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Disruption of Ritual: Doctor/Patient Interactions in the Era of Internet

Amanda Seeman

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**DISRUPTION OF RITUAL: DOCTOR/PATIENT
INTERACTIONS IN THE ERA OF INTERNET**

by

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BACHELOR OF ARTS, MCMURRY UNIVERSITY

THESIS

Submitted in Partial Fulfillment of the
Requirements for the Degree of

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Sociology**

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DEDICATION

I dedicate this research to my husband, Aubrey Seeman. You nurture my dreams, encourage my compassion, and help shoulder our challenges just as you promised on our wedding day. Without your support and strength, this would be a far more arduous task. I also dedicate this research to Nyla Harper and Lisa Larson for their loving support and kind words of encouragement. Finally, to my parents Mike and Kathy Brown, your example of hard work and dedication inspire me daily to press-on when faced with adversity. I thank each of you for the love, support, inspiration, and strength you provide to me on this life journey.

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DISRUPTION OF RITUAL: DOCTOR/PATIENT INTERACTIONS IN THE ERA OF INTERNET

by

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ABSTRACT

The historical establishment of medicine as a profession laid the foundation on which it claims dominance and authority over medical decision-making. Through scientific discoveries and a state-recognized monopoly over medical work, doctors were able to subdue patients during doctor/patient interactions and conceal specialized knowledge from the public. Ritualized doctor/patient interactions are characterized as expert physician decision-making for passive compliant patients. However, the democratization of information on the internet has disrupted the ritual interactions of doctors and patients by granting open access to specialized medical knowledge.

Internet informed patients bring their own knowledge to clinical encounters and use it to be actively involved, redefining their traditional role in doctor/patient interactions. Doctors usually respond to internet informed patients in two ways based on the literature: they support and accept active informed patients as the new normal, referred to as *ritual change*; or, physicians reinforce traditional roles that restrict direct involvement of patients in medicine, referred to as *ritual conflict*. Responses reflect the ideological position of physicians regarding patient information seeking online and strategically work to embrace or refuse active patient behaviors. This research explores the historical evolution of the medical profession, the establishment of ritualized encounters, and the disruption of ritual interactions in the era of internet.

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Before internet, a patient experiencing chronic pain, fatigue, and mood disorders would have suffered in private. The doctor would have been the primary source of information regarding treatment, and patient compliance would be easily achieved during clinical encounters. If there was no identifiable disease, the doctor would determine that stress was likely the cause and prescribe aspirin or tranquilizers. The patient would be unlikely to communicate with others suffering from the same illness as a result of limited communication technologies.

After internet, striking differences emerge. The patient could use internet retrieved information to challenge the doctor's indeterminable diagnosis; finding online communities of people suffering from the same illness would be relatively simple. They could communicate trans-geographically with others, gathering lay expert knowledge on the daily management of symptoms. The doctor would find patient compliance a more difficult prospect, especially when the doctor/patient relationship became strained through conflict over decision-making processes. Internet information can empower the patient to take a responsible, active role in the management of their health, in effect, relying less on their physician for desired information access. These differences result in doctor/patient interactions that are disrupted by challenges to the doctor's decision, redefining patient-hood and altering ritualized clinical practices.

Introduction

The internet has changed the way patients experience illness due to the amount of medical information that has become available to patients over the last two decades (Clarke, Shim, Mamo, Fosket, & Fishman, 2003; Conrad & Stults, 2010). The internet has become a place where patients can go for information, treatment options, supportive

online communities, and validation of the illness experience (Barker, 2008; Broom, 2005b; Conrad & Stults, 2010; Diaz et al., 2002). Researchers have suggested that deprofessionalization, the weakening of sovereignty in medicine, of health providers occur as patients actively gather and exchange health information via the internet (Conrad & Stults, 2010). Furthermore, Broom suggests that the internet has presented a challenge to the traditional roles in the doctor/patient interaction:

The potential of patients to become more informed both about their disease and the performance of their medical specialist is seen to be a new and significant challenge to the classical models of medical care where the doctor is expert provider of information, and the patient is the ‘passive’ recipient. (2005a:321)

The discussion of how internet informed patients might be challenging physician authority is growing as researchers seek to better understand what implications internet will have on the traditional practice of medicine in the United States.

The first web browser, Mosaic, became available to the public in 1993, however, internet was not widely used until the late 1990’s when the renowned search engine Google was created. According to Conrad and Stults (2010), about 360 million people used the internet in 2000 with that number growing significantly to 1.5 billion in 2007. Based on a September 2012 data collection by the PEW Internet and American Life Project, 81 percent of American adults use the internet (Fox & Duggan, 2013). Harris Interactive conducted a survey in 2011 and found that 74 percent of U.S. adults have obtained health information using the internet (Taylor, 2011). Internet use continues to rise each year as mobile devices, high speed internet, and other infrastructure projects increase availability of internet access to consumers. As healthcare information becomes

commonly retrieved online, we question how it changes patient-reliance on physicians who traditionally supplied it.

The goal of this inquiry is to examine the available literature on the internet informed patient within the doctor/patient interaction. To best understand how the nature of medical encounters may change where informed patients are concerned, it is necessary to explore the historical transitions in medicine as it achieved professional status. During the early 1800's, medicine moved from the homes of patients to the offices of doctors, power dynamics and doctor/patient role patterns changed to reflect the expanding specialized knowledge of doctors. By 1910, medicine was a formalized institution regulated by a powerful state-recognized medical association, responsible for creating standards in the training of medical students; doctors achieved medical dominance. The implementation of these standards in medical schools resulted in a cohesive set of values, norms, and beliefs among doctors (Starr, 1982); the practice and training of physicians became a ritualized process. Complicated medical markets began to form in the late 1960's when government legislation attempted to decrease the rising cost of care in America, challenging medical dominance; meanwhile, patients became disillusioned to medical professionals as they became increasingly aware that they made mistakes. As internet became a commonly available resource, patients began to retrieve information online to supplement time-constrained doctor visits or challenge doctor decisions that they were discontent with. The ritual practices that characterized medical encounters during the mid-twentieth century were disrupted by internet informed patients. The shift was a gradual process as patients went from passive trusting clients to disillusioned internet-savvy consumers.

Current research on internet use among patients and the impact it has on clinical interactions is informed by shifting power dynamics witnessed throughout history. In exploring the historical evolution of American medicine, ritual practices intended to secure the position of medical professionals are revealed, with implications for the current responses to informed patients. It has been suggested that the internet informed patient is redefining patient-hood and that physician authority may be challenged by empowered, internet-savvy patients (Fox, Ward, & O'Rourke, 2005). Others have suggested that the physician's role is not being redefined; rather, it is expanded to one of medical consultant where the doctor helps the patient understand the information obtained online (Conrad & Stults, 2010). Furthermore, some researchers suggest that informed patients complement the role of physicians and it is necessary for the culture of medical practice to adapt accordingly (Blumenthal, 2002; Broom, 2005a).

Changing Rituals in Doctor/Patient Interactions

Prior to the nineteenth century, medical practitioners were not considered prominent members of the community; only through exhaustive measures were professionals able to secure their place economically, socially, and culturally (Starr, 1982). Furthermore, before the Flexner Report in 1910, there was considerable variation in training requirements to be a physician, approach to medical healing, and state-level legislation dealing with medicine in America. Historical events took place that laid the foundation for the medical professions establishment of authority and sovereignty over medical services (Starr, 1982). Important to this research is the resulting institutionalized values, beliefs, and cultural norms that dictate behavior of physicians creating ritual practices during doctor/patient interactions. This reveals medicine's arduous journey to

professional dominance and the high stakes for physicians should they relinquish their authority.

