Accepted by the faculty of the School of Social Sciences, Morehead State University, in partial fulfillment of the requirements for the Master of Arts degree.

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# DEATH IN THE MEDICAL SOCIAL SYSTEM: AN ANALYSIS OF DEVIANCE

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A Thesis

Presented to

the faculty of the School of Social Sciences

Morehead State University

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In Partial Fulfillment

of the Requirements for the Degree

Master of Arts in Sociology

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by

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# CHAPTER 1

## STATEMENT OF THE PROBLEM

This investigation is designed to provide further analysis of Wheeler's (1972) conceptualization of the dying person as deviant in the medical subculture. Wheeler found in his research at a university medical center that dying persons elicited a higher attitudinal aversity from physicians than did a nondeviant category of persons, the executive. He then attempted to show that the higher the attitudinal aversity of physicians toward dying persons, the higher the probability that physicians avoided them. Although the latter hypothesis was not supported, the tendency of the physician to avoid the dying person as a means of decreasing aversion should not be completely ruled out.

One of the major weaknesses of Wheeler's research is that the physician sample, alone, is not sufficiently representative of the medical subculture, but rather constitutes only one of the many audiences dying persons encounter. Therefore, this study will expand the scope of analysis to include an additional medical audience, e.g., the medical student.

First, we shall compare the attitudes of physicians and medical students toward the dying person and five other person concepts in order to determine if significant differences

exist between them. Second, we shall attempt to expand upon the conceptualization of the dying person as a deviant in the medical subculture initiated by Wheeler and to provide further insights into why dying persons elicit aversive responses from their medical audiences.

## Theoretical Perspective

Presently, the major school of thought explaining deviance is the labeling perspective. This perspective does not focus on the act or actor, but rather on the audience observing them. According to Kai Erikson (1962:308) "... the critical variable in the study of deviance is the social audience rather than the individual person..." and it is this social audience,"...which essentially decides whether or not any given act or actions will become a visible case for deviation." He continues: "Deviance is not a property inherent in certain forms of behavior; it is a property conferred upon these forms by the audiences which directly or indirectly witness them."

Becker, (1963:11) perhaps the most well known labeling theorist, states that: "Whether or not an act is deviant... depends on how others react to it. Deviance is not a quality that lies in behavior itself but in the interaction between the person who commits it and those who respond to it."

Kitsuse (1962:253) also addresses himself to the labeling perspective of deviance when he states: "Forms

of behavior per se do not differentiate deviants from non-deviants; it is the responses of the conventional and conforming members of the society who identify and interpret behavior as deviant which sociologically transforms them into deviants."

Edwin Schur (1971:24) notes, in reference to the labeling perspective:

> Human behavior is deviant to the extent that it comes to be viewed as involving a personally discreditable departure from a groups' normative expectations and it elicits interpersonal or collective reactions that serve to "isolate," "treat," "correct," or "punish" individuals engaged in such behavior.

It follows then, from all of these statements, Schur's in particular, that when a person is labeled deviant, he is stigmatized. Goffman (1963:3), who has written extensively on stigma, describes the stigmatized individual as a person who is "...reduced in our minds from a whole and usual person to a tainted, discounted one." He goes on to say: "...an individual who might have been received easily in ordinary social intercourse possesses a trait that can obtrude itself upon attention, and then turn those of us whom he meets away from him, breaking the claim that his other attributes have on us" (1963:5).

Therefore, the key to the identification of deviance is found in the audiences that label the individual or act as deviant. Hence, in analyzing the dying person as deviant in the medical subculture, we must look to the medical audiences who interact with and participate in labeling him.

When a person is labeled deviant, an entire interactional framework is created within which the normals relate to the deviant. Regardless of whether or not the individual is responsible for his deviant label, the stigmatized individual is still discredited and is treated with less respect than normals. Freidson (1972:235) addresses himself to the concept of responsibility for the deviant label when he states:

> What is analytically peculiar about the assignment of stigma is the fact that while a stigmatized person need not be held responsible for what is imputed to him, nonetheless, somewhat like those to whom responsibility is imputed, he is denied the ordinary privileges of social life. As the term implies, the societal reaction, although ambigously, attributes moral deficiency to the stigmatized.

Henceforth, as Freidson (1972:236) notes, when a person is labeled deviant, the stigma "...interferes with normal interaction for while people need not hold the deviant responsible for his stigma, they are nonetheless embarrassed, upset or even revolted by it." Therefore, the assumption can be made that the deviant person elicits certain aversive attitudes from the audiences with whom he interacts. These aversive attitudes may be of sufficient strength to elicit attempts to manage them and to decrease aversion through avoidance behavior.

