

# Life in the Hospital: A Review

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UNTIL THE 1960S, STUDIES OF HOSPITALIZED patients and their social worlds made up a significant part of an expanding literature on life in hospitals. However, as Renée Fox (1989, 162) has observed, these studies were set in chronic-care hospitals more frequently than in acute-care ones “and [were] more likely to have been conducted in the period extending from the 1940s to the early 1960s, than in the 1970s and 1980s.” In this article I will attempt to explain why a once lively research tradition is now largely moribund and why the traces that do persist have been confined to staff rather than patients and to the hospital areas least relevant to contemporary concerns about health care.

I argue that the research tradition that made the social world of hospital patients its central concern disappeared for good reasons, reasons mirroring transformations of the hospital itself. I suggest, however, that those very transformations of the hospital that have made the older research tradition largely irrelevant to contemporary concerns imply an alternative intellectual and policy agenda that may give the experience of hospitalized patients a high priority, albeit in a very different intellectual context.

## The Early Ethnographies

Through the 1960s a number of superb ethnographies shared three preoccupations. First, they were intent on demonstrating the presence within the hospital of a distinct social world created and populated by patients, largely independent of staff. Second, they documented the complex set of relations between patients and staff. Third, and perhaps most important, they argued that the health outcomes of hospitalization often depended directly on the character of both types of relations.

The earliest of these ethnographies—including the most important, Stanton and Schwartz's *The Mental Hospital* (1954) and Caudill's *The Psychiatric Hospital in a Small Society* (1958)—were limited to psychiatric settings. (See also Greenblatt, Levinson, and Williams 1957; Dunham and Weinberg 1960.) There, the claim that social organization affected health outcomes (although still new in the context of the 1950s) was perhaps less startling than it would have been in general hospitals populated by patients whose diseases are more clearly physiological in character, if not always in origin. The 1959 publication of Fox's *Experiment Perilous* (1959), a book that drew self-consciously on the earlier versions of a still emerging tradition, did, however, creatively extend the insights of the mental hospital studies to a setting populated by patients with diseases of a different sort. However, Fox's research concentrated on the special case of an experimental ward (for patients with metabolic disease) and was the most cautious of the major studies within the tradition under review here in its claims about the effects of social organization: Fox carefully limited herself to the claim that relations among patients and between patients and staff affected adaptations to stress rather than health outcomes themselves. Only in the 1960s, then, in Coser's *Life in the Ward* (1962) and in Duff and Hollingshead's magisterial but now largely forgotten *Sickness and Society* (1968) did the tradition of hospital ethnography settle firmly in the archetypal setting of contemporary health care: the floors and wards of the general hospital.

Much, for example, of Coser's *Life in the Ward* is devoted to exploring the relations that developed between patients on a single ward of "Mount Hermon" hospital. Rather than an experience endured alone, Coser discovered a collective experience of illness and hospitalization, an experience mediated by an intricate social structure. Thus, Coser found both "newcomers" and "opinion leaders" within the ward, a system of

social support based on the shared conditions of temporary handicap and submission to the same authority, and joking relations that helped build and sustain solidarity among patients. Rather than a single, undifferentiated experience, Coser (1962, 100) found one distinguished by the patients' orientation to doctors and hospitals—on the one hand, there was the “instrumental” orientation, whereby the hospital was viewed as a place “equipped to do a specific job”; patients with a “primary” orientation, on the other hand, saw the hospital as a source of general care, attention, and gratification.

Although *Life in the Ward* paid only passing attention to inequalities between patients, Duff and Hollingshead's *Sickness and Society* placed them center stage. Published in 1968, but based on research conducted at Yale New Haven hospital in the early 1960s, *Sickness and Society* is not only the most comprehensive study available of the American hospital in the years prior to Medicaid and Medicare, but also a searing indictment of the medical system it represented. At the core of its analysis is the documentation of pervasive inequalities, most significantly as they shaped the willingness of physicians to assume “committed” (rather than merely “casual”) sponsorship of the patients in their care.

