the orientation course told the students that knowing they had a limited time on each rotation helped them keep their enthusiasm up.

Enthusiasm is also presented as the most important attribute of a third year medical student in a handout the students received. Titled, the “Insider’s Guide to Acing Third Year—From Your Future Residents,” this guide began with a section called, “What are the general expectations of third years?” Again, enthusiasm was listed as the number one trait, along with the admonishment to “SMILE!” In the second section of the handout, “What makes an excellent MS3?” the first item was again “ENTHUSIASM (can’t say this enough)”

Last, at the end of a workshop on how to read CT scans and X-rays, the group facilitator told the students:

“It takes a long time.” He reassured the students that he also doesn’t know everything. “You aren’t going to get everything right, but if you show that you’re thinking through something systematically, you will show you’ve thought about it and it will show them you care,” he told them.

Showing the other team members that you care is a form of engagement. That engagement can be done by trying to think systematically, even if one fails, reinforces what Dr. Haskell presented about enthusiasm and effort being more important than raw knowledge.

Punctuality and Cleanliness

It is also important for medical students to be on time and to be clean and well-dressed. According to the “Insider’s Guide to Acing Third Year,” an excellent third year medical student “is on time to rounds/conferences/teaching” and his/her “notes are done

on time, and had thought put into the assessment/plan (even if it's wrong)." This again deemphasizes raw knowledge in favor of social attributes of the third year student.

In her introductory lecture, Dr. Haskell stressed the importance of dress. "You should be clean, clean, clean," she said, referring to the white coat. "You want to represent yourself as a professional, as a doctor." Here, cleanliness is tied to dressing like a doctor. Dr. Haskell went through some things the students are not allowed to wear: "no open toed shoes," "no scrubs unless told it is okay," "no UGGs [sheepskin boots], jeans, tank tops, stretch pants." Last, she told them, "use your attending as a guide." So, not only should students dress themselves like a doctor, but they should use the most senior doctor as their guide.

Collegiality

During the orientation to clinical transitions, students also learn to be good colleagues to their peers. Many of the other dispositions they must effect are to show their collegiality with respect to their superiors, but there are distinct lessons about collegiality that promote both solidarity and peer regulation amongst classmates. During the first lecture of the week, Dr. Jensen showed the students a series of videos. In one video, student A found out a piece of information about student B's patient, and passed it on to student B so that she would be aware of it when the team was rounding. Dr. Jensen commented on the video, saying, "You guys are going to have to be each others' best buddies. You want each other to shine as brightly as possible." Solidarity here means protecting each other from looking unprepared and not further compromising their already subordinate status on the team. It also promotes peer solidarity that students will

take with them as they advance in their careers. This is one reason why the medical profession has been referred to as a fraternity.

Later in the week, Dean Peters gave a lecture on “Self-preservation: Succeeding as an MS3.” She reminded the students to keep an eye out for signs of distress in one another. The dean told the students that she wanted to encourage them to be in a profession where they keep an eye on each other. This echoes Dr. Jensen’s comments about solidarity, but also the notion that the medical profession is self-regulating. This was long used as a justification for keeping the profession free from external regulation. She continued with a few “myths and truths of academic and professional success.” The first myth was that “the most successful MS3s get through by acting aggressively and outcompeting peers.” Dean Peters told the students, “That’s not how it works in the MS3 year. When students are just gunning it at the expense of the team, the hierarchy, patient care, that looks like unprofessional behavior.” She told the students that if this has been their model in the past, then this may be the only way they know how to shine. Dean Peters made clear that this is not the right model to use during the MS3 year.

Hard Work

Medical Students at WCMS receive a “survival guide” that is passed down to them from the cohort above. In the survival guide for the class of 2015 (written by the class of 2014), there was some advice about succeeding during clinical rotations. That the class of 2014 had not yet embarked on clinical rotations at the time this survival guide was written indicates that this was handed-down wisdom from past years. Under a section on evaluations of clerkship performance, the first bullet point was:

Work Hard: Attendings and residents look highly upon the medical student that takes the initiative to look up all of the data on their patient, run errands, pick up new patients, and anything that isn't really fun.

Favor is important to gain when one is the most subordinate member of a social structure.

Here, students are told that taking the initiative to do undesirable tasks is something that will put them in a good position with the team. This is a way of showing devotion—if someone did not care, they would not volunteer to do undesirable work.

Flexibility

Another session during the orientation to clinical rotations course was a panel of rising fourth year students and fourth years who were about to graduate. The first question asked by a rising third year student was what the panelists wished they had known before they started third year. One panelist immediately replied, “I wish I had known that I had no control over anything that will happen to you as a third year.” The students laughed. Another student added that the biggest life lesson was that students have no control over anything. Yet another students said that on her surgery rotation, she had no idea where she would need to be each day, and her resident would call her and tell her to go. One panelist characterized third year as “a lesson in jazz: improvisation.” The panelists reiterated that the students should be flexible and should not expect rhythm or consistency. “Try not to freak out,” one panelist said. “You will freak out,” he quipped. Flexibility is another attribute of low social status. Students are not in the position in the hierarchy to set the agenda for work time.

