

AIDS and Its Impact on Medical Work: The Culture and Politics of the Shop Floor

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IN 1979 WHEN UNDERGRADUATES APPLIED IN RECORD numbers for admission to medical school, AIDS was not a clinical and diagnostic category. In 1990 when the applications to medical schools are plummeting, AIDS is unarguably with us, and not just as a clinical entity. AIDS has become what the French anthropologist Marcel Mauss called a “total social phenomenon—one whose transactions are at once economic, judicial, moral, aesthetic, religious and mythological, and whose meaning cannot, therefore, be adequately described from the point of view of any single discipline” (Hyde 1979). For cultural analysts, present and future, the 1980s and beyond are the AIDS years.

This article is about the impact of AIDS on the shop floor of the academic urban hospital, an attempt to understand the impact of AIDS on everyday practices of doctors providing inpatient care. Following Mauss, we wish to view AIDS as a total social phenomenon rather than as a mere disease. Procedurally, we shall concentrate on the house officer (someone who, after graduation from medical school, participates in medical specialty training) and the medical student to see how this new infectious disease changes the content of everyday work and the education of apprentice physicians learning how to doctor and to

assume the social responsibilities of the role of the physician. We are going to look at professional and occupational culture as a set of shop-floor practices and beliefs about work.

At the close of this article we will make some generalizations about the impact of AIDS on medical training and reflect on how this affects the professional culture of physicians. This may distort the picture somewhat, as the urban teaching hospital is not representative of the whole world of medical practice. To the degree that AIDS patients are concentrated in them, any inferences drawn from large teaching hospitals overstate or exaggerate the impact of AIDS. At the very least, such sampling fails to catalogue the variety of strategies individual physicians may use to avoid patients with AIDS. It fails, as well, to capture the innovative approaches to AIDS of pioneering health professionals in nontraditional settings.

This sampling problem notwithstanding, the urban academic teaching hospital is the arena of choice for studying the impact of AIDS on the medical profession. The concentration of cases in urban teaching hospitals means that students and house officers have a high likelihood of treating patients with AIDS. They are the physicians on the clinical front lines, the ones with the heaviest day-to-day operational burdens.

Further, our attention to the house officers and students possesses a secondary benefit for this inquiry into shop-floor or work-place culture: namely, the natural state of the work place in its before-AIDS condition has been extensively documented. We use the terms shop-floor and work-place culture to invoke the sociological tradition for inquiries into work begun by Everett C. Hughes (1971) at the University of Chicago in the post-World War II years. This tradition emphasizes equivalencies between humble and proud occupations, the management of "dirty work," the procedures that surround routines and emergencies, and the handling of mistakes. Above all, the perspective invites us to reverse our "conventional sentimentality" (Becker 1967) about occupations. The idea of the hospital as a shop floor is one rhetorical device for reminding us that house officers and students are workers in a very real and active sense.

Numerous autobiographical accounts beginning with the pseudonymous Dr. X of *Intern*, catalogue the conditions of the shop floor (Dr. X. 1965; partial list of subsequent narratives includes Nolen 1970; Rubin 1972; Sweeney 1973; Bell 1975; Haseltine and Yaw 1976;

Horowitz and Offen 1977; Mullan 1976; Morgan 1980). There have also been similar commentaries on medical schools (Le Baron 1981; Klass 1987; Klein 1981; Konner 1987; Reilly 1987). Novels by former house officers have also described the work-place culture of physicians in training and the tensions inherent in it. (Examples of this genre include Cook 1972; Glasser 1973; and Shem 1978.)

In addition, there is a large literature on the socialization of medical students and house officers; each of these can be viewed as studies of shop-floor culture. (For a critical overview of this literature see Bosk 1985; individual studies of note include Fox 1957; Fox and Lief 1963; Becker et al. 1961; and Coombs 1978.) The literature on house officers is even more extensive. (See Mumford 1970 and Miller 1970 on medical internships; Mizrahi 1986 on internal medicine residencies; Light 1980 and Coser 1979 on psychiatry; Scully 1980 on obstetrics and gynecology; and Bosk 1979 and Milman 1976 on surgery; Burkett and Knafelz 1976 on orthopedic surgeons; and Stelling and Bucher 1972 have focused on how house officers either avoid or accept monitoring by superordinates.)

