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American Medicine's Golden Age: What Happened to It?

John C. Burnham

Summary. In the first half of the 20th century, American physicians enjoyed relative freedom from adverse comment in mass and highbrow media. In unexpected ways the physicians' high ideals and the campaigns against socialized medicine brought criticism not only of the priestly but also of the technical functions of the medical profession. In the late 1950's this led to a campaign to modify the elevated position of physicians in American society.

During the first half of the 20th century, up until the late 1950's, American physicians enjoyed social esteem and prestige along with an admiration for their work that was unprecedented in any age. Medicine was the model profession, and public opinion polls from the 1930's to the 1950's consistently confirmed that physicians were among the most highly admired individuals, comparable to or better than Supreme Court justices (*1*). Highbrow and mass media commentators alike associated medical practice with the "miracles" of science and made few adverse comments on the profession (*2*). By the 1970's, however, statesmen of medicine were writing unhappily about being "deprofessionalized" in the wake of attacks by articulate and knowledgeable critics, attacks that by 1981 were reflected specifically in substantial mistrust of the profession among the public at large (*3, 4*). One can conduct a historical postmortem of this unexpected turn of events by examining changes in direct public depreciations of the medical profession, using the different kinds and levels of criticism of M.D.'s as indicators of what happened.

The attitudes of leaders and shapers of opinion and of the public toward physicians did not translate directly into the behavior of patients. For economic and social reasons, amounts of money spent by Americans on medicine continued to increase dramatically even when attitudes changed. But, as was revealed both by polls and by a resurgence of alternatives to conventional medical practice, over time the critics not only affected doctors' sensibilities but also demonstrably damaged the social credibility of the profession as a whole (*4, 5*). Since public acceptance is necessary for a profession to function, the criticism had tangible effects.

A long and honorable tradition of denigrating doctors was known to Aristophanes and Molière and continued to flourish in 19th-century America (*6*). As late as 1908 a set of satirical "Medical maxims" in this tradition included, for example (*7*):

> Diagnose for the rich neurasthenia, brainstorm, gout and appendicitis; for the poor insanity, delirium tremens, rheumatism and gall-stones . . . fatten the thin, thin the fat; stimulate the depressed, depress the stimulated; cure the sick, sicken the cured; but above all, keep them alive or you won't get your money.

But in those same early years of the 20th century, the tradition of doctor baiting tended to die out as the golden age of medicine dawned. Whereas the post-1950's resurgence of criticism that culminated in Ivan Illich's *Medical Nemesis* (*8*) recalled traditional themes such as physician greed, pretension, and imposition, the later critics were also responding to new and untraditional characteristics of both medical practice and American society (*9*). Moreover, the few particular criticisms that survived in the golden age helped shape and define the new deluge.

Evolution of the Medical Image

During the 19th century, physicians seeking to professionalize their calling were fair game for hostile comment, with quacks and sectarians on one side and the practitioners' actual therapeutic impotence on the other. Some aristocrats of medicine and the medical ideal they represented did enjoy high prestige, but most (often deservedly) did not. Occasionally, antimedical diatribes based on these earlier struggles persisted after the 1890's, along with other anachronisms like attacks on the germ theory of disease. But by and large, in the wake of medical, and particularly surgical, successes, publicity about the profession was favorable, and leaders of the American medical profession succeeded by the early 20th century in their campaign to persuade the public to want and expect uniformly well-trained, well-paid physicians who themselves set standards of practice (*10–12*).

So effective was favorable publicity about both science and doctors that Americans in general began to view extensive medical care as a life necessity. Expansion of hospital care at the beginning of the century was an important indication of the change.

After some years, publications of the Committee on the Costs of Medical Care (1928–1933) and other surveys generated

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much criticism of the medical profession—not for members' inferior technical performance or misbehavior but for their failing to make physician services of any kind available to more people through economic and organizational means (*13*). By the late 1930's the modern campaign for "socialized medicine" or compulsory health insurance had begun, and for many decades organized medical groups opposed any change in the structuring and financing of health care delivery (*14*). All parties to the controversy, however, continued to agree that medical care was highly desirable.