Deference

Because students are at the bottom of the hierarchy, it is also important for them to be able to act deferently around superiors. On a clinical team, much of deference

revolves around being compliant and not questioning superiors, particularly in front of patients. Dr. Haskell told the students, “Do not argue with other members of the team, especially the attending [the senior doctor]. If a resident or intern asks you to do something, then do it. If for some reason you can’t do it, you need to let them know. Always be polite to everyone.”

The “Insider’s Guide to Acing Third Year” also contains a list of things a third year medical student should “definitely not do.” First on this list is:

NUMBER ONE NO-NO: never argue with or challenge an attending or resident in front of a patient. Probably not a good idea to argue with an attending ever. Sounds obvious, but happens all the time, and never ends well. Of course it is ok to question the plan, but remember that you have minimal experience in actual clinical medicine. If you have a question about why something is being done or not done, wait until after rounds and ask your residents or attending respectfully – “Can you explain why we did (or didn’t do) ---?”

Other lecturers touched on the subject of hierarchy, as well. This was presented as a very central and important theme during orientation to clinical rotations. Dean Peters and Dean Bingham came to give a presentation on what constituted medical student hazing/harassment on the wards. There have been problems across the United States with third year medical students being taken advantage of, being asked to do inappropriate types of work, or being even abused because they are low on the hierarchy. The students and the deans worked through a series of vignettes. One vignette featured a student who questioned the attending in front of a patient. Dean Bingham reminded the students that there was a time and place for questions. During this discussion Dean Bingham told the students a story about when she was on surgery rotation as a medical student. One of the patients started to have an adverse reaction. The attending fumed and asked what was

going on with the patient and Dean Bingham, then a “lowly third year,” piped up and mentioned that one of the new medications the patient was on had the adverse reaction as a side effect. The attending did not react positively to the dean’s contribution, she reported, and the moral of the story was that “questions are not always directed to the whole group.”

Dean Peters explained how question-asking cycles can work during rounds. She explained that sometimes the attending asks the medical student before the resident so that if a situation arises where the resident does not know the answer but the medical student does, then no one will know. Dean Peters said, “If it’s your patient, assume they’re talking to you; usually they start at the bottom and work their way up [the hierarchy].” One of the students on the panel interjected and said, “third years used to be the lowest on the totem pole, but that’s not really true anymore—you are part of the team now. If you act like you’re at the bottom of the totem pole, you will look disengaged.” Both the student and the deans made important points—engagement and deference must be balanced as students work with clinical teams. Students must be involved in what is going on, but there are right and wrong ways to be involved. This is similar to learning how to properly communicate with patients, and these examples show that epistemic boundary setting is a problem that happens during learning to be a colleague, not just learning to be a good doctor.

Professionalism

Again from the “Insider’s Guide to Acing Third Year”, at the bottom of the list of traits that make for an excellent MS3, was written:

Notice much of this list has to do with professionalism. We, like you, rolled our eyes at this talk before third year, but it is REALLY important in the clinical years. There have been many brilliant, knowledgeable students who frankly sucked to work with because of a bad attitude, etc – these people often won't honor (and sometimes won't even pass) rotations, while someone who maybe struggles more with the clinical stuff but works hard and is enthusiastic, will! (Same often goes for the residency match...Scores aren't everything anymore!)

In this list professionalism is listed as a combination of several dispositions, including good attitude, hard work and enthusiasm. This ties into Dr. Haskell's original introductory slides at the beginning of the orientation week. Students need to master these dispositions as a package in order to be perceived as a professional.

Medical Team Structure

When they go to the hospital, the students join clinical teams consisting of one attending physician, 2 or 3 residents, 1 or 2 interns and 1-3 medical students. The teams vary in size and composition, but have generally 5 trainees (residents, interns & medical students) and one attending. These teams display a social hierarchy that matches both the division of labor and the knowledge base of each team member. That is, attendings bear the legal responsibility for the care of the patients and have the greatest knowledge and experience, so they sign off on all team decisions. Attendings are advised by the chief (or highest-ranking) resident on the team. The chief leads the team in the attending's absence and makes all on-the-ground treatment decisions. The chief resident delegates work to the interns, who are unlicensed medical doctors in their first year of post-graduate training.

Interns are responsible for filing all necessary paperwork for each patient—this includes medication orders and instructions, diet plans, test and imaging orders—and following up on these orders and tests. They interface with other medical specialties,

particularly radiology, pharmacy and the hospital laboratory. Interns may also provide care at the bedside in the form of small procedures (putting in lines, tubes and drains, performing diagnostic procedures like lumbar punctures, changing bandages, lancing abscesses, etc.), particularly on surgical teams. The majority of the grunt work falls to interns, who have local-level responsibility over the patient (i.e. they are in charge of making sure the orders given by the chief residents are implemented and followed, but they don't bear the type of oversight or legal responsibility as the higher ranks). This tracks with their knowledge—they can competently provide medical care, but do not have much experience.