The number of organizations and actors with a stake in the medical industry has become far more expansive than it was during the early twentieth century. As the Golden Age of doctoring, used to describe the mid-twentieth century when doctors possessed unquestionable authority in medicine, declined in the late 1970's, public and private organizations sought reform that served their own interests and reflected their respective concerns within the expanding medical economy (McKinlay & Marceau, 2009).

Contemporary medicine is shaped by the relations between differing medical institutions and the consumerism of patients. The functions of these institutions narrow physician dominance and increase the power of patient demand for affordable healthcare (Light, 2009). Diverse alternative medical markets undermine physician authority over patient health maintenance by providing alternatives to orthodox medicine; the disruption of doctor/patient interactions began with diversifying markets, further perpetuated by internet capabilities.

The purpose of this research is to provide a review of literature related to clinical interactions, between doctors and patients, before and after internet; it aims to understand the disruption of ritualized medical encounters when internet informed patients challenge physician authority. Through this examination, I have found two emerging responses: *ritual change* and *ritual conflict* within doctor/patient interactions. As patients redefine their role, they force physicians to either respond by: acceptance of patient's behavior as the new normal and thus responding in a supportive and sensitive manner (*ritual change*), or reinforcing medical practices that restrict direct involvement in medicine by patients

(*ritual conflict*). It appears that these responses reflect the physician's ideological perspectives on role norms and are a strategic attempt to perpetuate their position, which I refer to as *strategic response*. When physicians strategically respond by embracing internet use, offering quality web sources and guiding users to supplemental resources, they are empowering patients to actively engage in their own medicine. However, when physicians respond with negative feedback or reject patient involvement, they alienate the patient, increasing discontent with physicians. By framing medical encounters as ritual behaviors, we can explore the power dynamics that influence role systems (socially recognized patterns of communication between actors). Patients challenge medical standards of doctor/patient relations when they disrupt ritualized activities, demanding they be treated as people, not as objects of medical study. Given that physicians currently possess authority within medical encounters, this research seeks to understand the strategic response of physicians when confronted with internet informed patients. Challenging physician authority reflects broader social concerns over healthcare cost, lucrative gatekeeping practices, and availability of informed patient preference options.

Evolution of the Doctor/Patient Relationship: A History

Each era of medicine possessed unique relations between doctors and patients. Bedside medicine, during the eighteenth and early nineteenth centuries, occurred in the home; patients provided information of their illness to a doctor or lay healer that approached healing in a manner that complemented the patient's preference (Jewson, 1976). During these interactions, it was more common for the patient to control the encounter as doctors relied on patient-provided evidence of their illness and patient satisfaction. By the second and third decades of the 1800's, medicine began to move to

clinics where doctors could collaborate with one another and advance their scientific knowledge of disease and illness. Moving medicine outside of the home of patients resulted in their decreased control over doctor/patient encounters; patients no longer could dismiss from their homes doctors that they were dissatisfied with. Interactions became increasingly controlled by doctors through the nineteenth century, and by 1910 medicine attained a state-recognized professional status. Education of medical professionals became standardized; doctor/patient interactions became ritualized through standardization and unchallenged as a result of social and cultural authority. Mid-twentieth century medicine was characterized as the Golden Age of Doctoring, whereby physicians possessed unprecedented control over medical matters, and patients, who had merely become objects of medical study and healing, became passive recipients of what medicine could offer.

The ritualization of medicine occurred from 1910, with the standardization of medical training and practice, and was firmly rooted in American medicine by the 1960's, as evidenced by sociological research conducted during this time period (Goffman, 1961). The rituals established during this time are what internet informed patients challenge when they disrupt traditional interactions by attempting to be actively involved in the management of their health. Historical trends of doctor/patient relations help identify the evolution of physician authority through specialized knowledge and practice; it also identifies the diminishing power of patients during medical encounters that contribute to disillusionment, discontent, and alienation in the modern era.

The Era of Bedside Medicine

Prior to 1820, medicine was practiced in the homes of patients. In what Jewson (1976) refers to as bedside medicine, rivalries flourished under contradictory theories of the causes of disease and disagreement over 'disciplinary boundaries' in practicing medicine; Jewson (1976) describes it as 'polycentric' and 'polymorphous' (p. 227). The 'sick-man' (or patient) was treated as an expert on their affliction, which was housed in the integrated system of mind and body. Furthermore, since doctors conducted their work in the houses of their patients, they could easily be dismissed by the 'sick-man' if his work proved unsatisfactory (Jewson, 1976; Starr, 1982).

The 'sick-man' possessed the most authority and power in doctor/patient interactions during this time period. Physicians did not find themselves inherently higher on the social status ladder, in fact, the status of physicians depended more on their clientele's status and family heritage than their qualifications as a healer (Starr, 1982). As such, the majority of doctors fell into the 'rank and file' (Starr, 1982) by having some training. The self-taught were considered to make up the lowest-ranked medical advisors, while the highest ranking attended the best schools and training opportunities, eventually serving prominent members of society (Starr, 1982). However, even formal training during the nineteenth century couldn't guarantee success in medical practice. Many trained medical men ended up in public offices or alternative industries to replace or supplement inadequate incomes (Starr, 1982).

Interactions between doctors and patients were greatly shaped by this power dynamic. Decision-making was done by the 'sick-man'; they choose their doctor based on personal attributes, there was a wide range of distinction in role behavior, and disease

was considered ‘mysterious and enigmatic events’ (Jewson, 1976:231). Doctors lacked a scientific and specialized knowledge of the human body that limited their role in medicine. Doctors did not possess the authority in medicine to assert their expertise over it; instead they were healers that assisted the ‘sick-man’ in recovery through varying types of sectarian practices.

The first two decades of the 1800’s witnessed the shift from dogmatic practices to empirical evidence (Starr, 1982). New inventions allowed for physicians to better understand the internal functions of the human body, for example, the earliest version of a stethoscope was invented by Laennec in 1816 (Starr, 1982). The realization that medical knowledge was limited by inadequate biological understanding emerged, however, effective replacement therapies did not exist. Nonetheless, scientific discoveries increased specialization areas even if knowledge was limited; it also created a demand for new and improved medical technologies that might aid in the expansion of empirical knowledge (Starr, 1982). Clinics began to open, moving medicine from the bedside to formal institutions where doctors were able to assert themselves and their expanding knowledge of physiology. Patients were redefined among physicians as objects that suffered from internal affliction; the ‘sick-man’ had disappeared (Jewson, 1976).

The shift from person orientated role behavior to object orientated role behavior was significant (Jewson, 1976). In person oriented processes, decision-making is determined through the judgment of attributes possessed by persons within role systems that reflect personal identities. “Ambiguity and ambivalence are commonplace in this type of role structure, and person orientated cosmologies sensitize actors to its presence”

(Jewson, 1976:231). Life-force was the subject of philosophical debate and open to interpretation (p. 231). Object orientated processes are significantly different, “decision-making processes are invested in the formal status of the members” (p.232). Role separation is clearly defined, “the power and privileges accorded to each being precisely and generally designated” (p.232). Medicine refocused on quantitative, objective, and reoccurring knowledge of disease and illness, replacing the study of life with the study of organisms (Jewson, 1976). The shift in orientation from person to object resulted in significant changes to the role behaviors of doctors and patients; it also restructured the practice of medicine on the basis of scientific knowledge and discovery, displacing the ‘sick-man’ in medicine. New doctor/patient interaction rituals in medicine were forming under scientific and object oriented processes.