If we make the assumption that the dying person is deviant in the medical social system, then our next logical step is to investigate why this is so. In this analysis

we shall seek to show how the consequences of death for the medical social system make the dying person a deviant.

The functionalist perspective, according to Merton (1949:21) "...is expressed in the practice of interpreting data by establishing their consequences for larger structures in which they are implicated..." Therefore, as Gouldner (1959:243) notes, the emphasis in functionalism is placed on the social system and "...the interdependence of a number of 'parts' and the tendency of these to maintain an 'equilibrium' in their relationships."

Gohen (1968:34) observes that functionalism is the perspective in which "...all the institutions, beliefs, and morals of a society are interrelated as a whole, so that the methods of explaining the existence of any one item in the whole is to discover the law which prescribes how this item coexists with all the others."

Early functionalist theorists, such as Durkheim and Radcliffe-Brown (Gouldner, 1959:241), attempted to explain the functionalist perspective by comparing the social system to an organism. They explained that the organism has various interrelated parts, each of which has its specific function in the overall functioning of the entire organism. These individual parts of the organism must all function at the optimal level to insure the persistence and maintenance of the organism.

Parsons (1949:21) states "...the most essential

condition of successful dynamic analysis is continual and systematic reference of every problem to the state of the system as a whole." He continues:

> A process or set of conditions, either contributes to the maintenance (or development) of the system or it is "dysfunctional" in that it detracts from the integration and effectiveness of the system. It is thus the functional reference of all particular conditions and processes to the state of the total system as a going concern which provides the logical equivalent of simultaneous equations in a fully developed system of analytical theory.

Parsons (1951:28) further elaborates that there are four basic functional prerequisites for the survival and well-being of society: pattern maintenance, integration; goal attainment and adaption.

Pattern maintenance has its basis in the cultural value system and the essential task of motivating the actors in the social system to fulfill role expectations and to sustain the social system. Parsons (1951:29) notes pattern maintenance concerns itself with "...the need to secure adequate participation of a sufficient proportion of these actors in the social system, that is to motivate them adequately to the performances which may be necessary if the social system in question is to persist of develop." Parsons (1951:29) goes on to say:

> The prerequisite of adequate motivation subdivides into two main aspects, a negative and a positive. The negative is that of a minimum of control over potentially disruptive behavior. This means action which interferes with the action of others in the roles in the social

> system. It may involve either aggressive action for others or for an aspect of the system, without aggressive intent.

The second functional prerequisite mentioned is that of integration. Integration according to Rocher (1975:48), refers to the maintenance of the link between the social system and its individual units: "...the purpose of which is to establish control, to inhibit deviant tendencies, to maintain coordination between parts and to avoid too serious disturbances." The third functional prerequisite, according to Parsons, is that of goal attainment, which has as its task to define the goals of the system and to provide the means whereby the system can achieve them. The fourth functional prerequisite is that of adaptation, which basically serves to integrate the social system with the external environment. As Rocher notes (1975:41):

> Adaptation consists of taking diverse resources needed by the system from the environing systems, in exchange for products originating within the system itself, and arranging and transforming these resources to serve the needs of the system. As its name implies, this function includes activities by which the system adapts to its environment and the constraints, exigencies and limits it imposes, as well as those activities by which the system adapts the environment to its needs, modifying, controlling and exploiting it.

Parsons maintains that these four functional prerequisites are imperative to the persistence of any social system. Therefore, in a social system, every unit regardless of how seemingly insignificant it may appear, serves a useful function in the over-all operation of the

entire system. The key to the functionalist perspective is the "interrelatedness" and the "interdependence" of the units with one another.

In addition to the functional prerequisites necessary for the persistence of any social system, Parsons (1951: 101) states that there are four pattern-variables which can be used to set forth a "...classification of 'value-pattern types' defining role orientations..." The pattern variables are posed as dilemmas the actor must solve as he relates to objects or persons in his social environment.

The first of the pattern-variables is that of universalism-particularism. Universalism is the judgment by the actor of a physical or social object according to criteria applicable to an entire range of objects. Particularism, on the other hand, is the judgment by the actor of a physical or social object in accordance with its uniqueness, by criteria peculiar to the individual object.

