

The Sick Role and the Role of the Physician Reconsidered

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The main substance of this paper was presented orally at a meeting on the Sick Role, organized and chaired by Andrew Twaddle. It was a commentary on four papers and the oral discussion of them.

In response to these the paper first discusses the relation of the sick role to deviant behavior and the motivation to become and remain ill. The position was taken that the author never had meant to confine the category of illness to deviant behavior, though its negative valuation should not be forgotten. Nor had he confined it to cases of acute illness, omitting consideration of chronic and other types. The most important issue, however, concerned the structure of the relation between physician and patient. Though insisting that interaction between them is two-way, not one-way, the author insisted that the relation is basically asymmetrical because of the physician's expertise in health matters, gained through training and experience, and his special fiduciary responsibility for the care of the sick. In this respect the relationship is different from others such as the competitive market or the democratic association, but is comparable to the relation of teacher and student in higher education.

This paper will attempt a restatement of certain aspects of the so-called sick role, and its relation to the performances and functions of physicians, or more generally therapeutically oriented health service agencies.¹

The papers and oral discussion presented at the ISA session, in their discussions of my own previous contributions to the field, stressed the extent to which I had emphasized the ways in which sick role could be considered a form of social deviance. There was also a tendency on the part of authors and commentators to suggest that this analysis was applicable only to the case of acute illness, and neither to chronic illness nor to matters having to do with a preventive orientation. Especially in the oral discussion, however, another note became particularly prominent. In my own earlier work I had stressed the asymmetry of the role patterns of patient on the one side, physician on the other. The quite incorrect im-

¹Its primary reference is to the papers and discussion which were presented at a session on the sick role at the meeting of the International Sociological Association in Toronto, Ontario, in August 1974. The session was organized and chaired by Professor Andrew Twaddle, of the University of Missouri.

plication was made by some of the participants that I had claimed the role of patients to be purely passive, as objects of manipulation, and not as, in any important sense, participative. However, there was a good deal of criticism of this position, and a certain tendency to allege that any fundamental structural asymmetry in this role complex should be regarded as anomalous and pathological. The present paper is oriented to a reconsideration of some of these issues, I hope in a somewhat more extended theoretical context than either my own earlier work took advantage of or the work of the authors of papers or oral comments.

First, may I say something about the relevance of the concept of social deviance. I do not think it was ever my intention to attempt to make this concept cover the whole range of phenomena associated with the sick role on the one hand, the roles of therapeutic agents on the other. My own earlier thinking was heavily influenced by a concern which was widely prevalent in medical circles at the time the work was done, namely the 1930s. This was true not only of psychiatry and psychoanalysis but, with respect to conditions where the symptomatology was mainly somatic, of the so-called "psychic" factor in disease. I found this in my field investigations to figure very prominently in the thinking of internists, and by no means only of psychiatrists.

These considerations suggested that, on the part of the sick person himself, there might be, more generally than had been believed, an element of "motivatedness" not merely in the etiology of the pathological condition, but also in the maintenance of it, a context which included resistance to therapeutic efforts on the part of various agencies. Seen in this perspective then, one primary aspect of therapeutic roles came to be their functions as mechanisms of social control.

It was on this basis that I built up an analysis of some of the functionally significant features of the role of the sick person, attempting to distinguish between the state of illness as such and the role of patient in interaction with therapeutic agents. In complementary fashion, then, the role of the therapeutic agent was analyzed, stressing the functions of social control. It was emphasized throughout that the prevailing attitude toward illness was that it was an inherently undesirable state, and that the role of therapeutic agencies should be "the recovery of the sick person." This concept has been particularly closely related to capacity for full and satisfactory functioning in a system of social relationships.

In this connection, a particularly valuable contribution seems to me to have been made by Eugene Gallagher (1974) in his paper presented to the session. This was Gallagher's conception of health, which he suggested should be regarded as a category of the capacity of the human individual. From this point of view, illness would be a state of affairs which would impair, in varying ways and degrees, the capacity of the sick person to function, as the saying has been, "normally." We can think of a variety of aspects of this impairment of capacity. The privilege of exemption from ordinary day-to-day occupations which has gone with the institutionalization of the sick role is a kind of institutional measure of incapacity when it is combined with the fundamental tenet that being ill, if it is genuine and not malingering, cannot reasonably be regarded as the sick person's "fault."