Establishment of a Profession: From 1820 to 1920

Hospital medicine was on the rise in Europe as the production of medical knowledge shifted to anatomical discoveries through structured medical research (Jewson, 1976) but was slow to take hold in the U.S. There were gradual shifts in role systems as hospital medicine was established; doctors began to move their work into formal structures outside the homes of their patients, providing them with more control and authority in medicine. Doctors’ also felt the need “to maintain a front of propriety” (Starr, 1982:85) to combat their unstable class and status position within society. The insightful inclusion of citations from *The Physician Himself*, by D.W. Cathell, can be found in Starr’s work. Recommendations included never appearing in public unclean or disheveled, but always exhibiting manners, dignity, and characteristics of the extraordinary man. It was more important to appear confident, competent, and unhesitant

than it was to be right. Knowledge was to be confidential, never operationalized in front of the patient in case they should think of themselves as capable of self-curing. Above all, one must protect their authority from the argumentative patient, or their affiliates, who could jeopardize ones' medical authority (Starr, 1982). Doctors needed to set themselves apart from lay practitioners; they began to establish standards for proper behavior and manners among legitimate physicians.

Medicine in the 19th century U.S. was marked by sectarian disputes; medical societies were constantly battling to secure their place within the liberal medical economy. They were distinguished by their healing practices and the ritualistic interactions with patients. Regular physicians could be identified by their orientation to “heroic” medicine, prescribed to healing through “copious bleeding, purging, and blistering” (Starr, 1982:34). Irregulars consisted of all other competing medical sects that did not identify with regular physicians' doctrines and standards to practice medicine. From 1820 to 1920, medicine entered a period of transition from a historically liberal and diverse medical economy to the formation of a singular state-protected monopoly.

The establishment of a medical profession began to take shape as European trained physicians returned and created medical associations. State-recognized professional status was desired because it would allow medicine to create rules, standards, and exclusive membership criteria that strengthened their authority (Starr, 1982). “The historical success of a profession rests fundamentally on the growth of its particular source of wealth and status—its authority” (Starr, 1982:79-80). Doctors needed to prove that their work constituted recognition as a profession, similar to what European physicians had managed a few decades earlier. Although scientific knowledge

was limited, regulars claimed specialized competence through newly developed scientific research; they used this to set themselves apart from other medical sects and markets. When state institutions refused to grant regulars privileged status over medicine, they resorted to excluding irregulars from powerful positions within hospitals, colleges, and associations that were in the control of regulars at the time (Starr, 1982).

While the battle over state licensing ensued, scientific research and new more invasive treatments displaced the active patient from medical interactions. Physicians, belonging to the more established medical sects, refocused their work to studying the patient as an object suffering from internal dysfunction that could be identified and categorized specifically (Jewson, 1976). Consultations were refocused from the experience of a disease, to the processing of symptoms according to anatomical knowledge and deductive reasoning (Jewson, 1976). Regulars and irregulars began consulting in a similar way, and treatments became more uniform as successful outcomes were positively correlated with them. The doctor/patient interaction was becoming less variable as approaches to healing became more centered on a common understanding of internal functions of the human body.

By the late 1800's, the era of medical sectarianism began to wane. The American Medical Association (AMA) maintained that unorthodox medicine was unfit to practice medicine. However, prominent medical men began to revolt against this stance, noting the cooperative adoption of consistent educational training for all medical students regardless of sectarian orientations (Starr, 1982). The gap separating the sects had narrowed as scientific strategy advanced and interdependence of general and specialists care had deepened. Furthermore, by the 1880's, orthodox and unorthodox sects were

coming to the shared conclusion that it was necessary to seek licensing laws to protect the profession from ‘quacks’ and untrained practitioners (Starr, 1982).

Early licensing laws were minimal, usually only requiring a medical diploma; and since the three major medical sects (regulars, homeopaths, and Eclectics) all had medical schools that offered these diplomas, they provided a united front in pursuit of licensing legislation (Starr, 1982). As might be expected, the licensing laws increased the demand for diplomas and some universities and colleges took advantage of this. Diploma mills started to open, operated by physicians interested in making profits off this demand (Starr, 1982). Starr (1982) points out that, contrary to popular belief, irregulars (homeopaths and Eclectics) thrived when regulars bitterly sought to denounce their legitimacy in medicine; it wasn’t until the sects began to cooperate under common interests and concerns over frauds in the profession that their numbers dwindled. Furthermore, the AMA saw large increases in membership numbers after they revised their code of ethics to include irregulars, giving them strength in numbers and more unity in pursuit of legislative policies. The AMA had also revised their internal legislative body to function more adequately and modeled it after the House of Representatives (Starr, 1982); this new legislature allowed the AMA to establish itself as the national association of medical professionals increasing interests in membership. A strong association, which the AMA was becoming, was necessary in the fight for state-recognition of medicine as a profession (Goode, 1960). Medical associations impacted doctor/patient interactions through the process of standardizing medical practices and uniting legitimate practitioners in the fight for licensure.

As the once diverse medical economy became more uniform, patients found it increasingly difficult to locate doctors that had not adopted the new standards. The early 1900's proved to be a major turning point in the education of physicians, alienating patients through specialized knowledge exclusively available to doctors. Medical schools had to be reformed to further strengthen the status of the medical profession, according to the AMA (Starr, 1982). Reviews of medical schools were conducted and the results were shocking; out of 160 schools, only 82 scored well enough to be approved by AMA standards (Starr, 1982:118). Following these results, an independent firm was invited to conduct a similar review of medical schools, which came to be known as the Flexner report, named after the reviewer Abraham Flexner. Published in 1910, the Flexner report contained reviews of all the medical schools in operation, finding that most of the schools were inadequately supplied to properly train and educate physicians (Starr, 1982:118-121). John Hopkins University had become the example for all medical schools; those that could not meet the necessary standards were recommended to be closed (Starr, 1982). The number of students admitted to medical school dropped as institutions, working to meet quality standards, increased the minimum qualifications for students and enrolled them on a competitive basis. AMA regulations had achieved the weight of laws backed by the states (Starr, 1982). Medicine had finally achieved a state-recognized and regulated professional status.

This early formative stage of the medical profession united doctors and laid the foundation for medical dominance to be established. Patients were becoming passive recipients of doctors specializing skills and bedside medicine was no longer the standard. Interactions between doctors and patients reflected expanding medical knowledge that

alienated patients from their own health. Doctors had managed to distinctively set themselves apart from lay practitioners and quacks.

Golden Age of Doctoring: Cultural and Social Authority in Medicine

Defining medicine as a profession acknowledges that it possesses distinctive characteristics that other occupations do not; in this case a combination of specialized knowledge, collegial discipline, and service oriented work.

A profession, sociologists have suggested, is an occupation that regulates itself through systematic, required training and collegial discipline; that has a base in technical, specialized knowledge; and that has a service rather than profit orientation, enshrined in its code of ethics (Starr, 1982:15).

Medicine is in fact a *consulting profession* (Freidson, 1970); through their claim to professional status and specialized competence over medicine, patients are attracted to their expert services. In the past, theoretical work on professions has often focused firstly on the historical development of its status, and only secondarily on its application to work (Starr, 1982; Freidson, 1970); however, the application of a professional's work should not be overlooked.

Professions are shaped by ecological conditions and vie for jurisdiction over the content of their work (Abbott, 1988). The profession of medicine was given jurisdiction over all things medical by 1920; however, as the economy became more complex and new niches formed, other professions established a jurisdictional claim to specialized work. In this process “. . . some parts of an occupation may become routinized and cast off, while others may become elaborated and defined as the core of the profession” (Tolbert, 1990:411). When studying professions, it is important to look at both the

occupational characteristics that are present and professional jurisdiction over a market niche, accounting for ecological changes in industry as reflected in work activities (Abbott, 1988).