The second of these pattern variables is that of performance-quality. Performance is the judgment by the actor of a physical or social object based on performance of the object, i.e., judgment is based on what the object does. At the opposite pole of performance is the variable of quality which is a judgment by the actor of the physical or social object based on its intrinsic worth, i.e., based on what the object is.

The third pattern-variable is that of affectivity-affective neutrality. Rocher (1975:38) coments "... if the actor chooses affective neutrality, he sets his own feelings or emotions aside, for the benefit of an instrumental relationship itself." Affectivity, on the other hand, connotes the inclusion of emotional content in the judgment.

The fourth pattern-variable, according to Parsons (1951:109), is that of specificity--diffuseness. Specificity refers to the secondary relationships of an actor to others. The physician may have many secondary relationships with people on a physician-patient level. However, in these secondary relationships, he is involved with the patient on a purely professional, not a personal level. Diffuseness, on the other hand, connotes the involvement of the actor with others by multiple ties and as a whole person.

The physician's role in contempoary society is based on universalism, performance, affective neutrality and specificity. The physician in the contemporary organizational context does not view the patient in a holistic sense, but rather views him as someone with a particular disease or ailment that needs to be treated. The physician's goal, therefore, is purely instrumental. His task is to utilize his expertise and cure the patient's disease, returning him to health.

Secondly, with regard to performance, the physician views the patient not by what he is but by what he does. The physician is not concerned with the patient's life history or social background, but rather he is concerned with pulse-rate, respiration and other vital signs. Hence, the physician is concerned with external indicators of the patient's progress.

Thirdly, the physician takes an affectively neutral stance when dealing with his patients. His goal in the medical social system is the instrumental task of returning the patient to normal role functioning. Instrumentalism and the corresponding subordination of expressive interests are the predominant traits of the physician's role.

The final pattern variable describing the physician's role is that of specificity. The physician's relationship with the patient is purely on a professional level. The relationships of physician and patient are secondary relationships with little or no involvement as whole persons.

## A Suggested Conceptualization of the Dying Person As a Deviant in the Medical Social System

According to Talcott Parsons (1951:430), one of the first sociologists to suggest illness as a form of deviance, "...by almost any definition, health is included

in the functional needs of the individual members of the society, so that from the point of view of functioning of the social system, too high an incidence of illness is dysfunctional." Therefore, to assure that the normal functioning of society continues and that sufficient numbers of individuals fulfill their role expectations--in other words--that there are a sufficient number of individuals in conformity with the societal value of "staying healthy," there must be positive and negative sanctions for conformity and non-conformity, respectively.

Parsons (1958:108) extends his analysis of illness as deviance by enumerating the functions of the health-illness role structure:

> The first of these is the insulation of the sick person from certain types of mutual influence with those who are sick and from association with one another. The essential reason for this insulation being important in the present context is not the need of the sick person for special "care" so much as it is, that motivationally, as well as bacteriologically, illness may well be contagious.

The primary reaction, therefore, to deviance of any type, whether it be criminal deviance or social deviance --as in the case of illness--is punishment of some sort. Durkheim (1961:175) points out:

> ...to punish then is to reproach, to disapprove. Furthermore, the principal form of punishment has always consisted in putting the guilty on the "index," holding him at a distance, ostracizing him from decent people. Since one cannot reproach anyone without treating him less well

> than those whom one esteems, since there is no other way of translating the feeling that the repudiated behavior inspires, all such repudiation generally ends in inflicting some suffering on the delinquent.

Parsons notes (1951:312) that "...the definition of the deviant as criminal overwhelmingly emphasizes the negative side. It constitutes a kind of extrusion from the social group, with little concern for his return. He is used rather in a sense as a scapegoat on whom to project sentiments in such a context as to strengthen the institutionalized values. What happens to him becomes secondary."

This is in keeping with Durkheim (1961:176) who points out that the primary purpose of punishment is not for the deviant himself, but "...to affirm, in the face of the offense, the rule the offense would deny." Hence, if we take Parsons' (1958:108) conceptualization, illness is a rejection of the societal value of health, and he is correct when he observes that:

> The stigmatizing of illness as undesirable and the mobilization of considerable resources of the community to combat illness is a reaffirmation of the valuation of health and a countervailing influence against the temptation of illness, and hence the various components which go into its motivation, to grow and spread. Thus, the sick person is prevented from setting an example, which others might be tempted to follow.