Gallagher's conception of health as capacity seems to me to help show the relevance to this analysis, not merely of acute illness, but of chronic, even terminal, illness. There are many conditions which are, in any given state of the art of medicine, incurable. For them the goal of complete recovery becomes impractical. However, recovery is the obverse of the process of deterioration of health, that is, a level of capacities, and in many of these chronic situations tendencies to such deterioration can be held in check by the proper medically prescribed measures based on sound diagnostic knowledge. An outstanding example is diabetes, where diabetics, by such measures as a modest regulation of diet, and stimulation in the milder cases by oral medication, in the more severe ones by the use of insulin, can maintain a relatively normal pattern of physiological functioning and the many activities of life which depend on normal physiological functioning. To be sure, there is a cost involved in this. The cost consists, above all, on the diabetic's part, of adhering to a proper regimen and of deferring to a competent professional authority in defining what it should be. The fact then, that diabetes is not, in the sense of pneumonia, "curable," does not put it in a totally different category from that of acute illness.

The other most important issue at this level seems to me to be that of the concept of the "motivatedness" of illness, looked at either in the etiological or maintenance context or both. It seems to me quite clear that modern knowledge of unconscious motivation makes a much more extended scope of the concept of motivatedness entirely acceptable than older common sense, including that

of the medical profession, has allowed for. I would not, however, at all claim that this covers the whole ground. Certainly human beings, like other categories of organism, are subject to pathogenic influences of many sorts which are altogether independent of the processes we call motivational. Thus, doubtless, most cases of bacterial or viral infection or of degenerative processes may be so regarded, as can some of the traumatic consequences of accidents.

It is, however, important to note that the interweaving of motivated and non-motivated factors at both conscious and unconscious levels is complex indeed and any simple formula about these matters is likely to prove misleading. We can, thus, speak of accident-prone people even though the physical consequences of an accident, once it has occurred, are clearly not analyzable in motivational terms. Such people, however, may unnecessarily expose themselves to the risk of such accidents. Probably somewhat similar considerations apply to such fields as infections, and indeed, to the degenerative diseases like cancer. In sum, then, the relevance of the category deviance from the point of view of the sick role itself should be confined to the impact of motivated components in, on the one hand, etiology and therapy, and, on the other hand, maintenance of states categorized as constituting illness. Our conception is that the motivated and hence potentially deviant element shades without specific breaks into those areas where motivation is not a relevant interpretative category.

Some of the papers submitted to Professor Twaddle's session made the suggestion, which had already been made independently by Twaddle himself, that adaptation was a more general and more appropriate category of characterizing the functions of the sick role than was deviance. I should like to conclude the present section of the paper with a brief comment on this issue. I should regard deviance and social control as phenomena concerned with the integrative problems of a social system. Illness we may speak of as, at least in one primary aspect, an impairment of the sick person's integration in solidary relationships with others, in family, job, and many other contexts. Seen in this perspective, therapy may be interpreted to be predominantly a reintegrative process. To be successful, such a process must take account of adaptive considerations, notably the pathological state of the organism and/or personality and the nature of the patient's adaptive problems in various aspects of his or her life.

The most important consideration I wish to put forward, however, is one that is not commonly taken into account in sociological analyses. This concerns an underlying relativity as between the concepts and functions of integration on the one hand, adaptation on the other. Certain concrete problems and phenomena may belong in one of the other category according to the system reference in terms of which they are treated. Just to take an organic case, the circulating body fluids, notably blood, from the point of view of the functioning of internal cells and tissues, constitute an environment. What is or is not available in the bloodstream in what concentrations and the like, constitutes a fundamental set of conditions under which the physiological processes of cells, tissues, and organs operate. Thus, in the example of diabetes I gave above, a deficiency of insulin in the blood will lead to an excessively high level of blood-sugar concentration in the blood with pathological consequences. From the point of view of the organism as a whole, however, the bloodstream constitutes an aspect of the internal environment which must be distinguished from the environment external to the organism as such, for example, the physical environment, and indeed, most of what Durkheim and others have called the social environment. From the point of view of the relation of the organism as a whole to its external environment, the problem of maintenance of the circulation of the blood and of its biochemical composition is to be regarded as primarily an integrative problem not an adaptive problem, though there may well be adaptive repercussions relative to the external environment. It therefore seems to me that the proposals to supplant the emphasis on deviance with one on adaptation is not very helpful unless it pays very careful attention to the relativities and complex interrelations between integration and adaptation.

The main concern of the present paper, however, is not with the problem of the relation between illness and deviance but rather with the problem of the symmetry and/or asymmetry in the role relations between sick people and therapeutic agencies. I should now like to address myself to this topic as such.

I start, as I have for many years, with the proposition that illness is not merely a state of the organism and/or personality, but comes to be an institutionalized role. There is no such thing, of course, as perfect coincidence in that people, who from a medical

point of view are more or less sick, may refuse to acknowledge that this is the case, and behave as if nothing were the matter. I have, on occasion, used the neologism "hyperchondriac" to designate the type of person who, rather than exaggerating states of illness, takes the opposite tack and minimizes them. There are a great many such people.