The ritual practices of doctors reflect their jurisdictional claim to direct interactions with patients regarding disease and illness. State recognition of their jurisdiction over this work was granted through professional licensing. Prior to the distinction of professional status, claims of specialized knowledge or competence were disregarded and liberal market economies encouraged competition between medical sects. These events had significant effects on doctor/patient interactions. As doctors became a self-policing profession and science advanced medical knowledge, patients gradually became more passive during encounters, yielding to professional decisions. Quality standard requirements for universities created a more cohesive profession with “common values and beliefs among doctors” (Starr, 1982:123). The actions and activities of doctors were becoming ritualized, especially when they interacted with their patients. The Golden Age of Doctoring was being ushered in by unprecedented social and cultural authority, where physicians had jurisdiction over all medical work.

The Golden Age of Doctoring (mid-twentieth century) was characterized by unprecedented power and dominance over medical work by physicians (McKinlay & Marceau, 2009). Doctors had obtained social and cultural authority, whereby they could practice medicine without restrictions or interruption from other institutions. Healthcare costs were on the rise, in part through fee-for-service payment schedules that were set by individual physicians, and lucrative medical treatments. McKinlay and Marceau (2009:214) characterize professional activities during the Golden Age of doctoring as

“insulated from observability by secrecy, protective subordinates, and impregnable institutions”.

Interactions between medical professionals and patients are shaped by the degree to which doctors have been granted cultural and social authority over medicine. Cultural authority recognizes the unique qualifications of licensed medical professionals to make judgments, predictions and provide definitive meaning to medicalized topics. Social authority is used during doctor/patient encounters when physicians make medical decisions and give instructions to patients. Starr (1982) notes that this follows the sociological “. . . distinction between culture, the realm of meaning and ideas, and society, the realm of relationships among social actors” (p. 13). Social authority is a significant component to doctor/patient interactions because it is used to gain patient compliance.

During the Golden Age, doctors rarely were challenged by their patients regarding medical diagnosis and intervention. Patients generally knew less about medicine and disease given limitations in information distribution (Broom, 2005c); and general social consensus that physicians were the authority in medicine resulted in passive patient practices. Physicians were also making important medical discoveries through research, strengthening their cultural authority through advancements in technologies and treatments.

Conducting research on doctor/patient interactions, during the latter end of the Golden Age, Erving Goffman (1961) found them to be “relatively structured” (p. 329). The interaction with clients contain ritualized practices, whereby the actors verbally exchange *technical* information about the illness, *contractual* agreements regarding costs

and treatment, and *social* deference and courtesies (Goffman, 1961:328-329). Patients provide technical information in the form of symptomology; doctors use their technical skills combined with patient information to deduce the illness present. Good patients trust their doctors, and gratefully pay for their expertise in healthcare. “The full assimilation of the interaction between server and client to this framework is often for the server one of the tests of a “good” service relation” (Goffman, 1961:329). Likewise, interactions between doctors and patients that don’t assimilate to these standards result in poor or dysfunctional encounters.

Medical Dominance Challenged: Countervailing Powers

The decline of the Golden Age of doctoring began as concerns over rising costs of care and expanding health disparities became the topic of national debate (McKinlay & Marceau, 2009; Timmermans & Kolker, 2004). The 1970’s and 1980’s brought structural and political changes to the medical profession; federal regulation required the creation of health maintenance organizations (HMO’s) to control cost, the government began to make fee schedules limiting what they would pay out for medical services, and insurance companies created cost saving measures of their own. Donald Light (2009: 240) refers to these shifts as countervailing powers in the industry, focusing “. . . attention on the interactions of a few powerful actors in a field in which they are inherently interdependent yet distinct”. The profession managed to expand its sovereignty in medicine through innovations and discoveries in pharmacology, genetics, and molecular biology. However, its autonomy weakens as other actors infringe on their work through quality evaluations, implementation of standardized procedures, and power dynamics purchasers possess through economic practices. The distinction between

sovereignty (authority) and autonomy (freedom) are crucial because they inform us of the arena in which the profession of medicine has managed to strengthen their value versus where it has deteriorated in the wake of development and technological advancement (the changing ecology of the medical profession). Furthermore, the deterioration of their autonomy, and expansion of sovereignty, has occurred in a rather short time span.

Pharmaceutical companies and medical supply companies were invited into the monopolistic medical markets by physicians because it expanded and enriched their work; however, doctors act as gatekeepers to prescription drugs, protecting their jurisdiction over medical services (DiMaggio, 1989; Light, 2009). Rising costs of care and services caught the attention of President Nixon and other political leaders in the early 1970's. Nixon announced the investment in health maintenance organizations (HMOs) designed to decrease cost and increase efficiency in medical practice (Light, 2009). Their soft "provider-friendly" approach resulted in no significant change by the end of the 1970's; as such, more aggressive action was taken by the government and corporations to create consistent procedures, treatments, and costs in practicing medicine. Light writes; "the sacred trust enjoyed by the profession during the golden era of doctoring" had been eroded through the inconsistent performance of doctors (2009:242). The processing departments of government assisted insurance plans create their own fee schedules, and demanded that private insurance pay bills more effectively or lose business. Doctors and hospitals retaliated by doing more business with the privately insured populations known to pay more for services than the government agencies would; despite government encroachment, doctors still maintain rights over fee-for-service billing. The resistance to reorienting work practices to decrease cost for consumers and

the government gave the impression that doctors were the culprits responsible for high medical expenses. The struggle over cost and profits waged between the profession of medicine and government agencies demanding reform; a growing sense that doctors were in it for the money motivated legislation to regulate the market and establish countervailing powers in the medical industry. Doctor/patient interactions were changing through all this as outsiders impinged on the work of doctors to combat rising costs of care; there were growing concerns among patients that doctors were motivated by greed and there were growing inequalities in healthcare.

HMOs were on the rise during Nixon's presidency; in 1976, there were 175 HMOs, of which 6 million members belonged to. By 1987, that number had grown to 650 HMOs with 29 million members (Light, 2009). To increase their appeal, they created options to see physicians outside the network under the premise that buyers would pay more of the invoice. Thus, preferred provider organizations (PPOs) were created; providers agreed to discounted prices on services and business insurance plans encouraged the use of these providers among employees to mitigate some the costs of care. Managed care was also instituted to limit unnecessary over use of expensive services (like inpatient admittance days) and profile physicians that might over use these expensive services (Light, 2009). The integration of countervailing powers, such as those described above, decreased the autonomy of the profession as they were forced into instituting practices that decreased cost of care and overuse of services. This by no means suggests that doctors are 'corporatized workers' (Light, 2009:246); they maintain their ability to be in individual practice, choose their clientele, and operate using fee-for-service billing. The profession has also increased their control over what is considered

medical through advancements in technology and discoveries in molecular biology, genetics, and pharmacology. Nevertheless, physician dominance was challenged through the formation of a check and balance system in operation whenever public or private insurance companies were expected to pay medical bills (Light, 2009; May, 2011).

These organizational changes impacted clinical interactions with patients. During the Golden Age, doctors were freely able to perform medical interventions and charge customers what they saw fit. However, HMO's and managed care procedures were being used to check their fiscal responsibility and efficiency. Patients became increasingly aware that doctors made mistakes and may not always have their best interests in mind, resulting in decreased trust in physicians (McKinlay & Marceau, 2009). Doctors were being watched and critiqued by outsiders, including their patients. When doctors' lost their unbridled dominance in medicine, their work became more transparent and patients were able to critically evaluate the motives of doctors' actions. Early forms of conflict emerged as advocacy groups formed to seek change, usually on a local level due to limited technological advances. For the most part, doctor/patient interactions remained undisturbed.

