

# Prepaid Group Practice and the New "Demanding Patient"

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*Based on an extensive field study of the practitioners in a large, prepaid service contract group practice, this paper discusses how a prepaid service contract and closed-panel practice brings a new dimension into doctor-patient relations and how physicians respond to it. Unable to manage "unreasonable" demands for service by use of a fee-barrier or encouragement to "go elsewhere," as in traditional, solo, fee-for-service practice, they were particularly upset by a new type of "demanding patient" who claimed services on the basis of contractual rights and threatened appeal to higher bureaucratic authority. Modes of dealing with such patients are briefly discussed.*

The future dimensions of medical practice in the United States are beginning to emerge now, both through the steady increase in prepaid insurance coverage for ambulatory care, and through the pressure on physicians to work together in organizations. But what will be the impact of those changes on the people involved, and on their relationships with each other? What will the doctor-patient relationship be like? There can be little doubt that prepaid medical care insurance plans will, by changing the economic relationship between doctor and patient, also change many ways in which they interact with each other. And there can also be little doubt that when physicians routinely work in organizations where they are cooperating rather than competing with colleagues, other elements of their relationships with patients and colleagues will change.

Obvious as it is that change will occur, we have rather little information relevant to anticipating its human consequences. We have fairly good estimates of the economic consequences of those changes in the organization of medical care, and we have hopeful evidence on how the medical quality of care might be affected, but between the input and output measures there is only a black box: we have little information on how the human beings in medical practice produce the results which are measured, on the quality of their experience in practice, and on the characteristic

ways they try to manage their problems at work. Without knowing something about that, it is rather difficult to anticipate how doctor-patient relationships will change and what problems will be embedded in them.

This paper is an attempt to provide some information about how the participants in a medical care program which anticipated present-day trends responded to each other and to the economic and social structure of practice. The data upon which I shall draw come from an eighteen-month-long field study of the physicians who worked in a large, prepaid group practice. Most of the primary practitioners (internists and pediatricians) worked on a full-time basis in the medical group, and most of the consultants worked part-time, but all fifty-five of them were on salary, officially employees of the institution. Their medical group contracted with an insurance organization to provide virtually complete care to insured patients without imposing on them any out-of-pocket charges. In studying the physicians of the medical group, a very large amount of observational, documentary, and direct evidence was collected in the course of examining files, attending all staff meetings, listening to luncheon-table conversations, and carrying out a series of intensive interviews with all the physicians in the group. The research obtained a systematic and comprehensive view of how the group physicians worked and what their problems were. Because of a lack of space here, however, only a summary of findings bearing on a single issue is possible.

## The Administrative Structure of the Group

To understand practice in the medical group, it is necessary to understand the framework in which it was carried out. The group did not have an elaborate administrative structure, since it lacked clear gradations of rank and authority and had rather few written, formal rules. It was not organized like a traditional bureaucratic organization. The few rules which were bureaucratically enforced all dealt in one way or another with the *terms* of work—with how and what the physician was to be paid, and the amount of time he was to work in return for that pay. Ultimately, the terms of work were less a function of the medical group administration

than of the health insurance organization with which the medical group entered into a contract. The absolute income available for paying the doctors derived primarily from the insurance contract, which specified a given sum per year per insured person or family, plus additional sums by a complicated formula not important for present purposes. The administration of the medical group could decide how to divide up the contract income among the physicians but had to work within the absolute limits of that income.

By the same token, critical aspects of the *conditions* of work stemmed more from the terms of the service contract than from the choice and action of the group administration. The most important complaint of the physicians about the conditions of work in the medical group was of "overload"—having to provide more services in a given period of time than was considered appropriate. Such "overload" was a direct function of the prepaid service contract, which freed the subscriber from having to pay a separate fee for each service he wished, and encouraged many physicians to manage patient demands by increasing referrals and reappointments.

It was around these externally formulated contractual arrangements that we found the administration of the medical group establishing and enforcing the firmest bureaucratic rules, perhaps because it had no other choice than to do so in order to satisfy its contract to provide services. The prepaid service-contract arrangement could be conceived of as purely economic in character—simply a rational way of *paying* for health care, which did not influence health care itself. But it was much more than that, since it organized demand and supply, the processes by which health care takes place. In fact, it was closely connected with many of the problems of practice in the group. This is not to say that it created those problems in and of itself. Rather, it gave rise to new possibilities for problematic behavior on the part of both patient and physician and prevented the use by both of traditional solutions. To understand its relationship to the problems of practice in the medical group, to the way the physicians made sense of their experience, and to the ways they attempted to cope with it, let us first examine the way the physicians responded to the differences they perceived between prepaid service-contract group practice and private, fee-for-service solo practice.