There are, however, three primary criteria of accepting the social role of being sick. The first of these is the assertion with the view to its acceptance by both self and others, that being in a state of illness is not the sick person's own fault, and that he should be regarded as the victim of forces beyond his control. A second social-structural feature of the sick role is the claim of exemption from ordinary daily obligations and expectations, for example, staying at home in bed instead of going to school or office. The third is the expectation, if the case is sufficiently severe, of seeking help from some kind of institutionalized health service agency. This seeking of help further includes the admission that being sick is undesirable and that measures should be taken to maximize the chances to facilitate recovery or, if the condition is chronic, as noted above, to subject it to proper "management." It is true that in my earlier work I noted the physician as a particularly central health service agent. Of course, at the time that work was done, the physician by no means stood alone, and, for example, I did a great deal of my own observation in hospitals which were very complex organizations involving staff personnel way beyond that composed of physicians. This, however, is not the place to enter a complex analysis of the social structure of complex health service agencies, an exceedingly important subject in its own right. For convenience, therefore, I shall continue to focus on the physician.

In order to approach the problem of symmetry and asymmetry, I think it best to build up a certain context in the form of a typology of social structure. First it seems to me that there are at least two main types of which the especially salient characteristic is a presumption of symmetrical equality, though perhaps the list should be extended to three. An historic example has been that of the relations between participants in a competitive economic market. Participation in market transactions is held to be basically voluntary, and the doctrine of economic rationality suggests that people participate only so long as they can see it to be to their economic interests to do so. Much publicity, of course, has been

given to many different sources of inequality in market relationships, such as some kind of monopoly power on one side, various kinds of coercion more on one side than on the other, or the pressure of need on the part of certain participants which reduces the range of their alternatives and makes it difficult for them to withdraw. These considerations, however, do not invalidate the pattern of the potentially equal and free competitive market nexus.

Closely related to the market is what is sometimes called a communications network, where what is transmitted from one participant to another is not rights of possession in goods and services but in some sense information, that is, access to symbolically meaningful representations; particularly important cases are to be found where such information is "broadcast" whether through the printed word as in publication or through electronic media like radio and television. With certain exceptions there is no institutionalized obligation to transmit information, especially when one considers this at a particularized level; though, for example, a member of the faculty of a high-standing university may have an obligation to publish the results of research, it is not inherent in his role that he is obligated in advance to publish any particular content. One has a certain choice as to what newspapers to read and what parts of any given issue of a newspaper, what periodicals to read, what books to read, and what radio or television programs to tune in on or to shut off. Similar considerations about factors of inequality apply to communication networks as do to markets, but this is not to say that a communication network is inherently unequal.

Finally, the third case is that of the voluntary association or at least the association in which the status of participants or members is declared to be formally equal. There is a sense in which the status of citizen is not altogether voluntary, but in modern democratic societies a fundamental equality as between citizens is typically institutionalized, for example, in the principle, one citizen, one vote. I think probably the best designation for the presumptively egalitarian type of association is the term "democratic" association. This, of course, is by no means confined to citizenship.

Equality in these respects is closely related to what, in Anglo-American tradition, is often referred to as "equality before the law." I do not think that this conception is in need of extended dis-

cussion on this occasion, but this case exemplifies a very important type of complication of the equality problem. This is to say that administration of a legal system not infrequently brings citizens into some kind of legal complication where they are in the need of advice of lawyers and may be participants in proceedings before courts of law. Presumably in a court of law in the role of plaintiff or of defendant a citizen enjoys the rights we sum up in the phrase "equality before the law." It does not follow, however, that with respect to the procedure of the court, every participant in such a proceeding is an equal. Litigants before a court are not the equals of judges who are conducting the procedure of the court. If there happens to be a jury, in certain respects members of the jury occupy a special status which is carefully separated from that of litigants or for that matter their counsel. Litigants, that is, are not permitted nor required to issue legally binding verdicts of guilty or not guilty, which jurors are. Similarly, litigants cannot make procedural rulings about the conduct of a court case as a judge can. It is notable here, however, that some courts involve more than one judge. In such cases, the judges are ordinarily equals of each other. Where decisions of the court are arrived at, it is on the principle, one member, one vote. Thus, in the case of the United States Supreme Court, though the Chief Justice has certain executive privileges and functions, in the Court's decision of cases, he has only one vote, not a heavier weight because of his position as Chief Justice.