Becoming Consumers

Despite the emergence of countervailing powers, medical thinking has expanded its jurisdiction and cultural reach through medicalization. Previously non-medical behavioral issues were beginning to fall under the jurisdiction of medicine, from emotional distress to deviant behavior (Conrad, 1992). Conrad (1992) defines medicalization as “a process by which nonmedical problems become defined and treated as medical problems, usually in terms of illnesses or disorders” (p. 209). It occurs during

doctor/patient interactions when “a physician defines a problem as medical (i.e. gives a medical diagnosis) or treats a ‘social’ problem with a medical form of treatment (e.g. prescribing tranquilizer drugs for an unhappy family life)” (Conrad, 1992:211). Patients can also advance medical jurisdiction through their consumer demand for services and treatments. Around the 1980’s: “. . . patients began to act more like consumers, both in choosing health insurance policies and in seeking out medical services” (Conrad, 2007:15).

The role and power of doctors and patients during medical encounters has varied throughout the history of the medical profession. Prior to their professional status and scientific knowledge, doctors relied on the bedside accounts of the patients’ illness as their only source of medical information. Practicing medicine in the homes of patients also meant that doctors could be easily dismissed by their clients if they were unsatisfied with the physician’s approach to healing (Starr, 1982) During this time, patients maintained the most power during medical encounters (Jewson, 1976). In the early nineteenth century, the expansion of medical knowledge through scientific discovery provided doctors with a specialized knowledge of the internal function of the body, although it was still quite limited in scope. Clinics for the poor became more common in the U.S. allowing doctors to collaborate on medical issues; however, sectarian disputes plagued the medical community. Through publications, like Cathell’s, on behaviors that would set regular physicians apart from others, doctors tried to increase their authority over medicine (Starr, 1982). Doctors began to operate out of offices where patients would come to them, increasing their autonomy; patients became less powerful during medical encounters as symptomology became secondary information through medical

discoveries. Doctors achieved state recognition of their authority when they were granted licensure laws to protect them from quacks. In 1910, with the publication of the Flexner Report, the training of medical professionals was strictly standardized resulting in a cohesive set of norms and values among medical professionals; this also resulted in ritualized standards of practice with patients. By the Golden Age of Doctoring, physicians had accumulated enough cultural and social authority to possess unprecedented power over medical encounters; patients became the passive recipients of what doctors had to offer. Interactions were firmly ritualized; they were guided by doctors with patients answering questions about symptomology, submitting to examination, and trusting their physicians' decision on diagnosis and treatment.

The shift from powerful patient/ less-powerful doctor to passive patient/powerful doctor interactions developed through the discoveries of specialized medical knowledge that alienated patients from their own health. Professional status was important to medicine because it protected it from laymen openly practicing medicine, giving licensed doctors a monopolistic jurisdiction over medicine. Cultural and social authority rooted professional ideology within society, protecting its status through larger social practices regarding healthcare seeking. What is most influential to the power attained by doctors is the development of specialized medical knowledge. Without it, doctors would be unable to claim that they knew more than patients about their disease or illness. When patients are able to bridge the knowledge gap even a little, they can become empowered to actively participate in their healthcare. Informed patients can use information to evaluate the performance of their doctor and engage in decision-making based on what they feel is

in their best interests. The internet makes this not only possible, but far more easily obtainable.

Internet in the Doctor/Patient Ritual

The internet allows what was once expert knowledge to be readily available to users, representing a democratization of information (Clarke et al., 2003; Barker, 2008). Patient accessibility of this information creates tension in the traditional doctor/patient ritual. Doctors have to contend with informed patients that reassert themselves, while negotiating with outsiders that impinge upon their clinical autonomy. Traditional interaction rituals hinged on the expert knowledge of doctors and their passive patients as trusting recipients of their specialized skills. Today, among uninformed patients, the encounters still fit this paradigm; however, among internet informed patients, there is an increased chance that patients will reassert their own special knowledge of their illness experience paired with internet retrieved information that empowers them to actively engage in medical decision-making. Barker (2008:21) describes this as the “waxing of lay expertise” and the “waning of deference toward expert knowledge systems”.

Health information, prior to the advent of internet, was not generally open to the public; formal and informal barriers in operation during the mid-twentieth century protected the medical literature from becoming common or lay knowledge. One such formal barrier was the use of jargon-rich writing that proved difficult for general readers to comprehend (Clarke et al., 2003; Broom, 2005c; Conrad & Stults, 2008). Informal barriers include; time to collect resources from multiple institutions, required knowledge of public library resources, and transportation to facilities that housed specific medical profession publications (Broom, 2005c). Even if someone was able to gather the

information, often they still required the experience and skills of their medical professionals to understand the information (Clarke et al., 2003).

Technological innovations have revolutionized the accessibility of information; consumers can easily and readily research health related concerns online. In fact, Conrad and Stults (2008:180) state; “On any given day more people in the United States go online for health information than consult a health professional”. This historical shift is commonly referred to as the ‘information revolution’, defined as “the emergence of new communication technologies that have dramatically increased access to and opportunities to exchange new and existing healthcare information” (Blumenthal, 2002:526). The *information revolution* is a driving force for individual responsibility and the trend in preventative care that motivates consumers to manage their health status (Anderson, Rainey, & Eysenbach, 2003).

Sources of Online Information

The internet’s expansive capabilities allow patients to gather peer-to-peer advice and information from professional medical websites (like WebMD). Community websites form to offer peer-to-peer advice based on the experience of illness and promote medical recognition of their shared illness (Barker, 2008; Fox et al., 2005) through electronic discussion feeds or public bulletin boards. For example, in pursuit of a shared interest to medicalize their disease, fibromyalgia sufferers recount their interactions with doctors and receive support and recognition from other members (Barker, 2008). Internet users visit websites, like WebMD, that provide medical information on diseases and illnesses from reliable sources in an easy to understand format for health information seekers. Contributors to WebMD include board-certified physicians working with

journalists to format medical information for the general populace (www.webmd.com).

Peer-to-peer webpages contain lay expertise, while professional medical websites provide information from licensed medical personnel.

Patients gather treatment option and medication information online from pharmaceutical and complementary and alternative medicine (CAM) webpages. Prescription companies advertise on many of websites, including patient run websites, with links to their own webpages. Direct-to-consumer advertising (DTC) by these companies encourages patients to ask their doctors about possible prescriptions for their symptoms (Conrad, 2007). In some cases, patients can purchase medications without prescriptions and have them home delivered (Conrad, 2010). On the other hand, CAM webpages promote treatment options that might be better suited to patients' preferences. The scientific support of CAM claims is a concern for patients and doctors alike; however, patients generally seek physician expertise on information accuracy on these websites. Pharmaceutical and CAM websites are generally more bias and motivated by profits (Blumenthal, 2002). A major concern for most doctors is the quality of health information online and the patients' competence in determining its safety (Anderson et al., 2003; Broom, 2005a, 2005b, 2005c; Fox et al., 2005; Hart, Henwood, & Wyatt, 2004; McMullian, 2006).

In an effort to better inform the public, the government also runs several websites to track health statistics, vital health safety information and recalls, preventative health measures, and new health threats to the public (www.cdc.gov). The Department for Health and Human services runs many of these websites; for example, the Center for Disease Control (CDC) site contains information on the spread of infectious diseases and

publishes immunization schedules for specific age groups. The Food and Drug Administration (FDA) provides information on government regulated industry standards with a specific page for consumers (www.fda.gov). Government operated health websites provide reliable information on treatments and standard medical practices for consumers with a focus on public health safety.

Patients can gather information from peer-to-peer, medical professional, pharmaceutical, CAM, or government run webpages. The quality of information varies on these webpages; the most bias tend to be pharmaceutical sites motivate by consumer profits, while the most reliable information comes from legitimate medical professionals or government operated websites. The quality of online information relies heavily on the source; it is the nature of online health information. Physicians are more likely to assume peer-to-peer support group information is harmful, but evidence shows that small percentages contain “possibly dangerous” advice, while the majority represents personal opinion (Conrad, 2010:187). Patients are more likely to distrust pharmaceutical websites because the companies stand to gain profit off the sale of their drugs. Internet informed patients challenge their doctors intellectually based what they feel is in their best interests; doctors, on the other hand, challenge the intellectual quality of the patients requests.