While many public figures attacked the American Medical Association (AMA) and state and local medical groups for their political activities, the public image of scientific medicine improved constantly (*15*). By the 1940's virtually everyone had heard of miracle drugs and many people knew that they owed their lives to them. As writer Evelyn Barkins (*16*) observed in 1952, "Most patients are as completely under the supposedly scientific yoke of modern medicine as any primitive savage is under the superstitious serfdom of the tribal witch doctor."

Ultimately, however, the socialized medicine debates undermined public confidence in medicine as a profession. The heavily financed publicity campaigns undertaken in the name of the AMA generated political statements that few people could take seriously and raised questions about the claims of members of the profession acting in scientific and clinical roles (*17, 18*). Even before World War II the evident social insensitivity of physician groups such as the AMA tended to tarnish the doctor as a public figure, and many people began to associate the physician with another familiar stereotype, the small businessman, who was presumably not only grasping but slightly dishonest (*19*). As one writer of the early 1940's observed of organized medicine, its "social outlook turns out to be . . . scarcely distinguishable from that of a plumber's union" (*20*). Indeed, the actions of physician groups caused the Supreme Court in 1943 officially to refuse to recognize doctors' professional claims and instead to find physician groups, including the AMA, guilty of restraint of "trade" (*21*).

Beginning in the 1940's, a number of reformers within the medical profession worked to expose inferior medical practice and upgrade medicine to a level appropriate for the age of penicillin and high technology. Some of the self-criticism revealed through these efforts was repeated by the general press. The combination of internal criticism and external distrust eventually had a negative effect, just as the social environment for all professions turned from favorable to unfavorable.

The End of the Golden Age

The rare public doubters of the medical profession in the late 1940's and early 1950's gradually increased in number. By 1954, Herrymon Maurer, writing in *Fortune*, could cite a series of sensational articles in mass media magazines attacking not only moneymaking but incompetence in medical practice. Maurer's article was entitled, "The M.D.'s are off their pedestal" (*22*). A few more years had to pass, however, before the number of recriminations reached the threshold that marked the end of an era.

Despite the ineptitude of the campaigns against socialized medicine, the public image of the physician per se was very favorable in the proscientific post–World War II period. This image was reflected, for example, in the activities of Dr. Kildare (a stereotype later known as Marcus Welby, M.D.) who moved from the novel and motion picture to the television screen. Physicians showed up in over half of 800 Hollywood films surveyed in 1949 and 1950. But in only 25 instances was the doctor portrayed as a bad person, and when he was bad there were often extenuating circumstances. He was almost never a humorous character, either (*23*).

Around 1950 many physician organizations across the country began systematic campaigns to reduce the number of legitimate complaints of the public against physicians. Leaders in the profession had concluded that actual experiences of everyday Americans with medical care were the source of much of the antipathy directed toward the profession. An early and exemplary effort was that of the California Medical Association, which conducted a double program. First, California M.D.'s made medical care available (but on their own terms) to answer complaints about access to it. Second, and more important, they carried out a campaign to protect the public by hearing complaints against four types of abuses: (i) malpractice; (ii) "unnecessary or incompetent procedures"; (iii) excessive fees; and (iv) unethical acts of physicians. All over the United States grievance committees of local medical societies tried to adjust physician-patient disputes and effect some of the professional self-policing so notoriously absent theretofore (*24–26*).