The most subordinate members of the medical team are the third- and fourth-year medical students. The students are familiar with the anatomy and physiology of different medical conditions, but do not have as much experience with diagnosis, treatment, and management, especially in specialized or procedure-heavy fields. For this reason, the medical students are given small, generally inconsequential tasks. For example, tasks that could easily and quickly be done by other members of the staff or tasks that are redundant (such as pre-rounding on “their own” patients, even though the ultimate responsibility for these patients is borne by the chief resident or one of the interns, who also rounds on them). Students may also be asked to do less medical and more psychosocial tasks that the other members of the team don't have time for (talking to patients for extended amounts of time). Medical students are also asked to do small, medically meaningless but nevertheless necessary operational tasks (fetching supplies, waiting for patients to be brought in for imaging or surgery and notifying the resident of the patient's arrival). Some of this work is delegated by the interns, and some by the chief residents. When they

are not doing errands or exploratory medical tasks (like seeing their own patients and learning how to present on them and keep track of what is happening to them), the students are taken around by the residents or attending and allowed to observe and assist with procedures, admissions and exams.

Resisting and managing ‘devotedness’

Managing the extent of devotion to work is interesting in terms of medical student training because the medical students’ function on the team is often inconsequential—for all of the time they save team members by running errands, they cost time because they complete team tasks more slowly than interns or residents would be able to do them. Furthermore, most of the work that medical students can help with is accomplished by the early afternoon. Even if medical students take on the responsibility of drafting patients’ medical history or discharge summary, these are generally done by 3pm. Students are told by faculty members during clinical transitions week that they will be sent home—they must have permission to leave, and it is not up to them to decide when to come and go. This extends even to mealtimes and, on overnight call shifts, going to sleep. During the orientation to clinical rotations, students are told that they will generally be sent home between 5pm and 6pm on a non-call day. Getting sent home any earlier than expected is a big deal and can engender favor for the intern or resident in charge.

Medical students talk amongst themselves about which residents “keep you” in the hospital and which are better about sending students home when there is no more work for them to do, and students also talk about the different start and finish times of their specialties. For example, on the general surgery team at “University Hospital Midtown,” students begin their workday by 5:30am; their responsibility is to enter

patients' medical information into the "sheet" used by the team on rounds, which begin at 6am. The bulk of procedures and patient care is accomplished during the morning, and the afternoon is reserved for paperwork, the evening's lab and medication orders and diet plans, and preparing for the next day. The interns need to wrap up the care on their patients so that they can transfer their patients to the night intern in late evening, and one resident stays on call for continuity. The medical students do what they can to help out during the afternoon, but the afternoon is remarkably slower than the morning on many services.¹¹ Aside from an occasional afternoon round or sitting in on a procedure, direct patient care is finished for the day. Sometimes the afternoon is filled with other non-patient care tasks besides charting, such as case conferences, where issues with the care of recent patients are discussed. While one medical student will stay with the team into the evening or overnight monitor the patient panel and accept new admits, the other medical students are sent home for the evening.

But what do medical students do between the time they finish their work and when they are sent home? There is usually a gap in the afternoon between the end of productive work time and when students are sent home. Students talk amongst themselves and advise each other to use this time to study for the exams that come at the end of the rotation, or read up on the patients to try to prepare for tomorrow's case presentations or procedures. Hanging out in the hospital can have advantages, too. For example, students will often be brought along to the ER to see if a patient needs to be admitted, or if students are hanging around when something unusual or interesting

¹¹ Exceptions include those that provide specialty assistance to the Emergency Department, such as the neurology team, which responds to stroke calls (incoming patients with possible strokes) made from the ER.

happens, then they may be brought along to see that. There may also be opportunities for direct teaching from the resident. For example, on general surgery rotation, I received lessons in suturing, how to systematically read computerized tomography (CT) scans, and explanations of particular surgical procedures. But, at some point, the students are tired and bored, there is no more work for them to do, and they want to go home. In order to go home, students must initiate a delicate conversational exchange in which they hint for permission to go home. Here is how Monica determined when it would be appropriate to initiate this exchange:

- AV: At what point in the day does this period—because I assume there's a period where you sit there and twiddle your thumbs for a bit—so at what point in the day does that start? And how long after that do you start asking to go home?
- Monica: Well, it has to be after rounds, in general after lunch, like noon conference, whatever. You have to have *all* of your work done. If it's been told that some teaching is going to happen, it has to be after the teaching has happened, be it resident teaching or formal teaching or whatever. It has to be once sort of everything that's planned for the day is done and you have contributed all that you can contribute and you're like *actively* sitting there not doing anything.