Patient Practices Online

Several researchers have suggested modern patient practices changed with the introduction of internet based information and a general increase in educational attainment (Anderson et al., 2003; Broom 2005a, 2005b, 2005c; Clarke et al., 2003; Conrad 2008; McMullian, 2006):

Health information is one of the most frequently sought topics on the Internet (McMullian, 2006:25); . . . Internet far surpasses other media in its ability to be “consumer centric” (Anderson et al., 2003:68); . . . people rely on the Internet to make critical health decisions, often bringing information retrieved from the Internet into medical consultations (Broom, 2005c:325).

Patients become informed about treatment options, symptomology, risk/rewards of medical procedures, and the experience of disease/illness from lay expert testimony through online support communities (Barker, 2008; Conrad & Stults, 2008). Many of these researchers argue, as a result of increased consumption of health information, patients are redefining patient-hood in the 21st century; however, the suspected impact this will have on the profession of medicine remains controversial.

Internet features three characteristics that make it a desirable resource: (a) publishing is simple and inexpensive for professionals and consumers, (b) feedback from readers allows publishers and webmasters to adapt or change information, and (c) speed and flexibility in responding or making changes is inexpensive (Anderson et al., 2003). These features reflect the consumer-centric aspect of online content; “We only have to look at it, and what we see on the internet is the same as we observe in the real world: a general trend toward self-reliance and patient power” (Anderson et al., 2003:69). The convenience of home access to an expansive, consumer oriented collection of health and illness literature online allows patients, if they choose, to bypass medical gatekeepers and be self-reliant. Consumer centered websites, like WebMD, offer reliable medical information, written so that consumers are able to comprehend the content. Home or over the counter treatments are also available through WebMD for less severe illnesses

like colds, mild allergies, and non-poisonous insect bites (www.webmd.com).

Consumer-centered does not mean it simply aims to appeal to consumers; it also tries to educate patients through less jargon-rich content.

Furthermore, the internet allows patients to choose the degree of interaction they are most comfortable with. Patient-to-patient (P2P) interactions have flourished through the internet's expansive infrastructure; the content of these interactions include information exchange, discussions of illness experience, or experiences with healthcare professionals (Blumenthal, 2002). Through these interactions, patients connect trans-geographically (Fox et al., 2005) forming communities that reflect the ideologies of its members (Barker, 2008; Blumenthal, 2002; Broom, 2005a). Researcher in this area reveals that these communities are often outspoken when medical professionals fail to meet patient needs and expectations (Fox et al., 2005); lay experts step in to advise and support these members. If they prefer, patients can choose to lurk (be non-participants) treating the post of other active participants as their own segregate questions or experiences (Barker, 2008; Broom, 2005c; Fox et al., 2005). Interactions online can be anonymous, a valuable characteristic for those who might feel foolish, stigmatized, or otherwise unwilling to ask or share information face-to-face (F2F).

Patient oriented websites have been studied by researchers seeking to understand the experience of illness and P2P interactions on discussion boards that reveal values held within these communities (Barker, 2008; Fox et al., 2005). Some of these communities might qualify as subcultures given that they possess values, normative interactional behavior, and social hierarchies (Conrad & Stults, 2008; Fox et al., 2005). This is best illustrated in Fox et al. (2005) study on European women taking a weight loss drug,

Xenieal. The researchers used triangulated data consisting of textual analysis of posts, participant observation, and 12 in-depth online interviews collected among willing participants. They found this community to have values of body shape and weight that mimicked popular media: ‘slimness is desirable while overweight bodies are not’. They also had a positive stance on the use of pharmaceutical drugs to lose weight, supporting a biomedical approach to treating overweight bodies. Expert patients, defined as ‘those who can manage their own illnesses and conditions by developing knowledge relevant to maintaining health and countering illness’ (Fox et al., 2005:1299), provide guidance and information to newly registered women as lay expert advisors. Fox et al. (2005) conclude “the expert patient is a reflexive patient contextualizing her life-story and experiences within available systems of thought, which—at least in policy formulations—are biomedical” (p.1307).

P2P interactions can also situate themselves in opposition to medical society’s stance on a condition; they are not just gathering the information, but they are also challenging it with alternative lay expertise. People suffering from chronic and contested illnesses have been known to do just this. Barker’s research into an electronic support group (ESG) established for sufferers of fibromyalgia, a contested disease characterized by debilitating pain, fatigue and/or mood disorders of which medical science has been unable to identify as related to biological or organic abnormalities (2008:23), explores the context of these interactions between patients. Through non-participant content analysis, Barker (2008) found that participant posts consisted of accounts with their physicians, and the discontent they felt when these physicians refused to legitimately recognize and treat the symptoms they suffered from. I think that these encounters reflect a strategic

response by physicians to disempower patients through a conflictual response to active patient behavior. In a supportive manner, participants encouraged the search for less “ignorant” doctors who would take their disease seriously (Barker, 2008:28). Others posted the relief they felt having finally been diagnosed, a legitimizing process that recognized their symptomology as a real disease; likewise, they felt sharing their experiences was therapeutic (p. 27). The shared experiences of the participants, and their lay expertise, requests that orthodox medicine recognize their experience of illness as real, thereby challenging the position of the physicians who claim it to be a psychosomatic problem. They want legitimate recognition of their experience and possible treatment options to relieve their suffering. Barker concludes:

It is precisely this dependency that fuels the existence of groups like *Fibro Spot* and motivates patients in their quest for medical affirmation and treatment. Nevertheless, as seen in these typical exchanges, the search for physician compliance, premised on an unquestioning acceptance of patients’ embodied knowledge, represents a significant challenge to the traditional doctor-patient relationship and the epistemological assumptions upon which medical knowledge and practice are based (2008:31-32).

The recognition of patients to seek communities for therapeutic recognition of their illness experience, and share negative encounters with medical experts, presents a modern demand for reform within the medical community.

Patients behavior online can support biomedical approaches to health management (Fox et al., 2005), but they also challenge the knowledge of doctors that fail to recognize patients’ illness experience as evidence of disease (Barker, 2008). Doctors

develop specialized knowledge through advancements in scientific discoveries; the flaw in medical science is the reliance on scientific evidence to prove the existence of an illness or disease. But what medical science cannot measure, patients can through their lived illness experience. Traditional interaction rituals maintain the value in scientific evidence and the doctor's expert ability to combat disease. The new ritual interaction that active patients' desire recognizes of their own expertise on the function of their body, and the ability to be involved in medical decision-making that reflect patient preferences. *Ritual change* happens when doctor/patient interactions become collaborative partnerships that account for each actors respective knowledge and decisions are mutually agreed upon. *Ritual conflict* occurs when doctors assert their professional status and specialized expertise of medicine as dominant over patient competence of medicine.

Physicians: Opinions of Internet use Among Patients

Internet has changed patient-to-doctor (P2D) interactions (Blumenthal, 2002); it allows patients to 'grade' their physician's performance and can empower them to locate a new physician should their current one 'fail' to perform adequately. Patients can personally assess the decisions of their doctors through online information retrieval (Broom, 2005a), or gather second opinions from lay experts (Barker, 2008) or medical experts (Anderson et al., 2003). When patients seek internet based health information, they are likely to find varying degrees of accuracy expanding the role of physicians to that of medical consulting. They also ask professionals to decipher, determine, and assess the accuracy of online information (Blumenthal, 2002; Conrad & Stults, 2008; Henwood, Wyatt, Hart, & Smith, 2003); this is evidence of *ritual change* in doctor/patient interactions. Patients rely on the experience of doctors in determining

effective treatments, medications, and explaining potential complications when it comes to healthcare intervention (Blumenthal, 2002); however, patients may not feel they are fully informed during time constrained clinical encounters and seek supplement guidance from internet resources (Anderson et al., 2003; Barker, 2008; Conrad, 2008). Physicians that feel their authority is being challenged may engage in conflictual behaviors such as interruptions, dismissal of source, or characterizing outside information as dangerous (Broom, 2005a; Murray et al., 2003); all ways to disempower patients resulting in *ritual conflict* with doctors.