Grievance committees were, in fact, but one facet of a major attempt of reformer physicians to get each practitioner to emphasize and upgrade his or her personal relationships with patients. The doctors set out to fight bad public relations as one did syphilis, one case at a time but with a cumulative effect (*27*). California M.D.'s in 1951 employed the psychologist Ernest Dichter to suggest how each practitioner should manage his or her patients. Every encounter between a physician and patient is, of course, an intensely and unabashedly narcissistic experience for the patient and therefore eminently suitable for psychological manipulation. A patient's gripes about high fees, for example, may mask a real grievance related to some personal slight inflicted by the doctor. Psychological studies and systematic research on patients, analogous to consumer surveys, both gave specificity to concerns about the individual doctor-patient relationship and helped inspire and shape programs to improve such relationships (*26, 28*). As an osteopath concluded in 1955, the trust of every patient had to be gained in order to overcome the belief that medicine was emphasizing business and quantity rather than service or quality (*29*). The popular press also soon reflected the medical campaigns, elements of which were familiar from earlier AMA publicity favoring the old family doctor as opposed to the cold, impersonal specialist. By 1959 an article in *Life* was popularizing this idea, portraying physicians favorably but still strongly emphasizing how much they needed to add sympathy to their science (*30*).

At the same time that physicians were working on their public relations in the 1950's, overt popular indictments were pushing the profession off the "pedestal." Exactly where and when the final shove came is not certain. In the third quarter of the 20th century there were no fewer than 20 investigations of the New York City health system, and in 1966, after it was clear that the medical profession was in trouble, journalist Martin Gross (*31*) traced the new criticism to the first of these investigations in the cultural center of the country (*32*). In 1965 an anonymous writer in *Consumer Reports* (*33*) dated modern criticism from the publication of a study conducted in 1956 in which investigators actually rated physician performance. Perhaps the most important date was 1958, when Richard Carter's *The Doctor Business* (*25*), the first of a number of muckraking

books, appeared. Carter's exposé and others that followed it drew heavily on both public investigations and exposés that members of the profession had written for internal professional purposes. Whatever the source, clearly adverse criticism had entered a novel phase by the end of the 1950's, reflecting and also creating new social circumstances within which physicians practiced.

Indignant lay writers and reformer M.D.'s shared an elevated opinion about what physicians ought to be. They were, wrote a journalist in 1954 (*34*), supposed to be part of a double picture: "on the one hand, a group of dedicated and white-coated scientists, bending over test tubes and producing marvelous cures for various ailments, and, on the other, equally dedicated practitioners of medicine and surgery, devoting themselves to easing pain and prolonging human life, without thought of personal gain and at considerable self-sacrifice." Both the public and the profession, he noted, were beginning to notice substantial deviations from this widely held ideal and to become filled with "disillusionment . . . tinged with a bitterness which breeds public hostility" (*34*). Other observers traced the rising level of adverse comment to unrealistic hopes. As the 1950's ended, columnist Dorothy Thompson summarized for readers of the *Ladies' Home Journal* this growing public criticism of American physicians. There was bad hospital care, there were bad doctors, and there were excessive medical costs. But she went on to note the cause (*35*):

> In a rather profound sense the current attacks on the medical profession compliment it. People, it seems, *expect* more of physicians than they do of other professional men with the possible exception of the clergy. The medical profession has invited that expectation, and in the opinion of this writer, and with exceptions that only prove the rule, has deserved it.

In later decades, as Americans came to expect the medical profession to furnish comfort, happiness, and well-behaved children as well as health, the disillusionment grew.

Adapting to Change

Since ancient times, critics—and the public at large—have usually discriminated sharply between their own personal physicians, who command professional trust, and the medical profession as a whole, which does not and which is susceptible to harsh judgments (*36*). In the mid-20th century, however, doubts about medicine in general or "the doctor" intensified so much that even personal professional trust was often impaired, especially when a patient could not get the attention that he or she wanted. Critics at all levels who started by blaming the system, particularly the clinic and hospital, inadvertently raised questions about the M.D.'s who collaborated in the faulty operation of the institutions.

