Forgive and Remember
Managing Medical Failure
Second Edition

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To the memory of my mother and father, whose norms I cherish, whose quasi-norms I miss
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Field work, like surgery, is a “body-contact” sport, and the surgeons at Pacific Hospital never shrank from this contact. In what were often very trying circumstances, they were considerate, candid, and courteous beyond the limits of any social and academic obligation. If they taught me nothing else, the surgeons taught me that delivering high-quality humane care is hard work. This study is a testimony to their openness and honesty which the use of pseudonyms belies.

While the surgeons were teaching me that high-quality care is hard work, a number of sociologists were trying to teach me the same lesson about sociological research. This work is better for their support, encouragement, and criticism. Fred Strodtbeck introduced me to the problems with which this dissertation deals, and constantly challenged me to find ways for documenting the reliability and validity of my inferences. Charles Bidwell often saw more clearly than I what I was struggling to say, and was a useful guide through and disposer of needlessly labyrinthine arguments. I owe a singular debt to Barry Schwartz. His insistence that I look beyond the particulars of the field situation to more general social processes improved this work immeasurably. Odin Andersen provided both intellectual and financial assistance through National Center for Health Services Training Grant, HS 00080-08 through 12. Renée C. Fox read and extensively commented on various versions of this manuscript. Her colleagueship and support have been invaluable to me. I cannot do justice to her contribution to this work and to my own growth as a sociologist of medicine in a simple acknowledgment and/or appreciative footnote. Harold Bershady read and gently but firmly critiqued numerous drafts of the manuscript.

Marjorie Waxman, my wife, helped in ways too numerous to
Introduction
At 6:30 A.M., only a few physicians and staff walk the still-darkened corridors of Pacific Hospital. Within an hour, the hospital will pulse with activity: nurses will wheel medication carts and chart racks down the halls; technicians will draw patients’ blood, orderlies will place patients on line for the various diagnostic and therapeutic procedures the hospital provides; vendors will hawk the morning newspaper; and teams of physicians and students will make rounds on their patients. In the predawn, however, there is no hint of the burst of activity to come. A lone houseofficer trudges down the hall. A few nurses from the night shift gather at their station, chat while charting the previous night’s activity, and share a last cup of coffee before ending their day at the beginning of everyone else’s. Only one small group of physicians is already engaged in the purposive and feverish activity that one associates with the hospital during the day. For them, the day is in full swing. This group of physicians moves from bleary-eyed patient to bleary-eyed patient while jotting down what work must be done that day. Their movements are swift and precise; no energy is wasted in extraneous chatter with patients or each other.

Who are these few physicians? Why are they up so early? They are members of the surgical housestaff of Pacific Hospital. The two or three days a week on which the services they are assigned to operate, these men and women begin rounds at 6:00 A.M. so that they can be scrubbed, capped, gowned, and ready to operate on their first patient at precisely 8:00 A.M. This starting time is important to them for a number of reasons. First, they know if they miss it they will be behind schedule all day. Although the twenty-minute difference between 8:00 A.M. and 8:20 A.M. is not great, it is often the difference between a hurried lunch and a twelve-hour fast. Moreover, this is not a quiet, meditative fast, but one during which the hungry houseofficer must remain standing; assist with or perform operative procedures; pass “ad hoc” quizzes on anatomy and the advisability of various treatment modalities; engage in witty repartee with his superordinate, the attending surgeon; or accept silently his role as butt of his superior’s jokes. Second, houseofficers who are not ready on schedule appear to their superordinates as inefficient, lazy, or unreliable. As houseofficers well know, “attendings” do not suffer wasted time—or those who force them to waste it—gladly. A houseofficer’s good name rests in part on his ability to keep events running on schedule.

For eighteen months, I was a participant-observer of the surgical training program of Pacific Hospital. Three interrelated problems captured my interest and attracted me to this field setting. First was a question of social control. On precisely what kinds of behavior does a houseofficer’s good name rest? What kinds of actions discredit him? How are evaluations of competence constructed by superiors, how are these evaluations shared, and how consequential are they? To use the vocabulary of Everett C. Hughes (1971), I was interested in how a segment of the medical profession exercises its “license” and “mandate.”

Second was the question of social support. The superordinate’s task is a delicate one. He must control mistakes. Yet at the same time, if he wishes to train competent, independent, and (eventually) autonomous professionals, he must allow his subordinates enough room to make the honest errors of the inexperienced. To allow this requires a certain cold-blooded calculation on the part of the superordinate. On the one hand, he needs to restrain himself from taking charge of situations too quickly lest he damage a subordinate’s confidence. On the other hand, he needs to know when to rescue a subordinate—and patientlest a surgical accident shake the novice’s belief in his abilities. So the superordinate has a dual problem: (1) he must control his subordinate’s performance and make sure that errors are corrected and not repeated, and (2) he must allow his subordinates room to make errors or they will never learn the judgments and
techniques necessary to perform properly. At all times we should remember that this give-and-take between ranks is more than a mere academic exercise; the clinical material for these lessons is another human being who has placed his life in the surgeon’s hands. Surgical superordinates who are permissive run the risk of abusing the patient’s trust, while those who are restrictive may retard or destroy the careers of fledgling surgeons. The forces that lead a superordinate to monitor his subordinates’ behavior more closely or those that lead him to forego close supervision are therefore not trivial matters. Because the consequences of these different modes of control and support are so fateful, rationales must be provided for their employment. Studying the different modes of control and their rationales will allow us to understand how a group of professionals conceptualizes its privileges and responsibilities.

Third was the question of sustaining individual commitments, motivation, and action in the face of failure. How does the surgeon cope with the knowledge that his clumsiness, forgetfulness, or tardiness contributed to another’s death and/or suffering? How does the individual surgeon accept this responsibility and yet not shrink from future action? All groups possess devices for making failure a normal and accountable feature of everyday life. Surgeons are no different from the rest of us in this respect; the difference lies in the consequences of a failure. We assume that where the possibility of such consequential failure exists on each and every occasion for action, there will be powerful, shared devices for coping with these failures. Again, this is not a trivial matter, for to understand and analyze these devices is tantamount to analyzing the structure of the profession’s conscience: its sense of right and wrong, and its sense of how large the gray area between them is.

This report centers on three themes: (1) How a professional group draws a boundary around itself and determines its own identity through the selection and rejection of recruits. (2) How superordinates attempt to control performance and how subordinates accept or avoid such controls in a professional training program. Of particular importance here is how norms of responsibility to patients and colleagues are articulated and how their violations are sanctioned. (3) How a professional copes with the existential problem of the limits of his skill and of his knowledge. In the course of things a surgeon’s best efforts will sometimes fail and he must explain this failure to himself, his colleagues, and the family of his patient. We are interested in how the surgeon achieves accountability to each of these significant audiences and in what situations the surgeon fails to achieve this accountability. Taken together the three issues of membership in a professional group, social control of performance in that group, and shared patterns of explaining, understanding, and neutralizing failure and error are critical not only to our understanding of surgeons but indeed to all of the professions in modern American society.

These are, of course, not new issues; they have been much rehearsed in the sociology of medicine and the sociology of the professions. If these issues are not new, why engage them here? First, I want to recapture and refine the old Durkheinian insight that each occupational group possesses its own morality. I want to specify what for the surgeon is the “complex of ideas and sentiments, [the] ways of seeing and [of] feeling, [the] certain intellectual and moral framework distinctive of the entire group.” As an occupational group, surgeons have a collective conscience. I shall make clear what it is, how it is formed, and what functions it serves. I then want to examine how this conscience serves the solidarity of the professional group and at what cost to the larger society. I want to know if any element in this “intellectual and moral framework” defines the essence of a profession in our society. Second, the occupational morality of the surgeon tells us much about how members of a profession interpret, act on, and defend their prerogative of social control. Any programmatic change which intends to make professionals more accountable to clients must of necessity start with a complex phenomenological understanding of what currently passes for accountability and how it is achieved. Field research such as this informs policy by grounding it in a firm understanding of how participants con-
struct their social worlds. It is only from this concrete understanding of the present, practical order that any changes in the existing interactional politics of social control can be negotiated.

The Field Setting and Data Collection

The setting for this study of how surgeons detect, categorize, and sanction error is Pacific Hospital. Pacific Hospital is an elite medical institution affiliated with a major medical school and university. In both medicine and surgery, it has a luminous reputation and a grand tradition. Everywhere one looks, one is reminded of Pacific's special place in the medical universe. Portraits of distinguished faculty grace hallways and classrooms. Lecture rooms and entire wings of the hospital are named after past greats that Pacific claims as its own. In addition, Pacific sponsors several endowed lectures a year which are named for its most eminent embodiments of the clinician-researcher ideal. These lectures are given by current great names from other leading medical institutions. This practice underscores symbolically Pacific's great past, its current status, and its hopes for the future. Its reputation for excellence attracts the top talent to both Pacific's medical school and residency programs. By and large, these recruits are considering careers in academic medicine; they often have strong and well-defined research interests.

At one time, the splendor of Pacific's medical reputation was matched by its physical setting in what was once the "gilded" section of a large urban area. Most of the middle-class inhabitants of the neighborhood have long since moved away and their elegant mansions have been either leveled or subdivided into many small apartments. The area that surrounds Pacific is mostly lower-class black. This population generally uses the emergency room at Pacific as its primary mode of obtaining medical care. As a result, the surgical staff of Pacific sees many patients who are in extreme pain and/or who are the victims of traumas such as gunshot wounds, beatings, and stabbings. As a consequence, a good number of the surgical patients at Pacific meet their surgeons under conditions that are considerably less orderly than those for typical middle-class patients who are often referred after some diagnostic tests by their private physicians. As we shall see later, the nature of a patient's first meeting with the surgeon is often invoked to explain failure and/or error; however, for reasons I shall specify, such accounts are never accepted as legitimate excuses in themselves.

If the splendor of Pacific's neighborhood has faded, that of the hospital itself has not. Its central shell remains a magnificent Gothic structure with elaborate stonework, turrets, and gargoyles. Attached to the original building are several new wings of concrete and glass. The original square floor plan of the main building has with these additions become a bewildering maze of passageways, tunnels, and crosswalks linking old and new. The emergency room, the operating rooms, the surgical intensive care units, X ray, and the patient wards are all located on different floors in different parts of the hospital. Because of this, simply carrying out tasks in some logical order is often no mean feat.

Pacific is now approximately a 450-bed structure. Of those beds, 200 are allocated by the Admitting Office to general medicine and 193 to surgery. The remainder is for inpatient psychiatric services. Of the 193 beds allocated to the surgical services, approximately 120 are reserved for the surgical sub-specialties such as neurosurgery, orthopedics, ENT (Ear, Nose, and Throat), plastics, cardiac and thoracic, and vascular. This leaves 75 beds or so for all four general surgery services which are the subject of this report. At Pacific, the general surgery services perform operations ranging in complexity from removal of hemorrhoids to esophagojejunostomies [an operation which binds the esophagus to the upper intestinal tract]. The general surgery services train housestaff to manage what are considered "normal, typical," surgical problems, and at the same time the services perform procedures which would not normally be undertaken elsewhere because of a patient's compromised condition, the lack of available support technology, or the presumptive lower level of competence and confidence of surgeons in other less elite institutions. The general surgery services have two classes of patients:
those referred from colleagues at Pacific or elsewhere because of
the unusually complex nature of their problems, and those who
entered through the emergency room. I did not observe that the
two different types of patients received differential types of care.
Attending surgeons in charge of services stress that they need an
appropriate mix of both patients with complex and routine
problems so that they can keep themselves challenged and at the
same time give their housestaff adequate experience.

During the time of my observations, each of the four general
surgery services performed an average of 24.5 major operations
and 10.2 minor operations per week. The weekly mortality and
morbidity rate, that is, the rate of death and complications, was
5.1. Our task here is not to evaluate whether this rate is high or
low, but rather to explain what this rate means to two groups of
participants, attending surgeons and surgical housestaff. In fact,
one of our first tasks is to see what relationship, if any, exists
between the morbidity and mortality rate—or the official rate of
error—and the surgeon's construction of what an error is and
what its seriousness is. A major focus of this inquiry, then, is the
social processes invoked to construct these rates and the meaning
these rates have for actors in this environment. In this
context, it
is interesting to note that each week the Department of Surgery
at Pacific Hospital posts a list of deaths and complications by
service, thereby distributing knowledge of misadventure very
freely within its ranks.

I made observations on two different surgical services: first the
Able and then the Baker (names and identifying characteristics
have been altered). These two different services were chosen by the
logic of the constant comparative method (Glaser and Strauss
1967). The general surgical services at Pacific Hospital varied in
their approach to surgical work along a continuum, the poles of
which were low clinical-high research orientation and high clinical-
low research orientation. Able represented the high research end
of the continuum, Baker the high clinical. The formal division of
labor on each service was identical. At the top of the hierarchy
were attending physicians, all of whom were full-time faculty of
Pacific Medical College whose practices were limited to the pa-
tients on their service. At Pacific all patients were considered the
private patients of the attendings whose service they were on: there
were no surgical patients who were considered the housestaff's
responsibility alone. In a strict legal sense, the attending surgeon
was responsible for what happened to patients under his care. It
was the attending who decided when to operate and what operation
to perform. The attending surgeon was clearly the superordinate
on the service. He was the final authority in any disagreements with
housestaff; only the attending could give orders binding on every
member of the service. Both the Able and the Baker Service had
two attendings, each of whom had the final say for his patients.
Attendings on a service might disagree with each other about
patient care procedures, but each recognized the right of the other
to treat his patients as he saw fit and proper.

On each service beneath the two attendings was a chief or
senior resident. This resident was responsible for the day-to-day
management of patients. He saw to it that the treatment plans of
the attending for patients were carried out. The smooth running
of the service—making sure that diagnostic tests occur on
schedule, that patients do not run into any unexpected troubles,
and that all work is done properly—is the chief or senior
resident's responsibility. Essentially, he functioned as an attend-
ing in the attending's absence; his major task was to anticipate
and treat problems before they occurred and to keep the attend-
ing informed of these actions. Beneath this level of authority are
second- and third-year residents whose precise responsibilities are
difficult to state. They must make sure the orders of the chief or
senior resident are carried out. They lack responsibility for the
entire service but have great responsibility for individual patients.
Keeping medications straight, staying up to date on chart work,
making certain the patient follows his postoperative regimen
(usually walking and expanding the lungs to prevent pneumonia),
and maintaining smooth working relations with nurses all seem to
be part of this resident's responsibility.

At the bottom of the hierarchy are, in descending order, an
intern, a senior medical student, and two or three junior medical
students. To use a military analogy, these are the noncommis-
Chapter One

sioned officers of the surgical world. The intern organizes the students so that the routine but necessary work (scut) of clinical care is done. Unlike the students, the intern can write medication orders and admit patients to the hospital. However, his authority in the hierarchical world of surgery is limited. Surgical interns often express resentment at how little they are allowed to take charge of. Senior medical students who may be contemplating surgical careers receive additional undergraduate exposure to surgery. For junior students, the surgery rotation is their first exposure to clinical surgical problems; for many who find surgery unappealing, it is also their last.

Each service varied at times in how it was staffed; there were variations in the number of individuals assigned to each service and in the ranks that were filled. On occasion, there were two second-year residents; at other times there was only one. On occasion, there were no senior students. The number of junior students varied between two and four. Variations in manpower were unrelated to patient load and were determined by the scheduling needs of graduate and undergraduate students. Whatever fluctuations existed in staffing, the formal tasks of both services were identical; preoperative and postoperative care, operating itself, evaluating referrals from other services, providing follow-up care to outpatients in the clinic, and supplying emergency room care and continuous coverage for patients of other services during “on-call” periods. The volume of work and the proportion of time devoted to each task varied, both among surgical services and within the same service for different time periods. Slack periods alternated with periods of frenzied activity. A brief description of the Able and Baker Services, excerpted from my field notes, follows.

The two attendings for Able Service, Dr. White and Dr. Peters, run the service from a distance. The two surgeons spend more time involved in their research activity than they do in direct clinical care of patients. Dr. White’s main research interest is the problems surrounding organ transplantation. Maintaining the service allows him to control hospital beds for his kidney transplants. The activity of Able Service is geared to kidney transplants. Periods during which one or more transplants are being performed and/or managed are periods of peak activity; all members of the Able team are animated by a heightened sense of purpose. These periods contrast sharply with those when there are no transplants. Dr. Peters’ major interest is research. Both Drs. White and Peters have excellent professional backgrounds and reputations, each having trained with a great name in American surgery. Attending rounds are made by Drs. White and Peters once a week on Saturday morning. They begin at nine in the morning and are over shortly after noon. Neither Dr. White nor Dr. Peters spends a great deal of time instructing residents in surgical techniques; only rarely do they run through a whole operation with subordinates. Chief residents are very active on Able Service; they have a great deal of decision-making power, they get to do a great deal of operating, and they are very much in charge. Residents and interns are not as a rule overly enthusiastic; they are critical of the range of cases that they see and of their actual operative experience. Students, especially those not heavily invested in a possible career in surgery, often relish being assigned to the Able Service since it has the reputation of being a “cakewalk.” Dr. White feels that both he and Dr. Peters devote enough of their time and energy to clinical care:

It all depends on what you mean. I know a lot of patients complain that they don’t see us around; they think we’re not concerned. What they don’t understand is that just because we’re not there doesn’t mean that we don’t know what’s going on. I talk to X [current chief resident] every day and so does Peters. I have complete confidence in X. I’ve helped train him for the last five years. When the year started I really stood over his shoulder; but now I know that if he runs into anything that he can’t handle, he’ll call me. I live only fifteen minutes away. X can control the bleeding from the worst gunshot wound until I get here. Look, everybody expects Mehta to conduct the orchestra; but they don’t expect him to play every instrument himself. Nobody criticizes Mehta when the oboe player hits a wrong note. Well, I lead the service. I don’t do everything or watch everything and nobody expects me to. What I do expect is that my residents will keep me fully informed of everything that happens on my service.
The two attendings on the Baker Service, Drs. Arthur and Grant, spend more time involved in direct patient care than do the attendings on the Able Service. Most of Dr. Arthur's research publications are based on his clinical experiences. Dr. Grant does some laboratory work but his current research involves a large clinical series. The Baker Service has the reputation of dealing with the most difficult problems of the four general surgery services. Dr. Arthur specializes in diseases of the colon; Dr. Grant, the biliary tract. Dr. Arthur has a very powerful personality; many of his colleagues and residents think of him as an anachronism, a throwback to the time when surgeons were the prima donnas of the hospital. Dr. Arthur himself is aware of his reputation for theatricality but claims, “It is always well controlled. I use those tricks in very select cases in order to get a very specific response.” He states that he learned this theatricality from the renowned surgeon for whom he was a resident. Dr. Grant, on the other hand, is more reserved. In most matters, Dr. Grant defers to Dr. Arthur. Attending rounds are made five days a week on the Baker Service by either Dr. Arthur, Dr. Grant, or both. The attendings use these rounds as their major teaching vehicle; in addition, Dr. Arthur holds a tumor conference once a week to discuss the management of cancer patients; and Dr. Grant meets with students on the service at least once a week to discuss general principles of surgery. Drs. Arthur and Grant are active in teaching surgical techniques to housestaff; they look over their subordinates' shoulders, running through the entire operation with them and giving lessons in basic anatomy to the others assembled in the operating room. Both Drs. Arthur and Grant do a lot of operating themselves. Occasionally, this is a source of tension for the service. Chief residents complain that they do not get enough cases. Residents and interns make the same complaint. By and large, however, housestaff like being assigned to the Baker Service. They state that they get an interesting mix of cases, that they are kept busy, and that both Drs. Arthur and Grant are superb teachers. Some housestaff express a distaste for the service because of Arthur's personality. The Baker Service is busier than the Able Service. It operates more frequently than does Able; and for the period of observation, it had more inpatients and more requests for consultations. Dr. Arthur explains his clinical emphasis as follows:

Surgery is a body-contact sport, there is no question about it. You can't be a good armchair surgeon. If I want to know if my resident is doing a good job, I have to be in the operating room watching him. I can't tell what kind of a job a colleague has done from just looking at his patient. I may have suspicions but unless I was there and know what kind of situation he was presented with, I can't really say anything. There is no way of telling what kind of surgery was done without watching it. There is no way to teach surgery outside of the operating room that I know of—and I've been in this business a long time.

I made an initial assumption that was incorrect in a way that proved serendipitous. I assumed that, both because of the different leadership styles of the Able and Baker attendings and because of the different emphases of their services, I would have a natural comparison of the ways errors were detected, coded, and redressed in two different social groups, while holding the task constant. However, no interactionally significant differences emerged between the Able and the Baker Services in the handling of errors. What was considered a serious breach on one service was serious on the other. What was a trivial mistake on one service was likewise trivial on the other. More strikingly, the phlegmatic Dr. White and the theatric Dr. Arthur, given comparable situations, tended to respond with the same degree of animation. This alerted me to an underlying uniformity that informed the surgical world view and I began to specify what the elements that accounted for that uniformity were and how when taken together they formed a unique gestalt. I began to feel that perhaps Durkheim was more correct than he knew when he suggested that each occupational group had its own unique morality.

During the period of field observation, I made the shared problem that deaths and complications present the work group and the shared and socially patterned ways that emerge for
meeting these difficulties the focus of my research. Since these problems do not arise on any scheduled basis, it was necessary for me to follow the schedule of a house officer in surgery in order to gather data. This involved following surgeons through their daily activities: I visited patients twice daily on rounds, drank coffee in the doctors’ lounge during time-out periods, scrubbed in and assisted on operations when hands were short, stood over bodies as they were pronounced dead, and stayed on call at night and felt the rush of adrenaline that a life-threatening emergency brings.

I systematically varied the ways I interacted with the surgeons. On occasion, I actively questioned them about their actions; on others, I helped wheel the chart rack and medication cart on rounds, was available as a “gofer,” and was as much as possible an extra pair of hands; on yet other occasions I observed as quietly as possible. I was by turns a more or less active participant in the scene. I could not correlate any set of roles I assumed with my informants’ openness, that is, their willingness to share their thoughts and feelings on the unfolding social activity. The demands of medical work are so great and immediate and the field-worker is such a relatively unimportant figure that I felt my presence affected the phenomena I was interested in only in insignificant ways, if at all. Whatever the day-to-day or scene-to-scene shifts in the researcher persona, my overarching procedure did not vary. For two to three months, I would be totally immersed in fieldwork; I would go to the hospital six days a week and stay the course of the day. Notes were taken as soon after events as possible, routinely within twenty-four hours. Field notes attempted to record events in as narrative or straightforward fashion as possible. Then, after this intense immersion, I would leave the field for two weeks to a month and perform an “in situ” analysis of my field notes. I developed categories, interpretations, and hypotheses from the field notes and discovered where my data were weak and where my observations needed to be concentrated in the future. I then returned to the field for further observation. In this way I “saturated” my categories and “grounded” my theory (Glaser and Strauss 1967). I left the field only when I was convinced that my observations had reached the point of diminishing marginal utility.

Not all the problems I set for myself could be appropriately answered by data collected by participant observation alone. Among the questions I was interested in was the following: How consequential are negative sanctions to an individual’s career path? To get at this question, I had to ask: How do superordinates, attending physicians, construct an evaluation of a house officer’s competence from observations of the house officer’s day-to-day task performance? I used two sources of data to supplement my field data: (1) I perused the written evaluations of house staff by attending surgeons as contained in personnel files (to safeguard individual identities, to preserve confidentiality, all names and dates were removed from the documents before I received them), and (2) I attended the faculty meetings of the Department of Surgery at which the decision to retain or terminate junior house staff in the training program is made. The process of this decision making has, to my knowledge, never been used in sociological studies of social control in the professions. This is an unfortunate omission since this is one of the few points in a professional career where controls exerted have a formal impact. These decisions serve to allocate medical manpower to different environmental niches in medical practice. The grounds on which these decisions are made reveal much about how effective we may expect the norms of medical culture to be in different environments and hence how effectively we may expect controls to operate.

