

THE OUTPATIENT DEPARTMENT AS SOCIAL SYSTEM:
STRUCTURE, IDEOLOGY AND BEHAVIOR

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Introduction

Two elements are characteristic of all bureaucratic systems. They maintain: (1) a network of social relations which forms the structure of the system, and (2) a collection of shared beliefs and values which serve to validate relationships and influence behavior (Blau and Scott 1963; Caplow 1964; Georgopoulos 1972). This paper describes the structure of a general medical clinic and shows the ways in which this structure creates and maintains an explicit system of beliefs which in turn influences the actual delivery of medical care.

The research here described was carried out during the latter part of 1970 and the first months of 1972 in the Outpatient Department (hereafter referred to as OPD or Clinic) of Western Hospital and Medical Center¹, a non-sectarian, non-profit general hospital located in Northern California. Typical of many urban outpatient clinics, Western draws its patients principally from an indigent inner city population. Medical care is administered primarily by house officers (interns and residents) who are required to spend a portion of each year in training as outpatient department physicians. A number of attending staff physicians volunteer a limited amount of service as well.

The structural core of the Clinic is formed by a staff of nine people: a clerk, a licensed vocational nurse (LVN), the nurse co-ordinator, a head nurse, a nursing supervisor, a part-time medical director, a part-time consulting psychiatrist, a medical secretary, and a medical social worker. These nine are the Medical Clinic's only salaried, permanent staff and they derive a significant amount of prestige and authority by virtue of this position. Further, many

staff members have worked in the OPD for a number of years. This provides continuity based not only on the permanent set of roles and interactive patterns that has evolved over the years, but additionally because the same individuals have performed these roles for a relatively long period of time. Although they comprise little more than administrative machinery set up to assist patients with obtaining health care, and doctors with an opportunity for ambulatory care training, in effect they color the actual character of doctor-patient interaction by: (1) controlling patient and medical staff access to each other and to services; (2) socializing patients; and (3) restructuring the scope of the physician's traditional authority.

Structural Constraints on the Physician's Role

The two elements traditionally integral to the physician's role, as formulated by Freidson (1970), are professional dominance and professional autonomy. That is, physicians are granted self-regulation and control of their activities because it is assumed that the public lacks the training and expertise to make informed judgements and that physicians, by virtue of their professional stature, will serve as guardians of the public trust. These aspects of the physician's role have been the target of recent criticism (see Bloom and Wilson; Ehrenreich 1971; Goffman 1961; Waitzkin and Stoeckle 1972), but within the private sector the physician-patient relationship has not undergone serious change.

The Western Hospital Clinic, however, because of its institutional structure, transforms the physician's role by pre-empting some of his traditional dominance and autonomy. First, the physician's authority is limited both by a body of rules which set forth OPD procedure, and by administrators (the medical director, nurse supervisor, and head nurse) who have the power to countermand individual medical decisions. For example, doctors may prescribe only the drugs appearing in the OPD formulary unless authorization from the medical director has been obtained. Requests for medical appliances must be channelled through an eligibility clerk. Physicians therefore cannot make decisions based solely on their reasoned medical judgement: certain recommendations must be justified; others must be discarded entirely. The effect is a clear restriction of traditional medical authority, and as much it alters the nature of doctor patient interaction.

The right of doctors to make specific types of work-

related decisions is similarly constricted: a clerk decides how many patients a doctor will treat each day, which particular patients that doctor will see, and the order in which they will be treated - in effect, the amount of work a doctor will do on any particular day. As one intern said:

Most of my patients are women. The nurses set it up that way.... (For instance) sometimes I get to do a history and physical on a young patient if Martha (the LVN) wants to be nice to me.

And even the decision of whether to work in the OPD at all is not made by the doctors themselves, since here, as in many other hospitals, such work is mandatory rather than voluntary.

Added to these concrete restrictions are a series of more abstract elements which further restrict the authority of the clinic physician. The private and privileged communication that classically characterizes physician-patient interaction is broadened to include an entire staff who have access to patients' medical and personal information. The consequence is that staff members volunteer opinions and advice during staff meetings and in private conversations with doctors and patients. The tension this occasionally brings to physician-staff interaction is described by the nurse co-ordinator:

Sometimes, because I know the patient, I am able to make suggestions...but I have to be very careful when I do this. Basically it depends on the doctor in charge. If he is self-confident himself, he will usually appreciate a suggestion that he hasn't considered. But if he is insecure, he often gets angry and tells me I'm speaking out of line.