As professionals, physicians always functioned in part on the social level. When, in the 20th century, major changes occurred in the immediate social context within which medicine operated, the profession did not adapt quickly in either the formalities of practice or the self image it produced. One of the major new forces was the startling increase of chronic (as opposed to acute) diseases as the dominant concern in practice. A second new force was the growth of huge bureaucratic institutions, particularly hospitals, in the regular health care system. A third force was the greatly increased sophistication of consumers. And a fourth was the rise of psychological explanations for illness, leaving the physician dealing with the uncertainties of psychosomatics. All of these changes were well under way before the 1950's, and each helps to explain what happened to the golden age of medicine.

Critics and reformers outside the profession were also slow to respond to the changed situation. Carter's *The Doctor Business* (*25*), for instance, was targeted chiefly on the fee-for-service organization of medicine, and at most only a quarter of the volume was devoted to actual faults in health care. Even in 1960 in perhaps the most crucial of the new critical publications, *The Crisis in American Medicine*, the authors still tended to emphasize the economics of medicine even while recognizing that "Millions of people are bitterly dissatisfied with the medical care they are getting" (*37*).

What eventually transformed the criticism was the addition of another ingredient from society as a whole: widespread anti-institutional sentiment along with a general disillusionment with many aspects of American life (*38*). Among the target institutions were the professions, particularly professions based on expertise. In the mid-1950's writers in the highbrow and mass media began to paint negative or at least ambivalent images of many American institutions that in the 1940's had been beyond reproach: the city, the automobile, the large family—and the doctor. In making their unfavorable remarks about doctors, various kinds of public commentators drew from both past and then current concerns to focus on three aspects of the physician's function: the priestly, or sacerdotal role; the technical role; and the role of the physician as a member of the health care system.

The Sacerdotal Role

In the first half of the 20th century, when medical intervention was becoming increasingly effective, such critics as there were tended to concentrate not on the technical role of physicians but on their priestly functioning as they went through medical ceremonies and acted as wise and trusted personages. In this preoccupation, commentators reflected basic popular attitudes. In novels, for example, despite the shift of physician characters from priestly and scholarly roles to scientific, their most important duties still centered on nonphysical problems and relationships (*39*). Regardless of the passing of the old-fashioned family doctor, there was a well-understood public demand for a sympathetic personal relationship such as that furnished by the idealized country practitioner. "His successors have much to learn from him," observed an editorial writer in a typical comment as early as 1908. "At all events they must learn to be men, not merely scientists" (*40*). And even as the socialized medicine debate heated up, the impersonal system rather than individual M.D. performance was the subject of adverse comment.

In all of the criticism during the golden age, the emphasis on priestly personal functions of the physician, as opposed to effectiveness or even competence, is striking. As late as the 1950's, lists of common criticisms to which physicians were sensitive included most prominently "A failure to take a personal interest in the patient and his family," "Inability to get a doctor in cases of emergency," "Waiting time in doctors' offices," and other such items reflecting the continuing demand for personal attention (*41*). The only other conspicuous categories of complaint had to do with fees and failure to communicate with the patient. Only in later decades did the demand for competence become very conspicuous (*4*, *42*).

It is against this background of emphasis on the sacerdotal function of medical personnel that the great constant of criticism, greed, has to be viewed. Greed on the part of a physician violated a sacerdotal stereotype because most Americans expected that under ideal circumstances a physician was a dedicated professional who provided a service be-

cause the service was needed, not because it was profitable (*43*). Greed showed up earlier as a concern in attacks on quackery, fee-splitting, and then, to a small extent, physician financial interest in laboratory and drug store enterprises (*44*). But it was only after physicians had in general substantially increased their incomes that critics fastened on the evident wealth rather than specific fees of M.D.'s as evidence of unseemly grasping. This recent phase had to wait for the development of what David Horrobin has called "the politics of envy" in the late 20th century (*45*, *46*).

That physician greed was a constant in criticism meant that even in the recent period, when technical as well as priestly performance in medicine was again subject to question, the motive that critics identified in errant physicians was avariciousness. Why else would a rational M.D. commit undesirable acts and reduce the quality of the medical care that he was delivering? And in the continuing socialized medicine controversy, when the physician as entrepreneur was an issue, greed was, again, imputed to medical advocates of laissez-faire (*47*).

