Framing a Profession:
Meaning and Autonomy in Medicine

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Abstract: Research has stressed the importance of autonomy to professional identity. Autonomy, scholars have said, grants professionals the license to use their unique skills and esoteric knowledge on behalf of clients. The growth of constraints upon professional autonomy in the last several decades has been predicted by some scholars to herald a proletarianization of the professional class. Existing work also suggests that people turn to culture to reconcile themselves to challenges to their worldviews.

This dissertation examines professionals' use of cultural logics to organize their work experiences into coherent landscapes of meaning. By using culture in this way, they manage the experience of declining autonomy and link their work to a vision of the good. Cultural logics do not exist solely in professionals' minds; rather, they exist in dialectical tension with the institutional infrastructure in which professionals work.

As professionals for whom autonomy has been particularly emphasized but who face extensive intervention from external forces, doctors represent a highly appropriate group with which to analyze the use of culture in managing professional constraint. I identify and outline three cultural logics doctors use to make sense of and adapt to infringements upon their autonomy. Each logic places a special emphasis on one particular form of autonomy and encourages doctors to defend or pursue it. Sardonic pragmatism directs doctors' ambitions toward small victories and cultivates indifference toward the decline of autonomy. It stresses negative autonomy and encourages doctors to withdraw (emotionally if not physically) from that which is seen as distracting or counterproductive. Progressive planning fosters a tentative embrace of the structural changes as a means of directing the field toward the conservation of scarce resources and away from the preservation of exceedingly medicalized life. It emphasizes a form of hierarchical autonomy in which the peopling of the hierarchy is determined by insight rather than simply tenure. Neoclassical professionalism resists structural changes through a combination of denial and conflict, stressing the importance of preserving human connections between doctors and patients. It asserts interpersonal autonomy, through which doctors are empowered to make the connections to others that are, in this view, essential to optimal medical care.

The larger implications of this research speak to the sociology of culture, the study of professions, and the contested organizational and moral visions underlying contemporary medical care. Through the use of culture, individuals can accommodate themselves to constraints that might seem intolerable when viewed through an economic or institutional logic. It is shown that action can, in fact, be driven by cultural models and not merely by practical consciousness. Additionally, the stakes of the cultural contestation at work in the medical field inform discussions regarding the meaning and value of life and the role of the medical field in managing it.

Table of Contents

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Introduction

It is 10 AM at Harborside Hospital, and a group of doctors is preparing for a "family meeting." The loved ones of Chris Hoffman[1] are about to receive upsetting news. Chris, a middle-aged man, is suffering from incurable cancer. Efforts at treating his cancer have come to include the surgical removal of his spleen, which is why he now sits in the Surgical Intensive Care Unit (SICU). Unfortunately, the removal of his spleen has accomplished little in the way of improving his overall condition. At the meeting, his family is to be told in no uncertain terms that his life is nearing its end. Chris is fading quickly, and additional efforts at aggressive treatment will likely accomplish little more than the prolonging of his suffering. He stands no meaningful chance of ever returning to the life he once lived. The family will then have to decide whether to direct the doctors to continue the intensive treatments in spite of their apparent futility or to give permission for Chris to be transferred to palliative care – in other words, to acknowledge that his death is imminent and simply try to make his last days as comfortable as possible.

After a brief delay to wait for a tardy hematological oncologist to arrive, the practitioners began to file into the room. I cautiously follow along with them, still feeling conflicted regarding the appropriateness of my presence as an outsider. Given the intensely intimate and grave nature of the event, I would not have attempted to sit in had Dr. Janet Davis, a chief resident, not encouraged me to attend in order to experience this uniquely powerful example of the tension and emotion that color the work she and her colleagues engage in. Before I enter the room, Brad, a resident and another member of the medical entourage who will be in attendance, turns to me. "Matthew, it's a small room," he says. "So if you wouldn't mind…" His intent is clear, but as I turn to retreat

[1] All names are pseudonyms.

back into the hallway, Dr. Davis, who as a *chief* resident stands above Brad in the institutional hierarchy, uses her professional prerogative to overrule him on my behalf. "No, he can come in," she states firmly. As I rejoin the group, Brad shoots a glare my way, obviously perturbed about the loss of face.

Brad had not been lying when he said that the room in which the family meeting would take place was small. There are approximately ten people present, split roughly evenly between practitioners (both doctors and nurses) and Chris's loved ones (Chris himself is not in a condition to attend). The gravity and intensity of the moment are palpable. A doctor tells the family that Chris's circumstances are grim. The doctors in the room must articulate the facts of the matter in terms that the family can comprehend and that lay out the full extent of Chris's problems; there is a shared understanding that this is not the occasion for vagueness or for putting a rosy gloss on things, as sometimes occurs in less formal interactions. As Chris's loved ones begin to grasp the doctors' message, many of them begin to cry. They remind the doctors of positive signs they saw from Chris. "He wiggled his foot," one points out, in a tone of pleading rather than disbelief or defiance. Each time they offer this sort of recollection, the doctors calmly explain that the event they are recounting does not alter the ominous underlying facts of Chris's condition.

Eventually the family has no optimistic anecdotes left to recall. The doctors then gently present them with their choice between continued treatment and palliative care. They tell the family that they are simply laying out their options and are not seeking to influence them one way or another, but it is clear to me that the doctors are trying to steer the family toward a decision to put Chris in palliative care. The family is resistant.

Through his tears, Chris's brother says "he wouldn't want to give up." "It's not about giving up," a doctor gently responds. "It's about not prolonging his suffering." A female family friend is also crying, but now anger begins to creep into her voice. "So you're saying there's nothing to do? Pull the plug?" The doctors then try again to convey the unfortunate reality of Chris's prognosis and to shift the Hoffmans' understanding of palliative care away from the coldness and impersonality of a phrase like "pull the plug." Their countenances are grave and sober throughout the meeting, although the beeps and buzzes emanating from their electronic devices periodically disturb the solemnity.

Once it becomes clear that the Hoffman family is not willing at that moment to give permission for Chris to be transferred to palliative care, the doctors tell the family that they will leave the room and give them some time to discuss the matter amongst themselves. As soon as they shut the door behind them, the doctors' miens shift. The thin pretense of neutrality under which they presented the family with their choice between continued treatment and palliative care is tossed aside. While I remain awed by the intensity of the moment I've just witnessed as an outsider, the doctors demonstrate their ability to shift effortlessly from the self-presentation of compassion, concern, and ostensible neutrality to one of tactical professionalism. They openly strategize about how to get the family to come to their preferred conclusion and place Chris in palliative care. One speculates that "if we go back in there now, they'll get angry." They ultimately leave the family to talk privately and think it over while they move on to their next patients, of whom there is a seemingly limitless supply that discourages extended reflection on any particular one. Only a day later, Chris Hoffman's condition takes

another turn for the worse, and his family agrees to withdraw treatment. He dies that same day.

The family meeting with the Hoffmans distills many of the paradoxes and challenges facing contemporary physicians into a single event. While they are unquestionably rich in power and agency in comparison to the average person, we see in events such as the Hoffman meeting and its aftermath the extent of doctors' frustrations and constraints. We see doctors face the challenges of building connections with patients and families, and we also see them carry a clear sense of mission into an interaction they frame as a neutral choice. We see them approach an individual patient's circumstance with seriousness and a presentation of single-minded focus while in a frontstage setting, and we also see them shift out of that focus and back into open acknowledgment of what they feel their larger institutional context and their vision of the good require of them on the backstage. We see them grapple with the limits of their autonomy as they try to coax the family into taking an action that they cannot simply order themselves. At its essence, the family meeting shows doctors engaging with the questions of what they and their profession owe to patients and to society as a whole, and of how they can meet these obligations in the context of the institutional infrastructure in which they work.

This dissertation explores the manner in which doctors make use of culture in adapting to the decline of professional autonomy. The erosion of a privilege long held to be essential to a professional identity requires many doctors to adjust the expectations and goals they hold for their careers, as well as to craft creative strategies to achieve fulfillment at work. I argue that doctors make use of culture, in the form of what I call logics, in adapting to lessened autonomy. Three logics – sardonic pragmatism,

progressive planning, and neoclassical professionalism – allow doctors to adjust their expectations and ambitions and accommodate themselves to a uniquely taxing work environment in which autonomy is limited. Through these logics, doctors use culture to manage relationships with the institutional infrastructure in which they work and to retain a sense of their own efficacy and dignity. In so doing, they also outline the contours of a broader debate emerging within the medical field regarding the contentious art of balancing the needs of the many with the needs of the few.

The Study of Professions

The professions captivated sociologists throughout much of the twentieth century. While forerunners can be found amongst the earliest and most foundational of sociologists (e.g., Weber [1919] 1946), it was, as Gorman and Sandefur (2011) make clear, the middle of the twentieth century when research on professionals reached its peak of volume and influence. This research was valuable but ultimately limited in its focus and scope. Scholars concerned themselves greatly with the matter of just how professions ought to be defined. Greenwood (1957), for instance, would apply the term to any field which claims those traits which "all professions seem to possess: (1) systematic theory, (2) authority, (3) community sanction, (4), ethical codes, and (5) a culture" (45). This definition, like most of those provided, generally makes intuitive sense, but consensus proved elusive and petty differences were legion. Even as scholars began to concern themselves with "critiques" of the search for the ideal definition (Habenstein 1963) and to label the quest a "problem" (Cogan 1955), definitional matters remained at

the forefront of scholars' attention, as did related debates regarding whether certain fields, such as business management (Bowen 1955) and foreign student advising (Davis 1961), qualified as professions according to the various definitions being proposed. Amid these definitional debates, a general consensus held that autonomy was a key determinant of professional status. For Freidson (1970), in fact, autonomy stood apart as "The most strategic and treasured characteristic of the profession" (23-4), while Gannon (1971) referred to it as "probably the single most critical dimension in the analysis of professions" (68). The importance of autonomy lies in its role as the guarantor of professionals' license and ability to use their esoteric knowledge and skills on behalf of clients, with minimal interference from those who would replace the professional's sound judgment with the ruthless efficiency of the market or the bureaucratic sluggishness of the state (Starr 1982). Autonomy, it is suggested, grants the professional the freedom to focus solely upon the facts of the case and to use them as the basis for informed judgment and action.

Gorman and Sandefur (2011) demonstrate that the limited intellectual ambitions of professions scholarship in the 1950s and 1960s were rendered somewhat obsolete by the changes that took place in the 1970s and 1980s, as professions confronted new competition for their services, challenges to their autonomy from economic and governmental actors, and demands for representation by communities that had been largely excluded from professional ranks, to name just a few issues. Through a brief review of the circumstances of medical work between the middle and the end of the twentieth century, we can see the journey of professions and professional scholarship epitomized. The 1950s and 1960s were said to be, for physicians, a "Golden Age of

Doctoring" (McKinlay and Marceau 2002), when autonomy was strong, patients followed orders, and interference from administrators, government officials, and insurance companies was minimal. Scholars of the day affirmed the doctors' professional identity and discussed such matters as the strategies by which medicine's innovative spirit could be nurtured and empowered most effectively (Ben-David 1960).

Empirical evidence and contemporaneous accounts (e.g., Becker at al. 1961; Neumann 1957) demonstrate that the professional and cultural circumstances of medical care in the mid-20th century reflected a higher prestige and autonomy for doctors and a greater degree of trust and interpersonal connection between doctors and patients than is present today.[2] "Broadly speaking," wrote Fisher in 1966, "patients trust doctors, all doctors" (118). Indeed, survey data show that 73% of Americans held a great deal of confidence in the leaders of the medical profession toward the end of the Golden Age in 1966 (Blendon et al. 2014; Harris 1982). The high standing of American medicine in the middle of the twentieth century had much to do with the fact that, as Starr points out, "Americans now gave science unprecedented recognition as a national asset" (1982:335). Doctors' association with science provided them with a compelling cultural foundation for authority. The professional standing of medicine also benefited greatly from portrayals of doctors in early television dramas as infallible heroes who never let a patient die. Professional organizations would even provide consultation to the producers of such programs, in order to ensure that doctors would be portrayed in a flattering light (Feasey 2008). Dramatic medical success stories such as the development of a polio vaccine

[2] It should be stressed that this trust and interpersonal connection existed alongside circumstances viewed far more dimly today, such as paternalism on the part of practitioners and White male predominance among physicians' ranks.

further deepened the trust between the American citizenry and the medical profession and ensured that research funds would flow freely, at least for the time being (Starr 1982).

This state of affairs would not last. The percentage of Americans holding a great deal of confidence in the leaders of the medical profession dropped from 73% in 1966 to 30% just 13 years later and stood at only 34% in 2012 (Blendon et al. 2014; Harris 1982). While this dramatic decrease is part of a broader decline in confidence in American institutions more generally (Putnam 2000), the high confidence of 1966 is an indication that medicine was very much a part of the greater experience of social trust and connection in mid-20th century America compared to today. Patients largely acquiesced to the instructions of the physician and were said to be "passive creatures for the most part…their passivity [being] linked to an understandable dependency which is inseparable from illness" (Wilson 1963:70).

As the 1970s and 1980s progressed, acquiescence and dependency gave way to agency, and heretofore excluded perspectives began to find a voice. The "Golden Age," after all, likely would not have been perceived as such by women struggling to gain a foothold in a male-dominated field (Harrison 1982; Mandelbaum 1978), by patients who felt powerless to challenge the decisions of their doctors (Haug and Sussman 1969), or by African Americans from whom treatment for syphilis was purposefully withheld as part of the infamous Tuskegee Study (Jones 1981). By the last decades of the twentieth century, discontent with the arrangements of the "Golden Age" would become impossible for physicians and scholars to ignore. Challenges would take many forms, but most of them have been understood as threats to professions' cherished autonomy.

Challenges to Autonomy

By the dawn of the 1970s, the foundations of the Golden Age were crumbling. While it was not as complete a collapse as the "great fall" that Merton (1958) predicted would eventually occur "If the face which the profession presents to the public is more attractive than the reality" (53), doctors undoubtedly experienced a distinct downturn in power and prestige. A "Revolt of the Client" (Haug and Sussman 1969) saw medical paternalism increasingly rejected by patients, many of whom had begun (spurred on by entrepreneurial pharmaceutical companies) to adopt a consumer identity, and to pursue medical treatments in accordance with their own diagnoses of abnormal or suboptimal appearance, sexual performance, or attention span in themselves or their children (Davis 2014; Zheng 2015). Meanwhile, corporate encroachment into the medical sphere eroded physician autonomy (Starr 1982). As critical eyes turned toward the Golden Age, its less flattering characteristics came under greater scrutiny. Its empowered practitioners held the potential to induce illness as well as to cure it (Illich 1976[2013]). Its glorification of long work hours as a rite of passage of residents facilitated costly mistakes and drove young doctors to burnout and exhaustion (Kellogg 2011). Women and people of color were largely excluded from the ranks of physicians and taken less seriously as patients (Mandelbaum 1978; Moskowitz 1994; Werner and Malterud 2003). By century's end, the glory of the Golden Age had eroded substantially, as had the practitioner autonomy that had been associated with it.

Engel (1970) describes professional autonomy as taking two related forms. The individual practitioner can hold autonomy to carry out the tasks of one's work as he or

she sees fit, and the profession itself can hold autonomy relative to other occupations and institutions. The individual practitioner feels the forces shaping the medical profession acutely, but these waves of change have the potential to wear down both forms of autonomy. Doctors, for instance, find themselves tied ever closer to a highly quantitative decision-making apparatus that requires much in the way of data entry and leaves relatively little room for the practitioner's own judgment and decision-making. Electronic medical records are frequently named as key culprits in this process, as the understandable institutional desire to streamline patient data and make information easier to share and transform tethers practitioners to computers (Miller and Sim 2004). Stricter adherence to evidence-based medicine and algorithms for determining the course of patient care also hold the potential to erode the role of the practitioner's own decision-making (Timmermans 2005; Timmermans and Kolker 2004).

In addition to aggressive quantification, individual doctors have also come to face increased pressure to take the wishes and concerns of patients into account. The greater visibility given to medical malpractice and associated lawsuits illustrate this point most vividly (Hicks 2008; Weiler 1991). Efforts to prevent dissatisfied patients from resorting to litigation have given rise to widespread patient satisfaction surveys designed to identify what patients see as flaws in the work and dispositions of their physicians (Fullam et al. 2009). Medicare reimbursement is now linked to patient satisfaction, with low ratings costing hospitals money in the form of decreased reimbursements (Rau 2011). The greater attention being paid to patients' preferences and experiences is also said to play a role in the prevalence of "defensive medicine" – treatments and procedures that are unlikely to be effective but that a doctor feels compelled to administer in order to

satisfy a patient who is asking for them or to prevent the failure to administer such a procedure from being raised (perhaps illegitimately, but raised nonetheless) as an issue in malpractice litigation (Fielding 1995; Kessler and McClellan 1996).

Shifts that have attenuated the autonomy of the field itself vis-à-vis other large institutional actors create consequences that impact individual practitioners as well. Insurance companies and health management organizations enter relationships with hospitals that have the effect of placing constraints upon physician autonomy through coverage and reimbursement policies (Light 2004). We are ultimately left with no choice but to conclude that today's physicians are far less empowered and autonomous than their predecessors (Burdi and Baker 1999; Holsinger and Beaton 2006). Fearful of lawsuits, boxed in by insurance companies, and obligated by algorithms, these doctors are workers for whom the effects of quantification and neoliberalism are impossible to ignore.

Yet even amid great structural constraints, individuals and groups can use shared cultural understandings in the service of finding meaning and empowerment (Hays 1994; Pugh 2009). In the process of exploring these issues, I suggest that to view doctors' fate simply in terms of deprofessionalization or proletarianization is to overlook the possibility that doctors call upon the institutional and cultural resources they still possess in order to negotiate these changes and emerge with a resilient sense of agency and empowerment. With this in mind, I ask: How are doctors able to call upon existing understandings of what it means to do their job well in order to manage the new constraints? I identify the existence of what I call logics that doctors can use to derive meaning from their work, give their efforts a sense of purpose, and articulate broader goals for their profession.

Logics and Institutional Infrastructure

There is a general consensus among sociologists of culture that the older understanding of culture as a sort of "ether" or "mist" in which individuals passively operate represents an inadequate model (Eliasoph and Lichterman 2003). Scholars have moved toward an understanding of culture as multifaceted, available for individuals and groups to adopt, set aside, and modify. This availability is not, of course, unfettered by structural constraints; indeed the intersection of culture and structure is more intimate than is often assumed (Hays 1994). But to overlook culture or subsume it into structure is to ignore a rich realm of human resilience and creativity. Pugh (2009) crystallizes this approach when she writes that "we might conceive of culture, then, as a patterned, collective process by which people attach personal, emotional significance to their world" (23). Worth noting in this definition is the idea that people can use culture to *find something*, that it *does something for them*. In the abstract, we might refer to this "something" as coherence between personal meaning and the world in which they live. For doctors in particular, we can take note of how they might use logics to find meaning and fulfillment in their work.

As I define them here, logics are somewhat similar to ideologies as described by Fine and Sandstrom (1993). For them, ideology describes "*a set of interconnected beliefs and their associated attitudes, shared and used by members of a group or population, that relate to problematic aspects of social and political topics. These beliefs have an explicit evaluative and implicit behavioral component*" (1993:24; emphasis in original).

Logics play much the same role in my research, but I use the term "logic" instead of "ideology" in light of the fact that my respondents' actions are geared less toward political projects (though these are hardly absent) than toward interaction and recurring processes of decision-making. These logics set a template for what should be embraced and what should be rejected, formulating goals and a vision of the good (Chan 2009; see also Lareau 2002). They give doctors their identities as, for instance, uniquely patient-centered or concerned about costs (Lok 2010).

Against Vaisey (2009) and other scholars who would argue that culture motivates action largely through the practical consciousness we feel viscerally in our "gut," I suggest that these more extensively elaborated logics play a significant role in shaping behavior. Through their statements in interviews and their discussions with colleagues, doctors call upon what Pugh (2013) refers to as the honorable and the schematic. When people speak of the honorable, they share their vision of the good and their understanding of what is admirable. While much been made of the notion that individuals might articulate their notion of the honorable as part of a post-hoc attempt to explain their behavior or to mask the unflattering reality of their conduct (Pager and Quillian 2005; Vaisey 2009), I suggest that the content of individuals' notions of the good is deserving of careful consideration. Even if they are not consistently reliable predictors of their behavior, and even if individuals might adopt and scuttle different notions of the good in various contexts, our willingness to publicly associate ourselves with a particular understanding of honorability allows a glimpse of the raw material with which we make sense of the world around us. Pugh refers to the schematic as "language and non-verbal cues…[people use to] convey the frameworks through which they view the world"

(2013:50). These gestures may not reflect a notion of the honorable, but they are meaningful as gestures in their own right and as windows onto processes of sense-making and coping with daily lived experiences. They can also play an important role as conduits through which individuals can translate their visceral response to a form of stimulation into the response accepted as, if not honorable, at least tolerable in their social context.

Each of the logics discussed in this dissertation is used within the context of Harborside Hospital's institutional infrastructure. Following Scarborough's (2015) articulation of the concept, I use the term institutional infrastructure to refer to the structural circumstances that are largely imposed upon individuals and groups. They are not easily altered and much everyday interaction takes their influence for granted. Culture is not divorced from the institutional infrastructure (Hays 1994). The institutional infrastructure provides the plausibility structure, which Berger and Luckmann (1966) use to refer to shared understandings that make coherent social interaction possible, on which the cultural logics I discuss build their meaning, and culture provides many doctors with the tools they feel they might need if they are to carve out a meaningful and fulfilling role for themselves. Nevertheless, while the institutional infrastructure has culture embedded within it, a great deal of its influence comes from elements that transcend the realm of culture and take the form of structural power. Much of this strength can be traced to the patterns of institutional isomorphism that reproduce organizational patterns across a range of independent hospitals (DiMaggio and Powell 1983). I speak here of such forces as insurance reimbursement policies, requirements to

obtain patient consent for most non-emergent interventions, and hierarchical chains of obligation and responsibility.

At Harborside Hospital, for example, the institutional infrastructure establishes a hierarchy under which senior doctors have final authority and residents and medical students are expected to learn from them. It is a particularly sturdy piece of the institutional infrastructure, drawing strength from its replication across many large academic medical centers and other professional (and business) organizations. If a nurse practitioner were to attempt to take charge of the course of treatment, his or her effort would quickly conflict with the institutional infrastructure, and the nurse practitioner would lose face (Goffman 1959) and possibly his or her job.

Institutional infrastructure is not entirely unrelated to the concept of the plausibility structure. However, institutional infrastructure encompasses structural constraints that are not purely cultural, such as legal restrictions on doctors' behavior and limits on financial reimbursement for certain procedures[3]. Institutional infrastructure ultimately looms large as the arena in which doctors make use of cultural logics. It is not easily altered or circumvented, but by calling upon logics, doctors can forge strategies to find meaning and satisfaction in their work in spite of these restrictions.

The institutional infrastructure in place at Harborside Hospital links its practices and organizing principles to what I refer to as the contemporary medical model. I use this term to describe the broader landscape of meaning and structure underlying medical practice at Harborside and beyond. This model has brought economic considerations to greater prominence in medical care, as corporate conglomerates take ownership of clinics

[3] It should be stressed again that to say that such constraints are not *purely* cultural is not to say that they are completely *divorced* from culture.

and hospitals (Fennell and Adams 2011; Starr 1982). Even hospitals that have managed to avoid these sorts of takeovers cannot fully escape what Reich (2014) refers to as "the commodification of hospital care" (1577). Doctors and administrators at an academic medical center such as Harborside Hospital must still pay attention to reimbursements from insurance companies and government benefit programs (chiefly Medicare and Medicaid), the costs of intriguing but untested new equipment, and fees that could be received from affluent patients willing to pay for non-emergent personal enhancement procedures such as plastic surgery (Light 2004).

The contemporary medical model also formally codifies a rejection of the paternalism and inattention to patient wishes that facilitated the practitioner autonomy of decades past. This rejection is not totalizing, but it is significant. Concern for patient consent is widespread, and doctors can do relatively little in terms of care provision without permission from the patient or whomever is legally authorized to make decisions on his or her behalf (Bruce et al. 2013; del Carmen and Joffe 2005). Additionally, hospitals have adopted patient satisfaction surveys to assess the extent to which patients are pleased with their treatment, and poor scores can impact doctors' pay and professional standing (Press and Fullam 2011; White 1999). The contemporary medical model is one in which the patient has come to take on the role of the consumer, empowered to make choices and demand satisfaction. Not all patients have the resources and social standing necessary to adopt a consumer role; the uninsured, for instance, have fewer options available to them (Hall and Schneider 2008). Nevertheless, the empowered patient is a central part of the contemporary medical model.

Continued devotion to the individual patient, at least as a matter of official policy, is also a part of the contemporary medical model. Some argue convincingly that, in practice, macroscopic concerns often outweigh the circumstances of the individual patient in shaping doctors' decision-making (Rosoff 2014). However, in an age of autonomous patients, there are strict limits on the extent to which a doctor can decide to take particular course of action against the wishes of a patient in order to enhance the greater good. Emphases upon the individual patient and the larger society exist in an uneasy tension (Garbutt and Davies 2011), but the former remains a powerful influence.

The Logics in Brief

My research led me to identify three prominent logics doctors at Harborside Hospital can use to find meaning and direction in their work. Each logic is rooted in the long and evolving history of the medical profession and its sociocultural identity in the United States. Through a variety of channels, including the tenets of the institutional infrastructure, doctors' life experiences and social positions, and the logics' connections to strands of the medical profession's historical character, doctors are led to call upon these logics in their efforts at meaning-making. In different ways, each logic offers a doctor an avenue toward accomplishment – a sense that, despite all of the obstacles, he or she has used his or her unique talents and perspective in order to bring their vision of the good a small step closer to fruition. Logics represent a cultural resource doctors can make use of to come to terms with the challenging environment in which they find themselves. But the logics do not coexist tranquilly. Each offers its own model of what

medical practice ought to represent, and these competing visions are not easily reconciled. Doctors thus advocate for the logics they subscribe to most directly, seeking to impress upon colleagues the importance of their particular approaches to the practice of medicine.[4]

The first such logic, *sardonic pragmatism*, takes the most modest view of these efforts at achieving the good. For sardonic pragmatism, the doctor can be proud if he or she manages to spare patients from entanglement in the thickets of superfluous pretense and experimentation that have come to surround medical practice. It casts a skeptical eye upon the idea that medicine is a highly esoteric and challenging field in which uniquely skilled individuals must call upon their rare talents to bring about positive outcomes. This logic can be traced back to the Age of Jackson in the early 19th century of the United States, when understandings of medicine as intricate and complex experienced a popular rejection as part of a larger suspicion of elites and an embrace of the folk wisdom of the common person. For sardonic pragmatism, the importance of autonomy lies in its role as the tool with which a doctor can protect a patient from those colleagues who are so enamored of the intricacies and innovations of their field that they would lose sight of the basic essentials that are all that is required for the treatment of most patients. With truly challenging and unique patients being rare, and with so many opportunities for the institutional infrastructure of the medical field to have harmful effects upon patients, sardonic pragmatism finds a sense of achievement in its ability to forestall the many potential pitfalls that surround the doctor and the patient. In the process of doing so, it makes use of dark humor and a dry, disinterested affect to tweak the pretense of the

[4] Doctors do not carry out these attempts at advocacy on a neutral playing field; hierarchical rank gives senior doctors a more prominent platform for their views.

profession and discourage colleagues from making patients the centerpieces – and, therefore, potential victims – of grandiose plans. At its heart, sardonic pragmatism offers doctors a form of emotional exit from the stress and disappointment that accompany attempts to perform heroic medicine in the face of contemporary constraints.

While sardonic pragmatism finds solace and satisfaction in the absence of disaster and other modest victories, *progressive planning* subscribes to far more ambitious goals. It enables doctors to use their autonomy to advocate for a greater focus on public health and social medicine. Progressive planning is rooted in the efforts of American elites at the turn of the 20th century ("The Progressive Era") to use expert knowledge and theories of efficiency to manage the social problems associated with industrialization. Like their predecessors, contemporary users of progressive planning call upon elite leaders to manage institutions in such a way as to "do the most good." In practical terms, this means that the progressive planning logic urges greater attention to waste and how doctors can manage to reduce it, specifically the degree to which extensive investments of time, money and resources into individual patients in late stages of life preclude the possibility of making as great an investment in other forms of medical care or public health stewardship that might hold the potential to bring more benefit to larger groups of people. Doctors, it is suggested, ought to use what is left of their autonomy to advocate for the distribution of power to only a select group of elite physicians and policy-makers who are wise and farsighted enough to see the wastefulness and non-sustainability of current patterns of medical spending and the emptiness of much medically-enabled life. To the extent that structural constraints and declining autonomy facilitate this goal, they are not always destructive and may even warrant celebration.

For progressive planning, autonomy is a valuable resource – so valuable, in fact, that to empower each and every doctor to wield it would be misguided. It is better to restrict autonomy to those with the long-term and wide-ranging vision necessary to use it judiciously. Progressive planning ultimately allows a doctor to make peace with the changes that have altered the medical field and weakened professional autonomy, and to see these changes as, at least in part, harbingers of a more enlightened future. At the very least, the changes are heralds of continuing inevitable evolution, and doctors would be wise to shift their emphases to work alongside these new trends, rather than withdraw to the comfort of small victories, as with sardonic pragmatism.

Lastly, *neoclassical professionalism* sits roughly in between the other two logics with regards to the scope and ambition of its notion of the good. Neoclassical professionalism invests a sense of virtue into the "Golden Age of Doctoring" from the mid-20th century. It holds fast to the sanctity of the relationship between the individual doctor and the individual patient and looks askance at progressive planning's efforts to take a more societal view of health and welfare, as well as to the larger transformations medicine has been subjected to over the last several decades. In particular, the quantification and digitalization of medical care, as reflected in the increased use of electronic medical records and predictive algorithms, are viewed as irrelevancies at best and as distractions from the truth to be uncovered through direct interaction with patients at worst. For neoclassical professionalism, the value of autonomy rests in its capacity to empower individual doctors to do the best work that they can for their patients within the constraints imposed by the realities of contemporary medical practice, and to resist or ignore those constraints when possible. When viewed through this logic, the highest

professional accomplishment is the use of genuine respect, responsibility, and mutual obligation between the practitioner and the patient to bring the best possible outcome to that patient and his or her loved ones, irrespective of what efforts or sacrifices this might require from others or what opportunities might be lost in the process of doing so.

Each logic places a strong emphasis on a particular manifestation of autonomy. By using the logic to understand one's work, autonomy comes to take on urgency and efficacy in a certain context and to fade in importance in other contexts. For sardonic pragmatism, *negative autonomy* looms largest. By negative autonomy, I refer to the ability of a doctor to prevent the occurrence of disaster or disengage from contexts likely to interfere with, or prove irrelevant to, the achievement of modest medical aims. Progressive planning places stress upon *hierarchical autonomy*. As I use it here, hierarchical autonomy does not refer to the unsurprising ability of individuals with high-ranking positions to exercise greater autonomy than those working below them. Rather, hierarchical autonomy comes to be infused with an urge to see that the right people – those who recognize the internal and external dangers facing the profession – take roles that allow them the autonomy to utilize their talents and insights. Lastly, neoclassical professionalism places value upon *interpersonal autonomy*, by which I speak of the ability of a doctor to forge a human connection with a patient and, in doing so, reap the personal and professional rewards that come from such connections.

These logics animate the way doctors make decisions about medical practice, what counts as good medicine, training, and engagements with patients and colleagues. They are ideal types, and they don't represent all the different ways doctors think about medicine. Doctors can subscribe to or enact several in one day depending upon the

circumstances in which they find themselves, although most doctors embrace one to a greater degree or more frequently than the others. The logics are contextual, although some might be more consistent than others and the institutional infrastructure does not make each similarly welcome across all settings.

But despite these limitations, the usefulness of the logics as analytical devices is clear. They are, as I have said, important as tools with which doctors reconcile themselves to changes in medicine. However, they also have larger implications. The differences between them point toward larger conflicts that the medical field will be forced to grapple with in decades to come. They speak to fundamental questions underlying the entire profession, of what its goals ought to be, of who is authorized to practice it, and of what balance it ought to strike between the needs of the many and the needs of the few.