Once fieldwork was completed, I interviewed those attendings and house staff with whom I worked most closely. The interviews served two purposes. First, they served as a check on the validity of my data. Many of my interpretations were rephrased as questions for comment. In this way, I could match my assessments against those of actors in the scene; and I could fill in those spots where my observational material was thin. Second, the interviews allowed me to see my observations in a larger context. For example, house staff were asked to compare their performance on different services. This provided me a fuller picture of their activity and their reaction to it than I could gather from my
field observations. Two different interview schedules were constructed: one for housestaff and one for attendings. These schedules served as guides rather than formal instruments. All interviews were kept as conversational as possible. Interviews lasted between forty-five minutes and one and a half hours. For attendings the focus of the interview was on how they decided if a subordinate was good or bad and what they considered to be unforgivable errors. Of housestaff, I asked what they thought superordinate’s performance expectations were, what they considered to be unforgivable errors, and what they considered the major difficulties in becoming a surgeon.

I have collected data on the problem of deviance and social control among general surgeons in an elite academic teaching hospital by a number of methods: participant observation, perusal of staff personnel folders, and interviews. I cataloged performance from several different sources, in addition to my own observations. This triangulated approach to data gathering (see Webb et al. 1966) gives me confidence in the validity of the inferences which I have drawn. Often conclusions reached about performance from one data source are confirmed by another.

Theoretic Foundations
This is a field study that asks how surgeons recognize, define, punish, and/or neutralize failure. As a study of social control among surgeons in an elite academic teaching hospital, this research adds to our theoretical and empirical understanding of how the quality of professional work is controlled. To answer these questions about failure and error I utilize ethnographic methods. So this study is also an ethnographic account of the ordinary and extraordinary rites, rituals, and practices which comprise the everyday life of surgeons. As ethnography this research provides, I hope, a vivid, resonant description of behavior as it naturally occurs. With ethnography properly done, ethnographic description has such a sense of verisimilitude, such a sense that “this must be the way things happen,” that the descriptive materials provide a prima facie case for the validity of theoretic argument, in this instance a discussion of the nature of social control in the medical profession. At times, unfortunately, the distinctive virtue of ethnography, its phenomenological richness, becomes a vice and one cannot see the theoretic forest for the too-richly described trees. As a result this ethnography, like so many others, runs the risk of being dismissed as “merely description” as if description itself were neither valuable nor necessary. In order to highlight as starkly as possible the way in which doing ethnography is always both a theoretic and a theoretically motivated activity, it is necessary to specify the theoretic and empirical questions that guided this research. After all, it was neither a love of surgeons nor of description that led to this study but rather my sense of what was deeply problematic about deviance, social control, and socialization in the sociology of the professions and the sociology of medicine.

When looking at the literature on deviance and social control in the professions, I have always been struck by the importance of the topic for various perspectives on the professions. Social control is the criterion variable that distinguishes one sociological perspective on the professions from another. Its analytic importance as a variable is matched by its empirical significance because of the policy implications that flow from how one conceptualizes professional behavior. If one follows Freidson, the doctor-patient relationship is an economic transaction in which the physician’s primary motivation is to maintain a privileged and protected position for himself in the marketplace. If one follows Parsons, this relationship is one of fiduciary trust in which the physician’s primary interest is to safeguard the health of the individual and collectivity. In large part, the policies one advocates at the macrolevel of state and profession are determined by the motivations one thinks operate on the microlevel of doctor and patient. In other words, whether or not the standard caveat emptor applies to the doctor-patient relationship is a question of profound sociological and empirical significance; any answer to this question is, of course, dependent on the degree to which the profession takes responsibility for its own social control.

However well or poorly the medical profession has managed
career path. I shall show what breaches the surgical profession considers tolerable, and what breaches are unforgivable. I shall explore how the day-to-day performance of subordinates is evaluated and how the judgment "this is a promising surgeon" is constructed. In this analysis we can see the operation of license and mandate collapsed into a single act: the promotion and dismissal of recruits.

Chapter 6 concludes the study by showing how professional self-control operates. I show how professional deviance is identified. I demonstrate how controls operate. I assess one consequence of this definition of the situation: the hypertrophy of individual controls and the atrophy of corporate control. I also present a methodological appendix which describes how I collected and coded my data and how I made myself a part of the surgeon's routine environment.
When deaths and complications disturb the surgical expectation of success, those involved are compelled to find good reasons to account for failure. A grammar of motives is manipulated to find an acceptable answer to the question, What went wrong? Moreover, deaths and complications are only one way in which surgical action is disrupted. Nurses and housestaff quarrel; diagnostic procedures do not occur as scheduled; patients fail to follow surgical regimens; and worried families disturb what are, for the physician, the most prosaic of procedures with questions, requests for more information, and demands for reassurance. All of these activities—in addition to the failure of surgical intervention itself—lead attending surgeons to question a houseofficer's competence. None of these events is a failure in and of itself, but all such events carry failure's frightening imputations. These events are occasions for negotiating whether a failure did in fact occur, whether that failure is a result of individual error, and whether or not that error is excusable.

The failure to sustain orderly surgical activity varies in intensity as a threat to a subordinate's competence, depending on how rudely expectations are breached, how frequently an individual breaches expectations, and how easily, if at all, the action may be reversed. This chapter explores the meanings that are negotiated in the wake of breached expectations, relates these meanings to the division of labor, and explores how these meanings are fateful for those involved. The explanation of failure has far-reaching ramifications since it morally typifies the person who is considered responsible. My concern here is with only the informal working understandings of superiors and subordinates that sustain continued action in the face of failure. Later I will discuss formal negotiations, as they occur in peer review, and formal evaluations of performance, as they occur among attending surgeons when tracking housestaff into different career paths.

A surgeon's attempts to explain preventable failure may be divided into four categories: (1) technical error, (2) judgmental error, (3) normative error, and (4) quasi-normative error. Although other interpretations of failure exist, only these four categories deal directly with the issue of physician competence and the social control of performance. Other labels are an attempt to locate responsibility in an area outside the surgeon's control, and are thus often of questionable legitimacy because of the highly developed ethic of individual responsibility among surgeons.

**Technical Errors**

When a surgeon makes a technical error, he is performing his role conscientiously but his skills fall short of what the task requires. Technical errors are expected to happen to everyone, but rarely. They are expected to happen to everyone because surgeons understand that theirs is at best an imperfectly applied science. At times, interventions fail because techniques have been less than perfectly performed. Certain failures of technique are expected as a routine and calculable part of the work environment: they are built into training. Knots tied by the unpracticed may leave dead space for infection or may split; probes and scopes in the hands of the inexperienced may explore more of the body than desired:

There are always complications from unfamiliar techniques. A resident may get a pneumothorax [air or gas introduced into the pleural cavity] when he taps a chest, or he may get a hematoma [a large bruise] after a procedure. If these things didn't happen to him, he wouldn't need us; he'd already be a professor of surgery. These things still happen to me but not nearly so often. They are the reason we have a training program, so housestaff can learn to do procedures without incident (Attending).

Further, attending surgeons claim that they can forgive even the most serious lapses in technique, the grossest of mistakes:
Look, suppose when a resident opens the abdomen he nicks the aorta—now that's dumb, stupid, anything you want to call absolute incompetence; I mean, the only way to do that is to really dig in with the knife. It's plain dumb, but it's not unforgivable. It's a mistake and everybody makes mistakes one way or another. Our job is to minimize these mistakes and give people the kind of training that makes them rare (Attending).

Certain failures are then interpreted as technical in nature. They are seen by attendings as an occasion for passing on to apprentice surgeons the “tricks of the trade.” Such failures highlight a training definition of the situation. In cases of technical error, the role-relation of attending and houseofficer is that of teacher and student.

For an error to be defined as technical, two conditions must be met. First the error has to be speedily noticed, reported, and treated. Such a chain of events serves as a signal of the subordinate’s good intentions at the same time that it allows treatment of the problem before it becomes unmanageable. The same objective condition reported immediately on one occasion and later on another will meet with a different response from attendings. Given the inevitability of problems, their speedy report under­scores a houseofficer’s conscientiousness and his concern for the patient; it pays tribute to the norms of clinical responsibility at the same time that events themselves mock these norms. As we shall see, a slow discovery of a technical error leads attendings to suspect that more than a technical failure was involved; they begin to think a moral lapse may have been involved as well. Moreover, quick reporting of error maximizes the possibility of routine remedies and thus minimizes for all the cost of failure.

We left Julio Jimenez’s room after rounds. Mark, the chief resident, shook his head and spoke: “I had bad dreams about Julio all night. He’s got this horrible infection going on in his belly; and I can’t figure out what’s causing it. This infection is clearly the result of some technical error. It could have been caused by any of a multitude of factors, really. But it’s a technical error, no doubt about it. Fortunately, for us and for him, Carl [the intern] noticed it right away or else he’d be awfully sick and we’d have a real mess on our hands” (Able Service).

It is nevertheless important to remember that the costs of technical failure never shrink to zero, and it is the patient who always pays. The patient pays financially in increased hospital costs and pays personally in the discomfort of a complication. For subordinates, quick report of failure is one of the primary means of establishing that the error is not representative of its maker, that it signals only a momentary lapse, and that it occurred merely because of its maker’s inexperience.

A second condition must be met for failure to be defined as technical; mistakes must not be frequently made by the same person. When an individual makes mistakes frequently, he cannot legitimately claim that a momentary lapse occurred. Moreover, attendings would not accept such a claim because frequent failure makes them doubt not only a subordinate’s efforts but also his intentions:

When a person makes the same mistake over again, you know you’re not getting through. For example, if a person comes into the operating room and he’s tying knots improperly, then you tell him, “You practice tying knots on your bedpost and not my patient.” And if the next time you’re in the operating room he’s doing the same thing, you can see that he’s not making progress. And if he’s not applying himself in one area, he’s probably not applying himself in others (Attending).

In fact, when an error occurs, attendings ask themselves how often this housestaff member has been involved in this sort of thing:

When you see residents make a mistake, you ask yourself: “Are they repeating the same mistake?” It’s a matter of memory. To be frank, it’s holding a grudge. I’m sure you’ve heard us say: “Forgive and remember.” When you see something, you ask yourself: “Has that happened before? Is it a pattern?” (Attending).
For their part, housestaff are worried not so much about making a mistake as failing to learn from those mistakes that they do make. They report, almost universally, the same feelings: at the beginning of their training they are terribly afraid that they will make errors that will have disastrous consequences for patients. Then they learn that they and all those around them make mistakes and that generally the consequences of such mistakes can be managed. Finally, they fear repeating the same mistakes and not learning from their experience. However, all report that their errors are etched indelibly in their memory:

Of course I worry about making a mistake and it really being disastrous for a patient. But really the crime is not making a mistake; everybody is going to make mistakes. The crime is not learning from your errors. What is really inexcusable is making the same mistake twice. For example, once I remember sending home a young girl who came into the emergency room at four in the morning and who had abdominal pains and couldn’t urinate. I was lucky somebody read over what I had done the next day and said: “Good God, get her back right away—she has appendicitis.” So they brought her back and operated that afternoon and she did have appendicitis. That was a case of me not knowing enough and making the wrong decision, but nothing like that will happen again. I learned from it (Intern).

Mistakes bother you less and less as you go on. I was really sensitive when I started. Fear of doing something wrong and being yelled at was a real motivating factor for me at first. I combatted the fear by working hard and paying a lot of attention to detail. During training you find out mistakes are not such a bad thing and that everybody makes them. But my first year I was extremely afraid. I became less afraid as I went along, but I also made fewer mistakes because I had more experience (Chief Resident).

This knowledge—that a mistake once made should never be made again—is a commonsense understanding that allows both housestaff and attendings to face the unpleasant fact that, because they carried out a task less than competently, another individual was caused to suffer. Technical errors and their lessons are even transformed on occasion into positive experiences. Benefits of the error are believed to outweigh the costs. One individual suffers, but legions of patients yet unseen have the lesson gleaned from this error passed on to them. Moreover, attendings need a certain number of errors in order to teach housestaff how to avoid common problems or how to meet them when they arise. Housestaff need exposure to a wide range of problems so that when training is completed, they are prepared to meet any of the contingencies which disrupt surgical action.

Be that as it may, neither attendings nor housestaff are sanguine in the face of technical error; and every effort is made to keep the number of technical errors small. While the acceptance of technical error is easy as a long-run and abstract proposition, concrete instances are most unwelcome. Work is organized on a surgical service in order to suppress the absolute number of technical errors. Two factors are most noteworthy. First, there is the technical division of labor which is arranged so that subordinates do not advance to complex tasks until they have demonstrated their competence at simpler ones. Before doing nonoperative procedures on their own for the first time, housestaff are shown how by more experienced service members and they are routinely monitored the first time they perform a task. Operations are performed by housestaff under the watchful eyes of attendings or more experienced residents who give advice during the procedure. So much is this supervision expected that when it does not occur, subordinates feel abandoned by superordinates:

Paul, a second-year resident, was to perform his first colostomy [opening and externalizing a segment of the colon] on Mr. Herman, a patient with cancer of the rectum. Dr. Peters, Mr. Herman’s attending, entered the room before the procedure began and asked Paul if he had ever done one of these before. Paul said he hadn’t. Peters told him it would be no problem, that they would whip right through it. Peters then took a marking pencil and drew a line on Herman’s abdomen indicating how he’d like the body opened. Peters then turned to Paul and said, “Scrub and begin. I have one or
two things to take care of, but I'll be back to help you." Paul scrubbed, prepared and draped the body, and began the operation. Peters never returned. Paul began to grumble as he did the procedure. A few times he asked the scrub nurse for instructions: What type of suture was normally used? How big an incision should he make to bring the colostomy out? How much bowel should he exteriorize? and so on. As soon as the procedure was finished, he sought out Able's chief resident, Mark, and complained: "Listen, if I had known Peters wasn't coming back, I would never have done that alone. I didn't know what I was doing." Mark did what he could to calm Paul, who was very upset. Mark kept pointing out how well the operation had gone. Paul remained unconvinced (Able Service).

Such breaches are, however, rare; and it is these exceptions and the strong feelings that they mobilize that allow us to infer how much a tightly controlled, well-supervised division of labor is the norm.

A more common problem is the reverse situation: beginning housestaff feel that the training process moves too slowly and that they are not getting enough experience or enough opportunity to exercise their judgment:

In the dinner line this evening, Brian, an intern, was complaining to Josh, a second-year resident, about doing a breast biopsy with Ernest, Baker's chief resident. Brian said, "I lost my biopsy to Ernest today." Josh asked, "What do you mean? Didn't he let you do it?" Brian answered, "Yeah, he let me do it. But he's real intrusive to work with. He couldn't keep his hands out of my operative field. If that ever happens again, I'll refuse to scrub with him again" (Baker Service).

The threat is idle, but the complaint is real. We should be alert to the fact that when this incident occurred Brian had been an intern only a month, yet he already felt the control of work confining. Another event a few days later further illustrates the point:

After rounds, Ernest broke off from the rest of the Baker Service and went to the outpatient department to do a biopsy. After he left, a junior student asked where he had gone. Brian answered, "To do a junior student case." He then turned to me and went on without prompting, "Ernest takes a lot of cases that a chief resident has no business touching. Cases that Josh and I should be doing. It's really frustrating—he just grabs up everything." I asked Brian why Ernest would do this. He responded, "It's because Arthur and Grant do things that you just don't expect attendings to touch. So Ernest never feels he has enough to do. So he takes cases from Josh and then Josh takes cases from me. It's all very frustrating" (Baker Service).

The argot of a surgery service associates operative problems with rank: a "junior student case" is a simple procedure, one for the most untrained; and an "attending case" is the most difficult of procedures. To accuse the chief resident of doing junior student cases is therefore to make a serious complaint about the division of labor and responsibility. Nevertheless, what is at issue here is not whether the two attendings hogged cases; on the same service at the end of the previous training year, there were no complaints about the division of labor. Control of work and supervision is most intense during the early stages of the training year and relaxes as training proceeds and subordinates gain exposure to and experience with new techniques. We should not be surprised that the graduates of elite medical schools find a rigid division of labor frustrating, but neither should we overlook how this division of labor serves to minimize technical error.

A second factor is operative on surgical services which also serves to suppress the absolute number of technical errors: namely, all requests for help are viewed as legitimate. When instructions for tasks are given, they are invariably followed by the tag line, "If you run into any problems, give me a call." This statement is more than conversational filler; it is a reminder to subordinates that their superordinates are legally responsible for their actions and are available to help. Further, the statement passes
on to the subordinate the responsibility of seeking help in situations beyond his level of competence. An important part of the subordinate's training is learning to discriminate between situations which he can and cannot handle. A request for aid is always honored. Two superordinate responses are common: (1) either the next person in the hierarchy performs the task himself, or (2) verbal instructions or pointers are offered. The first option is exercised when either time demands quick performance of the task, or when the task itself is seen as more complex than previously imagined:

A myleogram [a diagnostic procedure involving the removal of spinal fluid and the injection of dye in the spinal column] was ordered for Mr. Eckhardt. A senior student was to instruct a junior student in the procedure. They tried without any success to get the needle in the proper space. After some fumbling and a few sticks at Eckhardt the senior student instructed the junior student to "get Paul." Paul came in and surveyed the situation. After examining Eckhardt's back he told the students, who were profusely apologizing for their failure, not to worry; that the problem was in Mr. Eckhardt's anatomy and not in their skills. He then proceeded with some difficulty to complete the procedure, instructing the students all the while (Able Service).

The skill of housestaff with such procedures helps establish their authority to students. The ease with which they place intravenous needles in the veins of the most troublesome patients is a very common way to impress students; it serves especially to humble senior students who are planning surgical careers and who are often competitive with first-year housestaff. The second option, verbal instructions and pointers, is exercised when, in the judgment of the superordinate, the task is not beyond the skill of the subordinate but rather the individual's lack of confidence in his own abilities is preventing task performance. Here, the subordinate is made to see that he can accomplish the task and at the same time he is offered support. Surgical housestaff learn to operate in much the same way that small children learn to ride bicycles. An unseen hand supports their efforts. The hand is withdrawn by stages and the novice finds himself operating on his own:

Carl, the intern, was closing an incision while Mark, the chief resident, was assisting. Carl was ill at ease. He turned to Mark and said, "I can't do it." Mark said, "What do you mean, you can't? Don't ever say you can't. Of course you can." "No, I just can't seem to get it right." Carl had been forced to put in and remove stitches a number of times, unable to draw the skin closed with the proper tension. Mark replied, "Really, there's nothing to it"; and, taking Carl's hand in his own, he said, "The trick is to keep the needle at this angle and put the stitch through like this," all the while leading Carl through the task. "Now, go on." Mark then let Carl struggle through the rest of the closure on his own (Able Service).

Technical errors, then, are distributed throughout the surgical division of labor, but unevenly. More are made by beginners than the experienced. Technical errors do not damage an individual's claims to competence so long as he appears to learn from them and to make less of them over time. Supervision and the division of labor are arranged to keep such errors at a minimum.

Judgmental Errors

A judgmental error occurs when an incorrect strategy of treatment is chosen. These errors are also unevenly distributed through the division of labor. Subordinates who have only little discretionary power make few and relatively minor judgmental errors. Attending surgeons in charge of devising treatment plans make the most and the most serious judgmental errors. In these cases judgment is not always incorrect in any absolute sense; the surgeon, given the clinical evidence available at the time, may have chosen an eminently reasonable course of action, but the result—a death or complication—forces the surgeon to consider whether some alternative might have been more profitably employed. Clinical results, not scientific reasoning, determine how correct judgment is. Surgeons have an aphorism that expresses
Chapter Two

this: “Excellent surgery makes dead patients.” By this they state most flat-footedly their understanding that textbook principles of care have to be compromised to meet the immediate situation, that results and not the elegance of a clinical blueprint separate acceptable from unacceptable practice.

The two most common judgmental errors that attendings make are (1) overly heroic surgery, and (2) the failure to operate when the situation demands. Overly heroic surgery involves the decision to operate when the patient cannot tolerate the procedure. This decision to operate is a surgeon’s commitment to his skills; it is also a moral-ethical decision about what “tolerable” risk is and a decision about what the proper role of the physician is—whether he is charged with merely sustaining life or whether he may subject his patients to great risk in order to upgrade the quality of life. Needless to say, these are not easy or pleasant decisions. Consider the following:

Mrs. Hardy is an old patient of Dr. Peters who has metastatic cancer. She has at most a few months to live. Recently her condition has worsened. Without an operation, she will probably literally vomit to death within a month. She has poor pulmonary and cardiac function; it is not clear whether she could tolerate an operation. If one is successfully performed, her life expectancy would be between three and six months—a month and a half of which would be postoperative convalescence (Able Service).

In this case can the surgeon justify putting a patient through the risk and trauma of surgery for such dubious rewards? But in good conscience can he stand idly by and sentence her to such an unpleasant death? An attending makes these decisions for himself. He may ask his subordinates what they would do if the decision were theirs. A favorite way of phrasing this question is, “What would you do if the patient were your mother?” After listening to his subordinates, the attending announces his decision. He need not justify this choice to other attendings. He need not explain the basis of his decision to his subordinates, although the didactic situation of surgical training encourages such explanations. To mobilize the resources necessary for action,

the attending need only make up his mind. In this sense, his patients are his to do with as he wishes.

If subordinates disagree with an attending, there is very little they can do. A common tactic is to anticipate complications from a procedure and ask the attending how he intends to manage them:

Mrs. Pratt is an obese woman with metastatic cancer on whom Dr. White has decided to perform an adrenalectomy and an oophorectomy [surgical removal of adrenal glands and the ovaries; an attempt to achieve a remission from cancer]. Mrs. Pratt’s obesity and very poor pulmonary function make her a very poor operative risk. Both Mark and Paul seemed uneasy with White’s decision. Mark told White that Mrs. Pratt would be like “a beached whale” following surgery and then he asked White a series of questions about the possibilities of embolism and the prophylactic measures White had in mind and about the difficulties of managing her pulmonary status following surgery. Paul then asked about gallstones and the possibilities of cholecystitis [inflammation of gallbladder]. After answering these objections, White left. Paul and Mark confided to each other that they felt uneasy about the surgery. Neither was certain that they would recommend it for their mother. Later, when I told Paul he seemed uncomfortable about the decision to operate, he replied: “Well, there is a great risk involved and it’s not clear to me that the benefits are greater than chemotherapy, although White is right—the results of surgery can be absolutely dramatic, if you are lucky. Look—it’s one thing for a patient to die from disease; you don’t like it, but there’s nothing you can do about it; you accept it. But for a patient to die because of something you did to him, because you gave him pulmonary edema [filling of lungs with fluid], or from a leaking anastomosis [seams that join resected body parts], that’s a whole different thing. It makes you feel real bad when something you did kills somebody. It gives you pause for thought. Doctors aren’t supposed to do that” (Able Service).

However, no matter how much they disagree with an attending’s decision, no matter how much they grumble among themselves, subordinates defer to decisions with no more than polite question-
ing. The decision to operate is an apparently unchallengeable element in an attending's professional autonomy:

I just make it a point not to disagree with attendings for two reasons. First, I'm not as smart as they are. And, second, the ultimate responsibility is theirs; and if they think that something should be done, I'll do it (Intern).