One area in which the public could and did react to physicians in their nontechnical roles was indifference to patients, epitomized in the contrast between house calls and clinic or hospital practice. Personal attention was the theme of the solo practice advocates both inside and outside the profession. It was the chief complaint of detractors of specialization, before and after the late 1950's. It was the object of the local grievance committees set up after World War II. And it was the subject of studies after mid-century by members of a new subspecialty, medical sociologists.

In an era of high technology, when the secrets of medicine became increasingly inaccessible and incomprehensible to the public, responsiveness to the patient remained the one aspect of practice by which most people could judge the M.D. By the 1960's, case histories of patient mistreatment on a social, not technical, level were standard in the growing literature of criticism. But the critics who wanted atttention and care from the physician still did not usually specify what the care consisted of until well into the age of malpractice suits (*48*).

"Pshaw! I grabbed the wrong bag."

Drawing by R. Taylor; © 1959 The New Yorker Magazine, Inc.

The Technical Role

Although the technical performance of the physician called forth little adverse comment before the 1950's, both the application of medical science and the individual competence of the M.D. in applying it had earlier been traditional and continuing subjects of recrimination. Kept alive for a time in the campaign against obviously incompetent nonphysician quacks, the theme of pretension and ineffective treatment continued to be an issue in occasional attacks on unnecessary surgery. Remarkable, however, was the fact that one type of criticism, that directed toward the laziness, negligence, and incompetence of M.D.'s, remained largely undeveloped for over half a century. There were a few stories about outright malpractice, and there were suggestions (usually made by M.D.'s trying to upgrade the profession) that many physicians were not keeping up with scientific literature (*49*). But no rash of damaging exposés appeared until after the 1950's.

One dark side of the physician as technologist was the fear that practitioners would impose too much medicine, not only forcing inoculations and surgery on unwilling persons but, indeed, using patients for experimental purposes. In the 1920's, Sinclair Lewis's *Arrowsmith* helped keep this traditional fear alive, but the physician as scientist who imposed on patients in the name of technique remained largely a literary figure. For decades, serious critics restricted themselves to the impersonality of the specialist, not his mania for medical intervention and innovation. Lay commentators, in fact, tended to write about fads in medicine in terms of progress and to ignore the discarded fashions. Publicists who did discuss faddism did so gently, like the 1928 humorist in *Collier's* who commented (*50*),

> An' now it's the gall bladder. Doctors are *mad* over it. The appendix, tonsils, teeth, autointoxication, acidosis—all are forgotten; an' the gall bladder is now the undisputed belle of the body. For a medical man it has all the lure an' emotional appeal of a Swinburne poem, a Ziegfeld chorus or a moonlight party in Hollywood.

By the 1960's and 1970's critics were saying that, as one of them put it, medical faddism reflected "the underlying bias of the technological mindset and its activity orientation . . . that newer must be better and that doing more must be better than doing less; hence the possibility of harm is always a second thought . . ." (*51*). By this time, then, deliberate risk had been added to lack of knowledge and skill. Moreover, the public ultimately developed a very high level of distrust of what critics had been characterizing as excessive use of drugs and surgery (*4*).

The Social Role

Beyond the priestly and technical requirements of medical practice, one of the well-understood demands society makes of any professionals in granting them special status has been that their activities be harmless to society (this is one reason that advertising, for example, cannot qualify as a profession). The traditional issue of whether the monopoly

granted physicians was or was not antisocial became a crucial one in the 20th century. The reorganizers of American medicine at the turn of the century took pains to show that the newly licensed monopoly, "the medical trust," as early critics characterized it, that outlawed quacks and sectarians and vested licensure in the profession, *was* in the public interest (*52*).