Although very different in scope and intent, both *Life in the Ward* and *Sickness and Society* emphasize the relevance of their findings to health and healing within the hospital. Thus, Coser's interest in mutual support, solidarity, and joking relations between patients was not simply a matter of anthropological curiosity. Rather, she addressed such matters as aspects of patients' adaptation to the hospital sick role and factors in their ability (and willingness) to resume normal obligations outside the hospital. Thus, although Coser has a good deal to say about what makes the hospital pleasant or unpleasant, “humane” or “inhumane,” her criteria for evaluating the quality of patient life in the hospital are quite different. Indeed, her central finding suggests that the ability of patients to build a rich social life among themselves and with the hospital staff may actually detract from the hospital's primary mission: Whereas “acceptance of hospital norms and a primary orientation toward the hospital or doctor may facilitate adaptation to the ward, they may also make it difficult for patients to leave the sick role and the ward and take up again their normal lives and work” (Coser 1962, 112).

Similarly, Duff and Hollingshead's account, although surely animated by egalitarian impulses, was also driven by something more. Many of the conditions that brought patients to hospitals—somewhere

between one-third and one-half by Duff and Hollingshead's estimate—were psychological in origin and often required treatment of a “way of life” as well as of a specific disease. However, failures of communication between doctor and patient, exacerbated when the patients were lower class in origin, Duff and Hollingshead argued, led to frequent misdiagnoses and consequent failures to develop appropriate courses of treatment. Inequality became important, then, even within a narrowly constructed vision of a hospital's mission, because it interfered with the effective treatment of the sick.

Taken together, *Life in the Ward* and *Sickness and Society* make a convincing argument that physicians can ignore the social setting of treatment only at risk to their own purposes. Yet, *Life in the Ward* and *Sickness and Society* are today rarely cited. For example, in two recent compendia of social science findings in medicine—Aiken and Mechanic's *Applications of Social Science to Clinical Medicine and Health Policy* (1986) and the fourth edition of the *Handbook of Medical Sociology* (Freeman and Levine 1989)—not a single reference appears to either book. I suggest that the intellectual agenda represented by Coser and by Duff and Hollingshead—a preoccupation with social factors in illness in the specific context of the hospital—exhausted itself in an environment unresponsive to its concerns.

## The Disappearing Patient

### *The Social Research Agenda*

Since the 1960s, there has been little research on life in the hospital to match the scope of the work by either Coser or Duff and Hollingshead. Rather, we have been presented with more detailed research, either conducted in specialized units (the maternity ward, the emergency room, the intensive care unit, the dialysis unit) or directed toward particular groups among hospital staff (most often physicians in training or nurses). This change in focus is not necessarily a matter to regret. We could as easily learn from the accumulation of a large number of specialized research projects as from a smaller number of more general ones. The change, however, represents something more than a change of research strategies: It also denotes a shift of focus, and it specifically indi-

cates an abandonment of the patient and the patient's social world as the primary subject matter of research on life in the hospital.

The disappearance of the patient from a social science research agenda about life in the hospital is especially striking in light of the extraordinary and methodologically diverse body of research on doctor-patient communication outside the hospital. This research has consistently demonstrated patients' dissatisfaction with physicians' instructions, documenting both the techniques used by physicians' to maintain interactional domination and (sometimes) how these failures of communication affect the patient's compliance with medically prescribed regimens (Stoeckle 1987).

In this research, filled with analyses of the implications of social organization for health outcomes, the intellectual and policy agenda represented by the older research on hospitalized patients is very much alive. Inside hospitals themselves, however, it is not. The reason, I would suggest, is a change in intellectual fashion based on a recognition (more often implicit than explicit) that hospitals themselves have changed. Developments internal to the social sciences, particularly sociology, may have contributed to the disappearance of the older research tradition. Three developments have likely exercised significant influence: the growing dominance of quantification and the concomitant decline of ethnographic styles of research; the fall from favor of functionalist analysis, which, particularly in its emphasis on the analysis of institutions as social systems, was a driving force behind many of the earliest hospital ethnographies; and the decline of a psychoanalytically oriented social science. Yet, neither any one of these developments nor all of them taken together seem sufficient to account for the nearly complete disappearance of ethnographies organized around the analysis of patient cultures.