A second common judgmental error of attendings is the failure to establish a clear-cut plan of action for chronic problems. For most of these patients, secondary problems make operating impossible. These patients tend to linger in the hospital. They are not discharged nor are they aggressively treated. Often diagnostic tests reveal conditions in addition to the original problem requiring hospitalization. Each test in turn requires a further one. Intensive diagnostic studies are done on the patient even though he will not be extensively treated:

Surgeons in general don't like theoretical or psychological problems. Things are either black or white. If they don't understand something, they try to put it out of their minds. For example, there are two patients on our service now whom we can't do anything with, and they really need something done. I think they will die without operations. But they are too sick to be operated on. The surgeon in this case gets frustrated and less aggressive. One of the worst things that can happen to a patient is to spend a long time on a surgical service. Surgeons lose interest in chronic problems. When the surgeon begins to lose interest, he starts asking for consultations, hoping that someone will take responsibility for the patient. Unfortunately some patients, not a lot, die because the surgeon loses interest (Chief Resident).

The error in judgment here need not express itself in a death or complication; surgical patients can spend considerable periods of time in the hospital, have little done for them, and be discharged without incident. Nevertheless, precious healing resources have been misallocated—a bed is taken up, time and effort are expended, and what the surgeon hoped to accomplish for the patient is never made certain. Moreover, such mistakes are more likely to be overlooked than others because they are not marked by an objective event such as death.

Though judgmental errors are most commonly made by attendings, some are also made by housestaff who have to make immediate decisions about patient management:

Sam Jerome had his appendix removed on Baker Service. His postoperative recovery was anything but smooth. He was reoperated on for what was diagnosed as an obstruction but turned out to be an ileus [a condition where bowel has no peristaltic action]. Following the second operation, he developed a wound infection. Two days after the second operation, Brian, an intern, was sitting in the Baker conference room. I asked him how it was going and he replied, “Not so good. This responsibility can be devastating. It’s just awesome. Take Jerome—I couldn’t help thinking that the phenobarbital I ordered for him postop may have given him the ileus that caused us to think he was obstructed. That made us reoperate, and then he gets this wound infection” (Baker Service).

Housestaff routinely make such self-criticisms of their behavior, especially after deaths and complications. They review their entire course of action to see where they might have acted differently. Attendings encourage this reexamination of action and see it as symbolic of a subordinate’s determination to learn:

Until he is confident and secure, any good surgeon dreams about his operations. He reoperates, taking stitches in and out, revising his approach. He does this, too, for clinical situations. He rethinks how each patient was managed. This happens until he’s secure. I did it. I expect my housestaff to do it. You need this kind of attention to detail, absolute dedication, and personal honesty to be a good surgeon (Attending).

Despite their claims of making serious and consequential judgmental errors, housestaff are not sanctioned for them for a number of reasons. First, they do not have the responsibility to make serious judgmental decisions; and, as Stelling and Bucher (1972) have shown for psychiatric and medical wards, one cannot be
accountable for an event unless one is also responsible for it. Second, like technical errors, when quickly reported and infrequently committed, judgmental errors are seen as an inevitable cost of training. They do not indicate that an individual is incompetent but rather they serve as evidence that he needs further teaching. Judgmental errors, then, also reinforce a "training" definition of the situation. Furthermore, as we shall see in chapter 4, there are structural limits placed on the housestaff's ability to indulge in self-criticism. While social control of action rests on self-criticism, the process of self-criticism itself is subject to social controls.

Attendings are also somewhat insulated from the negative implications of their judgmental errors. First, their professional accomplishments protect them from the imputation of defective judgment: any individual failure must be weighed against many successes, research publications, and the like. Second, operating on difficult cases that others would not handle is a pride of place. The attendings at Pacific pride themselves on their ability to treat such cases. Death from judgmental error in such trying situations is an uncomfortable fact of life:

It would look suspicious if you are doing major surgery and, week after week, you have no deaths and complications. You're going to have these, especially deaths, if you do major surgery. You can lead a long and happy life without deaths and complications, but you have to give up major surgery (Attending).

There are times then when the surgical expectation of success is waived. The reputation of the individual attendings of the surgery department at Pacific and the reputation of the department itself encourages heroic surgery in risky situations. In these cases, some judgmental error is expected. These are not severely judged. Such cases are seen not so much as mistakes but as a privilege and as a burden of rank. Judgmental error in heroic situations—operating too often in heroic situations—may earn an attending a reputation among his colleagues and subordinates as a "matador," a "gunslinger," or "someone who sees a patient as just so much meat on a table." Yet while such terms are indicative that the attending is not held in high esteem by his colleagues, being so labeled seems to have no noticeable effect on day-to-day behavior. It should also be noted that as a term of opprobrium there is a certain ambivalence involved in calling someone a "gunslinger" or a "matador." After all, in their respective cultures, such figures symbolize the heroic ideal. I suspect that most surgeons would rather be compared to Wild Bill Hickock or Billy the Kid than to Caspar Milquetoast or Walter Mitty.

**Normative Errors**

A normative error occurs when a surgeon has, in the eyes of others, failed to discharge his role obligations conscientiously. Technical and judgmental errors are errors in a role; normative errors signal error in assuming a role. These errors are not distributed throughout the division of labor but are almost exclusively subordinate errors. Normative error occurs when, in the attending's judgment, a houseofficer's conduct violates the working understandings on which action rests. When a normative error occurs, the mistake renders it impossible to consider the person making it—in legal terms—a just and reasonably prudent individual. Viewed sociologically, normative errors challenge tacit background assumptions about how reality in a scene is constructed.

When spelled out, the background assumptions that govern clinical action are few, and they are drilled into the subordinate from his first clinical rotation as a medical student. The covering law for all behavior is, simply stated, "No surprises." Superordinates expect their subordinates to inform them of all changes, however small, in the service's status:

During the orientation meeting for the Able Service, Mark, the chief resident, explained what he expected during the next rotation: "If anything comes up, I want to know about it. I don't care what time it is; I want you to call. If there is a problem at four in the morning call at four in the morning."
Most likely, I'll listen to what you tell me and fall right back to sleep. I may even forget that you called. But call. I don't like to walk in here in the morning and find myself surprised by what's going on in my service. I'm ultimately responsible for what goes on here, so call me." He repeated this message a number of times in a number of ways (Able Service).

The no-surprises rule is shared by all attendings. When interviewed, they all stated that the first expectation for housestaff performance is compliance with the rule of no surprises. Interpreting the no-surprises edict is in actual practice a complex decision for housestaff. Attendings dogmatically state the rule to impress housestaff with its importance and to rescue everyone from the technical and judgmental errors that are part of being inexpert. Nevertheless, whether or not in any particular instance to invoke the rule and call is a recurrent problem for subordinates. On the one hand, the housestaff member does not want to look foolish, as if he cannot handle the simplest situations; and on the other, he does not want to risk the attending's anger or the patient's life should his assessment of the situation be incorrect. Perhaps it needs to be pointed out that when a subordinate chooses not to invoke the rule and does not call, he still risks the attending's wrath even if he acts in a technically correct fashion. At no time did I observe superordinates reacting negatively to subordinates who called them for what later became unnecessary reasons; and often what appears at the time as an unnecessary reason appears retrospectively as very consequential:

Don, the senior student, at the end of a long and an eventful day—there had been one unexpected death and one kidney transplant—was talking with Greg, a junior student. "I called Mark last night about Thelma Halsted [the unexpected death]. It was four in the morning and he wasn't too pleased. He told me to do what I would have done anyway. But the way things worked out today, I'm really glad I called." (Able Service).

Idealists may be dismayed that Don's reaction to an unexpected death is relief that he cannot be blamed. The more hard-boiled and pragmatic will be grateful that from a personal tragedy, a moral lesson was salvaged and reinforced: when in doubt, call, lest a death be your undoing. For the subordinate, calling is always a safe strategy. Interpreting the no-surprises rule in the framework of a zero-sum two-person game, a subordinate always makes a game-correct decision to call. Yet subordinates feel that there are costs attached to calling and may be under great pressure not to call because more than a correct response in an interaction game is involved. In addition to the fear of looking foolish, there is the desire to participate early in the intrinsic gratifications of surgery, the belief that one learns from managing new clinical situations, and a sense of dedication to the heroic ideal that one is made or unmade by the quality of one's tests:

The way you learn as an intern is by being put on the spot and coming through it. You develop a self-awareness that you can handle a lot of situations. The problem is learning what you can't handle. There's a lot of pressure not to ask, a lot of fear of appearing foolish (Intern).

Despite these tensions and the resulting temptation for the subordinate to go it on his own, the no-surprises rule is the overarching principle by which normative errors are defined.

We may ask, What is a surprise? The most correct answer is anything that an attending chooses; and even though housestaff occasionally feel that attendings apply no principles of selection, attending behavior is more predictable than that. First, a surprise for an attending is any violation of the principle of full and honest disclosure. A surprise for the attending carries with it the implication that a housestaff member was lazy, negligent, or dishonest. In practical terms, an attending finds himself surprised when he discovers for himself something a patient that housestaff knew and neglected to tell him, or when he discovers for himself something his housestaff should have known:

I walked into the intensive care unit with Carl, Able's resident. Dr. White was on the phone. "I see a glucose value of 540," he grunts, and screws his face in an expression of pain. "Well, we were planning to operate today, but obviously
we’ve changed our thinking.” White hung up and asked, “What’s this I hear about Thelma Halsted?” “I’m just getting the story myself, sir,” Paul, a second-year resident, answered.

“She had to be rushed to the Cardiac Care Unit for a pacemaker. She’s doing terribly,” Carl volunteered. “Carl, why wasn’t I told?” Carl: “You were operating on the transplant, sir.” White: “That’s no excuse. If you couldn’t get away, you could have called up to the OR and they would have tucked a note on the door that I would have gotten the minute I finished the case. That way, after surgery, I wouldn’t stop for coffee. I wouldn’t stop and talk to people. Listen—when one of my patients is dying, I don’t like to be told by some damn medical intern. I want to know what’s going on with my patients.” White then wadded a piece of paper and threw it across the nurses’ station (Able Service).

Dr. Arthur was concerned that a complication from the operation on Mrs. Prewitt might be a peroneal nerve palsy [temporary paralysis of the foot from operative damage to the peroneal nerve]. In clinic when he asked Ernest, the chief resident, and Josh, another second-year resident, about it, they both assured him that on morning rounds she was quite all right. However, her examination on afternoon rounds revealed a peroneal nerve palsy. Dr. Arthur’s anger was apparent as we left the room. We walked about sixty feet down the corridor before he stopped to speak: “Goddammit! I will not have this on my service. Do you understand? I ask if the patient has a peroneal nerve palsy and am assured by my housestaff that she doesn’t and she damn well does. Now, this is not caused by your not being smart enough to recognize the problem. It’s not your skill that is wanting here. This is a case pure and simple of your being too lazy to get off your ass and look at the patients. I will not tolerate this. Did you see this patient this morning, Ernest?” “I did—yes, I did, sir.” Arthur: “And you didn’t notice that she had no dorsiflexion [movement of the foot at the ankle]? Ernest: “No, sir.” “Well, what the hell were you looking at? What am I going to have to do to get this service running right? If I can’t count on my housestaff to provide decent preoperative and postoperative care for my patients, then Grant and I will cancel our operations

until the patients we have are under control and until we are sure that we have housestaff who can do the job. Do I make myself clear?” (Baker Service).

Normative breaches are breaches of the etiquette governing the role relations between attending surgeons and housestaff. A normative error in turn carries with it the implication that a fundamental breach of etiquette governing the role relation between doctor and patient has occurred. When making decisions, the surgeon—any physician, in fact—is expected to bracket all systems of relevance to him as an actor in his other social roles and even bracket all systems of relevance to him in his other capacities as a surgeon. He is expected to treat conditions as they arise or to make certain that they will be treated before he moves on to other tasks. Fatigue, pressing family problems, a long queue of patients waiting to be seen, a touch of the flu—all the excuses that individuals routinely use in everyday life, are inadmissible on a surgery service. An attending who is surprised assumes that his housestaff have not been dispensing proper clinical care. Had they been, housestaff would have informed him of changes in clinical status.

Attendings are most frequently surprised by housestaff not keeping them abreast of unfolding events, but there are two other types of surprises that are treated as normative errors. A housestaff member’s inability to get along with nurses is a failure that attendings treat as normative. It violates the tacit assumption that one will not let personality intrude on clinical care:

After rounds, Arthur turned to Sharon, the head nurse of Baker Service, and asked: “Are there any nursing problems?” “Plenty!” Sharon replied. At Arthur’s suggestion, we all went into the conference room to discuss it. Sharon explained that Dr. Carter and the nurses “didn’t seem to get along this weekend.” Arthur turned to Carter: “All right, Carter—what’s the problem?” Carter explained: “Well, we had some problems getting a urinalysis done on Mrs. Yardley. The urine was collected but no one took it to the General Services Lab until I did at midnight. That’s just one thing, but, really, the nurses on this floor are incredible. All the housestaff have
complained about it. The other night I was called every fifteen minutes. Once I was called because Crane’s IV wasn’t running. When I came down, I saw he had rolled over and kinked it. It was obvious that the night staff hadn’t even looked at it.” Arthur answered: “None of that bothers me. If you have to get up every fifteen minutes because nurses are too tired, lazy, or stupid, that’s too bad for you, but it’s what you’re paid to do. You may even lose a pound or two. [Carter is overweight.] What bothers me is your fighting with staff. That accomplished nothing. In fact, it makes things worse. Look—you’re a professional, you are better educated, better trained, and supposedly more mature than the staff. If you can’t get along with them, we’ll find someone who can. Do I make myself clear?” (Baker Service).

Housestaff failure to maintain good working relations on the ward is a serious mistake; it indicates that a subordinate lacks the skills necessary to run a surgical team. A housestaff member who quarrels with support staff is blamed—whatever the legitimacy of his complaint—for placing his own needs above those of patient care. There are ways of dealing with improper nursing; public quarreling is not among them. Further, as far as an attending is concerned, the problem with a subordinate who quarrels with nurses because they call too often for unnecessary reasons is that when he becomes a chief resident he may complain about his interns and that when he becomes an attending he may complain about his chief residents. This complaining may communicate that he is unavailable to help. In this case the whole set of controls built into task performance by the division of labor and norms of clinical care breaks down. Complaints about unnecessary work indicate to superordinates that a subordinate lacks the proper commitment.

A second serious error is similar to inability to work agreeably with nurses, that is, the inability to secure the cooperation of patients and their families. To housestaff fall the problems of obtaining informed consent, of gaining the patient’s cooperation for preoperative and postoperative care—this is especially important because the involved patient can do much to prevent some postoperative complications, and of managing the anxieties of the patient and his family. A failure at any of these tasks is an indication that a subordinate cannot control the normal troubles of his environment. In addition, failure at any of these tasks creates extra work for attendings—these are unpleasant surprises—and all of this work is considered avoidable. It all stems from a subordinate not conscientiously filling his role. Technical and judgmental errors also create extra work, but such work is seen as an inevitable part of surgery. However, the extra work of normative errors is unnecessary. It is not viewed as an inevitable part of major surgery but as an inevitable consequence of minor surgeries.

Although normative errors are committed by both subordinates and superordinates, only those of housestaff are criticized and punished. Housestaff make normative errors because they are subject to so many cross-cutting systems of relevance that it is often impossible for them to bracket all systems of relevance, keep unfolding action under control, and avoid unnecessary problems for attendings. An intern or second-year resident’s schedule is a grueling one: he works six and a half days, fifty weeks a year; a light working day is twelve hours; and at least two nights a week he stays in the hospital on call for emergencies. Given such working conditions, many other systems of relevance impose on the clinical one. There is the physiological one: housestaff need to eat and sleep. There is the social one: housestaff need time-out periods (this is an especially acute problem for married housestaff). There is the student one: housestaff need to study the problems they are treating. All of these are in addition to the multiple systems of the clinical role itself, which requires housestaff to coordinate treatment for as many as thirty-five patients, to provide a full complement of ancillary services, and to keep the ward running smoothly. Undoubtedly, trying to meet such multifocal demands explains to some degree why normative error occurs. Attendings, however, never allow such factors to excuse normative error. For them, there is no “good” excuse for a normative error because no other system of relevance is ever allowed ascendancy over the basic doctor-patient dyad and because normative errors are always interpreted as evidence that the houseofficer placed some other concern above patient care.
This is so despite the fact that normative errors such as quarrels with nurses or the failure to keep attendings fully informed need not result in outcomes that directly harm the patient. On the other hand, technical and judgmental errors always involve some discomfort to the patient yet are often interpreted as evidence of the individual houseofficer's commitment to clinical care.

Attendings escape blame for their normative errors for three reasons. First, the privileges of rank insulate them from many of the housestaff's cross-pressures. Because of their rank they are directly accountable to no one on a day-to-day basis. Second, membership in the American College of Surgeons, appointment to the Pacific faculty, and other credentials such as research publications and professional awards are a presumptive moral licensing. To be an attending at Pacific is to stand at the symbolic center of the value system of American medicine. Basically, an attending is not publicly blamed for normative errors because there is no one to accuse him of such moral lapses. No one stands above him in the hierarchy and enforces the rule of "no surprises." The attending's position contrasts sharply with that of the houseofficer who has not yet been certified as morally fit to be a surgeon, whose commitments are now being tested. Third, although the attending is the legally responsible agent for patient care, the division of labor does not always reflect this. Generally attendings spend the greater portion of their time teaching or doing research rather than providing direct clinical care.

The division of labor itself frees the attending from the more prosaic demands of patient care, a fact which exposes them to concrete charges of normative failure. Rank, moral authority, and everyday task-structure insulate the attending and expose the housestaff to the danger of normative error.

Normative errors are taken seriously by housestaff and attendings. Housestaff fear normative error much more than they do technical and judgmental errors. They fear that normative errors destroy their credibility as responsible workers; they fear bad recommendations and other negative sanctions:

After he failed to inform Dr. White of Thelma Halsted's deteriorating condition and after White had reprimanded him, Carl left the room and sat dejected on a bench. He said: "That's it. I just blew two months' hard work in two minutes. It doesn't matter now what my work on the service was like. This is all he'll remember. It was a really dumb thing to do, a serious faux pas. I don't think she would have had any different care, really there was nothing White could have done about it. I guess it's just embarrassing for him to have a resident from another service tell him about his patient's"

(Able Service).

This fear of normative error on the part of housestaff runs deep and is shared by medical students. Among the students, we can see more clearly the logic-in-use that develops around performance and failure. Junior and senior medical students often state that the tasks they are assigned are so minor as to be worthless in evaluating their clinical skills. As a result, they think evaluations are based on their ability to be team members. Like housestaff, they are frightened of receiving recommendations that brand them as individuals who have difficulty respecting proper lines of authority. Interns and students both suffer the less rewarding aspects of their position in silence for fear of the repercussions of an overly noisy complaint:

Irv and Larry, the two students on Baker, have been dissatisfied with their stay on the service and were vigorously complaining to Christian, the intern, about it. Irv said: "It's not the amount of work, Chris—it's what we learn from it. We are not learning the principles of surgery and that's why we are here. What are we going to learn from anyway: doing the scut work or working-up a few patients and following through on them and reading about their problems?" Larry added: "Yeah, I don't mind being on call with the service because then you learn something. You work-up patients and see things. But to stay at the hospital just to change IV's—that doesn't make any sense." Chris answered: "Look—I didn't arrange the way that the service runs. If you have such complaints, if you feel this way, you should talk to Dr. Grant or Dr. Arthur." Irv replied: "C'mon, Chris. You know that we
can’t do that. We don’t want a recommendation that says the student is unmotivated, uninterested in patients, and hard to work with. We want to work with patients, but we want to learn something, too” (Baker Service).

Attending reaction to normative error justifies housestaff’s fear of these breaches. Attendings react strongly to normative error for a number of reasons. First, in the early stages of training, there are only minor variations in skill among subordinates. Normative performance is seen as an indicator of honesty and responsibility, two qualities that attendings feel subordinates must possess if they are to be capable colleagues:

The most important thing is complete intellectual honesty, a willingness to admit problems and personal deficiencies. Someone who recognizes his errors and ‘fesses up.’ Look, I could teach a gorilla to operate in six months, but I can’t teach honesty and responsibility. It’s the people who have these qualities who make outstanding surgeons (Attending).

A technical or judgmental error then says something to an attending about a recruit’s level of training; a normative error says something about the recruit himself. A second reason that normative breaches are so serious is that patients for whom attendings are legally responsible can be lost, without the attending’s best effort being made on their behalf. A normative error then compounds the normal troubles of a surgeon’s life. In addition to the inevitable deaths and complications, he must worry with those caused by personal as opposed to professional shortcomings; he is dealing with reducible error:

Covering up is never really excusable. You have to remember that each time a resident hides information, he is affecting someone’s life. Now in this business it takes a lot of self-confidence, a lot of maturity, to admit errors. But that’s not the issue. No mistakes are minor. All have a mortality and a morbidity. Say I have a patient who comes back from the operating room and he doesn’t urinate. And say my intern doesn’t notice or he decides it’s nothing serious and he doesn’t catheterize the guy and he doesn’t tell me. Well, this guy’s bladder fills up. There’s a foreign body and foreign bodies can cause infections; infection can become sepsis; sepsis can cause death. So the intern’s mistake here can cause this guy hundreds of dollars in extra hospitalization and it could cost him his life. All mistakes have costs attached to them. Now a certain amount are inevitable. But it is the obligation of everyone involved in patient care to minimize mistakes. The way to do that is by full and total disclosure (Attending).

A normative error breaches this system of full and open disclosure: this system protects attendings at the same time that it frees them for other activities. They need not be omnipresent if their housestaff keep them omniscient. The subordinate who fails here can expect severe punishments. The rule of thumb attendings apply here is, even the most technically incompetent can be trained for something—he will rise or sink to his own level of proficiency. But the morally bankrupt represents a threat to the surgeons at Pacific and must be treated as a serious problem.

Quasi-normative Errors

Normative errors are breaches of standards of performance that all attendings share: quasi-normative errors are eccentric and attending-specific. Each attending has certain protocols that he and he alone follows. A subordinate who does not follow these rules mocks his superordinate’s authority; his behavior is a claim that his judgment is as adequate as his superior’s; and even though in no absolute sense can one claim that a mistake has been made, a subordinate who makes a quasi-normative error risks his reputation as a trustworthy recruit.

There are many decisions which surgeons are forced to make in the absence of scientifically established criteria. Great uncertainty surrounds much medical behavior. From their own clinical experience and from medical journals, attendings marshal evidence to support one approach to a particular problem as opposed to another. However, the evidence is far from conclusive, debate continues, and a consensus fails to emerge. Some attendings approach a problem in one fashion with very good results;
others have equally good results with a competing approach. Despite the open-ended nature of the question "Which approach is better?", attending in their everyday behavior can be quite dogmatic. Attendings believe that housestaff are on their services to learn their approach to the surgical management of disease. On other services, they can learn other approaches. Nevertheless, attendings are quite capable of making the theoretic distinction that separates quasi-normative from genuine error:

First, you have to recognize that there are two different types of mistakes. There are genuine mistakes and there are mistakes of the "I don't do it this way; do it my way" variety. Those really aren't mistakes. At this hospital, for instance, take a patient with gastrointestinal bleeding. If he enters Dr. Arthur's service, Arthur wants to locate the source of bleeding. He performs an endoscopy [a procedure to view an internal organ; in this case the stomach is viewed through the mouth] on the patient, takes X-rays, and maybe does an angiogram to locate the source of bleeding. Now, Dr. Henry doesn't think it's important to locate the source of bleeding. He places a nasogastric tube down the patient to suction any clots and get the stomach free of blood; he milks the stomach with an antacid bath; and if the bleeding stops, he doesn't care about the source. He figures if the bleeding doesn't stop, he still has time to do the tests to locate the source. One approaches the problem conservatively; the other, radically. Now these are both tremendously prominent men in the field. Who is to say that one way is right and the other is a mistake? (Attending).