Medical leaders succeeded in winning the public's trust and approval (*11*). Not even the failure of the self-policing that was a direct (though not essential) concomitant of the monopoly elicited much comment before the 1960's. Only insofar as physicians as a group failed to take positive action to provide medical care for all who wanted it, or as medical groups opposed institutional arrangements designed to improve and extend medical care, did criticism fall on the monopoly. Then, attribution of greed to physicians was one aspect of the accusation, but so also was conservatism, which was a characteristic of other monopolies that consistently drew criticism in modern America. It was not until the 1960's and 1970's that new, well-educated groups tried to break the monopoly by developing new kinds of "health care deliverers" and by introducing lay control. Such developments grew out of distrust of the intentions and and customs of the medical profession.

Attention to the social aspects of medicine was the qualitative characteristic that most clearly differentiated detractors of medicine before and after the 1950's. More recent critics not only decried the monopoly and maldistribution of medical care but also loaded physicians with responsibility for any number of social transgressions: exploiting menials, failing to provide incentives for improving health care delivery, encouraging unnecessary bureaucracies, increasingly setting arbitrary boundaries to illness, ignoring "positive" health, and in general, to use the term of the leading critic, Illich, "medicalizing" the whole society to the detriment of individual dignity and well being (*8*).

The Erosion of Professional Status

Physicians have always been sensitive to criticism (*53*). For half a century they were relatively free from public censure or actual interference in clinical and professional activities, and they enjoyed great public and personal admiration. Few people other than doctors knew about iatrogenic disease or the placebo effect. Criticism—and lack of it—reflected both the impression conveyed in public about the miracles of medicine and the persistence of the sacerdotal role of the physician, demanded by the public at all levels. But the physician as priest was already in some trouble by the 1930's. Attacks on impersonal specialism and on well-meaning social reformers' attempts to spread the technical benefits of medicine through prepayment (that is, insurance) and institutional reorganization laid a basis for doubts about the whole profession. Demand for a priest was still intense, as surveys even in the 1950's showed, but the profession in general was by then set in place to be the object of a more general social attack. This attack portended the end of generous funding for medical research and the end of such extremes of freedom of action as professionals might aspire to (*54*).

Commentators with a sense of the tragic, or even just of the ironic, can find in the 20th-century physician ample justification for their views. As sociologist Eliot Freidson pointed out at the beginning of the 1960's, conflict between patient and physician was inevitable because the function of the physician was to apply general knowledge to a particular individual, the patient (*55*, p. 175). Applying knowledge involved trying to control the patient, and the patient in turn was interested in controlling his or her destiny (*26*). In attempting to maximize the client-professional trust that would permit patients to yield control, physicians emphasized the validity of their science—and in so doing created a sophisticated public. That public in turn became increasingly competent to expose shortcomings of the profession and to react when physician reformers spoke out about their colleagues' failures (*56*). "I wrote about . . . abuses and asked for changes," wrote District of Columbia internist Michael J. Halberstam in the mid-1970's. "And now changes are coming, but alas . . . they will probably be the wrong ones" (*2*).

One of the major results of the new criticism of the 1960's and 1970's, in which the technical as well as the sacerdotal function of the physician came into question, was therefore a series of demands for greater patient participation in the medical relationship, demands exacerbated by a resurgence of romantic individualism in the culture as a whole (*57, 58*). By 1972 one analyst (*59*) could add to the "engineering" and "priestly" models of health care and delivery two more, the "collegial" and the "contractual." Both of these last models involved patient participation and were flourishing in various settings (*59*).