### *The Changing Hospital*

To state the matter bluntly, patient culture is probably less elaborate and the patient's experience is perhaps less consequential for health outcomes now than at any other time in the past century. Of course, precisely because there has been little research on patients' experience of hospitalization over the last two decades, these assertions are difficult to document. Nonetheless, certain well-known trends in the character of hospitals (and the patients they treat) make them at least plausible.

In the first instance, the last two decades have witnessed a continuation, and perhaps even an acceleration, of a century-long decrease in the length of hospital stays. Although the sources of this decrease are complex, the implications for the matters at hand are fairly straightforward. The development of a distinctive patient culture requires some degree of continuity, even among a population that is inherently temporary. An average length of stay that has now reached approximately one week is simply not sufficient to sustain the kind of elaborate social structure described by Coser, let alone the more elaborate social structures of patienthood described by historians as characteristic of the late nineteenth- and early twentieth-century hospitals when stays averaged several weeks for each patient (Vogel 1980; Rosenberg 1987).

Second, the vitality of patient culture has also undoubtedly been sapped by the apparently rapid (but largely undocumented) decline of the large, open ward in the years following the passage of Medicaid and Medicare (Thompson and Goldin 1975). For the large, open ward not only provided the opportunity for patients to mix and mingle, but virtually required that they do so. Although the open ward's replacements—either semiprivate rooms or smaller wards—have by no means eliminated the opportunity for patients to meet, they have surely both curtailed that opportunity and given patient social worlds far more of a voluntary character than was once the case.

Third, one of the hallmarks of the contemporary hospital is the special unit, particularly the intensive care unit (ICU). Found only occasionally in large teaching hospitals as recently as 1970, ICUs now account for as much as one-tenth of the beds in some hospitals (Russell 1979). Even apart from the character of patients' experience in such units, they have changed the "career" of the hospitalized patient. It seems likely that a significant proportion of patients—especially of patients whose stay in the hospital is protracted—transfers in and out of an ICU at some point during their hospital stay (see, for example, Mulley 1983). By siphoning off longer-term patients who might otherwise play a critical part in the construction of a patient culture, the special units eviscerate the ward experience. Thus, these transfers create discontinuities even beyond what the simple proportion of special-unit beds would suggest.

Finally, and more speculatively, it is possible that the social worlds of patient and staff have, in fact, become less important in accounting for health outcomes within the hospital. Although I know of no data that address this issue directly, it is a plausible result, in part, of the de-

creased length of hospital stays and the consequent weakening of patient culture. It is also a probable outcome of the increased acuity of illness characteristic of hospitals, resulting in greater reliance on physiological interventions. However, it is a consequence, most significantly, of the developments of more effective diagnostic and therapeutic techniques, both in chemotherapies and in electronics. None of this is to deny the well-documented findings of a large literature that both stress and social supports exercise significant effects on health and healing outside the hospital. It is only to suggest that in the hospital, particularly under conditions of acute illness and persistent medical intervention, matters of social and psychological adjustment assume a dramatically reduced significance.

### *The Impact of Doctors and Nurses*

It is far less speculative to observe that physicians and nurses themselves show little receptivity to concerns about the patient's experience of life in the hospital. Nowhere is this more apparent than in the abundant accounts—autobiographical (Shem 1978; Harrison 1982; Konner 1987; Conrad 1988) as well as sociological and anthropological (Fox and Lief 1963; Mumford 1971; Millman 1977; Bosk 1979; Scully 1980; Mizrahi 1986)—of the hospital experience of medical students and house staff. (Despite their growing importance, one can search long and hard for equivalent accounts of staff physicians beyond their training.) In many of these accounts—Mumford's *Interns*, for example, or Bosk's superb *Forgive and Remember*—patients figure only as the human backdrop for dramatic enactments of professional socialization. Even when the accounts emphasize patients, they do so only to explain how physicians-in-training are taught systematically to ignore them.