In Parsons' (1951:436-7 conceptualization of illness as a form of deviance, he enumerates four aspects

of the institutionalized expectation system relative to the sick role:

1. Exemption from normal social role responsibilities.
2. Institutionalized definition that the sick person cannot be expected to get well by an act of decision or will.
3. Definition of the state of being ill as itself undesirable with its obligation to want to get well.
4. To seek technically competent help and to cooperate in the process of trying to get well.

Parsons' interpretation of society's role expectation of the sick person dictates that the sick role be a temporary one. The sick person is exempted, temporarily and is expected to cooperate with medical personnel--follow the doctor's orders--and get well. The key, therefore, to Parsons' conceptualization of illness as a form of deviance is the temporal aspect of the condition. The individual who is ill but who, with the correct type of medication, can get well, is granted temporary legitimation of his illness. Therefore, the individual with a "treatable" illness is exempted temporarily from normal role responsibilities.

However, a problem arises when we attempt to apply Parsons' conceptualization of illness as deviance to the dying person, for the dying person defies the role expectations of the culture in general, and the medical subculture in particular. Parsons assumes that illness is by definition undesirable and therefore carries with it the obligation to get well. The dying person, however,

can seldom assume normal role functioning, although he views his illness as undesirable and has tried to cooperate with medical personnel to get well. The dying person, therefore, is permanently cast into a deviant role due to his inability to respond to treatment and get well.

We will attempt to expand Parsons' conceptualization to include the dying patient as deviant in the medical subculture. We will further illustrate how the medical students' and physicians' attitudes toward and treatment of the dying patient are functional to the maintenance of order in the medical social system.

Crane (1975) notes that studies of the doctor's role in medical care have come primarily from the symbolic interactionist perspective rather than from the functionalist perspective. In the symbolic interactionist perspective, a greater emphasis is placed upon the interactions between occupants of different roles. Glaser and Strauss (1965) are primarily concerned with the patient and how the patient's perception of the situation affects others toward him. Sudnow (1967:10) is primarily concerned with certain characteristics of the patient and how these characteristics affect the physician's attitudes toward and treatment of these various patient types. He observes: "...death and dying as physicians

and nurses themselves regard them cannot adequately be described without consulting the socially organized character of these judgemental activities and administrative considerations which are involved and eventuate in their discovery, treatment and consequent events."

We think it is necessary that societal reactions to death be taken into account, as well as the medical subculture's attitudes toward and reactions to death. Just as Durkheim related differences in suicide rates to differences in social currents, we will attempt to relate differences in attitudes toward death to differences in social currents. The medical subculture's responses to and treatment of the dying person are not peculiar to the medical social system but are ineed a reflection on the entire death-denial, death-avoidance patterns which pervade our cultural value system.

Parsons' famous articles on illness and the medical profession contain only indirect references to death and dying. However, this article, "Death in American Society" (1967) has, as its central thesis, the notion that death is avoided both by members of the society and investigators, for it constitutes a central threat to the stability of the social system in a society based on the protestant ethic of achievement.

Therefore, in this research we will use Parsons' thesis of "death as a central threat to the stability

of the social system" and illustrate how death is managed in the medical social system.

## Hypotheses

The purpose of this research is to test the following hypotheses:

1. Dying persons elicit attitudes from medical students significantly more aversive than the attitudes elicited by a nondeviant category of persons, the executive.

2. Medical students exhibit a tendency of avoidance of dying persons.

3. The stronger the medical students' aversive attitudes toward the dying person, the higher the probability that he avoids the dying person.

4. Aversive attitudes toward the dying person vary directly with year in medical school.

5. The medical students' tendency of avoidance of the dying person varies directly with year in medical school.

6. Medical students have a greater aversion toward the dying person than physicians.

7. Medical students avoid the dying person to a greater degree than do physicians.

8. There is no relationship between the sex of medical student and aversive attitudes toward the dying person.

9. There is no relationship between the sex of medical student and avoidance tendency toward the dying person.

## Review of Literature

The cultural values we now hold toward death have gone through dramatic shifts over the past century. Prior to the 1960's, death was considered unmentionable and a distasteful topic for discussion. Henslin's (1972: 55) comment that "because our cultural emphasis is on escape from the reality of death, anyone deciding to do death research is staking a deviant claim and is going against the prevailing ethos" is indicative of the death-denial, death-avoidance typical of our society.

Parsons (1951:443-4) notes that: "American culture in general seems to have an 'optimistic bias', one aspect of which is the 'playing down' of death, the avoidance of too much concern with its prospect of its implications, and, when it must be faced, 'getting it over with' as rapidly as possible, our tendency is to 'get on with living' as nearly in the usual pattern as possible." He further notes "...in the light of psychological knowledge and the evidence from comparative cultures, it seems highly likely that this attitude is maintained only by virtue of strong disciplines which repress preoccupation with anxiety about death."