Similarly, patients tend to identify not with a particular doctor ("my doctor") but with "the Clinic," "the doctors," or "the staff." The effect is a dilution of affect within the physician-patient relationship as patients cease to be totally dependent on an individual doctor. Clearly, on a

number of levels the authority of the physician is restricted as he finds his role transformed from an autonomous authority to a highly skilled, but nonetheless easily replaceable, technician.

Physicians try to establish greater control in the clinic by provoking minor confrontations between themselves and the staff. Most doctors, for instance, never learn clinic routine although many have been exposed to it for months or years. However often they are instructed in proper procedure, doctors continue to fill out prescription slips improperly, to misplace patients' charts, to fail to call if they intend to arrive late. Since the staff has no legitimate sanctioning authority over these physicians, this type of manipulation achieves its goal of a symbolic show of control.

Physicians further respond to their restricted position by placing a very low priority on OPD work. While Clinic doctors suggest their own reasons for this opinion - their busy schedules or the low prestige and limited educational opportunities that clinic work provides - the answer lies deeper than this, for doctors are chronically pressed for time, and in reality OPD work differs little from private ambulatory care.

It appears that the explanation, in part, lies with the structural position of the Clinic physician and his resulting lack of dominance. In his office, the private physician makes the rules; on hospital floors, the house physician makes decisions and gives orders-- orders which may not be challenged even by the hospitalized patient's private physician. This, then, may explain one intern's assessment of the problems with OPD work:

All housestaff hate the Clinic. They see every patient as "fat, black, and forty with hypertension and headaches"....The attendings hate it even more than I do. They feel they are doing the same shit they do all day in their office, only they're doing it for free. The rest of the staff likes it OK, but they have to work with doctors that aren't interested, and they probably don't like that.

That is, the work that some find objectively tedious becomes additionally distasteful when, the position of authority of the physician is challenged or in some way re-

stricted. Therefore, any attempt by the staff to alter the work load or work situation provokes an immediate and harsh response on the part of OPD doctors:

The issue of housestaff coming to Medical Clinic one additional afternoon a week to reduce the backlog of intake physical exams was raised during Resident's Report today. One resident said he was completely opposed to the idea. He felt it was more important for the housestaff to be spending that time on the wards. Another said he would refuse to go down to the Clinic even if he were ordered to do so. He said that he had too many other things to do.

It becomes clear that the effect of these various structural constraints on physicians' role performance results in a minimal commitment to the Clinic and to institutionalized ambulatory care.

The Patients and the Staff

Parsons, in his classic conceptualization of the doctor-patient relationship (1950), suggests that patients and doctors participate in a set of mutually complementary social roles which fit together in such a way that the health needs of the patient - which Parsons defines principally in sociological terms - are largely satisfied in the course of interaction with the physician. But for Parsons, the social universe of health and illness consists of unmediated doctor-patient interaction, clearly an incomplete version of the contemporary medical system. For Parsons fails to consider the differing perspectives and expectations which participants socialized in radically different social systems (the professional and the lay) inevitably bring to the locus of interaction. Freidson, a structurally oriented medical sociologist, builds the idea of conflict into his analysis of physician-patient interaction. He writes:

...the separate worlds of experience and reference of the layman and the professional worker are always in potential conflict.... The practitioner, looking from his professional vantage point, preserves his detach-

ment by seeing the patient as a case to which he applies the general rules and categories learned during his protracted professional training. The client, being personally involved in what happens, feels obligated to try to judge and control what is happening to him (1961:175).

However, the client uses his own and not the professional's criteria to reach judgements about his own course of action. The essence of the conflict therefore lies with the doctor's expectation that his recommendations will be followed and the patient's desire not to relinquish control. More generally, though, the conflict is grounded in the differing assumptions that individuals performing contrasting roles bring to their interaction (Merton 1957).

A further shortcoming of the Parsonian model is its failure to consider the larger context in which much contemporary medical treatment takes place. For while the dyadic model continues to dominate sociological analyses, solo private practice has been serving as the arena for medical treatment in a progressively smaller proportion of total cases (Bloom and Wilson 1963). Instead, patients are turning to outpatient clinics, prepaid group practices, and other institutionally based health plans since they can no longer easily afford the high cost of private care. As such, the traditional physician-patient relationship is transformed as it is mediated by the health institution and its professional and para-professional staff.

The institutional staff is in a powerful position to affect the course of doctor-patient interaction. For example, it plays an important role in diminishing inter-group conflict and tension, in part, by making the assumptions and expectations of each group more comprehensible to the other. To some extent, the staff at Western's Medical Clinic operates simultaneously in both the doctor's and the patient's social worlds. In this way they serve as brokers (Mayer 1966; Barth 1963) or cultural translators.