The processes through which doctors come to adopt logics or to rely on one more than another are complex. This research suggests that doctors' lived experiences and the ambitions and motivations behind their decisions to pursue a career in medicine are consequential. Doctors also tailor their use of logics to their broader dispositions and preferences regarding social relationships, with, for instance, a doctor reporting a broader disinclination toward "small talk" less likely to embrace neoclassical professionalism, with its celebration of personal engagement with patients. Power dynamics also play a role; sardonic pragmatism's use of negative autonomy is, in practice, more available to high-ranking practitioners with the freedom to disengage from a task and leave it for subordinates to handle. The appropriateness and attractiveness of logics to doctors are ultimately rooted in an intricate tangle of motivations and restrictions.

An Introduction to Harborside Hospital

To answer my animating questions, I call upon eighteen months of ethnographic research at a large academic medical center in the South Atlantic region of the United States that I call Harborside Hospital. Harborside is a large institution that enjoys a generally strong reputation and is affiliated with a highly-regarded public university and its medical school, but is nonetheless facing challenges from local competitors for medical "market share" and from the larger structural changes shaping the field.

Over the course of eighteen months, I shadowed physicians in the Division of Acute Care and Trauma Surgery (ACT) as they went about their work in the sprawling medical complex. Three main settings would ultimately provide me with most of my relevant data. (I also accompanied doctors from time to time as they performed other duties in other settings, including operating on unconscious patients in formal operating rooms, but I discovered that these occasions were not as enlightening as time spent in the three major sites proved to be.) The first is the auditorium where what I call the "Monday Meetings" are held. Each Monday morning, two highly ritualized meetings are held for an audience of practitioners from throughout Harborside's Department of Surgery. The first such meeting, the Morbidity and Mortality Conference, is a formal review of patients who encountered bad outcomes, with the aim of determining what (if anything) could have been done differently to bring about a better result. After the conclusion of the Morbidity and Mortality Conference comes Grand Rounds, which is a talk from a notable medical professional, followed by a brief question-and-answer

session. The second venue to prove essential for my research was the "Thursday Conference," a weekly meeting held by members of the ACT team, including attendings, administrative support staff, nurse practitioners, and the residents and medical students who were rotating through the ACT team at the time. The Thursday Conference plays host to a number of events, ranging from discussions of challenging patients to presentations from medical students to informal banter about the state of the medical field. The final important venue is the Surgical Intensive Care Unit (SICU), where surgical patients requiring close observation are held. Attendings,[5] along with an entourage of residents and medical students, conduct rounds at the SICU each morning, discussing the course of each patient's treatment and talking briefly with the patient and his or her loved ones.

The SICU includes fifteen beds, most of which are occupied at any given time, along with approximately eight beds in the adjoining Surgical Intermediate Care Unit, or SIMU, where patients requiring less intensive observation are kept. Each room contains a bed and extensive medical gadgetry. Some patients' rooms are bursting with pictures, cards, and balloons from loved ones, while others lack any indication of a patient's life outside of the hospital. The hallway outside the patient rooms is usually crowded with practitioners and the occasional gurney. On the other side of the hall sits a workspace where nurses monitor patient data on computers and residents intermittently sit down to fill out medical records and talk with colleagues. Signs on the wall track the number of days that have passed since the last time a patient suffered a preventable fall (the higher the number, the better) and encourage practitioners to observe proper "hand hygiene" by,

[5] "Attendings" are doctors who have finished all stages of training and hold senior positions. They are responsible for supervising residents and medical students and for guiding the overall course of patient care.

at a minimum, rubbing their hands with disinfectant immediately before entering and after exiting a patient's room (plastic disinfectant dispensers are located outside each patient's room for this purpose). Pamphlets titled "The Journey Through Your Loss," which promote Harborside's bereavement services, are available for patients to peruse. The odor is typically that of the cleaning fluids used by the busy sanitation service, though certain patients' rooms smell of urine, feces, or, on occasion, necrotic flesh.

The SICU reflects earnest effort on the part of administrators to provide some semblance of levity and friendliness to an environment that is largely sterile and even somewhat foreboding in its very nature (it is, after all, where surgical patients facing serious conditions are kept). Around holidays, the SICU will be decorated with paper cutouts of Thanksgiving turkeys or Christmas trees and menorahs. If flowers are ever received from a patient as a token of thanks for their care, they are sure to be prominently displayed. However, these small gestures can do little to alter the technological coldness of the environment.

In addition to the ethnographic observation, I conducted interviews with the attending surgeons who figured most prominently in my observations and with various other practitioners[6] who found time in their busy schedules to meet with me. ACT doctors are responsible for treating patients who have sustained traumatic injuries. Gunshots, car accidents, and falls are among the most common incidents through which patients sustain injuries that lead them to the SICU, where the ACT team spends much of its time. Contrary to the stereotype of a surgeon who has little interaction with a patient beyond operating on them while they are unconscious, the ACT team frequently spends days or even weeks treating their patients as they slowly recover from their injuries. As

[6] Additional information regarding methodology can be found in the appendices.

they direct the course of a patient's treatment, doctors create and encounter many opportunities to use culture to manage the constraints they confront and pursue their vision of what medicine should stand for.

In this dissertation, I ultimately show that doctors make use of culture, in the form of what I call logics, in the process of finding meaning and direction in their work. I identify three logics that play a vital role in shaping professional action: sardonic pragmatism, progressive planning, and neoclassical professionalism. *The overarching finding of this dissertation is that doctors use these logics to reconcile themselves to the environment in which they work, and in particular to the relative absence of autonomy.* Amid an overall decline in autonomy, the logics allow doctors to recast their own preferences and ambitions in a more narrowly tailored fashion. The logics empower doctors to undertake a process of prioritization in which various tasks are assigned levels of importance in such a manner as to allow the doctor to strike a balance between long-term ambition and immediate fulfillment. As a consequence, doctors are then able to make peace with the decline of autonomy or to use it as a means of channeling their energies toward the specific means through which the profession can be directed into the pursuit of a particular vision of the good. In the process of making use of culture through these logics, doctors engage in a dialectical relationship with the institutional infrastructure in which they work. This institutional infrastructure does much to provide a plausibility structure (Berger and Luckmann 1966) for the logics and to give them their resonance, but it also imposes constraints upon their adherents' ability to use the logics in service of their vision and creates new challenges that force them to reevaluate their

goals. In other words, doctors cannot simply adopt a logic and use it to shape their world with no fear of pushback.

My research reveals the complexity behind what we think we know about contemporary challenges to doctors' autonomy. The logics doctors can use to bring order and purpose to their careers allow them to take a nuanced approach to autonomy and its role in the broader mission of medical work. They provide them with a diverse range of strategies for surviving in a challenging work environment that alternates between monotony and exhilaration, triumph and disappointment, even life and death. Yet they also provide a mechanism of escape, a means of denying purchase to the autonomy challenges they face. The logics can become stories doctors tell themselves about themselves in order to retain an agentic identity that is otherwise under extensive challenge.

In exploring these issues, I pay special attention to the potential for disagreement between practitioners with regards to their goals for the profession and the place of autonomy within these goals. It is necessary for sociologists to expand upon a macroscopic view of professions as unified institutional actors and to explore what Abbott (1988) refers to as internal differentiation within professions. Professionals do not all agree about the proper position of their profession vis-à-vis the state, or about the wisdom of sharing their duties with less-credentialed employees, or about the appropriate balance between the needs of individual clients and those of the larger society. There is an ongoing struggle taking place over these issues, and all parties involved hold the potential to utilize cultural logics and institutional infrastructure in service of their perspectives. Professionals are not a proletarianized mass of deskilled laborers, but

neither are they a loose confederation of "lone wolves" fighting change in their own idiosyncratic styles. They engage with their colleagues, sometimes as allies and other times as rivals, in their efforts to adapt to a changing world.

An Outline of the Dissertation

This dissertation argues that professionals use cultural logics to find meaning and fulfillment in their work amid structural constraints, that they do so in differing ways that belie the myth of the profession as a unified monolith, and that, through the use of these logics, they adapt their expectations and ambitions to accommodate a reality of limited autonomy. Chapters Two through Four feature in-depth explorations of sardonic pragmatism, progressive planning, and neoclassical professionalism respectively. Each of these chapters showcases a particular attending surgeon who uses that particular logic more than the others, though of course the logics are not limited to specific individuals. The chapters explain both how the logics are used in the immediate context of Harborside Hospital and what they suggest as a vision for the profession and its future more broadly.

Chapter Five explores the contradictions and dilemmas that arise from the circumstances in which these logics come into dialogue and conflict. Ultimately, the visions expressed by the logics are difficult to reconcile. Neoclassical professionalism holds considerable power as an embodiment of doctors' heralded autonomy, but progressive planning is increasingly embedded in the institutional infrastructure of the hospital, while sardonic pragmatism enables doctors to separate themselves from the high expectations of presuming either the individually-centered or the societally-centered physician knows best. The fate of medical autonomy will be determined in large part by

the extent to which any of these logics can emerge as the dominant moral vision of what the medical profession ought to pursue.

Chapter Six turns toward the impact this logic conflict can have upon patients. Ultimately, patients are the canvas onto which doctors use logics to attempt to paint their vision of the good. There is widespread agreement that patients deserve the best possible care; conflict emerges around the thorny question of what a banality such as "the best possible care" looks like in practice. Doctors must weigh the relative importance of various responsibilities related to patient care, such as taking the patient's wishes into account, making communicative connections with them on a personal level, and bridging the considerable social gaps between themselves and many patients. Logics provide varying systems of understanding through which doctors manage these demands.

Finally, Chapter Seven concludes the dissertation by reflecting upon what contemporary doctors can teach us about professional autonomy. It shows that autonomy's importance, while considerable, is open to negotiation and interpretation amid new institutional realities. The dissertation ends with a consideration of the place of medicine in contemporary American life and the trajectories of the logics with which doctors engage with it. The power and centrality of medicine are imposing, but they are not a historical inevitability. In considering the fate of the professions, we should reflect upon their place alongside other cultural currents and institutional forces in American life. My own deliberations lead me to conclude that one logic in particular, namely progressive planning, is poised to take a powerful position within ongoing debates about health, scarcity, and justice.

By studying doctors' efforts at meaning-making and accomplishment in the contemporary medical field, we can understand the role of culture in mediating structural change, and the ways it can shape changes in the future. We better understand the medical field both as an institutional entity interacting with the economy and the state, and as a muddled arena of internal contestation, where professionals negotiate stark differences between the visions they have for their field and their understandings of what it can and should do in order to represent a force for good.

Chapter 2: Sardonic Pragmatism

"Nothing that makes money ever gets better."

-Dr. Wesley

Doctors at Harborside Hospital hold varying opinions on the issue of whether nurse practitioners and physicians' assistants ought to be empowered to perform certain basic medical tasks that have traditionally been reserved for doctors, such as prescribing medication and making diagnoses. Dr. George Witherspoon, for instance, is adamantly opposed to such arrangements, while his colleague Dr. Brian Minter is tentatively open to them. When I asked Dr. Steven Wesley about these proposals in an interview, his response offered a revealing illustration of his broader perspective on contemporary medicine. He told me

> Obviously I'm good with [these proposals], because I think it's not all that complicated. My son's in med school now, and I think one of the funny things of listening to what he's learning every day is going "well that's totally irrelevant," like "I've never used that knowledge in thirty years since med school"…So I think physician's assistants, nurse practitioners, they are taught as much "you see A, you do B" as we are. But doctors are given a further depth of knowledge. [But] I think the funny thing is, does that depth of knowledge have any value whatsoever? I think doctors would say it does, [but] many people would say it doesn't. I think the thing that makes you the most effective clinician is the amount of experience. If you have an NP with a tremendous amount of experience, they're gonna be better than a doctor with very little experience.

Calling upon the cynicism and dry sarcasm that are his personal trademarks, Dr. Wesley turns a skeptical eye toward the more grandiloquent trappings of medicine's professional identity. In doing so, he articulates the logic he prefers to use to make sense of his work. He is a subscriber to sardonic pragmatism.

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Abbott (1988) notes that professionals must be able to fend off challenges from alternative practitioners in order to defend their identities and prerogatives. So critical is this process to his theory of professional identity that he writes "Indeed, it is by competing in this way—via the cultural reconstitution of human problems—that an occupation identifies itself as a profession" (Abbott 2010:175). In light of this observation, one might expect doctors to be in widespread agreement regarding the ability of scientific medicine as practiced by a trained physician to bring about more optimal outcomes for patients than would the efforts of faith healers, herbalists, laypersons, or other potential claimants to the physician's authority. Much existing research (e.g., Dye 1980; Gloege 2013) documents such a professional consensus and its efficacy in delegitimizing competitors. These consensuses can fragment over time and the suppression of rivals is not always permanent (Ash 2005; Winnick 2005), but they are highly efficacious nonetheless. As Starr (1982) illustrates with his account of the formal medical field's suppression and expulsion of "quacks"[7] in the early 20th century, a broad consensus on what is and is not effective amongst individual practitioners could be seen as a necessary foundation for the profession's ambitions. The practitioners could be counted on to defend the usefulness of their profession, as well as its complexity, of which they are the only masters. Their livelihoods and identities depend upon broad respect for the profession, its efficacy, and their own credentials as the only individuals with the expertise necessary to ply this intricate trade. A decline in autonomy would be devastating in such a circumstance; it would constitute a significant infringement upon the doctor's ability to work for the betterment of the patient, and a decline in

[7] The pejorative term "quack" is typically used to refer to an avaricious person promoting some form of dubious cure or health supplement without credentials from mainstream professional organizations or degrees from accredited schools (Brown 1947; Everett 1923).

demonstrated effectiveness could, in turn, jeopardize their privileges and prerogatives. To avert this sequence of events, it is necessary for doctors to maintain the "professional consensus" (Starr 1982:102) that gives them their collective strength.

For the doctors at Harborside Hospital, there is much about this portrait that is accurate, but it does not tell the entire story. An environment where Dr. Wesley can say (as he did) "I try to make the way that we practice medicine simple, because I don't think it's all that complicated" is not an environment in which all doctors say they think of themselves solely or even mostly as possessors of rare skills and intricate knowledge necessary for proper care. This chapter will explore the contours of sardonic pragmatism, one of three major cultural logics that doctors use to forge an understanding of their identity, their profession, and the impact of autonomy's decline. It is a logic that views the medical profession's claims and powers with a striking degree of skepticism, and it exhibits a world-weary cynicism that is managed through dark humor, a defensive posture, strategic disengagement, and comfort in small victories.

In an environment of managed care, consumerist patients, and evidence-based medicine, sardonic pragmatism casts the potential decline of autonomy stemming from these challenges as, if not necessarily welcome or pleasant, at least tolerable. At its base is the suspicion that greater autonomy would not empower doctors to "do good" to any greater degree than they already are, as well as a broader disengagement from sweeping ambition. Autonomy is valuable not so much as an end unto itself but as a means toward accomplishing the basic tasks that are all that is necessary for proper patient care in the vast majority of circumstances. Sardonic pragmatism also values what I call "negative autonomy," referring to the ability of some practitioners (particularly those with high

status) to strategically disengage from situations that they see as counterproductive or irrelevant to their responsibilities. It is therefore the case that, through sardonic pragmatism, doctors both scale down expectations of their own power and defend themselves against claims others would make upon their power.

Rejecting high-mindedness and idealism, sardonic pragmatism casts doubt upon the notion that medicine is complex, esoteric work that can only be performed properly by a highly trained and well-credentialed doctor who is given autonomy to use his or her rare skills. When viewed through a sardonic pragmatist logic, doctors are largely incapable of serving the broader good by taking up heroic mantles, casting themselves as ambitiously daring saviors of individual patients or larger communities. For a doctor to pursue grand ambitions – using experimental treatments to rescue patients from the brink of death, bringing higher standards of health care to entire communities, assisting patients with their social dilemmas as well as their biomedical dilemmas – is to court frustration, set oneself up for disappointment, and risk spectacular failure. A good doctor is instead one who sticks to the facts, recognizes his or her limitations, stays faithful to proven procedures, and greets pretense and excess with the dry derision they deserve. Sardonic pragmatism is exemplified in Dr. Wesley's dryly sarcastic response to a medical student's enthusiastic presentation at a Thursday conference. The medical student, acting as eager and passionate as those in his role are expected to be during these presentations, reviewed the "milestones" associated with the increased use of robotics and automatization throughout the medical field. After he touted these accomplishments, Dr. Wesley offered a counterpoint: "The Harborside milestones [from the use of robotics] were the patient whose stomach was ripped in half and the patient whose pancreas was

taken out instead of their adrenal [gland]. Please go on." The surprised medical student recovered quickly enough to do so, helped by the fact that Dr. Wesley's derision was obviously directed more at the field of robotics than at the student himself. But he had gotten a taste of Dr. Wesley's sardonic pragmatism in a startling fashion.

Historical Background

The sociohistorical underpinnings of sardonic pragmatism can be traced back to America's "Age of Jackson" in the early-to-mid 19th century, with its widespread skepticism of medicine's image as a scientific practice accessible only to the highly-trained (Starr 1982). It was an era in which the dominant civil religion of the country was established, with an emphasis on what was said to be the virtue and industriousness of its ordinary citizens (Langston 1993; Shyrock 1947). These ordinary citizens, wise, adroit, and practical as they were, possessed common sense, and little more was thought to be necessary to ensure good health to the extent that doing so was possible. Given the extreme discomfort and ultimate inefficacy involved in much of what passed for mainstream medicine at the time (Young 1961), this perspective is at least somewhat understandable, and a few of its tenets, such as the defense of midwifery against medicalized childbirth (Bogdan 1978; Young 1961) have even come back into vogue today. A push for "medical democracy" – the elimination of strict licensing and credentialing requirements for doctors – emerged as a representative manifestation of the glorification of the common person and of hostility to elite claims to authority. These efforts ultimately proved quite successful; Young (1961) observes that "By mid-[19th]

century only three states made any pretense of trying to regulate who should and who should not practice the art of medicine" (582).

Even as the zeitgeist shifted and the medical profession became highly successful in its quest for autonomy and respect, dissenting voices did not vanish completely. 20th century critics (e.g., Freidson 1970; Illich [1976] 2013) looked upon doctors' consolidation of control and found much cause for worry. Most relevant for sardonic pragmatism is the belief that the trappings of complexity with which the medical establishment portrayed its work were unjustified and served to mask the pursuit and defense of privilege and power.

Many scholars who hold this perspective have come to use the term *medicalization* to refer to the focus of their critique (Conrad 1992). Medicalization, in this view, is the process by which the medical profession obtains the right to address problems that might not previously have been viewed as medical issues, as well as the right to define experiences as "problems" in the first place. While a minority of scholars has argued that medicalization and its consequences can improve health and, in some circumstances, subvert rather than enhance existing power structures (e.g., Reiheld 2010), denunciations of medicalization have been louder and more numerous. Critics contend medicalization does not improve health outcomes (in childbirth, for example; see Rothman 1984; Stoller Shaw 1974), and they describe medicalization as a force behind a series of problematic social currents, including sexism (Tiefer 1994), racism (Taylor 1999), and body-shaming (Saguy 2014).

The critiques of medicalization issued by Ivan Illich are both among the most polemical and among those that most directly engage with the perspectives underlying

sardonic pragmatism. Illich expresses his desire to "allow the layman effectively to reclaim his own control over medical perception, classification, and decision-making…My argument is that the layman and not the physician has the potential perspective and effective power to stop the current iatrogenic[8] epidemic" ([1976] 2013:4). At the time he wrote them, Illich's trenchant barbs received relatively little attention from the medical establishment, which was powerful enough to wave his critiques away (Bunker 2003). I intend to argue, however, that even if doctors didn't receive knowledge of medicine's limits from reading the work of commentators such as Illich, their own lived experiences have the potential to lead some of them to similar conclusions.

A General Theory of Sardonic Pragmatism

As it is used at Harborside Hospital, the sardonic pragmatist logic can be described as the following: A professed rejection of excess and improvisation in medicine, combined with a stated lack of confidence in the viability of grand professional ambitions and accompanied by a stance of world-weariness that ultimately leads one to claim satisfaction and accomplishment in the absence of extreme failure rather than the achievement of dramatic success. Extreme failure, after all, is very much a possible outcome of contemporary medical practice, while dramatic success is usually less of one. Routine patients with familiar injuries do not offer the chance of a "great save," in which a patient is rescued from the brink of death or an unusual challenge is conquered, but they

[8] "Iatrogenic" is a term Illich uses to describe problems that are created or exacerbated by doctors and mainstream medical practice.

do offer the potential for a catastrophic bungling of what should be an ordinary and manageable task.

Among its most committed adherents, sardonic pragmatism manifests itself not in an urgent desire to effect radical change but in a general exhibition of weary resignation, workmanlike labor, and sarcastic humor. When compared to the language of progressive planning, which I will discuss in the next chapter, sardonic pragmatism generally shares a sense of skepticism regarding the promises and ambitions of modern medicine. But while progressive planning seeks to replace the contemporary model with an alternative it sees as desirable, sardonic pragmatism sees the contemporary model, even with its flaws, as superior to any other practical option (if it even engages in such comparisons in the first place). To the extent that sardonic pragmatism seeks to channel its critique into proposals for change to the contemporary medical model, it does so on the margins.

The Usefulness of Modesty

Modesty is at the center of sardonic pragmatism. In this context, modesty takes the form of a professional disposition rather than a broader personality trait. Sardonic pragmatism views efforts to use advanced medical procedures in service of patient well-being as likely to be counterproductive. Sometimes, it suggests, the passage of time or recuperation at home are the best strategies for helping a patient feel better and sustain a higher quality of life. The most important antecedent of sardonic pragmatism is the process by which certain doctors conclude over the course of their careers that the medical profession's claims to be able to bring about positive outcomes for patients through its learned expertise or technical wizardry are, at least on some occasions,

exaggerated, misguided, or patently false. Often doctors would speak of the degree to which the body can, in some cases, heal itself without doctors' intervention. Dr. Minter, for instance, is fond of saying that while "surgical problems typically get worse when you neglect them," it is actually the case that "non-surgical problems typically get better when you neglect them." One cannot help but note the fact that, as a surgeon, Dr. Minter is identifying a valuable role for himself and his skill set as the person capable of intervening to stave off the decline that would come with neglect. Nevertheless, the statement is striking in its willingness to identify a capacity for the human body to recover from illness and injury even in the absence of medical intervention.

On another occasion, residents in the SICU discussed the possibility of addressing the broken ribs that a patient had suffered along with many other injuries in a life-threatening accident. Dr. Wesley felt that, since the patient was getting better overall, extensive interventions (such as an attempt to fix his ribs) might do more harm than good. He cautioned them: "This is worrisome, because he's getting better, and we're talking about doing a lot of freaky stuff to him…if this was your dad, would you want him to get his ribs fixed?" A resident jokingly responded that she wouldn't want her parents in the hospital at all, and Dr. Wesley concluded "well, that says it." Sardonic pragmatism is similarly skeptical of the relevance of sophisticated medical diagnoses to the broader thrust of some patients' circumstances. When a resident says of an elderly woman who fell down the stairs "she's got a case of the olds" (after Dr. Wesley imitates the sound of a person falling down the stairs, a typical example of his style of humor), the resident is making a joke, but he is also indicating that a focus on the biomedical specifics of this woman's body obscures the essential fact of her circumstances – she is simply old, and

old age brings a greater vulnerability to injury. When other doctors speak of the need for aggressive educational campaigns to warn of the dangers falls pose to elderly persons, sardonic pragmatism would remind them that the inevitable aging process carries its own logic and its own force, and that while doctors might manage to ease or delay it under certain circumstances, they have not yet been able to stop it completely.

Foundations of the Logic

The embrace of sardonic pragmatism can be traced to the absence of broader ideological missions behind a career in medicine, disinterest in the emotional and communicative aspects of medical care, the spread of routinization and monotony, the belief that doctors are limited in their ability to alter some patients' health, and the lure of escape. For those with the power and security to be able to make use of it, sardonic pragmatism offers a means of disengaging from the struggle to innovate and do great things, and instead to find comfort and satisfaction in small victories.

Doctors who enter the medical profession without a coherent personal mission or a vision of what the profession ought to accomplish and represent are prime candidates for the articulation of sardonic pragmatism. When I asked Dr. Wesley what motivated him to pursue a career in medicine, he told me "I can't remember when I didn't want to do it…I don't know, I have to say that at least part of it is the stature of physicians, that was part of it. Then I found that I enjoyed the clinical care when I was an EMT and that sort of thing…I think mostly it was probably the beginning, just what a doctor was and the general stature in society." Dr. Wesley speaks of his certainty and confidence that

medicine was the right path for him, but he was motivated by the pursuit of stature more than any coherent vision of what he as a doctor could do for others.

It is also reasonable to suspect that sardonic pragmatism to arise when a person who does come into the profession with a driving motivation finds those ambitions frustrated. Perhaps, we might muse, an embrace of sardonic pragmatism comes in response to the experience of having broader ambitions stifled and as a source of "consolation prizes" after a doctor realized that his or her original goals were unattainable. In practice, however, I did not see this particular path manifest itself to a great degree. Individuals with driving service-oriented motivations for pursuing careers in medicine were more likely to either speak quite enthusiastically of the extent to which they were satisfied with their ability to accomplish their goals or to channel frustrations into progressive planning rather than sardonic pragmatism. Additionally, respondents' stories of how their attitudes or expectations had changed over time were often told in terms of their optimism and ambition increasing rather than decreasing. Dr. Jennifer Hoover, a resident, illustrated this phenomenon when she recalled:

> You know, when I was in medical school I had this attending who was like our, the program director of the residency for surgery there, who told us that residency and intern year especially was all about embracing the suck. You just had to embrace the suck, and as long as you do that you're gonna be fine. So I had this really negative, like image of how it was gonna be in my head, and it's proven to be much, much better than I had anticipated based on that.

In an interview with Dr. Wesley, he reflected on his experiences decades previously in medical school, when he was figuring out which branch of medicine to pursue a career in. He recalls the colleagues for whom time spent in the operating room represented the pinnacle of their professional lives. The specialty he ultimately pursued – trauma surgery

– does not offer as much opportunity for operating as do other specialties, such as cardiac surgery. Looking back, he told me:

> I think it's a little bit of a fantasy for me to think I would have been happier [in a specialty that offered more time in the operating room], because I think I would get pretty bored…One thing I thought about was heart surgery, you know. Really it's like seven or eight cases, you do the same seven or eight cases your whole career. And you know, I think I would have probably gotten tired of it. I also didn't want every case I do to be a big case. I kind of like small cases like hernias and stuff like that. And in some of those specialties, everything you do is a big case.

Dr. Wesley also recounted the differing opinions he and a medical school classmate had regarding the allure of the operating room. If a patient needed to be taken to the OR, Dr. Wesley recalled, his reaction was often "Oh, shit, there's another person who needs to go to the OR." His friend, on the other hand, would exclaim "it's great!" and celebrate "another chance to operate." We see even in the very beginning of his career a sort of reluctance on the part of Dr. Wesley to rush into the crucible of the operating room, where the stakes are high. His appreciation of small victories may not be a new phenomenon learned in the face of accumulated disappointment as much as it is a steady preference for more modest medicine.

My finding of the relative absence of gradually accumulated cynicism is reminiscent of prior research from Becker and Geer (1958), who critiqued the impression of doctors becoming more jaded and less idealistic over time, as well as the more recent work of Testerman et al. (1996), who found "a reduction in cynicism and hostility from their highest levels among medical students, to lesser levels during residency, and to the lowest level among faculty physicians" (S44). It must be noted, of course, that I do not have longitudinal data on the evolution of Harborside practitioners' attitudes and logic use; I can only based my findings upon my eighteen months of observations and

practitioners' stated recollections of their previous perspectives. In addition, individuals' current perceptions and attitudes have undoubtedly been influenced by the incidents they have been involved with in the past, and it is likely that Dr. Wesley has, over the course of his career, accumulated experiences that reinforced the notion that the pursuit of modest victories is the most reliable source of fulfillment and accomplishment. Nonetheless, a conclusion that the gradual adoption of a cynical perspective is responsible for the presence of sardonic pragmatism is not warranted by this study.

A sense of dull routinization and monotony is another key force behind sardonic pragmatism. This monotony takes several forms. Doctors frequently bemoan the relative shortage of "interesting" or "exciting" patients. These are patients whose injuries or illnesses are in some sense severe, unusual, or complex, providing the doctors with challenges. A young man involved in a motorcycle accident was one such patient. On morning rounds, Dr. Wesley and Dr. George Witherspoon reviewed images of the man's pelvis. "Shiiiit" exclaimed Dr. Wesley in a high-pitched voice as they grappled with the severity of the patient's injuries. Dr. Witherspoon noted that "his groin's gone. He has no groin. His coccyx is gone." This language might suggest discouragement on the part of Dr. Wesley and Dr. Witherspoon, but on the contrary, they both seemed excited about the challenge. The young motorcyclist was, in one sense, a perfect patient – he had very severe injuries, but there was still a chance that timely and skillful intervention could save his life. He was a patient for whom ambitious and extensive intervention was appropriate. At the end of his brief conference with Dr. Witherspoon, Dr. Wesley concluded "we gotta save *this* guy." His emphasis on the word "this" suggests not that he doesn't bother to try to save other patients but that, presented with a demanding case, he

and his colleagues were obliged to rise to the occasion, while still making sure to relish the uncommon opportunity in front of them. We see here that Dr. Wesley is not opposed to dramatic medical intervention as a matter of principle or because he does not personally enjoy such procedures. Rather, he suspects that misunderstandings of patients' circumstances, underestimations of the body's own healing ability, and excessive derring-do on the part of some doctors lead to dramatic interventions and risky surgeries taking place when they are not called for. When such efforts *are* called for, as in the case of the injured motorcyclist, Dr. Wesley happily embraces the challenge.

This sentiment came to the fore in an interview with Dr. Wesley. Asked to reflect on what made for a good day at work, he told me that "If I do get to do a real trauma operation, somebody's bleeding to death, and we get them through it, naturally, then that makes a very good day, but those are few and far between in reality." Therein lies the frustration; for every patient providing an opportunity for challenge and excitement, there are many more who offer neither. Dr. Minter told me prior to removing one patient's diseased gall bladder that the operation he was about to perform was one he had performed about 1,500 times before. It's possible that he's exaggerating, and he is careful to add that you can never take a positive outcome for granted no matter how often you've performed a particular operation. Nevertheless, the monotony can grate. Frustration over these ordinary patients shows through many small incidents, such as Dr. Wesley dryly and sarcastically saying "fascinating" upon leaving a patient's room or declaring a particular patient's case to be "a true Dr. Wesley 'whatever'" (referring to himself in the third person).

If Dr. Wesley's appreciation of "interesting" patients is considered alongside his discomfort with specialties where "every case is a big case," we are left with an impression that he appreciates challenge and exhilaration in small doses and in situations where that excitement can be put to good use; he simply doesn't view them as the daily essentials of medical care. To glorify exciting cases excessively might be to risk falling into the role of the hammer to which everything looks like a nail; a taste for the thrill of risky intervention could lead one to believe that such interventions are necessary in cases where they actually are not. Dr. Wesley's steady and unflappable disposition may well be the product of strategically managing his engagement with high-stakes medicine. Involving oneself too extensively with the risky side of the job would be to tempt the fate that many doctors speak of with caution and dread: burnout. Kuerer and Holleman refer to burnout as "a syndrome of emotional exhaustion, depersonalization, and feelings of low personal accomplishment" and note "it is epidemic among [physicians] (2012:634)," with 40 percent of them meeting the criteria for burnout according to a survey they reference. Concerns about burnout are common among practitioners at Harborside Hospital, particularly with regards to the potential for burnout at work to impact the quality of their family life. Sardonic pragmatism likely takes on appeal as doctors weigh the consequences of prolonged involvement in the most intense and emotional aspects of medicine for their personal well-being.

Still another important influence upon sardonic pragmatism is the belief among some doctors that, regardless of what professional expertise they might seek to utilize in a patient's care, it is ultimately the patient's genes and evolutionary biology that will determine his or her fate. As Dr. Minter once observed, "what makes us think that we

can outthink 400 million years of mammalian evolution?" On another occasion, during a discussion of ileus[9], Dr. Witherspoon predicted that we would increasingly find that "the answer to this, like most things in medicine, is genetic," while Dr. Minter once noted that "if hypothermia survived over thousands of years of mammalian evolution, it's probably beneficial" as a means of prolonging survival in situations of extreme cold. A belief in the genetic inevitability of certain biomedical circumstances provides even more ballast to sardonic pragmatism's contention that some dramatic interventions are misguided and doomed; often they would run up against the stubborn weight of evolutionary biology.