Monica described this conversational exchange as a dance:

- Monica: It's like a mating ritual, it's this complex dance of like, back and forth. I mean, it's not mating. It's not, but it's just as complex as some animalistic mating ritual.
- AV: What makes it complex?
- Monica: Because it's all just like this cultural undertone. And like the back and forth [...]

The students, even though they want nothing more than to go home, are taught during the orientation to clinical practice to refuse initially and offer to stay longer and do more work. This specific advice was given during a lunch with rising fourth year students. The

students told the new third years that if nothing was happening around 4 or 5pm, they could go to the most senior resident and casually check in to see if anything needs to be done. Often then the resident will remember that the student is there (students were warned frequently that the residents will forget about them and that it is not to be taken personally) and realize that there is nothing for the student to do. Then the resident should send the student home. When a student is sent home without having to engage the routine above, s/he should still check to see if there's anything s/he can do to help out before s/he leaves the hospital—the students were told that this would engender good will in the resident. This even carried over to going to sleep when on call. At 4am during an overnight shift on the trauma team, the medical student I was with refused at least twice when the resident told us to go to sleep.

There is a chance that the student will indeed be given more work after asking if there is anything else s/he can do, so this move is somewhat risky: “Actually,” a resident might say, “could you start the discharge summary for Mr. Smith?” Here is how Rachel described her process of going home and how she handles it when the resident gives her more work to do instead of releasing her:

- AV: When your shift is over and you want to go home, how do you leave the hospital?
- Rachel: What do you say [laughter]
- AV: What do you say to get out?
- Rachel: I think I did follow [the dean's] advice on the “do you need anything else?” Also, I've heard a good one is, “*On my way out*, do you need me to do anything?” So, you're saying, “I'm leaving, but I could do something as I'm leaving.” But I never use that. I think I usually say, “Oh, do you need anything else?” And then, if they're like, “No,” then I'll be like, “Well, I finished this, this and this. If you don't need anything else, umm, can I go home?” Kind of thing.
- AV: So you would just ask

Rachel: Yeah, especially you get a lot better at asking as time goes on. I think that first block you're real uncomfortable about leaving everyday, but after that it gets so much easier to just be like, No, I've got to leave...now. And plus, like, on one of the rotations, my friend and I would carpool everyday because we were on the same team, and so we'd be like, we're both done, so we'll see you tomorrow—bye!

AV: So you didn't wait for someone to initiate--

Rachel: Nooo

AV: --the process of you going home

Rachel: Because otherwise, I think I probably did do that on the first rotation and realized that that [getting sent home without asking] might never happen. So, yeah. I think also like it's better to like kind of establish rapport with them earlier that, like, hey, look I'm here to work, here to get everything done. I don't want to waste your time, I don't think you want to waste mine. So, like, when I'm asking you to go home I really think I did everything I think I can do today. And I think that's probably, like when you think about yourself being in their position later, you're like, that's probably all you want—to feel like they did what they could do for you.

AV: Have you ever been kept longer by anyone?

Rachel: Oh, yeah!

AV: For no reason—or for a reason?

Rachel: Usually for a reason. They're like, oh yeah, and can you do blah, blah, blah, blah for, like, my other patients. Then you're just like [groan].

AV: So, you've been in a situation where you've said, “is there anything else I can do for you, I did these 4 things and they're like actually--”

Rachel: They're like “Yeah!” and then they light up and they're like getting all their papers, like “here you go! And can you look up their history from, like, the last five VAs they've been at and find out all the medications and highest dosages they've been on? Like, literally. And then I'm like, okay, yeah, sure—no problem. And, then, like—is there anything *else* I can do for you because, like [said to self] once I finish these things, I'd like to go home—in my mind. But yeah, like, I feel like if they just tell you straight up these are the things I need to do today, can you help me attack all these, I'm very happy to do it. And that makes the next day easier. Yeah, I think that's one thing to keep in mind, too. You always have to come back the next day and do that again, so it makes the next day shorter and this day's

longer. Oh, well. You know? So, yeah, there were a lot of times where it was like, you could do something else. You could do *five* other things. And you're like, okay, that's fine. I thought it was reasonable.

Because medical students are taught that they must demonstrate enthusiasm and be hardworking under all circumstances, they must counter an offer to go home with an offer to do more work. In a circumstance where there is no more work that the medical student can help with, the higher-up will usually reply, "No, it's okay, go on home." The medical student might check in again, but generally just thanks the resident and leaves as quickly as possible—before the resident changes his/her mind. The students are taught that when they are sent home after initially refusing, that they should take the resident seriously and go home. It can actually be helpful for the interns and residents to have no medical students there, so the students should not stay and bother them.