## The Meanings of Entrepreneurial and Contract Group Practice

All of the physicians interviewed, including those who had left the group and were solo practitioners at the time of being interviewed, had at one time or another worked on a salary in the medical group. Thus, they reported on circumstances in which they could not themselves charge the patient a fee for the services they rendered. Their income was independent of the services they gave, just as the cost to the patient was independent of the services he received. The patient demanded and the physician supplied services on the basis of a prepayment contract which established a right for the patient and an obligation for the physician. Furthermore, the group was organized on a closed-panel basis, so that in order to obtain services by the terms of his contract, without out-of-pocket cost, the patient had to seek service only from the physicians working at the medical group, and no others.

Virtually all of the physicians interviewed had also had occasion to work on the traditional basis of solo, fee-for-service "private" practice. In that mode of organizing work and the marketplace, the physician makes a living by attracting patients and providing them with services paid for by a fee for each service. The physician's income is directly related to the fee charged and the number of services provided. He has no contractual relationship with patients. He must attract them by a variety of devices—accessibility, reputation, specialty, referral relations with colleagues—and maintain a sufficiently steady stream of new or returning patients to assure a stable if not lucrative practice. In theory, the patient is free to leave him for another physician, and relations with colleagues offering the same services are at least nominally competitive.

How did the physicians interpret these different arrangements and what did they emphasize in their experience with each? In the interviews, the prepaid group physician was often represented as helpless and exploited, with words like "trapped," "slave," and "servitor" used to describe his position. Since the contract was for all "necessary" services, however, it was hardly accurate to say that the physicians had to provide every service the patient demanded. They could have refused. But at bottom it was not really the formal contract which was the issue. Rather, the physicians

were responding to the absence of a mechanism to which they were accustomed, a mechanism which, by attesting to the value of the physician's services in the eyes of the patient, and by testing the strength of the patient's sense of need, precluded the necessity of actually refusing. The physicians were responding to the absence of the out-of-pocket fee which is a prerequisite for service in "private practice."

The fee was seen as a useful barrier between patient and doctor which forced the *patient* to discriminate between the trivial and the important before he sought care. The assumption was that if the patient had to pay a fee for each service, he would ask only for "necessary" services, or, if he were too irrational or ignorant to discriminate accurately, he would at the very least restrict his demands to those occasions when he was really greatly worried. The fee served as a mechanical barrier which freed the physician of the necessity of having to refuse service and of having to persuade the patient that his grounds for doing so were reasonable. Since a fee operates as a barrier in advance of any request for service, it reduces interaction between physician and patient. In the prepaid plan, the physicians were not prepared for the greater interaction which the absence of a fee encouraged.

In addition to the service contract, there was also the closed-panel organization of the medical group. The physicians themselves were aware that some patients often felt trapped, since, in order to receive the benefits of their contract, they had to use the services only of a physician employed by the medical group. If he wanted to be treated by a particular individual in the group, he might nonetheless have had to accept another because of the former's full panel or appointment schedule. And when patients were referred to consultants, they were supposed to be referred to a specialty, not to an individual specialist. Some of the physicians themselves found this situation unsatisfactory because they were not personally chosen by patients, but were seen by patients because they happened to have appointment time free or openings on their panel, not because of their individual reputation or attractiveness.

Finally, there was the issue of group practice itself, of the constitution of a cooperative collegium rather than, as in entrepreneurial practice, an aggregate of nominally competing practitioners. In the latter case, the physician may be "scared that

somebody would . . . take his patient away,” or that the patient may “walk out the door and you may never see him again.” Nevertheless, if he can afford it, the physician in fee-for-service solo practice can choose to refuse to give the patient what he asks for, and can even discourage him from returning. But in the group practice, the physicians did not generally have the option of dropping a patient with whom they had difficulty. The reason was not to be found in any potential economic loss, as in entrepreneurial practice, but rather in the closed-panel practice within which colleagues were cooperating rather than competing. When physicians form a closed-panel group, they cannot simply act as individuals, “drop” a patient who is troublesome, and allow him to go to a colleague, for if each of the group dropped his own problem patients, while he would indeed get rid of the ones he had, he would get in return those his colleagues had dropped, as his colleagues would get his. And so the pressure was to “live” with such patients and try to manage them as best one could—something for which the physician with ideological roots in private practice was poorly prepared.