What Sardonic Pragmatism Offers

The importance of professional modesty to sardonic pragmatism was illustrated when, in an interview, I asked Dr. Wesley what he would consider to be a great day at work. He told me:

> I think as you evolve as a physician, especially as a teaching physician, a lot of it is just that things don't go wrong, that things are following the path that you think they should go. So I think a day where I see the residents and everyone else doing everything right and anticipating so that I don't really have to tell them to do anything is a good day…also if I do get to do a real trauma operation, somebody's bleeding to death, then, and we get them through it, naturally, then that makes a very good day, but those are few and far between in reality. So contrasting, days when I'm not happy [are] if the patients aren't doing well or the residents are doing things off the path.

For Dr. Wesley, in other words, a great day at work would be a day in which he is presented with the opportunity to take part in an exciting and challenging case. But these cases are few and far between, so he finds a more reliable sense of satisfaction in simply avoiding catastrophe. This might appear at first blush to be a strikingly pessimistic

[9] Ileus refers to a form of intestinal blockage.

approach, but by keeping his goals and expectations modest, Dr. Wesley allows himself to access a more consistent and dependable source of fulfillment and accomplishment than would be available to a doctor who craves more dramatic achievements. He spares himself the disappointment associated with the inability to realize the grander dreams that neoclassical professionalism and progressive planning cultivate. He also avoids the roller coaster of exhilaration and crushing disappointment that would come with extensive involvement in high-stakes medicine. Sardonic pragmatism offers a doctor the comfort and steadiness of reliable small victories. On rounds one morning, for instance, Dr. Wesley took a moment to note his thankfulness for a well-placed chest tube. "Nice chest tube," he told the entourage of residents and medical students. "You've gotta appreciate a nice chest tube." Correct placement of a chest tube is not widely considered to be a particularly unique or impressive feat, but Dr. Wesley, veteran practitioner that he is, has undoubtedly seen the consequences of a misplaced chest tube often enough to be able to savor the avoidance of that particular brand of disaster, at least for this patient.

We also see sardonic pragmatism's embrace of small victories manifest itself with regard to electronic medical records. Dr. Brian Minter, an adherent to neoclassical professionalism, makes a flamboyant show of his hostility to HealthNote[10], the electronic medical records [EMR] program at use in Harborside Hospital. As he sees it, HealthNote spreads misinformation, tethers doctors to computers, and distracts from the truth and meaning that are found in face-to-face interactions with patients. To call it a menace would, for Dr. Minter, constitute only a slight exaggeration. Chief resident Dr. Keith Tillman agrees with Dr. Minter, referring to HealthNote sarcastically as "the truth machine." Dr. Wesley, the committed sardonic pragmatist, takes a more insouciant

[10] Not the actual name of the program

approach. Borrowing from the apocryphal Winston Churchill quote about democracy, he told residents that "HealthNote is the worst, except for every other EMR." Similarly, while other doctors lament the volume of patients who are transferred to the Acute Care and Trauma (ACT) service from other departments, Dr. Wesley takes it in stride and considers the alternative, observing that "as much as we get dumped on, general medicine gets dumped on more." On another occasion, Dr. Wesley spoke with a patient who was unhappy about having to wear a cervical collar (a bulky neck brace) as part of their course of treatment. Dr. Wesley, who had to wear the same type of collar as part of a surgical treatment he underwent, told the patient "I had to wear the collar for six weeks too, so I know how bad it is, but it's better than the alternative." On still another occasion, a resident told Dr. Wesley that he had asked a patient to tell him what month it was. These sorts of basic factual questions are commonly used to get a sense of the patient's lucidity. When the resident told Dr. Wesley that the patient had incorrectly named "July" as the current month, Dr. Wesley found a silver lining – "at least she didn't say 'dog.'"

The modest expectations of sardonic pragmatism also allow doctors to shrug off the frustrations that might exasperate a doctor with bigger dreams. While Dr. Wesley appreciates the necessity of formal efforts to disentangle the root causes of poor patient outcomes, such as the Morbidity and Mortality Conferences that will be described in Chapter Five, he also sees validity in a more glibly philosophical perspective: "Sometimes you just have too much shit wrong, and you're gonna die." He also cuts through elaborative clutter with his "GB scale." Scales and acronyms are ubiquitous in the SICU, but according to Dr. Wesley, some patients only need to be evaluated with the

GB scale – the "Good-Bad scale," on which a particular patient who encountered a poor outcome rated a "B."

It must be noted that the glibness with which sardonic professionalism allows practitioners to shrug off setbacks and absurdities seems not to be rooted in obliviousness. Rather, it seems to express a world-weary pessimism on the part of practitioners who have "seen it all." "It all" in this case refers to the vast landscape of incidents and encounters that can frustrate or exasperate a doctor, ranging from miscommunications with colleagues to conflicts with institutional bureaucracy to patients whose actions leading up to their injuries might perplex or infuriate a layperson. When, for instance, practitioners were casually recounting the offbeat manner in which patients injured themselves over the course of the Memorial Day weekend, often involving alcohol and bonfires, one junior resident attempted to join in the jocularity: "What about the woman who fell asleep smoking?" This might have been what counted as a uniquely reckless injury to a junior resident, but Dr. Wesley, the seasoned veteran, responded "shit, that's routine."

A shot of dark humor allows the practitioner and his or her colleagues to press on to the next case instead of dwelling on the unfortunate circumstances that they or their patients find themselves in. The practitioner who has seen so many things go wrong that even small victories are worth savoring has likely also concluded that genuine angst over each new misfortune is likely fruitless. If there is no victory to be found – not even a small one of the sort sardonic pragmatism savors – dark humor and sarcasm appear to be attractive tools with which to process discouragement and bewilderment. For instance, after encountering yet another patient who had injured themselves while falling off of a

horse (the animals that the ACT team refer to as "the ATVs of the rich," given their shared likelihood of causing injuries to riders falling off of them), Dr. Wesley said to no one in particular "stop horsing around" and then made a slurping "neigh" sound imitating a horse. Sometimes even a nonverbal gesture gets the point across; Dr. Witherspoon in particular will, after hearing an account of how a patient injured themselves through bizarre conduct, simply smile and shake his head.

Sardonic pragmatism encourages a conservative and pessimistic sensibility, characterized by Dr. Wesley's summation of one patient's problem: "I don't know why we're discussing this. There's nothing we can do." Having seen so many mishaps in the past, a sardonic pragmatist will constantly be on the lookout for signs that a promising patient might suddenly take a turn for the worse. We therefore see exchanges such as Dr. Wesley asking a resident how a patient is doing and, after being told by the resident that the patient is doing "really, really well," responding with "ahh, don't get cocky. He ain't done till he gets home." The pessimism can extend to encompass a practitioner's opinion of his or her colleagues. They are frequently suspected of incompetence or indifference, as when Dr. Wesley said on rounds the day prior to Thanksgiving "I thought maybe I saw a med student. That would be amazing – a med student the day before Thanksgiving! Maybe they missed their plane." The clear implication is that, much to Dr. Wesley's dismay, the current generation of medical students lacks the commitment required to work through holiday weekends.[11]

[11] Of course, the fact that Dr. Wesley can make such a statement while he himself can tell a resident on another occasion that he was unaware of a particular development because it happened "at the end of rounds" when "I don't usually pay attention" speaks to the power differential between an attending such as Dr. Wesley and a medical student.

A Tricky Mix of Optimism and Pessimism

My depiction of sardonic pragmatism up to this point might seem contradictory. I have, after all, noted its chief adherent's willingness to see the bright side ("HealthNote is the worst, except for every other EMR") along with his pessimistic streak ("ahh, don't get cocky. He ain't done till he gets home"). By way of explanation, it should first be remembered that, as Pugh (2013) pointed out, "people *are* contradictory" (2013:47; emphasis mine), and seeming contradictions in their accounts of action need not be viewed as an indication that these accounts are not valid or meaningful.

Additionally, a careful consideration of sardonic pragmatism does much to explain the seeming contradiction. The following observation from Dr. Wesley regarding the American medical field as a whole is revealing:

> I'd give [the medical field in general] B+[12]. I think in America you still, if you have a serious problem you're gonna get treated. You may be, it may be inconvenient, you may wait in long lines, you may have a nasty waiting room, you may wait in a nasty ER, but in general in America we still don't let people die because they don't have insurance.

In this statement, we see the positive and pessimistic aspects of sardonic pragmatism come together into a coherent landscape of meaning. The medical field offers much to be disgruntled about to doctors and patients alike, but for Dr. Wesley, who has seen so much of what can go wrong, an ability to distinguish between the intolerable and the merely unpleasant emerges. The hospital can be a place of chaos and frustration, and Dr. Wesley makes no pretense otherwise. But it is also the environment in which he plays his part in preventing what he sees as a far greater evil – the absence of even the imperfect care that is currently provided. It is clear that Dr. Wesley sees himself and most of his colleagues as forces for good, even as they are manifestly imperfect.

[12] I did not specifically ask for Dr. Wesley to give a letter grade to the medical field.

Engagement with Institutional Infrastructure

Each of the logics I discuss is cultivated through doctors' engagement with the institutional infrastructure of the medical field – the structures of hierarchy and administrative policy and sturdy cultural norms within which they work. Doctors, even attendings, are generally incapable of fundamentally altering or completely eliminating the institutional infrastructure in one fell swoop, and seldom do they even want to. They instead use sardonic pragmatism and the other logics to lay the intellectual and cultural groundwork necessary for a long-term effort aimed at slight adjustments to the fundamental assumptions and circumstances within which they find themselves, or to carve out some sort of domain and meaning autonomy for themselves. Sardonic pragmatism emphasizes the latter goal.

Economic logics represent one important component of modern medicine's institutional infrastructure. The growing prevalence of economic logics takes its form in part through concern among practitioners and administrators regarding the cost of treatment, but it is also present in the growth of entrepreneurial medicine, as companies attempt to sell medications and technologies to hospitals. Sales pitches from these companies tout the products as cutting edge and innovative. By investing in a surgical robot, it is said, an institution such as Harborside Hospital can perform groundbreaking new procedures in pursuit of better patient outcomes. Sardonic pragmatism looks upon these products and their associated marketing efforts with skepticism. They promise to lead practitioners far afield from the reliable basics that represent the heart of medicine, and toward the sort of ambitious experimentation that sardonic pragmatism sees as

capable of doing more harm than good. As Dr. Wesley told me when reflecting on how the medical field has changed, "We didn't have MRI [when I began my career]. MRI still in many ways is not an absolutely essential tool. You know, in reality, much of surgery has kind of changed at the periphery, but for cutting people and manipulating what's inside, [that], you know, has been the same for hundreds of years." Dr. Wesley is therefore suspicious of any company claiming that a familiar procedure can be performed even more easily or safely through the use of an expensive new medical device.

At a series of meetings that I refer to as the Thursday Conferences, where ACT team members review notable patients and hold informal discussions, the entrepreneurial side of medicine is both negotiated and skewered. Medical students routinely give presentations at the Thursday Conferences. The students typically present an unanswered clinical question (often a question inspired by a recent patient) and discuss several papers that have been written about the issue. If the student mentions a paper that purports to show that a certain medicine or device can solve a pressing problem, the attending surgeons in the room can be counted on to ask the student if the research in the paper in question was funded by a company with a financial stake in the results. Often the answer is yes, and in such cases, the attendings and residents – even those who aren't, on the whole, committed adherents to sardonic pragmatism – will express great skepticism of the findings. In doing so, they speak to much more than the limitations of any particular device. They are addressing the larger issue of the impact funding and sponsorship by companies can have on research related to the company's products. Meta-analyses (e.g. Sismondo 2008) have demonstrated this sponsored research is more likely to show a beneficial impact from the company's product than is other research. The ACT team

generally views this sort of suspiciously enthusiastic research as a threat to sound medical practice. It floods journals with shoddy research and might lead more impressionable doctors and administrators to embrace new technologies that both waste money and endanger patients. This perspective gives rise to sentiments such as Dr. Minter's question at one Thursday Conference about surgical dressings. The ACT team had been debating the usefulness of a certain type of surgical dressing, and Dr. Minter was beginning to be persuaded that his confidence in the dressings had been misplaced. "I am willing to raise the specter that I was wrong about these dressings," he admitted. He then added "Who is the knowledge leader in this area who does not have a financial stake?" The implication is clear; Dr. Minter is concerned that any effort to identify the most effective brand of surgical dressing will be complicated by the efforts of dressing manufacturers to promote their brands.

Occasionally, a representative of a private firm will come to the weekly conference to make a presentation in an attempt to convince the doctors to purchase their device or medicine. These invitations usually were not extended unless the doctors were already seriously considering purchasing the item in question, but even in these cases, their wariness of private sector medical entrepreneurs and their financial motivations was made clear. On one such day, the product representative asked if those of us in attendance were familiar with the product she had come to pitch. Dr. Wesley sarcastically responded "yeah, you can get it on Amazon." The representative, now clearly irritated, responded by interjecting that "you can get the *old* version on Amazon." While the doctors did end up purchasing the product, their caustic attitudes and repeated insistence that there were only ten minutes allotted for the representative to make her

pitch point to their deep-seated skepticism of the profit motive's influence on medicine. The fundamental issue is that the ubiquity of private industry and the extent of its influence upon research makes it difficult to determine if claims that certain new procedures or medications represent "breakthroughs" are warranted. Prolonged treatment of patients in a hospital setting has financial implications for many parties; in addition to the patient's bills and the possible cost to his or her insurance, lengthy treatment means that resources are used up – and, therefore, must be replaced – more quickly than otherwise would be the case. These circumstances lead Dr. Wesley to define what he calls "Wesley's theorem": "Nothing that makes money ever gets better." If sardonic pragmatism needed a motto, this would be it.

Dr. Wesley's suspicion of medical entanglement with the logic of the market can also be seen in his discussion of those medical procedures that, in his view, do more to generate income for doctors and hospitals than to genuinely help patients. He told me "I…get very mad at procedures and stuff that are done solely to get or garner market share. You know, a lot of laser surgery and a lot of stuff like that has all turned out, much of it has turned out to be detrimental to patients." Here again we see skepticism of ambitious and "cutting edge" procedures such as laser surgery. Dr. Wesley views these efforts as offering little medical benefit and the potential for actual harm to patients. When he goes on to say that "Robot surgery now [is] a thing that's kind of a hammer looking for a nail," we see him express a fear that the quest to develop innovative procedures will lead to the procedures themselves being valued and utilized with insufficient regard for the question of whether they are actually useful tools for the alleviation of patients' problems.

Despite sardonic pragmatist misgivings, however, the institutional infrastructure of Harborside Hospital is such that some of its doctors and administrators feel compelled to adopt these questionable new innovations. They are obligated to pay attention to income and expenses, and if a new laser surgical procedure offers the potential for high fees, they must consider it. A refusal to do so will displease administrators who fret over Harborside's ability to compete for what is referred to as "medical market share" – the payments and prestige that come from treating well-insured, affluent patients – against "competitors." Specifically, doctors and administrators at Harborside often fret about a private medical center located in the same community as Harborside. This hospital is seen as Harborside's chief competition for what Dr. Wesley referred to as "market share." In particular, Harborside doctors say that the rival hospital draws many affluent and insured patients away from Harborside with the lure of comfortable facilities, more private rooms than are offered at Harborside (Dr. Witherspoon refers to this hospital's clientele as "the chi-chi crowd that doesn't want a roommate"), and a general sense of being more "cutting edge" than Harborside, which is enmeshed with the bureaucracy of a public university. Dr. Wesley is ultimately contributing to an emerging debate over the consequences of market-tinged competition between hospitals (Gift et al. 2002; Mutter et al. 2008). He clearly views its effects as potentially pernicious and as encouraging violations of the simplicity and defensiveness and humility that he associates with the best form of medical practice.

Managing Autonomy through Sardonic Pragmatism

When I asked Dr. Wesley to share his thoughts on the degree of autonomy he possessed at work, his response was dispassionate and unconcerned. He told me:

> I have pretty complete autonomy over what the surgeons would do. I don't have autonomy if it involves people from other specialties or, uh, ICU beds, I mean whatever the hospital can do. I have autonomy over those decisions, but whether they meet the need, I can't just make an ICU bed or kick someone out of a bed that someone else is in. But as far as what gets done with my patients, I pretty much have complete autonomy.

What we see here is undoubtedly in part the privilege of the attending surgeon at the top of the administrative hierarchy, in comparison to the nurse practitioner or medical student who takes orders from the attending. Even with this knowledge in mind, however, Dr. Wesley's banal affirmation is indicative of sardonic pragmatism and its system of priorities. Autonomy, viewed through this logic, is more attractive to the opponents of modest and steady medical practice than to its adherents. For Dr. Wesley to say that he has "complete autonomy" is true less as an objective statement than as an indication that he has not attempted to push the bounds of his autonomy beyond the point at which his efforts would meet resistance. He has the autonomy he needs to organize the practice of medicine in line with his own vision. A physician who was more focused on ambitious medicine than Dr. Wesley is might have run up against limits to autonomy that he or she saw as far more restrictive.

Reference was made at the beginning of this chapter to Dr. Wesley's openness to the proposal to allow nurse practitioners and physicians' assistants to take up responsibilities traditionally reserved for doctors. Indeed, sardonic pragmatism suggests a somewhat democratic approach to autonomy. If medicine (or at least effective medicine) is not as complicated or esoteric as it is often assumed to be, it stands to reason that sharing autonomy and empowering other practitioners to be able to practice it offers

a great many potential benefits. It could allow for smoother work flows, shorter delays in advance of procedures, and perhaps even some degree of professional empowerment for those physicians' assistants and nurse practitioners who are given new responsibilities. The only group with something to lose in this arrangement would seem to be the doctors, who would be sacrificing some portion of their professional monopoly. For sardonic pragmatism, as long as patients receive necessary treatments (but no unnecessary treatments) and doctors retain high salaries and social prestige, this process would be tolerable.

Negative Autonomy and Strategic Disengagement

We need not think of autonomy solely in terms of the ability to take action. Sardonic pragmatism places value on what I call "negative autonomy." Loosely following the efforts of Hinsch (2001) and Meyer (1987), I use negative autonomy to refer to the ability of a practitioner to reject or denounce responsibility for a certain person or task and have this gesture be respected by colleagues. The practitioner using negative autonomy may leave the task for someone else to handle, or it may end up not being handled by anyone.

We see Dr. Wesley exercise negative autonomy when, for instance, he declines to involve himself extensively with family members of patients. On one occasion, a young man, who was brought to Harborside Hospital after sustaining a self-inflicted gunshot wound to the head, was declared deceased. The young man's father then became suicidal at his son's bedside. Recounting the incident later, Dr. Wesley expressed exasperated frustration over the fact that he had been asked to "do something" about the distraught

father. "He's not a patient!" Dr. Wesley blurted. We see in this episode that negative autonomy blends rather seamlessly with the modest approach that sardonic pragmatism takes toward medicine in general. In this view, a doctor getting involved with a patient's family member and a doctor using ambitious "heroic medicine" are analogous; both represent attempts to go beyond the basic professional obligations of the physician and are likely to be counterproductive and wasteful.

The ability to exercise negative autonomy is unequally distributed according to hierarchical status. Dr. Wesley, who is secure in his status, has the freedom to be blasé and disinterested when doing so suits him. Residents and nurse practitioners possess no such luxury. Lacking the autonomy to simply move on to the next patient or delegate work to someone beneath them with no second thought, they must pick up where the attending leaves off. Disengagement is ultimately a privilege. While practitioners of all ranks can tap into sardonic pragmatism, the ability to have the invocation of this language respected consistently is accessible only to those who can be confident in their status and their standing. This ability to disengage is itself a form of "negative" or "passive autonomy" that attending surgeons such as Dr. Wesley have managed to retain even while more "positive" or "active" forms of autonomy have eroded. They can still conscript someone to pick up where they left off.

Conclusion

Hirschman (1970) outlined a theory of possible responses to perceived decline in the quality of an organization and its output. Depending upon the extent of one's loyalty

to the organization in question, one may use their voice to articulate objections and seek to have them addressed, or one may simply exit. Exit is a rather casual act if one is upset over the declining quality of the food served at a restaurant, but to exit a profession to which one has devoted extensive training and twenty years of prior work is another matter. Through its use of negative autonomy, sardonic pragmatism offers doctors a sort of "symbolic exit" from the developments within the profession that they might find objectionable, while stopping short of a complete abandonment of the rewards that still come with the field, such as high salaries and social prestige.

We therefore see in sardonic pragmatism a circumstance in which a high degree of loyalty to a profession does not predict a greater use of voice, as Hirschman predicts is most likely to occur if an organization to whom a person feels loyalty undergoes troubling changes. On the contrary, sardonic pragmatism encourages a withdrawal from what would be a futile effort to resist the change. In that sense, it is demonstrated again that the successful use of sardonic pragmatism is highly dependent upon the power and privilege, or lack thereof, of the person attempting to implement it. An attending such as Dr. Wesley has the security in his position to be able to emotionally disengage and strive for modest victories. He is already in a position of power and is not obligated to "prove himself." He is free to simply swim with the current. Meanwhile, his colleague Dr. Witherspoon prefers a far more ambitious agenda.

Chapter 3: Progressive Planning

"Not every second of life is value-added."

-Dr. Witherspoon

An exchange between Dr. George Witherspoon, Dr. Brian Minter and Dr. Manuel Reyes that took place at one Thursday Conference gathering is typical of the vigorous, but friendly, debate that so often takes place at those meetings. As frequently happens, a discussion of one particular patient evolves into a larger conversation regarding the medical field and its underlying logics. In this case, the patient in question is an elderly colon cancer patient for whom the Acute Care and Trauma (ACT) team must decide if surgical intervention is worthwhile and justifiable. Dr. Witherspoon shifts the conversation into a broader direction with a lament that while "Harborside is very married to how we've always done things," the hard truth is that, as he sees it, "we can't afford to do everything for everyone," and far too often, "how Harborside has always done it" has amounted to just that – an attempt to do "everything for everyone." Dr. Minter disagrees. "Can you simultaneously be an advocate for society and your patients?" he asks rhetorically. "Can you look at a patient and say 'I don't think we should do this because society can't afford it?" In other words, should medical services be rationed? Dr. Minter believes that the answer to each of those questions should be a firm "no," at least in so far as dealings with individual patients are concerned. Dr. Reyes disagrees. "Medical service is a limited resource," he says. "We can be open or hidden about the rationing of it that goes on." He goes on to say that they are hiding the fact that rationing goes on (behind such smokescreens as the veneer of free choice between

continued intervention and palliative care that was presented to the Hoffman family in the meeting recounted at the beginning of this dissertation, though Dr. Reyes did not refer to this particular incident as an example), which, he says, is "more evil" than being open about it. Dr. Witherspoon chimes in to say that "advocating for patients in the macro means not operating on an 85-year-old with colon cancer." Dr. Reyes adds "we subsidize [MRI] scans by taking resources from third world people dying of diarrhea" – in other words, dying of something that could be treated very easily if resources were redirected toward those efforts. While Dr. Minter holds fast to his perspective, Dr. Witherspoon and Dr. Reyes have issued a thorough indictment of the American medical profession and its practices – so thorough, in fact, that the resident sitting next to me tosses his identification badge on the table and says "I kinda wanna quit now." It's clear that he's only half joking.

Dr. Witherspoon is highly mindful of waste. The devotion of time and effort to the task of prolonging the life of someone with what Dr. Witherspoon facetiously calls "stage 27 cancer" comes with an opportunity cost. Giving attention to a patient with stage 27 cancer, as opposed to allowing them to die peacefully at home, means that this attention is not being given to individuals and social forces that are, it is suggested, worthy of greater concern. The progressive planning logic encourages doctors to look beyond their individual patients and even beyond the walls of the hospital to see people around the world suffering and dying from illnesses and injuries that could be addressed with efforts far more modest than those that are given to late stage cancer patients in the United States.

As discussed in the previous chapter, sardonic pragmatism provides little in the form of an agentic and ambitious agenda for the medical profession, instead steering doctors away from the pursuit of such efforts. The suspicion that grand ambitions are likely doomed to disappointment leads it to assign value to the abstention from any effort that might bring on such a debacle in favor of a simplified and modest model of medicine. The two other logics used in the practice of meaning-making at Harborside Hospital reject the caution and conservatism inherent in the sardonic pragmatist approach. While each logic showcases significant ambition, they direct their ambitions in different directions. Neoclassical professionalism, to be discussed in the following chapter, focuses its efforts on the individual patient in an attempt to make that patient's experience of treatment become a triumph on every level, with a successful biomedical outcome accompanying concern for the patient's emotional well-being and their social circumstances. Progressive planning channels its professional ambitions in a different direction. It seeks to transcend the common focus within contemporary American medicine on the individual patient at the expense of more macroscopic concerns. It shares with sardonic pragmatism a rejection of convoluted and excessively ambitious intervention in individual patients, believing that to use such efforts to extend life in a biomedical sense is to neglect pressing questions regarding when and under what circumstances a patient is in a position to find life to be worth living. But unlike sardonic pragmatism, progressive planning sees and articulates an alternative direction in which those energies can and should be channeled. It seeks to shift doctors' focus from a determination to bring the full weight of contemporary medicine to bear on each

individual patient toward a societal concern with doing the greatest good beyond the walls of the hospital.

Historical Background

Progressive planning, like sardonic pragmatism, holds roots in one particular phase of the history of American medicine and its entanglements with broader American culture.[13] Mann (1963) once wrote that "the foundations of the society we live in today were created between 1880 and 1920 by industrialization, urbanization, and immigration" (1). The Progressive Movement, which through its efforts gave the 1880-1920 time period the "Progressive Era" label, represented an attempt by elites and reformers to respond to the birth pains of modern industrial America without jettisoning capitalism entirely, and in the process to "reconstruct the individual human being" (McGerr 2003:80) for the betterment of humankind. Their undertakings tended to blend an awareness of the structural, rather than individualized, bases of much suffering and social strain with a desire to use the efficiency models of Taylorism (and industrialism more broadly) in addressing these circumstances. Doctors and public health officials were among the most prominent of Progressive Era reformers. They targeted the medical problems related to overcrowded cities, unsanitary living and working conditions, excessive alcohol use, and prostitution (Anderson 1974; Crooks 1986; Kunitz 1974),

[13] I have two purposes in referring to this logic as progressive planning. Neither involves an attempt to link progressive planning specifically with what is generally understood as "progressive politics" in the contemporary American context. Though the logic does have some overlaps with this political position, I choose to call it progressive in light of its emphasis on pushing the medical profession out of what it sees as its complacent and shortsighted torpor and toward a greater awareness of the needs of a changing world, with a special focus on the amelioration of the harmful effects of structural inequality. I also use the name to acknowledge its echoes of the Progressive Era at the turn of the 20th century.

while campaigning against those who might compete for their authority and influence, such as faith healers (Gloege 2013). Progressive activists also played prominent roles in the eugenics movement of the day (Engs 2003; Freeden 1979), arguing for intervention by authorities into the reproductive and sexual habits of the public. The stated purpose of these efforts was to ensure that future generations of Americans were, to the greatest extent possible, born with the genetic endowments thought to be necessary to let them live "worthwhile" lives (not, for instance, to be disabled or mentally ill) and be virtuous citizens. Today, these efforts are rightly recognized as human rights violations and contribute to the ambivalence with which we look back at the Progressive Era. The medical endeavors of the day also provide early indications of the hostility with which efforts to introduce elite opinion into personal health matters are often greeted. Colgrove (2005) notes this response in his analysis of Progressive Era campaigns to encourage parents to vaccinate children; the idea that "experts could claim to be better qualified than parents to judge the well-being of children" (172) was highly controversial. Resistance to the idea of elite interference with personal medical decisions and unwillingness on the part of some elites to countenance an ordinary person's wishes with regards to health remain formidable obstacles to the public embrace of progressive planning.

The many influences and practices of Progressive Era health reformers provide the roots of the contemporary language that I refer to as progressive planning. We see in the history of the period the combination of support for the basic underlying institutions of American life and the rejection of radical transformation (such as Communist revolution) with a desire to ameliorate the rough edges of the country's lurch into industrialized modernity. The Progressives disdained to sit still; they used their privilege

and advantage to take the leadership role through which they could effect what they saw as social betterment. In doing so, they would sometimes override the decisions of others and conveyed a certain intolerance of competing notions of the good, and some of them perpetuated the injustices of eugenics. But they also rose to the challenge of grasping the macroscopic nature of social problems and recognized the inadequacy of individual effort as a solution.

A General Theory of Progressive Planning

As used today at Harborside Hospital, the progressive planning logic can be described in the following terms: First, it opposes extensive interventions in the health problems of individual patients, particularly if these interventions are deemed to be grossly wasteful in a financial sense, are insufficiently rooted in sound scientific research, or are intended to bring or keep the patient in a state in which they are alive in a strictly biomedical sense but are incapable of performing basic human functions. Second, in working to shift professional attention away from biomedical interventions in the health problems of individual patients, it seeks to turn that attention *toward* a concern for the structural inequities that give rise to much illness and injury in the first place, and for which the individual efforts of doctors are unlikely to offer a truly transformative response.

Viewed through the logic of progressive planning, a young man who arrives at the hospital with a gunshot would is not simply an organism that has sustained a penetrating trauma to the abdomen. He is also a human being whose condition cries out for a number of larger issues to be addressed. Why did this young man get shot? Does he live in a

neighborhood with a high crime rate? If so, what role have racially discriminatory redlining or police practices played in making that neighborhood a dangerous place? What does the young man's circumstance tell us about the weakness of gun control laws in the United States? When viewed through a progressive planning logic, the sociological character of many medical issues is brought into sharp relief. This is particularly true for the sorts of patients the Acute Care and Trauma (ACT) team at Harborside Hospital sees – the aforementioned young man with a gunshot wound, the patient with burns sustained from the explosion of a methamphetamine lab, the homeless person hit by a car after wandering the street. As resident Dr. Jennifer Hoover told me in an interview, "trauma can be a social disease." Dr. Witherspoon observed on rounds one morning that "Trauma is still a young man's disease, by and large." People of color and the poor are disproportionately represented among traumatic injury patients (Demetriades et al. 1998; Mackersie 2014), but the trauma field is not entirely unusual in this regard. Disparities between the privileged and the disadvantaged are common across a wide range of health measures (Barr 2014). Working with the ACT team simply gives practitioners a particularly vivid look at a wide-ranging problem.

The foremost adherent to progressive planning at Harborside Hospital is Dr. George Witherspoon, an attending intensivist[14] and emergency medicine doctor. More than any of his colleagues, Dr. Witherspoon embraces change and disruption, in so far as change presents an opportunity to advocate or implement a move away from spendthrift practices. He is also the ACT team member who articulates his philosophy of medicine most coherently. His perspectives are well-known among his colleagues; on multiple

[14] An intensivist is a doctor who specializes in treating patients who are in intensive care units (such as the SICU) and require consistent close attention.

occasions other practitioners who found themselves sympathizing with his philosophy on particular matters would say something to the effect of "Gee, I can't believe it, but I'm sounding like George." Dr. Witherspoon articulated a key component of his philosophy in an interview:

> I am very, very cost-conscious, very, very system-aware at most times. And I think philosophically, one of the biggest differences between me and most of my colleagues is that I don't think that every second of every life is value-added. I think life well-lived in relative health is value-added for people, but a lot of the stuff we do here at the end of life I don't think adds value to people's lives, and I am probably the most progressive, I don't want to say aggressive, but the most progressive when it comes to having that conversation with people, to say "is this the life you want to live? Is this the life that your father, husband, wife, daughter wanted to live?"

As he describes above, Dr. Witherspoon challenges the assumption held by many of his patients and colleagues that the purpose of medical care is to prolong life, with any consideration of what that life would encompass given only secondary importance. For Dr. Witherspoon, the latter deserves equal, if not greater, concern. We also see from that statement the degree to which Dr. Witherspoon sincerely believes that his philosophy of restraint in medical care does not merely promise financial savings but also allows for patients to engage in serious reflections that lead them toward more insightful conclusions regarding their loved one and his or her wishes. Livne's (2014) account of the synthesis of cost containment and compassion is brought to life through Dr. Witherspoon's statement.

Foundations of the Logic

Progressive planning shows roots in some doctors' recognition of the social circumstances in which they work. It also arises as a result of the greater visibility given to worldwide health inequalities in this age of globalization. The desire to reconcile logics of efficiency with conceptions of morality also plays a key role.