Such accounts date from the 1950s and 1960s. Yet the earlier formulations are typically more sympathetic, emphasizing "training for detached concern" or a "loss of idealism" (Fox and Lief 1963; Becker et al. 1961). Despite efforts to "humanize" medical education (Kendall and Reader 1988), the more recent accounts are typically more critical, suggesting a movement among physicians from ambivalence to explicit hostility—as in, for example, Mizrahi's (1986) recent formulation that the dominant perspective of house staff is to "get rid of patients," whether through discharge, transfer, or death. Taken together, these accounts make a few points consistently: that a good part of medical training

consists of teaching students and house staff to manage their emotions, to concentrate on technical matters, and to ignore the social and psychological aspects both of disease and of the patient who suffers from that disease. To be sure, most, if not all, regret that physicians are not more attentive to the felt experience of patients. Consider, for example, the bitterly ironic reminder to house staff in the "second law" of Shem's *House of God* (1978): "The patient is the one with the disease." Yet few, if any, hold out hope that physicians will, in fact, become more attentive.

There is only somewhat more ambiguity in the accounts (again, both autobiographical and ethnographical) of nurses (Anderson 1978; Melosh 1982; Reverby 1987; Wolf 1988). Certainly, as a number of nurses—along with the historians and sociologists who have become their chroniclers—insist, the distinctive professional skill of the nurse lies in caring rather than curing. Moreover, caring implies a receptivity to the patient's experience of hospitalization that is, to judge by the available literature, absent among physicians.

Some research suggests that nurses are more concerned than physicians with patients' experience. Yet accounts of nurses treat the experience of patients as background to a professionalizing process rather than as foreground in the explanation of health outcomes. Moreover, accounts of nurses' commitment to caring are better understood as expressions of a professionalizing aspiration, an attempt to differentiate nurses from physicians, than as empirical descriptions. Aspirations notwithstanding, nursing is, for most nurses, a job rather than a calling. Few nurses are willing to challenge a structure of work organized around specific tasks rather than specific patients. In the face of physicians' primarily technical orientation, few are prepared to insist on a patient-centered ethos distinctively their own. As Zane Robinson Wolf (1988, 254) has observed in her careful study of one hospital, "Nurses' defensive response to those who invaded their territory remained largely rhetorical." Even nurses, Wolf (1988, 180) reports, view "the efficacy of medications in a magical or unexplainable way and often did not consider the possibility that other care-giving actions or self-healing could have been responsible for improvements in a patient's condition."

Thus, accounts of physicians and nurses alike exemplify the disappearance of the patient from the social science literature about life in the hospital. Moreover, insofar as they document a weakening of staff and patient relations, with staff indifference to patients intensifying over the last two decades, they also help account for that disappearance.



Some qualifications are in order. First, there is undoubtedly a good deal of market research, collected primarily for private purposes, on patients' responses to hospitalization. However, in such research the patient's experience is individual rather than collective and becomes important only as a matter of what hospital he or she will "buy" from, not for its contribution to health outcomes. Second, the large body of field observations generated by Anselm Strauss, his colleagues, and his students over many years retains a focus on the patient. However, even Strauss, in his attention to the patient's part in managing the "trajectories" of illness, treats the patient in isolation from other hospitalized patients. Moreover, even he formulates the patient's part in managing illness as a type of work, thus metaphorically assimilating the patient's experience into that of the staff (Strauss et al. 1985).

Only in a few specialized units treating chronically ill patients have social scientists reported—or even continued to look for—much in the way of intense staff–patient interaction or the creation of distinct social worlds among patients themselves. For example, in her study of a dialysis unit, its staff and patients, O'Brien (1983) reports that a majority of the unit staff (primarily nurses and therapists) assumed the role of "confidante," or "counselor," toward their patients, whereas only about a fifth contented themselves with the role of "machine tender." Not only did staff often form close relations with patients, but so, too, did patients among themselves. Although O'Brien found significant variation between patients and a general disinclination to form new friends after the death of a patient–friend, many patients did rely on each other for support of both an instrumental sort (monitoring each other during dialysis sessions) and a more expressive sort (finding solace in a shared burden).