From the view which the physicians presented, it seemed that the medical group involved them in a situation in which traditional safety valves had been tied down and the pressure increased. The service contract was thought to increase patient demand for services, while at the same time it prevented the physician from coping with that demand by the traditional method of raising prices. The closed-panel arrangement restricted the patients’ demands to those physicians working cooperatively in the medical group, so the physicians could not cope with the pressure by the traditional method of encouraging the troublesome patient to go elsewhere for service. Confrontation between patient and physician was increased, and both participants explored new methods for resolving them. Indeed, the insurance scheme itself provided the resources for some of those new methods of reducing the pressure on demand and supply.

## Paradigmatic Problems and Solutions

The basic interpersonal paradigm of a problematic doctor-patient relationship may be seen as a conflict between perspectives and a

struggle for control or a negotiation over the provision of services. From his perspective the patient believes he needs a particular service; from his, the physician does not believe every service the patient wishes is necessary or appropriate. The content of this conflict between perspectives is composed of conceptions of knowledge, or expertise, the physician asserting that he knows best and the patient insisting that he is his own arbiter of need.

The conflict, however, takes place in a social and economic marketplace which provides resources that may be used to reinforce the one or the other position. In the case of medicine in the United States, that marketplace has in the past been organized on a fee-for-service basis, practitioners being entrepreneurs competing with each other for the fees of prospective patients. The fee the patient is willing and able to pay, in conjunction with the physician's economic security, constitute elements which are of strategic importance to private practice. If the physician's practice is well enough established, he can refuse service he does not want to give or does not believe necessary to give, even though he loses a fee and possibly a patient. On the other hand, if he desires to gain the fee and reduce the chance of "losing" the patient, he may give the patient the service he requests even if he believes it to be unnecessary. Like a merchant, he is concerned with pleasing his patients by giving them what they want, suspending his own notions of what is necessary and good for them in favor of his gain in income should he desire such gain.

The patient, on the other hand, has his fee as a resource (if he is lucky), and the freedom to turn away from the practitioner who does not provide him with the service he wants and pay it instead to the physician who does. He may take his trade elsewhere, but before he does he may introduce pressure by implying that if he does not get what he wants he will find someone else. In essence, the patient can play "customer" to the physician's merchant.

In contrast to these marketplace roles, there are those more often ascribed to doctor and patient by sociologists—that of expert consultant and layman. The layman is defined as someone who has a problem or difficulty he wishes resolved, but who does not have the special knowledge and skill needed to do so. He seeks out someone who has the necessary knowledge and skill and cooperates with him so that his difficulty can be managed if not re-

solved. In dealing with the expert, the layman is supposed to suspend his own judgment and instead follow the advice of the expert, who is considered to have superior knowledge and better judgment. When there are differences of opinion of such character that the patient cannot bring himself to cooperate, the *generic* response of the expert is to attempt to gain the patient's cooperation by persuading him, on the basis of evidence which the expert produces, that it would be in his interest to cooperate and follow the recommended course. To *order* him to comply, or to gain compliance by some other form of coercion or pressure, is a contradiction of the essence of expertise and its "authority." Analytically, expertise gains its "authority" by its persuasive demonstration of special knowledge and skill relevant to particular problems requiring solution. It is the antithesis of the authority of office.

As a profession, however, medicine represents not only a full-time occupation possessed of expertise which participates in a marketplace where it sells its labor for a profit, but more particularly an occupation which has gained a specially protected position in the marketplace and a set of formal prerogatives which grant it some degree of official authority. For example, the mere possession of a legal license to practice allows the physician to officially certify death or disability, and to authorize pharmacists to dispense a variety of powerful and dangerous drugs. Here, albeit in rudimentary form, we find yet a third facet by which to characterize a third kind of doctor-patient relationship—that of the bureaucratic official and client. The latter seeks a given service from the former, who has exclusive control over access to services. The client seeks to establish his need and his right, while the official seeks to establish his eligibility before providing service or access to goods or services. In theory, both are bound by a set of rules which defines the rights and duties of the participants, and each makes reference to the rules in making and evaluating claims. In a rational-legal form of administration, both have a right of appeal to some higher authority who is empowered to mediate and resolve their differences.