As a result of their professional or para-professional training, as well as the demands of their professional roles, the staff identifies with the clinic physicians, and they have a generally sympathetic understanding of the basis of physicians' behavior. The medical director, for example, commented:

The Clinic could be better organized. I'd

like to see the doctors happier...If there were more supportive services we might get more cooperation from the doctors. Many of them are unhappy about the lack of assistance they get.

A remark made by the clerk is even more to the point:

Some people expect too much of the doctors. The Clinic is supposed to be a learning situation, and so to schedule two Histories and Physicals in one afternoon is too much. And besides, the residents can't be asked to do the H & P's because they generally have a large patient following of their own.

Interestingly, it is the medical director and the clerk, the staff members positioned at absolute opposite ends of the Clinic's hierarchical structure, who offer these remarks. While the director is closest to the medical staff by virtue of his background and training, the clerk is at the other end in both categories - she is a black, high school-educated woman. But by making herself a guardian of the medical staff's interests, she integrates herself more securely into membership on the Clinic's professional team.

At the same time, the staff members feel they understand patient behavior and patient interests, and they try to make them more comprehensible to the medical staff. The institutional staff shares a number of ascribed characteristics with many of the Clinic's patients, giving this understanding a solid basis in reality. In addition to having class origins which are often not far removed from those of the patients, like the patients, the staff is largely outside most sources of institutional power. Thus, for most staff, a distinct advantage of OPD work, as compared with other hospital jobs, is the increased responsibility and authority it affords them. One staff member commented:

This is the most rewarding job I've ever had. The challenge is great, but I've learned a lot....I would never go back to the floors.

In addition, the Clinic's population is overwhelmingly fe-

male; roughly three fourths of Medical Clinic visits are made by women. All of the Clinic's full-time staff are also women, thus providing a further common interest bond between patient and staff. For example, after recounting an incident in which a patient failed to follow her doctor's instructions because she wasn't feeling ill, a nurse went on to say:

We ourselves don't remember to take our meds, get yearly Pap smears. How can we expect patients to? When I have a bladder infection, I stop taking pills the day the pain stops, even though I know it will return if I do.

Identification with patients is therefore not difficult for the supportive staff.

The staff's brokerage functions extend beyond merely facilitating doctor-patient communication. Traditionally a broker is a middleman who is able to obtain favors for his clients from those with economic or political power. The broker's own power is therefore indirect, and lies with his ability to influence those with actual access to the power structure (Mayer 1966; Barth 1963). However, the OPD staff operates as brokers as they direct the flow of services within the institution. As permanent, full-time workers in an institution with an irregularly serviced clientele and a temporary medical staff, the Clinic staff easily fits into the middleman role. For as a rule, patients do not know their doctors very well, and the time they spend in face-to-face interaction with a doctor is only a fraction of the total time spent in the Clinic; most of it is passed instead in the waiting area, in the company of the staff. Further strengthening of the staff's intermediary position comes from their simultaneous functioning in the patient's and the doctor's social worlds.

The staff willingly embraces the role of broker because it affords them influence and authority greater than their institutionally established position. The staff encourages patients to transfer affective ties from the physicians - who regard these ties as burdensome - to themselves. In this way, the staff can function as legitimate representatives of patient interests. This, in turn, serves to increase their prestige both with physicians and with patients, who are grateful for any interest shown in what is otherwise an essentially anonymous bureaucratic setting. Ties with particular patients are considered dyadic and strongly personal, and such ties are jealously guarded by the staff. Newcomers to the staff are advised that each current member has her own

group of patients who come to clinic solely to see her. They therefore believe that attempts made by others to communicate with these patients will most probably be received with silence or hostility.

But although the staff serve as bidirectional brokers, their primary influence lies with the patients. Here they function as principal agents of patient socialization. For instance, soon after a new patient registers in the Clinic, she recognizes that merely being sick is not enough to guarantee medical treatment; she must know how to manipulate the Clinic's social world as well. As one new registrant remarked:

I wasn't told anything in Eligibility: Not when to make appointments or how to make appointments or what kinds of doctors you could see....

An array of specialized knowledge not required with a private doctor is now needed. And a new medical role in addition to the familiar sick role (Parsons 1951) must also be mastered: That of the clinic patient. Such a patient must accept, among other things, a rotating staff of doctors, none of whom the patient has selected and none of whom will be her personal doctor for very long; a seemingly endless series of laboratory tests, procedures, referrals, and x-rays; and long waits in the pharmacy, in the laboratory, and in the doctor's waiting room. Many clinic patients are relatively new or attend clinic only infrequently. Their socialization is generally incomplete, and they are less accepting of the frustrating aspects of the Clinic's services. As one patient said:

I've been coming here for three months and I haven't been helped at all. They haven't done anything but send me from one doctor to another, and from one clinic to another. Why don't they just admit me to the hospital once and for all so they could do a complete series of tests. This way all that happens is I lose time from my job; I just sit here and wait for hours.