We can construct a before-AIDS shop-floor culture as a first step in assessing what difference AIDS makes in the occupational culture of physicians. Our picture of the after-AIDS shop floor arises from the pictures drawn in the medical literature, our teaching and consulting experience in large university health centers, and 30 interviews with medical personnel caring for AIDS patients. These interviews were conducted with individuals at all levels of training and provide admittedly impressionistic data which need more systematic verification. The interviews averaged an hour in length and explored both how workers treated AIDS patients and how they felt about the patients.

Shop-floor Culture before AIDS: Exploitation and Powerlessness

The pre-AIDS shop floor in academic medical centers is not a particularly happy place, as depicted in first-hand accounts of medical education. The dominant tone of many of the volumes is a bitter cynicism, captured in two of the dedications: Glasser's work "For all the Arrow-

smiths"; Cook dedicates his volume "to the ideal of medicine we all held the year we entered medical school." The set of everyday annoyances extends considerably beyond the long hours of work, although these alone are burdensome. Beyond that there is the fact that much of the work is without any profit for the house officer; it is "scut" work, essential drudgery whose completion appears to add little to the worker's overall sense of mastery and competence. (Becker et al. 1961 first commented that medical students, like their more senior trainees, disliked tasks that neither allowed them to exercise medical responsibility nor increased their clinical knowledge.) Consider here a resident's reaction to a day in the operating room, assisting on major surgery:

I urinated, wrote all the preoperative orders, changed my clothes, and had some dinner, in that order. As I walked across to the dining room, I felt as if I'd been run over by a herd of wild elephants in heat. I was exhausted and, much worse, deeply frustrated. I'd been assisting in surgery for nine hours. Eight of them had been the most important in Mrs. Takura's [a patient] life; yet I felt no sense of accomplishment. I had simply endured, and I was probably the one person they could have done without. Sure, they needed retraction, but a catatonic schizophrenic would have sufficed. Interns are eager to work hard, even to sacrifice—above all, to be useful and to display their special talents—in order to learn. I felt none of these satisfactions, only an empty bitterness and exhaustion (Cook 1972, 74).

The complaint is not atypical.

In all accounts, house officers and students complain about the ways their energies are wasted because they are inundated with scut work of various types. If procedures are to be done on time, house officers have to act as a back-up transport service. If test results are to be interpreted and patients diagnosed, then house officers have to track down the results; they are their own messenger service. In many hospitals house officers and students do the routine venipunctures and are responsible for maintaining the intravenous lines of patients requiring them. Routine bloodwork comprises a large amount of the physician-in-training's everyday scut work.

Their inability to control either their own or their patient's lives, their fundamental powerlessness, and the exploitation of their labors by the "greedy" institution (Coser 1979) that is the modern academic hospital are all at the center of physician's accounts of their training.

Clinical Coups and Defeats

The juxtaposition of labors that are both Herculean and pointless account for the major narrative themes in accounts of patient care. First, there are stories of "clinical coups." These are dramatic instances where the house officer's labors were not pointless, where a tricky diagnostic problem was solved and a timely and decisive intervention to save a life was initiated. Such stories are rare but all the house officer accounts, even the most bitter, tell at least one. These tales reinforce—even in the face of the contradictory details of the rest of the narrative—that the house officer's efforts make a difference, however small; that the pain and suffering of both doctors and patients are not invariably pointless; and that professional heroism may still yield a positive result, even if only rarely.

More numerous by far in the narratives are accounts of "clinical defeats." A few of these tales concern the apprentice physician's inability to come to the right decision quickly enough; these are personal defeats. The bulk of these tales, however, concern defeat (indexed by death) even though all the right things were done medically. Narratives of clinical defeats generally emphasize the tension in the conflict between care and cure, between quantity and quality of life, between acting as a medical scientist and acting as a human being.