It seems best to introduce a discussion of the problem of asymmetry of health care role structure by reviewing the principal types of social structure where asymmetrical structures are involved. I confine this consideration of asymmetry to the cases that involve a hierarchical component of authority, power, prestige, and the like. It is a somewhat different question, whether, for example, the role in marriage of the partners, by virtue of the fact that they belong to opposite sex categories is or is not asymmetrical. I think it is in certain respects. This issue, however, will not be involved in the present discussion.

Subject to these limitations, then, I think it is important to distinguish three principal types of hierarchically asymmetrical roles. The first concerns the relation between the incumbent of elective office in the democratic association as that concept was reviewed above, including of course, governmental office, and other mem-

bers. The incumbent of an office in this sense, for the period of his incumbency, stands in certain relations of superiority to the ordinary constituent who is "only a member" of the association. We are exceedingly familiar with this situation with respect to democratic government, and of course similar principles are operative in the institutionalization of office in a wide variety of different types of private associations.

The second type is almost equally familiar. This is what may be called administrative-bureaucratic authority in organizations. Such authority in modern cases is ordinarily legitimized primarily by the powers of appointment of superordinate elected bodies, in limiting cases constituents as a whole. Within the limits defined by the organizational roles the incumbent of this type of office enjoys a status superior to that of those connected with the organization over whom his office gives him jurisdiction. Thus appointees of the Internal Revenue Service in the United States may call in taxpayers to review the adequacy of the tax returns they have submitted, and, within a set of rules, revise the obligations they have made or agreed to make under those returns. Similarly, administrative officials of a hospital may make many and complex decisions about the admissions of patients, the financial charges to be assessed against them, and various other aspects of the behavior of participants in the hospital social system, including physicians, nurses, and other health service personnel.

The third primary type is of a different order from either of these two. It is what I have been referring to in a variety of publications as the exercise of fiduciary responsibility in the context of what it has often been convenient to call "collegial association." A striking type case of such a collegial association is a multijudge court of law; another is a university department or faculty. A wide variety of boards or other such collectivities may also be included.

In the collegial association members of a given stratum are typically treated as equals of each other, as was noted in the case mentioned above of the United States Supreme Court. By no means all people who participate in relevant interaction in such a system, however, are treated as the equals of each other. As I noted above, only judges can vote as participants in the decisions of an appellate court. Only members of an elective body in democratic politics like a legislature or one house of a legislature can vote in contributing to the binding decisions made on behalf of that body. Clearly only members of a department can vote on matters of

the educational or appointment policy of that department in the academic world.

I suggested above that litigants before a court of law stand in a status very different from that of judges of the court or, in another context, members of a jury. Similarly, it is clear, in an academic type of organization, faculty members within their own departments, or more generally within the faculty, stand in a status different from that of students on the one hand and administrative personnel of the academic organization on the other. On occasion, and for certain purposes, of course, all members of a professional group may be collegial equals, as would be the case for licensed physicians, vis-a-vis government, in enjoying a common right to engage in the practice of medicine. Similarly, all members of the faculty of a complex university may have common rights in that capacity independent of what subdivisions of the organization they are attached to.

I should now like to suggest that social organization of health care, overwhelmingly in modern societies, but particularly in North America, has come to be organized in terms of an asymmetrical hierarchy with respect to the functions of this particular system, of which the two polar aspects are the role of physician as the highest grade of publicly certified expert in health care and the role of sick person independent of the latter's status in other respects. As I have suggested, the health care agency may include a number of different role types other than that of physician, but there is as yet little tendency to challenge the basic position of the physician as having the highest order of professional—as distinguished from administrative—status in such an agency. The sick person, of course, may himself be a physician, but in his role as a patient he stands, relative to non-sick physicians, very much as do patients who medically speaking are lay people.

The most general basis of the superiority of health agency personnel generally, and physicians in particular, seems to me to rest in their having been endowed with special responsibilities for the health of persons defined as ill or as suffering threats to their future health who have come under their jurisdiction, that is, who have become in some sense patients of the individual physician or of the health care organization in which he performs a role. This is to say in very general terms that the physician has been institutionally certified to be worthy of entrusting responsibility to in the field of the care of health, the prevention of illness, the mitigation

of its severity and disabling consequences, and its cure insofar as this is feasible.