Patients more familiar with OPD routine better understand what is required of them as clinic patients, and they often see as assets what newer patients regard as disadvantages. One long-

time patient, for example, said:

The doctors here seem to take a real interest in you. They confide in each other about you and try to do everything possible...I don't even mind waiting here; as a matter of fact, I come here even earlier. I can talk to people and it takes worries off my mind (Zborowski 1966).

Socialization by the Clinic's staff ranges from explicit health education to more subtle instruction on behavior appropriate to clinic patients. As one nurse suggested during a discussion of patients' perceived shortcomings of the Clinic:

Patients complain because they want an unattainable ideal. They like the warmth and the personalism here, but they also want the efficiency of (the University Hospital)...but they can't really have both. The patients just have to be educated not to be so demanding.

An additional aspect of the staff's role as agents of socialization is their encouraging behavior in patients which approximates the physician's image of the ideal patient, thereby reinforcing the physician's own conceptualization of that role. According to clinic physicians, two essential components of the model patient are that: (1) the illness be a physical one without significant emotional overtones; and (2) the patient be responsible and motivated to follow the prescribed treatment regimen. First, the staff assists in fostering the former by encouraging patients to bring their emotional problems and social concerns to them rather than to the medical staff. The director and nursing supervisor support the staff's functioning in this capacity, and they encourage the development of warm, personal relationships between patients and supportive staff members. Second, the staff regard training in "responsibility and motivation" as part of their broader socialization goals. As the nurse coordinator remarked:

We haven't succeeded in properly teaching the patients responsibility to us. We don't give them the proper orientation toward what we expect. Part of the population we have here

has never had to be responsible to or for anything, keeping appointments, for example... In the future, as part of my job, I'd like to interview every new patient and orient them to the Clinic to tell them what their responsibilities to us are and what are ours to them.

The staff, therefore, sees itself as not only helping patients become better clinic patients, but better citizens as well. In this way they represent an intermediate level between doctor and patient, as they transform the goals and intentions of the medical system into terms laymen are more likely to understand and more willing to accept because they are offered by those who present themselves as representatives of the patient interest.

The Staff's Construction of Reality

Although not a group in the formal sense (Mair 1972; Nadel 1951), the Clinic's staff is organized around principles of permanency: it is a bounded, highly structured unit in which pre-existing standards determine both the recruitment of new members and the bases of internal organization. As such, the staff creates and maintains explicit and readily articulable belief systems which legitimate and orient their own activity within the OPD. These systems of shared beliefs and values, which include ideas about the group's goals and purposes, play a fundamental role in maintaining solidarity and internal organization in the Clinic (Parsons 1951; Malinowski 1944). However, rather than one single belief system to orient all activity, the staff simultaneously maintains at least two competing systems, and each is called into action depending on staff needs.

The set of beliefs which form the basis of OPD ideology is a coherent set of principles which describes the staff's stated attitudes toward the Clinic's social world: toward patients, doctors, their own jobs, and the OPD itself. In brief, it is philosophically humanistic, drawing heavily on the "patients are people; treat the patient, not just the disease" approach that is currently popular among health educators and social scientists (Balint 1957; Bloom 1963; Kosa 1969; Norman 1969; Simmons 1958). As one nurse summed it up: "We try to set it up so patients have a different feeling about this place. We try to be flexible to patient needs." Another remarked: "...the real advantage is our attempt to deal with the entire patient. In most medical offices they

never look beyond the heart and lungs."

Since the total patient is seen as the proper target for all medical treatment, the staff place the highest value on direct verbal interaction with patients, and their vaguely defined conception of "quality care" has this concept at its core. One staff member said:

I'd like to be able to spend more time with patients...If we had more time to talk with them and visit with them, I think we would be able to help them. I think we would cut down on the number of visits patients make to the doctor.

Conversation with staff is thus considered the adequate, if not preferred, treatment for many patient complaints.