What makes this interaction so delicate is that the students cannot show that they want to go home without compromising their performance of devotion to the team and the patient. As Monica described:

- AV: When your shift is over, how do you get out of the hospital?
- Monica: Oh. [laughter] I always just say, "Oh, is there anything else you need me to do?" And then, like, if it's really not working, I'll say, "If there's nothing else for me to do, would you mind if I go study?" Or, be like "go home and study" – and it's not, "go home".
- AV: Never "go home"?
- Monica: No, no.
- AV: Why?
- Monica: Because you just don't.
- AV: You just don't "go home"?
- Monica: No.
- AV: Just don't go home and not study?
- Monica: You're always doing something related to medicine.
- [...]

AV: But why is it that you can't just go home?
 Monica: You just can't.
 AV: Why?
 Monica: Because...you can't. [Laughter]
 AV: What would happen if you did?
 Monica: The risk of being seen as not as devoted. You should be eating, breathing medicine 24/7.
 AV: Why?
 Monica: 'Cause. [Mutual laughter] That is what it is. I don't know. It has been somehow ingrained into me. I have not thought about it. [...] It is—it's part of the culture, it's just the culture!

The very fact of having to wait to be dismissed puts the students at the mercy of the interns and residents and orients them to the team hierarchy. “Going home” is only one practice in which medical students learn about themselves in relation to other team members. The duties and responsibilities of team members track along with their knowledge, experience, clinical responsibility, and legal responsibility for the patients. As the most junior members of the team, students learn some medicine, demonstrate the knowledge of anatomy and physiology they learned in their classroom years, but above all, engage in practices that help them become members of the medical team and build relationships with patients. These are largely social, not medical practices, whereby the medical students demonstrate their allegiance to the profession and display their devotion to work.

Managing Work/Non-work Conflict on the Wards

Of course, while students use these conversational tactics to demonstrate their allegiance to the profession and dedication to their team, they also use this device as a form of self-preservation. As Monica described:

AV: But if you're going to leave the hospital, you basically have to—

- Monica: It's not written anywhere--
- AV: Whether or not you actually go home and study, you have to say, I'm gonna go home and study
- Monica: Well, I don't *say* I'm going to go home and study. If someone says, hey, you should get out of here, you say, "Okay, if you're sure you don't need anything else" "No, I'm fine, I don't need anything else, you should get out of here." "Okay, cool, thank you. Bye." But if it's like I'm *trying* to get out, then it's like, Well, look, I have other *important* things to do
- AV: Like study?
- Monica: Like study. Can you please let me go. Or, like I said, catch a plane or meet with a faculty member or whatever it was. Like you have to have something—if no one's actively letting you go and you're trying to weasel your way out, I feel like you have to have something like more important than what you're doing at the moment. So, sitting there twiddling your thumbs versus doing something else more important.
- AV: [...] So, about how often, so when you say, is there anything more I can do, even, not, is there anything more I can do before I leave or whatever, how often are they like, oh yeah—could you do X, Y, and Z?
- Monica: Not very often.
- AV: Oh, ok.
- Monica: I've found. Because most of the time I knew what had to be done and I had already done it. You're not *actually* asking.
- AV: Right, totally—you're not *actually* asking, but other people could be like...
- Monica: Well, every now and then they're like, actually yeah and you kinda go "shit" but it's better than twiddling your thumbs.
- AV: But then after you finish that you have to come re-initiate again and be like, so is there anything *else* I can do...?
- Monica: Yeah

As Monica points out, even though she is technically asking for permission to go home (in that the sentence is formulated as a question), it is not really a question. Often this conversational device works well and she is sent home, but as I noted above, it does carry the risk of the student being given more work to do. As the examples from Monica and

Rachel show, even if students are asked to do more work in response to asking for permission to go home, they accept this as a reasonable request. Students did, however, identify unreasonable grounds on which to be asked to stay in the hospital. As Spencer explained:

Spencer: There have been—I had one resident when I was on Medicine who liked to keep us later than was necessary. He believed in, it sounds so cynical to say this, but he believed each patient was an educational experience, so even if you're not picking up another patient, so your docket is full, you're already taking care of three patients, if a new patient comes in, like, come with me to evaluate them because you're going to learn something from them even if it's a case that you've already seen before. Whereas for a lot of us, it's like, come 5 o'clock, it's been a long day, I'm tired and you have studying to do. And I explained to him at the end of the rotation when he asked for feedback, I was saying, I really appreciate that you value our educational experience and you put a lot of thought into it. But you have to understand, when we go home we're not going home to jerk off with friends, get drunk, all this stuff. When we go home, we're going home to read up about our patients, we're going home to study, we are *hardworking people*. So, sending us home is not, like, cutting us a ton of slack and being a bad resident by not providing us educational experience. You're just allowing us a *little* more control over what we study. So, I explained that to him.

[...]

Like, he wanted me to come in on Thanksgiving. And my family was here from out of town. And I just said no. Especially because the attending gave me the day off and then he was like, Um, I think you should come in. And I was like--

AV: Why?