### *Intensive Care*

Neither dialysis units nor AIDS units, where similar research is now in process and promises to generate corresponding results, are equivalent to the hospital (Fox, Aiken, and Messikomer 1990). More representative are ICUs. However, the little available research on the experience of patients in these units most often is framed around so-called ICU psychosis. That concept not only emphasizes the primarily individual (rather than collective) character of patients' experiences, but also helps explain why even the healthiest patients in ICUs are unlikely to develop a distinctive patient culture. At the same time, a growing body of research

on the experience of intensive care staff documents, more thoroughly than in any other setting, that staff's indifference to patients. In intensive care nurses are more attentive than physicians to interactions with patients (Coombs and Goldman 1973; Frader 1979; Guilleman and Holmstrom 1986; Anspach 1987). Even nurses, however, share in a general orientation to physiological, rather than social or psychological, intervention. In an environment dominated by technical virtuosity, confronted with frequent deaths, the tendency of physicians and nurses alike to pull back from involvement in the lives of patients is stronger than elsewhere.

Patients have not, of course, vanished from hospitals. However, their experience is likely to be more solitary. If patients have not disappeared as individuals, they may be on the verge of disappearing as a collectivity. Moreover, although I would not want to exaggerate the degree to which physicians or nurses have ever been receptive to concerns about the patient's experience, it seems likely that they are now even less receptive than in the past. Certainly, patients themselves continue to "experience" the hospital—whether as reassuring or "depersonalizing," humane or inhumane. This experience, however, seems to have become psychic rather than social, seems to link the patient neither to other patients nor to hospital staff, and may have fewer consequences than was once the case for health outcomes. Although shaped by the social structures of the hospital and medicine, it is an experience that is fundamentally privatized.

### *Patient Decision Making and Informed Consent*

If we have not seen many recent studies of the social worlds of hospitalized patients, of the relations between patients and hospital staff, or the effects of either on health outcomes, it may be because those social worlds and relations are less consequential than they have been even in the past. The abandonment of the social world of the patient as a subject matter for social science research represents, in effect, good intellectual judgment. Yet this is not to say that we should abandon the patient altogether. Quite the contrary: If the social worlds of patients have perhaps become less important in explaining the outcomes of hospitalization, patients themselves have surely become more important in the process of medical decision making.

In invoking a notion of patients as decision makers, I am relying, in part, on an image of the "patient as consumer," as elaborated by Marie Haug, Bebe Lavin (Haug 1976, 1983; Haug and Lavin 1981), Leo Reeder (1972), and others. According to Haug, younger and better educated patients are particularly prepared to challenge physicians' authority in both belief and behavior. Yet Haug's claims should be read with some caution. Based on cross-sectional survey data, they are more convincing about variations within the patient population than they are about transformations of the patient population over time. Moreover, as Charles Lidz and Victor Meisel have demonstrated in a series of detailed studies of the uses of information among hospitalized patients, only a small minority of patients is interested in assuming roles as decision makers. Thus, whereas many patients expressed an interest in receiving information either as a basic courtesy or so as better to comply with physicians' orders, "patients rarely wanted information in order to direct their treatment" (Lidz and Meisel 1982; Lidz et al. 1983, 540; 1984).

The case for understanding patients as decision makers does not, then, rest on an assumption of any transformation of patients themselves. Rather, it is better understood as a transformation from above, brought about by forces external to the hospital, outside the control of both patients and physicians, and (at least at the outset) heavily resisted by physicians. In particular, it is a transformation wrought by the legal system and, more specifically, by the elaboration of the doctrine of informed consent.

As a legal doctrine, the notion of informed consent was first formulated in a 1957 California decision and has since been extended through a long series of malpractice cases and legislative actions in all but three states (President's Commission 1982; Katz 1984; Faden and Beauchamp 1986). Although it varies according to state, the doctrine of informed consent requires physicians to provide patients with information about the risks and benefits of treatments and procedures as well as about alternatives to any proposed treatment or procedure. Informed consent does not—and is not intended to—allow patients to demand particular treatments. However, it is meant to assure patients the right to refuse treatment. Put simply, the goal of informed consent is to allow patients to participate in decisions concerning their own medical care.