This humanistic perspective leads some of the staff to see the appropriate role of the Clinic extending far beyond the usual medical and socio-psychological services such facilities typically provide to include legal advice, assistance with insurance policies, consumer advocacy and the like. Patients are thought to lack the social skills and emotional resources that the more privileged classes have for tangling with bureaucracies. For in addition to being powerless, patients are generally seen as insufficient, multi-problemed personalities whose connections with the larger society are at best fragile ones. "I don't think patients take advantage of the clinic," said a nurse. "They have so little to start with, they try to get everything out of us that they can. They deserve everything they get. We'll try not to give it to them, only they have so little to begin with." This "humanitarian" view of patients allows the staff to see themselves as patrons (Foster 1967) who can successfully manipulate worlds patients ordinarily find closed to them. But this definition of the patient's world additionally serves to reinforce the structurally dominant position of the staff by defining "quality care" in terms so broad that it may potentially be mediated by staff members in a multitude of areas not directly related to medical care.

The picture of patients as weak and helpless beings further works to the staff's own advantage for it augments their role in the Clinic as it allows them to transform themselves from ancillary employees to workers indispensable to patient care and well-being. This is important on two levels: (1) Since most of the staff's responsibilities involve day-to-day routine chores (e.g., paperwork, answering telephones, assisting doctors), their contribution to patient care is characteristically un-

dramatic. But by highlighting the interpersonal aspects, the staff have the ready potential for making a meaningful contribution to patient recovery. (2) Supportive staff roles are generally undervalued by physicians, and the frustrations this brings to supportive staffs during daily interaction is amply documented in the literature (Kramer 1969; Mauksch 1969; Smith 1955). But by attempting to create an ideological alliance with patients by offering them a service not otherwise available (e.g., sympathetic conversation), the staff tries to solicit them to be their supporters, challenging doctors to deal with staff members on a more professionally equal basis. Furthermore, the solidarity created between patients and staff, through exclusion of doctors, also serves to increase the staff's own sense of professional self-esteem.

But like a true ideology (Berger 1963; Mannheim 1936), this humanitarian view is, in some ways, a distortion of the actual social reality. The staff's conception of patient needs, for example, applies to only a small number of OPD patients who do use the Clinic as a source of emotional support or stability. The overwhelming number of OPD visits, however, are made by otherwise healthy patients suffering acute episodes of illness. These patients want only quick, efficient, effective medical treatment. Nevertheless, by emphasizing the needs of the few, the staff strengthens their own position on the medical team.

When staff behavior is examined, the differences between the values they express and those on which they base their activity become clearer. Instead of a humanistic orientation, the values of rational bureaucracy are most evident, because decisions which maximize efficiency, equilibrium, and control are preferred. Conversation with patients, for example, is given low task priority, and structural change is in the interest of preserving the status quo. The medical director, for example, regrets that his door is often closed to patients, but feels that administrative meetings demand priority; the nursing supervisor and the head nurse also allow administrative duties to come before time spent in direct patient interaction. The nurse co-ordinator spends several hours a week on paperwork she admits could easily be done by a clerk. In these and other ways, the staff's definition of quality care more closely approaches the rationally bureaucratic one.

What is seen is the staff maintaining multiple, job-oriented value systems, and selecting among these systems as it suits their purposes at a given point in time, choosing the humanistic system when they seek to legitimize their structural position and the rational one when it is expedient in practical terms to do so. As Firth writes:

The notion of value involves judgement on a preference scale, a grading... Choice is exercised in the light of these values. From among the available means, those are chosen which seem most appropriate to the given ends...Choice at some level of consciousness is required for most types of action (1961:123).

The staff therefore operates within at least two value systems: one which orients their behavior (the rational) and another which legitimates ideology (the humanistic). In the course of their interactions with the other two important groups in the OPD - patients and doctors - the staff exploits the system that is suitable for their needs in a particular situation, choosing the humanistic, for example, when an alliance with patients will strengthen their position in the organizational hierarchy and the rational when objective work demands require that chores be efficiently completed.

Summary and Conclusion

The elements which characterize all bureaucratic systems - namely the existence of a network of social relations which forms its structure and the presence of a shared system of social beliefs - exist in the Western Hospital Outpatient Clinic in forms which explicitly affect the quality of interaction within the organization. This paper has described some of the ways in which this structure not only influences the manner in which the staff perform their own roles, but additionally some of the ways that the structure affects the behavior of physicians and patients, the other two groups in the Clinic. By controlling access to patients and to the administration of medical services, the staff defines the boundaries of physicians' performance. By mediating doctor-patient interaction, the staff translates the expectations of each group into terms meaningful to the other. And by maintaining multiple value systems, the staff manipulates social reality to retain structural control despite their actual ancillary positions. In these ways a group formally low in an institutional hierarchy is able to establish and maintain situational dominance and control.

NOTES

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¹ A pseudonym.

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