For the attending, more than professional pride is involved in quasi-normative errors: housestaff using their own independent judgment appear insubordinate to him. Compliance with attending dictates, however open to debate they are, is an indicator that a subordinate is a responsible member of the team who can be trusted. Attendings feel that the subordinate who makes quasi-normative errors is also likely to make normative errors: his behavior does not inspire trust:

The thing that offends me the most is when I tell someone they made a mistake and I give him my list of reasons—because he's always entitled to know why he is wrong—and then he tells me that it was okay, and that he was entitled to make a mistake for his own experience. When people put their own experience above patient care, I find it intolerable. Just the other day, I had a fourth-year student pull a nasogastric tube on the second day postop of a patient of mine. I told him that this was not wise. The patient had no bowel sounds nor had he had a bowel movement, and I take both as indications that a nasogastric tube is ready to be pulled—however, in this guy's judgment what he did was okay. He ignored my reasons. In fact, this guy's goal was not to be responsible for patient care but to be independent of higher-
He told me what he did was important for his own clinical development. He didn't give a fig about patient care. And nothing—nothing—nixes my confidence quicker than that. It's a privilege to learn here and the student is obligated to have a respect for our methods. They have to respect that the responsibility for the patient is ours; it's not the resident's patient—it's ours (Attending).

When a normative breach is made, a double error is involved: standards of clinical care are breached and the etiquette governing role relations among attendings and housestaff is breached. For quasi-normative errors, clinical care may be correctly administered and the general etiquette of role relations may even be followed—the subordinate may have informed his superior of the problem and been told to take care of it in the "usual" way. When a quasi-normative error is made, the subordinate is wrong for all the right reasons: his fault is that of hubris: he tried to act like an attending. Quasi-normative errors are idiosyncratic; behavior that would be formally correct on one service is not so on another. This is the cutting edge that distinguishes normative from quasi-normative errors: what counts as a normative breach is fairly constant from service to service. Nevertheless, attendings recognize each other's right to organize and run their services as they see fit; they hold that it is the subordinate's responsibility to accommodate himself to this state of affairs; and they agree that quasi-normative errors indicate that something is seriously awry with a subordinate.

The organization of work on a service determines how much room a subordinate will have for independent judgment and consequently how likely it is that he will make quasi-normative errors. On the Able Service, where supervision is relatively loose, subordinates have a great deal of room to maneuver and quasi-normative errors are relatively rare occurrences. On the Baker Service, supervision is relatively tight, subordinates have little room, and quasi-normative errors are more common. Housestaff when on the Baker Service state that they have to be "company men." Dr. Arthur has numerous personal eccentricities which he expects housestaff to respect and learn from. These express themselves in various eponyms: there are Arthur variations of operative procedures; there is the Arthur fluid-management regimen for postop care; and there is the Arthur method for managing gastrointestinal bleeding. Given the autocratic nature of surgical authority, the strong personal preferences of superiors are translated into absolute rules of conduct for subordinates. In everyday life, we label those with this power prima donnas: their own likes and dislikes become the rules others follow.

For their part, housestaff are eager to avoid quasi-normative errors. They fear finding themselves on an attending's wrong side, a state of affairs which can have devastating effects given the amount of control that attendings have over their careers. Often, the steps subordinates take to avoid quasi-normative errors can be amusing to the observer and sufficiently detached participant:

Mark, Baker's chief resident, and Stan, a third-year resident, walked into Mr. Johnson's room on morning rounds. "Oh, my God! What's this?" they said in unison. "That's the patient with gastrointestinal bleeding I called you about last night," said John, the intern. "But you're treating him with an antacid bath," Stan said. "Sure! Is that the usual treatment? It's the way Henry does it on Charlie," said John. "You never treat gastrointestinal bleeding that way on Arthur's service. He'll blow his top if he sees this. We better get this out of here quickly," said Stan, all the while removing the antacid bath. As we left the room, Mark turned to me and said that a lot of surgery was foolishness and a lot of what surgeons believed was magic. But you couldn't argue with results (Baker Service).

More commonly, housestaff are not good-natured about meeting what seem to them the mere whims of superordinates; quasi-normative errors are a source of tension among housestaff and attendings. Housestaff resent that their judgment is not trusted; they feel that they are not given tasks commensurate with their skills; and they feel exploited as a cheap source of labor. Especially vexing to housestaff is the lack of debate and questioning that precedes many decisions:
I don't like it when orders are given down from above without reasoning. I do not like decisions when there is no discussion. I realize that questions are not always appropriate; but when they are and you can't ask them, that makes things unpleasant. You can always ask some attendings why they are doing something, but you have to read the mood of others. It's all a matter of participation. When you are taken as a colleague, it is very pleasant; but when you are there just to carry out orders and to do the work, then I don't like it (Intern).

Housestaff also feel defenseless against the whims of attendings. They know that there is nothing they can do in the face of an attending's anger. They know that there is nothing they can do when attendings make errors, save talk among themselves. This inequality is, in fact, in one way or another one of their favorite topics of talk. Interestingly enough, it is not the amount of room itself which determines housestaff resentment of attendings. Housestaff can accept very narrow limits if they respect an attending's judgment and skill and if they feel they are learning despite eccentricities that must be tolerated. They then speak of the attending's behavior giving the service "color." On the other hand, housestaff may find relatively more freedom chafing if they do not respect an attending's judgment and if they feel that they are not learning much from a service. This finding parallels Goss's (1961) that professional expertise determines how well or poorly advice is received. Competent professionals need not pull rank since they can persuade by reason.

Now, when you're on Arthur's service, you don't mind too much the way decisions are made. You know Arthur is such a good clinician that even though he's dogmatic, you believe him because he's usually right and when you disagree, you're usually wrong. But with Steele, you argue more because his opinions are not always sound, he makes wrong judgments in the operating room, and his clinical judgment is often poor. Your argue more—it's easier to argue—but since he is less secure, you have less leeway. He's always confused; and when you disagree with him, you feel he is probably wrong (Chief Resident).

On Baker Service, we were having coffee after morning rounds. Josh was talking about working with different attendings: "It's really funny. When Arthur speaks, it's as if he has a pipeline from God himself—he's that sure that what he says is right and the only way to treat a patient; and you don't think to question him. Then, when you're on Charlie Service, Henry will tell you with equal conviction an exactly opposite way of doing things. And when he says it, you believe him" (Baker Service).

Quasi-normative errors are serious mistakes for subordinates to make; for them to damage a subordinate, however, he must make them on more than one service or he must make them blatantly (see chapter 5 for a fuller discussion). Housestaff are forgiven an error or two that may reflect a lack of familiarity with a service. In fact, strong reactions of attendings to these errors is a way they communicate to housestaff how seriously they take their personal rules. It is a way of showing what the proper alignment of roles is, of communicating to housestaff that they are in the hospital not so much to treat patients as to learn to treat them. Attendings acknowledge that the system is one in which it is difficult to be a subordinate:

Surgery is a funny business: You force strong-willed, aggressive, intelligent individuals to become peons. The goal is by having these individuals sublimate all their own independence, they will come out five years later as strong individuals with confidence in their own skills, judgment, and ability (Attending).

Exogenous Sources of Failure

Surgical intervention also fails for a number of reasons that do not implicate the competence of the surgeon in any direct way. The surgeon's strong sense of individual responsibility has him turn to these reasons only when the search procedure fails to reveal any physician error or when the reason is glaringly obvious. These labels for failure are then a residual category. They raise
no questions of physician competence, deviance, and the social control of performance.

First, there is failure from disease. Sometimes the best efforts of surgeons cannot cure those in the more advanced stages of terminal illness. Operative complications always raise questions about the adequacy of surgery; but deaths, especially when separated from the operation by a respectable period of time, do not terribly threaten surgeons. These deaths indicate to surgeons what the limits of their skills are; and they are seen as inevitable. Much disease is irreversible. An interesting feature of the allocation of effort on a surgery ward is the division of patients into two classes: salvageable and nonsalvageable. Heroic care goes only to salvageable patients. The nonsalvageable do not receive emergency cardiac resuscitation or other aggressive life-prolonging measures. This is not to say that the surgeons at Pacific practice euthanasia; rather they limit their heroism. Nonsalvageable patients are allowed to die from their diseases and not saved to suffer from them. These patients are still treated—they are not ignored—but the surgeon does not play all his cards. Salvageable patients help determine the allocation of scarce healing resources.

Second, there is patient procrastination or noncooperation. Often surgical intervention fails because patients neglect to report symptoms until too late. This happens for a variety of reasons. They may read the symptom correctly and fear the cure—women with breast cancer, for example. They may have religious beliefs that inhibit medical intervention—Christian Scientists, for example. They may not have easy access to health care by virtue of being poor or uninsured. Surgeons view these patients with a mixture of incredulity, compassion, and disgust. Also, patients may report symptoms, consent to care, and then balk at proposed cures—patients facing amputations are an example. These patients refuse to consent to the more radical treatments offered them and agree only to procedures more limited than what the surgeon desires. Here, the surgery performed is a compromise between what the surgeon thinks he can get away with and what the patient will accept as necessary.

On Able Service, Mark and I had left the room of a patient who had refused to consent to a procedure that White thought best—a below-the-knee amputation and a dissection of the lymph nodes in the groin. Despite Mark's best efforts—he appealed to the patient's responsibility to his family, to his youthful appearance, and the greater promise for a vigorous life the more extensive procedure promised, and claimed that the operation was not as bad as the patient feared—the patient refused to hear any of it: "You can cut to here and no further," he said, drawing an imaginary line across his knee with his hand. When we left the room, I asked Mark if such refusals were common. He answered: "It happens. It's rare but it happens. When it happens, I try to explain to the patient why we want to do the procedure we do. I mean, I really try to explain so that he understands. I never try to bullshit somebody into an operation. And then if he still refuses, I try to work out some compromise that the patient and I can live with. Now, take this guy: he might be right to gamble. If I were in his place, I'd accept the knee amputation and the groin dissection. But I can't say for sure that the lymph nodes are the source of his problem so I can't in good conscience play God and demand he have the fuller operation. He may be right—who knows? As a surgeon, I can't put a gun to his head and demand that he have what I think is the best operation" (Able Service).

Here, the patient must share responsibility for the outcome with the surgeon. The necessity for "informed consent" often compromises what the surgeon would like to do.

Third, there is nursing and support staff error. Often failure can be traced to the mistakes of nurses and others involved in direct patient care. Medication fails to get passed properly; intravenous solutions are not replaced on time, or they are run in too fast or slow; tests are scheduled but fail to get carried out; blood samples are contaminated; dressings are not changed promptly and wounds are not kept clean enough—the list is endless. On the one hand, subordinates are responsible for seeing that nurses are mobilized and that work gets done properly; but, on the other hand, housestaff cannot be responsible for everything everyone
does. So housestaff are held accountable for nursing error that emerges from creating tension with nurses, and they are held accountable for not properly dealing with nursing error. Normal nursing errors are treated by doctors as difficulties in a different chain of command. They are reported to the appropriate authority, and it is assumed that nurses will keep their own house in order.

Fourth, there is *machine malfunction*. Some failures occur because of breakdowns in the enormous technology that supports care in the modern hospital. Computers print out the wrong values for diagnostic tests; ventilators fail; pumps fail. Such things happen, and there is little the surgeon can do, save have the offending machinery replaced or repaired. Failure does not threaten the claim to competence. However, for novices the breakdown of machinery can pose a real threat to confidence. The inexperienced may connect the failure of the machine with a failure of their own skills since they do not have enough practice to form a sense of mastery at the task. The recruit may even feel that the machine is trying to tell him something.
form of the stories, especially the emphasis on inexperience, makes this anxiety all the more clear. Horror stories allow participants to communicate in a backhand way their awe at the tasks before them, their reverence for sound clinical judgment and experience, their apprehensions about the levels of their skills, and the secret knowledge that one learns from misadventure. Horror stories allow surgeons to comment on how ill the title “doctor” sometimes clothes the wearer. Second, horror stories allow guilt to be communicated and shared. These tales act to mitigate the strong norms of the role that prohibit physicians from expressing their feelings. Daniels (1961) presents a good discussion of how these norms are communicated in training. Third, horror stories are cautionary parables—they instruct the beginner that pride goeth before a fall.

Horror stories, then, are a recurring feature of behavior which helps mitigate the tensions of surgical training. By circulating secret knowledge such stories help recreate a sense of group after dressing-downs. As a rule, superordinates tell such stories for their heuristic value, but they also serve as a bit of comedy that relaxes tensions. Subordinates use these stories to establish their credentials as members of the group of surgeons. A repertoire of tales indicates a depth of experience. At the same time, horror stories allow access to affective dimensions of the self that normal fulfillment of the role denies. As such, they are a social control of the harsher aspects of ward rounds.
We have so far seen how failure is managed at the level of the work group. We have discussed the types of accounts that are given when deaths and complications occur, seen how these accounts are distributed throughout the division of labor, and shown how everyday routine surveillance acts as a means for superordinates to prevent and/or minimize failure and evaluate subordinate performance. Two features of this system of social control are noteworthy. First, knowledge of everyday performance is limited to members of the work group. Other colleagues do not observe each other's work and what information they do receive is systematically biased hearsay. That is to say, attendings, as well as housestaff, are most likely to grouse among themselves and spread information in those cases where they feel that the objective fact of a death or complication reflects unfairly on their performance. The segregation of everyday controls and the great range of expressive behavior that attendings are allowed permits us to characterize such controls as private or backstage performances (Goffman 1961). Second, the power of attendings in the system of everyday controls is truly remarkable. They alone decide if mistakes are forgivable or not, if subordinates are trustworthy or not. The binding understandings of failure forged at the everyday level are the attending's. His tolerance of technical and judgmental errors creates loyalty among subordinates and encourages greater efforts from them in the future to repay the obligation incurred by the attending's forgiveness. The swift and harsh dressing-downs that follow normative and quasi-normative errors define the boundaries within which forgiveness is permissible. Intolerance here creates rage and anger among subordinates and weakens ties to superordinates.

These two features of everyday controls—their privacy and the extent of the attending's authority—arrest our attention, first for their everyday operation and short-run consequences and second, and even more important, because they seem to indicate that the system of social control and socialization rests on an internal contradiction. On the one hand, one overarching norm governs the evaluation of performance, the rule of “no surprises”; full and complete disclosures are demanded of subordinates. Yet, on the other hand, superordinates are at an everyday level free of this constraint. The privilege of their rank is that they need not provide subordinates with any explanations for their actions. This freedom from the constraint of full and complete disclosure is what Weber defines as authority. Simply stated, this is the attending's power to give orders and expect that they will be carried out. Earlier we have seen what beliefs attendings invoke to legitimize their treatment of subordinates, that is, to justify their use of authority. What we have not yet explained is how attendings maintain this considerable authority. This is not an unimportant question, for authority does not just exist; its holders must take great pains to maintain it against persons and events that challenge it.

In this chapter we shall explore the ways attendings dramatize their claims to authority and hence maintain it. Such dramatizations are important for a number of reasons. To begin with, they help explain the stability of attending authority. This stability should not be taken for granted, because when deaths and complications occur the primary responsibility is the attending's. Failure contradicts the attending's claim to powers beyond his housestaff in a public and undeniable fashion. Furthermore, these dramatizations explain what factors limit superordinate authority and allow subordinates to accept it despite its occasional arbitrariness. Also, by displaying what norms attendings must satisfy in order to maintain their legitimacy, they show how attendings meet the requirements of full and open disclosure that they demand of subordinates. Such dramatizations remind everyone that attendings remain accountable for their actions and go a long way toward resolving the contradiction between what
attendings require of their housestaff and what they require of themselves.

The attending’s claims of authority rest first and foremost on external symbols independent of his day-to-day performance. These are his training, his experience, and his research contributions; however, such reputational assets would mean little if not reaffirmed by day-to-day performance. Therefore, attendings must both explain their failures—that is, they must neutralize or divest failures of their negative meanings—and they must also make their successes highly visible. The privilege of the attending’s rank is not that he is free from accountability but rather that the forum in which his accounts for failure are demanded, given, and accepted is much more formalized, ritualized, and polite than the forum he provides his houseofficers and, further, he is provided a special forum to celebrate his successes. These two forums are the Mortality and the Morbidity Conference and Grand Rounds, respectively.

Below we shall analyze both as occasions which attendings use to legitimate their claims to authority. In so doing, we shall see how paradoxically the harshness underlying the system of social control is at the same time mitigated and reinforced.

Varieties of Normal Action

In chapter 1 I stated that the presumption of success, which is the only warrant for subjecting a patient to the risk and trauma of an operation, makes surgeons more accountable than other physicians for failure. I claimed that the surgeon’s craft and his beliefs about it make surgeons sensitive to what failure implies about their skill and judgment. In chapters 2 and 3 I examined how attendings held housestaff accountable for their actions. I am now in a position to demonstrate how attendings transform the private troubles housestaff create for them into public issues in the Mortality and Morbidity Conference and Grand Rounds. Through these conferences attendings justify their claims to authority by public displays of virtuosity to the entire collegium of subordinates and superordinates. The accounting of attending surgeons is not a backstage activity but a very carefully staged presentation of self. Subordinate accounting is always a test of competence; superordinate accounting is always a display of confidence.

As with all social accounts, those offered in the Mortality and Morbidity Conference and Grand Rounds attempt to align discrepant outcomes and expectations. The possible relations among any actions, expectations, and outcomes can be simply conceptualized. To any action we attach either positive or negative expectations; the action therefore either achieves or fails to achieve its purposes. Merely for theoretic convenience are we assuming that action in everyday life shares definitive endings with dramatic action. Exactly when the curtain drops and the scene ends is itself often an issue in everyday life. People express their awareness of this by employing the following tactics to align discrepant expectations and outcomes: they attempt to suspend judgment and continue. They argue that the evidence is incomplete or that all the bugs in a plan are being worked out or, most boldly, that success has already occurred but is not yet visible. A good examination of this delaying tactic is found in Halberstam (1972). Surgery, however, does not afford the same opportunities as the Vietnam War for using this technique. The time horizon for determining outcomes is restricted in surgery. This is one of the features of the task-structure that makes surgeons so accountable. So, aware of the conceptual shortcomings involved, we can, nevertheless, combine these two dimensions of action to form a fourfold table that captures the possible relations among expectations and actions.

Action occurs in all cells, and groups evolve shared and patterned ways for treating such events. The more strained the fit of expectations and outcomes, the more shared and patterned the ways of treating them. The confusion and anxiety that occur when things turn out other than the way we have planned need resolution. In such cases more elaborate structures evolve for explaining the failure of our calculations than is the case when events
emerge as planned. In this table, cells 1 (expected success) and 4 (expected failure) represent no-confusion events. Expectations and outcomes are congruent. No elaborated ground rules are needed for actors to explain events. Relations are relaxed and there is great variation in interpersonal styles.

### Varieties of Normal Action

<table>
<thead>
<tr>
<th>Expectations</th>
<th>Outcomes</th>
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<tbody>
<tr>
<td>1: Expected Success</td>
<td>+</td>
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<tr>
<td>2: Unexpected Success</td>
<td>-</td>
</tr>
<tr>
<td>3: Unexpected Failure</td>
<td>-</td>
</tr>
<tr>
<td>4: Expected Failure</td>
<td>+</td>
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</tbody>
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Cells 2 and 3 are those in which more elaborate social accounting is necessary. These are confusing events. When an action turns out other than as planned it dams nothing so much as the power to diagnose a situation. Not surprisingly, the ability to diagnose a situation is something about which a physician cannot afford confusion. In the accounts offered to end this confusion, relations are formal and there is little variation in interpersonal styles. Cell 2 is unexpected success; accounting for it occurs in Grand Rounds. Cell 3 is unexpected failure; accounting for it occurs in the Mortality and Morbidity Conference, as well as at the everyday level that we described in chapters 2 and 3. As we shall see, the accounts offered in these two conferences differ substantially from those offered in the everyday face-to-face interaction among subordinate and superordinate.

In cell 1, where both expectations and outcomes are positive, we have routine, unquestioned successful action. In surgery as in everyday life, people do not ordinarily stop to question this action or challenge those persons who achieve results. Given the didactic component of clinical training, it is not entirely accurate to state that attendings do not ask questions about routine and ordinary successes. They do. However, they need not ask these questions of their housestaff or of themselves. Routine success, the happily removed appendix or the artfully repaired hernia, threatens neither a houseofficer's nor an attending's credibility. On the contrary, such success anchors their claims of expertise in the empirical world and makes them substantial. However, such success may create problems for the medical student. Since routine success does not compel the attending to exert time and energy either keeping his subordinates in line or reexamining his own decisions, he has more time for testing his student's knowledge. Where the intern or resident is asked: “What went wrong?” “How did this happen?”, the student is asked: “Why did this work?” “Why did we choose this course of action rather than some other?” Routinely such questioning is not very intense. The student serves as a convenient foil for the attending. Since this rotation is the student's first exposure to surgery, attendings do not always expect correct answers to such questions. Attendings use such questioning to expose and to impress on students their ignorance, to demonstrate the intellectual rigor needed for the surgical management of disease, and to illustrate some general principles of surgery. Thus, even though routine and expected success may make an occasional student uncomfortable, it does not create confusion about what is going on. Colleagues do not take excessive notice when one simply meets the expectations of others. Only the most professionally infantile, the students, are invited to speculate about why success occurred. There is a parallel here to parents who ask children how simple objects work in order...
to demonstrate some simple causal relationships. Those initiated into a social world no longer wonder how such things work. They take them for granted. Action that falls in cell 1 ratifies the tacit assumptions on which surgery rests. It is not a topic for social accounting; rather, it is the background from which accountable events emerge.