We should harbor no illusions that the legal doctrine of informed consent has been applied simply and unproblematically in hospitals. As Lidz, Meisel, and their colleagues (1984, 401) have observed, "Law's vi-

sion of medical decisionmaking involves an implicit assumption . . . that medical practice is discrete—that is, broken into distinct parts, or decision units—and that there can be consent by the patient to each of these individual parts.” Only in surgery—where decisions are more discrete than in medicine and where an explicit hierarchy assigns responsibility to identifiable medical personnel—does the practice of informed consent even approximate that envisioned in the law. Elsewhere in the hospital, physicians (and perhaps patients) honor the legal doctrine of informed consent ritualistically more often than in substance.

The notion of the patient as a decision maker is not, however, limited to legal doctrine. It has, rather, within the last two decades, become part of the culture of medicine itself. In this sense, the notion of the patient as a decision maker does not revolve around a specific right of refusal or even around specific decisions. It involves, rather, a very general orientation on the part of physicians to provide individual patients direction over the broad purposes of their own medical care.

In the first instance, variants on informed consent—particularly the intention that patients should become decision makers—have been a central concern of the large bioethics movement that has emerged in the United States over the last two-and-a-half decades (Fox and Swazey 1984; Fox 1989; Rothman 1991). Although bioethics appeared first at the margins of medical practice, it has found its way into the central institutions of medicine. Reported in leading journals, taught in medical and nursing schools, discussed routinely on rounds, bioethics has become part of the culture of the hospital. In the second instance, there is considerable evidence that physicians themselves are newly prepared to turn decisions over to patients. Perhaps the single most striking piece of evidence is a 1979 replication of a 1961 study of what physicians told cancer patients. Whereas in 1961 88 percent of physicians reported that they generally did not tell a patient of a cancer diagnosis (and over half said that they never or rarely made exceptions to this rule), by 1979 fully 98 percent reported that their general policy was to tell the patient (and two-thirds said that they never or rarely made exceptions to this rule) (Oken 1961; Novack et al. 1979).

Moreover, there is also considerable evidence that physicians may actually be less inclined to defend their authority than are the patients they treat. For example, a Harris Survey, commissioned for the President’s Commission on Biomedical Ethics, found that 22 percent of a

sample of the general public agreed strongly with the statement, "Time spent discussing diagnosis, prognosis, and treatment with patients could be better spent in taking care of patients" (Harris 1982). In contrast, only 7 percent of a sample of physicians agreed strongly and, compared with 28 percent of the public sample, over half of the physicians disagreed strongly. Even Haug's data support this argument. Thus, in a matched sample of patients and physicians drawn from three Midwestern states, Haug and Lavin (1981) found that "81% [of physicians] claim views that question physician authority, a higher percentage than the public evidences on the same index."

None of this is to say that physicians do, in fact, share decisions with hospitalized patients. In my own research in ICUs, I found that physicians frequently resist patients' decisions, particularly as they become more specific and bear more on technical matters. At the same time, however, I found that physicians—as they have not in the past—now not only recognize patients' basic right to make decisions bearing on the general direction of their medical care, but also often encourage them to do so (Zussman 1992). This creates a tension between acknowledging patients' rights in the abstract and their denial in the concrete. Moreover, this tension promises to be a major issue in the organization of hospital care in at least the immediate future.