Spencer: Because he believed in rounds. And he believed—he's like, this is your educational experience, you need to get the most out of it. And my defense to that is like, I'm 25 years old. I understand that I'm part of a team here. Like, you always have to balance these two competing sides, which is like, is this Spencer's educational experience for which he is *paying* or the other side to that is, like, you are part of a

team and you have to step up, you have to go above and beyond and do things that are not necessarily immediately valuable to your education but learning how to be part of a team *is* part of your education. So, like, balancing those two sides is always tricky, but for him, it was like, you need to be here for rounds not even to contribute to the team but because *you, Spencer*, will learn from a patient. And my response to that is, if you need me as part of a *team*, if rounds will go haywire without me and they will go slowly, *yes*, I will come in and round, but if you are making me come in because you think it's an educational experience for me, I'm 25 years old and I'm able to make that decision to say, for Thanksgiving Day, one day off is not going to kill me.

As Spencer points out, he is an adult and has been a lifelong student, so he is acquainted with how to make sure he has a good learning experience in medical school. What he resents—and refuses to do—is to come in to the hospital to round when the request to do so is inconvenient and comes from a person lower in the status hierarchy than the person who gave him the day off. Instead of using the “going home” conversational device for its protective function, as Monica does when she wants to go home, Spencer flat out refuses to come in to the hospital.

Third year medical students set boundaries around their work so that they do not have to completely relinquish their private lives. This is how they maintain work/life balance. Yet, as the students point out, one must make the request to go home at a reasonable time, and the request should make the student seem devoted to the team and the patients. Achieving this reinforces the affective mandate that students be engaged. Spencer rejects the notion that going home is a signal for not being engaged when he asserts that medical students are hardworking people who go home to study. Monica, on the other hand, was likely to use studying as an overt reason to leave the hospital.

Whether she actually did study every time she used this justification is less relevant than the fact that going home to study is a reasonable reason to leave the hospital in the evening.

Here the students display some of the dispositions that are desirable for third year students, helping us to understand how the work devotion schema is cultivated in new professionals.

Differential or Homogenous Socialization?

One of the main concerns of the work devotion literature is to understand differences in how men and women negotiate work/non-work conflict and how employers judge men's and women's fitness as employees. In my ethnography, in general, I did not find evidence that women and men were systematically treated differently in the school or hospital setting. Understanding medical school as a time where medical students are socialized in a fairly homogenous fashion provides an important counterpoint for studies of differential socialization, such as occupational sex segregation. The young age and tendency to be unmarried of many medical students gives us an example of where organizational features that create occupational segregation (chilly climate, motherhood penalty, leaky pipeline, etc.) and personal/familial features that create occupational segregation (opting out, family devotion schema) can be separated and treated as distinct forces. In this way, my conclusions do not dispute the findings of other researchers who find divergent career trajectories for men and women physicians at later stages of training (Ku 2011). Indeed, while I did not observe differential socialization of the students in the class of 2014, attitudes about women versus men as employees were reflected in the curriculum. For example, during a CP

lecture where he touched on the changing demographics of the medical profession and how this affected work-life balance, Dr. Horner explained:

And this is the feminization of medicine [shows graph on PowerPoint slide]. Alright, so when I was in medical school there were eight girls in our class. Out of 110. You look around here, it's 50/50. It's been 50/50 for lots of years in medical school. And you can see the age groups now here, right. You can see that under 35 [years of age] it's [gender balance] equal. Well, what does that mean? That means that for every graduated physician who's a woman, you're going to get less work hours. I have to be very careful how I talk in the next 10 minutes here, the next 5 minutes. You're going to get a lot less hours work in the aggregate from female physicians because they're busy birthing babies and unfortunately in our society taking care of them more than us guys do. And so that makes their productivity as physicians a little bit less. And it also means, another factor of change is the younger physicians are working less hours. Right? They've decided, yeah, I don't really want to bust my ass 500 hours a week anymore. That's not what I see as my life in medicine. That transition's been going on for a while, too.

Here Dr. Horner pinpoints two demographics in which orientations to work seem to be different from his orientation to work (or his generation's orientation to work more broadly), the under 35 demographic and women. It is worth noting that he assumes that all women will have children and take time off to do so, and that this is a pattern exclusive to women. Based on his generational data, this could actually be a broader parenting trend for both men and women.

Work-life balance is an underlying theme in this chapter. Dr. Jensen and Dr. Horner both address it (here above and at the beginning of this chapter). Yet, the students receive strong and consistent messages about work devotion across the four years of their training. Work devotion and work/life balance come into conflict in a profession that takes seriously its service orientation as one of the cornerstones of physician identity. While Dr. Horner does not provide enough data to make any forecasts, ideologies about

work are likely to keep changing in the medical field. What the data from WCMS do show, however, is that the work devotion schema is intentionally cultivated in third year medical students as a set of dispositions like enthusiasm, collegiality and hard work that are to be executed through linguistic and affective practices.