I hasten to add that this fiduciary responsibility for the health of participants in the health care system not only need not be confined to physicians but need not be confined to members of a health care agency as such. It most definitely should be regarded as shared by sick persons. Indeed, the acceptance of the role of patient, that is, participation in interaction with the health care agency, may be said to impose a definite responsibility on the patient in working toward the common goals of the system as a whole. The first of the obligations thereby assumed, seems to me to consist in the commitment to cooperation in the health care therapeutic or management functions of the system. This commitment may, in certain cases, be confined to the patient exposing himself as a passive object to the manipulations of the health care personnel. It may not, however, be confined to this passive level. In many different degrees and respects, patients are asked to, and they often do, take the initiative in assuming the responsibility for a more active role in the care of their own health. The case of diabetics, cited above, is very much to the point. It should not be forgotten that other known sick people, who medically speaking are lay people, may often be involved as well. A striking case is that of family members, particularly a spouse, in the case of the very demanding techniques of home dialysis for patients with severe cases of renal failure.

The implementation in concrete action of what I have just called the fiduciary responsibility of the health care agent, particularly the physician, seems to me to work out in three principal contexts, which I should now like to review.

The first of these may be called the presumptive competence of the health care agent to deal with the kind of health-threatening or health-impairment situations that the relevant category of sick or potentially sick people face. Competence in this sense seems to me to rest on three principal grounds or bases. One of these is the level of capacity independent of personal experience of the health care agent himself. In other words, a good physician requires high intelligence and moral probity of an order which is probably higher than that required at least by many other occupational roles in modern society.

Building on the innate aspect of ability, or capacity however, there must be a development of technical knowledge and skill

which is acquired typically through two closely interrelated processes, namely, formal training and experience. The modern physician is subjected to a very elaborate formal training, starting with the basic sciences which underly effective medical practice, a very large branch of physical and biological science, such as biophysics, biochemistry, physiology, bacteriology, and the like, and gradually increasing, I think, behavioral science—in the first instance psychology, but sometime extending even into the non-individual-oriented sciences of behavior and action, like sociology.

This knowledge at more general scientific levels is then articulated with the exigencies of the health care roles through the device of clinical activity and orientation. Thus the medical student is rather early exposed to the processes of the actual going care of concrete sick people, learning the rudiments of physical examination and diagnosis, of history taking, of the interpretation of all manner of pathological symptoms presented by concrete cases. There seems to be a very fundamental consensus that both of what in medical parlance is called “basic science” training and clinical training are the central ingredients of the competence of a physician. In detail, of course, the ramifications are exceedingly broad and various.

I should like, however, to add a third component essential to the implementation of fiduciary responsibility in this field. This essentially is the willingness of the person assuming such a role in fact to exercise such responsibility and to act within the limits of his prerogatives as a genuine trustee of the health interests of the patient population relative to whom he assumes responsibility. This is a component which goes beyond competence in the more narrowly technical sense. It involves an important component of moral authority, grounded in the common assumption of health care agents and sick people that health is a good thing and illness by and large a bad thing, and that the balance should, insofar as it is indeed feasible, be altered in the direction of maximizing the levels of health and minimizing the incidence of illness. It is in this connection that the health care agent performs functions of social control in the sense in which that concept is relevant to the emphasis on deviance and social control as part of the health care complex.

Indeed, I should insist that this last circumstance extends the relevance of the deviance concept well beyond the range within which illness, particularly in the etiological context, may be regarded as motivated. Here, the relevant point is that the health care

agent, notably the physician, is conceived as reinforcing his patient's motivation to minimize illness and its disabilities. In the case of relatively acute illness, the meaning of this is relatively simple: it is the physician's obligation to reinforce patient's motivations to recover. In the case of chronic illness, like diabetes, the corresponding obligation is to reinforce the patient's motivation to minimize the curtailment of his capacities because of his pathological condition, even though that condition cannot be eliminated in the sense of total cure. The case of clearly terminal illness, where death is regarded as not merely inevitable but likely to occur relatively soon, raises a few special problems, which, however, probably need not be entered into here.

Let me reiterate the importance of the fact that the health care agent, and, very notably, the physician, is typically caring for sick people as a full-time occupation. Day in and day out his or her work is concerned with this order of problems. Of course, the occupation need not be totally confined to patient care, since many physicians, especially those attached to important organizations like high-level hospitals and medical schools typically devote a substantial amount of their time and effort to non-therapeutic functions. Of these the most important clearly are, on the one hand, research, regarded as relatively independent of treatment of the individual sick patient, and, on the other hand, what broadly may be characterized as administrative functions, as in the case of a physician who acts for the time being as chief of service in his hospital situation.