Gorer (1965:196) notes that by the mid 20th century attitudes toward death had shifted from the Victorian view that death is a normal part of life to the attitude

that it is unmentionable and an "obscene" topic for discussion. He (1965:196) further elaborates:

> The natural processes of corruption and decay have become disgusting, as disgusting as the natural processes of birth and copulation were a century ago; preoccupation about such processes is (or was) morbid and unhealthy, to be discouraged in all and punished in the young. Our great great grandparents were told that those who have passed on are changed into flowers or lie at rest in lovely gardens. The ugly facts are relentlessly hidden; the art of the embalmers is the art of complete denial.

Prior to the 60's, Steinfels (1974:1) points out, "...books on death tended to be psychiatric explorations of the death instinct or the fear of death, pastoral or theological considerations of death for religious audiences, anthropological studies of rituals surrounding death in primitive societies, or philosophical monographs on the treatment of death by some philosopher." Most of this research was consumed by a very select audience; little of it was read by the average reader.

However, after the 60's this trend reversed itself. The number of books dealing with death increased dramatically. What was of even greater significance was the fact that these books were being read by the average reader. Steinfels (1974:1) notes that after 1970, the books on death began appearing at the rate of one per month. "The New York Times Book Review found itself reviewing eight such books at a time, and the reviewer could refer to ten other works in this 'avalanche of death renaissance.'" Ingelfinger (1974:46) points out that

Cumulated Index Medicus for 1973, listed over a hundred titles of books dealing with death.

The interest in death and dying has reached the stage at which Crane (1975:10) feels it has evolved from a topic of interest to a social movement. Crane (1975:10) states that technological and social changes provide the context for the emergence of a loosely coordinated norm-oriented social movement with two principal goals.

> The first goal appears to be improvement in the quality of interaction between dying persons and both professionals and non-professionals. A second goal of the movement is the enactment of legislation to strengthen the patient's right to refuse treatment.

The value of these long overdue changes in the treatment of the terminal or dying patient cannot be disputed. However, Steinfels (1974:3) fears that our present "...over-zealousness in researching and writing about death may only assert itself in new efforts directed toward controlling death." He continues:

> We can exhaust our energies (and our fears) protesting the laws and medical practices which make dying needlessly hard--and indeed there is much to protest. We can go further and construct how-to-do-it guides for the dying or further yet, and look for a technological "solution" to dying whether in medical rejuvenation, cryonics or those combinations of classification, coercion, and benevolence which the imaginations of numerous novelists have glimpsed in our future.

The well-known Princeton philosopher, Paul Ramsey (1974: 502), cautions that the "...same outlook and program

that gave us "calisthenic sexuality," when addressed to the "last taboo" can only eventually lead to the same thing: to "calisthenic dying." Steinfels (1974:3) raises the question, "How long before some Joy of Dying (A Gourmet Guide to Passing Away) makes the best seller lists?"

These changes in cultural values toward death cannot be understood without first looking at the changes that have occurred in the society in general in the past fifty years. Cassell (1974:43) points out the business of dying has shifted from the moral to the technical order. "The moral order has been used to describe those bonds between men based on sentiment, morality or conscience that describe what is right. The technical order rests on the usefulness of things, based on expediency and not founded in conceptions of the right." (The moral and technical order that Cassell refers to is identical in meaning to Parsons' pattern-variables of particularism--universalism mentioned earlier).

Some of the contributing factors in this shift from the moral to the technical order are the advances in medical technology in combating death. In addition to medical advances, there has been a change in the place where death occurs. In past generations, death took place in the home, where the dying person was surrounded by family and friends. In our present-day society, death takes place in institutions, hospitals, nursing homes and other extended care

facilities.

Cassell (1974:43) notes an additional reason for the shift from the moral to the technical order: "...the widespread acceptance of technical success itself... . For individuals what has changed is their death expectancy; they do not expect to die... . The belief is that death need not occur in the forseeable future, that death is a reversible event."

The belief that death is a reversible event, a problem to be solved not a fact to be accepted, Ramsey (1974:502) attributes to the shift from the moral to the technical order. Thereby, making death, as Cassell (1975: 43) points out "...a technical matter, a failure of technology in rescuing the body from a threat to its functioning and integrity."