Insofar as the entire society was moving toward social leveling, the high status necessary for professional authority was being eroded throughout most of the century (*55*, p. 187). By the 1960's even the popular image of the physician as portrayed on television reflected a change from a charismatic figure, who used mysterious powers to resolve problems, to a new type of hero, one with only ordinary endowments and who potentially could behave unheroically (*60*). But as early as the 1930's the sociologists, who surveyed Muncie, Indiana, as "Middletown" had commented that physicians, and lawyers, too, were increasingly less visible as independent community leaders. Older physicians continued to be aware of a change, but few could cite convincing detail as did J. A. Lundy of Worcester, Massachusetts, who in 1952 recalled the time when townspeople customarily tipped their hats to the physician (*61*). Another perceived sign of erosion of the physician's place was the fact that patients felt increasingly free to shop around for an M.D. who suited them (*62*). The loss was felt not by the technically oriented specialist whose bedside manner might be imperfect, but by the traditional family doctor. By the 1960's and 1970's physicians were complaining not only of lack of deference but of lay interference and assaults on professional privileges. The politics of envy were building in new ways upon traditions of criticism that had been muted in the first half of the 20th century but had not died.

Conclusion

The golden days of the medical profession can be defined by the amount and the content of criticism that the profession received—what little adverse comment there was, was often to the effect that highly desirable professional services were insufficiently available or that physicians had lapsed from their sacerdotal roles. In both cases the critics tended to fasten on the old theme of the doctor whose greed overcame his more professionally disinterested concern. The practice of medicine always involved M.D.'s in ambivalent relationships with both individual patients and society, and high-status professionals who could not or would not respond to patients' personal and selfish concerns of course generated complaints and could even become both personal and social scapegoats (*63*). But it was the continuing politics of the socialized medicine debate that first planted the

seeds of major and pervasive mistrust. When, after World War II, physicians themselves spoke out to increase the beneficent results of medicine and upgrade the profession in the direction of the professional ideal, they unwittingly opened the door for the latter-day critics who attacked not only priestly pretension but technical performance. The influence of these critics combined with other social forces in movements that in the 1960's and 1970's tended to impair the trust and freedom that had once marked medical practice (*64*).