Dr. Witherspoon is one of the few African Americans to work as an attending surgeon at Harborside Hospital. He arrived just a few years prior to my study after having spent an extended period of time working in a hospital in a large urban center that served a patient base made up primarily of impoverished African Americans and Latinos. As he explained to me in an interview, his experiences at this hospital had a profound impact upon his vision of the role doctors are, and are not, able to play as agents of positive social change. He told me:

> I remember the day that put me on the path to public service. I was on call and I had a fifteen-year-old kid, came, no, sixteen-year old-kid came in stabbed in the abdomen by a fifteen year old kid. And they were, the stabber thought the stabbee was staring at his girlfriend as they were walking down the street. It turns out the stabbee was actually staring at the stabber's coat because they had the same coat, and he was basically admiring the coat, not the girlfriend…The stabbee died…so now he's dead and the stabber's in jail. So two lives are ruined, on top of family members, the girlfriend who saw the whole thing, just the ripple effect of this terrible disease that is interpersonal violence…

As Dr. Witherspoon explains, this was not the first time his work compelled him to reckon with interpersonal violence among teenagers and young adults. This is due in part to the fact that he paid attention and devoted serious reflection to the social circumstances from which patients arrived. He did not view such matters as extraneous distractions in the manner that sardonic pragmatism might encourage a practitioner to view them. Dr. Witherspoon continues:

> And I remember, I already had kind of gotten sick of telling yet one more person who looked like me on the outside that their nineteen-year-old son who was out of the house at three in the morning on a Wednesday, during the middle of the work week or during the middle of the school week, was dead from some act of violence committed by yet some other 19, 20, 22 year old person who looked like me, often from the same neighborhood, often from the same block as they were. It had gotten old. It had gotten very deeply old. I remember I, thinking after that kid, that, I remember thinking "I can't just stand around and wait for the next one to come." Because there's another one coming, right? It's just a matter of when, am I gonna be on call. Some other kid who looks like me is gonna shoot at some other kid who looks like me soon. It's knowable stuff, it's predictable, knowable, we're gonna get to have this conversation again, I can't take it.

So he took a local government position with the health department, focused on prevention:

> I thought "well, maybe I can get policies changed, get some laws changed that put some programs in place that help people in circumstances like this solve problems differently than getting a gun."

Dr. Witherspoon had come to recognize the limitations of the medical model and the individual doctor as instruments for bringing about wellness. The biomedical wounds that gunshot victims bore were his immediate responsibility, but these wounds were inextricably linked to structural forces that exist over and above the individual doctor or the individual patient.

Dr. Witherspoon's belief in the value of redirecting resources away from excessive end-of-life care and toward underserved populations is also influenced by his periodic work as a volunteer practitioner at a clinic in a largely impoverished Latin American nation. Another practitioner I interviewed, a pediatrician at Harborside Hospital named Dr. Lindsay Donnalley, spoke of growing up wanting to be a doctor due in large part to a family friend who worked as a physician in the Democratic Republic of the Congo. These sorts of experiences are increasingly common, as organizations such as Médecins Sans Frontières (Doctors Without Borders) facilitate American doctors'

exposure to the realities of medical practice in other parts of the world. To see human beings dying of easily preventable and treatable diseases due solely to the absence of resources in their home environments is, for some doctors, to take a different perspective about the allotment of medical resources in the United States. Dr. Donnalley has now traveled extensively as part of her own medical career, and she recounted meeting disabled children in South American and Africa: "I saw kids with disabilities…who would just be kept hidden at home…a lot of kids with disabilities around the world don't get to go to school at all, so I kept seeing kids who didn't have any opportunities or didn't have a hearing aid or didn't have a wheelchair." A hearing aid costs relatively little, particularly in comparison to health care expenditures in the United States. But hearing aids were not commonly available to children who needed them in the countries Dr. Donnalley visited. To provide the hearing aid was to stand a great chance of having a profound and dramatic positive impact upon the life of a child and the child's family, for the fraction of the cost of futile efforts at prolonging the lives of cancer patients in the United States.

In many ways, progressive planning could be understood as a cultural outgrowth of an increasingly mobile and globalized world. To a greater extent than would have been the case a century ago, American professionals have the resources and technology necessary to bring stark global inequalities into sharp relief, and to then address them. Indeed, of all the logics I document in my research, progressive planning is the one that pays the greatest attention to the world beyond the walls of Harborside Hospital. The other two logics are not necessarily provincial, but progressive planning stands out in its focus on political and socioeconomic trends that have the potential to impact the medical

profession and the patients it serves. Progressive planning takes seriously the idea that doctors have obligations beyond the individual patient they happen to be treating at the time. They are also obliged to consider global health inequalities, the intersections of poor health and structural disadvantage in the United States, and the long-term economic sustainability of Medicare and Medicaid, to name just a few concerns. If sardonic pragmatism epitomizes the rejection of extensive ambition and concern, progressive planning represents a cautious adoption of the same. It does not encourage extravagant efforts to "change the life" of each individual patient, but it does compel doctors to look beyond the walls of the hospital at the social forces impacting their work.

We see in progressive planning the echo of an emerging body of literature (e.g., Ruger 2006; Venkatapuram 2010) regarding the ethical issues underlying global health inequalities and our obligations to address them. To a significant degree, progressive planning also evokes Livne's (2014) account of hospice care. Livne describes the efforts of hospices to win moral legitimacy for the notion that hospice care is an ethical enterprise – no small feat given the cultural and legal emphasis traditionally placed upon the preservation of life. Through the cultural work involved with framing "acceptance" of death and the setting of death in a serene environment less sterile and medicalized than a hospital as righteous social goods, hospice care administrators and the physicians working in concert with them have attached an mantle of integrity to an approach to the end of life that is less expensive and resource-intensive than prolonged intervention. "Ending a person's life to save some money" is viewed as contemptible, but putting a patient in hospice care now combines low costs with moral acceptability, even virtue.

As it is used at Harborside Hospital, progressive planning has much in common with the hospice ethic that Livne describes. It expresses concern for the expenditures involved with care at the end of life and seeks to steer patients and their families toward hospice and palliative care. In making this case to the patients, of course, the doctors do not stress the lower costs the hospital stands to sustain. Instead, they cast the decision as a virtuous one, through which the patient can die "peacefully" and "naturally," with the implication that such a death is more pleasant than death in the intensive care unit on chemotherapy would be. Adherents to progressive planning such as Dr. Witherspoon do not see themselves as lying to patients about the benefits of abstaining from active intervention at the end of life. When Dr. Witherspoon says that "not every second of life is value-added," he is expressing a sincere belief that is the product of sober reflection and much prior experience. While he does take seriously the cost savings involved with rejecting active intervention and the potential for using those savings to do good elsewhere (such as through giving hearing aids to deaf children and thereby potentially using the resources to bring about far greater benefit than would have come from devoting them to end-of-life care in the United States), he is not simply placing a thin disguise upon a cold economic logic when he encourages patients and colleagues to think seriously about when death is worth resisting and when it is worth accepting.

What Progressive Planning Offers

In contrast to the reliable satisfaction of small victories on offer from sardonic pragmatism, progressive planning stresses rewards that, while idealistic, are far more elusive. Through attention to structural forces underlying injury and illness, doctors

confront a challenge that can seem intractable and does not offer a steady stream of easily identifiable successes. This is not to say that doctors who subscribe to progressive planning are inattentive to individual patients or incapable of deriving deep satisfaction and fulfillment from their care. Dr. Witherspoon speaks reverently of some of his experiences treating the individual patients he has encountered over the course of his career, such as "the brain-injured kid…that we all thought was gonna die from that brain injury," and the great joy and satisfaction that he took from seeing that patient recover, live his life, and return to visit the Harborside practitioners a year after his injury to thank them for saving his life. "That's what's important to me," says Dr. Witherspoon, not "the blood and the excitement and the drama and the gizmos."

But progressive planning also offers practitioners a larger calling, as well as the satisfaction of knowing that this calling has not been ignored. It represents a cultural logic through which doctors can connect their careers to their political and moral commitments. Doctors come to link inequalities in health care access to disagreements regarding its status as a contested human right, and they debate the benefits and drawbacks of a single-payer health care system. Progressive planning also links doctors' experiences treating patients to larger questions regarding the dignity and worth of life and when, if ever, a person who is alive in a strictly biomedical sense is nonetheless living a life so empty of activity and meaning as to justify intervention to end that person's life. When a doctor sees an unconscious end-stage cancer patient hooked up to a dozen tubes in an intensive care unit, he or she is provided with an opportunity to reflect on their own mortality and to ponder what is most important in their own life. If, for instance, they were unable to recognize or communicate with their loved ones, would

they want doctors to continue efforts to keep them alive? Professional duties can facilitate thoughtful reflection on what matters most to them in their lives. The conclusions they come to can, in turn, influence their vision for what constitutes the ideal distribution of resources for the profession as a whole. Dr. Witherspoon, for one, told residents at a meeting, "if you're gonna do crazy things that are resource-intensive, do them in 17-year-old kids. If [the patient is] my age[15], stop."

Engagement with Institutional Infrastructure

Dr. Witherspoon's recommendation that resource-intensive procedures not be performed on patients his age is more a political statement than a deliberate instruction. Both Dr. Witherspoon and the residents he was addressing recognize that Dr. Witherspoon cannot impose his will unilaterally and that the residents need to consider the preferences of other stakeholders when deciding whether to act on his advice and recommend against resource-intensive intervention on an older patient. Indeed, the incident is indicative of a larger conflict between the institutional infrastructure of Harborside Hospital and the reflections on justice, equality, and worth that characterize progressive planning. Doctors might come to their own conclusions about whether a certain procedure represents an efficient use of resources or stands a good chance of having positive effects for a patient. They are also empowered to voice these perspectives, and attendings in particular have no shortage of fora and audiences for their views. But no individual doctor, even an attending physician, can go about the course of their work without taking the opinions of others into account. Even if they wanted to direct the entire course of care themselves, their decisions would inevitably require them

[15] Dr. Witherspoon looks to be in his 40s.

to access a device or medication of which another practitioner controls the distribution, and complex procedures invariably require the willful participation of one's colleagues. Attendings' autonomy vis-à-vis the institutional infrastructure in which they work is limited.

Patients themselves represent a major component of the institutional infrastructure that can obstruct progressive planning and its visions of the good. Except in certain cases where an injured or ill patient is brought to the emergency department and doctors are authorized to launch right into efforts to stabilize the patient, practitioners can do relatively little to patients without their consent, or the consent of an authorized representative if the patient is incapable of expressing his or her own preferences. The account of the family meeting at the beginning of this dissertation is vividly representative of doctors' obligation to consider consent, as well as their attempts to work around these constraints. It was clear that the practitioners in the room had come to a consensus among themselves that continued treatment of the patient, Chris Hoffman, would be futile. It would represent the devotion of time and resources to an effort that was unlikely to achieve its ostensible purpose: helping Hoffman fight his illness and live a pleasant life in spite of his diagnosis. If the institutional infrastructure within which they worked did not require them to give serious consideration to the viewpoint of the patient and his family, the decision to withdraw active intervention and send Hoffman to palliative care would have long since been made. But the practitioners needed consent from his family before they could take that step. I therefore witnessed them enter the meeting and proceed to do all that they could to nudge the Hoffman family into accepting their preferred course of action. When the family nonetheless opted to continue active

intervention, the practitioners had no choice but to regroup and plan for how to get them to accept their preferred course of action at a later time ("if we go back in there now, they'll get angry").

Patients also contribute to the institutional infrastructure's interference with progressive planning and its visions through the great deal of emphasis placed upon their satisfaction. The institutional infrastructure gives doctors incentives to do what must be done to make sure patients are happy. If the patients are unhappy, doctors stand to receive poor administrative evaluations and the hospital can lose a portion of its Medicare reimbursements (Rau 2011). Patients' preferences often run counter to doctors' understandings of what would represent a wise allocation of resources. If a patient requests a certain medication or procedure that will undoubtedly do great harm to their well-being, practitioners at Harborside Hospital will decline and accept whatever consequences come their way. But if meeting the patient's request would only be wasteful or inefficient and not patently dangerous, doctors face a difficult decision. As Dr. Jennifer Hoover described it to me:

> So a happy patient is one in which you never refuse antibiotics that they request, you never refuse opiate narcotics, like, narcotic medications when they request, you don't refuse to do like a test that somebody wants, that you know isn't merited for their particular condition, and you don't refuse to admit them to the hospital when they want to. So if you do all those things, you're gonna have a very happy patient, but they're gonna have a worse outcome because you're doing much more testing, you're treating them inappropriately, creating superbugs of antibiotics, et cetera, giving narcotics when it's not justified that can lead to all kinds of issues.

Dr. Hoover described a specific example of this phenomenon. One patient had demanded to be administered liquid Tylenol through an intravenous tube (IV) instead of simply swallowing a Tylenol pill. There was no medical reason why the patient was incapable

of swallowing a pill, and, as Dr. Hoover explained, "one dose [of IV Tylenol] costs at least 100 times more than an oral dose of Tylenol." Dr. Hoover recalled that, after a bit of dialogue, she eventually told the patient "You know, I'm sorry, you don't meet the criteria for [IV Tylenol]. We only try to give this to patients that aren't able to eat, and so on and so forth." As she recalled "He was very, very unhappy with that. I mean he made a huge issue about it. And I mean I still refused because it was inappropriate. But that would ultimately give me a very poor patient satisfaction score, even though I was using resources appropriately."

When I asked Dr. Hoover what she felt was driving the emphasis on patient satisfaction, she told me in no uncertain terms that the effort "did not start from physicians, I can tell you that." She added:

> That's the hard part about our profession, is that so much is mandated by people who have no clinical experience and know nothing about clinical care whatsoever, but somebody says "oh, this may be a great idea, let's make people happier," so this whole notion of patients as consumers and customers, yeah patients as customers instead of patients…I think it's gonna have really awful effects on our profession and patients.

From the perspective of progressive planning, the patient is horribly miscast in the role of a customer. He or she lacks the information and understanding necessary to make wise choices. To have customers requesting unnecessary IV Tylenol, and to have some doctors less resolute than Dr. Hoover accede to these wishes, is to be wasteful, and regardless of what one thinks of wastefulness as a vice in the abstract, in a medical context, wasting money on IV Tylenol has as its consequence fewer resources to be devoted to the care of those in much greater need and continued erosion of the long-term sustainability of the style of medicine to which Americans have become accustomed.

Dr. Witherspoon bemoans the influence of consumerist logic upon the medical field. While he shares Dr. Hoover's concern regarding demanding patients shopping for IV Tylenol, he also sees capitalist market forces as a catalyst behind the medical field's engagement with large institutional actors such as "Big Pharma." When I asked him what steps he would take if he were to assume the role of an American "health care czar" who was empowered to make sweeping changes to the structure of American medicine, he told me that, among other things, "I would probably gut the drug industry. I would have a single-buyer system for all medications." The single buyer in this scenario would be the government, which would also take a role in manufacturing some medications itself. While he makes clear that he would not do away with the private pharmaceutical industry entirely, he emphatically states "I would absolutely do away with the shameless profiteering that goes into drug companies, by making them come to the payer who can outspend them, the federal government, for their prices."

Through his use of the progressive planning logic, Dr. Witherspoon comes to see a place of leadership for the government in medicine. Those who subscribe to the stereotype of doctors as resolutely opposed to "socialized medicine" would be surprised to hear him speak of the government as a positive force that is sometimes the only entity capable of getting doctors to do things that, in his view, need to occur but that many doctors would not otherwise take part in. (An example would be the government inducing doctors to discontinue use of an ineffective medication or procedure by eliminating the Medicare reimbursements associated with it.) To be sure, Dr. Witherspoon does not view the government as incapable of doing harm; he would recoil at the decision to link Medicare reimbursements to patient evaluations. But he does see

the government as an indispensable partner in any effort that might be undertaken to provide the most well being for the most people. It is, after all, beyond the purview of even the most energetic or ambitious doctor to single-handedly alter the structural poverty and widespread availability of firearms that contribute to so many of the traumatic injuries he treated at the urban hospital where he used to work. What is ultimately necessary is for a select group of particularly far-sighted doctors to work in partnership with the government to do what can be done to address the root causes of illness and injury. Autonomy is necessary for practitioners – but only for the right practitioners.

Managing Autonomy through Progressive Planning

When I asked Dr. Witherspoon to share his thoughts on the autonomy he possesses at work, his first response was to tell me "Individually, I would say I have nearly complete autonomy." As he continued to speak, however, he began to belie this initial declaration. He told me:

> I suppose the trauma service model, in which Steven [Wesley] and Brian [Minter] have sort of prescribed each step that we'll do in the trauma service, limits [my autonomy] to some degree. For a year and a half here, I was tilting at windmills saying "I don't agree with that, let's not do it that way" and then I got yelled at by Steven and Brian and, you know, rightly so, because they have a system, I was new to the system, and so the means by which I was going to influence it were not being in the moment. But trauma is not a huge part of my practice any more, which is fine with me. So I just, I'm like a puppy, I roll over, expose the belly and say "do what the book says." Don't think, do what the book says.

When Dr. Witherspoon discusses how he feels pressure to "not think" and to just "do what the book says," his frustration is evident. It is clear that, as a relative newcomer to Harborside who has had less time to accumulate administrative clout than his colleagues,

he has chafed at the limitations placed upon his ability to practice medicine as he would prefer to. Dr. Witherspoon sees himself as a person bearing compelling ideas for how to improve the ACT team and medicine more broadly. What he seeks is the license to put his plans – for the de-emphasis of active intervention at the end of life, for the discontinuation of expensive and ineffective drugs, for partnerships between doctors and political leaders – into action. His claim to have adopted the stance of a puppy is largely belied by my ethnographic observations; he may have accepted that Minter and Wesley are unlikely to change any time soon, but he clearly has not abandoned the effort to voice his perspectives.

The Thursday Conference is the forum in which Dr. Witherspoon argues his case most frequently. It provides one of the few consistent opportunities for him to be in the presence of Dr. Wesley and Dr. Minter and to respond to their claims. One on Thursday, the conversation turned to the topic of tracheostomies.[16] Dr. Witherspoon argued forcefully that "we do too many trach[eostomie]s." He added that, while "it's our practice" to perform a lot of tracheostomies, "It [being our practice] is not the same thing as it being the right thing to do necessarily." Tracheostomies make doctors' lives easier, he admitted, because they allow patients to breathe consistently and free practitioners up to focus on other matters, but they are "not necessarily helping the patient" in light of the potential for complications to arise. On another Thursday, Dr. Minter addressed a medical student who had been a bit too enthusiastic about a paper he cited as part of a presentation. Dr. Minter told the student to "practice the way you were trained. Do not change your practice on the basis of one paper" unless patients are really suffering and

[16] A tracheotomy is a procedure in which an incision is made in a patient's trachea for the purposes of inserting a breathing tube. A tracheostomy is the actual incision that the procedure brings about, although the doctors were blurring this linguistic distinction.

you're grasping at straws. Dr. Witherspoon then spoke up and said "I'm going to disagree with Dr. Minter slightly. Our obligation is to continue asking the questions and not just default to the way we were trained." Dr. Witherspoon is polite in his objection, casting it as only a "slight" disagreement, but he lays bare their differing philosophies quite explicitly.

As evidently as Dr. Witherspoon longs to possess greater autonomy for himself, his attitude with regard to autonomy for his colleagues is quite different. He does not support the wholesale empowerment of all doctors to pursue whatever objectives might interest them. If autonomy were to be widespread among all doctors, some of them would use their autonomy to implement the sort of wasteful practices that Dr. Witherspoon rejects. He indicates as much when discussing albumin, a protein in blood plasma that is often provided to patients who have suffered a diminished blood volume in the wake of a traumatic injury. Dr. Witherspoon explains:

> I think you probably have, certainly our division we have a little bit too much freedom of choice in some areas, to be honest. We're having a discussion right now about the use of a particular fluid called albumin, that's really expensive and the data don't support its use in any setting, but there are those who just deeply believe in it. It's kind of like a religion. So as a cost containment guy, as you know, I never prescribe it. The residents are being trained to use it. We would be better off as a system to not buy as much as we do now, because it's expensive, and it doesn't help anybody more than anything else does.[17]

Dr. Witherspoon's statement illustrates the power of progressive planning's challenge to the traditional notion of autonomy as a professional prize that practitioners will doggedly defend. For an adherent to progressive planning, autonomy is valuable only in so far as it is selectively allotted to farsighted practitioners who can fit their individual decisions into

[17] Dr. Witherspoon points to both his own experience as a practitioner and to skeptical literature (e.g., Caironi et al. 2014) to justify his mistrust in albumin.

a broader landscape of concern for societal health inequalities and the long-term sustainability of programs such as Medicare and Medicaid. A doctor who would use his or her autonomy to order the wanton use of albumin, or a doctor who, to use a memorable Witherspoon put-down, "can't see the world beyond their little universe of 12 beds" lacks the vision and insight necessary to be a good steward of his or her profession.

In the last analysis, progressive planning rejects a broad emphasis on "professional autonomy" in favor of what we might call "hierarchical autonomy." The hierarchy in question is not only the familiar model of doctors giving orders to medical students and nurses. Some of the doctors who might expect a comfortable perch at the top of the hierarchy need to have their autonomy restricted. Ultimately, the "right" doctors, those who *do* recognize the importance of reigning in expenditures on individual patients, must be empowered to take a leadership role in the profession and police their more nearsighted colleagues. The hierarchy in question must be based upon vision, not simply tenure. If wise men and women are not empowered to take leadership roles, either the market or the government will take that responsibility, or there will be a "day of reckoning," in which years of wasteful expenditures culminate in the breakdown of Medicare, Medicaid, and private health insurance. Preventing this sort of outcome requires coordinated action and sophisticated planning.

Viewed through the progressive planning logic, sardonic pragmatism's acceptance of small victories amounts to irresponsible inattention to the big picture. It does not make enough of an effort to ensure that farsighted practitioners are empowered to steer the profession away from danger. Adherents to progressive planning thus feel a special responsibility to educate young doctors in stewardship of the profession. One

morning on rounds, for instance, Dr. Witherspoon began to discuss what he views as the excessive eagerness of some other services at Harborside to transfer patients to the SICU, where beds are scarce and the intensive care provided uses resources and staff time at a rapid rate. In explaining his firm opposition to unjustified transfers, Dr. Witherspoon declared that "I am laying the groundwork for future generations who will not be given the choice to say no" if they do not make a stand now. There are several representatives of the future generations – residents, medical students – on rounds with him as he makes this statement; they smile nervously as Dr. Witherspoon paints their future as one in which they must either resist or submit. It is one of many occasions in which, upon hearing a senior doctor issue an ominous projection on the future of the profession, a look crosses the faces of the residents and medical students that suggests they might be asking themselves just what they've gotten themselves into.

The emphasis on hierarchical autonomy within the progressive planning logic also manifests itself through opposition to the transfer of authority to conduct certain procedures from doctors to lower-credentialed individuals such as nurse practitioners. In stark contrast to Dr. Wesley's blasé openness to the idea, Dr. Witherspoon takes a dim view and offers a specific rationale for his opinion. He says of this sort of proposal:

> I think it's very dangerous. I know some excellent nurse practitioners who are really good at what they do [but] I don't know one who knows what I know, even if they've been around a long, long, long, long time. It isn't a criticism, it's a statement of fact. It's a statement of fact that we are very different professions, we have very different approaches to our profession. You know, it's a different level of dedication that I think drove me into medicine versus another field, that includes working 80, 90, 100 hours a week. Nurses are dedicated people, they work very, very hard. But most nurses typically speaking, in my experience of now 25 years of doing this, they work their shift, they punch out, and they go home and that's it. And they're off for three days. Um, you know, physicians generally speaking don't call in sick. Right?

He goes on to express doubt that must nurse practitioners would want the responsibility and liability that come with a doctor's role, saying "there are some NPs, but very, very few of them, who say 'the buck stops with me.'"

Dr. Witherspoon clearly knows full well that his opinion on this matter is bound to ruffle feathers, and his desire to minimize the bite of his words is apparent in his tone of voice and the disclaimers he offers to assure that he does see less-credentialed practitioners as moral people who have a work ethic ("Nurses are dedicated people, they work very, very hard"). Ultimately, however, he holds fast to a vision of medical work in which hierarchies are strong and readily apparent, and only those who have demonstrated the utmost skill, insight, and commitment (through their completion of medical school and their willingness to work long hours) are entrusted with great responsibility. His skepticism even extends to residents, who, unlike nurses, are actively training to hold positions similar to his; on one occasion, after learning that a resident had gone against a policy that had been put in place by more senior doctors, he groused "we've gotta stop doing things because residents think they're a good idea when they're not a good idea." For progressive planning, hierarchy matters, because, when used correctly, hierarchy ensures that the right people are in a position to call the shots. The "correct use" of hierarchy entails basing it upon vision and attention to the broader social circumstances of the American medical profession, not simply upon tenure or basic competency at the mechanical tasks of health care.

The effect of this perspective is such that the emphasis within progressive planning on entrusting autonomy to those farsighted enough to make good use of it encompasses more traditional models of medical hierarchy. In other words, being a

licensed doctor (as opposed to a nurse practitioner) is necessary but not sufficient for being entrusted with autonomy. The vision of progressive planning is ultimately one in which a small group of doctors are empowered to make decisions that constrain the autonomy of other doctors, who are then entrusted with a bit more autonomy than the practitioners who work underneath them.

In that sense, the reality of the institutional infrastructure at Harborside Hospital is not far removed from the vision of what progressive planning would suggest it ought to be. Harborside Hospital is a world away from the image of the individual practitioner hanging up a shingle in private practice. Hundreds of doctors walk its halls, and not all of them are equal in the power and influence the institutional infrastructure invests in them. Some doctors, such as Dr. Minter and Dr. Wesley, have high-ranking administrative positions in addition to their medical duties. It is those positions and the rights that come with them that led Dr. Witherspoon to "tilt at windmills" in ineffective attempts to implement his own visions when he first arrived at Harborside Hospital. The ACT team and the hospital in which it works both follow the progressive planning model of hierarchical authority fairly closely. The patient-as-consumer orientation runs against this trend, but even here, the institutional infrastructure in place allows excesses to be curtailed through reference to policies for the distribution of resources (such as the policy that Dr. Hoover cited in denying IV Tylenol to the patient who demanded it). From the point of view of someone like Dr. Witherspoon, the overarching problem is simply that he isn't as high enough in the hierarchy as he would like to be, not that the hierarchy itself does not exist. The administrative infrastructure is in place to allow doctors

entrusted with high positions to advance their visions of the good; he must ensure that he and those who feel similarly obtain those positions.

Indeed, the fact that hierarchical authority was frequently coupled with the social vision of progressive planning by Dr. Witherspoon and other members of the ACT team does not suggest that a similar model could not be adopted by individuals with a very different agenda. Their understanding of "the good" toward which practice should be directed might be diametrically opposed to that of progressive planning. One can imagine a doctor resolutely opposed to non-interventionist approaches to end-of-life care suggesting that only wise practitioners should be given autonomy to implement their agenda, based upon their own understanding of who the wise practitioners are. The hierarchical structure called for by progressive planning is at least somewhat in place to allow this potential outcome.

Though it is making great strides (Gawande 2014), progressive planning has not triumphed yet in the battle of ideas. Dr. Witherspoon has, for instance, not yet been able to convince administrators that the hospital's adherence to ponderous standards of recording patient consent is based upon a "1950s TV version of medicine." Nor has he been able to successfully argue for a model of medical care that would free him from having to take other practitioners' opinions into account and act according to their wishes in order to obtain the resources they control. He therefore still finds himself in moments such as a morning rounds in which he laments what he perceives as the meddling of primary care doctors in a particular patient's case. Dr. Witherspoon pantomimes kicking the wall and exasperatedly says "if [the primary care doctors] will just get out of my way, I will make the patients better!"

But there is reason for Dr. Witherspoon to be optimistic when he looks out at the lay of the land. The institutional infrastructure of the medical field has begun to take shape according to his preferences. He knows exactly which chairs he needs to sit down in - those of the elite medical planners who work in partnership with policymakers and hospital administrators. The adherents to sardonic pragmatism and neoclassical professionalism who currently occupy those chairs should not be expected to give them up without a fight, but with each uptick in Medicare spending and each instance of a family member expressing appreciation that their loved one passed away peacefully at home instead of covered in tubes at the ICU, his case grows more compelling. This is evidenced in recent scholarship (e.g., Rosoff 2014) and popular writing (e.g., Gawande 2014) and through, for instance, Dr. Minter's discussion of "systems" in an interview. Dr. Minter himself is not a devoted adherent to progressive planning, but he told me that he sees "system design and critique" emerging as key responsibilities for doctors in the future – in other words, doctors will be obligated to concern themselves not merely with patient care but also, in some cases, decisions regarding the distribution of resources and the efficacy of treatments. In fact, Harborside Hospital has, according to some attendings, taken on the identity of a venue in which the elite doctors of tomorrow are educated in the decision-making skills and responsibilities that will distinguish them from the small town general practitioner in just the fashion progressive planning emphasizes. "If you're at Harborside," Dr. Minter told residents on one occasion, "It means that someone at some point identified you as being really smart, and you're being set up to be a leader."

Conclusion

Progressive planning offers practitioners a link between the professional duties and larger social commitments. To return to Hirschman's (1970) model of exit and voice as responses to discontent toward an organization, progressive planning represents a form of voice through which doctors weigh in on the changes and their consequences. Specifically, it allows them to identify themselves and find something to like in the decline of individual autonomy. Progressive planning is notable for its willingness to question the assumptions underlying much of the contemporary medical model regarding the value of the life that it provides to patients. It represents a beachhead of a coming shift in medical perspectives in the face of limited resources.

Chapter 4: Neoclassical Professionalism

"We're here to take care of patients. We'll let the money take care of itself."
-Dr. Minter

Coughing is a familiar sound in the Surgical Intensive Care Unit (SICU) at Harborside Hospital. From practitioners' perspectives, it is not a particularly unwelcome sound; a patient who is coughing is a patient who is still alive, after all, as sardonic pragmatism would have us remember. But for one particular patient who has sustained broken ribs, coughing causes both excruciating pain and mental anguish. When Dr. Brian Minter comes to visit with him on rounds on morning, the patient explains his fear that he is putting additional strain and stress on his lungs and broken ribs by coughing. Dr. Minter tells him not to worry; he is almost certainly not doing any additional damage. In fact, Dr. Minter explains, his coughing is actually a positive sign, because patients who cannot cough are at an increased risk of contracting pneumonia. The patient says it is hard for him to believe that, given the pain he feels when he coughs. "I know," responds Dr. Minter. "You're just going to have to trust me on that." The patient, a man who appears to be in his 60's, responds by saying "yes, sir" to Dr. Minter, who is about twenty years his junior. It is, for Dr. Minter, a near-perfect encapsulation of all that he values most in medicine – being present with a patient, explaining a situation, extending trust, and having that trust accepted rather than challenged or rejected.

Dr. Minter is a believer in the power of aphorisms – or, as he calls them, mantras – to provide medical students and residents with all of the hard-won knowledge they won't necessarily find in textbooks. His use of them is part of a broader commitment to

educating the next generation of practitioners to learn from his mistakes. As he explained to the medical students and residents on rounds one day, seeking to soften the blow from a particularly stern bit of instruction, "Everything I teach about is stuff that was hard-won lessons for me because I'm stupid. So if I seem a little heavy-handed with some of these lessons, it's not because I think I'm smarter than everybody else." As he says this, the residents and medical students visibly relax, particularly those who have recently arrived at the Acute Care and Trauma (ACT) unit for a rotation and have not yet heard Dr. Minter's mantras. Most of the mantras contain an element of humor, though this humor is shot through with serious commentary on the shortcomings of contemporary medical practice; an example is his assertion that "the main purpose of HealthNote[18] is to perpetuate lies." One particular mantra stands out from the others, however, as a summation of the philosophy that guides Dr. Minter's practice. "We cannot simultaneously advocate for our patient and society," he has said. "One of them will always lose." With this in mind, he ultimately concludes that, in the context of his role as a practitioner, the needs and concerns of the individual patient – as an object of physician knowledge, not a consumer – must usually carry the day.