There is a sense in which the sick role sometimes matches the full-time occupation of the physician in the case of acute illness. The patient who is sufficiently sick to be bedridden is, in a sense, devoting his whole attention for the time being to coping with the state of illness and to goals of facilitating recovery. These circumstances, however, do not apply literally to the whole range of illness. Many of the cases of chronic illness require only a very partial attention on the part of the patient as well as the physician to take the appropriate measures which a management regimen requires. Thus, in the case of diabetes, for the relatively mild case, sufficient care to take the medication prescribed according to the regimen, some attention to testing of sugar level in urine, and some attention to diet are daily routine obligations of the patient. Usually, if he is under medical supervision, there will be, in addition to that, periodic checks on his condition by the physician in question. Outside of performance of these obligations, however, in cases of

this sort, the "sick person" goes about his business in other concerns of life than participating in a health agency-illness interaction. He presumably engages in occupational work, in family and friendship relations, and the rest of the normal concerns of people who are not defined as ill.

It is particularly important for the health care agent, again notably the physician, that his concern with problems of illness is typically a career occupation which, following the completion of training, can be expected to go on throughout his more active life. In the type case of acute illness, the state of being sick is, for the sick person, however, a temporary episode, such that every effort will be made, both by himself and by his physician, to limit its duration as much as possible. Once "recovered" he relinquishes the sick role, but even in cases of chronic illness of the sort discussed, though the role of being sick is not temporary, it becomes a part-time but not totally absorbing role, except in very severe cases, which of course are by no means of negligible importance.

I have already noted that it is erroneous, as some interpreters of my previous work in this area have maintained, to consider the role of the sick person, notably in the capacity of patient, who is positively related to health care agencies, as that of a purely passive object of manipulation or "treatment." Indeed, I should regard even the acceptance of such treatment as one type of active participation of the sick person. However, his activity very generally goes well beyond this. We might suggest that the level of activity is minimized for acutely ill patients, particularly when they are hospitalized and subject to the ministrations not only of physicians but of nurses and other hospital personnel. Even in these cases, however, some active participation in addition to merely accepting hospital treatment is generally involved. And, the less acute the mediate situation, the more likely it is that this participation will be substantial. Such as it is, it may concentrate on a role complementary to that of the health care agent in furthering the goal of either recovery or minimization of the curtailment of the capacities of the healthy person. It may, however, extend into functionally different areas. A notable example has been described by Dr. Renee Fox in her *Experiment Perilous* (1959) with respect to the way in which the patients on Ward F12 actually participated in substantial ways in the research program to which the ward was committed. They served in a very real sense as research assistants

of the investigating medical team. This assistance above all focused on self-observation and reporting to the medical team on what had, in fact, been observed about their own conditions.

This topic of the sick person's active participation shades over into another very important one. This concerns the fact that lay people, as a consequence of their education and experience, have a certain amount of knowledge and understanding in matters of illness. At the very minimum, this should concern decisions about when professional help is indicated and when it can safely be dispensed with. Of course the matter of the concern is not only with the decision maker's own state of health or illness but of others close to him, in particular, members of his family. There is a considerable range of situations in which self-care or non-professional care in the household is not only undertaken but not infrequently proves to be adequate. Lay judgments in these matters are, of course, notoriously fallible. Thus, how many women have died because of failure to seek professional investigation of a lump in a breast which might be a symptom of cancer of the breast? The woman in question may have observed this herself for a long period without seeking professional judgment. But surely, no ordinary medically untrained woman would be able to deliver a competent judgment, simply from feeling her own breast, whether a lump which was present was malignant or not.

I do not mean to contend that lay opinion and decision making are infallible. For example, various kinds of health examinations and checkups may be extremely important. (I might simply report that my own mild diabetic condition came to light as a result of a general medical checkup. At the time I underwent that checkup I had no intimation of being a diabetic, but the routine urine tests conducted in connection with the general checkup revealed sugar in the urine.)

It has been my intention in the above discussion to set forth the most important reasons why the professional-lay relationship in the field of illness and health care cannot be treated as a fully symmetrical relationship in the hierarchical dimension. This is to say that, with respect to the inherent functions of effective care and amelioration of conditions of illness, there must be a built-in institutionalized superiority of the professional roles, grounded in responsibility, competence, and occupational concern. This is not

for a moment to say that the exact ways in which the lines should be drawn can be neatly deduced from such general considerations as my discussion has advanced. These matters are inherently extremely complex, and the situation is far from being static. Hence, it is entirely reasonable to suppose that the lines should be shifted from time to time in the light of new knowledge and changing conditions. I fail, however, to see how it is at all possible to eliminate the element of inequality. To go too far in attempting to do so would surely jeopardize the therapeutic benefits of the vast accumulation of medical knowledge and competence which our culture has painfully built up over a very long period.

Perhaps the health-illness case can be somewhat clarified by a relatively extended comparison with the academic example. This, probably even more conspicuously than the health-illness case, has recently been a subject of passionate polemical disagreement, with one school virtually taking the position that the relation between teacher and student, notably at the level of higher education, must be a fully egalitarian one with no special authority or privileges on the professional side. It seems to me that this position is basically wrong and rests on inadequate understanding of the nature of the functions of teaching and its conditions.