**Cell 4: Expected Failure**

Cell 4, in which expectations and outcomes are negative, contains cases for which no elaborate social accounting is necessary. Patients who are hopelessly ill with terminal diseases fall into this category. What happens to these patients, although tragic, could not have been otherwise. According to Fox (1974), attitudes toward the discussion of the practical, existential, and ethical issues surrounding the care of the dying patient have changed considerably in medical schools over the last twenty years. What was formerly dismissed as merely philosophical is now openly discussed. In surgery, as in other areas of medicine, there is a concern for the humane treatment of dying patients. This enlarged discussion indicates a greater sensitivity on the part of medical educators to the fact that expected failure can be a trial on the personal and individual level at the same time that it is a normal event in a professional life. With the increased healing power of modern medicine there has arisen the need to make more explicit the individual strategies for handling the question, How do I recognize when a situation is hopeless and then what do I do? Confusion exists in this situation, to be sure, but this confusion is of a different order than that of cells 2 and 3, where expectations and outcomes are discrepant. The confusion that surrounds the hopeless cases of cell 4 is existential and individual. In cells 2 and 3, confusion is social and scientific. The difference is this: in cell 4, the physician must account for why an individual patient developed an untreatable cancer that both he and the patient would have preferred not to occur. In cell 2, he must account for how he salvaged an incurable. In cell 3 he must account for how he lost a curable. There is here a question of responsibility. Cells 2 and 3 clearly raise questions of professional responsibility. Cell 4 is at the boundary between individual and human responsibility and professional responsibility. To help their subordinates deal with the problems raised by the hopeless cases of cell 4, attendings pass on to housestaff and students their beliefs about when and how a patient should be allowed to die:

**We reached Mr. Starvos’s room on rounds.** We paused a long time before his door. Nothing was said. Everyone looked at the ceiling or down at the floor. Eye contact among people was not established. Finally Arthur said: “Goddammit.” It was the group’s signal to enter the room. Mr. Starvos complained of pain. He was alert and lucid. We left quickly. Arthur spoke: “He’s too damned alert—that’s all there is to it. Look, I’m not one to give up on patients but we have to realize that there comes a time when we can do nothing more for a patient and we should no longer support life but the let the patient die comfortably with as much dignity as possible. In all honesty I think we have to admit we’ve reached that point with Mr. Starvos. He’s too alert for that much pain. He shouldn’t be that awake. Let’s begin to give him Librium and morphine. Yeah—Librium and MS [morphine]—that should make him more comfortable. Mark, first talk to his wife. Make sure that his will is in order, all his bank accounts are square, and the property straight away. Then begin the Librium and MS. He’s too alert. He needs sedation. Also, are they Catholic or Greek Orthodox? His wife was asking about a priest—I think it’s time to tell her to bring him in. We can’t do any more for him.” The group saw one more patient on rounds and then Arthur mentioned Starvos again: “Look, there comes a time when you have to acknowledge your limits and make the patient as comfortable as possible. I think we can discontinue monitoring his vital signs at night. There’s no reason to wake him up in the middle of the night to take his temperature, pulse, blood pressure, and all that other bullshit. Let’s close the door, leave him with his family, and let him die with some dignity, as a man instead of a patient with a glass tube up his ass. We’ve done what we can. Let him die, poor man” (Baker Service).
On rounds, Arthur was discussing proper care of the dying patient. "You can't offer these patients shit but you have to go in there and perform a laying-on of hands, so to speak. You can't abandon them." The service had just visited a consult on the medical service and Arthur had decided that the patient's cancer was too advanced to warrant an operation.

He continued: "That patient is terminal. Let's send her home with morphine and Librium and let her be with her family. If it was your mother, would you want her in the hospital? Remember that Chinaman they wanted us to operate on last week? He died forty-eight hours later. Christ, you could look at him and see that he was half dead—the medicine people said, 'No, it's because he's Chinese and they all look like that.' They'd be hanging IV's into their patients all the way to the morgue if we'd let them" (Baker Service).

There are, of course, grave differences of opinion on when it is the "proper time" to allow a patient to die with dignity. Surgeons are not known for throwing in the towel quickly. Nurses and physicians in other specialities are often critical of what they consider needless surgery, claiming that it extends suffering rather than life. Moreover, as a rule, subordinates are quicker than superordinates to decide that a patient is beyond help, a fact which is possibly more a comment on their control of treatment and their investment in its correctness than in their personal philosophies. But this is all quite beside the point: when it is expected, death threatens neither the professional self of the subordinate nor of his superior. One of the hard lessons that one must learn in surgery, as in all branches of medicine, is that there are times when nothing more remains to be done. Again, colleagues do not need to account when the unsalvageable are not salvaged. Action that falls into cell 4, like that which falls into cell 1, ratifies the tacit assumptions that make action in a scene possible, although these assumptions are of a different order. Action in cell 1 underscores how much suffering surgery is able to alleviate. Action in cell 4 points to the limits of surgery. It indicates how much is beyond the surgeon's skill and knowledge. Routine success and routine failure both have an air of inevitability which renders accounting unnecessary and which makes the extraordinary success or failure all the more conspicuous.

Confusing Situations

In terms of the sheer volume of cases, most action falls in cells 1 and 4. Cases in cells 2 and 3, unexpected success or failure, is much more rare. Because of their scarcity, these are professional events of some importance and at Pacific—as at most teaching hospitals—special ceremonies for the entire congregation of surgeons have evolved for witnessing them, resolving the confusion they create, and incorporating them into the group's history and the individual's biography. The fact that the marking of unexpected success or failure is a group ceremony of special importance is indexed by two facts. First, the two conferences in which they are discussed—Grand Rounds and the Mortality and Morbidity Conference—are the only occasions when all ranks and subgroupings of the Department of Surgery gather. And, second, they are the only occasions when work groups will put off tasks at hand—save operating, drop whatever they are doing, and attend a conference. As others have noted (Miller 1970), the house officer is faced with the dilemma of having to attend numerous conferences and provide patient care. The demands of both on his time cannot be satisfied and the individual adopts a short-run perspective which allows him to get by: he provides patient care and skips conferences. I also found this pattern—except for Grand Rounds and the Mortality and Morbidity Conference where the individual's normal accommodation is reversed. In surgery, all conferences wait until work is done, save these two. This is true for all ranks of the hierarchy. Attendings, as well as their underlings, feel compelled to attend and be on time. This punctual assembly of those accustomed to letting others cool their heels is quite remarkable. Schwartz (1974) has discussed waiting as an index of power of persons. Here punctuality testifies to the power of events.

What interests us about these meetings is the role attendings play in them. Attendings use these meetings to demonstrate their
clinical wisdom which, as we noted, underlies their authority. The arbitrary elements of quick decisions justified only by rank and contradicted at times by scientific evidence are mitigated. By reserving for himself the right to resolve confusion, the attending legitimates his authority in these forums. The fact that unexpected success allows this is hardly surprising. However, that they are able to transform the negative experience of an unexpected failure into a positive one that serves as evidence of their wisdom is surprising and in need of some explanation. For the moment, suffice it to say that this satisfies the demands of the "heroic" element of the surgical role. The hero takes credit for his success but he is also able to accept the responsibility for his failures, to admit them openly, and to seek to remedy them. Through his trials, the hero learns the value of humility. As we have seen at the subordinate level, those who cannot behave with proper humility are seen as normatively wanting. This is also true at the attending level. In the following discussion of Grand Rounds and the Morbidity and Mortality Conference, we shall see how attending performance legitimates the application of everyday controls and how attendings use both meetings to demonstrate that they are worthy of the mantle of leadership since they accept its burdens along with its rights and privileges.

**Cell 2: Unexpected Success—Grand Rounds**

Grand Rounds celebrate the extraordinary successes of surgeons in cases where expectations are negative and outcomes are positive. In cell 2 of our chart we have ground-breaking success, such stuff as medical journal articles are made of. As we stated earlier, surgeons do not ordinarily operate with negative expectations. However, there are certain circumstances in which the presumption of success is suspended. Most commonly, two conditions make waiving the presumption of success warrantable. First, it is acceptable to waive the presumption of success when surgery is the only alternative left for a patient and it offers some hope, however slim, of salvaging the patient. Such situations inform the notion of the surgeon as hero. Less glorious are cases where the patient's condition intersects with the surgeon's research interests. At such times the surgeon rules out alternatives quicker than usual and operates. Colleagues appreciate the courage, judgment, and skill necessary to succeed in these situations. Grand Rounds allow them to express this appreciation. Grand Rounds also allow each attending the chance to demonstrate that good reasons exist for the tyranny of his clinical judgment.

At a group level, Grand Rounds allow the entire collegium to review the most recent successes of their colleagues and beyond that the generalizable principles that are emerging for the surgical management of disease. As a weekly ritual, Grand Rounds reconfirm for everyone that Pacific deserves its national reputation for excellence. At an individual level, Grand Rounds provide attendings an arena to display their virtuosity. When questioned about why they chose careers in academic medicine, attendings invariably mention the importance of peer recognition:

> When I started medical school, I had the desire to be a surgeon. Surgeons were the most impressive guys, they got a lot of attention, they always seemed to be doing things. And I had a desire for all this; but the decision comes later when you graduate from medical school and you have all the training before you. The training comes in two phases. In England, they are kept quite distinct, but here they are often intermingled. In the first phase, you must simply learn surgery: you have to learn techniques, pick up the basics. In the second phase, you have to learn judgment; you have to learn when to operate, when not to, and what operations to perform. And then when you finish, you have to decide if you’re happy with this status or not. Now the “true” doctors who serve a community and are content to perform the common operations for the common conditions stop here. But there are those of us dissatisfied with this status who go into academic medicine. We want to do things that others can’t. We want all the difficult cases referred to us. We want to train others to be good surgeons. We want to be recognized by our colleagues as an expert on some problem (Attending).

> Well, there are two aspects to that. One is, it’s a real ego trip. You’re surrounded by a small nucleus of people; and you’re always patting each other on the back, telling each other how
great you are. Sometimes it's nothing more than a group of men playing children's games ... the support of the peer group makes up for the financial sacrifices. So it's really a supportive atmosphere. It's gratifying to be at the top of the profession and have people tell you how good you are all the time. Second, although there are a lot of advantages to being in private practice—you can make more money, you can come home earlier, you have more free time—it can be very boring. You don't get the most interesting cases and you're surrounded by a lot of crap. Doctors who let patients die because they think that cancer is always incurable. You can really go out of your mind watching people practice bad medicine because they don't know any better. But here you can practice medicine in the highest quality circumstances. It's an ego trip. You pay heavily for it in terms of salary, administrative nonsense, long hours, family life, and personal life and leisure. A lot of it is really childish stuff but a lot of it feels really good. It's an ego trip to handle the toughest cases, to challenge yourself, and be among the best (Attending).

Grand Rounds provide an itinerary for the attending's ego trip; this conference assures that the peer recognition that attendings desire is provided in a fairly regular fashion. This recognition of skill comes in a much more direct and personal way than research publications provide. Of course, there are many other ways that colleagues pay homage to each other's skill. Informal consultation is one. More dramatic is when an attending acts as his colleague's first assistant. Here, he willingly subordinates himself to his equal, merely for the opportunity to watch the other work. Given the crowded nature of the attending's weekday, such tributes are rare. When they occur, they highlight an aesthetic appreciation of flawless technique. Regularly scheduled, Grand Rounds are a device to distribute the amount of formal colleague support, approval, and recognition equitably. The rotation of the one to three cases presented weekly at Grand Rounds among services helps guarantee that the distribution of peer support is at least formally equal, despite whatever inequities evolve in the methods that colleagues informally grant approval. Grand Rounds then serve to legitimate attending authority by demonstrating the high regard that attendings have for one another. For attendings, this regard is one of the primary rewards of the work environment.

More important, Grand Rounds allow attendings to model for their subordinates the proper way to accept their place in the medical elite. At the same time, this modeling is done in such a fashion to dramatize for subordinates the distance they must travel during training before they can claim to be equals. The standards of decorum that govern case presentation, the complete presentation of the clinical history, the review of the relevant literature, the elegant technique amply illustrated by slides of the operation, and their own restricted roles in the proceedings—all impress on subordinates the seriousness of the tasks before them, the accomplishments of their superordinates, and their own insignificance in bringing about these miraculous results. Grand Rounds model the virtuous performance of virtuous performance. The recurrent, almost invariant, mode of case presentation makes this modeling specific. First, subordinates present the clinical history of the patient. A good performance by a subordinate is one that as clearly and concisely as possible recounts an involved, complex clinical history. The subordinate gives a simple report, something which is not always a simple task. The subordinate is then for all practical purposes finished. He sits down and the superordinate takes over. First, the superordinate clarifies any ambiguity that arose during the subordinate's account. He then interprets the case history just presented. This interpretation routinely comprises a review of the clinical literature, a review which indicates that the attending's method for handling the case can improve the current mortality and morbidity rates. He adumbrates general principles which indicate that his results are replicable for all who would correctly apply his techniques.

But for one digression from professional and technical demeanor such an order of events would be entirely unremarkable. During the change of actors from subordinate to superordinate and the change of action from narration to interpretation the patient is often brought in and displayed for the group. Now, in some cases such as orthopedic ones, where the lame are literally
made to walk, such presentations make sense; in most instances, however, the purpose is less clear as the group witnesses nothing more than a closed scar. The patient is asked a few questions about how he used to feel and how he feels now. Then he is led out. Once the patient is removed to the wings, the attending begins his exposition of the case. He renders a technical and learned account of the success. Case presentation lasts from thirty to forty-five minutes. The patient is present for generally less than three minutes.

These interruptions in what is for the most part very highly technical talk are striking for their brevity and their superficiality. Housestaff and attendings make jokes about the practice and complain that it serves no discernible purpose and that they learn nothing from it. Yet, if this is the case, why is this practice so regularly adhered to and why in those cases in which it is forgone is the attending presenting the case likely to include in his slide presentation a smiling snapshot or two of his cured patient? First and most concretely, the patient is a living testimonial to the validity of the claims being made. Second, the interview with the patient shows the attending surgeon at his humanistic best. It allows him to demonstrate that alongside the technical expert about to teach a lesson, there is a humane healer who deals with the patient as a person. Third, the presence of the patient is gratifying for the attending. He is displaying one of the achievements he is most proud of, and he is in turn praised by his colleagues for this. Fourth, the introduction of the patient in the middle of the discussion reinforces group commitments by showing a case when the limits of the possible were extended. The whole group can share the sense of worthiness such patients inspire. The proud display of patients is a striking feature of Grand Rounds; however, display is limited to this conference. When patients who fall into cell 2 return to the clinic for follow-up visits, attendings round up as many subordinates and colleagues as possible for “ad hoc” displays:

I was in the clinic with Josh and Brian. They were writing charts in the work area when Arthur came in and told us all to go to examining room “D.” There, Josh, Brian, and I were introduced to a patient. Arthur recited a brief history and invited an examination of his patient. Josh and Brian quickly examined the patient, nodded appreciatively, and then went about their tasks. Arthur thanked the patient and we left the room together. In the work area he turned to me and said: “That’s why we’re so demanding around here. By all rights that man should be dead. But there he is. That’s the edge you get when you really bust your hump.” He whistled to himself as he wrote a progress note in the patient’s chart (Baker Service).

Finally, the last remark of Arthur’s alerts us to what may be the most important feature of patient presentation. The display of past successes is an irrefutable argument to subordinates for the attending’s hegemony. It is as if by this practice the attending tells his subordinate: “We can talk as equals when you have results like this to show off. Until then, respect the experience that achieves such results.” Such displays of patients dramatize the distance between attendings and housestaff who do not have a ready stock of miraculous cures to parade.

Grand Rounds legitimate an attending’s authority by dramatizing his most spectacular successes. Skill at presenting such cases is known as “roundsmanship”; it is a much appreciated skill. Those who have it are able to make the most of their extraordinary successes; and it is such ability that builds surgical reputations. Surgeons demonstrate this ability by elegantly explaining the extraordinary. Such performances dramatize the distance between them and their subordinates who, for whatever private praise they are given, are only allowed a very minor role in the proceedings.

Cell 3: Unexpected Failure—The Mortality and Morbidity Conference

It is not surprising that attendings use their extraordinary successes to legitimate the rigid hierarchical authority system of a surgical service. It is, however, noteworthy that they are able to use unexpected failure to serve the same end. In this section we
explore the transformation of negative evidence into a positive display of an attending's skill. This transformation occurs in the Mortality and Morbidity Conference, in which cases that fall into cell 3—where expectations are positive and outcomes are negative—are discussed. The Mortality and Morbidity Conference is a form of retrospective peer review. The fact that attendings are able to use this forum to further consolidate their claims to authority is all the more remarkable when we consider that in this forum the attending's failures are presented for all to see and that this is the only occasion in surgical training that exists for public and open criticism of attending surgeons.

In the Mortality and Morbidity Conference the private understandings of failure achieved at the everyday level (chapters 2 and 3) are transformed into public knowledge. This transformation consists by and large of purging from the accounts the categories of normative and quasi-normative error and with them the implications of careless, lazy, negligent, or insubordinate performance they carry. At the Mortality and Morbidity Conference failure is accounted for professionally, that is, the reasons presented for it—with one notable exception—are formal and technical. In a sense this fact alone increases the power of the attending and further obligates his housestaff since the attending allows the knowledge of such substandard performance to remain a form of private, albeit guilty, knowledge. Four factors account for the omission of normative and quasi-normative errors from discussion. First, such errors are an implicit indictment of an attending's control of his staff since he would ill serve him to publicize them. Second, attendings believe that if a subordinate makes a normative or quasi-normative breach on one service, he is likely to make them on others. There is no need to publicly humiliate subordinates; events will do so soon enough. Third, these errors are seen as indicative that unfit subordinates have character or personality disorders. There is little profit from exposing them since there is little hope of correcting them. Fourth, one purpose of the Mortality and Morbidity Conference is to illustrate that failure and error are an inevitable part of surgery and the best that one can hope for is to learn from these unfortunate happenings so as not to be condemned to endlessly repeating them.

To introduce the scolding that accompanies normative and quasi-normative errors into the Mortality and Morbidity Conference would only encourage attempts to conceal complications. The metapurpose of the conference would be destroyed if failure were not treated as matter of factly as possible.

Like Grand Rounds, the Mortality and Morbidity Conference has a remarkably consistent structure. However, the proceedings have one more degree of freedom than do Ground Rounds, and it is a very significant one. At the beginning of the meeting an agenda is circulated. The agenda lists the order of case presentation. The agenda provides the following information for each case: the patient's age and sex, the service responsible for him, the preoperative diagnosis, the procedures performed, and the reason for presentation at the conference (either death or a specific complication). Also on the agenda is a record of the number of major and minor operations performed by each service in the preceding week. The agenda is a box score, and case presentation is the play-by-play commentary. Case presentation is similar to the format of Grand Rounds. The subordinate begins and gives a case history. However, his job does not end here. He is on stage to answer questions about the propriety of his behavior until either his superordinate steps forward to give an interpretation of the clinical history and an explanation of nodal choices, or until another superordinate directs a question to his colleague. This option of the attending to step forward or not is the degree of freedom that the Mortality and Morbidity Conference possesses that Grand Rounds do not. It is the exercise and use of this option that allows attendings to transform a conference ostensibly about their failure into a forum to celebrate their authority. We shall now see how this is so.

The cases that are presented at the Mortality and Morbidity Conference can be described in four basic ways. These are the "normal troubles" of surgery. Each of these has its own accounting strategy. Two are relatively straightforward and do not involve the attending playing a role in the proceedings unless forced to. Two are relatively more complex and involve the at-
tending taking an active role in the accounting. In the first two cases it would be beneath the attending's dignity to explain failure where the causes are painfully obvious. In the latter two cases it would be beyond the houseofficer's skill to explain the failure, interpret the attending's strategy, and determine why events took the untoward turn they did.

The first and most simple case is when there is a routine complication easily managed after surgery. The complication is resolved without incident and, aside from the complication, the patient's recovery is uneventful. An example of such a case is a wound infection. For such cases accounting is as a rule solely the subordinate's responsibility. Subordinates in this case align expectation and outcome by the claim that when all factors are taken into account—factors that were by their very nature unknowable before surgery—the outcome is really a success. The case belongs in cell 1 of our fourfold table. The argument that the complication notwithstanding the surgery was in fact a success hinges on the following claims: that although the rate of complication is known for a population at large, any individual occurrence cannot be predicted; that in this case sound prophylactic techniques have been applied but to no avail; and that once the complication presented itself, it was routinely and successfully treated. Such cases do not greatly arrest the attention of the conference's participants. So long as the subordinate clearly presents the case and competently answers a few questions, the case is quickly dispatched. Competently answering questions here means demonstrating that one knows what went wrong and why and that one has learned a lesson from this experience. The superordinate need not step forward since the patient's recovery as well as the thoughtful performance of his subordinate indicates that he is well aware of the situation and has it under control. The complications that are easily and quickly resolved are the ones that concern surgeons least, both in formal peer review and in everyday social control. In either circumstance, they are not seen as threats to competence but rather as routine and calculable parts of the environment.

The second straightforward case is the terminally ill patient and the questions his treatment provokes. When such patients are operated on, it is usually to palliate the more gruesome aspects of disease or to make a heroic attempt to rescue a trauma victim. The tactic of interpretation here is to have the expectation of success waived. The subordinate claims that the only reason that the service operated was because the situation provided no alternative, save the speedy signing of a death certificate. He claims that had the surgery been successful a miracle of modern medicine would have occurred. The case would have fallen into cell 2 of our table and have been appropriate for discussion at Grand Rounds. But since nothing of the sort happened, the patient was really without hope, and the case belongs to cell 4.

Straightforward as this accounting strategy is, it is not as readily acceptable to superordinates as the first tactic of interpretation outlined above. This is understandable if for no other reason than that death rather than recovery is the outcome in need of explanation. There are certain situations in which this accounting strategy is easily accepted by the audience. For example, there is the case of the trauma victim who receives multiple injuries and whose life is mechanically supported until the family decides if they will allow the cadaver to donate organs. Another example is a patient operated on previously for the palliation of cancer's more gruesome sequelae who is successfully discharged and returns to the hospital some months later for terminal care because the family can no longer provide supportive care at home. Now, for such patients, ethical and philosophical questions may be raised: Did intervention add to or subtract from the patient's suffering? What is the relationship between the technical expertise we may demonstrate as surgeons and our humane responsibilities as healers? Though such questions are raised, they routinely serve to end discussion rather than begin it. In fact, those who raise questions about whether an operation was necessary or not often note that these questions are philosophical and inappropriate since the action has already occurred. Surgeons have a studied dislike for discourse on philosophical
questions. They define such questions as endlessly debatable and, with their action ethic, surgeons have an almost trained incapacity to debate questions without answers. This is all the more so in cases where the patient’s death is a certainty. Surgeons view debate here as unprofitable because “we know that exit is assured and all we would really be talking about is the mode” (Mortality and Morbidity Conference). Philosophic and ethical questions in this context signal members of the conference that, from the viewpoint of surgery as a scientific and value-free activity, they have nothing more to discuss. Moreover, attendings resist public discussions about the necessity of surgery and for good reasons. They fear publicly accepting any general principles for the limitation of effort. The internalization of such principles by the lazy, the unprincipled, or the inexperienced would, they feel, dilute the quality of care and provide an overly broad rationale for less than committed care. Noteworthy here is the contrast between the public silence of attendings at the conference and their private speech backstage on rounds about the limits of care and the treatment of the dying.

There are two situations in which the questions usually raised to end discussion begin it. The first of these is very rare. Attendings explain those cases which by all rights should have been the miraculous cures of cell 2, but which they chose instead to treat as the hopeless cases of cell 4. So extraordinary is such an event that it is set off from normal proceedings by the fact that the superordinate handles the presentation himself. He gives both the narration and exposition. He takes total responsibility. The subordinate plays no role in the proceedings at all.

Dr. Porter, a pediatric surgeon, stepped forward to present the third case himself, mumbling as he walked to the front of the room, “I think I’d better take care of this myself.” He began: “This third case is very different from the first two presented. Where the first two cases involve questions of patient selection and the taking of risk to prolong life, cases where everything must go right if the surgical intervention is to succeed, this third case involves the taking of risk not to prolong life. This is a decision that only an attending physician can make and for which he alone is responsible. This infant was born with ‘prune belly’ [wrinkling of skin on the belly from absence of abdominal muscles], complete atresia of the urethra [closing of outflow from urinary bladder], various deformities of the legs and feet which may have been the result of the fetus’s position and may have been corrected with time, an omphalocele [a large hernia at the umbilicus], and a heart murmur. The obstetrician and the pediatrician at the hospital where the infant was born put the baby aside to die; but, as luck would have it, it did not. They then called me up to arrange a transfer. They both expressed the hope that the baby would die, but in my hands. Here is where the situation gets complicated. The mother is a thirty-year-old woman. She married at twenty-six and put off conception a number of years while she was under psychiatric care. Then she had some trouble conceiving and finally she had this baby. She had never seen the child. The father, acting with the obstetrician and the pediatrician, had arranged the transfer and supported the decision not to make heroic efforts to save the child’s life. I thought we had to be straightforward enough in this case to inform the mother of the baby’s problems and its chances because of the psychological aspects of the mother-child, mother-father, doctor-patient relationship, as well as our various legal responsibilities. So I did the minimum necessary to give the baby a chance until the mother could see it. I repaired the omphalocele. The mother did come up and see the baby. She was obviously under heavy sedation and quite difficult to deal with. She waxed and waned in her support of the child. She couldn’t decide if the baby should survive. It was then that I decided that the baby should not be considered for cardiac arrest treatment, and that no urgent or emergency measures should be taken to save the baby’s life. These children need total support if they are to have any chance at all. This baby would never be normal and without the total support of both parents there was no hope for a satisfactory adjustment. I have seen many marriages totally disrupted by the extensive hospitalization that such cases require after a number of years. This is why I decided to let the infant die. This is, as I said before, a decision that only an attending can make. It
is needless to say a very difficult decision. Yet in this case it is one that I'm totally comfortable with." (Mortality and Morbidity Conference).