The repeated accounts of clinical defeats reinforce at one level the general pointlessness of much of the house officers' effort. They recount situations in which house officers either are too overwhelmed to provide clinical care or in which the best available care does not insure a favorable outcome. But the stories of defeat tell another tale as well. Here, house officers describe how they learn that despite the failings of their technical interventions they can make a difference, that care is often more important than cure, and that the human rewards of their medical role are great. Each of the first-hand accounts of medical training features a tale of defeat that had a transformative effect on the physician in training. Each tale of defeat encodes a lesson about the psychological growth of the human being shrouded in the white coat of scientific authority. For example, Glasser's *Ward 402* (1973) centers on the unexpected decline and death, following initial successful treatment, of an eleven-year-old girl with acute leukemia. The interaction with her angry, anxious, and oppositional parents and the futile medi-

cal struggle to overcome neurologic complications forces the protagonist to see beyond the narrow medical activism that he had been carefully taught. In the end the intern hero literally pulls the plug on the child's respirator and goes off to see the angry, drunken father vowing, this time, to listen.

Psychological Detachment and Adolescent Invulnerability

The shop-floor culture of house officers and students is largely a peer culture. The senior authority of faculty appears absent, at best, or disruptive and intrusive, at worst, in the first-hand narratives of clinical training. That is to say, the clinical wisdom of faculty is unavailable when house officers need it; when clinical faculty are present, they "pimp" (humiliate by questioning) house officers during rounds with questions on obscure details or order them to perform mindless tasks easily performed by those (nurses, technicians) far less educated about the patho-physiology of disease.

As a result, house officers feel isolated and embattled. Patients, other staff, and attending faculty are the enemy; each is the source of a set of never-ending demands and ego-lacerating defeats. Konner (1987, 375), an anthropologist who acquired a medical degree, is quite eloquent on the theme of the patient as enemy:

It is obvious from what I have written here that the stress of clinical training alienates the doctor from the patient, that in a real sense the patient becomes the enemy. (Goddamit did she blow her I.V. again? Jesus Christ did he spike a temp?) At first I believed that this was an inadvertent and unfortunate concomitant of medical training, but I now think that it is intrinsic. Not only stress and sleeplessness but the sense of the patient as the cause of one's distress contributes to the doctor's detachment. This detachment is not just objective but downright negative. To cut and puncture a person, to take his or her life in your hands, to pound the chest until ribs break, to decide upon drastic action without being able to ask permission, to render a judgment about whether care should continue or stop—these and a thousand other things may require something


stronger than objectivity. They may actually require a measure of dislike.

This sentiment is not, of course, unique to Konner. One sociologist, writing about the socialization process in internal medicine, found negative sentiments about patients so rife that she titled her account *Getting Rid of Patients* (Mizrahi 1986).

Feelings about patients are most visibly displayed in the slang that physicians in training use to describe patients. Beyond the well-known "Gomer" (George and Dundes 1978; Leiderman and Grisso 1985), there is a highly articulated language that refers to patients in distress. Along with the slang, there is much black and "gallows" humor. This black humor is a prominent feature of Shem's (1978) *House of God*.

The slang and humor highlight the psychological and social distance between patients and those that care for them medically. This distance is best exemplified in Shem's "Law IV" of the *House of God*: "The patient is the one with the disease." The reverse, of course, is that the doctor does not have a problem. He or she is invulnerable. In the first-hand accounts of training, physicians' feelings of invulnerability appear and reappear. The doctors treat disease but they are rarely touched by it (save for the occasional exemplary patient with whom physicians make a psychological connection). To these young apprentice physicians, disease is rarely, if ever, personally threatening and rarely, if ever, presented as something that could happen to the physician. (Many doctors reacted with shock at Lear's (1980) account of her urologist-husband's careless and callous treatment. These readers seemed to have assumed their M.D.s protected them somehow.) Moreover, given that hospitals (outside of pediatrics and before AIDS) housed a high proportion of patients substantially older than house officers, patterns of mortality and morbidity themselves reinforced the sense of invulnerability. It is the rare patient close in age to the author who provokes distress and introspection about doctoring on the part of writers of first-hand narratives.

The fantasy of invulnerability takes on an adolescent quality when one notes the cavalier tone used to describe some of life's most awful problems and the oppositional stance taken toward patients and attending faculty. There may be something structural in this; just as adolescence is betwixt and between childhood and adulthood, the



physician-in-training is likewise liminal, betwixt studenthood and professional independence.