Physicians are skeptical of the safety of internet retrieved information and its helpfulness in educating patients (Anderson et al., 2003; Broom, 2005a; Conrad & Stults, 2008; Murray et. al., 2003). These concerns are based off two primary issues: information quality from online sources and medical incompetence of patients. Physicians that find internet informed patients troublesome often mention that they disrupt traditional doctor/patient interactions. Doctors depict their ideal patient as trusting of the physicians decisions, stoic, and disengaged during interactions (Broom, 2005a); similar to role systems during the Golden Age of doctoring. However, internet informed patients are more likely to come armed with questions, preferred treatment options, and a self-diagnosis already in mind (Hart et al., 2004). Such patient behaviors may make physicians feel their authority is being challenged, and they respond by asserting their specialized competence and knowledge in medicine (*ritual conflict*).

Time efficiency is also a concern to doctors (McMullan 2006; Murray et. al., 2003); some physicians report that internet informed patients require longer visits (Broom, 2005a; Murray et. al., 2003) while others report that it increases time efficiency

(Siegel et. al., 2006). Time efficiency may be linked to the strategic response of physicians. Doctors reporting that visits were longer when patients used internet for information gathering were more likely to respond with *ritual conflict*. Doctors that improved their time efficiency with internet informed patients had recommended professional websites, like MedlinePlus, and were more comfortable with *ritual change*. The position of the physician on this matter may be reflective of the ideological perspective of their role and status in medicine and aim to strategically reinforce (*ritual conflict*) or adapt (*ritual change*) their position.

Ritual Conflict

Physicians that believe internet use by patients' results in negative and dysfunctional medical encounters are more likely to engage in behaviors that support the status quo and insight conflict. They point to lack of medical literacy among patients, limited time to answer patient questions, and loss of control over health management as significant disruptions to professional authority. They think that patients experience information overload and are incapable of making sense of medical information (Anderson et al., 2003; Broom, 2005a, 2005c; Henwood et. al., 2003). In studies conducted on patient information retrieval, researchers have concluded that patients are sometimes unaware of what organizations are responsible for the content of information they collect (Henwood et. al., 2003); they also may strategically avoid medical websites because they believe pharmaceutical companies and medical professionals partner together restricting the content to therapies they are circumscribed to use (Henwood et. al., 2003). Physicians are also concerned that patients will ask about alternative therapies

that they are uninformed of or are unavailable, threatening their professional knowledge and status (Anderson et. al. 2003; Broom, 2005a).

Interviews with prostate cancer specialists and their opinions of the impact of internet informed patients on doctor/patient relations found a majority of participants felt it was disruptive (Broom, 2005a:98). These specialists' appeared to feel threatened by patients who questioned their ability or approach to medical treatment. The interviews displayed physicians' reinforcement of their expert status and control within medical encounters. In fact, statements made in some interviews equate men involved in online support groups as participating in feminine activities, statements that reflect *ritual conflict* behaviors.

Representations of 'the patient' (incompetent/irrational), 'the support group member' (dissatisfied/argumentative/bitching) and 'cyberspace' (anarchistic/chaotic) come together within these specialists' accounts to provide a discursive platform for justifying 'expert' control over decision-making processes and, effectively, to limit patient involvement and power within the medical consultation. (Broom, 2005a:101).

Physicians of this opinion appear more combative against active and empowered patients. They even resort, in Broom's (2005a) findings, to threaten the gender identity of patients that participate in online activities. Physicians often cited their expert status to qualify them to make medical decision for their patients. To challenge this power was to insult their qualifications and professional status. Perceived threats to physician authority in medicine were the biggest predictor of doctor/patient conflicts (Murray et. al., 2003). Researchers speculate that some doctors are uncomfortable with more-equal

doctor/patient relations (Broom, 2005a; Murray et. al., 2003); *ritual conflict* discourages this shift in relations and attempts to gain patient compliance through asserting professional authority.

Qualitative narratives of physicians that disapprove of internet use by patients are limited. Many researchers agree that there remains much resistance from physicians to adopt its use and they discourage patient use (Bosslet, Tarke, Hickman, Terry, & Helft, 2010; Broom, 2005a; Murray et. al., 2003; Powell, Darvell, & Gray 2003; Siegel et. al., 2006). More research into what makes physicians feel challenged by internet informed patient behaviors is necessary to understand the use of *ritual conflict* to prevent active patient practices. It is possible that sample selection is skewed, and resistant physicians self-select out of research studies (Siegel et. al., 2006). There have been some attempts at nationally representing physician opinions on the subject; one study found that 54% of respondents thought there was a neutral effect on doctor/patient interactions when patients brought information with them and 38% percent felt it harmed their time efficiency (Murray et al., 2003). However, these studies are relatively outdated as internet culture and technologies are far more advanced than they were in the early 2000's. Furthermore, the authors of the previously mentioned national study mention they do not possess objective data regarding physician perception of patient behavior (Murray et al., 2003). Many of the studies conducted to date cannot be replicated and do not capture the complex interactions between doctors and patients (Waitzkin, 1990).

Ritual Change

Not all physicians are averse to online activity of patients. Some physicians felt online patients were more compliant with treatment regimes, especially when doctors

advised them of internet resources with quality information (Broom, 2005a; Siegel et al., 2006). They were characterized by one specialist as being self-motivated, better educated individuals (Broom, 2005a:327). Furthermore, they felt informed patients were more secure by being actively involved in healthcare decisions (*ritual change*) and accepting of unfavorable treatment outcomes (Broom, 2005a). This can be especially true regarding chronic diseases that lack biomedical certainty (Barker, 2008). By allowing patients to make informed choices regarding treatment strategies, physicians gain compliance and an approach that takes into account the patients' preference (O'Connor et al., 2007); this is evidence of physicians that accept new conceptions of patient-hood and changes in the ritual practice of medicine. Internet informed patients can also participate in more intelligent conversations with their physicians, empowering them to be actively engaged during clinical encounters.

Physicians of this perspective develop more cooperative relationships with their patients and, although it may take more time, value the informed choice of the patient (Broom, 2005a). It alleviates fears of being blamed for failed or adverse outcomes during treatment by allowing the patient to decide the amount of risk they are willing to take in medical procedures. The roles in this person oriented system harken back to that of bedside medicine, although the amount of power possessed by patients is still substantially less comparatively. Rituals established when medicine became a profession and gained unprecedented power over medical things are replaced with holistic people focused care, changing what doctor/patient encounters look like.

Internet also provides ways to better serve patients. Patients want to be able to communicate with their physicians through email and receive test results from the

convenience of their home or work (Blumenthal, 2002). This option could save patients money, by decreasing unnecessary office visits, and could provide a way to get lingering questions answered (McMullan, 2006). Patients could lose confidence in doctors that are not familiar with internet technologies (Conrad & Stults, 2008).

Some physicians remain apprehensive because they worry about time demands, liability issues, confidentiality, and receiving adequate compensation for these additional services (McMullan, 2006). Anderson et al. (2003) report that physicians indicate that they would delegate email management to a subordinate employee; of the few physicians that did use email to communicate with their patients, they reported their relationships with their online patients were strengthened through this form of communication.

Doctors benefit from online information; it allows quick access to medical information that assists in prescribing medications and providing patients with take-home instructions (Siegel et al., 2006); however, some physicians worry that this will make them appear less competent.