After this presentation, no questions were asked. The attending's right to make this decision and his grounds for doing so remained unexplored. Rare as these cases are, they do establish what considerations are used to establish the boundaries of effort. Interesting here is the surgeon's definition of his client as the entire family network; his interpretation of the Hippocratic injunction, "First, do no harm"; and his weighing the quality of life against the mere fact of life itself. The very extraordinariness of this set of circumstances and the attending's public account of his decision making show how firmly embedded the principle is that the surgeon must do everything possible to prolong life.

This brings us to the second set of circumstances in which the attempt to assign patients to cell 4 as a hopeless case raises rather than ends questions for the audience. Here, the audience questions the subordinate's interpretation that the patient was in fact a hopeless case. They challenge the subordinate's interpretation of the case as inevitable death. Such challenges are likely to bring attendings in conflict with one another since it was the attending in charge who more likely than not made most of the management decisions with regard to the case and who has discussed the cause of death and the case's presentation with the subordinate onstage and on-the-spot at the moment:

Andrew, a resident, had just explained that the death of an elderly lady following a gallbladder removal was caused by her old age and general physical weakness. He was immediately challenged by an attending. "That's not what I would call thinking real hard. I mean, you didn't exactly scratch your head until it bled on this one, did you, Andrew? You can't stand there and tell us this lady died from old age. If she was going to die from old age, why operate on her to begin with?" Dr. White, the attending on the case, rose to his resident's defense: "You're not exactly being fair. You know well enough that things like this can happen any time. It was just one of those unpredictable catastrophes." The other attending answered: "That's bullshit. It doesn't sound like the treatment of this lady was very well thought out." White replied, "C'mon now, you have your share of cases like this. She was a very strange old woman" (Mortality and Morbidity Conference).

The attending's defense of his subordinate is a defense of himself and his control over events. Beyond that, the attending rescues the houseofficer from an uncomfortable situation. In so doing he repays the subordinate for the indignities he subjects him to in everyday situations. Such defenses are evidence of the attending's authority and how it is used to shield as well as attack subordinate performance.

You have to remember when something bad happens it's usually at my instigation. Now, my orders may not have been properly carried out. I may have ripped into the resident before M&M. But I'm the responsible agent and I have to back up my own people. You can't allow yourself to fall into the syndrome of everything-that-goes-wrong-is-the-resident's-fault (Attending).

While disagreements may become as heated as the one above, this rarely happens. The attending's support of his subordinate and his assurance that everything possible was done is usually sufficient to quiet debate. So, despite the perturbations described above, the strategy of having some failures redefined as cases that fall into cell 4 is accomplished easily enough. This may be a self-protective mechanism operating among attendings, an operative norm of reciprocity: if nobody pushes too hard, nobody will be pushed too hard. Further, pushing too hard challenges the deeply ingrained norm of individual responsibility for the patient and is an affront to the decorousness of relationships among colleagues.

The majority of the cases discussed at the Mortality and Morbidity Conference are dispatched by the two tactics of interpretation discussed above. However, accounting for some failure is relatively more complex. In these cases, the attending plays a very important role in the proceedings and this role is an addi-
tional method for legitimating his authority. There are two types of problems that require this more complex method of social accounting.

In the first of these, surgeons must choose from among a number of procedures, none of which particularly recommend themselves. The probability of success for procedure A is the same as for procedure B or C and is in any case uniformly low. The surgeon must account for the procedure chosen when there are no clinically established protocols for it or any other procedure. These are the procedures that attendings at Pacific perform in order to maintain their standings as members of the national elite. Such cases are very important to attendings, they are evidence of their special place in medicine. Failure here disturbs the assumption that the attending's pride of place is deserved. This pride of place is, by the way, not a tacit background assumption but is right at the foreground of social consciousness, a constantly reiterated and well-articulated part of the work environment:

The nurses on Baker Service were having problems with a patient. He was, in their opinion, irascible and they said they were tired of his addressing them in abusive tones. They complained to Dr. Grant, claiming it was not so much the patient’s requests as the way he made them that bothered them. Dr. Grant answered: “Look—we will not put with this. We have all been under a lot of strain lately. You girls have been working particularly hard and we do not have to put up with an abusive patient. The way I look at it, we are doing Mr. Jameson a favor by operating on him—no other hospital around here would. He is an extremely poor operative risk. We do not promise our patients first-class hotel accommodations when they come here, nor do we promise them excellent cuisine. We only promise to get them better when no one else will treat them. It is we who are doing them a favor and not they us. This is really the same thing we went through with Michael Chometz. I’ll talk with Mr. Jameson. And if he doesn’t like what I say, then—fine! That is one less headache for us all!” (Baker Service).

Arthur had just operated on the wife of a close friend—her prognosis was poor, and he was complaining to me (he had

steered me to a corner where we were alone). “In academic medicine you’re motivated by the desire to be the best. That means that you do a lot of cases that no one else would touch, and that a lot of friends send their families to you. And while I really hate the work, I’d hate it more if they thought someone else was better and they went to him. It’s tough treating these problems. Son of a bitch, it’s the toughest part of practice” (Baker Service).

Earlier, we noted that in such cases attendings need not prospectively justify their course of action to subordinates or colleagues. We noted that when their plans go awry there is no everyday questioning such as they subject their housestaff to. Such failures we coded as judgmental errors which we saw as a privilege of rank. In the Mortality and Morbidity Conference attendings pay for this privilege. They are obliged to explain how eminences such as they made errors in judgment. After the subordinate’s narration of the clinical history the attending steps forward to field questions about the case. His taking over for the subordinate indicates to his colleagues that the decisions in the case were made by him and him alone, and that he alone will answer for them. Difficult cases usually provoke a number of questions from the audience, questions that are highly technical in nature. For these cases, where a high degree of clinical uncertainty exists, the discussion reflects the academic and scientific component of surgery. The conference becomes a seminar in abstract problem solving. The longer the discussion continues, the more complex it grows, the less subordinates participate, the more discussion takes place among professional equals alone—the attending surgeons. I shall hold off analyzing the attending’s account of the judgmental error until I have described the second type of complex accounting situation since attending behavior is similar in both of these situations.

The other complex failure an attending must explain is the failure of a statistically preferred treatment, especially when the consequences of that failure are grave. Here the surgeon must face the personal consequences of the statistical concept of variance. In the first complex accounting situation, the working consensus of the group momentarily disintegrates. Individual opinions
predominate. There is no consensus as to what proper treatment is. In the second situation—the failure of a preferred treatment—the working consensus of the group is highlighted. Instead of procedure-oriented concerns and scientific detachment, we find patient-centered and emotionally colored statements. The patient’s age and social status are often invoked. Attributions about the patient often reflect the surgeon’s feelings. They speak of “this poor, unfortunate teenage boy,” or “this courageous mother of five,” or “this unpleasant, unattractive alcoholic.” During these accounts there is often a macabre and irreverent humor in which the whole group shares compared to the sombre discussion when treatment alternatives are unclear:

Roger, a chief resident, was accounting for his decision to remove the hemorrhoids of a patient in the end stages of cancer. The patient had not been able to withstand this normally routine procedure and had bled to death. The wisdom of operating on a patient in such a compromised position was questioned. Roger replied: “He was in great pain from the hemorrhoids—he really was. Everyday on rounds he would beg us to do something for it. We agreed, but only reluctantly. But I can tell you one thing: when he died, he sure as hell died without pain from hemorrhoids.” It was some time before order was restored (Mortality and Morbidity Conference).

Finally, when preferred treatments fail, the audience often offers supportive remarks to the surgeon involved, such as “We all have a few cases like this,” or “It’s a mystery to me.” In extreme cases the moderator of the conference will place an arm on the shoulder of the speaker before he returns to his seat. In these cases, attendings also accept and publicly acknowledge their responsibility by taking control of the proceedings from their subordinates. How they use this control to dramatize the distance between themselves and their subordinates and to legitimize their authority is the topic we now turn to.

In both complex accounting situations, the major ritual that substitutes for the public sanctioning of attendings occurs. Attending surgeons publicly abase themselves before an audience of their colleagues and subordinates. They publicly claim that they made mistakes in the handling of the case. They put on the hair shirt, as the argot of surgery has it. When an attending puts on the hair shirt, he points out to the group what lessons he learned from treating the patient; he explains why he might better have followed some other course of action; and he urges all to consider the case before acting on similar cases in the future. The hair shirts the attending dons in each of these two complex accounting situations are slightly different from one another. In the first type of case, the attending points out what clinical evidence he in retrospect seems to have valued too little, that is, why he made his miscalculation and how he will correct it in the future.

In the discussion of the death of a sixty-eight-year-old woman on the cardiac service, the attending in charge of the case said the patient’s death presented two questions to him: (1) should the woman have been operated on in the first place, and (2) should she have been taken off antibiotics. He then claimed that the patient’s death indicated that he was wrong for deciding to operate in the first place. He then lectured the group on the parameters one must evaluate in choosing to operate or not (emphasizing as he did the parameter whose importance he paid too little attention to). This finished, he gave a similar lecture on the use of antibiotics (Mortality and Morbidity Conference).

Two infant deaths were presented by the pediatric surgery service. Both cardiac patients with similar problems were presented at the same time. After the recital of the two clinical histories, the attending in charge took over. He discussed the technical problems involved in handling the case and what research needed to be done before one could hope to successfully treat these patients. Then he claimed that “as it stands now anybody that comes to me with this problem already has their ticket punched”—a reference to the inevitability of death. He then gave a very short speech about how both patients were very young infants and how these young infants accounted for almost all the mortality among pediatric cardiac patients. He claimed that such patients represented the greatest challenge in the field and that he hoped the next
generation of surgeons would be able to solve these problems and wonder how come his generation lost all these cases. His presentation lasted six minutes and no questions were asked (Mortality and Morbidity Conference).

With this hair shirt, the attending demonstrates for his subordinates the behavior that he expects when they make lesser technical and judgmental errors. He shows how he has reconsidered his behavior as the emerging events brought them into question and he shows what lessons such reconsiderations have brought home to him.

The second type of hair shirt demonstrates a different type of expected behavior from subordinates, that is, total integrity and complete disclosure of shortcomings rather than any attempt at cover-up. In the second type of case, when an attending puts on the hair shirt he grounds the failure in his improper supervision of his subordinates. Attendings believe that these are deaths and complications that should just not occur and when such misadventures do occur, they blame themselves for their own lack of foresight. While privately they damn their subordinates for what they see as treacherous behavior for a physician, attendings publicly state that it was their negligence and not that of their housestaff that accounts for the failure:

After the case of Mr. Will was presented, Arthur sprang from his chair and said that he had a few words to say in the matter. He said: "I think that this case represents all the things that are wrong with the hierarchy of a teaching hospital. Here we have one of society's unfortunates. Mr. Will came to us with no kith or kin. He was comatose when he arrived and we still really don't know who Mr. Will is or why he came to us. The first in the comedy of errors made on this man was made by the medical service. The decision by them not to dilate his abdomen was tantamount to gross neglect. I only mention the medical service because they are here and because I'm now going to turn to the errors we made in treating this man. First, I made a fundamental error this early in the training year in allowing the chief resident to operate solo in this emergency. We should have learned from experience never to do this. In our defense we discussed this case with the resident involved over the phone. The third guilty party is the chief resident involved. By not calling for help when he ran into trouble, the resident took undue risk with the patient's life. Fortunately, the case looks like it will have a happy ending because of some heroic efforts made to undo the damage. Now, Mr. Will is an old, unattractive, abandoned, cirrhotic black man whom we almost abandoned to surgical pathology. Our surgical responsibility rests evenly with our unattractive as well as our more attractive patients. In this case, we have clearly committed surgical immorality." When he finished, no one spoke (Mortality and Morbidity Conference).

After the presentation of a case in which there had been a complication from the insertion of a subclavian catheter, Dr. Stone rose to speak: "This case is unfortunate and represents a want of supervision on my part. Clearly, this is a simple error in technique that could have been avoided if the resident had had proper instruction. The insertion of a subclavian catheter can be a very tricky business. It requires poise and confidence. It should be carefully supervised. Unfortunately, it is one of those procedures that we are least likely to monitor. All too often, we instruct our residents to insert subclavian catheters as we walk off the floor on our way home for the night. We should not—as I did in this case—do this. We should make sure our subordinates are properly equipped to do this and we should be there to provide help until we are confident our housestaff can do these things on their own. It is our responsibility to be available and provide instruction. We cannot always count on our housestaff to properly assess the trickiness of techniques" (Mortality and Morbidity Conference).

In the first type of account, the attending takes total responsibility for all decisions and for the way that they were carried out. He indicted his judgment in handling the case. In the second case, he takes responsibility for decisions, even maintains they were correct, but tries to separate himself from the way the decisions were carried out. He does not totally excuse his sub-
ordinates but blames himself for allowing their performance to proceed unchecked. If the subordinate makes a mistake it is only because his superordinate allowed him to do so. On the face of it, this is quite an admission for an attending to make; it is tantamount to the confession of a normative error. The attending tells all assembled that his commitment to patient care was wanting and some patient was caused unnecessary suffering. The only redeeming feature of this confession is that it sets a standard for full and open disclosure and complete intellectual integrity that houseofficers are expected to match. In either case, when an attending puts on a hair shirt he admits error, points out the lessons in it, and urges all to consider these before hasty action in the future. Attendings wear a hair shirt because a death or complication, especially when unexpected, is a pretty damning piece of evidence that forces them to consider alternatives. However, that they so willingly admit error and humble themselves before a group of colleagues and subordinates seems strange. How are we to account for this practice which seems to run against the grain of human nature, which usually conceals, minimizes, and denies error?

Two factors seem most noteworthy. First, as attendings often state, one purpose of the Mortality and Morbidity Conference is to instill professional “superegos” in junior staff. When an attending puts on the hair shirt, he makes the working of his own professional superego transparent. He shows what considerations should inhibit a too hasty impulse to act. Second, these public confessions serve to mitigate the rigid hierarchical authority system of a surgical service. When he dons the hair shirt, the superordinate humbles himself before an audience of many subordinates over whom he has complete career control and whom he chews out daily. The conference is the only occasion when an attending is open to criticism. That this is self-criticism rather than the more acrimonious and harder to bear ill judgment of others is important but beside the point. These public ritualized admissions of fallibility contrast sharply with the everyday behavior of attending surgeons and serve to mitigate it somewhat.

This interpretation of the hair-shirt ritual is given greater plausibility when we consider additional aspects of the practice. The humbling effects are ordinarily softened, either by other attendings who indicate that they would have handled the case in the same way or who cite similar examples from their own clinical history or by pathologists who indicate that the patient was ravaged by disease and beyond repair. More interestingly, “wearing the hair shirt” is a prerogative of status. Although junior staff are forced to wear the garment in the informal setting of rounds (in fact, having thought through a death or complication, admitting responsibility, and pointing out the clinical lesson learned is one of the ways they establish that they are competent and trustworthy), they are not allowed to wear the hair shirt in the public conference. In these cases, the breach between expectation and outcome is not satisfied until the attending offers his exposition of events. Even though a subordinate may know the facts of a matter, he cannot authoritatively resolve the confusion these facts create.

The attending’s refusal to let subordinates wear the hair shirt in public is an attempt by senior surgeons to illustrate to junior surgeons what the acceptable limits of a professional superego are. Attendings want subordinates to be mindful of the consequences of their action; however, they do not want them to be overly scrupulous. They do not want excessive thought—an overestimation of risk—to inhibit clinically indicated action. By refusing to allow subordinates to blame themselves for certain failures, attendings show that professional second-guessing properly ends where professional authority ends. In so doing, they once again underscore the status differences among their ranks. There is a very subtle give-and-take going on in the Mortality and Morbidity Conference. On the one hand, attendings encourage subordinates to question the grounds for their action; yet on the other, attendings try to limit that questioning so that it does not impair the quick judgments necessary in surgery.

There is yet another reason why “wearing the hair shirt” is a privilege of rank; it would be unseemly in a junior surgeon. If a junior surgeon claims he is mistaken often enough, we must take him seriously. At this point in his career, when competence is
always an issue, weekly self-incriminations would ill serve the junior surgeon. Also, the hair shirt might prove too attractive for the subordinate. He might wish to wear it too often and therefore not be self-critical enough to see how his performance can be improved, or he may never learn to discriminate between those failures which he can and cannot control. An unrestrained mea culpa, mea culpa ill fits the heroic ideal of grace under pressure into which surgeons are socialized. Now, this is not so for the attending surgeon who stands at the top of his profession. He has a luminous professional biography and history—his credentials are unshakeable. The cases in which he assumes responsibility are marginally worthless in assessing his competence. These pale in comparison to his great achievements. In fact, for the subordinate, putting on the hair shirt only emphasizes the surgeon’s charity, humanity, and the scope of his wisdom. It allows him to round out his professional self by adding to it the secondary qualities associated with the healer in our culture: humility, gentleness, wisdom, and a certain wry acceptance of the universe that allows him to accept the limits of human activity. It allows him to express guilt without being consumed by it. Such expressions of guilt might consume the subordinate who does not yet have the same mastery. It is difficult to adopt a long-run perspective and be philosophical without the stock of experience that encourages such wisdom. By allowing actions that cause guilt to be openly confessed, putting on the hair shirt is a form of institutionalized self-protection for attendings. At the same time, it communicates to subordinates that no one is perfect; it models for them the proper expression of guilt and teaches them to accept that such accidents are an inevitable, unfortunate, and intractable fact of professional life:

The conference is for the housestaff really. First, we go through the dialogue to point out verbally, schematically, and theatrically the issues involved. It is a teaching device first and foremost. Second, it shows by example honesty and lack of immunity from the problems of the profession. It teaches that these problems will be with them their whole professional life. Third it’s good for our own characters to admit mistakes.

Deaths and complications are great levelers in surgery. It teaches that you are not the archangel Gabriel, that you bleed when cut (Attending).

Putting on the hair shirt is the major and most striking activity of formalized retrospective peer review. By this practice surgeons excuse their mistakes by admitting them. The major punishment of the practice is the embarrassment of a public confessional and the pain the outcome itself actually causes the surgeon’s conscience. As a form of social control, this admission of error rests on the self-surveillance and self-reports of the individuals involved. In this sense, it is part of a chivalrous code of behavior. Moreover, when an individual can wear the hair shirt, he has more or less passed beyond the few available social controls surgery has. So this is a hair shirt on the outside only; for the wearer it has the silken lining of unconditional professional support. Nevertheless, it is proper to ask how common it is for attendings to avoid this public embarrassment and to conceal their failure and what the consequences of this behavior are.

The actual extent of concealment is difficult, if not impossible, to measure. On Able and Baker Services we never observed such activity. Yet all subordinates are able to recall cases when services they were absent from the conference at strategic points. Both superordinates and subordinates take a dim view of such behavior; and although all agree it occurs, they also agree its actual extent is rare. When such behavior is even suggested it is met with severe distaste:

Paul asked Mark if Carlos’s wound infection was on this week’s Mortality and Morbidity agenda. Mark replied: “Of course.” A student asked: “Why did you do that? You schedule the cases yourself. You know that there’s no one looking over your shoulder to check out what should be at M&M.” Mark answered sharply: “That would be no good. A physician that doesn’t own up to his own mistakes is no better than the shit that’s draining out of Carlos’s wound. No, this leak in the anastomosis is clearly a technical error. I still don’t know what caused it. It could have been caused by any of a multitude of factors. But it is our error. No doubt about
it, and we're going to have to take our lumps for it" (Able Service).

Sure, a few complications are hidden by senior staff. I know of three right now. It's predictable behavior from the individuals involved. It's a case of insecurity leading to weakness and weakness leading to dishonesty. The individuals involved are destroyed by this. They lose all credibility and professional respect (Attending).

The refusal of superordinates to wear the hair shirt is a serious breach, comparable to the lack of total disclosure attendings demand from housestaff. Those attendings who do not wear the hair shirt often enough or who, worse yet, conceal their complications, undermine their own authority with colleagues and subordinates. Wearing the hair shirt and scrupulously reporting all operative misadventures serves as evidence to subordinates that an attending applies to his own work the same standards he applies to theirs. It serves as evidence to colleagues that he respects the highest professional ideals and is ready to sacrifice face to protect them. An attending that is publicly honest and open about his own shortcomings earns the right to be arbitrary, stubborn, and dogmatic on occasion because his own integrity and motives are beyond question. He has demonstrated that he is dedicated above all to the improvement of patient care.
An Amended Appendix

An Ethnographer's Apology, a Bioethicist's Lament—The Surgeon and the Sociologist Revisited

After rereading his novella, *A River Runs Through It*, Norman MacLean said that he would not change so much as a comma. Having read that work, I agree. Beyond that, I envy MacLean his certainty. After periodically rereading my own work, there is much that I would change. I remember that just before *Forgive and Remember* was published I obsessed about the possibility that I got this or that detail wrong. I then went on to magnify my obsessions: What if none of the interpretation was correct? What if I used my data to construct a plausible delusional system? I knew that I had written a tight, coherent argument. But I also knew that nothing is so coherent as the ranting of a paranoid. I was not particularly reassured by the kind words from my informants who looked at the manuscript and commented on how much I had gotten right. In fact, such appreciative comments merely fueled my panic. I had not created an independent delusion of a specialized social world; I was not that creative. What I had done was more pedestrian; I had simply bought into and crudely represented the surgeons' collectively organized and professionally shared delusional system. Irrational as they were, such were my fears on the eve of publication.

I had always been taught that a good fieldwork account contained insights unpleasant to subjects, the dirty professional secrets that subjects would prefer to keep hidden, the ass end of the sacred. There was, I also had been taught, a similarity in fieldwork and psychoanalysis—both make the latent manifest—the truth of what is brought to light is indexed by the amount of resistance these new insights provoke. The implication of these beliefs for me, as an ethnographer, was
that if my subjects approved of what I had written, if they identified with it, if they liked it, then I must not have penetrated too deeply into their world. And so it went. On the eve of publication, I still went back and forth between two conflicting fears. Either I made it all up or I just stated the obvious. In the end, I comforted myself with the thought that though veracity was a goal, though a commitment to getting the facts right was what separated ethnography from fiction, I still had told a good story, a useful story. I began to think that maybe what was important was not literal or even interpretative truth, which I now saw as an elusive goal. What was important was to create a version of reality that would in Levi-Strauss' memorable formula be “good to think with.”