The Coming of AIDS to the Shop Floor: Risk and the Loss of Invulnerability

Before AIDS entered the shop floor, physicians in training had many objections to work-place conditions. Not only that, AIDS entered a shop floor that was in the process of transformation from major political, social, organizational, and economic policy changes regarding health care. These changes have been elaborated in detail elsewhere (Light 1980; Starr 1982; Relman 1980; Mechanic 1986) and need only brief mention here. Acute illnesses, especially infectious diseases, have given way to chronic disorders. The patient population has aged greatly. There has been a relatively new public emphasis on individual responsibility for one's medical problems—diet, smoking, nontherapeutic drug use, "excessive" alcohol use, exercise, etc. (Fox 1986).

Of great importance has been the redefinition of medical care as a service *like any other* in the economy with individual medical decisions subject to the kind of fiscal scrutiny applied to the purchase of automobiles or dry cleaning. Achieving reduced costs through shorter hospitalizations and other measures, however, has created more intensive scheduling for those caring for patients on the hospital's wards—even if the hospital's capacity shrinks in the name of efficiency. Fewer patients get admitted to the hospital and they stay for shorter periods of time, yet more things are done to and for them, increasing the house officers' clerical, physical, and intellectual work while decreasing the opportunity for trainees to get to know their patients (Rabkin 1982; Steiner et al. 1987). The beds simply fill up with comparatively sicker, less communicative patients who need more intensive care.

All the shifts in the medical care system have changed the reality of hospital practice in ways that may not conform to the expectations of those entering the medical profession. In addition to the usual disillusionment occurring in training, the contemporary urban teaching hospital brings fewer opportunities for hope (Glick 1988). To the extent that AIDS contributes to the population of more desperately ill hospitalized patients, it exacerbates house officers' feelings of exploita-

tion and, because of its fatal outcome, AIDS adds to their sense of powerlessness. We must assess the impact of AIDS against this background of old resentments and new burdens.

AIDS has certainly not improved the work climate of the medical shop floor. The most apparent phenomenon related to AIDS in the contemporary urban teaching hospital is risk or, more precisely, the *perception* of risk. The orthodox medical literature proclaims, over and over, that the AIDS virus does not pass readily from patient to care giver (Lifson et al. 1986; Gerberding et al. 1987). But some medical writing dwells on risks (Gerbert et al. 1988; Becker, Cone, and Gerberding 1989) and observations of behavior make clear that fear on the wards is rampant. Workers of all types, including doctors, have at times sheathed themselves in inappropriate armor or simply refused to approach the patients at all. Klass (1987, 185) put it quite starkly: "We have to face the fact that we are going through these little rituals of sanitary precaution partly because we are terrified of this disease and are not willing to listen to anything our own dear medical profession may tell us about how it actually is or is not transmitted."

Perceptions of risk can and do change with time and experience. Our interviewees and commentators in the literature indicate that as individuals and institutions have more patients with AIDS they begin to shed some of their protective garb. In one hospital we were told that the practice of donning gown, gloves, and masks became less frequent as doctors, nurses, housekeepers, and dietary workers "saw" that they did not get AIDS from their patients. This, of course, raises another interesting question: In what sense did personnel come to this conclusion? After all, the diseases associated with HIV infection typically have long latencies, up to several years, before symptoms develop. None of the institutions where our informants worked conducted routine surveillance to assess development of HIV antibody among personnel. Thus, staff could not really know if they had "gotten" HIV infection. Moreover, reports of individual physicians anxiously awaiting the results of HIV tests after needle sticks have now become a staple of the oral culture of academic medical centers.

On AIDS wards all personnel are far less likely to place barriers between themselves and patients for activities where blood or other body fluids might be transmitted. Beyond subspecialty units, however, medical, nursing, and support staff are far more fearful and employ many more nonrational techniques to prevent contamination. (We refer to

simple touching, as in noninvasive patient examinations, back rubs, etc., as well as activities involving no patient contact at all, such as the placing of meal trays on overbed tables or sweeping the floor.) One informant told us that HIV-infected hemophilia patients in one hospital often refuse hospitalization if it means getting a room on certain floors or nursing units. The patients prefer to delay needed treatment until a bed becomes available on a unit where they feel more humanely treated.