Internet democratizes health and medical knowledge; however, it is difficult to know if the information is objectively published by certified medical professionals (Clarke et al, 2003). Doctors can actively reduce the number of poor information retrieval activities among patients by prescribing information from trusted websites like MedlinePlus (Siegel et al., 2006). Patients are more likely to trust websites recommended to them by their doctors. According to physicians that participated in a study on “information prescriptions”, referring patients to MedlinePlus for medical information improved doctor/patient communication (Siegel et al., 2006). Professionally

recommended websites encourages patients to share retrieved information with providers improving interpersonal communication between actors and increasing patient education.

Discussion

Historically, doctor/patient interactions were ritualized as the profession developed specialized knowledge through scientific discoveries and implemented standards for practice; cultural and social authority allowed physicians to establish and maintain professional dominance during the Golden Age of Doctoring (McKinlay & Marceau, 2008). The democratization of information through the internet allows patients access to this specialized knowledge, which was once relatively unavailable to laymen. Informed patients are better equipped to be active participants during their clinical encounters because they can ask questions and determine preference. However, active patients disrupt the traditional ritualized behaviors during interactions causing physicians to reaffirm their ultimate authority (*ritual conflict*) in medicine or adapt to new relations between doctors and patients (*ritual change*).

The history of medical professionals relates the arduous journey to dominance and authority over medicine in the U.S. Normalized physician behavior developed through the struggle to gain professional status and distinctively set themselves apart from lay practitioners during the mid to late nineteenth century. For example, maintaining a front of propriety required a public performance in the form of dress, mannerisms, and service orientation (Starr, 1982). The behaviors during doctor/patient interactions were also meant to perpetuate their specialized skills; doctors deduce a patient's ailment through systematic body function tests coupled with patient symptomology, a process that began in the late 1800's and was perfected by the mid-

twentieth century. Patient behaviors reflected the expanding specialization of scientific knowledge in medicine; patients became more passive as doctors' knowledge became more advanced. Through the course of 150 years of medical history, doctors became increasingly dominant over medical decisions and patients gradually became passive recipients of their services.

The decline of physician dominance, following the Golden Age, and creation of internet technologies mark a new historical shift in doctor/patient relations. Doctors must operate within an increasingly diverse medical economy. Patients, on the other hand, are using internet technologies to gather information from a variety of resources that they use to actively engage in the management of their health. Doctors not only have to negotiate with outsiders that impinge on their autonomy, but they must contend with internet informed patients that reassert themselves during medical encounters. This recent historical shift is characterized by a decrease in physician dominance and autonomy and increasing self-reliance of patients in managing their health through easily accessible information technologies.

The traditional doctor/patient interaction ritual was grounded on the premise of specialized knowledge being exclusively possessed by medical professionals. However, the internet allows 24/7 access to both expert and lay knowledge about health topics. The democratization of information online provides patients and consumers with the tools they need to challenge ritual traditions by empowering them to take a more active role in health decisions. Physicians direct the course of interactions based on their response; *ritual conflict* or *ritual change*. When doctors respond to internet informed patients by interrupting them, discouraging information seeking, and using their professional weight

to gain patient compliance, patients are likely to search for a new doctor. However, doctors that respond to internet informed patients in a cooperative and respectful fashion are able to strengthen relations with their patients.

Internet informed patients began to bring their research with them to clinical encounters, asking questions about alternative treatments or self-diagnosis ideas. Some patients sought to redefine patient-hood and be active participants in the management of their health. However, many physicians found it to be a challenge to their competence and status as doctors. Typically, these physicians responded by dismissing the patient and asserting their specialized training to conduct medical work. This conflict alienated patients from their physicians, quite often resulting in the search for a new more sensitive doctor; conflict also reduced patient compliance through patient discontent. Conflict during doctor/patient encounters reflects a struggle over power to make medical decisions. It also tries to reinforce traditional doctor/patient interactions where patients passively comply with physicians' decisions and treatment regime; this reflects the object oriented role systems common during the Golden Age of doctoring.

Some physicians are choosing to embrace the internet as a valuable patient tool to manage chronic diseases. These physicians feel that informed patients pose less risk through active engagement and compliance with preferred treatment options. Patients feel more at ease with their treatment regime and show signs of self-motivation. The internet also provides a therapeutic outlet for peer-to-peer communication, lay expertise on practical daily management of symptoms, and supportive empowering dialogue. Physicians that embrace active informed patients recognize the benefits to changing the ritual of clinical encounters. If doctors want to keep up with their internet-savvy patients,

they will need to adopt practices that take advantage of online capabilities; strengthening their patient relationships and expanding their jurisdiction over internet based medical services.

The internet is changing the doctor/patient interactions and shifting power dynamics. Doctors are becoming more familiar with internet based information resources that will allow them to advise patients of which websites to use for information retrieval. This could be a promising strategy by physicians because it will increase patient confidence and expand professional authority; but, doctors would need to approach patients in a collaborative service-oriented manner. The success of physicians in expanding their jurisdiction to internet technology services will be influenced by the manner in which doctors define their role.

Research on disruption of ritual in doctor/patient interactions from the perspective of physicians is limited. This could be a reflection of their workload, busy schedules, or they might be a more difficult to reach population for researchers. A thorough understanding of physicians' experience and opinions of internet use among patients would better inform this research. Future research should try to understand physician motivation in responses to patients; furthermore, up-to-date national sampling of doctors will allow researchers to better understand shifting opinions of internet use in modern healthcare.

Conclusion

Professional authority and dominance, in part, rely on exclusive specialized knowledge of physicians; the internet disrupts traditional interaction rituals because patients gain access to an expansive digital encyclopedia of expert and lay medical

knowledge that they can use in making healthcare decisions. Often, patient internet use is met with negatively charged dialogue from doctors; professionals may be unfamiliar with internet technologies and are not well trained to utilize it as medical tool. However, there is a growing consensus among some specialized physicians that informed active patient behaviors are more ideal because they decrease sole decision-making pressure on the doctor, and promote a collaborative relationship decreasing blame of doctors when outcomes are not favorable.

Generally, internet grants access to the specialized knowledge of many professions. Webpages offer streamlined consumer-oriented software programs for legal documents, tax filing, and online banking or loan services displacing traditional face-to-face interactions with professionals. Furthermore, consumers can attempt home and mechanical repairs from information retrieved from discussion boards, do-it-yourself electronic forums, or online certification programs. Specialized knowledge is increasingly becoming open-access information which will have implications for many professional occupations. Occupations granted professional status, in part, on specialized knowledge will need to redefine their demand around quality in technical skills that attract clients to their services. The ability for consumers to compare pricing online for services stipulates that professionals offer competitive market compensation for services.

Traditional professional claims are altered in the era of internet with implications for server/client relations. It is currently unclear to what degree it will shift authority in decision-making from the server to the client as a result of open-access to specialized knowledge. Professionals are becoming consultants in modern server/client relations, offering advice based on experience and competence in their occupations. Clients are

becoming more critical of interpersonal relationships with professionals and, in some cases, dissolving relations when dysfunctional conflicts between actors dismantle service relationships. The response of professionals in the internet era will certainly impact their jurisdictional claims to their work, but if it will expand or contract their role has yet to be determined for many occupations, including medicine.

There remain many unknowns about the impact of internet on professions but change is guaranteed. Today, internet is highly integrated into society marking a historically prominent shift in a globalizing culture. Specialized knowledge is the mechanism that granted professional authority pre-internet; research into power dynamic shifts in server/client relations post-internet will help identify the new mechanism of professional authority in the era of internet. Although keeping up with internet technologies will be a challenge to researchers, it will provide a better understanding of internet as socially integrated global network that empowers consumers and the impact this has on professional occupations.

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