In the predominant form of practice in present-day United States, the physician is more likely to be playing the role of merchant and expert than the role of official, though the latter is real enough and too important to be as ignored as it has been by sociologists and physicians alike. It is, after all, his status as an



official which gives the physician a protected marketplace in which to be a merchant. Nonetheless, to be a true official virtually precludes being a merchant, so that only in special instances in the United States can we find medical practice which offers the possibility of taking the role of official on an everyday rather than an occasional basis.

The medical group we studied was just such a special instance, for it eliminated the fee and discouraged the profit motive, while setting up its physicians as official gatekeepers to services specified in a contract with patients, through an insurance agency with supervisory powers of its own. The contractual network specified the basic set of systematic rules, and established the official position of the physician. Under the rules, the physician served as an official gatekeeper to and authorizer of a whole array of services—not only his own, but also those of consultants who, even though “covered” in the contract, would not see a patient without an official referral, and those of laboratories, which do not provide “covered” tests without an official group physician’s signature. In other reports of this study I show how the physicians were led to use their official powers to cope with problems of work, and how they exercised their role of expert. I also show how some railed against a situation which prevented them from using the more familiar techniques of the merchant to resolve their problems.

Here, however, I wish to point out that in the medical group the physician was not the only participant to whom a new role was made available. The situation, which left open the option of official and closed the option of merchant for physicians, also left open the option of bureaucratic client and closed the option of shopper or customer for patients. And when the patients acted as bureaucratic clients they posed different problems to the physician than they did when they acted as a customer, or as a patient: they asserted their rights in light of the rules of the contract. This untraditional possibility for patient behavior was one which upset the physicians a great deal and served as the focus for much of their dissatisfaction. Most of their problems of work stemmed ultimately from their relationships with patients and tended to be characterized in terms of the patient, so that it is important to understand the way the physicians saw their patients. Typically, work problems stemmed from patients who “make demands”; “the demanding patient” was seen to lie at the root of those difficulties.

### Three Types of "Demanding Patients"

It is very easy to get the impression from this analysis that the work-lives of the group physicians were constantly fraught with pressure and conflict. Such an impression stems partially from the strategy of analysis I have chosen, a strategy which focuses on work problems rather than on the settled, everyday routines which stretch out on either side of occasional crises. Without remembering that most medical work is routine rather than crisis, one could not understand how physicians manage to get through their days. Indeed, the kinds of medical complaints and symptoms which are most often brought into the office were such that the daily routine posed a serious problem of boredom to the practitioners. Furthermore, most patients were not troublesome. As members of the stable blue- and white-collar classes, most knew the rules of the game, respected the physicians, and were more inclined than not to come in with medically acceptable (even if "trivial") complaints.

Nonetheless, the fact of routine, even boredom, would be difficult to discern in the physicians' own conversations. They did not talk to each other, or to the interviewers, about their routines; they talked about their crises. They did not talk about slow days, but about those when the work pressure was overwhelming. They rarely talked about "good" patients unless they received some unusual letter of thanks, card, or gift of which they were proud; they talked incessantly about troublesome or demanding patients. They almost never talked about routine diagnoses and their management, but talked often about the anomaly, the interesting case, or one of their "goofs." So the analytical strategy for reporting this study is not arbitrary, since it reflects the physicians' own preoccupations. It was by the problematic that they symbolized their work and it was in terms of the problematic that they evaluated their practice. Even though all agreed that "demanding patients" were statistically few in number, many who left the medical group ascribed their departure to their inability to bear even those few patients.

Most important for present purposes was the fact that, upon analysis of the physicians' discussion of "demanding patients," it was discovered that the most important type was a new one for them. They posed demands which the physicians were unaccus-

tomed to dealing with, for the demands stemmed from the contractual framework of practice in the medical group and were generic to the role of the bureaucratic client rather than the customer or layman. Perhaps this was why they seemed so outrageous and insulting, for such demands treated the physicians as if they were officials rather than "free professionals." The distinction between that kind of demandingness and others was more often implicit than explicit in the physicians' talk when they were asked to characterize demanding patients. The tendency, however, was to distinguish one kind of demanding patient as dictatorial and another as essentially the opposite—eternally supplicant.