Several other curious phenomena have emerged regarding risks and AIDS in the medical work place. While in some locations lack of experience has led to classic reactions of fear and avoidance, in other places the paucity of experience permits denial to dominate. The comments of house staff in a hospital with only an occasional AIDS patient indicated that few residents followed Centers for Disease Control or similar guidelines for "universal precautions." Various explanations were offered, including the conviction that starting intravenous infusions, blood drawing, or similar procedures is more difficult when wearing gloves. When asked how surgeons accomplish complex manual tasks while wearing one or two pairs of gloves, residents usually replied that they had not learned to do things "that way." Here, one kind of inexperience (with gloves) reinforces another (with AIDS), bolstering the feeling of invulnerability that was widespread before AIDS.

Some medical students and physicians have dealt with the problem of risk globally. They want to avoid encountering patients with AIDS altogether. In one medical school where we teach, there is a policy prohibiting students from refusing to care for HIV-infected patients. The policy infuriates many students, a fact we learned in medical-ethics discussion groups which met to discuss an AIDS case. They cited several reasons. The rules, some felt, were changed midstream. Had they known about the policy, they might have chosen another school. They felt they had no role in the formation of the policy and that the tremendous economic investment they made in the institution, in the form of tuition, entitles them to some decision-making authority. They objected to the rule's existence. They said such rules have no place in medicine. Doctors, they believe, should have as much freedom as lawyers, accountants, executives, or others to accept or reject "clients" or "customers." When presented with the notion of a professional obligation or duty, based upon generally acknowledged moral precepts, they balked. At other institutions we know there has been more controversy

among medical students, with some making impassioned statements about the physician's obligation to treat. In this debate we see AIDS as a total social phenomenon acting as a vehicle for debating and defining standards of professional conduct.

Another aspect of medical risk avoidance may be revealed through the changing patterns of residency selection. For some time there has been a shift away from primary care specialities like internal medicine, family practice, and pediatrics toward specialities such as orthopedics, ophthalmology, otolaryngology, and radiology (McCarty 1987). The reasons for this phenomena are not entirely clear, but include the technical, rather than personal, orientation of the medical training system and the higher compensation available in the latter group of specialities, sought, in part, because of staggering educational debts. In the past few years, the trend may have accelerated, with internal medicine (whose house staff and practitioners provide the bulk of the care for AIDS patients) training programs failing to find sufficient qualified applicants (Graettianger 1989; Davidoff 1989). This crisis has been most marked in the cities with large numbers of HIV-infected patients. A similar trend toward avoiding residencies in AIDS endemic areas may be emerging in pediatrics, according to faculty rumors; a substantial proportion of pediatric house officers, like those in internal medicine, would not care for AIDS patients if given the choice, according to one survey (Link et al. 1988). (This does not imply that defenses such as denial and risk avoidance were not part of the medical educational culture prior to AIDS. Indeed, denial is at the center of the syndrome of adolescent invulnerability. Such sentiments, however, have now appeared in professional journals.)

Surgical Risk and Historical Precedent

Even more remarkable in the AIDS-risk reaction has been the appearance in prestigious medical journals of complaints, whines, and pleas for understanding from doctors worried about contamination and ruination (Guy 1987; Ponsford 1987; Dudley and Sim 1988; Carey 1988; Guido 1988). These pieces offer various estimates of risk to person, career, family, future patients deprived of the skills of the author or his or her esteemed colleagues, and other justifications for not treating HIV-infected persons. (At last, the attending authors may have forged

an alliance with their house officers by championing the cause of self-protection.) The articles proclaim a kind of anticoup, i.e., they are declarations of futility, contrasting sharply with the verbal swaggering of pre-AIDS narratives. It is important to note that the medical literature on AIDS is not entirely negative; complaints can be matched against calls to duty (Gillon 1987; Zuger and Miles 1987; Pellegrino 1987; Kim and Perfect 1988; Friedland 1988; Emanuel 1988; Sharp 1988; Peterson 1989). On the shop floor and in the literature, AIDS as a total social phenomenon has become the lens for focusing on the obligations of members of the medical profession.