This shift from the moral to the technical order in viewing death and the recent "avalanche of death renaissance" continues to result in viewing death as a threat to the functioning of society. Parons statement that death is avoided, both by members of the society and investigators, for it constitutes a central threat to the stability of the social system in a society based on the protestant ethic of achievement remains true, even in the 1970's.

This "death as a threat to society" attitude has become even more intensified in our shift from the moral

to the technical order in the care of the dying patient as Callahan notes (1974:ix):

> The ability of medicine to give more people more years of life has not been matched by an ability to deal with the infirmities and chronic illnesses which mark the lives of many of the old, and medicine has surely not been able to deal with the social, cultural and psychological questions posed by the changing age structure of the population, with its increasing numbers of the elderly.

Callahan (1975:ix) states that far "...from leading to a lowering of anxiety about death, the success of medicine may well have increased it." Alban Wheeler (1972:90) found in his research on physicians' attitudes toward the dying patient that attitudes toward the dying person were uniformly aversive. "...53.9 percent of the respondents reported that they did not feel as comfortable with dying patients as with other patients, while only 30.8 percent said they did. Further, 32 percent reported that treating dying patients was one of the most unpleasant aspects of their profession."

Wheeler (1972:91) also found evidence to suggest that dying persons were avoided by the physician sample he studied:

> It was found that 29.6 percent of the respondents reported that they probably would spend less time with dying patients than others and 6.2 percent said that whenever possible they would avoid dying patients.

Cassell (1975:46) makes the point that the medical profession, alone, cannot take total responsibility for

the cultural value of death-denial, death avoidance:

> Frequently we explain depersonalization by saying that it is the physician's psychological defense against the emotional burden imposed by the care of the dying. Though, this may be true, it is only a part of the truth. We have seen how the whole society has shifted its public focus from moral to technical in many areas of life. The problem cannot solely lie among physicians, or the society would not let them get away with it. Social forces would drive doctors back towards a more holistic view of their patients.

The medical social system's values toward death cannot be viewed as distinct and separate from the generally held cultural attitudes toward death. Cultural attitudes toward death constitute the basis from which the medical subculture's attitudes toward death are based. As Cassell (1975:5) points out, "...the medical subculture's attitudes must also be accepted by the society at large, for their attitudes to remain."

What factors then, in addition to cultural attitudes toward death, contribute to the death-denial and suggested death-avoidance response, of the medical subculture, as found by Wheeler (1972) in his research on physicians? We propose that the cultural death-denial, death-avoidance orientation lays the contextual framework for the individual entering the medical profession and that through the process of "professionalization," the neophyte medical student assimilates various ways of dealing with the dying person that enable him/her to deal with death

in a manner that is functional in the medical social system.

# CHAPTER TWO

## METHODOLOGY AND PROCEDURES

The procedures and methods utilized in data collection will be presented in the following chapter. A description of the sample and its limitations will be included.

### Data Collection

#### Method

The data utilized in this research were obtained by Wheeler (1972) in a two-stage process. The first stage consisted of forty-eight hours of participant-observation at a university medical center. The purpose of this initial stage was primarily for exploratory purposes and for construction of a questionnaire. The second stage of data collection involved the employment of survey techniques in which a questionnaire was utilized.

#### The Sample

Data were collected from two samples: physicians and medical students. The physician sample was obtained by means of a mail out questionnaire to 210 physicians in private practice in 11 counties in a southern state and to 60 physicians who were full-time attending staff at a university medical center. Eighty-one physicians returned

TABLE I

SELECTED CHARACTERISTICS OF SAMPLES

| SEX | | AGE | | RELIGION | | SPECIALIZATION | | YRS. OF PRACTICE | |
|---|---|---|---|---|---|---|---|---|---|
| PHYSICIANS | PERCENT | PHYSICIANS | PERCENT | PHYSICIANS | PERCENT | PHYSICIAN | PERCENT | PHYSICIAN | PERCENT |
| Male | 94 | 45 or younger | 52 | Protestant | 85 | Medicine | 33 | 15 or under | 48 |
| Female | 6 | 46 or older | 48 | Catholic | 9 | Surgery | 20 | 16 or over | 52 |
| | 100% | | 100% | Other | 5 | General | 36 | | 100% |
| | | | | None | | Other | 11 | | |
| | | | | | 100% | | 100% | | |
| | N=81 | | N=81 Average=47 | | N=81 | | N=81 | | N=81 Average=17.3 |
| Med. Stu. | Percent | Med. Stu. | Percent | Med. Stu. | Percent | Med. Stu. | Percent | Med. Stu. | Percent |
| Male | 91 | 24 or younger | 79.6 | Protestant | 82.2 | Medicine | 12.8 | First | 44.9 |
| Female | 9 | 25-35 | 20.4 | Catholic | 7.0 | Surgery | 28.3 | Second | 38.4 |
| | 100% | | 100% | Other | .8 | General | 32.6 | Third | 9.0 |
| | | | | None | 10 | Other | 26.3 | Fourth | 6.9 |
| | | | | | 100% | | 100% | Graduate | 0.8 |
| | | | | | | | | | 100% |
| | N=245 | | N=245 Average=23 | | N=243 | | N=141 (missing 104) | | N=245 |