Of the two kinds of demanding patients, one would be familiar to the informed reader as the ambulatory practice version of the "crock" met in complaints by medical students and the house staff in the clinics of teaching hospitals. The crock was the person who played the respectful patient role, but presented complaints for which the physician had no antibiotic, vaccine, chemical agent, or technique for surgical repair. All the physician could provide for such complaints was what he considered "palliative" treatment rather than "cure." He neither learned anything interesting by seeing some biologically unusual condition nor felt he accomplished successful therapy. And he worried that he might overlook something "real."

Clearly, this kind of demanding patient was irritating because he had to be babied rather than treated instrumentally and because the doctor had to devote himself to "treating people [whom he considers to be] well, or have the same kind of anxieties we all have." Furthermore, he confronted the doctor with failure: he "can never be reassured. You know you are not getting anywhere with him and you just have to listen to him, the same chronic minor complaints and the same business." "I'm just not satisfied with my results, and the patient just keeps coming back, worse than ever."

In light of the distinctions I made earlier, it should be clear that this kind of demanding person was not playing either the role of bureaucratic client or that of customer. The role of the helpless layman was adopted, which did not contradict the role the physician wished to play. The problem was that the nature of the com-

plaints was such that the medical worker could not play his role in a satisfying way—he could not really help, and his advice that there was no serious medical problem was refused.

The other kind of demanding patient was quite different, however, for he did not ceaselessly *beg* for help so much as *demand* services on the basis of his economic and contractual rights. Such rights do not, of course, exist in fee-for-service solo practice, but the analogue in such practice would be the demanding customer. Such a person is more likely to shop around from one physician to another rather than stick to one and demand his service. Given the structure of fee-for-service solo practice, we should expect in it rather less confrontation with demanding customers, though the physicians did tell stories about some who openly threatened to take their business elsewhere if they did not get what they wanted. Rare as such confrontation was, when it did occur, it was described with the same shock and outrage as was observed in the physicians' stories about demanding contract patients.

The “power of the contract” which one physician spoke of implied correctly that some patients, playing the role of bureaucratic client, threatened to and on occasion actually employed the device of an official complaint. They could complain either to the administration of the medical group or to an office established by the insuring organization to receive and investigate complaints. After all, if one has a contract, one also has the right to appeal decisions about its benefits. And naturally, the more familiar and effective with bureaucratic procedures the patients were, the more were they able to make trouble. The seventeen physicians who generalized about the social characteristic of demanding patients yielded in sum a caricature of the demanding patient as a female schoolteacher, well educated enough to be capable of articulate and critical questioning and letter writing, of high enough social status to be sensitive to slight and to expect satisfaction, and experienced with bureaucratic procedures. In the physicians' eyes, they were also neurotically motivated to be “demanding.”

Also specially nurtured in the framework of the prepaid group practice—contrary to the ideal of bureaucracy but faithful to its reality—was the use by the bureaucratic client of “pull” or political influence to reinforce his demands and gain more than nominal contract benefits. Analogous to political influence in the

free medical marketplace is the possession of wealth or prestige, making one a desirable customer who may refer his friends to the physician. Another form of "pull" lies in having connections with an especially influential and prestigious medical colleague. Both types of patients gain special handling in solo practice. In the medical group, however, "pull" was more related to influence in those segments of the community engaged in negotiating insurance contracts. There were occasional instances when a demanding patient was also an important member of a trade union, or had friends in high political places. Managing such patients was particularly difficult for the administration, since it was unable to protect its own staff in the face of such political influence.

### Managing Demanding Patients in the Future

In this paper I have assumed that a prepaid service-contract medical group has important characteristics which will become more common in the future and which, therefore, allow us to make plausible and informed anticipations of the problems of medical practice in the future. On the basis of extensive interviews with physicians who worked in such a medical group, I suggested that a new kind of problem of management was posed to them by the social and economic structure of their practice. Ostensibly, the problem was the familiar and traditional one of the "demanding patient." Looking more closely at the usage of that phrase, however, led to the conclusion that there was more than one kind of "demanding patient." Indeed, on the basis of the physicians' discussions of their problems, I suggested that there were three types of demanding patients, each posing a different problem of management and a different challenge to medical self-esteem.