Dr. Minter is a committed adherent to the third major logic for finding meaning and direction in modern medicine that is in use at Harborside Hospital, what I call neoclassical professionalism. Like progressive planning, neoclassical professionalism is a logic that directs practitioners toward a clearly articulated agenda for their field, largely rejecting the limited goals of sardonic pragmatism. But instead of steering practitioners' concerns toward macro-level outcomes, structural inequalities, and efficiency concerns, neoclassical professionalism makes the relationship between the individual doctor and the

[18] HealthNote is the electronic medical records system in use at Harborside Hospital.

individual patient the centerpiece of its agenda. It is the logic most deeply rooted in the so-called Golden Age of Doctoring from the mid-20th century, when, the legend goes, doctors were free to work on behalf of their patients and were at the zenith of their autonomy and prestige. Doctors who make use of it today can forge moments of intense emotion and connection between doctor and patient, with empathy, gratitude, and understanding emerging in the crucible of the intensive care unit. Neoclassical professionalism guides everything from doctors' communicative connections with patients, and the value they invest in those conversations, to their approach to training the next generation of practitioners. Justifiably or not, it retains much cultural resonance as a model of how doctors ought to engage with patients. Nevertheless, it finds the institutional infrastructure increasingly inhospitable. In many ways, it is the logic that is most imperiled by the current realities of American medical practice. The humanity it can help to foster is thus appreciated by its adherents as an increasingly rare taste of what the profession, at its best, has the potential to be, while its emphasis on individual patients is viewed in more critical corners as a dereliction of the duty to take macroscopic concerns into account.

Historical Background

The cultural foundation of neoclassical professionalism is found in the model of medical practice that achieved its greatest distribution and strength during the middle of the twentieth century – the individual doctor treats the individual patient with attention and care, allowing nothing to stand in the way of bringing about a positive outcome through the use of esoteric knowledge; in return, the patient offers the doctor obedience

and respect, and a bond of personal trust emerges between the two of them. Even as circumstances have changed, the imagery of the Golden Age has retained a great deal of cultural resonance as a prevailing impression on the part of doctors of what the profession could or ought to be (Goold and Lipkin 1999; Potter and McKinlay 2005). Fond nostalgia is not universal by any means; progressive planning, for one, would view the open-ended expenditures of the mid-twentieth century as a dangerous precedent that is not sustainable today. But doctors who rely heavily upon neoclassical professionalism in the course of finding meaning in their work can fairly be described as trying to defend or recreate what they see as the beneficent aspects of the Golden Age – trust, connection, and a commitment to do whatever must be done to care for a patient, regardless of the effort or cost involved – while claiming to reject the worst excesses of the paternalism, discrimination, and inequality[19] that also characterized the mid-20th century. In my studies at Harborside Hospital, I found neoclassical professionalism to represent a worldview distinct from that of sardonic iconoclasm and progressive planning. It is an approach to patients summarized by Dr. Minter when he says "we're here to take care of patients. We'll let the money take care of itself."

A General Theory of Neoclassical Professionalism

Several interrelated principles define neoclassical professionalism. These are the importance of doctor-patient dialogue, the virtue and efficacy of restrained empathy, the privileging of the individual over the social, and valuing established forms of practice. Running through all of these themes is the emphasis in neoclassical professionalism on

[19] Medicare and Medicaid did not exist until the mid-1960s, when the Golden Age was nearing its end. Freidson (1970) explicitly identifies the establishment of Medicare and Medicaid and associated cost increases as key factors in the Golden Age's end.

the need for individual doctors' authority over the treatment of each patient to be defended and maintained. Neoclassical professionalism defines itself in large part through opposition to progressive planning's notion that the needs and circumstances of individual patients must be weighted against the costs of addressing their circumstances at the expense of the larger society. Autonomy thus is necessary for the doctor to be able to build the open and trusting relationship with patients that is required for effective medical practice, to have the time and opportunity to demonstrate empathy, to advocate for individual patients, and to be free to pursue proven treatment plans. The practitioner must have the autonomy necessary to see and act upon information that is not captured in flowcharts or algorithms. As Dr. Wesley said on one occasion, "I don't think we're ever gonna write an algorithm that's gonna encompass everything." Autonomous doctors are necessary to catch the subtleties that algorithms miss. The sentiment is echoed by Dr. Manuel Reyes at a Thursday conference. "I don't think that you can reduce medicine and human beings to statistics and numbers," he said.

Among the chief obstacles in pursing this vision is the growth of administrative bureaucracy in large medical institutions like Harborside Hospital. Dr. Minter told me that there had been a "huge multiplier in the number of administrators that are interposed now between the patient and the clinician…The administrative overhead in clinical medicine now is tremendous." Dr. Minter plays an administrative role at Harborside Hospital in addition to his medical responsibilities, and Dr. Wesley holds a similar dual appointment. However, the presence of non-doctors among the administrative ranks is seen in medical circles as an intrusion of those unqualified to give instruction. Dr. Hoover's aforementioned lament regarding "people who have no clinical experience and

know nothing about clinical care whatsoever" but nonetheless infringe upon doctors' autonomy is illustrative of this perspective.

Neoclassical professionalism is, in many ways, comparable to the perspective in the field of education that would defend the traditional liberal arts education against those who would argue that online degrees promise greater efficiency and offer a semblance of education to those not fortunate enough to access the experience of a liberal arts college. In both cases, the response to these critics is twofold. First, it is argued that contemporary celebrations of that which is "cutting edge" may represent dangerous overcorrections. Second, it is suggested that the goal of offering a social good (be it medical care or education) to broader segments of the population, however noble, is shortsighted if the efforts to do so would strip that social good of much that made it so benevolent in the first place. It is proposed that to offer a minimalist approach to health care, even if doing so allows for greater numbers of people to be served, is to downgrade the collective professional and societal understanding of what medical care encompasses in such a way as to ultimately weaken the standard of care offered to all.

Foundations of the Logic

Neoclassical professionalism is, in large part, the product of the transitional period medicine has found itself in over the course of the past several decades. The hallmarks of the Golden Age – unquestioned expenditures, wide-ranging autonomy, and obedient patients – have not entirely vanished, but they are unmistakably undergoing significant change (Freidson 1985; Light 2004; Marmor and Gordon 2014; Starr 1982). Doctors see a new world coming into shape even as the old world has not yet faded

completely. Someone like Dr. Minter is thus a sort of bridge between two generations. He has, for instance, seen the benefit of face time with patients, but he has witnessed computers draw practitioners away from the patient's bedside, much to his dismay. A resident I spoke with recalled that "I feel like [when I was] an intern, instead of having time to interact with my patients, I was stuck hammering away at a computer. I had to write notes, I had to do discharge letters, I had to put in orders. And all these things, it honestly felt like I spent my day with a computer." Dr. Minter cringes when he hears accounts such as these. Truth, he says, is found in the patients themselves, not on an electronic medical record. "Don't believe anything you see in here," he tells residents while gesturing toward one of the rolling computers practitioners take with them on rounds. "The truth is in the patient" – the patient as a living, breathing human being in a hospital bed, not a case number on a computer screen.

For Dr. Minter specifically, the embrace of neoclassical professionalism has its roots in his college years. He told me: "I think that the ethics courses I took as an undergraduate really changed the way I think about medicine. I took, you know, courses in bioethics as an undergraduate and then some in medical school as well, and frankly, just some training in moral reasoning really influenced my thinking in this area." He continued: "If one understands that there are always competing ethical principles and priorities, et cetera, but if one can sort of reason out what the top priority is, I think it leads to better decision-making."

It is easy to see from Dr. Minter's reflections that his decision to side with the individual patient against the greater good of society when the two come in conflict is the product of explicit moral reasoning. For others, and in other circumstances, the

utilization of neoclassical professionalism carries much less of the weight of formal reflection. Dr. Janet Davis, a resident, told me that the ability to create compassionate communicative connections, a hallmark of neoclassical professionalism, is largely beyond our control: "We're either people who allow ourselves to feel or not. Compassion and empathy enhance our ability [to do our jobs well]. It doesn't interfere with our job to have compassion; it enhances it."

It is likely that the satisfaction that some doctors find in patient interaction is a major force behind the adoption of a logic that justifies and even exalts such interaction. Not every doctor feels this way; Dr. Tina Favors says she prefers operating upon unconscious patients to direct communication with conscious ones. But data suggest that Dr. Favors is in the minority. The 2014 Survey of America's Physicians indicates that 78.6% of respondents chose "patient relationships" as one of the two factors they find most satisfying about medical practice, ahead of "intellectual stimulation," "interaction with colleagues," "financial rewards," "prestige of medicine," and "other" (The Physicians Foundation 2014). Practitioners at Harborside Hospital frequently spoke of patient relationships in rewarding terms. Recall, for instance, that even Dr. Witherspoon, the committed progressive planner, spoke warmly of a patient brought back from the brink of death returning to visit the practitioners who saved his life.

Additionally, in considering what might encourage a doctor to adopt this logic, we cannot overlook the continued cultural resonance of its prescriptions for doctor-patient relationships. With its emphasis on the doctor's obligation to provide time, attention, and respect to individual patients and to put their needs and concerns above all else, neoclassical professionalism positions doctors to provide the sort of conduct that

researchers (e.g., Stone 2003) have found that patients say they want. According to Deledda et al. (2013), what patients desire is for doctors to "foster [a] relationship" with them: "Physicians are expected to be friendly, respectful, interested, non judgmental and sensitive and to treat patients as a person and as a partner" (303). The adoption of neoclassical professionalism represents a way for doctors to answer this call.

What Neoclassical Professionalism Offers

To a greater degree than is true for sardonic pragmatism or progressive planning, neoclassical professionalism offers doctors the satisfaction that comes (for most of them) with an unbounded effort to do right by an individual patient. It allows its users to take a quasi-heroic role as the lone doctor who will stand up in defense of his or her patients against creeping deprofessionalization and its pernicious effects – namely the neglect of patients that is said to be brought about by such things as electronic medical records. Through these efforts, doctors forge deep and long-lasting relationships with patients and families, and these relationships represent fertile ground from which open expressions of affirmation and appreciation can sprout. When doctors are confident that their patients have understood their efforts as helpful and supportive, there is, in the words of a resident I interviewed, "a moral satisfaction that goes along with that, and I think that if [doctors] neglect that, [they are] in the wrong field."

Doctor-Patient Dialogue: Making Communicative Connections

When viewed through the logic of neoclassical professionalism, doctor-patient dialogue is an essential component of compassionate and efficacious practice. It takes on

an almost sacred quality as the means by which ultimate truth is revealed through human connection, irrespective of advanced technology and quantification. The form of autonomy that is most cherished in neoclassical professionalism, the pursuit of which serves as a doctor's lodestar, is what I call interpersonal autonomy – the ability of a doctor to freely pursue the human connection to a patient that is at the heart of the best form of medical care. Unfortunately, this vital practice has been imperiled by competing demands upon doctors' time. The benefits of conversation with patients are both instrumental and empathetic. Dr. Minter believes that talking to patients is at least as effective in the diagnostic process as the review of charts. "I can't overstate this," he said on one occasion when a resident indicated being unsure of what exactly was troubling a patient even after a thorough review of the patient's electronic medical record. "If you listen long enough, the patient will tell you what's wrong with them." Talking can serve as a prescription as well as a diagnostic tool; according to Dr. Minter, "we say in the trauma service that the treatment for anxiety is talking, not Ativan."[20]

Dr. Minter is particularly distrustful of the reliance on electronic medical records as a supposed substitute for direct interaction with patients. He distinguishes himself from his colleagues Dr. Wesley (the exemplar of sardonic iconoclasm) and Dr. Witherspoon (the exemplar of progressive planning) in his insistence on conducting conversations about particular patients on rounds within a patient's hospital room instead of outside in the hall. Other attendings are usually content to stand outside the room with their entourage of residents, medical students, and nurses, all referring to electronic medical records on rolling computers, and then only step inside the patient's room for a moment of brief conversation at the end of the session before moving on to the next

[20] Ativan is a medication frequently used to treat anxiety.

patient. While Dr. Minter is not alone in his suspicion of electronic medical records, he is unique in his insistence on having the entire conversation within view and earshot of the patient and any loved ones who may be present. He insists upon it because, he says, "otherwise patients think we spend [only] nine seconds on them," as well as because the truth is in the patient and the main purpose of HealthNote, as mentioned earlier, is to perpetuate lies. While he speaks in exaggerated terms of "lies," it is clear that Dr. Minter is referring not so much to deliberate falsehoods as incomplete or outdated impressions that might be generated by neglecting the patients themselves in favor of near-total dependence upon the record as indicators of their conditions. He also told a patient's loved one that "we believe that you can't be our partner if you don't know what we know." There is a limit to the extent to which most patients and family members can interpret the medical jargon used in a typical rounding session, but Dr. Minter usually makes a concerted effort to translate any cryptic material. He also acknowledges that some patients and families may not want to hear the unvarnished truth. When discussing his approach to conversation with patients and families in an interview, Dr. Minter told me that:

> The primary thing from my perspective would be to try and meet the patient, meet patients and families where they are. To begin by assessing what their level of understanding is, what their emotional state is, and sort of feeling them out for what kind of style they want, and in the information that's going to be subsequently presented. I used to think that there was kind of one good way of being with patients, and that if you developed a good style that that would be, you know, one size fits all for everybody who was subsequently treated. And now I see clearly that different people need different things, and you actually have to ask them what they want.

While other doctors retain a rather consistent disposition across a wide variety of patients unless jolted by a notable event (such as Dr. Wesley being asked to take his hand out

from in front of his mouth, an incident that will be described in greater detail in Chapter Six), Dr. Minter makes a concerted effort to exhibit emotional versatility, being businesslike or humorous or compassionate, or even all of the above, depending upon his understanding of what the situation warrants. When a patient or a patient's loved one is palpably agitated, he presents warmth. On one occasion, on his way out of a patient's room, he told the patient "bottom line, you're doing great. Really." "It doesn't sound like it!" the patient's mom protested, in a tone expressing more nervousness than anger. She had a reason to be nervous, as Dr. Minter had remarked just moments earlier that "[the patient] makes me nervous. That wet, soupy cough I don't like." Cough notwithstanding, however, Dr. Minter was now committed to assuaging the mother's fears. He told her that his reference to the wet, soupy cough was not rooted in serious fear for the patient's survival but rather a manifestation of the fact that "it's our job to worry about everything," no matter how insignificant it may prove to be.[21] "We will continue to treat him like he is our own family," Dr. Minter concluded. On other occasions, particularly in interactions with residents and medical students, Dr. Minter uses offbeat analogies to get his point across. During a discussion of whether or not it would be wise to remove a breathing tube from a patient who was not following commands, for instance, Dr. Minter pointed out that "goats don't follow commands, but that doesn't mean we extubate them all." On other occasion, he told residents and medical students that "trying to heal decubitus [sores][22] when you're laying on your back is like trying to cure frostbite while you're still outside." He also uses a glib tone of

[21] It is possible that Dr. Minter was downplaying the degree of concern he truly feels that the patient's cough warrants, though he did not have a habit of soft-pedaling bad news with patients.
[22] Decubitus sores are bed sores that arise from a patient lying in a single position on the bed for an extended period of time.

affectionate sarcasm with patients when he is in a position to finally address a persistent complaint of theirs, as when he told a patient who had been anxious for a nasal tube to be removed "I know you're gonna be disappointed to hear we're thinking about taking that tube out of your nose."

In addition to the importance of doctor-patient dialogue in the execution of doctors' professional duties, it also serves as a means through which instances of intense meaning and emotion are created and negotiated. I refer to these moments as *communicative connections.* When viewed through the neoclassical professionalism logic, communicative connections are essential elements of medicine at its best and an important example of what this logic offers more reliably than do others. Communicative connections are occasions in which face-to-face interaction between a doctor and a patient conveys a sentiment or an emotion (see Pugh 2013). What's more, they represent moments in which the professional-client relationship reaches what some doctors and patients think is its ideal state – trust and openness on the part of the client and devotion and obligation on the part of the professional (Deledda et al. 2013; Stone 2003). These are the occasions that provide doctors with what many of them described as the most fulfilling aspect of their job – meaningful and heartfelt connections that both serve both instrumental and empathetic purposes. They are some of the richest rewards that neoclassical professionalism has to offer to those practitioners who make use of it.

In facilitating communicative connections, neoclassical professionalism provides interactions that promise both professional and personal benefit. A resident I interviewed, Dr. Robert Manning, recalled:

> I like sitting on the bed with a patient, talking to a patient and spending that time with a patient, and trying to help them understanding the disease. Because I think

> if we educate our patients, they tend to have better outcomes, and I think they do better in the postoperative or preoperative periods if you just tell them what to expect and what we're doing and really, you know, try to break it down for them.

Later in that same interview, in continued conversation about the importance of connection with patients, Dr. Manning transcended the rather sterile language of "outcomes" that he used in the previous quote, telling me:

> I still think [medicine is] the coolest job in the world, no matter how many charts I have to write, or how many hours I have to spend in front of HealthNote, there is nothing in the world like sitting at a patient's bedside, and impressing upon them that you're gonna take care of them, and holding a hand, or being there in this patient's time of need. There's nothing like that in the world. There's no job that gives you that much satisfaction and gives you that much, kind of window into someone's most intimate moments with family and everything else.

It is clear that for doctors who embrace neoclassical professionalism, these communicative connections do more than offer biomedical healing to patients. They bring a fleeting moment of intimacy and humanity to a large institution that can be bureaucratic and impersonal, and they provide a great joy. Communicative connections deliver a reward that, for some physicians, is just as valuable as money or social prestige. It is a reward that gives them the energy and motivation to press on despite the job's many frustrations and limitations. The reward is human connection, and for adherents to neoclassical professionalism, it makes everything else worthwhile.

Communicative connections can be made even after a patient leaves the hospital. The existence of these longstanding relationships belie the common stereotype that doctors – and especially surgeons – have only very limited contact with often-unconscious patients before moving on to the next procedure. (This stereotype is further disproven by the fact that it was not uncommon for patients to stay in the SICU for weeks at a time.) I would often see greeting cards in the SICU, sent from patients or patients'

loved ones offering thanks for the care that they or their loved ones received. When I interviewed Dr. Manning, he told me that, if it is possible to do so and the patient or family is willing, he actively works to allow for such post-discharge communicative connections. One such case occurred with a high-powered Wall Street executive whose father sustained a traumatic injury. The man's father was treated at Harborside Hospital. Dr. Manning spoke poignantly of how he was moved by the sight of the powerful businessman weeping at his father's bedside. The father survived long enough to be discharged, but as Dr. Manning explained, shortly thereafter:

> I called [the patient's son] and I said "hey sir, you know, this is Robert, one of the surgical residents here at Harborside, just wanted to talk to you briefly if that's okay." I just said "how are you doing, how's everything going?" He said "well I don't know if you've heard, but my father passed." You know, "I'm very sorry." He started talking about, kind of, his experience and how he realized that he had done everything that was in his father's wishes…but it just didn't go his way, and it was a really, it was a powerful conversation that we had, and we talked 30, 40 minutes, he just said, you know, he appreciated everything that we had done, and he was very thankful that his father got care here, and, um, it was just, it's just very touching.

Accounts such as this offer a portrait of a work environment infused with deep meaning and human connection. Traditional literature on professions (e.g., Goode 1957; Parsons 1939) paints a picture of professionals as being obligated to their clients in the course of their work but uninvolved in any sort of more personal relationship. Some doctors at Harborside Hospital retain this general perspective, but others, especially those who utilize neoclassical professionalism, look forward to establishing deeper relationships if patients and their families are interested in pursuing them.

There are, however, limitations to the willingness of practitioners to forge communicative connections in certain circumstances. These limitations are worth

considering in light of their reflection of one major component of the dark side of the "Golden Age" that neoclassical professionalism seeks to revive and defend: the extension of greater respect to some patients than to others. In general, patients who are "good citizens" - pleasant, agreeable, and engaged in their own care without placing demands and expectations upon doctors that the doctors interpret as excessive - are the most likely to be able to make a communicative connection with a doctor. Dr. Harriet Foster, a resident, implies this point in an interview:

> I think globally speaking, the most wonderful patients, and I'm completely biased because I'm going into breast surgery, but I think [they] are the best patients…They're engaged in their care. They want to get better, they really want to get rid of their cancer, they're very compliant. And then the trauma population is sort of, I think on the other end of that spectrum. They've usually done something, like, sort of silly or stupid to get into their situation…That population in general can be a little bit more abrasive and has a lack of responsibility for their, um, actions, or the outcome, and so I think in general, the trauma population can be slightly more frustrating, but I do still think globally that patient-surgeon interactions are quite good.

If a patient is known or suspected to be "abrasive," the manner in which doctors engage with that patient, while still professional, is more guarded and less likely to facilitate communicative connections. Sometimes this wariness is explicit and official; an example is in the case of "two doctor order," which establishes that doctors should not be alone with a patient for fear that the patient might assault or physically overpower them. More often, however, this distancing process is subtler and occurs through "off the record" gestures that are not entered into a patient's file in the way that a two-doctor order would be. Examples include describing a patient with an alcohol problem as a "professional" drinker or privately mocking a patient's accent, mannerisms, or social class background. For instance, on rounds on morning, after learning that a particular patient had been burned when his methamphetamine lab exploded, Dr. Wesley began rattling off the

names of rural counties outside of Harborside Hospital, asking the nurse caring for the patient if these counties (as opposed to the more urbanized setting in which Harborside is located) were where the patient was coming from. The nurse replied "I heard West Virginia," to which Dr. Wesley responded "oh, even better," as in an even better embodiment of the stereotypes of methamphetamine users and their demographic and social circumstances.

Circumspection toward patients based upon their perceived social background is most vividly illustrated by Dr. George Witherspoon's instruction to residents to be alert to web-space[23] tattoos on patients; the ability to withstand the extreme pain involved in getting a tattoo in a web-space, he mused, was a sign of potential psychiatric problems. Even Dr. Minter's efforts at forging communicative connections have their limits; as he said of one quirky patient, "I try to honor the inner spirit of everyone, but this guy was weird." As will be discussed in subsequent chapters, barriers between practitioners and patients are not based solely upon practitioners' assessments of patients' idiosyncratic "weirdness," of course, but are in fact related to existing structures of social inequality.

Restrained Empathy

Empathy, encouragement, and gratitude are the centerpieces of many communicative connections that do occur. In the ICU, it is common to hear Dr. Minter tell a patient "I'm sorry this happened to you" or to tell the patient's loved one that he will take care of the patient as if he or she was his own family member. He also tries to avoid a prosecutorial or judgmental tone; he will declare "no judgment" when asking a patient suspected of having an alcohol problem if he or she had been drinking prior to an

[23] The term "web-space" is referring here to the fleshy, stretchy space between appendages such as fingers and toes.

accident.[24] In this sense, he is more inclined than many of his colleagues to extend the opportunity for communicative connections to patients who might be seen as "untrustworthy," though like his colleagues he is far more willing to speak less gingerly of patients' peccadillos and eccentricities when in private settings. An adherent to neoclassical professionalism will still, at a weekly conference at which no patients are present, join in the joking recollection of a patient's bizarre account of an injury, but when he or she is face-to-face with that patient, they are more willing than adherents to other logics to make an attempt at a communicative connection.

Practitioners can also use communicative connections to indicate to a patient that his or her feelings regarding the circumstances are not unreasonable. They indicate to the patient that their emotions and physical experiences of pain and discomfort are justified and that the practitioner themselves would react the same way if they were in the patient's position. Sometimes doctors are able to call upon their own personal experience in forging these connections, as when Dr. Wesley told a patient that he had also worn a cervical collar after a surgical procedure and could therefore sympathize with the inconvenience of it. More often, however, doctors must call upon empathy rather than personal experience to offer reassurance and understanding to patients.

The occurrence of moments of identification and agreement with a patient's frustrations is not dependent upon apologetic backtracking, but those gestures do represent the most common prompts of this particular form of communicative connection. One such occasion took place in the room of a 62-year-old woman who was itching to leave the hospital. "How do you feel?" asked Dr. Minter as we entered the

[24] The doctors need to have some understanding of the patient's alcohol dependency because, among other reasons, alcohol withdrawal can interfere with the course of treatment.

patient's room. "I feel fine," she stated firmly, "and I'm ready to go home." "Are you hungry?" Dr. Minter asked, to which she responded "I'm thirsty, I've been waiting for a Diet Dr. Pepper." Since no Diet Dr. Pepper was immediately available, Dr. Minter tried to offer something that was: "Do you want a pillow?" "I do not want a pillow," she responded. Eventually the patient made her feelings explicit: "I'm very disappointed and upset." When Dr. Minter asked why, she voiced a familiar complaint. "One doctor comes in and says one thing and then the next says another," she explained. As patients often did after voicing frustrations, the woman then tried to justify and even apologize for her frustrations: "I'm just voicing my opinion because I'm very irritated." Dr. Minter replied "I would be too if I were in your position," and then promised her "you have my personal assurance" that we would move forward in arranging her release from the hospital.

Another instance of a patient's supplication prompting a communicative connection took place with a patient I'll call Rhonda, a young woman who had an extensive stay in the SIMU. Rhonda's disposition was consistently glum and she spoke in a deliberate and plaintive wail (perhaps affected by medication) to articulate her physical discomfort and her many complaints about the care she was receiving. She frequently expressed a belief that practitioners were making decisions about the course of her care without adequately consulting her or taking her experiences into account. When, despite her objections, the medical team was planning to remove a catheter in order to avoid a potential infection, she moaned "no one listens to me," and on another day protested "people think of these ideas and they don't realize how they affect me, and hurt me." When Rhonda would make these sorts of complaints without apology, Dr. Minter

used humor to try to lighten the situation, jesting on one occasion "Despite all rumors to the contrary, we're here to help" (see Francis et al. 1999). But several days into her time under the care of Dr. Minter's team, Rhonda tempered her complaints. When a nurse tried to move her leg, she initially responded "ouch, ouch," but then told the nurse "I didn't mean to be mean to you," and then said to Dr. Minter "Dr. Brian [his first name], I didn't mean to be mean to you," likely referring to the events of the past several days and not merely to her leg being moved a moment earlier. "You know what?" Dr. Minter responded, "We're all good. If it had been me I would have levitated out of the room and tried to smack me."

These sorts of affirmative communicative connections illustrate the importance of empathy in the neoclassical professionalism logic, but they also indicate that such empathy is not always offered freely. Sometimes its expression was an almost transactional affair, provided after the patient offered an apology of sorts for being terse or, in Rhonda's case, "mean."[25] The circumstances of the exchanges suggest that there is a limit to the extent that practitioners will make unprompted efforts at empathy. The empathy on offer is a *restrained* empathy. This is, in part, an artifact of some practitioners' willingness to let patients set the terms of the encounter; some patients are not interested in deep empathetic connections with their doctors any more than they would be interested in such connections with their stock broker or with the employees at the corner store where they buy a soda every afternoon. The reluctance of some

[25] I would not have described Rhonda's behavior toward the practitioners as "mean." It could fairly have been described as "whiny" if one were to be uncharitable about it, but her description of her own conduct as having been "mean" seemed questionable, and is perhaps an indication of the extent to which patients, even in this era of ostensible empowerment, still see doctors as worthy of respect and obedience and any breach of decorum on their part as a serious affront that must be atoned for in stark terms.

practitioners to engage emotionally with patients they view as disreputable is also undoubtedly a factor, and will be discussed in greater detail in later chapters. What is just as important, however, is the fact that practitioners, even those who place a high value on personal connections with patients, are forced by the circumstances and traditions of their work to limit their emotional investment in patients. Dr. Minter described the challenge of striking the appropriate balance between detachment and investment: "One can be, can become so dissociated that one can be seen as cold and callous and uncaring, and at the other end of the spectrum…one can become incapacitated by one's emotions, especially if one can, in any way, in a substantial way, identify with the challenges facing the person in front of them…A balance is key." With this sort of balance in mind, and with so many other demands upon their time and attention, the establishment of a communicative connection is no easy feat. It is often dependent a patient to offer himself or herself as a supplicant – one who has transgressed the bounds of proper patient behavior (i.e., not to be whiny or rude to the doctors) and is therefore obligated to reach out to the doctor to seek a pardon. The burden is therefore on the patient to make the humbling effort necessary to establish a communicative connection, even with a heavy user of neoclassical professionalism such as Dr. Minter.

Engagement with Institutional Infrastructure

Neoclassical professionalism represents a cultural notion of medical practice that has retained a great deal of power and resonance. However, those doctors who subscribe to it find the contemporary medical center an increasingly inhospitable place in which to use the logic effectively. The electronic medical records that are the bane of Dr. Minter's

existence are indicative of the broader trend. Requirements and duties are foisted upon doctors by regulators and administrators who, according to the doctors, pay insufficient mind to the potential of those new tasks to disrupt that which ostensibly represents their common goal – the best possible patient care. The issue, of course, is that approaches to reaching this goal differ, and some doctors and administrators see the regulations neoclassical professionalism chafes at as working in concert with that goal. At one Thursday Conference, for instance, Dr. Minter lamented that he had not been able to perform a gynecological exam upon a patient for whom he felt that the exam was appropriate because the patient had not explicitly given consent to such an exam. Other practitioners around the table agreed with Dr. Minter that exams should be permissible in emergencies even if explicit consent had not been directly provided, but residents challenged Dr. Minter's dismissal of the consent concerns (in one of the relatively few examples of residents pushing back against an attending) by citing a recent news story they had seen about another hospital, where medical students had lined up to practice gynecological exams on unconscious patients.

Additionally, for an administrator, the best possible patient care involves using electronic medical records to make sure that information can easily be stored and shared, and even a powerful attending such as Dr. Minter cannot simply refuse to take part. Even while grudgingly going along, however, he holds fast to *his* vision of the best possible patient care, in which electronic medical records play little or no role.

Dr. Witherspoon, as an adherent to progressive planning, is not a knee-jerk opponent of efforts that might intrude upon practitioner autonomy; as was explained in the previous chapter, he feels that intruding upon practitioners' autonomy is sometimes a

worthwhile and necessary task. Nonetheless, he too perceives the growth of administrative requirements that erode doctors' autonomy (first and foremost through obligating them to devote some of their time to one particular task that they might not otherwise have taken part in). When I asked him to discuss what represented some of his least favorite aspects of his job, he responding by denouncing "Time Effort Reports," which are paperwork that he and other doctors must fill out in order to remain in compliance with the Centers for Medicare & Medicaid Services. The intent of the reports is for doctors to chronicle the amount of time they spend on various tasks, but Dr. Witherspoon calls them "disingenuous" because, in his view, they make it difficult for doctors to fully explain how hard they work and the extent of their efforts. "If we were to put all the things down we did," he tells me, "most of us would equal about 180% effort, which you can't write that down! It's not okay, you have to have 100%, no more."

Therein lies the essence of doctors' objections to the forces within the institutional infrastructure that chip away at their autonomy. In their view, electronic medical records and Time Effort Reports are not objectionable solely because attention to them takes time. If they were widely understood to be useful tools that facilitate smoother and more successful practice, negative reaction to them would be more muted. What frustrates the doctors the most is their perception that these new constraints do not actually serve their ostensible purpose of enhancing the quality of care, and in fact subvert that goal through the spread of misinformation. Dr. Minter made this point to me by remarking in an interview "If [EMR companies] produced a great documentation product, then maybe it would be something that you could feel good about…but very often the documentation that's produced, you know, is just a sea of data without much information."

While sardonic pragmatism would encourage physicians to simply roll their eyes at these follies and combat their pernicious effects when and where they happen to encounter them, a doctor with a sincere and passionate commitment to patient relationships and an interactional, face-to-face model of care – an adherent to neoclassical professionalism – would find them to be an intolerable intrusion. They constitute a violation of autonomy, but also a violation of the idea that it is the professionals themselves, not administrators or anyone else, who should be empowered to make decisions and evaluations regarding what sorts of practices support their work and what practices obstruct it. We hear the professionals say that the ability to make these evaluations is part of the rare knowledge that only they possess; that only by actually practicing medicine, as they have, can the utility of an innovation be fairly assessed.

Managing Autonomy through Neoclassical Professionalism

When I asked Dr. Minter to assess the autonomy he possesses at work, he replied that "my autonomy level is generally high." Later he even echoed progressive planning's sympathy for interventions that can have the effect of reducing autonomy, telling me that, while there has been a decrease in the profession's overall level of autonomy, "some of it has really been necessary." But as was the case with Dr. Witherspoon's assessment of his autonomy, a closer look at the totality of Dr. Minter's work paints a more complex picture. It is my contention that Dr. Minter's assessment of his current autonomy as being quite high is a product of the degree to which his powerful position at Harborside Hospital has, at least up to this point, shielded him from the effects of those forces that

would erode it. Dr. Minter's distinction between his own perceived autonomy (which is high) and the autonomy of the profession as a whole (which he says has declined) is indicative of this point.