With this conviction, I suppose I could claim some sort of foresight. I was a post-modernist ahead of the curve. I would gladly claim credit if I could. But the conviction that a good story was the best that I could do felt much more like a face-saving rationalization than an epistemological belief. In any case, as an empirical sociologist, I saw a clear difference between believing that many interpretations of one reality were possible and believing that only multiple interpretations existed, none more authoritative than any other. The fact that in surgery people acted and as a consequence people lived or died, professional actions were judged, residents and nurses were most likely to be found wanting, predisposed me to the “someone here has the power and authority to make decisions that matter” model of social life. The voice of unchallenged organizational authority in Forgive and Remember is, as the epilogue makes clear, the attending surgeon. I never directly challenged the authority of the attending surgeons in everyday decision making—it would have been the end of my study. I gave voice in the text to the residents’ complaints, but constantly reminded the reader how unrewarding frontal assaults on authority are for floor nurses and residents. The grumblings that I give voice to were all expressed in settings and at times when attending surgeons were not present.

Even so, it is more than twenty years later, and I still find myself bothered not by the story I told but by two stories I chose not to tell. At the time, each of the two omissions that I am now about to remedy struck me as not just morally justifiable but as morally necessary. But with all the hindsight that a long stretch of time provides, I see that each omission had theoretical consequences for the story I told. Each blunted the interpretation, analysis, and critique of surgical training and professional socialization, shop-floor ethics, and professional social control embedded in the ethnographic account.

The first omission occurs in chapter five, “Climbing the Pyramid: Professional Control and Moral Identity.” The chapter is an attempt to show how attending surgeons’ everyday judgments of residents’ performance exert a career influence. The chapter is described as a natural experiment testing the book’s major hypothesis: namely that technical and judgmental errors were blameless while normative and quasi-normative errors were blameworthy. The chapter unfolds to show how this is the logic attendings use either to promote residents to the next level of training or to deny such promotion. The chapter “demonstrate[s] that the promotion decision is a presumptive moral licensing that provisionally admits or blackballs a subordinate from the fraternity of academic surgeons” (149).

In the chapter, only the behavior of residents is problematic. I do not stop to question whether the criteria, standards, rationalizations, or processes that attending surgeons employ might themselves be problematic. I also do not display any of the data that I collected that would allow others to raise these questions. The absence of such data is important. Ethnography is less good to think with if it does not provide a rich enough database to allow readers to frame alternatives, to disagree with authorial certainty, to see things differently. Here I am documenting how omissions made Forgive and Remember less good to think with. I edited my data, changed a critical fact (and I recognize that changing the facts contravenes some rather stringent ethical norms of science) and, in so doing, made my own work less rich. I did so in order to obey the canons, as I understood them, of ethnographic ethics.

What is offered here is offered in the spirit of correction and apology.

1. To speak of this under a rubric as ancient and formulaic as canons of ethics is a misrepresentation in the extreme of how I thought about the omissions at the time. I did not think about these omissions in a way as systematic and organized as invoking canons of ethics suggests. At the time, each omission seemed reasonable and necessary—as time has passed, and as we shall read in but a moment, I now think one of the omissions was justifiable and the other not.
This then is an act self-revision; as such, it is not clear how much of this should be done in public. There is a thin line between improvement and indulgence. I tread it in the hope that, on balance, that the discussion presented here falls on the positive side of the ledger.

Changing the Facts

I suppose the time has come to present what was initially misrepresented, to correct what was changed. In order to make the correction I need to present a large section of text. The following material describes the promotion meeting at which surgical faculty meet to decide the fate of second-year surgical residents:

The faculty agreed as quickly as they did in Smith's case that a second candidate, Jones, lacked the technical skills necessary for a surgical career. But in this second case, they had grave doubts about whether Jones had any place in the medical profession at all. Jones combined technical maladroitness with an inability to admit mistakes and difficulties in communicating with patients and staff. This had led on occasion to small correctable errors growing into catastrophes.

Dr. Gray opened discussion of Jones by reporting: "Jones has had a lot of problems over the last fifteen months. This morning I talked with him and told him that an inability to communicate with peers and patients was not a quality we were looking for in our residents. I suggested to him that he meet with Dr. Cantor in psychiatry to discuss whatever personal problems he has before he makes any plans to continue his career in any capacity. He was quite adamant that he needed no help and that he wanted to be a surgeon." Dr. Grant said: "I did not know what to make of Dr. Jones his first few days on our service, but I have reluctantly come to the conclusion that this man is sick. I don't trust him around my patients." An attending asked, "How do you mean sick—physically or mentally?" Dr. Arthur answered, "Mentally. He's off his rocker. Totally out to lunch. He needs help and he needs it quick. The question is not whether we should keep him, but whether he should finish out the year. In my mind, I wonder if he's on drugs." Dr. Gray then said: "As I said before when I gave him the option of seeing Dr. Cantor, he was totally opposed to it." Dr. Grant added: "There is no doubt he needs help. Yesterday in clinic he was really around the bend. He couldn't focus on patients. You could not have a conversation with him. He couldn't deal with anything." Dr. Peters commented that "it doesn't sound like much has changed over the course of a year. Maybe he has a brain tumor." Dr. Ross said: "If he has a problem, I don't think we could in good conscience let him go without offering him help. I think we have a responsibility to see that he gets proper care. But our responsibility to our patients comes first. If there is any doubt about his stability, we cannot continue to let him see patients." Dr. Gray then summarized the comments about Jones by saying: "Then we are all agreed. Not only will Jones not be offered a position, but he will not be allowed to return to duty until he is investigated by someone in neuropsychiatry" ([Surgery Department Faculty] Meeting).

The attendings felt some responsibility for Jones as a person under their care. However, Jones' breaches were so consistent and so consistently denied by Jones that immediate expulsion was necessary. Unlike Smith, Jones was not a tracking problem. He was a total problem that attendings wished to rid themselves of entirely by shifting responsibility to the psychiatry department.

The contrast between the handling of Smith and Jones supports my argument about the differences between technical and normative error and also suggests inherent limits to professional control (156–57).

What the analysis nowhere suggests is that those inherent limits have to do with biases in applying available standards to mete out appropriate sanctions. In the above, I refer to Jones as a gendered person ("him, he, his, this man") a total of thirty-four times in the space of one manuscript page. All of these references are deliberately misleading; Jones was the sole female in the cohort of surgical residents I observed.

When drafting the manuscript, I did not think twice about changing
Jones' gender. I had promised my subjects confidentiality and anonymity. There was no way that I could think of to keep Jones a woman and honor that pledge. So “she” became “he,” and the analysis proceeded without missing a beat—a study of standards and their use. I raised no questions about whether those standards that reinforce group norms and that are so transparently fair on their face are ever used in ways that reinforce existing prejudices and inequities. The fact that I shared the attendings' discomfort with Jones, as did virtually all of her peers, helped blind me to the impact of gender. Jones was difficult to talk to; among the residents she was the one who avoided me the most and who volunteered the least. And what she did volunteer, I often had difficulty understanding. Beyond that, if Jones did distrust me—and I always sensed that she did—for me that was further proof of her limitations. After all, I was different than the male attendings and residents. I knew that, and I was not yet wise enough to see why Jones might quite reasonably not know it as well. I never gathered data that dealt squarely with how Jones understood the effect of her gender on her career as a surgical resident. Jones was silent with me and I did not know how to break through that silence. As a result, I never gave voice to her complaints, never allowed her voice to challenge directly the authoritative voice of attending authority.

I'd like to be able to say that today, anonymity and confidentiality be damned, I'd never change gender again. I recognize now that it is too important a determinant of behavior to ignore. Unfortunately, this is a goal that is hard to uphold. Before the publication of All God's Mistakes, one of the genetic counselors complained that her identity was too thinly veiled (I had kept gender and ethnicity correct when assigning a pseudonym). She wanted her name changed to “Bill Smith.” I fussed and fumed but I did what she asked. I did not think I had any choice. I had promised her confidentiality and anonymity and I felt I had to do anything she felt necessary to assure them, even if I thought the request unreasonable. But the two instances differ—in one case, a subject asked for protection; in the other, I provided it without being asked. In a peculiar way, the change involving Jones offered more protection to the surgeons of Pacific Hospital than it did to Jones. I don't know if Jones felt protected or if she desired anonymity. In fact, for the longest time, I didn't know what became of Jones. After the faculty meeting at which it was decided that she have coercive psychotherapy before resuming her duties, I never saw her again. Neither did anyone else. Faculty and residents alike knew only that she had moved out of her apartment. No one knew where she was. She had disappeared without a trace, as powerful an indicator of her social isolation within the group as one could imagine. When I first had the idea for this second edition, I decided to interview Jones and Carter to see how they viewed the events that Forgive and Remember chronicles. I knew where to find Carter and I set about to track down Jones. What I found on the Internet was a recent obituary that indicated that Jones had risen to great prominence in the world of emergency medicine. This confirmed that there was something amiss both in the original assessment of her performance and my unquestioning acceptance of it.

So now, over twenty years later, I look at the text and wonder how I could have left gender out. A good many of the points feminists make about male domination are present in the brief vignette: Dr. Jones is placed in the sick role and seen as a candidate for psychiatric care (She's “totally out to lunch,” “around the bend”). One physician even suggests, somewhat illogically since there had been no progression of symptoms, that “maybe she has a tumor.” Another suggests that Dr. Jones is “on drugs.” At this point in the 1970s, she would not have been alone among the surgical residents at Pacific if she engaged in sporadic, episodic recreational drug use. Who knows—perhaps that activity would have had the beneficial effect of connecting her with her peers in a mutually shared activity.

I have no doubt that changing genders theoretically impoverished my discussion of the moral order of surgical training. I also have no doubt that under the circumstances I had little choice but to switch Jones' gender. As a result, no matter how alive to the nuances of gender
I might have been, no matter how alive I was to why Jones had so much trouble communicating (and I was not as aware as I think I should have been), I was not free to share this knowledge with readers. In the text of *Forgive and Remember*, I go on at great length describing how much informal communication and bonding goes on in the surgeons’ locker room and the attached lounge. I detail in the text how the atmosphere of the locker room assuages and blurs for a time the hierarchy of an academic surgical service. In the locker room, surgeons relax, war stories are shared, and group solidarity is reinforced. Such moments were not planned; they did not happen according to a schedule or every time surgeons changed from street clothes into surgical greens. In fact, what is magical and wondrous about such moments, what intensifies the shared intimacy, is their randomness. They are not in any ordinary way planned for or predicted but they do happen. Predictable or not, such moments were not shared by Jones. She dressed with the nurses. She never hung around in the male lounge. Jones may have been unable to communicate because she did not get many opportunities. Beyond that, I realize now that without doubt Jones worked in a “hostile environment” and that she was a victim of sexual harassment. (I will explain my reasons for this below when I deal with the second omission in *Forgive and Remember*.)

In multiple ways, I was more a member of the team than Jones: I shared a locker room with the guys, played squash with them, slept in the same on-call room (Jones had a separate room), drank beer with them, shared lewd comments about the nurses, and swapped smutty stories. I was one of the boys and Jones was not. Here it is perhaps important to note that Jones and I were often misidentified by those who did not know our actual social identities. A sociologist in white lab coat and surgical greens, I was often thought to be a surgical resident. A surgical resident in lab coat and scrubs, Jones was often thought to be a nurse.

On those occasions when I have discussed with others my discomfort now about switching Jones’ identity then, I have been told that I am being unnecessarily hard on myself. I am judging my behavior by standards that did not apply at the time. While I think this is largely true, it is cold comfort and it points to a larger problem. Whenever I ask myself: how is ethnography justified as other than a privileged and self-indulgent professional activity? and what should ethnography do?—part of my answer is always ethnography provides data with which to critique the fit between our actions and our ideals. If we are trapped in the values of the everyday, how do we do this effectively? Beyond that, when we alter our data to protect our subjects, how do we know that the data we alter is not critical? What is an innocent change and what is not? (Davis 1991 and Chambers 1999). My problem with changing Jones’ gender is that it makes the critique I did not make impossible for others to make. To say that I was a prisoner of my times seems too convenient, too exculpatory. After all, it was not as if there were no criticisms in the late 1970s of the patriarchal excesses of medicine. It seems to me that what happened was more complex—a conflict with one sort of value (anonymity and confidentiality) led me to betray, wittingly and unwittingly, another kind of value (commitment to an egalitarian society).

**The Second Omission**

Above I suggested that I was sure that Jones was a victim of sexual harassment because she worked in a “hostile environment. This is a serious charge and I do not make it lightly. Yet there is very little in the text that would support such a charge. I do indicate that the work of being a surgical resident is stressful. But I generally paint a picture that has that stress flowing quite naturally out of the intrinsic problems of doing surgery at a major academic medical center—difficult cases that lesser surgeons will not touch, the shortage of ancillary services that routinely plagues academic medical centers, and the violent trauma and tragedy that are all too common in the inner city.

There was a dimension to the stress that I quite consciously chose not to mention. That dimension was the hectoring, often abusive behavior of senior surgeons. One of the reasons that I am so sure that Jones was sexually harassed is that verbal harassment was a rather routine event for all residents, regardless of their gender. Senior surgeons, many of whom had their first experience as battlefield surgeons, believed that residency was a stress test. Part of surgical training for them was recreating the battlefield conditions they felt were so critical in developing their own excellence. So when the world did not throw
enough problems in the fledgling surgeon's way, then the senior surgeons occasionally felt free to create some on their own. 3 The most spectacular incident of a "private stress test" that I observed did not find its way into the text of Forgive and Remember. Before I explain, let me describe.

I have been sifting through old field notes for more than a few hours over a couple of days now. While this unexpected stroll has had rewards all its own, the time-stained foolscap that I had been seeking has eluded me. This baffled me. There were more field notes in manila folders than I remember writing, each recording encounters that I had long ago forgotten. Yet missing were notes I recall writing that described an incident I recall as if it had happened yesterday. But the notes describing the particular incident that I wish to present are nowhere to be found among all the other notes that so meticulously describe people, places, and incidents that I no longer remember witnessing. 4 I am about to describe, in single-spaced indented form to

3. To be fair, there was a great deal of variation here. Some senior surgeons never harassed, embarrassed, abused, bullied, or treated their residents with disrespect. Other senior surgeons rarely missed the opportunity. If that formulation is too strong, then perhaps it is more accurate to say that very little inhibited their attack impulses. It is worth noting that the more mild-mannered surgeon often had nothing but contempt for his, and now sometimes her, more histrionic peers. Whatever feelings the theatrical attending created among his colleagues, they suffered in silence. I never heard one senior surgeon correct or confront another. But, then, this is probably not the kind of activity in which two senior surgeons would engage in front of the novice outsider.

Additionally, I suppose, one might argue that Forgive and Remember was written a long time ago and that surgeons no longer behave in any of these ways. The abusive behavior I am about to describe no longer takes place. That I think is true. But, then again, I chose not to include the incident that I am about to describe because it was so unrepresentative. However I recently have had occasion to interview all faculty and residents in six nontobscular training programs. Reports of the total demise of the dramatically bectoring surgeon are exaggerated.

4. The very fact that the notes describe so much that I have forgotten seems strange to me. When I was doing the fieldwork, recording the notes certainly felt like a needless chore, a species of academic ritualism—"how could I ever forget this?" I thought. Going back over the forgotten notes somehow vindicated the importunity of my teachers at the time and justifies my current nagging of students in the field. The notes themselves index a peculiar feature of fieldwork—we collect so much data and present so little of it.

signal typographically that it is from field notes, an incident which occurred over a quarter of century ago but which is being written up in the present. In texture and detail, the note is a palid copy of the lost original. I suppose this takes me from the realm of revision to the realm of creation. Empirically what I report here is an ethnographic urban legend that can't be verified. Anyway, here is something that happened that I can not find in my notes; something, in other words, that I have no business reporting as data:

I am late and not for the first time. I change alone in the locker room. As I change, I muse. I just have a white lab coat with adhesive tape covering its rightful owner's name. I do not have a hospital I.D. card. I have been at this fieldwork over a year. How come I have never been stopped as I move to and from restricted areas of the hospital alone—SICU, patient rooms, X-ray, supply closets, nurses' stations, doctors' lounges, E.R. treatment rooms, the O.R.? Once as I bolted from a toilet stall where I was taking notes and raced from the latrine without flushing or washing my hands, I was dressed down by an attending and given a lecture on proper hygiene. But, of course the very fact that he felt free to lecture me indicated that he never doubted that I belonged to one of Pacific Hospital's training programs. I suppose that early in the fieldwork I thought it necessary to take notes in a toilet stall indicated that I was not so confident that I legitimately belonged at Pacific as the attending who chastised me was. What kind of security system is it that can be breached by race and gender alone? I wondered,
how did the attendings, so intolerant of the residents’ lateness, view mine?

I raced into the operating room feeling, as always, slightly ridiculous in a green scrub suit, the bottoms of which I can never tie properly, paper booties, hairnet over a massive frizz, hastily tied mask, and fogged glasses. I enter operating room three looking for the Baker Team. They are in room two, I’m told. I enter room two from the scrub area. Dr. Arthur greeted me with effusive sarcasm. Sarcasm itself was not unexpected, his taking special notice of my presence was. “Oh, good, the sociologist has joined us. How nice of you to come, Bosk.” He was hanging on the side, unscrubbed—the Homeless Surgeon—this too was unusual. Christian was performing the surgery. Carter was acting as his first assistant.

After a short pause, Dr. Arthur spoke to me again, “Have you done your Mother’s Day shopping yet? Perhaps Dr. Christian [who is German] could make you a lampshade from the cuttings and trimmings today? You know, Christian, I haven’t seen this much blood since your relatives greeted the chief rabbi of Berlin during the war.”6 Arthur went on like this for a while. After he failed to get a reaction from Christian or Carter or me (we are both Jewish), he moved on to others. He turned to the anesthesiologist (who is an Asian woman) and, invoking his experience as a field surgeon during the Korean War, made some derogatory comments about “slopes, gooks, and dinks.” When Arthur failed to get more than a roll of the eyes from the anesthesiologist, he turned to his regular scrub nurse (who is black) and asked her, “Do you know how many times I had to practice this operation on blacks before they let me do it on whites?” The scrub nurse did not respond. Instead, she asked Christian if he was ready for some instrument or suture material. Failing to get a reaction, Arthur began to grumble about the pace of the surgery, then fell silent, and left the room as his residents prepared to close.

After the surgery was completed, after evening rounds were completed, I gathered with the residents in the cafeteria for dinner. Josh Carter was fuming: “I couldn’t believe Arthur today. Did you ever see a bigger Jackass? I felt like slugging him.” Christian said: “It’s part of his making everything a stress test. You have to let it go in one ear and out the other.” Carter then turned to me: “I’m not like Christian. I can’t stand that shit. But it’s part of what we have to put up with if we want to get through this program. We have to shut up and take stuff like that. Look I’m Jewish and so are you. I don’t know how you felt but I felt like walking out of the operating room. I don’t really want to scrub with him anymore. I don’t know if I can take it. But what choice do I have. If I say anything, I’m gone. So you have to shut up and take it. But did you ever see a bigger shithit than Arthur today?”

Truth was I probably had not. Arthur was a complex character, insulting one day, charming the next. With Arthur, one never quite knew what to expect. One did know that unless one met his standards, one’s rotation on his service was likely to be a very close approximation of a living hell. Further, even if one met his standards but was on his wrong side—as Carter was to become—then the standards changed in such a way that one could not meet them. It was on the Baker Service, after repeatedly watching Arthur in action, that I developed the concept of quasi-normative error.

Quasi-normative errors are eccentric and attending-specific. Each attending has certain protocols that he[sic] and he[sic] alone follows. A subordinate who does not follow these rules mocks his superordinate’s authority; his behavior is a claim that his judgment is as adequate as his superior’s; and even though

Of course, clearance and consent, as I later found out, are not much of a protection—for the researcher at least. In truth, they are not intended to protect the researcher. I had both for All God’s Mistakes (Bosk 1992). Nonetheless my physician-subjects tried to block publication and threatened a lawsuit. In this second case, the hospital attorney was less surprised and less delighted by the appearance of a manuscript (for a fuller description see Bosk 2001).

6. In the previous note, I indicated that the “reconstructed” note above contained materials that I was certain were not in the original. Here I should add that I am certain that these words were spoken in just this way. Much as I have tried to forget, to repress, these words, I have never had much success. But without the original note, you’ll just have to take my word for it.
in no absolute sense can one claim that a mistake has been made, a subordinate who makes a quasi-normative error risks his reputation as a trustworthy recruit (61).

Later in the text, in the chapter already discussed with regard to Jones, "Climbing the Pyramid," I spent a considerable amount of time analyzing the case of Josh Carter. In the promotion meeting in which Jones was determined to be unfit to continue, Carter was said to be an example of the head-strong type of resident who made quasi-normative errors and, as a result, failed to be retained in the training program. In the chapter, Carter's problems were seen entirely as a consequence of Carter's own doings. During the meeting, attendings praised Carter as an individual of great promise, talent, and ability. At the same time, he was criticized for being on occasion unreliable, untrustworthy, slovenly, and churlish. When I mentioned to an attending after the meeting that some of the criticism of Carter seemed to me petty, he responded, "Just because it's trivial, doesn't mean it is unimportant."

Although I was certainly aware of them for I had witnessed them, I did not discuss anywhere in the text of Forgive and Remember the provocations under which Carter and his peers worked. By not doing so I undermined my own intent in developing the concept of quasi-normative error. My intent, as I understood it at the time, was to show that the world of surgery was a highly authoritarian one and that that authority had a defect—it was occasionally eccentric, arbitrary, and capricious. Yet by not showing the degree to which Carter and others were baited, I lodge the defect not in authority itself, but in underlings who are too dim to discern its workings.

Looking back, I think I can see why I might have done so. I wanted my work to read differently than other sociological accounts of the time which seemed to engage routinely and somewhat unflexively in doctor-bashing. I felt that to present the most extreme examples of boorish behavior from my field notes would draw attention away from the book's central thesis—that in surgical education technical norms are subordinated to moral ones. I worried that parading Arthur's excesses—and Arthur, when I knew him, was a man of excesses—would draw attention away from the serious side of surgery and, for that matter, of Arthur. In the end, Arthur's colleagues tolerated his excesses be-

cause they recognized that they stemmed from his commitment to excelle

cnce and they recognized as well how closely his own performance as a surgeon approached that excellence. At the same time, Arthur's excellence was very much a tightly wound coil; picking at any loose end was a risky and explosive activity. In the end, I behaved like Arthur's colleagues—I forgave him his trespasses. I was appalled and I was charmed. I was only skilled enough as an ethnographic draftsman to present the charmed side.

But there are two problems with this that I now clearly see. First, my behavior, as well as the behavior of Arthur's colleagues, challenges my central thesis about the dominance of normative over technical standards. After all, Arthur's behavior was a normative abomination. We would not tolerate it now. I should not have been silent about it then. To be fair to myself, the text makes the point quite plainly that senior surgeons are not subject to the same rules as residents. It does talk about variation in attending style. But I think that this is all too coy, too clever by half. Second, I feel uneasy about Jones and Carter. The text makes them out to be social incompetents of a sort. They are too simple to figure out the rules of the game. Their problems then are of their own making. Yet this is neither entirely so nor entirely fair. So, I sometimes feel guilty about my treatment of these two residents. There are two dimensions of this guilt worth mentioning here. Most obviously, there is the breaking of generational ranks. I betrayed my peers. In addition, I sided with the aggressor. I know that this is a common enough thing to do in a total institution. All the same I'm not proud.

Some Concluding
Remarks, or Why I Told These Stories

Why tell these stories now, so long after they occurred? Why sully Arthur's reputation as a surgeon or my own as a field-worker? Absolution might be one reason that I am choosing now "to put on a hairshirt," but I do not think it is the principal one despite the quite obvious cathartic effect for me of what I have written. I tell these stories now to point out some difficulties embedded in storytelling for didactic purposes. I certainly wanted to emphasize that what stories we choose to
tell from our field notes and how we choose to tell them has important consequences. But there is more, I want the re-visioning of the occupational ethics of surgeons presented here to trace some of the fuzzy boundary between the established domain of cultural ethnography and the emerging one of narrative bioethics. I want to suggest why ethnography is not as likely, as some have hoped, to save the life of bioethics (Hoffmaster, 1992).