I should suggest that the academic role, to ignore for our purposes considerations touching teaching at more elementary levels than higher education, has in common with the commitment to health care interests the element of fiduciary responsibility. Just as we may assume that in the institutionalized value system of our culture health is better than illness, we may also assume that knowledge and competence are better than ignorance and related degrees and modes of incompetence. As it has worked out in modern societies, responsibility for implementation of this fiduciary function with respect to knowledge and competence has come to be institutionalized in differentiated social structures which we generally refer to as institutions of higher education, a conception in which I should like most emphatically to include the function of research, that is, pursuit of the advancement of knowledge as a goal, relatively independently of its practical applications.

The note just sounded in relation to the health-illness complex is completely relevant in the present context. The fiduciary responsibility of members of the academic profession rests in their

role of trusteeship for the preservation, development, and utilization of a major tradition of very obviously transgenerational significance. This is the tradition of significant and valid knowledge, which has been built over many centuries by extremely complicated processes, but has been preserved as available to many current generations in, for example, externalized symbolic form, books and other publication and the like, and in the competence of persons whose training and experience have exposed them to the essential characteristics of aspects of this tradition, including their history. What I refer to, of course, is the cultural aspect, the cognitive aspect, of what more generally we call the cultural tradition.

Seen in this light, the teaching function is essentially a matter of responsible contact between those who are specially trained in the relevant matters and members of oncoming generations or age cohorts who, for the first time in their particular lives, are becoming engaged in the problems of mastery of relevant aspects of this tradition and developing capacities to use it in their own lives and to contribute to its further development.

If we accept the value premise that where the choice is given, ignorance is always inferior to knowledge, just as illness is inferior to health, it seems to follow that alleviation of the condition of ignorance, which is to say the acquisition of knowledge about and mastery of the great cognitive tradition of our culture, can more effectively be promoted by people who exercise a special competence in these matters than by non-selective interaction among people who, from this point of view, are lay people.

Taking account of appropriate differences and also of the very substantial overlap, the analysis applied in the health-illness case seems to me to be fully applicable here. Of course, the technical character of knowledge varies enormously from elements where only very high-level experts can presume to have competent opinions, such as some of the central issues of the advanced sciences, to elements where professional expertise shades into the kind of competence which lay people can fairly readily acquire. Even, however, with respect to the sector of the spectrum of which the latter propositions are true, it should not be assumed that professional levels of competence are irrelevant to effective performance of what seems to be fairly generally agreed are the relevant functions. Thus, most students exposed to programs of

general education will not be technical experts in any particular cognitively central field.

Stress should be laid on the importance of the exposure in programs of general education of the student to the disciplines and procedures which have gradually come to be institutionalized in the great cognitive traditions of the culture. Indeed, as the cognitive culture has advanced, differentiated, and proliferated, stress has been placed decreasingly on direct mastery of specific content of knowledge and has shifted in the direction of emphasis on the importance of command of general principle, methods of mobilizing the necessary detailed knowledge, and the like.²

It seems to me to be an essential defining characteristic of the educated citizen, in the sense that Gerald Platt and I use that concept in *The American University* (1973; see especially Chapter 4), that such persons should, as part of their socialization experience, have acquired a high level of internalization of these more general characteristics of cognitive culture.

As also seems to me to be true of socialization in general, the fully egalitarian pattern of interaction between socializing agents and persons in the process of coming to be socialized would be inherently ineffective. Its ineffectiveness would rest above all on the fact that the socializing agent was deprived of any significant basis of leverage to exert an influence on his interaction partner which would lead to such internalization.

We would maintain that the teacher has a primary function in his capacity as a socializing agent of exerting such leverage to motivate the subject to learn and above all to acquire cognitive habits of orientation which will facilitate both new learning of cognitively relevant matters and their utilization in an indefinitely wide variety of practical affairs.

We would hold that the grounds of the capacity of the teacher are directly comparable with those of the expertise of the physician. That is, they rest on three primary factors: namely, the special, we hope on the average, above-average level of inborn ability in the relevant respects enjoyed by teachers at levels of higher education relative to the general lay population of non-teachers. The second concerns the effects of formal training ex-

²It seems to me that this is above all what Daniel Bell has in mind in his references to the increasing importance as modern society has developed of *theoretical* knowledge, as distinguished from discrete empirical items of information.

tending back into the elementary grades of education, but culminating at the higher-education levels, of persons who specialize in roles which involve assumption of the fiduciary responsibility to which we are referring. The third factor is that of experience with respect to which it is particularly relevant that teaching in higher education is generally conceived to be a lifelong career commitment.