In this chapter and the previous chapter I have focused on the second main focus of medical training—how to be a good colleague and member of the medical community. Students must master these skills during medical school and residency just as they master the skills of proper doctor – patient communication.

CHAPTER 8: CONCLUSION

In this dissertation I set out to examine how the medical profession adapts to changes in the organization of medical practice and broader changes in American culture. I proposed that the medical school would be a unique and advantageous place to examine these changes, since it is a social setting where currently practicing physicians explain how and why they do what they do to groups of medical students, who are largely naïve of actual medical practice. I found that these clinical professors are keenly aware of the conditions in which they practice, particularly changes in patienthood, physician regulation by third party payers, and the distribution of chronic versus acute disease. Clinical professors are also aware of what it takes to be a good colleague, and so they teach students how and why to act in order to be received as a colleague. They execute both of these aims through the curriculum, which was redesigned so that students from the class of 2014 and onward would learn about clinical and professional skills from the very first week of medical school. This is in stark contrast to the traditional “two plus two” model, where two years of strictly classroom teaching were followed by two years on the wards. The new integrated curriculum offered more than the integration of the scientific and medical research disciplines—it also integrated the classroom and the clinic through courses like CP and PBL. This was designed to help students learn medicine in an environment that resembled the environments they were likely to eventually practice in, outpatient medicine, and for 42% of the graduating class of 2014, primary care.

Chapter Review

In Chapters 4 and 5 I focused broadly on changes in patienthood in order to show how individual practitioners groom participatory or resistant patients. This was important

to investigate because broader medical sociology has found that, on the macrosociological level, physician professional stature is decreasing. An important counterpoint to the deprofessionalization theory is to look at the conservation of authority in the individual clinical encounter—or better, to look at how medical students are taught to manage the clinical encounter in order to get their work done. In Chapter 4 I focused on the experiences of the medical students as they learn about their role in taking the lead in the clinical encounter. This involved them being prepared to ask new questions of strangers. These were questions that were highly private or confrontational. The faculty members taught students to use material artifacts and communicative practices in ways that would aid their work.

In Chapter 5 I looked at even more sophisticated uses of language. Here the challenge for the medical students was to establish a relationship that the patient experienced as collaborative, but that still ensured that the patient agreed to the doctor's treatment plan. Many of the examples given were about chronic disease management, which requires difficult behavioral change and daily maintenance. The medical students were taught new motivational interviewing tactics to “activate” patients and to get them to agree to a particular treatment plan. That the medical students were taught to make a plan that the patient could agree to meant that the patient would be carrying out doctor-sanctioned daily health maintenance. This is very important in chronic disease management; since the patient cannot meet with the doctor every day, it is important that s/he be prepared (whether s/he knows it or not) to be an extra set of hands for the physician.

Chapters 6 and 7, in contrast, focused on how medical students learn to be medical colleagues. In Chapter 6 I discussed the changing function of the anatomy lab experience in medical education. As bedside manner is overtly taught in other areas of the curriculum, this function of the anatomy lab fell out of the medical student experience. Instead, I observed the students emulating surgeons and exploiting the material homologies between the lab and the operating room. This was a much less emotionally fraught lab experience for the students than others described in the literature. I attribute this, at least in part, to changes in American media culture. Medical practice and forensics have been demystified by television dramas, and BodyWorlds and other similar exhibits showcase the details of the body that hide under the skin.

After establishing that collegueship was salient to the medical students, I looked at the directed teaching students receive about how they ought to behave on their clinical rotations. I found that a lot of the desirable dispositions in a third year medical student resonated with another sociological concept, the work devotion schema. Yet I found that the process by which the work devotion schema is acquired by novice workers had not been described in the literature. I reframed this process to describe the process by which novice workers are *cultivated* to be ‘work devotees.’ I showed how students then negotiated a classic problem in the work devotion literature, which is how to balance proving one’s allegiance to work with proving one’s allegiance to family (or simply preserving one’s work/life balance). The chapter was bracketed with quotes from CP lecturers who explained professional ideologies about work and did some rudimentary forecasting for the future of medical professional orientations to work.

Epistemic Boundary Setting

In this dissertation I not only linked changes in medical education to larger changes in the profession, but I developed a theory of the reproduction of medical knowledge in order to explain both the stasis and the change I observed in medical education at WCMS. I call this process *epistemic boundary setting*. The epistemic boundary is the border between the practices conventional to the medical community (the form-of-life) and those practices not conventional to the medical community. Indeed, what binds the form-of-life together in the first place is that all of the members adhere to roughly the same set of practices. The epistemic boundary exists as a cultural construction and it is reproduced in the subjectivity of individual members. Members operate within the epistemic boundary when they do their work, and their work thereby becomes legible as the work of someone from that same community. In the medical community the epistemic boundary of one “generation” of practitioners is passed to another via evaluative standards for success in Clinical Practice and other similar courses.