In writing *Forgive and Remember*, one of my goals was social portraiture. The introduction to *Forgive and Remember* sets two goals for “analytical” ethnography to follow. “First, I want to recapture and refine the old Durkheimian insight that each occupational group possesses its own morality. I want to specify what for the surgeon is the complex of ideas and sentiments, [the] ways of seeing and [of] feeling, [the] certain intellectual and moral framework distinctive of the entire group…. [Second I want to] inform policy by grounding it in a firm understanding of how participants construct their social worlds. It is only from this concrete understanding of the present practical order that any changes in the existing interactional politics of social control can be negotiated” (pp. 5–6). *Forgive and Remember* is medical sociology, an ethnographic description of a professional group’s “occupational morals.” It is not neutral about those morals; suggestions for improving them are found in the conclusion. On the one hand, in researching and writing *Forgive and Remember*, I strained to provide as detached, neutral, and objective account as possible. Yet, on the other hand, I quite clearly fell short of this goal: with all the talk of “the moral order,” “normative codes,” and “blameworthy and blameless error,” *Forgive and Remember* has a point of view; it can just as easily be read as applied social ethics as empirical social science, as prescriptive and normative as descriptive and empirical.

With these alternative readings in my mind, I presented the two omissions as a device for showing how problematic using ethnographic data for narrative ethics is, for discussing how different the role of bioethicist is from that of ethnographer, and for suggesting some guidelines for writing ethnographies that are “good to think with” either as a social scientist or bioethicist. Before moving on to those tasks, I need to clarify how I assess each of the omissions. The switching of gender, transforming Jones from her to him, strikes me now as a blameworthy error. The error is blameworthy for any number of reasons but most notably, because it makes the text less “good to think with.” The very absence of women from the ranks of either attending surgeons or residents should have served as a clue that something worth discussing was out of kilter in the social world whose ethics I was describing. At the same time, I see leaving out the second omission—Arthur’s ethnic, religious, and racial slurs—as trivial. I had provided more than enough evidence to suggest that Arthur was difficult to work for, easy to anger, and arbitrary in his judgments. I had also provided more than enough evidence that these faults were not Arthur’s alone among senior surgeons, as well as evidence that residents found that the conditions of their employ were stressful. Leaving out the incident in the operating room did not make the ethnography any less good to think with. Including it, however, might have had that effect. It was so startling, so beyond the ordinary, and so offensive that the real danger existed that this behavioral outlier would skew the interpretation of the data. The incident was probably the single most offensive scene I observed during my year and a half of observation. My own sense of propriety, decorum, and fairness suggested to me that I would not want some observing other to hold up for inspection my most offensive professional behavior over the same time period.7

If that is so, why tell the second tale now? First, as a simple discursive strategy, the second vignette reinforces the point of the first: if the conditions that the men worked under included such coarse verbal harassment, then imagine what things must have been like for the others. Second, the thought occurs that I did not find extreme verbal abuse by authority shocking or extraordinary. It was certainly part of the all-male public high school that I attended. Coaches on any team that I played on indulged in it quite frequently. Faculty at the college that I attended were not shy about dressing students down in class. I think that I expected senior surgeons to be verbally abusive. I was no more shocked by this than I would have been by an abusive army drill instructor. This kind of verbal abuse was not an unusual occurrence in male settings.

7. Beyond all that, the thought occurs that I did not find extreme verbal abuse by authority shocking or extraordinary. It was certainly part of the all-male public high school that I attended. Coaches on any team that I played on indulged in it quite frequently. Faculty at the college that I attended were not shy about dressing students down in class. I think that I expected senior surgeons to be verbally abusive. I was no more shocked by this than I would have been by an abusive army drill instructor. This kind of verbal abuse was not an unusual occurrence in male settings. The very fact that I did not make much of verbal harassment is yet another reason why I did not make much of Jones’ hostile work environment. After all the hostility was not created by gender; it existed for everyone. However, as the lone woman, Jones may have experienced that verbal harassment differently than her male peers who were able to use each other for comfort and support.
women. For this point, I did not have direct evidence. Jones, remember, was a socially isolated woman in a group of men. She trusted me and spoke with me no more than she did with any of the other males around. At that time, I had not honed my own skills well enough to talk with a subject as marginalized and as vulnerable as Jones. Nor had I mastered ethnographic technique well enough to skillfully display reports of what did not happen, what was never observed, what was not asked and answered. So the second omission is told here to make the point of the first omission creditable: that had I paid attention to gender I might have noticed that the operation and application of quasi-normative standards undermines the formal fairness of the normative order of surgical training.

There is a second reason to remedy both omissions now. We have known for quite some time that ethnographic narratives are socially constructed, that they are told this way rather than that, that they privilege some voices rather than others. I have also said that the unchallenged voice of authority in the original version of Forgive and Remember is the attending surgeon. The epilogue discusses some of the changes that have occurred now that the voice of attending authority is no longer quite so unchallenged. In this commentary, I want to suggest some natural troubles of ethics presented as ethnography or ethnography presented as ethics.

Framing this as a discussion at the boundary between narrative ethics and cultural ethnography imperfectly reframes it as a discussion between cultural insiders and outsiders. By and large those that practice any brand of narrative ethics base their claims to expertise, their special purchase on affairs, to some sort of "insider" status. By the same token, those who produce ethnographies of medicine base their claims to expertise, their special purchase on affairs, on their "outsider" status: lacking any stake in immediate outcomes permits continued neutrality, makes objective observation and analysis possible.

When I began the research for Forgive and Remember, I was an outsider at Pacific Hospital. Not only that, I was fairly certain that by the time the research was published, I would no longer be at Pacific. I would only have a few sentimental ties to Pacific Hospital's Department of Surgery. At the beginning of the research, I was an outsider who knew nothing of hospitals or of residency training. As the research went on, I learned things; and, as I learned things, I became more of an "insider," but there was always a "responsibility barrier"—I never had to make decisions and do things on behalf of others. As the research progressed, I developed relationships, made friends, and built up obligations. These all affected what stories I chose to tell and how I chose to tell them. In my own eyes, I was there to reveal how some of the backstage of surgery was connected to its public presentation. That became the general narrative guideline (save for Jones's gender) for constructing Forgive and Remember. On rereading the text, I am struck at what I chose to leave out the first time around, and the cool detached tone through which events are narrated, judgments made, and solutions proposed.

Narrative ethics is generally practiced by insiders in health care. Some are employed in hospitals in other clinical roles, some are hired purely for their expertise as ethicists to sit on hospital committees, provide in-service, continuing and public education, contribute to research, and consult on difficult cases. In this work they develop relationships, make friends, juggle multiple responsibilities, and build up obligations. All of this work is done in an organizational environment in which strong professional norms of confidentiality exist and are routinely breached. If narrative ethicists wish to produce public ethnographic accounts of their work, they will need to trade on those relationships, betray some of those friendships, ignore some of their ethical obligations, and tread, however lightly, on those norms of confidentiality. The very work of telling stories, which may very well involve the public airing of some dirty organizational linen, may then transform insiders into outsiders in health care settings. Those with tales to tell may find themselves as frozen out of the everyday discourse as Jones was. This, then, may compromise their effectiveness as clinical workers in other domains, ethics committee members, or consultants.

All of this is to say that the intersection of ethnography, narrative, and ethics is vexed. The space between objective description and involved activity is closer than we might think if we are looking in the rearview mirror alone. Ethnographers can not retreat from studies of
contested ethical situations. Our credentials as outsiders or insiders need to be continually negotiated and renegotiated. We need to think more complexity than we have about where the line that separates observer effect and the legitimate exercise of expertise is, how we will know we have crossed it, and how we will know when such crossings are not just permissible but compulsory. Narrative ethicists also have to think about the tradeoffs in their work as well, about when to argue and when to let go, and when to make a public issue of a private trouble. For both ethnographers and narrative ethicists, how much of the backstage to reveal is a recurring question. How each answers that question is a function of how each defines the professional, the public, and the collective dimension of their role responsibilities. For cultural ethnographers as for narrative ethicists, social obligations and a sense of skill at meeting them spring from self-definition and from the paired questions: Why am I here and what am I doing?

The body of this appendix is a telling of stories I chose not to tell once upon a time. I pulled my punches even though I had no institutional interests to safeguard, no individuals that I needed to protect, and no agenda that I sought to promote. Even with that, as a moral tale, an example of applied ethics, *Forgive and Remember* is a thickly described, thin story. The thick description is in the everyday account of the resident's life and professional vulnerabilities. The thin story is the account that does not more strongly question all the prerogatives claimed in the name of attending authority. This defect also suggests a remedy for those that engage in some form of applied ethics, whether ethnographic or narrative, theoretic or applied. We need to ask ourselves: how many voices we have allowed to speak and how many hidden presumptions we have questioned. One mode of doing this for both ethnographers and narrative ethicists is to revisit our work from time to time and ask How would we act differently now, what story would we tell this time?

8. This is Mills' formula and it remains a good one to think with. As everyday actors, those who practice clinical ethics need a keen sense of the sociological imagination. One way to assure such an imagination is collaborative projects that are multi-sited.

**Works Cited**


Chapter Two

1. The sociological literature on accounts and motives deals with breached expectations. Worthy of special note are Dewey (1922); Lyman and Scott (1968); Foote (1951); Blum and McHugh (1971); and Mills (1944).

2. An acceptable answer in everyday terms is one which renders further questions unnecessary. It ends the search procedure. (See Churchill 1971.)

3. Orderly surgical activity occurs when attending surgeons have their plans carried out with little disruption by deaths and complications—physiological accident—or by others in the work group—social accident.

4. Citations with a name indicate interview material. Citations with service indicate participant-observer data.

5. I am grateful to Edward Shils (1975) for the conceptual imagery. Recently Barber et al. (1973) have questioned Merton's (1957) conception of medical schools as moral leaders. Right or wrong, Barber and his colleagues are somewhat beside the point. Medical schools, as they suggest, may not provide much in the way of moral leadership, but they are the only leadership the next generation of physicians has.


7. Two good early discussions of uncertainty are Fox (1957) and Davis (1960). Fox discusses how physicians learn to manage uncertainty as students; Davis deals with its control implications in the doctor-patient relationship.

Chapter Three

1. The traffic of rounds provides interesting grist for two of Goffman's mills: vehicular traffic (1971) and deference patterns (1967).

2. Freidson (1970a) discusses these in a different context.

3. Here it is perhaps necessary to remind the reader that a distinctive feature of surgical training is that until one reaches attending status the...
direct orders of superordinates are seen as legitimate (see Goss 1961; Stelling and Bucher 1972; and Miller 1970).

4. There is a rich underground lore among surgeons about researchers whose procedures were less than scientific.

5. The distinction between board-certified and occasional surgeons becomes meaningful given the great amount of surgery done by noncertified surgeons in this country. The board-certified surgeons claim that this is a major flaw in our delivery system; they cannot control surgery unless they can control who may act as surgeons. The power to decide who may do surgery is currently in the hands of hospital trustees who are often members of religious or fraternal orders; rarely are they professionals. A few times when I asked Arthur about controls at hospitals other than Pacific, he answered: “Five pounds of candy to Mother Superior at Christmastime will cover a multitude of sins.” By which I suppose he meant to make perfectly clear the nonprofessional manner in which work in a hospital is regulated.

Chapter Four

1. Field researchers (see Dalton 1959) have noted this phenomenon—the loose-mouthedness of the malcontent—as a general problem in coding the reliability of information that their field subjects pass on to them. Undoubtedly members of an organization are as aware as field researchers of this, but how they weight information against its source in building up their own interpretation of what is “really” going on is a largely unexplored topic.

2. As subordinates who must account for failure to superordinates are well aware, one person’s backstage is another’s center. Backstage refers to spaces where actors may retreat and allow some distance between themselves and their roles. I would speculate that the relationship between backstage privacy and status is U-shaped. The very poor, those who command no social resources, cannot afford a backstage area; and the very celebrated are often followed far backstage: Bob Dylan and Henry Kissinger’s garbage is ransacked. Jacqueline Onassis and Photographer Ray Gaeta bickered in court for quite some time over when public curiosity invaded private backstage and becomes a public nuisance. Recently, how far televised news may invade the private spaces of private individuals during public disasters has become a question of journalistic ethics (see New York Times, 6 July 1975, Arts and Leisure Section, p. 1).

3. The background resources that participants employ for understanding such action literally without thinking is the basic problem that ethnomethodology explores. Garfinkel (1967) and his followers (Sudnow 1972) have demonstrated how much work sustains the most ordinary interactions. Such work demonstrates how problematic cell 1 can be when subject to scrutiny. However, I have noticed that the field-workers who take Garfinkel’s ideas seriously pay little heed to his chief methodological injunction: “Procedurally, it is my preference to start with familiar scenes and ask what can be done to produce trouble. The operations that one would have to perform in order to multiply the senseless features of the perceived environments to produce and sustain bewilderment, consternation, and confusion; to produce the socially-structured effects of anxiety, shame, guilt, and indignation; and to produce disorganized interaction should say something about how the structures of everyday activity are ordinarily produced and maintained” (pp. 37–38). Field-researchers of an ethnomethodological frame of mind do not go out and create troubles—this is reserved for experimentalists (see McHugh 1968)—rather, they ask what participants in a scene see as their normal troubles and how they manage them to create artful interactions (for good examples, see Bittner 1967; Sudnow 1965, 1967; and Emerson 1970). There is in this approach a convergence with Hughes’ suggestions for studying occupations and the world of work.

4. Two features of the medical environment are important in understanding why such questioning occurs as it does. First, there is the depth of the student’s unfamiliarity with surgery. The students I observed almost uniformly expressed their surprise at the following: that immediately following surgery, previously healthy-looking individuals appeared so sick. Attendings work on convincing them that this is “normal” and “no cause for alarm.” Here a few good results go a long way in refocusing student concern from patient-oriented to procedure-oriented concerns, that is, from worrying about an individual bleeding to the methods used to control bleeding. Second, there is the surgeon’s sensitivity to the stereotype other specialists hold of him as a mere “thinker,” a “technician,” or a “body plumber.” Attendings and residents are well aware of and resist these views. As a result, surgeons spend a great deal of their time demonstrating to students the sophistication of their clinical reasoning. Undoubtedly some of this is encouraged by the academic climate; however, some of it appears as defensive reaction to a negative stereotype.
5. Two digressions are in order here. First, much of the surgery in medical potboilers and television dramas seems to be of this sort. In everyday life, when such dramatic surgery succeeds, it is often considered highly newsworthy, especially when the beneficiaries are young children. I suspect that if one were to take an index of articles in popular media about modern medical miracles, a greater proportion than one would expect by chance would be about pediatric patients—an indicator of how highly this society values youth.

Second, a question that I quite consistently and consciously bracketed during my field research was whether surgeons had met the demands of ethics and the law and obtained the "informed consent" of those patients for whom they wished to work miracles. I did not suspend judgment because I considered this problem unimportant. Quite to the contrary, it is one of the most complex and consequential questions one can ask about the delivery of care and the nature of professional-client relationships. I suspended judgment and bracketed the question because I was interested in surgeons' understandings of their social control responsibilities and in their definitions of error and failure. Whether the demands of "informed consent" were met or not was not a matter that surgeons considered a matter for social control. The quality of the consent obtained is not an issue that excites surgeons or affects their evaluation of each other. Moreover, I felt that acting as a conscience for my subjects and reminding them that "informed consent" was a matter that they should police would have been inappropriate; it would have made me a participant-advocate instead of a participant-observer.

I think that it is a sad commentary that in order to enter into the everyday world of surgeons one has to bracket such questions. However, it is also not clear whether a consideration of such matters would make surgeons any better or worse as surgeons. Here I apply the surgeon's own criteria of quality, which are clinical and narrow. Moreover, we might not be surprised that if the attending surgeon does not share his deliberations with his subordinates, he will not feel obligated to share them with his patients.

Further, there is in the very notion of "informed consent" as its definition has evolved a paradox that makes its achievement a virtual impossibility. To wit, to satisfy the demands of "informed consent," a surgeon, any physician, must, when suggesting a treatment to a patient, inform him of alternative treatments and their risks and benefits as compared to the proposed treatment. The patient's consent to treatment should ideally be free and not coerced. However, when the physician presents alternatives to the patient, he himself has already been persuaded of which alternative he prefers. So persuaded, it is hard to imagine that when he lays out to the patient his options, the physician does not order his discussion as a convincing argument for the alternative he favors and coerce the patient by his own belief in the correctness of his judgment. Hard to imagine because this is the way he has been taught to discourse on medical problems since his own training began.

In medicine, as opposed to sociology, making a diagnosis is not a value-free activity. Diagnosis is the rationale for intervention. It commits one to a course of action. Clinicians cannot leave the policy implications of their diagnoses for others to worry over. This is a luxury of sociologists and not of physicians in general or surgeons in particular.

Now, if the patient is informed of treatment plans by the physician's argument for what he thinks should be done, it is hard to conceive of truly informed consent for arguments themselves are structured by emphasizing some facts, minimizing some facts, and neglecting others entirely. If this is so, the physician's mode of discussion prevents him from laying out options in the impartial manner informed consent requires. Further, were he to do so, he might undermine the patient's trust and faith in his magical powers to cure—a trust and faith that medical anthropology informs us is an important part of the cure itself (Levi-Strauss 1965).

6. Unfortunately, I do not have data on the distribution of cases at Grand Rounds for the period of this study. However, the chief resident responsible for organizing the conference frequently voiced his concern to me that no service be underrepresented or overrepresented.

7. In the early days of open-heart surgery, there developed an interesting phenomenon known as the "Lazarus" syndrome, which is a corollary to patient presentation at rounds. Here, the surgeon waits in the recovery room with the patient and as he is coming out of anesthesia whispers in his ear: "You're alive. You're alive" (personal communication from David Schneider, Ph.D.). The syndrome is named for Lazarus rather than Christ, I imagine, more for the intensity of a patient's fear surrounding surgery, the awareness of the once-stopped heart beating again, and the patient's feeling that he has literally been raised from the dead than for the innate modesty and sense of propriety of cardiac surgeons. Patient presentation at Grand Rounds serves as evidence that all attendings have their Lazaruses and hence their opportunities to play Christ.

8. Coser (1961) and Hughes (1971) provide nice statements on how
guilty knowledge is shared by superordinates and subordinates. For all the protection attendings afford housestaff, they are given a great deal in return. In fact, a great danger to the professional whose activities are invisible to all but a handful of trusted subordinates is that a sharer of guilty knowledge will go public (see "Nurses Trigger Doctor Quiz," Chicago Tribune, 28 August 1974, p. 1). The codes of silence as they exist within secret and illicit occupations (see Maas 1968; Talese 1971) are a revealing aspect of group life. The secret has received little attention since Simmel and deserves a great deal more. What people choose and work to keep unknown says much about them. The fit between the skeletons and the clothes in the closet is always of some interest and importance.

9. The retrospective peer-review conference conducted by the Department of Surgery differs considerably from the one conducted by the Department of Internal Medicine. In this latter conference, only one or two cases of interest are reported on. They are chosen for their heuristic value. They are intensively researched. Their presentation is separated from their occurrence by six to eight weeks. There is no attempt at this conference or elsewhere to make public and demand accounts for each death and complication that occurs as there is in the surgical conference. The public accounting of surgeons also differs considerably from what Light (1972) reports for psychiatrists.

Thus far, the literature on peer review has concentrated on the prospective review of clinical research (Gray 1975; Barber et al. 1973). These researchers conclude that such review improves the ethical performance of researchers, but how great such improvement is remains difficult to measure. The same problems exist for measuring the effectiveness of retrospective peer review. When questioned, all housestaff reported that one could and that they indeed did learn from the Mortality and Morbidity Conference. However, at the same time, they also expressed the belief that the best way to learn to manage complications was by actually managing them—an echo of the surgery-as-a-body-contact-sport philosophy.

10. This rule has an elastic quality about it; namely, the more minor the complication and the more happy the outcome, the more likely that the complication will be seen as "just one of these things," and the more likely that the subordinate will have complete accounting responsibility. In such cases the subordinate's original accounting to the attending is a dramatic rehearsal of the explanation he must later give in public.

11. An interesting feature of the presentation of such cases is that the recitation of a long list of injuries indicating a hopeless situation provokes anxious laughter among members of the audience.

12. The attending is obliged only by his own sense of his role and mission: he need not step forward, he may allow his subordinate to take the heat or he may absent himself entirely from the conference. Such a course of action is fraught with danger for attendings, however. I will discuss these dangers below.

13. The dynamics by which authority is undermined fall outside the already broad scope of this study. My impressions as far as attendings are concerned are sketchy since I was not so much an insider among them that attendings carried tales to me of each other's behavior. As far as subordinates are concerned, my impressions rest on a firmer basis. The housestaff of Baker accepted Arthur's authority despite his histrionics because they respected his integrity—it was a popular topic of conversation. On Able, where White and Peters were less open, authority was more subject to breakdown.

14. The concern with impression-management and saving face (Goffman 1967) has perhaps blinded us to the dynamics of altruistic sacrifice of face.

Chapter Five

1. This is not to say that no controls exist beyond this point but rather that this is the last institutionally structured one. Superordinates can drum offensive subordinates out of training at any point. However, the longer training continues, the greater is the burden of proof required to discredit an individual and thereby ostracize him. Second, the institutionalization of decision making can soften the blow for those who do not make the grade. The claim can legitimately be made that the decision is no reflection on them but testimony to how stiff the competition was that year. So, as a general rule, the longer one continues to train beyond the institutionalized decision-making point, the more difficult it is to separate him from the training program. This is a case of "If it was done when 'tis done, then 'twere well / It were done quickly" (Macbeth, act 1, scene 7).

2. Freidson and Rhea (1972) identify exclusion as the primary social control mechanism in a group practice. Freidson, in other writings (1970), identifies exclusion as the primary social control mechanism of
the medical profession. I extend these earlier discussions by showing the logic that physicians apply in deciding whom to exclude and whom to include.

3. Miller (1970) has borrowed Matza's (1964) concept of drift to explain the careers of interns in an elite training program. The term seems inappropriate for two reasons. First, a career in an elite institution requires the commitment of too much time and energy to be unthinkingly pursued. Second, superordinates play a too-important role in determining the current subordinates are allowed to drift within. I think that in his interpretation Miller mistook what might have been a defensive rationalization subordinates used to soothe failure for a social process. Presumably people experience a great deal more difficulty than cream in drifting to the top.

4. Moreover, I suspect from my observations, but lack systematic evidence, that it is normative compliance rather than technical proficiency which leads attendings to choose subordinates as assistants on research. I expect a positive relationship between normative skills and sponsorship.

Chapter Six

1. Young physicians are taught techniques that encourage the patient to think he is "special" to the physician—always sit when visiting patients in their rooms, escort them from your clinic personally, develop a theme from their lives and structure discussion around it.

2. Retractors are known in the argot of surgery as "idiosticks." The phrase conveys the degree of skill necessary to hold them properly. The maintenance of interest while standing at attention and keeping the patient's flesh clear of the operative field for hours on end is no easy task. However, superordinates take an inability to do this as an indication that an individual does not care about becoming a surgeon. Further, flagging interest insults the attending who is operating: he expects that his art will be appreciated for art's sake, if not merely for the utilitarian lessons a subordinate may learn.

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