A young practitioner like Dr. Jennifer Hoover can recall that, particularly when she was an intern, she often felt that while she "really needed to be doing clinical things," her time was occupied by "administrative tasks, writing discharge summaries, things like that." An attending like Dr. Minter can spare himself this work by delegating it to others, and this privilege of rank buoys his assessment of his personal autonomy. Even while doing so, however, he can retain a philosophical objection to the idea that a low-ranking doctor, such as an intern, must perform a task that could potentially be performed by a nurse practitioner or other non-doctor (as Dr. Hoover suggested regarding the administrative tasks that occupied so much of her time as an intern).

Neoclassical professionalism casts the autonomy of the individual practitioner as the most essential form of autonomy in the medical realm and the one that is most worth defending. It exists in between the open-door policy of sardonic iconoclasm and progressive planning's determination to empower only a select group of the medical elite. From the view of neoclassical professionalism, the general practitioner in the heartland has as much need for autonomy as the chief of surgery at the Mayo Clinic, because the general practitioner must ultimately be willing to combat any effort to interfere with his ability to do whatever can reasonably be done for his or her individual patients. To be sure, neoclassical professionalism does not promote a fantasy under which all doctors would somehow be equal in status and power. Dr. Minter speaks frequently of how students admitted to Harborside's medical school are "the best of the best" and, as such,

should prepare for careers that allow them to play a role in the administrative side of medicine along with the clinical side (as he does). But even if not all doctors will ever be fully equal, what is important from the perspective of neoclassical professionalism is that no doctor be proletarianized (Navarro 1988) to the point at which they simply manage data from electronic medical records and execute the orders of algorithms.

In this sense, as was the case with both of the other logics, neoclassical professionalism's defense of autonomy does not stress "autonomy for autonomy's sake" as much as it values autonomy for its alleged ability to bring about the results valued in the logic's vision of the good. What is good, from the point of view of this logic, is for doctors to be empowered to follow established and scientifically validated procedures for optimal patient care, with minimal outsider interference. For a practitioner to use his or her autonomy to blithely embrace "fad medicine" or to voluntarily choose to simply obey the dictates of the algorithms would be regrettable. Indeed, neoclassical professionalism also exhibits a sense of respect for tradition and established forms of practice. While Dr. Witherspoon will say that the fact that something "is our practice" is "not the same thing as it being the right thing to do, necessarily" as part of his larger programmatic critique of wasteful or ineffective procedures, Dr. Minter encourages students to hold fast to those methods they were taught by their instructors. At a Thursday Conference, he tells those present that "any time you find yourself doing what you don't normally do in clinical medicine, you had better ask yourself if you have a really good reason for it." "Practice the way you were trained," he says on another occasion, "unless you find a randomized double blind control trial that proves you should do it differently." This is a high bar, to say the least.

Conclusion

Faced with declining autonomy, neoclassical professionalism weaves a tapestry of resistance and denial. Through its celebration of interpersonal autonomy, it allows doctors to take up the mantle of the defender of patients against the harmful effects of hurried and impersonal care. In this sense, like sardonic pragmatism, neoclassical professionalism can be viewed as a logic that is most easily adopted by those in positions of rank and power, such as Dr. Minter. He can insist upon directing his attention toward patients and in that sense momentarily deny the existence of constraints; when Dr. Hoover was an intern, she had no such luxury.

Ultimately, neoclassical professionalism, more than either of the other logics discussed in this dissertation, faces significant threats to its continued viability. Its chief rival, progressive planning, has intellectual, cultural, and political winds at its sails, and sardonic iconoclasm continues to chip away at its pretensions. The centerpiece of the neoclassical professionalist approach to medical care – face-to-face interaction with patients, with doctors retaining ultimate authority on the course of patient care – is eroded by competing demands on doctors' time and the rise of more impersonal forms of care, of which the electronic medical record is the epitome. The following chapter chronicles the manner in which adherents to neoclassical professionalism attempt to hold the line against competing logics in the course of their work. When multiple logics are brought to bear in a patient's treatment, the consequences of these contradictions are complex and profound.

Chapter 5: Logics in Dialogue

Each of the three previous chapters has outlined a major cultural logic doctors at Harborside Hospital can use to find meaning and direction in their work. Differences between these logics carry the potential to generate tensions between practitioners who subscribe most thoroughly to one rather than the others. This chapter explores the background and consequences of this logic dialogue. What is important is not simply that the logics differ in the visions and objectives they set forth for the profession. Certainly they do, as has already been demonstrated in the prior chapters. What has not yet been examined, and serves as the focus of this chapter, is the manner in which logic dialogue and other forms of conflict between practitioners is ultimately entangled with the institutional infrastructure of Harborside Hospital. Through a critical analysis of where conflict arises, who is empowered to engage in it, which issues it focuses on, and how it is resolved, we can develop a richer and more complete understanding of how logics, and the dialogues between them, are intertwined with the institutional infrastructure of the medical profession.

With institutional infrastructure come hierarchy, networks of obligation, and responsibilities. By taking these forces into account, we come to see that medical meaning-making is not defined solely by sardonic pragmatism, progressive planning, and neoclassical professionalism and the differences between them. It is also shaped by the institutional infrastructure that gives these logics their power and influence in certain circumstances and for certain people. The ability to take up the banner of a logic and use it to shape the direction of the profession is context-specific and unequally distributed.

The present chapter explores the deep contexts of logic conflict among doctors. After first acknowledging the shared plausibility structure that makes institutional medicine possible, I demonstrate the importance of institutional infrastructure in shaping its expression. The subject matter of this conflict both calls upon contrasting logics and transcends their differences to reveal the power differentials that give those logics their authority in the first place. These connections are illustrated all the more vividly when we consider what does not become a source of conflict along with what does. Only by first sketching out these contours of logic dialogue can its impact upon patients be fully understood.

Shared Assumptions

The existence of logic conflict among doctors is possible only in light of the shared understandings that create the conditions for contemporary medical practice in the first place. For all that they disagree on, doctors' roles and positions exist as social facts only because there is much that they accept with little questioning. There is a foundational system of shared understandings - a plausibility structure (Berger and Luckmann 1966) - undergirding mainstream medicine that is every bit as consequential as the internal dissent for which it serves as a catalyst. Hierarchy, for instance, is an essential element of the medical plausibility structure. The right of attending doctors to serve as the ultimate authority on the course of treatment is seldom questioned in the course of everyday interaction. It is likewise understood that while residents must answer to attendings, they possess greater authority and autonomy than do medical students and

nurses. The operations of the hospital are based upon a generalized acceptance of attendings as experienced and proven experts who are entitled to pass along their wisdom to junior doctors and to use this wisdom to direct the course of treatment.

A general acceptance of the virtue of science also transcends logic conflict in some ways. Considerable disagreement exists regarding the particulars of science, such as its relative importance vis-à-vis tradition and "common sense" in determining the course of treatment and the matter of what constitutes "good" or "sound science." On rounds, a recommendation from another service to take particular course of action, which the referring service saw as an implementation of sound scientific practice, was denounced by a chief resident on the ACT team as "voodoo." Nonetheless, an embrace of science in at least rhetorical terms is practically *de rigueur*, even if this embrace is sometimes grudging or nebulous in its substance. As is the case with hierarchy, an acceptance of science in the abstract serves as the springboard for disagreements regarding the proper manner and scope of its practical execution.

The Contexts of Dialogue

Dialogues between practitioners do not exist in a vacuum, nor are they purely abstract clashes between opposing logics. An analysis of three major settings in which the Acute Care and Trauma (ACT) team works at Harborside Hospital – the Monday Meetings, rounds, and the Thursday Conference – demonstrates that conflict cannot be disentangled from the institutional contexts in which it is, or is not, expressed. Goffman (1959) discussed the importance of distinguishing between frontstage and backstage

settings in evaluating social performances. Backstage settings provide an opportunity for the expression of sentiments that might seem uncouth or inappropriate on the frontstage. At Harborside Hospital, the Monday meetings serve as a frontstage and the Thursday conference is a backstage, while rounds teeter in between. What gives these settings their identities as frontstages or backstages is the extent to which they bring doctors into contact with those, such as doctors of similar rank from other units in the hospital, to whom they hold obligations, particularly obligations to downplay conflict or resolve it politely. These obligations, in turn, are shaped by institutional infrastructure, and therefore are not equally distributed. As a result, the contexts that are experienced by attending physicians as backstages in which they can wage logic conflict through friendly joshing or pointed putdowns are, for less privileged practitioners, still frontstages in which a civil performance is expected from them, and in which they are expected to engage in dialogue without crossing the line into waging overt conflict.

Monday Meetings

I use the term "Monday Meetings" to refer to two related events that take place most Mondays at Harborside Hospital – the Morbidity and Mortality Conference (or M&M, as it is often called) and Grand Rounds. Both events take place in an auditorium and are held early in the morning (M&M begins at 7 o'clock and Grand Rounds follows at 8) in order to allow the doctors in attendance to begin their individual responsibilities before too much of the day has passed by. Coffee and a generous breakfast spread are provided, and practitioners make earnest efforts to juggle cups of coffee, plates of eggs

and fruit, and purses and satchels while catching up with colleagues and trying to avoid spills.

M&M and Grand Rounds are both ritualized and ceremonial events steeped in professional tradition (see also Kunda [1992] 2006). In addition to their immediate functional efficacy, they serve the purpose of affirming the physicians' identities as members of a larger profession whose practitioners take part in similar rituals elsewhere (Bosk 1979; Harbison and Regehr 1999; Orlander et al. 2002). The first to take place each Monday morning, the Morbidity and Mortality Conference, is an event devoted to the discussion of recent patients who have experienced significant deleterious events (morbidity) or have died (mortality). A resident will stand at a podium and walk the audience through a PowerPoint presentation devoted to the course of the patient's care, the nature of the negative outcome, and reflections on what (if anything) could have been handled differently. The attending physician responsible for the patient, who is seated in the audience, will then offer his or her reflections, and lastly the resident takes questions from the doctors in the audience.

The proceedings at M&M are laden with tradition, formality, and decorum. The patients being reviewed are discussed in terms that are (particularly in comparison to the terms used in other settings) respectful and professional, if perhaps a bit transparently euphemistic; a patient whose obesity was said to be a factor in a surgical complication was described by the resident presenting her case as "not a particularly thin lady." In their presentations, residents will frequently refer to algorithms and formulas that led them to believe that a particular course of action was appropriate, only to realize after the fact that the calculation "fails to account for the added complexity of" some aspect of the

patient's unique circumstances. On one occasion, a resident recalled that he had entered data on a patient's condition into an algorithm designed to inform him of the patient's risk of experiencing necrotizing tissue. He entered one particular data point on a per-deciliter basis, which, he explained, was the standard unit of measurement for analyzing that data point at Harborside Hospital. The algorithm eventually led him to the conclusion that the patient was not at great risk. When the patient ultimately died, the resident began to retrace his steps and discovered that the data point he had entered on a per-deciliter basis actually needed to be entered on a per-liter basis in order to match the specifications of the algorithm. Had this data point been entered correctly, the algorithm would have led the resident to conclude that the patient was at much greater risk than he had previously believed.

Residents making presentations at M&M perform a sort of ritual public confession. They are obligated to take responsibility for poor judgments and oversights. Even when the mistakes they are discussing are not their own (they might, for instance, have been caused by the attending responsible for the patient), the resident becomes the "public face" of the mistake and must discuss it in a manner that does not through his or her colleagues "under the bus." As Bosk (1979) noted, a failure to take responsibility when it is appropriate to do so is perhaps the greatest professional misdeed a doctor can commit; it is viewed much more negatively than the error for which the doctor needed to take responsibility in the first place. Therefore, while residents make a point of identifying complicating factors that played a part in the negative outcome, they cannot appear to be shirking responsibility. The public confession of errors and the acceptance of responsibility for them, a process Bosk aptly referred to as "putting on the hair shirt,"

is required. But as long as the ritual is performed faithfully and completely, the resident is publically and officially forgiven. The episode is not completely forgotten, of course. A resident's informal reputation among senior doctors is consequential and is not necessarily altered through the formal forgiveness of M&M. Even here, however, these informal bad reputations are driven as much by perceived character flaws or attitudinal ones (such as a tendency toward excessive eye-rolling) than by the sort of explicitly medical mistakes that are chronicled at M&M, a finding that is consistent with that of Bosk (1979). Ultimately, regardless of whatever memories may linger, a properly executed M&M confession gives the resident his or her official blessing to move on to the next patient.

The attending doctor associated with the case will follow the resident's M&M PowerPoint presentation with his or her own assessment of the case. This usually takes the form of a testimonial to the reasonableness of the resident's handling of the case, or perhaps even a word of praise for the resident's valiant if unsuccessful efforts to care for a challenging patient. Indeed, when one considers that it is likely the attending who makes the major decisions regarding the course of the patient's treatment, including decisions of the sort that later come up for reevaluation at M&M, it becomes clear that M&M is a forum in which residents are training in the art of taking responsibility, not simply admitting to their own mistakes. The residents take responsibility for decisions that were not entirely theirs, and in so doing learn to take on obligations that are not present in medical school, such as the responsibility to account for a course of action and face a poor outcome head-on. When it is then time for doctors in the audience to ask questions of the resident, the questions are exceedingly polite and accompanied by

reassurances that the negative outcome was not the result of any sort of gross negligence on the part of the resident. "It sounds like an ingrown toenail would have been tough to manage with this guy" a senior doctor tells an attending before gently mentioning possible strategies for better management of similar cases in the future.

M&M is traditionally followed by Grand Rounds each Monday morning. Grand Rounds has little in common with the daily series of patient visits that are referred to as simply "rounds." Grand Rounds does not involve patients at all; rather, it consists of a preeminent figure in the medical world (sometimes a doctor from Harborside, though most often a visiting dignitary) giving a talk, followed by questions from the audience. The speakers at Grand Rounds use their platform to address issues related to the social and political aspects of medical care, and they often express strong (if somewhat generalized) opinions while doing so. In one typical Grand Rounds address, the physician giving the address spoke approvingly of the increasing representation of women in surgery's ranks (on the basis of studies suggesting that women are better than men at getting teams to work collaboratively and cooperatively) and argued that computer-assisted and robotic surgery was "the future" – a provocative claim, particularly to an adherent to neoclassical professionalism, given that the rise of such approaches is often thought to jeopardize the positions and prestige of human surgeons (Debas 2002; Lloyd 2011). Regardless of what the speaker says, the ensuing question-and-answer session is sure to drip with lavish praise. One senior doctor prefaced his comments to the Grand Rounds speaker who sees robots as the future by telling him "that was magnificent," and his ostensible enthusiasm is not uncommon among those who respond to Grand Rounds talks.

M&M and Grand Rounds are worth considering in tandem. Both are venues in which topics that might be expected to inspire fierce debate, such as poor patient outcomes and the sociocultural trends shaping the profession, are being discussed. However, there is little in the way of tension, hostility, or even vigor that characterizes the exchanges. A ritual civility carries the day. This is in part a product of the history and formality associated with M&M and Grand Rounds as events, the practice of which unites the physicians at Harborside Hospital with colleagues elsewhere holding similar events. There is a polite idioculture (Fine 1979) at M&M and Grand Rounds that is rooted in these meetings' roles as meaningful professional rituals and reinforced by the senior doctors who shape the direction and content of these events. In this sense, they are similar to the ritualized "white coat" ceremonies that welcome new interns into the fold; all represent gestures toward integration into, and continued participation in, "the timeless and international community of medicine" (Scarborough 2015:95).

In addition to their traditional formality and status as common professional practices, the lack of open conflict at M&M and Grand Rounds can also be attributed to the identities and roles of the physicians present. Both M&M and Grand Rounds are organized on behalf of the Department of Surgery at Harborside Hospital. The Department of Surgery encompasses the Division of Acute Care and Trauma Surgery (ACT), which is the focal point of my study, but it also encompasses many other surgical divisions, such as Pediatric Surgery and Cardiothoracic Surgery. M&M and Grand Rounds thus bring Drs. Wesley, Witherspoon, and Minter into contact with colleagues they work and interact with regularly but from whom they have more professional distance than they have from one another. The social proximity of the doctors in

attendance is such that they all end up needing one another sooner or later (to authorize the use of a medication, for instance, or to provide consultation regarding a patient), but they do not spend so much time together as to make intimacy and openness the rule rather than the exception. When they attend M&M and Grand Rounds, Drs. Wesley, Witherspoon, and Minter are therefore representing not merely themselves but their division within the broader Department of Surgery, and maintaining cordial and cooperative relationships between surgical divisions is essential to meeting the challenges of providing coordinated patient care. M&M and Grand Rounds represent a sort of Goffmanian frontstage on which a doctor plays the role of an ambassador of his or her division. A spirit of diplomacy is required; aggression or cynicism risk disrupting the civil relationships that are essential to a doctor's basic professional duties. Notably, M&M and Grand Rounds bring ACT attending surgeons into dialogue with other attending physicians. These individuals are, at least ostensibly, the ACT attendings' professional equals. Unlike the ACT residents with whom the ACT attendings engage at the Thursday conference, these other attendings have the power and stature necessary to make disrespect consequential. Drs. Minter, Witherspoon, and Wesley thus adopt a consistently diplomatic and professional tone, not unlike the dispositions they adopt in their interactions with patients.

Rounds

When conducting routine rounds in the Surgical Intensive Care Unit (SICU), the bonds of professional tradition and social proximity are slightly loosened. The audience for which doctors are performing on rounds differs from that of M&M and Grand

Rounds. Doctors from other divisions are largely absent, and the need to stifle expressions of conflict in order to maintain diplomatic relations is lessened. However, an equally important audience is in close proximity: patients. For different reasons, patients largely compel the same sort of courteous disposition that equivalently ranked colleagues bring about from attending physicians. The patient's room is another form of frontstage. This is due in part to the fact that patients do have some influence upon attending physicians' lives and careers; patient evaluations play a role in doctors' pay, and a patient's accusation of malpractice holds the potential to cause great damage to an attending's career and reputation. However, the overall power differentiation between patients and attendings overwhelmingly favors the latter. Courtesy toward patients is thus driven less by fear of the consequences of being discourteous and more by an important aspect of the medical profession's institutional infrastructure – the expectation of a nonjudgmental, if also professional, affect on the part of doctors when dealing with patients. This will be discussed in greater detail in the following chapter. Here it is worth simply observing that this professional affect involves keeping patients from learning about or overhearing disagreements and tensions between the various doctors involved with their care.

The practice of rounds typically encompasses an entourage consisting of an attending, several residents, and several medical students walking through the SICU to discuss the state of each patient. Radiologists, nurses, and nurse practitioners involved with the care of particular patients will join the entourage if their patient is under discussion. When Dr. Witherspoon or Dr. Wesley leads rounds, these conversations take place outside the patients' rooms in the hallways of the SICU, and the attending will go

into the patient's room and brief him or her on the essence of the conversation and his or her current condition before moving on to the next patient. Dr. Minter, as mentioned in the previous chapter, takes a different approach, opting to conduct the full proceedings in the patient's room. By doing so, he chooses to conduct rounds entirely on a form of frontstage, while Drs. Witherspoon and Wesley choose to work mostly on the backstage.

Rounds provide an occasion for Acute Care and Trauma doctors such as Minter, Witherspoon, and Wesley to discuss the impact of doctors from other divisions on the patients in the SICU, and these conversations are taking place in a setting where those doctors usually are not physically present. The ACT doctors are therefore comfortable gnashing their teeth over the decisions these other doctors have made, knowing that they are not present; they must only make sure that patients do not overhear their expressions of frustration and disagreement. Rounds become a forum in which Dr. Wesley feels sufficiently comfortable to say of another division's recommendations for a patient "it's all voodoo" and to call another patient an "official plastic surgery hostage." On another occasion, borrowing Lyndon Johnson's putdown of Gerald Ford, Dr. Witherspoon claimed of another unit's doctors "they can't walk and chew gum [at the same time]." He then covered his mouth in mock horror and gasped "oh gosh, did I really say that out loud?"

Dr. Witherspoon, indeed, is particularly inclined to use rounds as a setting in which he can express frustrations over the influence other doctors' decisions have on patients. With his commitment to the relative minimalism of progressive planning (combined with his rejection of the insouciance of sardonic pragmatism), he is uniquely frustrated by efforts on the part of his colleagues from other divisions to perform "heroic

medicine" and subject patients to tests and procedures he views as unnecessary. One day on rounds, upon hearing about all that had been done to a particular patient, he smiled, chuckled silently to himself in exasperation, and asked a resident "Do you have a gun? Shoot me in the head. Make sure I'm dead." He then pantomimed shooting himself in the head several times. The obvious hyperbole does not obscure his sincere frustration.

It must be noted that not all practitioners appear to feel comfortable making exaggerated displays of exasperation with their colleagues while on rounds. Only attendings appear to have the freedom to express frustration with such performative flamboyance. For a resident or a medical student to express frustration with other doctors in such vivid fashion would be to step out of their assigned role of the dutiful and serious student. Attendings are secure enough in their position to be able to act out exaggerated exasperation without having the performance misinterpreted as an indication that they are too theatrical or easily flustered or combative to do the job. As a veteran practitioner who sits near the top of the bureaucratic hierarchy, Dr. Witherspoon is secure and trusted enough to be able to perform exaggerated exhibitions of frustration without risking being misconstrued. Few of his more junior colleagues possess that luxury, and their need to self-censor is not restricted to rounds.

All of these candid acknowledgements of disagreement between practitioners as to the proper course of a patient's care are understood to be acceptable only when the rounding entourage is in the hallway of the SICU. Once practitioners step into a patient's room, discussion of disagreement must either cease or be cast in far more polite and encouraging terms. Dr. Minter, who limits his own ability to bluntly lament other doctors' efforts by holding rounds entirely in patients' rooms, tries to blend a candid

acknowledgement of disagreement with encouragement. He admitted to one patient that while the upside of being in a large hospital like Harborside is that you never have a doctor more than about 20 yards away, the downside is that a patient like him has probably had about 70 physicians coming into his room offering opinions that need to be sorted through.

Thursday Conference

The Thursday conference is the third major venue in which doctors can discuss logic conflict. It allows them to escape into an environment that is, for all intents and purposes, a pure backstage, at least for attendings. Patients and their families are not present, and neither (usually) are senior doctors from other divisions. Only the Acute Care and Trauma team is in attendance – the attendings, the residents and medical students who are currently on rotation through the service, ACT nurse practitioners such as Susan Kasay, and other administrative staff. Except for the residents and medical students, virtually everyone in attendance is a permanent part of the ACT team, and, as in rounds, residents and medical students are discouraged from being demonstrative. The result is that the Thursday conference becomes a setting in which the long-term ACT practitioners, particularly the attendings, can hold court with little of the concern for decorum that holds when in the presence of senior doctors from other divisions (as at the Monday Meetings) or patients (as on rounds). They're among their closest colleagues, most of whom are also their friends, and if there is an unfamiliar face in the room, it most likely belongs to a resident or medical student whose rotation has recently brought him or her to ACT, and an attending is under little obligation to perform politesse for the sake of

a resident or medical student. Secluded from anyone to whom they have behavioral obligations, they debate absent colleagues and one another with spirit that is blunt but jocular. The Thursday conference ultimately has two strains of significance. It is the venue in which logic conflict is negotiated most frankly and explicitly, and it is also a venue in which ACT attendings are able to build and enforce an idioculture that determines how conflicts are acknowledged and addressed.

The Thursday Conference has several official purposes. First and foremost, it is intended to be a forum for the ACT team to discuss prominent patients and review those patients whose care presents unique challenges. It is also used as a venue for medical students to make PowerPoint presentations about a topic related to trauma surgery, as part of their educational duties while on rotation with ACT, and occasionally it is also used to give representatives of companies a chance to discuss and demonstrate products that the ACT team is considering purchasing. In addition to these official purposes, the Thursday conference also serves as an opportunity for the ACT team to gather in the same room at the same time, to recount amusing incidents and engage in friendly banter, and to try to maintain an enthusiastic esprit de corps. Lunch is always served; a generous spread from a local barbecue or pizza or Chinese restaurant is available for attendees to sample from, and busy residents waste no time scarfing down heaping plates of food in a rare opportunity to eat. But before they dig in, the residents, along with everyone else, traditionally wait for the attendings to fill their plates.

Logic conflict between practitioners emerges from the discussion on most Thursdays. This conflict can exist between ACT practitioners who are both at the meeting and between the ACT team and practitioners from other divisions who are not

present. Logic conflict between attendings is most often waged under the auspices of the ACT team's backstage idioculture, with smart-alecky needling and tongue-in-cheek bombast existing alongside professional respect. By considering when and why the idiocultural balance between sarcasm and respect tilts more in one direction than the other, the cultural and institutional influences upon practitioner conflict are brought into sharper relief. When, for instance, conflict takes the form of ACT practitioners advocating for their preferred logics, mutual respect and affection runs deeply through the debate. One Thursday, the assembled practitioners watched a demonstration of a robot that was being promoted by its markers as a useful surgical tool. Dr. Witherspoon noted that the robot's instruments needed to be replaced after ten uses. This, he said, had soured him on the robot; he felt that the need to replace instruments so quickly indicated that the robot might be less an efficient and affordable surgical tool than a money-making scheme. Dr. Reyes then stated that "everything in the capitalist world is a money-making scheme." Smiling, Dr. Minter responded that "my clinic is not a money-making scheme." Dr. Reyes did not challenge his contention, but in smiling back at Minter, he conveyed bemusement at his protestations of purity. Throughout the dialogue, residents and medical students watch with attention and enjoyment, visibly taking a keen interest in the rare sight of an attending being challenged on his or her position – rare because only a hierarchical equal, such as another attending, is in a position to levy such a challenge without significant professional risk. The exchange captures the essence of logic conflict between close-knit ACT attendings at the Thursday conference. Dr. Minter carries the banner of progressive planning to object to the wasteful inefficiency of the robot, while Dr. Minter defends his practice as an oasis of high-minded professional altruism in the

neoliberal desert, and the debate takes place in the spirit of affable banter between familiar and friendly equals.

When practitioners use the Thursday conference to discuss conflicts with practitioners from other divisions, the mutual respect that characterizes internal debates is less present and hard-edged sarcastic humor fills the void. One Thursday, a senior resident said of a patient "we tried to sell[26] him to five east. They refused him." By "five east," the resident is referring to the psychiatry unit. Dr. Witherspoon then spoke up and asked "Anybody in the room going into psychiatry?" If any of the medical students and residents in the room as part of their ACT rotation did intend to go into psychiatry, they kept quiet about it, because Dr. Witherspoon continued: "Even if you are, don't put your hand up, because I'm about to say mean things about psychiatry." He then proceeded to lustily denounce ("Come on!") the psychiatry unit's temerity in refusing to accept a transfer of the patient, and tied his displeasure back to a familiar trope among non-psychiatrists, both at Harborside and elsewhere (Album and Westin 2008) – the idea that psychiatrists are not worthy of as much respect as other doctors, for reasons ranging from questionable scientific bases of their work to their supposed habit of sitting quietly on plush chairs talking to neurotic patients while other doctors are up on their feet.

While attendings are free to engage in zestful dialogue at the Thursday conference, the ability of those working underneath them (and may ultimately depend upon them for access to research opportunities, letters of recommendation, and the establishment of a strong informal reputation) to do the same is far more circumscribed. This is due in part to the fact that, while attendings can lead Thursday conference

[26] The resident's reference to "selling" a patient to another unit in the hospital is a glimpse of the way in which the Thursday meeting becomes a venue for speaking caustically of patients as well as other practitioners. Effects on patients will be discussed in greater detail in the following chapter.

conversation in whatever direction they desire, underlings are largely restricted to responding to whatever the attendings might bring up. Sometimes residents and medical students are even informally quizzed while at the Thursday conference. The attendings, particularly Dr. Minter, will, in the middle of a discussion of a certain patient, ask a resident or medical student what they think should be done. If the resident or student tries to evade the question or laugh it off with the same sort of winking bravado the attendings use in their interactions with each other, the attending will call them on it in a manner that is respectful and professional but firm. What's more, if a resident or medical student attempts to engage in a discussion with anything resembling heated emotion, they are shot down quickly. This was the case with a resident who began to discuss patient whose care had, in the resident's opinion, been obstructed by the indifference and incompetence of practitioners from another service. As the resident began to get somewhat (though not overwhelmingly) passionate in his account of his frustrations, Dr. Minter tartly reminded at a Thursday conference that "we don't want a lot of vitriol in this room." When the resident started to speak up again, Dr. Minter cut him off and reiterated the point.

What's at Stake in the Dialogue

Turf Wars

With its multiple arms needing to work together to accomplish any necessary task, an octopus is a fitting image to represent the complex organizational coordination that takes place in the medical field today. Countless roles and practices are embedded

within the vast institution that is Harborside Hospital. Under the conditions of contemporary mainstream practice, even those patients with the simplest and most common ailments require a synchronized effort on the part of multiple individuals with varying perspectives and agendas. While there is much that is taken for granted amongst all these practitioners, there is ample opportunity for logics, egos, and agendas to clash.

One of the most common and direct form of conflict between practitioners is centered upon battles for authority and "turf." Doctors frequently lament the fact that they must get permission from doctors from other services to follow a particular course of action; a regular example involves a surgeon needing permission from infectious diseases doctors to administer a certain medication. While practitioners resent having to call in colleagues for permission to complete tasks, the colleagues being called in can also come to resent consultations that amount to "come on, do this," with the doctor making the request obviously not interested in the colleague's perspective but solely concerned with having the consultant carry out a task that could not otherwise be completed. Dr. Minter tries to defuse the frustrations that this tangle of dependency and disinterest can breed. On one occasion he offered a creative analogy, telling residents "Do not yell at the fire department when the fire department arrives at your house, even if it's a false alarm."

Nevertheless, despite Dr. Minter's best efforts, obligatory consultations and the bad feelings they can breed present a challenge to doctors' morale, as well as their egos. These mandatory consultations, which are required by hospital policy in some cases, are understood by many doctors as insults to their intelligence. They know perfectly well, they say, that it would be completely safe to give this medication to this patient, so why can't they go ahead and do it? The frustration of having to make consultations that are

seen as unnecessary demonstrates that autonomy is not available in unlimited amounts to all practitioners. One doctor's autonomy can simultaneously serve as constraint upon another doctor's autonomy. The autonomy of the infectious disease doctor to set the terms for the distribution of certain medications is experienced by the trauma surgeon as an infringement upon his or her autonomy. The situation presents no easy answers, but it provides a glimpse upon one aspect of progressive planning's allure. In some of its less sophisticated and nuanced manifestations, progressive planning conjures up the image of the "one big decision-maker" – that far-sighted practitioner who sets the terms under which all other doctors will operate. To have one doctor or a small group of doctors play that role, and to have all other doctors told in no uncertain terms that they are to act according to instructions and not to stake claims to "turf," could eliminate the lingering visions of autonomy that allow each individual doctor to feel disgruntled and insulted over an unnecessary consultation.

Such a day has not yet arrived, however, and in the meantime, doctors are left to come up with strategies through which they can stake a claim to as wide a berth of autonomy as possible. ACT doctors, for one, can use disagreements with practitioners from other services as a means to present themselves as uniquely attuned to the totality of the patient's circumstances. Trauma surgeons and emergency medicine doctors must take the entirety of the patient's body into account; unlike other doctors, they are not especially concerned with one body part in particular. When discussing a conflict with specialists at one Thursday conference, Dr. Witherspoon argued "we [the ACT team] are the comprehensive doctors in the room." Neurologists and orthopedists, he continued, will likely be unduly concerned with the functionality of the brain and bones respectively,

at the expense of the patient's overall well-being. This sentiment was most memorably demonstrated at another Thursday conference, when the ACT team discussed a 61-year-old patient who had been involved in a motorcycle accident. The patient's leg was severely injured, and he and his doctors had to decide whether to amputate the leg or try to save it. Orthopedists argued vigorously for an effort to save the leg, as did the motorcyclist himself, and their preferred course of action was ultimately followed. The patient ended up having several expensive surgeries before dying. Lamenting the outcome, Dr. Wesley observed "if [the United States] were a totally paternalistic society, we would have taken his leg off," and therefore most likely have saved his life. "If that guy had been British," Dr. Witherspoon argued, "he would have lived." His reasoning was that British doctors would have amputated the leg immediately with no hesitation, because the British National Health Service sets limits on what procedures it will support and fund. Once again carrying the banner of progressive planning, Dr. Witherspoon urged consideration of how much it costs to save mangled limbs that put patients at risk and will likely never again be any more functional than a prostheses. The case of this motorcyclist is another example of what some doctors, particularly subscribers to progressive planning, would call a wasteful use of resources and an excessive concern for the wishes of the patient. But it is also a vivid illustration of service turf wars, and of the ACT team's belief that it is they who can see the "big picture" while specialists get bogged down in their own pet interests. In the case of the motorcyclist, the ACT team believed that the orthopedists with whom they shared responsibility for the patient's care were too invested in reconstructing, rather than amputating, the bones in the patient's leg.