I would suggest that at least some part of this new support for patients' rights to make decisions can be found not in a concern for patients, but in a distance from them. In this sense, the insistence on patients' rights becomes a flight from responsibility. Whether because of fear or indifference, overwork or diffidence, physicians may be prepared to abdicate responsibility for some decisions to patients. Giving patients direction over their care, physicians have discovered, may be easier than denying it. Whereas some observers of the medical scene have argued that patients and patient advocates may demand rights in response to the impersonality of relations with physicians (Rothman 1991), few have noted that physicians may also become advocates of patients' rights in response to the impersonality of their relations with patients. In this sense, a culture of rights is the product of the very disappearance of the social world of the hospitalized patient. For it hinges on a conception of the hospitalized patient as a more or less isolated individual. Just as shorter lengths of stay, an emphasis on technology in diagnosis and treatment, and an indifference to psychological

and social factors in disease all imply a weakening of the relationship between physicians and patients, so, too, do they imply the reconstruction of patienthood around a notion of individual rights.

## The Prospective Payment System

An acknowledgment of the empowerment of patients recasts the intellectual and research agenda for hospital life. If, as I have argued, hospital ethnographies are no longer likely to provide clues to the health outcomes of hospitalization, they have nonetheless become essential to understanding how public policy is implemented in hospitals. A case in point is the introduction of the prospective payment system (PPS) based on Diagnostic Related Groups (DRGs).

By establishing fixed rates of reimbursement based on diagnostic categories (rather than rates of reimbursement based on length of stay or procedures), DRGs provide a direct financial incentive to reduce length of stay and procedures. But DRGs do not provide such an incentive for individual physicians, especially those who are not in the direct employ of the hospital. Thus, the effectiveness of DRGs depends on the ability of hospitals to exert some control or influence over physicians. There is, to be sure, growing evidence that the PPS has succeeded in reducing some hospital expenses (Sloan, Morrissey, and Valvano 1988). However, the mechanisms by which the process operates remain very much a mystery.

To unravel the mystery would require detailed case studies of hospitals as organizations—case studies of the sort that currently available research only hints at (Notman et al. 1987). Such research would have to address the mechanisms by which hospitals inform physicians of the cost of the services they order as well as the processes by which they exert pressure on physicians to reduce those costs. It would have also to account for differing degrees of responsiveness to hospital financial considerations, not only by staff physicians, but also by private physicians—a group that is disinclined to respond to such considerations both by training and by interest. In all this, the relationship between physician and hospital would necessarily occupy center stage. So, too, however, would that between doctor and patient. To illustrate, I can draw again on my own research in intensive care.

Although most physicians, both staff and private, are largely indiffer-

ent to matters of cost in intensive care, they are not indifferent to limited resources more generally. Because the number of beds in any particular unit is fixed at any given moment and because those beds are frequently full, patients are often admitted only with strong advocacy by a physician. However, whereas private physicians and staff physicians respond similarly to questions of cost, they respond differently to the availability of beds. Private physicians, with investments in individual patients and only weak commitments to the ICU staff, are prepared to advocate forcefully for their own patients. In contrast, unit staff and house staff, with weaker investment in individual patients but powerful concerns for each other's convenience and for the unit as a whole, are less willing to do so. As a result, although private physicians and hospital staff each act on internally consistent principles, the aggregate outcome of their efforts may reintroduce inequalities in the service they provide to their patients.

Whether or not something of a similar sort is going on in response to PPS's more generally is very much an open question. Certainly, it seems unlikely that the reduction of hospital services that PPS's are intended to encourage is borne equally by each patient population group or contributed to equally by all parts of the physician population. Nonetheless, without detailed hospital ethnographies, it will be difficult to know either the extent of these inequalities or anything of the processes that generate them.

## Conclusion

I have attempted to make explicit a number of observations that I believe are implicit in research on life in hospitals. I have suggested that a research agenda animated by what we might think of as "humanistic" concerns—in particular, with the felt experience of the hospitalized patient—may have become irrelevant. Not only are such concerns seemingly less consequential for health outcomes, but also the potential audience for research driven by such concerns (physicians, nurses, and hospital administrators) meets that research with studied and systematic indifference.

I have suggested as well that there is an important place for a new type of patient-centered hospital ethnography. Rather than making the patient's felt experience a central focus, this new ethnography reintro-

duces the patient as a central participant in medical decisions. Moreover, this new focus provides an entrée to the process by which attempts at reforms and redirection of the hospital are translated into actual practice.

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