Surgeons have been particularly outspoken about the extent to which they are threatened, and there *is* reason for their special concerns (Hagen, Meyer, and Pauker 1988; Peterson 1989). After all, these doctors have a high likelihood of contact with the blood of patients. This involves not just working in blood-perfused tissues, but also a risk of having gloves and skin punctured by the instruments of their craft or having blood splash onto other vulnerable areas of the body (mucous membranes in professional parlance). Surgeons, by the very nature of their work, do more of this than many other doctors. But other physicians do find themselves in similar circumstances, depending on their activities. Intensive care specialists, invasive cardiologists, emergency physicians, pulmonary and gastrointestinal specialists, and others have frequent and/or sustained contact with the blood or other body fluids of patients who may be infected with HIV. House staff, as the foot soldiers doing comprehensive examinations, drawers of blood specimens, inserters of intravenous catheters or other tubes in other places, cleaners of wounds, or simply as those first on the scene of bloody disasters, are particularly likely to be splashed, splattered, or otherwise coated with patient's blood, secretions, or excretions.

We do not have data on the extent to which fears have or have not been translated into changes in behavior in operating and/or procedure rooms. In some communities there may now be fewer operations and these procedures may take longer as extra time is taken to reduce bleeding and avoid punctures. This may not turn out to be as good as it might at first seem. To the extent that high-risk patients have operations delayed or denied or must undergo longer anesthetics and have wounds open longer, patient care may be compromised.

It is interesting to compare the current outcry with what happened

when medical science discovered the nature of hepatitis and recognized the medical risks to personnel of serum hepatitis, now known as hepatitis B. As long ago as 1949 (Liebowitz et al. 1949), the medical literature acknowledged that medical personnel coming in contact with blood stood at risk from hepatitis. A debate continued through the 1950s, 1960s, and early 1970s about whether surgeons were especially vulnerable because of their use of sharp instruments, the frequency of accidental puncture of the skin during surgical procedures, and the likelihood of inoculation of the virus into the bloodstream of the wounded party. The risks were felt to be clearly documented in an article (Rosenberg et al. 1973) in the *Journal of the American Medical Association* that commented: "This study demonstrates the distinct occupational hazard to surgeons when they operate on patients who are capable of transmitting hepatitis virus. . . . We believe that serious attempts should be made to prevent future epidemics. . . . Education and constant vigilance in surgical technique are central to any preventive program." Nowhere does the article suggest surgeons should consider not operating on patients at risk for hepatitis.

Of course, hepatitis B is not associated with a fatal prognosis in a large proportion of cases and is not entirely comparable to AIDS. Nonetheless, the epidemiologic evidence gathered in the 1970s suggested that hepatitis B was very prevalent among physicians, especially surgeons (Denes et al. 1978), and that medical personnel seemed especially vulnerable to having severe courses of the disease (Garibaldi et al. 1973). A portion become chronic carriers of the virus, with the added risk later of liver cancer and liver failure from cirrhosis. Moreover, secondary spread from infected medical workers can occur to patients (through small cuts and sores on the workers' skin) and sexual partners (through exchange of bodily fluids). Despite all this, major medical journals did not carry discussions of whether doctors at risk might be excused from professional activities. It may be that our society's general risk aversiveness (Fairlie 1989) and tolerance of self-centeredness have escalated sufficiently to make public renunciation of professional responsibility more acceptable. More likely, the general medical professional ethic has changed to one closer to that of the entrepreneur, as was true for our students. But perhaps something else is going on that, being synergistic with the perceived loss of invulnerability brought on by AIDS, makes the AIDS era distinctive.

AIDS as a Total Social Phenomenon

The reaction to AIDS on the shop floor must be examined in light of the perceptions of risk, the epidemiology of AIDS, and moral judgments some make about activities that lead to acquiring the disease. Most AIDS patients have come from identifiable populations: the gay community, intravenous drug users and their partners, and those who have gotten the disease from medical use of blood and blood products. While hepatitis B infections were prevalent in these populations and also entailed risks to medical personnel, hepatitis in such patients did not cause doctors to deny their professional responsibility to provide treatment. We are arguing that the unique combination of factors associated with AIDS prompts the negative reactions among doctors: changing tolerances of risk, the shift to an occupation bounded by entrepreneurial rules rather than professional duties, a specific fear of the terrible outcome should one acquire AIDS from a patient, objections to some of the specific behaviors which lead to AIDS, and class and racial bias. Below, we discuss some of the social characteristics of AIDS patients which affect the negativity of the professionals.