There is, in our opinion, a notable parallel between the asymmetry just reviewed for the health-illness case and the situation in the educational area. This is essentially the asymmetry of role status as between professional components in the relevant interaction system and "lay components." Even though analysis of the health-illness situation is not to be narrowly restricted to the case of acute illness, we still have presented an analysis which strongly suggests that the fact that the typical physician as a career committed full-time occupational person presents a very sharp contrast to the role of the average patient, who is presumably not making a life career out of being sick. In the academic case, the typical teacher in the field of higher education is comparably committed to a life career. The role is that of a full-time occupation extending over many years. The teaching function is a central function in this occupational role, even though, as is very clear for the academic world, teaching is not the only function expected of and performed by academic professionals. Research has a particularly important part in the structure of the academic role as it has evolved in the more recent period, and so do administrative functions. Nevertheless, the function of teacher over long periods of time and in an occupational context is clearly central to the academic situation.

The student, however, is comparable to the sick person in one crucial respect. One is not, except in certain chronic cases, permanently ill, but rather is ill because of occasions which will normally be expected to be temporary. The type case is, of course, in the episode of specific, acute illness. The student role is different; however, one may speak perhaps, of a comparable state of "acute" ignorance. If a person is to progress beyond that state, he or she must be exposed to formal educational procedures. These, however, are not typically of lifelong duration, but are rather concentrated in relatively brief periods which are sectors of a more comprehensive life course. Thus, the perennial student who, let us say, after twenty years is still a student, has a certain parallel to the sick person who enjoys high levels of "secondary gain" in his ill-

ness and is highly resistant to pressures to recover. It is for this reason that students cannot qualify in, for example, presumptively revolutionary neo-Marxist thinking as a "social class," since social class is a status to which its members are in a typical case allocated for life. To be a student is not that kind of categorization any more than to be a sick person is typically such. Clearly, therefore, the population of the "ignorant," that is people who are under pressure to study, is no more a categorization of a permanent, lifelong group of human individuals than is that of the sick as a permanent category vis-à-vis the well, to say nothing of vis-à-vis the professional personnel whose services are relevant to the control of their conditions and the consequences of such conditions.

I therefore conclude that there is an inherent built-in asymmetry in the teacher-student interaction system which rather closely parallels the asymmetry of the physician-patient system.

Conclusion

I very much hope that the above embodies an adequate explanation of the fact, so it seems to me, that except in cases which are clearly marginal to the phenomena of illness and its care, the relation of sick person and health care agency is inherently asymmetrical on the hierarchical axis. It should be made very clear, however, that this hierarchical difference is relatively speaking functionally specific and not diffuse. Relative to sick people, physicians do not constitute an aristocracy occupying a diffusely superior status. Their superiority is focused on the specific functions of handling people who have impairments of health, that is, who in some specific sense or some respect are sick. Though the status of physician in our general scale of stratification is rather a high one, it is not at all infrequent that physicians will have patients who in general social status are their superiors, not their inferiors. This, for example, would be the case when very high officials of government become ill, including presidents and prime ministers. With respect, however, to the complex of health and illness, there can be no doubt of the institutionalized superiority of the health care agent, notably the physician. I have contended that this feature holds not only for the health care field but also all of those where

professional groups occupy roles characterized by what above has been called fiduciary responsibility.

This goes back to the role of parenthood. Where children are small, it is clearly out of the question that in every relevant respect they should be treated as the complete equals of their parents. Indeed, attaining a stage when such equality makes sense is normally the signal for ceasing to be in the role of child in the family orientation. The typical "grown" child tends to leave the parental household and live independently, often or rather in the majority of cases setting up with a marriage partner an independent household. I hope that sufficient evidence has been presented to make it clear that a similar asymmetry is to be found in the teacher-student relationship with special reference to functions of higher education. Of course, this patterning extends far beyond the two or three cases just mentioned. Brief mention was made above of the legal situation where an ordinary lay person who has sufficiently complex legal problems to require the services of professional lawyers is, with respect to the performance of the function of advocating or protecting the lay person's legal rights, definitely not to be considered the equal of the attorney. Just as we do find cases of self-medication or the calling on other medically speaking lay people to deal with some kinds of illness, so we find cases where lay individuals act as their own lawyers and, indeed, cases where people who are initially ignorant do not resort to the professional services of regular teachers but undertake to teach themselves. These marginal cases, however, cannot be legitimately used as a model for the institutionalization of these types of functions, all of which in different ways involve the assumption of fiduciary responsibility.

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