a completed or nearly completed questionnaire. Sixty-eight of the 210 physicians in private practice, or 33 percent who were mailed questionnaires, and 13 or 20 percent of the attending staff at the university medical center returned their questionnaires. Thirty percent of the instruments were returned.

TABLE 2. MEDICAL SPECIALIZATION OF SAMPLES

| Specialization | Physicians | | Students | |
|---|---|---|---|---|
| | Percent | Number | Percent | Number |
| Family Practice | 35.8 | 29 | 32.6 | 46 |
| Medicine | 33.3 | 27 | 12.8 | 18 |
| Surgery | 19.8 | 16 | 28.3 | 40 |
| Other | 11.1* | 9 | 26.3 | 37** |
| Total | 100.0 | 81 | 100.0 | 141 |

*6 Obstetricians-Gynecologists
2 Pediatricians
1 Ophthalmologist

**4 Pathologists
10 Pediatricians
9 Psychiatrists
4 Obstetricians-Gynecologists
1 Cardiologist
1 Neurologist
1 Ophthalmologist
2 Geneticists
5 Radiologists

The second sample was composed of 245 medical students at the same university medical center. Selected characteristics of the samples are presented in Table I and the

distribution of the respondents by medical specialization is indicated in Table 2. (The students were classified according to their anticipated field of specialization). The two samples are not representative of all physicians or medical students and no attempt to generalize beyond this study to a whole population should be made.

## The Instrument

The questionnaire[1] utilized consisted of four separate sections. The first section sought demographic information. Sections two and three consisted of attitude scales and the final section was composed of twelve statements designed to gather information about attitudes, beliefs and behavior in reference to the dying person.

Part I dealt with questions pertaining to age, sex, religious affiliation, year in medical school, size of hometown, schooling completed by mother, schooling completed by father, and family income.

Part II of the questionnaire employed a semantic differential scale which was used to measure the meanings and attitudes elicited by six person concepts, e.g., a dying person, an alcoholic, a tubercular person, an

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[1] See the Appendix for a copy of the questionnaire.

atheist, an emotionally disturbed person and an executive. Osgood, Suci and Tannenbaun (1957), the originators of the scale felt that it was possible to measure three dimensions of meanings in this manner. Through an exhaustive application of factor analysis, they were able to identify these meaning categories by which adjectives may be differentiated. The categories are evaluation, potency and activity. Therefore, a scale utilizing adjectives from all three categories is capable of measuring all three dimensions or factors.

The procedure used in this study with the semantic differential scale measures the meaning of the object or concept in question by having the respondent rate the object on a seven-point scale. For example:

Desirable___:___:___:___:___:___:___Undesirable

For this research, nine pairs of adjectives were chosen from Osgood, Suci and Tannenbaun's (1957:37) reports: happy-sad; tasty-distasteful; pleasant-unpleasant; hard-soft; large-small; rugged-delicate; sharp-dull; hot-cold; and fast-slow. The first group of three was representative of evaluation. The second group of three was representative of potency. The last group of three was representative of activity.

The scales were scored by assigning a score of 1

to the most positive and a score of 7 to the most negative. On the evaluative scale, the "favorable" pole was defined as positive and the "unfavorable" pole as negative. On the potency scale, the "strong" pole was defined as positive and the "weak" pole was defined as negative. On the activity scale, the "active" pole was defined as positive and the "passive" pole was defined as negative.

A varimax rotation to simple structure was performed to confirm whether the nine pairs of adjectives make three dimensions of meaninqs as Osgood suggested. Factors were extracted that had eigenvalues of 1.00 or greater. Items with factor loadings of .40 or greater were kept if they appeared in at least nine of the twelve factor analyses presented in tables 3 to 14. For example, if "tasty-distasteful" loaded .40 or more on Factor I for at least nine times our of twelve on different person concepts, then the item "tasty-distasteful" was retained.