"Our job is to help the whole patient," Dr. Witherspoon insisted, "and that guy needed his leg cut off."

Political Debates

The ACT team's Thursday conferences also served as showcases for a political divide between the attending surgeons and nurse practitioner Susan Kasay. When conversation around the table turns to the intersection of medicine and politics, as it frequently does, differences between the attendings' general liberalism and Kasay's strong conservatism often emerge. Kasay's conservatism is most starkly opposed to the progressive planning of Dr. Witherspoon. One Thursday, for instance, Dr. Reyes raised the rhetorical question of what social and political circumstances would best allow a doctor to tell a patient that they will not be undertaking some sort of procedure that the patient believes might benefit them. Dr. Witherspoon responded by declaring that, in order for doctors to have such decisions be accepted, someone would have to "kill Sarah Palin."[27] He is referencing Palin's role in publicizing specious allegations that the Patient Protection and Affordable Care Act ("Obamacare") would allow government officials to dictate which patients would receive treatment and which would be "left to die."

Kasay, for her part, forcefully rejects the sort of structural explanations for patient problems that progressive planning stresses. When encountering a patient who has injured himself or herself through conduct that some might call reckless, Kasay views the

[27] Dr. Witherspoon loathes Palin, whose promotion of the "death panel" myth represents just the sort of agenda that progressive planning resists – the promotion of the idea that hard choices and serious conversations regarding what can and should be done for patients nearing the end of life are not necessary, and that any attempts to suggest that they are necessary are smokescreens behind which government bureaucrats will begin planning the systematic euthanasia of those they deem unworthy of life.

situations with an emphasis on individual responsibility and irresponsibility of the patients. At one Thursday conference, while out of earshot of the attendings, Kasay fumed about a patient who had injured himself while riding his bicycle on a busy highway and who turned out not to have health insurance. "If you're gonna engage in risky behavior like riding your bike on 150, get some fucking Obamacare," she said exasperatedly. She then added "I'm just so angry all the time. Patients make me mad. People are so stupid, and then they yell at you."

The vociferous sincerity of Kasay's outburst is indicative of a larger difference between the interactional styles of attendings and those of lower-ranking practitioners, including residents and, especially, nurse practitioners. When jousting with one another and reflecting upon stressful cases, attendings are likely to adopt a disposition of wry bemusement and defiant mockery (while maintaining an underlying foundation of mutual respect). When, for instance, Dr. Wesley, was recounting his experience saving the life of a man with a swastika tattoo, Dr. Minter suggested to that he should have whispered into the man's ear "a Jew is going to save your life." (Dr. Wesley is, in fact, Jewish, but he did not take exception to Dr. Minter's remark; it was in keeping with Dr. Wesley's own dark, cynical humor). They will take up a more serious disposition when they see it as necessary to do so, but even then, they are far more likely to speak in terms of forceful instruction or stern repudiation than in terms of visceral anger or outrage. Dr. Wesley told me in an interview that, in his opinion, people do not work as well among supervisors who are "yellers." "I think you want to have people as relaxed as possible, because I think people think better that way, and do things better," he said. If a person veers too close to an overt expression of visceral, passionate anger or frustration, they

will be corrected, as when Dr. Minter reminded the resident that "we don't want a lot of vitriol in this room." The implication is that to be overcome by one's frustrations or passions, to let them "boil over," is to suggest that one is incapable of controlling one's emotions and thus, perhaps, not capable of being cool under pressure during a tense moment when clearheaded reason is called for.

Kasay is also drawn into conflict with attendings through her rejection of the progressive planning logic. At one Thursday Conference, during a discussion of how resources could be conserved and expenses could be limited, Dr. Minter reported that, as far as he understood, "in the [United Kingdom] nobody over 70 gets dialysis [because the National Health Service does not provide it]." This is the sort of regulation that Dr. Witherspoon would embrace, but Kasay was horrified. "That's wrong," she said with a tone of utmost urgency and sincerity. "We shouldn't do that. We're the US, not the UK, and that's wrong." Dr. Minter responded with erudite reflection. "My professor when I took an ethics class aid that you cannot advocate for your patient and your society at the same time," he told the group. "We all know we need to limit care. We need to be rational about how we allocate health care resources, which are not infinite, but still advocate for our patients." Kasay then countered "[A] 70 cut-off is arbitrary and scary. We shouldn't do that. That's what separates us from other countries."

The attendings' preference for aggressive jocularity with and underlying layer of mutual respect is, in part, a product of their positions within the institutional infrastructure at Harborside Hospital. They sit at the top of the hierarchy and have avenues available to them in which to express grievances and advocate changes. Above all, they possess autonomy – not always as much as they might prefer to have but

certainly much more than medical students or nurse practitioners. Their jocularity reflects the swagger that comes with privilege and authority. Susan Kasay, in comparison, seethes with the frustration that comes with the obligation to carry out the drudge work that the professionals are able to spare themselves from taking part in, such as extensive interaction with patients whose conduct offends her sensibilities. The attendings engage with Kasay and others like her in terms that often seem to ignore the real differences between their social and institutional contexts. Employees, to be sure, are compelled to take greater care in managing their interactions with their bosses than the bosses must take in managing their interactions with employees. Beyond the matter of institutional hierarchy, the demographic and cultural backgrounds of the attendings differ significantly from those of many lower-ranking practitioners, and these differences can cause strain that the attendings need pay little mind to but that irk the lower-ranking practitioners.

A comparison between Drs. Minter, Wesley, and Witherspoon on one hand and Susan Kasay on the other illustrates the point. The attendings are all men, as are most attendings at Harborside Hospital; Susan Kasay is a woman. The attendings all possess a prestigious educational credential (an MD) that Susan Kasay does not possess. The attendings all hold center-left political views (though not all doctors do, of course); Susan Kasay is a staunch conservative. The attendings inhabit a cultural universe of affluent cosmopolitan liberalism, Susan Kasay does not. Such differences have the effect of breeding tensions between high and low-ranking practitioners beyond those that might be expected from any workplace with a hierarchical system of authority. Susan Kasay's resentments are due in part to having to spend extra face time with patients whose habits

infuriate her; this is a function of her lower position on the hierarchy. But she also resents differences from her high-ranking colleagues that have relatively little to do with direct work responsibilities. At one Thursday conference, for instance, Kasay got into a brief debate with the attendings regarding gun control. All of the attendings that I ever heard speak up about the subject supported gun control; Dr. Witherspoon in particular sees it as a useful and necessary tool to lessen the scourge of interpersonal violence he witnessed at his previous job in an urban center. On this Thursday, however, the attendings were not making a serious case for gun control as much as they were mocking individuals who would oppose it. "I keep it under my pillow!" brayed Dr. Wesley in a sarcastic imitation of the voice a Southern gun enthusiast. Kasay attempted to argue a case against gun control, but the attendings were more interested in poking fun at a worldview none of them subscribed to than in engaging in a debate with a person who did subscribe to that worldview. Consequently, Kasay began to seethe as the attendings continued to laugh. Her frustration at being outnumbered by doctors whose views she did not share and whose influence far outstripped hers was obvious.

Indeed, by setting the terms of what is up for debate and under what conditions it will be discussed, attendings reveal the extent to which their perspectives and privileges lead them to focus on some issues and ignore others. In some cases, such as the gun control "debate," the attendings' influence upon the tenor of the conversation comes from their shared identity as liberals. On other occasions, it is the attendings' shared identity as men that serves to exclude the pressing concerns of women in medicine from open debate.

What Conflict Bypasses

The Balance of Work and Family

Sociologists have long recognized the extent to which women who work outside the home still perform a disproportionate share of household chores and tasks related to child-rearing (Hochschild 1989; Sayer 2005). These burdens were felt acutely by women working long and demanding hours as doctors at Harborside Hospital. It was only through talking to some of these women in interview settings that the extent of their struggle was fully revealed; work-family balance was seldom brought up for discussion by those (male) attendings who exercise control over "official" conversation settings such as Grand Rounds and the Thursday Conference. For men, tensions between work and family were obscured by their ability to act in accordance with cultural scripts through which men's attention to work in the public sphere, as well as their delegation of domestic affairs to women, is justified or even celebrated (Gal 2002; Kerber 1988). Women making careers in medicine must struggle against the weight of the expectation that they will still take the leading role in managing family life.

Dr. Harriet Foster juggles long work hours as a chief resident with the responsibilities that come with being the mother of a new baby. She told me that her role as a woman and a mother had already had a significant impact upon the course of her medical career. While it was not the only motivating factor behind her choice of specialty, she told me that, in pursuing breast oncology, she had "self-selected into a field where there's not quite as demanding…where there's not very many emergencies. There's not much stuff that happens at night." Additionally, she told me that her ability

to successfully juggle the competing demands of work and family had a great deal to do with her "phenomenal husband." For instance, when I interviewed her, Dr. Foster's six-month-old baby had been kicked out of day care for the day because she had come down with a fever. "I can't just leave work," to take care of the baby, she told me, "but my husband is taking a sick day to take care of child who is not really sick but is getting kicked out of day care." She goes on to tell me that "you have to have everything…tidied up. We have really excellent child care and some after-child-care child care." We see in Dr. Foster's account the extent which she walks a tightrope in managing the stresses of balancing work and family. Everything needs to be "tidied up," and one misstep could cause severe disruption of the fragile status quo (Clawson and Gerstel 2014). We also see the extent to which the arrangement by which she makes the balance of being a doctor and a mother work for her is highly individualized. If a doctor does not have a spouse or partner who is willing and able to take a sick day from work when the baby is unexpectedly thrown out of day care, that doctor would have been tasked with trying to make alternate arrangements for their child if they did not feel as though they could leave work without facing repercussions.

I was introduced to Dr. Tina Favors during round of small talk while she and her colleagues took a momentary break from surgically removing a patient's diseased gall bladder. When I told the group that I was a sociologist writing a dissertation,[28] Dr. Favors told me that what I really needed to be writing about was "how a woman could be a surgeon." "If you figure it out, let me know," she added. When we later sat down for an interview, Dr. Favors told me that she has not had kids as of yet but that the challenge

[28] I did not initiate conversation within the operating room. I did not want to risk disrupting the progress of the surgery and only spoke up when asked to introduce myself and briefly discuss my project.

of juggling a medical career with child-rearing already weighs heavily on her mind. She had devoted a great deal of thought to the question of how she could squeeze child-bearing into a busy schedule. "I can have a total, max, of two kids during residency," she told me. "That's four weeks [of the maternity leave the Harborside Hospital provides] per kids, and no more if I don't want to be held back. And that's not including any time I need if, say, I have preeclampsia and I need to go to the hospital, or say that there's a complicated delivery or say my kid's in the NICU [Neonatal Intensive Care Unit] or something." Again, we see a woman coming up with an individualized strategy for managing work family balance that leaves no room for error.

The institutional infrastructure at Harborside Hospital is not completely devoid of accommodations for doctors as they balance work and family, but the support that was provided was often rated as inadequate. Dr. Favors told me that Harborside offers its own childcare service that is open from 6 AM from 6 PM daily. The problem if she were to have a child, however, is that 6 AM was also the time when she needed to start work, and "that doesn't count coming in to pre-round," so "allowing child care that opened at 5 AM and was open until 8 PM or something would be more reasonable."

Gender Inequality

In addition to the challenges of work-family balance, women described other examples of the unique barriers they face in attempting to find security and recognition in the medical field. Some of these barriers took the form of microaggressions and subtle indignities, as when a female resident discovered that shirts and vests made especially for the ACT unit's residents and attendings as part of an effort to build "team spirit" were

only available in men's sizes. (After she mentioned the problem on rounds one day, Dr. Wesley responded dryly "it's a man's world.") Other examples of the marginalization of women speak to much deeper structures of inequality within the institutional infrastructure of the hospital. Dr. Foster is worth quoting at length:

> There's one female faculty member[29] who I know is making ten to twenty thousand dollars less than her [male] colleague who is equally trained, and they're in the same exact position. There's another female faculty who has been here five years, and she still doesn't have an office, and there are three male faculty who have been hired since her hire, who all have office space. And it's like those subtle things that are…still not quite even. And I don't know, you know, I'm a female so of course I am biased, but I don't know that there are examples in the opposite.

Dr. Foster went on to discuss the distribution of headlights, by which she refers to headpieces containing lights that doctors use to illuminate dark areas during surgical procedures. She explained that while male residents are often given brand new headpieces, she has seen women pass headlights along from one resident to another because new ones are not provided to them. She asks:

> And it's like, "well why do [men] get a brand new one?" It's hard to, it's hard not to think that that is a gender difference when there's a couple examples in the same gender direction. So, um, it doesn't really bother me, actually. You know, I think it's to each person to, you know, argue their contract when they're signing a contract, to make sure that they are making equal pay to their colleagues, that they do have equal, you know, office space and operative time, and things like that. Um, but, I mean it's obviously a well-known problem. You don't have to read the data too deeply to see that there's like a still glass ceiling in terms of salary, but that is actually worse in medicine and worse in general surgery. Um, and the day to day I don't feel it, like, how my attendings treat me I don't think is any different. Yeah, but it does exist. It certainly still exists.

Throughout this statement, we hear Dr. Foster vacillate and struggle. She is obviously aware of gendered inequalities at Harborside Hospital, but she resists the notion that they

[29] Because Harborside Hospital is an academic medical center, many of its doctors also serve as professors.

have any direct impact upon her and suggests, in the middle of a catalogue of slights and disadvantages[30], that it is ultimately up to women themselves to negotiate adroitly in order to avoid such problems. Her position is emblematic of the broader reluctance among practitioners to think boldly and ambitiously about how the conditions under which they work might be changed. Seldom does anyone question the notion that medicine is, by nature, a field in which 70-80 hour work weeks are necessary and inevitable. Nor is serious discussion devoted to the matter of how much money nurses make in comparison to doctors.

To make note of these topics that are absent from official discourse among practitioners at Harborside Hospital is to observe the ways in which dialogues between doctors and competition between cultural logics ignore some questions even as they grapple with others. When doctors, and particularly attendings, use cultural logics to debate the future of their profession, they ask deep questions about autonomy, the worth of human life, and obligations to individuals and to society. But they pay less attention to questions of inequality and discrimination. We are left to suspect that, amid the changes that continue to roil Harborside Hospital, issues such as sexism will continue to receive less attention than the facts on the ground would suggest that they deserve.

Logic Conflict between Attendings

With all that has been said in this chapter about how dialogues and debates between practitioners take shape along lines that reflect familiar structures of hierarchy

[30] A moment later, she volunteered to share still another example of gendered inequality: The "Intern of the Year Award" is given to men far more often than it is given to women, even though women make up about 50% of the residency program.

and inequality, it remains to be considered how individuals who are in roughly equivalent hierarchical positions, such as two different attending surgeons, make use of cultural logics in waging debates between one another. If sardonic pragmatism leads one attending to view a situation in one way and progressive planning leads another to see it differently, who carries the day? How is the issue resolved?

Among the ACT team at Harborside Hospital, doctors whose footprints within the institutional infrastructure of the medical center are larger tend to be successful in advancing their visions, at least in the short run. When I speak of "footprints within the institutional infrastructure," I speak first and foremost of the fact that Drs. Minter and Wesley hold high-level administrative positions at Harborside in addition to their medical duties, while Dr. Witherspoon holds less administrative influence. Dr. Witherspoon's comparatively smaller footprint has much to do with the fact that he has not been at Harborside for as long as Minter and Wesley.

For his part, Dr. Minter told me that he makes a clear differential between his role as a doctor and his role as an administrator. When he says, as he so often does, that "we cannot simultaneously advocate for our patients and for society," he does not mean that one must choose one side for posterity and abandon the other. While he will doggedly defend individual patients against the needs and claims of society while serving as a doctor, he told me that, in his administrative capacity, he is somewhat more open to progressive planning and its emphasis on limits and restraint. "I wear a few different hats here," he explained to me. "When I'm in [my administrative] role, I am not any individual patient's physician, and my job then is to potentially limit the choices of other physicians who might advocate for their patients in a way that would be

disproportionately expensive and resource wasting, when there is limited evidence of benefit." In other words, when serving in his administrative role, Dr. Minter is more willing to adopt a progressive planning logic. What continues to differentiate him from Dr. Witherspoon is the extent to which he sees his role as a clinician and his role as an administrator as cleanly separated. For Dr. Minter, the overarching use of one logic – neoclassical professionalism – constitutes honorable and appropriate conduct in one setting (the clinic), while openness to progressive planning constitutes honorable and appropriate conduct in another setting (administration). He explicitly adopts and discards culture at various points depending upon the context in which he finds himself. For Dr. Witherspoon, in contrast, progressive planning orients action in an honorable direction across a variety of contexts. If medical resources grow more and more scarce, the totalizing approach of progressive planning will become more attractive than an alternative that is based upon a form of epistemic "split personality" that some would find untenable.

Conclusion

In the dialogue between logics, we see further illustration of their differing visions and the difficulty inherent in reconciling their agendas. We also see the influence of the institutional infrastructure upon the contours of this dialogue – what is discussed, what is overlooked, the tone of the discussion, and who is free to take part. Conversations on rounds or at the Thursday Conference provide attendings with the means through which they can press the claims of their preferred logics, but they also represent occasions in

which the other practitioners experience the limits placed upon their own ability to shape their work experiences. It is shown once again that logics cannot be considered to simply be opposing abstractions. There is much that distinguishes them, but they are also linked through a shared status as tools that senior doctors can use with greater efficacy than other practitioners.

These conversations provide a glimpse onto the facility with which doctors shift from considerations of individual patients to reflections on the broader state of their profession. In their use of culture to navigate the immediate challenges they face in the course of their day at work and the disagreements that must be resolved in the process, they invariably come to touch upon larger visions for the field and the tensions between them. A doctor who claims autonomy to prescribe medication without permission from a colleague is, in doing so, also making a larger statement regarding the optimal organization of the institutional infrastructure of the medical field. Much is therefore at stake for patients, both those immediately present at Harborside Hospital and all those who will take on the patient role at some point in their lives.

Chapter 6: How Logics Impact Patients

Regardless of what logic they might be using at a particular moment, doctors are always on a frontstage when dealing with patients. Their interactions with them hold commonalities that transcend differences between their preferred logics. This chapter begins by exploring the unique contours of the manner in which practitioners can use each logic to manage their relationships with patients. It then takes note of the larger divides between practitioners and patients that shape the character of the contemporary medical field.

Sardonic Pragmatism and Patients

With its emphasis on small victories and avoiding disaster, sardonic pragmatism breeds a sort of conservative minimalism with regards to engagement with patients. The communicative connections cherished by neoclassical professionalism are largely absent from its patterns of patient interaction. On the contrary, sardonic pragmatism has the effect of encouraging an interpretation of engagement with patients as a sort of necessary evil that must be tolerated in order to get to other aspects of the job that the practitioner finds more compelling. As Dr. Tina Favors, a resident, told me with a laugh "I like my patients unconscious." She would rather be in the operating room, not so much for any great thrill she gets out of being there but for how operating allows her to nip problems in the bud. "I don't like sitting there for fifty minutes talking to someone about a very simple problem that I could have taken care of in five minutes in the OR," she explained to me, in words that would seem foreign to an adherent to neoclassical professionalism

but that serve as a vivid example of sardonic pragmatism – get in, get out, and go on to the next task.

When viewed through the logic of sardonic pragmatism, the patient's holistic humanity – their status as an individual with a personality, a family, hopes, fears, and ideals – represents a vortex into which doctors cannot afford to be sucked. Dr. Wesley's protestation that he saw nothing he could offer to the despondent father of a man who had committed suicide because "he's not a patient!" is illustrative. Discomfort and disinterest are frequently etched onto Dr. Wesley's face when he interacts with patients and families. He cannot completely avoid this part of the job. As the attending surgeon, he is in a position of ultimate authority over most cases. Patients expect to have a least some interaction with the person who is the ultimate decision maker, and Dr. Wesley does not completely deny this to them. Conversation with patients and their families also serve instrumental uses in many cases, as doctors attempt to learn more about the facts of the patient's case, particularly the details of the incident that led him or her to be brought to the hospital.

Aside from these bare essentials, however, patient interaction has little to offer sardonic pragmatism. Interaction with patients and their families is to be suffered through to the extent that it is absolutely necessary, and then it is time to move on. One day in the SICU, after Dr. Wesley provided a patient with an update on the status of his case, the patient asked about the general status of his case in such a way as to suggest that he had not been paying attention to the explanation Dr. Wesley offered. In response, an irritated Dr. Wesley told the man "I just kind of talked about [your case]. Did you not hear any of that?"

In its approach to patient interaction, sardonic pragmatism creeps dangerously close to the line separating conduct that reflects a certain type of professional distance and conduct that is interpreted as simply rude. For a patient to call a practitioner to account for an act of rudeness is not an insignificant gesture; the doctor is, after all, in a position of power and authority. When it does happen, however, the effect can be striking. A memorable instance of this took place in the SICU when Dr. Wesley spoke with the family of a patient. Dr. Wesley was as apathetic as ever, and he spoke to the family with his hand draped in front of his mouth. The position of his hand had the effect both of illustrating his conspicuous disinterest in the interaction and muffling his words. After a bit of discussion took place under these conditions, and older male relative of the patient curtly asked Dr. Wesley "Could you take your hand away form your mouth? I can't hear you." The impact of his words was dramatic. In an instant, Dr. Wesley sprang to attention as though someone had fired a shot. In an alert tone of voice, Dr. Wesley told the older man "I'm sorry."

For a doctor to apologize to a patient for something he or she did (as opposed to a nonspecific apology offered to express sympathy for a patient's plight) is a rare occurrence, but Dr. Wesley felt compelled to offer one. In considering what would motivate him to do so, one must first consider the fact that Dr. Wesley, like most people, does not want to be seen as a rude person if he can help it. But beyond this, the incident is indicative of the varied ways in which patients and practitioners assign meaning to interaction. It is possible that the older man who asked Dr. Wesley to move his hand away from his mouth interpreted his posture as an indication of a lack of respect and attention for their loved one and his condition. If the doctor cannot be troubled to express

interest in communicating the facts of my loved one's condition to me, can I trust that he is committed to, and interested in, the overall care of my loved one? In contrast, when practitioners view these interactions through a logic of sardonic pragmatism, they sometimes see them as distractions from the very work that the relative worries will not take place. Dr. Wesley believes that he best serves patients and their families not by engaging in small talk with them but by concentrating his efforts on the essentials of their care and minimizing distractions. On occasion, the desire to get conversations over with in order to move on to what is seen as the truly important work at hand leaves practitioners inclined to tell patients and families whatever they feel they want to hear in order to end the conversation on a cordial note. In the SICU one day, Dr. Wesley, talking to a patient and his family inside the patient's room, concluded his statement by saying "I'd be pretty confident that things are gonna work out pretty good." But after leaving the patient's room and rejoining the backstage entourage of residents and nurses, he admitted "that was a string of rationalizations on my part." The tendency to put a rosy gloss on complex scenarios is not borne solely out of expediency, of course; virtually all doctors at Harborside see value in helping patients and families retain a positive and optimistic disposition. But for sardonic pragmatism in particular, it is also a means through which practitioners are freed from the bonds of interaction and permitted to move on to the next task.

While it may seem cold, and in some cases even deceitful, the sardonic pragmatism approach to patients and interactions with them has the effect of attempting to recreate one of the practices traditionally viewed as one of professionalism's great virtues – a willingness to perform the necessary duties of the work without regard or

concern for the personal circumstances of the client. The professional is expected to treat all clients similarly without regard for whether they are personally attractive or compelling or virtuous. Dr. Wesley eschewed emotional bonds and communicative connections with virtually all patients. This has the effect of preventing the establishment of personal bonds with patients an outside observer might think are deserving of them, but it also has the consequence of allowing Dr. Wesley to treat all patients with a mix of professional competence and sardonic humor. Once at a Thursday conference, for instance, Dr. Wesley discussed a patient who had been brought to the hospital after attempting to kill himself. The patient sported a swastika tattoo, and Dr. Wesley is Jewish. When another practitioner at the meeting asked how the patient was doing, Dr. Wesley matter-of-factly said "well, he's still not a good person. Other than that he's fine."

The contours of sardonic pragmatism's engagement with patients are also vividly illustrated through Dr. Wesley's reflections on sociopaths – those individuals he referred to at one Thursday conference as "the nicest patients." He explained his thinking in an interview:

> You know, I've taken care of murderers, where they've murdered one part of the family and the other person they shot is in the next bed, and, you know, basically you go back on "I don't have to like them," you know, "I just have to do what's medically necessary for them." I think we don't withhold pain meds in those people, which is good. I think basically you try to do what you have to do to get them through it. And the funny thing about some of those, some criminals are that they're incredibly nice people because they're sociopaths. So they want to ingratiate themselves with you and it's kind of funny when that happens. You know, in general you just fall back on "what is it that I absolutely need to do to get them through this" and you do it.

Given that Dr. Wesley was able to shrug off the downsides of the HealthNote EMR system ("the worst there is, except for all the others") and the cervical collar ("it's better

than the alternative"), his unique perspective on engaging with sociopaths takes on a certain logical consistency. In each case, instead of dwelling on the negative, he finds something to appreciate and moves on to the next task at hand.

Progressive Planning and Patients

As is the case with all doctors and all logics, adherents to progressive planning see themselves as, first and foremost, acting on behalf of the well-being of patients. Dr. Witherspoon and those like him face a unique challenge in trying to convince patients and their families that, when it comes to active intervention, "more" is not always or necessarily "better." The reluctance of the Hoffman family to send their loved one to palliative care at the family meeting is illustrative of the resistance that the progressive planning logic often meets from patients. Another example came when Dr. Manuel Reyes, who largely shares Dr. Witherspoon's enthusiasm for progressive planning, faced with a young patient in poor condition. The young man's family wanted a "full court press" – a basketball term adapted for use in the SICU to refer to all-out, extensive interventions in an attempt to save a patient's life and not simply ease their suffering. But while that was the family's request (according to the residents recounting their interactions with them), the patient was too sick to tolerate surgery and no other real options to attempt to save his life seemed to be available. Consequently, when a nurse reminded the rounds entourage that the patient's family wanted "everything" done for him, a resident objected: "There is no everything!" I don't want to do things that won't help," agreed Dr. Reyes. He then ran through what he saw as the likely possible outcomes for the patient. "My expectation is he's gonna get more unstable," he began. The patient could contract sepsis (a form of tissue inflammation brought on by infection)

and die suddenly; Dr. Reyes referred to this possibility as the best possible outcome because it would mean a relatively quick end to his suffering. The worst possible outcome was for the young patient to miraculously rally and survive, because for him to survive would mean for him to live the entire rest of his life as a paraplegic on a ventilator. Unfortunately for Dr. Reyes, the patient's family had not abandoned hope in an even more miraculous event, whereby their loved one somehow proved able to resume a normal life, something that Dr. Reyes viewed as a medical impossibility. He ultimately decided to call in the hospital's ethicists[31] to help explain the sad reality to the patient's family.

Neoclassical Professionalism and Patients

Rhonda, the patient who spent an extended period of time in the ICU, had many complaints about the quality of the care she received, some of which were discussed in the previous chapter. For all that she was unhappy about, however, Rhonda took the time on one occasion to express thanks to Dr. Minter for listening and responding to her complaints. The fact that Dr. Minter, somewhat uniquely, holds rounds inside patients' rooms gave her the opportunity to have a forum on which the share her views. She noticed this difference between Dr. Minter and his colleagues, and she appreciated and wished that other doctors took the same approach. "No one ever comes and talks to me

[31] Dr. Jennifer Hoover told me in an interview that the hospital's ethics board is made up largely of doctors and nurses, along with some individuals who hold doctoral degrees in non-medical fields. A visit to Harborside's website confirmed that her description of a heavy medical presence on the ethics board was accurate; there is a preponderance of medical practitioners on the board, along with only a token presence from individuals with backgrounds in areas like social work and organized religion. This would lead one to believe that the board's decisions might disproportionately come to favor the perspectives of their medical colleagues.

but you guys," she told Dr. Minter and the rounding entourage one day. "I'm sorry about that," he responded. "That's wrong."

After leaving Rhonda's room, Dr. Minter asked the residents and medical students "what's the most important thing that she said?" The answer was that her claim regarding other services not talking to her was the most important. Dr. Minter called her statement "chilling." Some members of the entourage then began to question the technical accuracy of Rhonda's claim, but Dr. Minter dismissed their quibbles, saying "we all know, there's rounding and then there's rounding." When he says this, what he means to suggest is that there is rounding, and then there is rounding informed by the logic of neoclassical professionalism. It is the latter that entails a presence in the patient's room and a non-perfunctory effort to make a meaningful connection with the patient as a means to augment both their biomedical status and their emotional well-being.

Patients and Doctors: Gulfs Beyond Logics

Doctors' engagements with patients do not always differ along the lines of the cultural logics in use by practitioners. In some cases, doctors subscribing to different logics find themselves united in their opposition to, or bemusement with, patients who reject some of the essential tenets of proper health care that the doctors hold in common. For example, while an adherent to progressive planning is, in most cases, more willing to broach the subject of the end of life than an adherent to neoclassical professionalism would be, Dr. Witherspoon and Dr. Minter both see great value in organ donation. One week at a Thursday conference, Dr. Witherspoon recalled his annoyance with pediatric neurology over a turf war. He was frustrated that the pediatric neurologist who was

consulting on the case of a young woman whom the neurologist would not declare brain dead because, in the neurologist's estimation, she had a 5% chance of recovery. Dr. Witherspoon's frustration is a clear manifestation of his embrace of progressive planning, and would have been surprising to hear from someone like Dr. Minter. But when the conversation switched to the related matter of organ donation, Dr. Minter expresses his deep regrets that the young woman, who eventually did pass away, was buried with a set of healthy organs that would have been candidates for donation. A resident who had been involved with the family eventually revealed that the patient's family had an oral tradition according to which "donation people treat bodies badly," which had started from a grandparent who was a mortician. The doctors respond to this news with resigned acceptance, but their lingering irritation and incomprehension are written across their faces. For both Drs. Minter and Witherspoon, objecting to organ donation because of a family oral tradition is completely foreign to their scientific worldview.

Managing Consent

Bound by law and hospital policy to take patient consent into account in most circumstances, doctors frequently experience it as a nettlesome limitation on their autonomy. It is something that they cannot completely ignore but must instead learn to manage, walking a fine line between taking the concept seriously and not letting it present too much of an intrusion into pursuing what they consider to be a just distribution of limited medical resources. What makes the situation all the more exasperating is the degree of ambiguity on the part of practitioners regarding exactly what they are or are not obligated by law and hospital policy to do with regard to consent. Everyone understands

in a general sense that consent is important, but putting this understanding into action brings about many gray areas.

Consider a patient in the SICU who suddenly suffers a heart attack. This particular patient has a "do not resuscitate/do not intubate" (DNR/DNI) order on his file, meaning that he is not to receive a breathing tube, CPR, or advanced cardiac life support in the event that he stops breathing or his heart stops beating. Now, in the midst of a serious cardiac event, medical practitioners must decide what they should do in order to feel confident that they have struck the appropriate balance between the patient's own wishes and their professional and ethical responsibilities. The practitioners opt to approach the patient and give him an opportunity to reflect once again upon the question of what should and should not be done to save his life. In conversation with the practitioners, the patient, whose heart attack was not so debilitating as to render him incapable of communicating but nonetheless required immediate attention, decides that he will temporary waive the "DNI" portion of his order and consent to be intubated if need be, though the "DNR" portion of the order will remain intact.

After the discussion with the patient, the two practitioners involved, Dr. Sally Rucker and Dr. David Jenkins, take stock of the situation. They note the patient's reversal of his DNI order and his affirmation of his DNR order. Dr. Jenkins indicates to Dr. Rucker that he endorses her efforts to solicit the patient's current wishes regarding the DNR order, that he believes she did what needed to be done, and that, with the patient having affirmed the order, they can now provide the limited treatment called for by a DNR order without risking an accusation of not having given the patient a chance to advocate for more extensive treatment. In speaking of the patient's affirmation of the

DNR order's continuing validity as an indication of his intention, Dr. Jenkins says to Dr. Rucker "You heard it, I heard it, Joe [a nurse practitioner] heard it." The impression is that Dr. Jenkins and Dr. Rucker dread having the patient, the patient's family, or an attorney claim, regardless of the truth of such a claim, that the patient was not given an opportunity to advocate for extensive treatment and was instead "left to die" by callous doctors.