This concept becomes pertinent when novices are trying to learn how to participate as members in a new community with unfamiliar practices. This was most clear in chapters 4 and 5 when the students struggled to properly deploy the assemblage of material artifacts and linguistic practices in their interactions with patients. Importantly, their professors did not just let the students carry out patient interactions any old way they wanted to. Instead, they taught the students that they must enact a particular version of medical authority—one that is in line with the conventions of the profession. (Students were not allowed to, for example, interact authoritatively with patients by threatening or interrogating them in the manner of a mafia boss or police detective.) Teachers have been discussed for their role in transmitting the ‘lore’ and traditions of a

particular field to novices. Tradition generally encompasses the non-propositional knowledge that forms the ‘art’ of a certain activity. This type of knowledge transmission is particularly pertinent in fields that employ an apprenticeship model for training novices; despite changes in the structure of educational programs, medicine largely remains one such field. It is these approaches to teaching, particularly associated with the philosophical approaches of Polanyi (1974 [1958]) and Wittgenstein (1999 [1953]), which emphasize the rule-bound nature of activity within a certain social group, or form-of-life (see also Winch 1958, Bloor 1983).

Contemporary sociologists of scientific knowledge have become interested in rules because they structure social activity in a way that allows members of a community to work collaboratively under the same paradigm. Because meaning is attached to knowledge of a rule, this results in purposive action that is consistent from one use to the next, thus committing the social actor to a predictable course of action and allowing for the maintenance of a form-of-life (Winch 1958). Because of the nature of rules and their situatedness in forms-of-life, looking at how students make mistakes and how teachers correct them offers clues to the practices (actions) within a social group. This focus on rules underpins a larger theoretical turn within the social sciences to focus on the practices of group members (Schatzki, Knorr Cetina & von Savigny 2001), turning away from a focus on structure (see Conley 2009) or knowledge as ideas (see Collins 2004).

The professors’ control of which uses of artifacts or practices are appropriate ensures, for example, that students learn to be authoritative in the same way that other members of the medical profession are authoritative; students learn the professors’ version of authoritative practice. The professors teach the students the appropriate

practices by using specific examples; this is how they work around the problem of codifying their professional tacit knowledge (Collins 2010b). Not all practices are equally admissible in doctor-patient interaction and students learn the contours of the system of professional knowledge through their conversational failures, as well as through professors' examples of what they have done in the past.

Epistemic boundary setting seems to explain professional stasis rather than professional change, yet throughout my data collection I noticed that individual professionals seemed to share fairly unified views of the current social condition of the profession. This is the effect of being embedded in the medical community, either the local community of WCMS or the broader medical community in California or even the United States. By virtue of their training, the physicians who were teachers at WCMS shared a collective conscience and had been embedded in the medical profession for long enough for this collective conscience to adapt to situational change in the profession. When they entered the classroom, they were able to distinguish between doctor-like conduct and non-doctor-like conduct in the students and articulate conventional forms of doctoring for the students to emulate. Through skits, stories, standardized patient exercises and PBL cases, professors conveyed to students the conventional ways of thinking, acting and talking like a doctor.

The same process was articulated when the students transitioned to the clinical world. There are conventional ways of doing "being a colleague" and membership in the profession (or membership on a hospital wards team) is contingent on being able to execute these ways of doing and being. Professors overtly taught the medical students how to do these things. As opposed to other theories of developing practitioner

subjectivity, such as the social psychological approach of Haas & Shaffir (1977), students did not develop professional personas in isolation. Students also did not simply derive professional skills from the ether. The active presence in students' lives of their clinical faculty is evidence of change in medical education to favor more overt forms of clinical and professional skills training. This, in turn, is a response to an increasingly challenging clinical practice environment with pressures from all sides—to be efficient, to be warm and friendly, to allow patients choice, to keep patients from requesting unreasonable treatments, to maintain high satisfaction ratings and low utilization ratings, and to keep detailed electronic records while also talking to a patient in the office.

Looking Forward

In March 2010 the Patient Protection and Affordable Care Act was signed into law. The provisions of the Act are still rolling out and the academic community has not yet had time to examine the impact of the changes it will bring to the acquisition, provision and payment of medical care. However, one thing is already clear. Like managed care in the 1990s, the PPACA works within the private insurance structure (the public option was ultimately omitted from the legislation). Thus, the PPACA may more closely resemble managed care structures than previously thought. This means that current practitioners and their trainees will be able to preserve many of the strategies they developed in dealing with the switch from the fee-for-service model to the managed care scheme. This is the largest health policy implementation of the new millennium and the next few years will provide many occasions to examine how the practices that make up being a doctor and being a medical colleague adapt to this change.

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