The demographics of AIDS is striking and flies rudely in the face of the last several decades of medical progress. Most AIDS patients are young adults. This is true of gays, drug users, and even the hemophiliacs, by and large. Most house officers, however naive and unprepared they are to confront devastating illness and death, at least have a general cultural and social expectation of, if not experience with, the death of old people. With AIDS, many of the sickest patients filling teaching hospital wards in high-prevalence cities are in their prime years, similar in age to the house staff providing the front-line care (Glick 1988). People so young are not supposed to die. These deaths challenge the ideology of the coming-if-not-quite-arrived triumph of modern medical science implicitly provided young doctors in medical education. (Two former house officers have written about the effects of AIDS on medical training: Wachter 1986; Zuger 1987.)

We do not want to paint with too broad a brush here. There are some important differences among the groups of AIDS patients, which influence the reactions of resident physicians. Our informants describe three nonexhaustive groups of patients to whom young doctors and students react: hemophiliacs and others who acquired AIDS through

transfusion, young gay men, and drug users and their partners. (We have insufficient information to comment on the reaction to the rapidly growing infant AIDS population.)

In many ways, the patients who develop AIDS from blood products constitute a simple set. These patients are clearly seen as innocents, true victims of unfortunate but inevitable delay between recognition of a technical problem—blood-borne transmission of a serious disease—and its reliable and practical prevention—cleaning up of the blood supply. A chief resident commented that her house officers talk differently about patients with AIDS caused by transfusions from the way they speak about other AIDS patients. “The residents see these cases [with blood-product-related disease] as more tragic; their hearts go out to them more.” Hemophiliacs have an air of double tragedy about them: an often crippling, always inconvenient genetic disorder made worse as a direct consequence of their medical treatment.

Hemophiliac patients with AIDS in one of the hospitals where we made inquiries went out of their way to make the origins of their disease or other emblems of their identity known. These patients “display” wives and children to differentiate themselves from homosexual patients. One hemophiliac, reflecting on his desire to have others know that his HIV-positive status preceded his drug abuse, commented that this public knowledge was important because there is “always a pecking order” in who gets scarce nursing care. Even though few people hold these patients in any way responsible for their disease, behavior on the wards toward HIV-positive hemophiliacs clearly differs from attention given non-AIDS or non-HIV-infected patients. As mentioned earlier, their hospital rooms are not as clean as the rooms of hemophiliac patients not infected with HIV; the staff does not touch them as often as they once did. (Many of these patients were frequently hospitalized before the HIV epidemic; in effect, they have served as their own controls in a cruel experiment of nature.) Their care is compromised in small but painful ways.

Gay patients with AIDS occupy an intermediate position in the hierarchy. The social characteristics of many of these patients, in the eyes of our informants, were positive ones: the patients were well educated, well groomed, took an active interest in their treatments, had supportive family and/or networks that relieved some of the burdens from their care providers, and the like. Of course, not all medical personnel

appreciate all of these features. Interest in care has emerged into social activism about treatment, which some physicians resent. For example, one patient who had developed severe difficulty swallowing, and was starving as a consequence, requested insertion of a feeding tube through his abdominal wall into his intestinal tract. His primary physicians tried to put him off, apparently believing he would succumb soon, no matter what was done. When he persisted, a surgical consultant was called. The surgeon initially treated the request as a joke, finally agreed after an attempt to dissuade the patient ("So, you really want to do this?"), and then provided no follow-up care. This is but one case, but our general impression is that the "turfing" (Transferring) that Shem (1978) described as a major feature of shop-floor culture before AIDS has intensified. Physicians want to shift the burdens and responsibilities of care to others.

From the resident's point of view, there may also be a down side to the extensive support systems many gay patients enjoy. In the final stages of AIDS, little more can be done for patients beyond providing comfort. For the interested and compassionate resident, titration of pain medication and less technical interaction, i.e., talking with the patient, can be therapeutic for both. If the patient has become invested in alternative treatments for discomfort, from herbal medicine to meditation to imaging, and if the patient is surrounded by loving family and community, the house officer may feel she or he has nothing whatsoever to contribute. This helplessness amplifies the despair and the pointlessness of whatever scut work must be done. Here, there can be no transforming, heroic intervention, no redemption arising from clinical defeat.