Virtually unmet in the medical group (but mentioned by the physicians) were those who acted like demanding customers by insisting on either obtaining the services they wished or of taking their business (and fees) elsewhere. Such a strategy is of course generic to entrepreneurial practice, and most effective with weakly established practitioners in a highly competitive medical market. The second type of demanding patient was the traditional "crock," what a spokesman for Kaiser-Permanente once called "the worried well." Such a patient persisted in seeking consultation for com-

plaints which the physicians felt were trivial and essentially incurable. They were a more serious problem in the medical group than they were reported to be in fee-for-service solo practice because their demands could not be reduced by the imposition of a fee barrier or by suggesting that they go elsewhere for service. The third type of demanding patient was new and particularly disturbing to the physicians—the patient who demanded services which he felt he had a right to under the terms of his prepaid service contract and who had recourse to complaining about the deprivation of his rights to the bureaucratic system of appeal and review.

In the future, with prepaid group practice far more common, we should expect new problems in the doctor-patient relationship as that new kind of demanding patient is met with by more physicians. Insurance coverage in the future may be such as to maintain some kind of fee barrier (as in prepaid plans which now impose small charges for house calls), but the barrier will be less than that to which physicians were accustomed in fee-for-service practice and will be less effective in discouraging demandingness. In addition, since he will be working cooperatively with colleagues in group practice, the physician will be less able to simply “drop” his demanding patients. Unable to use money or evasion to cope with his relationship to problem patients, the physician will have to use other methods. What options are open to him?

Just as the structure of fee-for-service solo practice produces the possibility of using mechanical financial solutions, so does the structure of prepaid service-contract practice also produce the possibility of using mechanical solutions. The mechanical solutions observed in the medical group studied lay in providing all services covered by the contract which were not inconvenient to the practitioner—office visits, referrals, and laboratory tests. (The house call was not convenient, and was resisted strongly.) But whereas the former solutions were traditional and so regarded as “natural” and “reasonable,” the use of the latter was regarded as “giving in,” and treated with resentment and concern. Both are, analytically, equally mechanical, an equally passive reflex to the organization of the system of care.

The consequences of passive response to the new conditions by which patient demand will be structured are already clear. In the face of rising services and costs, strong administrative, financial, and peer-review pressures will force the physician to limit his

“giving in” and restrict the supply of demanded services. But how exactly can the physician limit services, and what kind of interaction will go on between him and his patient under such circumstances? I cannot provide empirical evidence from my study because in the medical group there was rather little organized pressure to limit services. The physicians could “give in” when they chose to. But the logic of my analysis would lead me to expect that when there is pressure to limit service to demanding patients in a structure like that of the medical group, the structure taken by itself provides the opportunity for doing so on the bureaucratic grounds of the official authority of the physician as a gatekeeper to benefits. He can simply refuse the patient, standing on the official position which the structure provides him.

But it need not be that way. While the prepaid service-contract group practice virtually precluded the adoption by physician and patient of a merchant-customer relationship, and allowed the adoption of an official-client relationship which was precluded in private solo practice, it did not *force* the practitioners to manage their problems that way. Some chose to adopt the interactional strategy which is an inherent possibility in medical practice no matter what the historical framework in which it takes place—the strategy of the expert consultant who relies neither on his position in the marketplace nor on his official position in a bureaucratic system but on his knowledge and skill. Some physicians were persuaded that if they invested extra attention and energy in “educating” their patients and developing a relationship of trust they would ultimately have fewer “management” problems. To cope with suspicion on the part of the patient they initially provided services on demand in order to show that they recognized the legitimacy of the patient’s contractual rights, and that they were not motivated to withhold services from them. At the same time, however, they tried to explain to the demanding patient the grounds for their judgment that the services were medically unnecessary. They undertook, in other words, to persuade and demonstrate, and avoided mechanical solutions to the problem of demandingness. The social, moral, and technical quality of the medical care of the future will depend on whether medical practice will be organized in such a way as to encourage such a positive mode of responding to patient demands, or whether it will, like traditional practice, be merely a fiscally and technically functional

structure which does not take cognizance of the human qualities of those it traps.

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