The episode recounted above illustrates the complexity of contemporary medical practitioners' engagement with the issue of consent. On the one hand, their willingness to give the patient an opportunity to retract his DNR and DNI orders reflects a degree of acknowledgement of consent as a dynamic and ongoing process, rather than a one-time assertion to be solicited and then filed away. Yet it is impossible to escape an impression of the practitioners' engagement with consent as a somewhat grudging, defensive, and cynical process. This tension colors the practitioners' work and highlights the reluctance and frustration with which traditionally privileged and autonomous actors begin to accept the forfeiture of some of this autonomy and act in accordance with new realities.

The three logics engage with the matter of patient consent in different ways that reflect their larger perspectives. Sardonic pragmatism takes the issue of patient consent largely in stride, in keeping with its broader tendency to avoid dwelling on constraints. When, for instance, a patient wanted to sign himself out of the hospital against the advice of doctors who suggested he stay, Dr. Wesley shrugged and said "he can go when he wants to go." When a resident reported to Dr. Wesley that the relatives of another patient "don't know if they want to consent to amputation" of an injured limb, Dr. Wesley replied "that's fine. It's a free country." But progressive planning and, to a lesser extent,

neoclassical professionalism both see problems in the current emphasis on patient consent. For progressive planning, strict attention to consent presents an opportunity for interference with the exercise of the elite judgment it seeks to empower. It creates a situation such as the one practitioners faced with the Hoffman family, when they initially refused to discontinue futile and expensive cancer treatments for their loved one. For neoclassical professionalism, consent can threaten to obscure the emphasis on the capability of the autonomous doctor to help guide patients toward optimal outcomes, but efforts by practitioners to respect consent and ask patients for their input are also important components of the larger project of building communicative connections.

Conclusion

Each logic in use at Harborside Hospital has consequences for patient engagement, and these consequences reflect the differing ways in which the logics empower doctors to cope with autonomy's decline. For sardonic pragmatism, standoffishness represents negative autonomy in action; they allow doctors to avoid the entanglements in patients' social identities and personal lives that would represent another in the series of distractions that the logic seeks to minimize. For progressive planning, patients are the clients who stand to benefit from the exercise of informed judgment by elites, and would therefore be well-served not to stand in the way of that process. For neoclassical professionalism, much of the joy in the work comes from engagements with patients, as long as the patient is willing to offer trust, respect, civility, and, eventually, obedience to the doctor.

In considering the impact of these logics upon patients, we must reflect upon both the affairs of individual practitioners and the field as a whole. For doctors at Harborside Hospital, the use of logics to guide engagement (or disengagement) with patients represents one aspect of their efforts to carve out satisfaction at work and take stock of what is, and is not, negotiable – for progressive planning, for instance, pressing a patient to consider amputation of a limb if, in a doctor's expert judgment, such an amputation is called for, is an example of best practices in action, and a means through which a doctor can feel confident that he or she has stood up for the highest ideals of the profession. For sardonic pragmatism, in contrast, going along with the patient's request ("it's a free country") is the best approach toward avoiding stressful battles and conserving one's energies for the purposes of pressing on. In both cases, patients loom large. But in addition to these personal concerns, the logics carry the promise of differing approaches to patient care that can have consequences for the field as a whole.

Conclusion: Matters of Life and Death

Reports of autonomy's death have been slightly exaggerated. Doctors, and particularly attendings, speak quite favorably of the extent to which they can set the terms of their own work. The phenomena that frustrate some of them – electronic medical records, Time Effort Reports, turf wars – frustrate them not so much because they violate autonomy in an abstract sense, or even because the ideas that motivate the proposals were bad. Instead, doctors speak of these constraints as undertakings that were understandable or perhaps even necessary but simply were not implanted or conceived of properly. Dr. Witherspoon, for instance, doesn't object in principle to the idea that Medicare and Medicaid might want to have some indication of how doctors are spending their time. What he objects to is the fact that the Time Effort Report, as it is designed, does not allow for this information to be provided in an accurate fashion.

Indeed, doctors' engagements with the concept of autonomy belie the notion of autonomy as the sacred prize that will be defended against all comers. Its challengers were not seen in all quarters or under all circumstances as illegitimate usurpers. Certainly, for instance, some attorneys who assist clients in bringing malpractice suits were simply looking to make a buck, and doctors talked frequently of the severe existential threat that a "bad lawsuit" might pose to the entire Acute Care and Trauma team. But under different circumstances, other attorneys would be viewed as purveyors of uncomfortable but necessary truths. Similarly, Obamacare, for many practitioners, is not an infuriating government intrusion of the sort suggested by rants about "socialized medicine" but rather an overdue if imperfect attempt to broaden access to health care for

as long as their ideal of a single-payer system remains politically unattainable – and the fact that such a system *is* the ideal for some doctors is notable in itself, in light of its contrast to depictions of doctors resisting "government overreach" in the past (Starr 1982).

More important, what are doctors doing with these different logics? How do the logics help them adapt to a new reality of constrained autonomy? Each logic ultimately allows a doctor to emphasize a particular manifestation of autonomy. Sardonic pragmatism encourages doctors to appreciate the autonomy they have left (at least if they are at or near the top of the organizational hierarchy). What they have left is negative autonomy - the right to avoid entanglement in "ambitious medicine" and the stress that comes with it, and the right to emotionally disengage from the less compelling aspects of the work. In contrast, progressive planning directs doctors toward the pursuit of a form of autonomy most of them do not currently exercise in any great amount – hierarchical autonomy, whereby wise and farsighted doctors are empowered to take the reins of the profession. Lastly, neoclassical professionalism directs doctors toward the defense of interpersonal autonomy – the ability to forge the personal connections between patient and doctor that are the foundation of the best forms of medical practice.

What is seen is that sardonic pragmatism is a means through which doctors reconcile themselves to a constrained new reality, accepting its constraints and choosing not to "tilt at windmills" against them. Progressive planning and neoclassical professionalism, in contrast, both allow doctors to see virtue and accomplishment in principled resistance to the contemporary medical model. They channel this resistance differently. Progressive planning objects to some of the residue of the so-called "Golden

Age," including inattention to expenses and the excessive glorification of life facilitated solely by medical intervention. Neoclassical professionalism channels its resistance toward the constraints upon individual autonomy that have arisen in the past several decades, such as algorithmic medicine and the electronic medical record. In the last analysis, when faced with a changing profession, these logics represent means through which a doctor can respond, albeit in different ways.

What Can Doctors Teach Us About Culture and Autonomy?

Studying the ACT team at Harborside Hospital illustrates the ways in which individuals can use culture to adapt to changes in the institutional infrastructure in which they work and live. In the face of increasing constraint and a stressful environment, culture offers some doctors the security and release that come with emotional withdrawal. For others, it offers a means through which they can identify, and defend, more specific visions of the good. We see at Harborside the ability and willingness of doctors to rely upon culture in the face of unsettled times, when, as Swidler (1986) predicts, culture can take a more pronounced role in shaping action. To say that the medical field is unsettled would undoubtedly be true, and with change underway and old assumptions open to question, doctors use culture to defend their own prerogatives and guide their decisions, while also seeking to influence the eventual outcome of the debates.

At the heart of this dissertation's contentions regarding culture is the idea that, pace Vaisey (2008; 2009) and those who would argue that culture takes a backseat to practical consciousness, culture can indeed serve as a compelling and meaningful force behind individuals' actions and visions of the good. As it is used in this capacity, culture

ultimately comes to represent an intriguing cocktail of diverse artifacts – the legacies of history, the lived experiences of those using it, and the informal prerogatives of rank and privilege, to name just a few. Culture is influenced by structure even as it represents a means for escaping or attempting to modify that structure. We see at Harborside Hospital the entanglement of culture and structure that Hays (1994) describes, as well as the interplay of schema and resources that is documented by Sewell (1992). By acknowledging this, we come to gain a more nuanced understanding of professionals' responses to structural changes in their work conditions. What we see is not "cultural lag" in which professionals stubbornly cling to older ideals of autonomy and simply resist or gnash their teeth at the changes that erode it. The structural changes, after all, are not themselves divorced from culture. Rather, they are, in part, manifestations of historical aspects of the medicine's engagement with culture. A proposal to give patients the right to evaluate the performance of their doctors would likely not have been implemented were it simply a bureaucratic edict. What gives the structural changes to the medical profession much of their force is their ability to articulate longstanding logics that have, at various times, been in use in debates over medicine specifically and in American culture more broadly. In the case of the patient evaluations, for instance, the cultural legacy of anti-elitism and belief in the wisdom of the common person plays a fundamental role in giving such proposals legitimacy.

The principle lesson of this research for the sociological study of autonomy lies in its efforts to complicate this deceptively simple concept by turning attention to professionals' willingness to be pragmatic and flexible as well as honorable and committed – to sacrifice autonomy in one realm in order to defend it in another. To

appreciate the role that autonomy plays in professional work today, it is not enough to simply understand it as the ability to set the terms of one's work, or even to make basic distinctions between the autonomy of the individual and that of the profession as a whole. Instead, we should be cognizant of the fact that, for contemporary professionals, autonomy is not valuable as an abstract good as much as an instrument through which a particular vision of the good can be pursued. It has been shown that doctors are willing to accept limitations upon their autonomy (and, less magnanimously, if perhaps more predictably, to impose limitations on the autonomy of their colleagues) if they can be convinced that, in doing so, they are furthering a vision of the good to which they subscribe. It is therefore suggested that doctors do not necessarily play the role of the venal, malevolent hoarders of power described by Illich ([1976] 2013), nor are they proletarianized automatons (McKinlay and Arches 1985). They are participants in a broader conversation regarding autonomy that has increasingly seen doctors at Harborside and beyond (Gawande 2014; Rosoff 2014) take the role of partners – ready and willing to advocate for their own self-interest and defend what for them is non-negotiable, but open to giving competing claims and new suggestions a hearing. This openness is not, to be sure, simply a reflection of their fundamentally generous and considerate personalities; in large part it is the result of strenuous effort on the part of marginalized voices to gain a presence in conversations regarding professional work (Epstein 1995; Haug and Sussman 1969). Nor is this openness to competing claims extended to all such claims; the influence of capitalism and the profit motive upon medicine is shown in this research to remain the subject of suspicion. But in other aspects – the protection of patient welfare, the acknowledgement of inequality, the

conservation of scarce resources – professionals countenance views that transcend a broad and totalizing defense of autonomy.

Lastly, this research demonstrates that culture and autonomy are closely related to one another as objects of sociological study, particularly in the case of the professions. Gorman and Sandefur (2011) list both autonomy and normative orientations as key themes of professions research and avenues for future exploration. This research confirms that, in the landscape of contemporary professional work, they cannot be considered independently of each other. An appeal to a shared vision of the good is a means through which doctors can reconcile themselves to limitations upon autonomy, and these visions, in turn, have consequences for how autonomy is to be distributed and defended.

Future Directions for Research

It would be worthwhile for sociologists of the professions to explore the extent to which other professionals engage with limitations upon autonomy in a manner similar to those of the doctors at Harborside Hospital. Is autonomy valued as an abstract good by other professionals, or is a more flexible approach taken, whereby threats to autonomy are considered, and perhaps even adopted, in light of their impact upon a professional's vision of the good? Would professionals who have not seen their autonomy constrained to the degree doctors have experienced take a more purist approach in defense of autonomy?

The particular manifestations of autonomy outlined in this dissertation – negative, hierarchical, and communicative – also warrant further exploration. Negative autonomy

represents a theoretical tool with which the lessons of this research on privileged professionals could be applied to workers who enjoy much less in the way of income and prestige. Could, for instance, a service worker utilize negative autonomy in the process of coping with a work environment that is, by turn, monotonous and stressful? Is the successful use of such a logic available to a manager in such a work environment, who can delegate responsibilities to employees, but not to an entry-level worker? The potential for intersections between negative autonomy and research on emotional labor is also compelling. Interpersonal autonomy and its associated argument for the beneficence of face-to-face interaction is worthy of continued attention in light of the progression of technological representations of humans and their relationships. Under what circumstances can a device mediate the relationship of professional and client (or parent and child, or friend and friend, or supervisor and subordinate) without draining it of meaning? The answers to such questions likely lie less with the particulars of the devices themselves and more with the social circumstances of the relationships they are mediating (Ticona 2016).

I also suggest that it would be worth considering the insights to be gained from analysis of logic contestation in other professional and organizational environments. Kunda ([1992] 2006) sets a template in this regard with his comparison of the sources of authority at work in shaping the culture of the organization he studies. Managerial authority comes in the form of "the documented views of senior managers"; expert authority "appears in papers, reports, and memos attributed to internal experts"; and objective authority is derived from "the selective representation of materials produced by outside observers" (53). Each has an impact upon the larger organizational culture and

helps to make it dynamic. For Kunda, these sources of authority have varied foundations that are clearly differentiated. But what is to be found when individuals or groups of equal rank, such as two attending surgeons, find authority and direction in different places? Through what processes do ostensible equals resolve these differences?

The Broader Impact of Logics

While sardonic pragmatism finds satisfaction in small victories and generally opts out of grand debates over the fate of the medical field, both progressive planning and neoclassical professionalism prescribe ambitious visions for the profession. Eighteen months at Harborside Hospital left me with the impression that while both of these latter logics are fluid and dynamic, in the final analysis, it is fair to say, with only a modest degree of simplification and exaggeration, that neoclassical professionalism defines what the medical field has represented in the recent past, while progressive planning represents the direction in which the profession is heading.

A reflection upon two books published in the past decade reinforces this conclusion and illustrates the notion of progressive planning and neoclassical professionalism as two ships passing in the night, heading in opposite directions, the former toward growth and the latter toward decline. The first book, Wellesley College sociologist Jonathan Imber's (2008) *Trusting Doctors: The Decline of Moral Authority in American Medicine*, reads like an elegy for the neoclassical professionalism that it sees fading from the scene. Among Imber's chief claims is argument that "doctors, who were once publicly perceived in this country as healers engaged in a sacred vocation, began to lose their moral authority as they increasingly became more valued for their technical

competence than for their noble character" (xviii). In Imber's view, this shift has left the medical profession, patients, and society as a whole more spiritually impoverished. He recoils at the antiseptic rationality of concepts like "public health," which, in his view, drain meaning and sanctity from fundamental moral questions of life and death. Imber writes that "The success of modern public health owes much to the logic of utilitarianism, where the simple formulation of the greatest good for the greatest number provided an impetus for collective improvements that helped to secure close ties between the modern state and public health authorities, leaving to patients and their physicians the control of those health problems seemingly unaffected by these policies" (147). For Imber, the decline of the trust between doctors and patients is a profound loss. The erosion of the "clear demarcation in the public mind" that once existed between "death and its gatekeepers" (170), and the concomitant rise of palliative care and efforts by doctors to coax patients in making use of it is, for Imber, a sorrowful manifestation of "the private abandonment of hope for and beyond this life" (193).

While Imber makes his case in the lyrical terms of a poignant lament, Philip Rosoff, a pediatrician and bioethicist at Duke University, takes an aggressive and prosecutorial tone in his *Rationing is Not a Four-Letter Word* (2014). Public discomfort with any approach to the distribution of medical resources that can be slapped with the "rationing" label is one of the foremost obstacles facing the efforts of Dr. Witherspoon and those like him. As they try to make the case for progressive planning as the appropriate organizing principal for the just and effective provision of medical care, Dr. Witherspoon must find a way to speak to doctors, policy stakeholders, and the public at a large that will overcome the visceral discomfort many still feel toward rationing.

Rosoff has plenty of ideas for how this case can be made, but his first order of business is to strip away the last remnants of what he sees as an illusion: the idea that medicine is or has been a sacred trust between doctor and patient of the sort Imber looks back at nostalgically. Beyond the illusion of the devoted doctor doing everything in his or her power to serve the patient and stave off the "abandonment of hope" lies a less wistful reality. "Many people think we don't ration now," Rosoff writes. "Nothing could be further from the truth. Currently, we ration mostly by happenstance, not by design" (15). While it is not commonly referred to as "rationing," Rosoff believes that the deep connection in the United States between income and health care – "platinum packages" for the rich; free clinics (if that) for the poor – amounts to a form of rationing in which one group of people (the poor) is systematically encouraged to pass away quickly and quietly so that more of the resources that they might have used up can instead be allotted to the group that the rationing system has designated as being deserving of them (the rich). "One can label this 'system' by any name one wants," Rosoff writes, "but make no mistake: it is a form of de facto rationing in which what kind and how much healthcare one can get are determined by how much money one has" (16). Rosoff's perspective brings back to mind Dr. Witherspoon's lamentation of the contemporary medical model's inability to truly do right by those young victims of interpersonal urban violence, for whom individual medical interventions are hopelessly insufficient as means to address the systematic and structural nature of their oppression. For Rosoff, to speak of medicine as a sacred domain in which doctors are devoted to their patients in such a way as to make any rationing system "unfair" is to ignore the questionable "fairness" of a society in which only some of us even get to step into that sacred domain. When Dr. Minter or

Jonathan Imber question whether an individual should be encouraged to die so that others might make use of scarce resources to live, Rosoff asks if the health care system we have today, to which rationing would supposedly represent an intolerably disruptive and profound transformation, does not amount to a system of rationing already. Are Aetna and Blue Cross Blue Shield – those entities that have taken up the leadership of the health care system in the absence of greater government involvement –not essentially implementing rationing today, ordering some (the uninsured) to die so that others (their clients) can make use of scarce resources? To state Rosoff's argument in these terms is to be somewhat more polemical than he is, but it does not distort his essential message. He concludes with the optimistic assertion that an overt rationing system that is fair and transparent – contested terms, to be sure – could overcome visceral distaste toward rationing and win public acceptance.

In reading Imber as a requiem for a fading past and Rosoff as a plan of action for the future, I am, in part, simply responding to the terms in which the authors have framed their own arguments. But why should Rosoff be confident in his plans? Why should Dr. Witherspoon continue to press his vision even after getting knocked down by Minter and Wesley when he first arrived at Harborside Hospital? Why should I see progressive planning as the wave of the future?

I suggest that progressive planning's power lies in its ability to make use of two compelling languages within American cultural life – justice and efficiency. Rosoff and Dr. Witherspoon can speak in compelling terms of what they see as the injustice inherent in giving extensive, even excessive health care to some while others go without it. To those who are not moved by such appeals, they can adopt the language of scarcity and

austerity to stress the need to cut back on health care expenditures. They can, in other words, harness the intellectual and moral power represented in the "hospice ethic" that Livne (2014) describes. A cultural movement that is able to take up the trappings both of compassion and thrift is a compelling force. Progressive planning also stands as the beneficiary of efforts by prominent philosophers such as Singer (1994) to challenge and complicate notions of the "sanctity of human life" in such a way as to provide intellectual legitimation for a shift away from reflexive abhorrence of rationing, palliative care, and other manifestations of a reluctance to "do everything" when "everything" will be of questionable efficacy.

My conclusion is only reinforced further by my observation that, as I said previously, the institutional infrastructure of contemporary health care is already set up as to allow for the implementation of a progressive planning agenda if those who subscribe to it are able to grab hold of the controls. Neoclassical professionalism's celebration of the autonomous individual doctor speaks largely to a cultural impression of the solo practitioner hanging up his or her shingle. While patients still want their doctor to fight for them, the extent to which it is even possible for a patient to speak meaningfully of "their doctor" is fading. Patients being treated at Harborside Hospital have no choice but to encounter multiple doctors (along, of course, with nurses, physician's assistants, and others) over the course of their care. To practice medicine in a large institutional environment – at a large hospital such as Harborside, as part of a health care conglomerate, perhaps even a large hospital under the purview of a conglomerate – is to work in an environment in which the institutional infrastructure makes the defense of individual autonomy by each doctor an increasingly untenable proposition.

But it would be a mistake to place utter and absolute confidence in progressive planning as the wave of the future in light of the extent to which it engages directly with the nettlesome question of life and death. In its willingness to ask questions regarding when life is likely to be experienced as worth living, progressive planning runs the constant risk of brushing up against the legacy of eugenics movement of the original Progressive Era. To say that Dr. Witherspoon and those who think like him are "neo-eugenicists" would obviously be an exaggeration and an insult, but it is difficult to overlook the fact that then, as now, widely-respected people raised questions related to the worth of life. A century ago, some of them provided – and acted upon – answers that we now rightly view as horrid. To tar progressive planning with the legacy of forced sterilization would be mistaken, but it would also be irresponsible to ignore the potential for reflection upon the worth of life to take treacherous turns and to become entangled with inequalities of power and voice.

Therein lies the great risk, perhaps, of trying to reexamine our understanding of life beyond the simple argument that "alive is better than dead" and "it's good to keep people alive." As Pernick ([1997] 2005) writes, there are "cultural value judgments that are inevitably part of defining any human difference as a disease or a disability" (30). These cultural value judgments are complex and contentious. In engaging with such issues, we oblige ourselves to take the wishes and perspectives of others into account and to consider the complex cultural foundations of the visions of the good that motivate our perspectives. This is the process I witnessed the doctors at Harborside Hospital engage in each day. The contemporary medical field ultimately transcends the realms of science and bureaucracy and grapples with larger questions of our duties to ourselves and to one

another. In reconciling themselves to the decline of autonomy, doctors simultaneously seek to find a place for themselves and their profession in this vast and shifting landscape of meaning and obligation.

Appendix A: Methodology

Data for this project were gathered through eighteen months of ethnographic observation at Harborside Hospital, a large academic medical center in the South Atlantic region of the United States. My observations took place in a variety of settings, though the three in which I spent the most time were the Surgical Intensive Care Unit (SICU), the auditorium where the "Monday Meetings" took place, and the conference room where the Thursday Conference took place. More infrequently, my observations would take me to the operating room to observe operations or to the emergency room to see patients be brought in for the first time. I ultimately tallied approximately 2,000 hours of observations, of which approximately 50% were spent on rounds at the SICU, 20% were spent at the Thursday Conferences, 10% were spent at the Monday Meetings, and 20% were spent in other settings (such as the operating room and the emergency room).

I chose to conduct my observations with the Acute Care and Trauma team at Harborside Hospital in light of the degree to which social forces play a larger role in trauma than in most other fields of medicine. By "social forces," I refer chiefly to the greater incidence of traumatic injury among disadvantaged populations (Demetriades et al. 1998; Mackersie 2014). An exploration of autonomy among trauma doctors would therefore potentially pit the traditional medical emphasis upon practitioner autonomy (Freidson 1970) against the structural nature of the inequalities underlying traumatic injury, which lie beyond the reach of any individual doctor to resolve on his or her own, no matter how autonomous. Additionally, the impression of surgeons as being arrogant swashbucklers (Hill et al. 2014) would suggest that, to the extent that the impression is

accurate, surgeons represent a group of practitioners for whom the decline of autonomy would be felt acutely.

I gained access to the ACT team at Harborside Hospital by approaching Dr. Minter, with whom I had become acquainted in the course of my work at an academic survey center he had contracted to perform statistical analysis on some research he was involved with. Dr. Minter proved to be a gatekeeper of sorts, and his approval of my presence at settings such as the SICU and the Thursday Conference was seen by most other practitioners as reason enough to allow me to be present without objection. It should be noted that, in light of Dr. Minter's position at the top of the institutional hierarchy, few other practitioners were in a position to have their views and claims given as much weight as his. In winning the trust of a powerful gatekeeper, I allowed myself to render objections on the part of residents and medical students impotent. This process is not without ethical complications; I was aligning myself with, and benefiting from, structures of unequal power and influence. It was therefore my obligation to retain a critical eye, even toward the gatekeeper who had been so generous to me.

In conducting my observations, I strove to be as unobtrusive as possible. I would stand or sit quietly while taking notes on a tablet device, not speaking unless spoken to. My observations in the SICU would bring me in proximity with the patients being treated there. I did not speak to patients under any circumstances.

In addition to ethnographic observation, I conducted thirteen one-on-one in-person interviews. Eleven of these interviews were conducted with individuals with connections to the Acute Care and Trauma service at Harborside Hospital: Three attending surgeons (Wesley, Witherspoon, and Minter), one administrative assistant, and

seven residents. I conducted one additional interview with a doctor from another service at Harborside Hospital and one final interview with a doctor practicing at another institution in another state, mainly for the purposes of comparing their experiences to those of the ACT team (though I did not have nearly enough exposure to other practitioners to make such a comparison a centerpiece of my research). These interviews lasted an average of 45 minutes.

I chose to interview each of the three attending surgeons that figure most prominently in the narrative (Drs. Wesley, Witherspoon, and Minter) in order to gain as complete an insight into their perspectives as possible. Other interviews arose largely from word of mouth, as I explained to most practitioners I encountered that I would be eager to talk to them in an interview setting if they could spare the time. These efforts ultimately yielded few interviews, for a variety of reasons; the doctors I observed worked long hours, I had nothing tangible to offer them as an incentive to sit down for an interview, and I did not make a more systematic effort at recruiting interview subjects because I knew that ethnography would be the centerpiece of my data. A copy of the interview schedule is provided in Appendix B.

In analyzing data, I took an approach rooted in grounded theory (Glaser and Strauss 1967), allowing themes to emerge rather than attempt to confirm or deny preconceived hypotheses. I knew that issues of autonomy were of interest, but I did not begin the project with a prior outline of the logics. They emerged organically through coding of notes on encounters and interactions in which doctors reflected upon the limitations of their autonomy and the directions in which they would like to see the medical field head..

Ethnographic observations generally proceeded smoothly for me, but the few occasions in which it did not underscore the ethical tensions at work for sociologists conducting ethnographic research in healthcare settings. I did not get permission from patients to observe their interactions with doctors, and doctors seldom identified me to patients as a sociologist conducting research. The doctors usually did not acknowledge my presence around patients at all. This approach was facilitated by the fact that I usually encountered patients only as part of large group of people, such as on rounds; had I been alone with a doctor and a patient, my presence would have been far more conspicuous and would likely have required some sort of explanation. I obtained permission to observe doctors' interactions with patients (without gaining explicit patient consent) from the Institutional Review Board (IRB) governing this project, with the stipulation that I was not to record information that could be used to identify patients, such as their names or dates of birth.

While I had obtained appropriate permission from practitioners and the IRB, the fact that I was observing patients' interactions with doctors without their permission, and as a person who could not justify my presence by contributing to their care, was a source of ethical conflict for me. This issue came to the forefront on one occasion at the SICU early in my observations. At that point, I was taking field notes on a small notepad. I usually tried to be inconspicuous with my note taking, but sometimes I would take notes immediately in order to get an accurate account of particularly evocative event. While doing so one day, I drew the attention of a man who was already agitated about his loved one's condition. The man angrily demanded to know if I was a newspaper reporter. With help from the practitioners, I was able to defuse the confrontation by explaining my

identity and then withdrawing from the situation, but the event led me to perform an act of what Hammersley and Atkinson ([1983] 2007) call "impression management" (66): specifically, I discontinued the use of a paper notepad to record data in favor of an electronic tablet, which allowed me to look somewhat similar to the pharmacists who also used tablets around the SICU. In doing so, I lessened the likelihood of unintentionally leading a patient or a family member to conclude that I was a reporter, but I reinforced my effort to blend in with the practitioners and, in a sense, deceive patients.

Despite my ethical misgivings, in the last analysis, I see my research efforts as acceptable and, indeed, the only reasonable way in which legitimate data on doctors' work – much of which occurs in the presence of patients – can be gathered. A long line of prior ethnographers (e.g., Becker et al. 1961; Bosk 1979; Cassell 1998) have come to the same conclusion. If one is to study professionals, an observation of their interactions with clients represents a component of the job that cannot be ignored, and one for which the seeking of consent on a client-by-client basis simply is not practical, at least not for doctors dealing with a high volume of patients, as was the case for the ACT team at Harborside.

Scholars such as Vaisey (2009) would have us believe that listening to doctors' accounts of themselves in interviews, and their engagements with colleagues to whom they owe respect, are limited in their ability to offer meaningful insight into their true feelings. In response, I argue that by using ethnographic observation in tandem with interviews, we obtain a rich body of data that encompasses both what Pugh (2013) calls the honorable and the schematic. We are able to assess the extent to which they correspond to one another – how often and how well, for instance, are doctors able to use

their engagement with the realities of their work, as witnessed in ethnographic observation, with their visions of the good, as articulated in an interview? My research led me to conclude that, when ideals and actions do not correspond neatly, what is witnessed is not simply "hypocrisy" but rather the struggle of human beings to reconcile themselves to an imperfect world.

Appendix B: Interview Schedule

- What motivated you to pursue a career in medicine? Was there a moment you remember when you decided to follow that path?

- Can you give me a brief description of your position at the medical center at this time?

- How many hours would you say that you work in a typical week?

- Do you ever feel as though it's difficult to balance the demands of work with your activities outside of work?

    - If so, how do you manage it?

- What would you say is your favorite part of the work that you do? What makes for a really great day at work? Can you give me an example?

- How much autonomy would you say that you have at work?
    - (If respondent is unsure what I'm getting at by "autonomy") By autonomy I mean the ability to make your own decisions and see to it that they are carried out.
    - Follow ups:
        - What sorts of things give you autonomy?
        - What sorts of things detract from your autonomy?
        - Do you think that the degree of autonomy you possess has changed since you started working here?

- Is there a part of your work that you find especially frustrating or unappealing? Was there a day when this was crystallized for you, or a moment that really serves as an example of that?
    - (Probe, if necessary:) What is it about [work the respondent doesn't like] that makes it so unappealing?
    - From your perspective, is there a way that [work the respondent doesn't like] could be made more tolerable?

- Do you find yourself having to adapt or change the way you do your job depending on which other practitioners you're working with on a given day?

- Have you ever been in a situation where a patient or another doctor wanted you to do something that you didn't think was a good thing to do?
    - (If yes) Can you tell me about that situation? How did you handle it?

- Imagine that you're at work and you're unsure about exactly what you should do in a given situation. Where, or to whom, would you turn for guidance or suggestions in a situation like that?

- Have you ever encountered patients or family members who were unhappy about the direction you wanted to take the patient's treatment?
    - (If so:) How did you handle that situation?

- Do you ever notice differences in how patients are treated that are rooted in anything other than the particulars of their medical situations? Have you noticed different patients with similar medical problems receive different types of treatment? Can you give me an example of a situation like that?
    - (Possible probe:) For instance, what about patients who have insurance versus those who don't?
    - (If respondent says that there are no differences:) What do you think prevents differences in how patients are treated from arising?
    - (If respondent says that differences exist:) Do you think that this is a problem that ought to be fixed? Why/why not?
        - (If so:) Do you think that there is a way that it could be fixed? What would have to happen?

- Could you briefly walk me through a typical day for you in your current position?

- You mentioned that you're a member of the [trauma/emergency medicine/neurology/etc.] service. How often do you find yourself interacting with practitioners from other services in the course of your work?
    - (If respondent indicates that he/she works with other services frequently:) How well do you think that your service and other services work together? Can you walk me through a recent encounter that was particularly smooth?
        - (Possible probe:) Are there ever miscommunications or "dropped balls"? Can you give me an example?
    - (If respondent indicates that miscommunications occur:) Do you think that anything could be done to address some of the miscommunications or help the services work together more smoothly?

- (May need to tweak this phrasing if respondent's earlier comments hint at the answer:) How often do you interact with patients during the course of your work?
    - (If respondent indicates that he/she has at least some interaction with patients:) What form does this interaction usually take?
        - (Possible probe:) Are you often having conversations with patients, or operating on them, for instance?
    - Would you say that you enjoy interacting with patients? What's an example of a really good interaction that you particularly enjoyed.
    - What about an example of an interaction that was unpleasant?

- Would you say that, on balance, the positive interactions outnumber the negative ones, or vice versa?
- How often would you say that you really get to know your patients in the course of your interactions with them?
  - (Adjust phrasing depending upon response:) What do you think determines how well you get to know a patient?

- How about patients' families? Do you interact with them very often?
  - (If respondent interacts with families:) Can you give me an example of a memorable interaction you had with a patient's family member?

- Have you ever interacted with a patient or a family member who was extremely angry or emotional?
  - (If so:) How did you handle that situation?

- If you think about the larger medical field, how good of a job would you say that it is doing in contributing to the common good?
  - Follow-ups
    - In what sorts of ways does it contribute to the common good?
    - In what sorts of ways does it detract from the common good?
    - Are there changes that could be made to help medicine do more to contribute to the common good?

- Knowing what you know now, if you had it do all over again, would you still pursue a career in medicine? Why/why not?

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