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28. R. Waterson and W. Tibbits, *GP* **4**, 93 (October 1951); M. Amrine, *Am. Psychol.* **13**, 248 (1958). For a summary of the research, see S. Greenberg, *The Troubled Calling: Crisis in the Medical Establishment* (Macmillan, New York, 1965), chap. 4.
29. *New York Times* (16 October 1955), p. 72.
30. *Life* (12 October 1959), p. 144; M. Austin, *Look* (15 March 1949), p. 34.
31. M. L. Gross, *The Doctors* (Random House, New York, 1966), p. 7.
32. R. R. Alford, *Health Care Politics: Ideological and Interest Group Barriers to Reform* (Univ. of Chicago Press, Chicago, 1975), p. 22. R. Bayer [*Homosexuality and American Psychiatry: The Politics of Diagnosis* (Basic Books, New York, 1981), p. 10] maintains that the public attack on psychiatry prefigured the attacks on medicine as an institution.
33. *Consumer Reports* (March 1965), p. 146.
34. B. McKelway, *Med. Ann. D.C.* **23**, 457 (1954).
35. D. Thompson, *Ladies' Home Journal* (April 1959), p. 11. Later, television productions greatly intensified unrealistic expectations; G. Gerbner *et al.*, *N. Engl. J. Med.* **305**, 901 (1981).
36. A striking modern survey, showing the generality of the phenomenon in all segments of the population, is Ben Gaffin & Associates, *What Americans Think of the Medical Profession . . . , Report on a Public Opinion Survey* (American Medical Association, Chicago, 1955).
37. M. K. Sanders, Ed., *The Crisis in American Medicine* (Harper, New York, 1961), p. vii.
38. R. C. Maulitz, unpublished paper.
39. A. J. Cameron, thesis, University of Notre Dame (1973), especially p. 157.
40. *New York Times* (21 August 1908), p. 6. An early sociological survey of patients [E. L. Koos, *Am. J. Public Health* **45**, 1551 (1955)] showed that the young modern patients as well as the old who had, for example, actually seen house calls, responded negatively to impersonality in practice. There were probably also changes in the social expectations for the "sick" role; see, for example, E. Kendall, *Harper's Mag.* **219**, 29 (1959).
41. J. T. T. Hundley, *Va. Med. Mon.* **79**, 540 (1952); E. Stanton, *J. Maine Med. Assoc.* **45**, 56 (1954).
42. By 1957 patients were almost evenly divided in wanting most kindly attention or technical skills and results (getting better): G. G. Reader, L. Pratt, M. C. Mudd, *Mod. Hosp.* **89**, 88 (1957).
43. No attempt is made in this article to deal directly with the issue of professionalization and professional status; there is already a large special literature on the subject.
44. For a particularly good example of the restricted criticism, see an anonymous editorial, "Unprofessional conduct," *J. Med. Soc. N.J.* **26**, 326 (1929). In the present discussion I treat the explicit content of the criticism and do not utilize the suggestion that complaints about fees were substituted for expressing other grievances.
45. D. F. Horrobin, *Medical Hubris: A Reply to Ivan Illich* (Eden, Montreal, 1977), p. 27. Ironically, high income was one of the factors that contributed to physicians' high prestige (*5*).
46. P. Starr [*Daedalus* **107**, 175 (1978)] suggests that this type of criticism did not appear conspicuously until after publicity about Medicaid abuses.
47. Stupidity was also an issue, being part of the argument that a reorganized, socialized physician would be better off economically.
48. For example, D. B. Smith and A. D. Kaluzny, *The White Labyrinth: Understanding the Organization of Health Care* (McCutchan, Berkeley, 1975).
49. R. S. Halle, in an article entitled "Unfit doctors must go" [*Scribner's Mag.* **90**, 514 (1931)], dealt entirely with clear cases of malpractice; and H. M. Robinson [*Am. Mercury* **38**, 321 (1936)] blamed lawyers, patients, and unrealistic expectations for a rash of lawsuits.
50. *Collier's* (4 August 1928), p. 27.
51. L. Lander, *Defective Medicine: Risk, Anger, and the Malpractice Crisis* (Farrar, Straus & Giroux, New York, 1978), p. 41.
52. A. D. Bevan, *Am. Med. Assoc. Bull.* **5**, 243 (1910).
53. O. W. Anderson, *Mich. Med.* **67**, 455 (1968).
54. P. B. Hutt, *Daedalus* **107**, 157 (1978).
55. E. Freidson, *Patients' Views of Medical Practice—A Study of Subscribers to a Prepaid Medical Plan in the Bronx* (Russell Sage Foundation, New York, 1961).
56. T. H. Stubbs, *Emory Univ. Q.* **3**, 137 (1947).
57. D. Nelkin, *Daedalus* **107**, 191 (1978).
58. E. Dichter [*N.Y. State J. Med.* **54**, 222 (1954)] is an important example.
59. R. M. Veatch, *Hastings Cent. Rep.* **2**, 5 (June, 1972).
60. B. Myerhoff and W. R. Larson, *Hum. Organ. Clgh. Bull.* **24**, 188 (1964).
61. J. A. Lundy, *N. Engl. J. Med.* **246**, 446 (1952).
62. R. S. Lynd and H. M. Lynd, *Middletown in Transition: A Study in Cultural Conflicts* (Harcourt, Brace, New York, 1937), p. 427n; J. Kasteler, R. L. Kane, D. M. Olsen, C. Thetford, *J. Health Soc. Behav.* **17**, 328 (1976); F. W. Mann, *J. Maine Med. Assoc.* **16**, 137 (1925).
63. N. Y. Hoffman, *J. Am. Med. Assoc.* **220**, 58 (1972). Another dimension—unchanging pop culture and the dangerous remoteness of the scientist—is not explored in this present article; see G. Basalla, in *Science and Its Public: The Changing Relationship*, G. Holton and W. H. Blanpied, Eds. (Reidel, Dordrecht, 1976), p. 261.
64. R. Branson, *Hastings Cent. Stud.* **1** (No. 2), 17 (1973).

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