The IV-drug-using HIV-infected patients represent the fastest growing and most problematic set of patients. Teaching hospitals have always had more than their share of patients who are "guilty" victims of disease, i.e., patients whose medical problems are seen as direct consequences of their behavior. Many of our prestigious teaching hospitals have been municipal or county facilities filled with substance-abusing patients with a wide spectrum of problems from which house staff have learned. Our informants suggested that the coming of AIDS to this population had subtly altered the way these patients are regarded. Now, drug users cannot be regarded with mere contempt or simple disrespect: there is fear among doctors who are afraid of acquiring AIDS from the patients. Whereas frustration and anger in some cases (espe-

cially when drug users were manipulative or physically threatening) and indifference in others used to constitute much of the response to drug-using patients, fear of AIDS has added a difficult dimension.

One might argue that before HIV, this underclass population had a set of positive social roles to play. Their very presence reminded doctors and nurses, perhaps even other patients, that things might not be as bad as they seemed. The intern might be miserable after staying up an entire weekend, but she/he could look to a better life ahead and know that she/he did not have to face homelessness and desperate poverty when finally leaving the hospital to rest. Moreover, the underclass patients provided chances to learn and practice that private patients could not offer. (The poor often have more complex or advanced medical problems, compared to wealthier patients, because of limited access to care and delays in diagnosis and treatment. In addition, attendings often permit house staff to exercise greater responsibility with "service" patients.) But AIDS seems to have changed the balance for many who might have tolerated or welcomed the opportunities to care for the undeserved. For a medical student contemplating a residency, what was previously a chance to gain relative autonomy quickly in an institution with many substance-abusing patients may have become predominantly unwelcome exposure to a dreadful illness. If this is so, AIDS will trigger, in yet another way, a dreadful decline in the availability and quality of care for America's medical underclass.

Conclusion

The full impact of AIDS on the modern system of medical care will not be clear for many years. Nevertheless, the disease has already affected the culture of American medicine in a pivotal place: the urban teaching center. Already a scene beset with anger, pain, sadness, and high technology employed soullessly against disease, AIDS has added to the troubles. We cannot know for certain whether this new plague has contributed to the decline in interest in medicine as a career or to the flight from primary care. There is certainly no evidence that AIDS has prompted many to seek out a life of selfless dedication to tending the hopelessly ill.

For those who have chosen to train in hospitals with large numbers of AIDS patients, the disease has added to the burdens of the shop

floor. The perception of risk of acquiring AIDS has undermined one of the best-established defenses house officers have relied on: the maintenance of an air of invulnerability. Some doctors are so scared they are abandoning their traditional duty and no longer seem able or willing to try to bring off the heroic coup against daunting clinical odds. To be sure, this fear is fed by other factors on the social scene: the economic changes in medicine, transforming the profession into the province of the entrepreneur; the youth and other characteristics of many AIDS patients; and the willingness of the entire society to turn away from the underclass, especially from those who are seen as self-destructive.

Nothing here suggests that AIDS will spark a turn to a kinder, gentler medical care system. Those in the educational system inclined to seek models providing compassionate medical care will likely find few attractive mentors. Instead, they will meet burned-out martyrs, steely-eyed technicians, and teachers filled with fear. Tomorrow's first-hand accounts of medical education and fictionalized autobiographies may, as a result, be even grimmer than yesterday's.

There is the possibility that this conclusion is too stark, too depressing. For those desperate for a more hopeful scenario, at least one other alternative suggests itself. As the numbers of medical students dwindle, perhaps those that enter will be more committed to ideals of professional service and, among those, some will enter with a missionary zeal for caring for AIDS patients. There is little to suggest this other than the portraits of the few heroic physicians one finds in Shilts's (1987) account of the early years of the AIDS epidemic. If these physicians inspire a new generation of medical professionals, then the tone of future first-hand accounts will be more in line with the highest ideals and aspirations of the medical profession.

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