From each of the factor analyses, three or four factors were predominant depending on the person concept. After careful review of these factors and factor loadings, we eliminated items associated with a factor fewer than nine of the twelve analyses. Consequently, we found only one factor common to all person concepts. This factor was labeled "evaluation," which was composed of three items, happy-sad, tasty-distasteful, and pleasant-unpleasant. (The values of our evaluative semantic dif-

ferential range from 3--the lowest possible value, to 21--the highest possible value. See Tables 3-14).

Part III was a modified social distance scale. The social distance scale was utilized to measure the behavioral tendency of avoidance. The scale used in the research consisted of items ranging from intimate relationships to complete avoidance. The respondents were asked to indicate their responses toward each person concept with regard to these items: (1) would feel comfortable sharing sleeping quarters, (2) would feel comfortable having as a weekend guest (3) would feel comfortable working beside every day, (4) would feel comfortable having as a neighbor on my street, (5) would feel comfortable attending weekly civic club meetings, (6) would limit personal contact, and (7) would avoid personal contact. To insure these seven items formed a scale ranging from intimacy to avoidance, Wheeler (1972) administered it to sixty-five university students and had them rank the items in order of intimacy implied by each.

Wheeler (1972:40) utilized Kendall's coefficient of concordance, symbolized by W, to test the degree of concordance between the judges. Kendall's W is a non-parametric statistic which expresses the degree of association between K sets of rankings of N objects or individuals (Siegel, 1956:229). In this instance,

TABLE 3

Factor Loadings of Nine Semantic Differential Items Measuring Attitudes Toward Executive, Physician Sample

| Item | Factor I | Factor II |
|---|---|---|
| 1. Happy-Sad | .79 | .08 |
| 2. Tasty-Distasteful | .91 | .01 |
| 3. Pleasant-Unpleasant | .87 | .05 |
| 4. Hard-Soft | .19 | .84 |
| 5. Large-Small | .20 | .76 |
| 6. Rugged-Delicate | .55 | .70 |
| 7. Sharp-Dull | .81 | .18 |
| 8. Hot-Cold | .54 | .50 |
| 9. Fast-Slow | .73 | .23 |

TABLE 4

Factor Loadings of Nine Semantic Differential Items Measuring Attitudes Toward Executive, Medical Student Sample

| Item | Factor I | Factor II |
|---|---|---|
| 1. Happy-Sad | .76 | -.27 |
| 2. Tasty-Distasteful | .75 | -.28 |
| 3. Pleasant-Unpleasant | .69 | -.45 |
| 4. Hard-Soft | .26 | .71 |
| 5. Large-Small | .52 | .30 |
| 6. Rugged-Delicate | .52 | .41 |
| 7. Sharp-Dull | .72 | .31 |
| 8. Hot-Cold | .45 | -.42 |
| 9. Fast-Slow | .73 | .19 |

TABLE 5

Factor Loadings of Nine Semantic Differential Items Measuring Attitudes Toward Atheist, Physician Sample

| Item | Factor | | | |
|---|---|---|---|---|
| | I | II | III | IV |
| 1. Happy-Sad | .61 | .10 | .38 | .07 |
| 2. Tasty-Distasteful | .77 | .10 | .21 | .32 |
| 3. Pleasant-Unpleasant | .77 | .17 | .24 | .21 |
| 4. Hard-Soft | .71 | .05 | .00 | .29 |
| 5. Large-Small | .09 | .78 | .08 | .14 |
| 6. Rugged-Delicate | .08 | .04 | .12 | .91 |
| 7. Sharp-Dull | .23 | .06 | .88 | .17 |
| 8. Hot-Cold | .42 | .77 | .24 | .01 |
| 9. Fast-Slow | .07 | .78 | .44 | .02 |

TABLE 6

Factor Loadings of Nine Semantic Differential Items Measuring Attitudes Toward Atheist, Medical Student Sample

| Item | Factor | |
|---|---|---|
| | I | II |
| 1. Happy-Sad | .76 | -.05 |
| 2. Tasty-Distasteful | .78 | -.21 |
| 3. Pleasant-Unpleasant | .83 | -.10 |
| 4. Hard-Soft | -.19 | .77 |
| 5. Large-Small | .70 | -.03 |
| 6. Rugged-Delicate | .00 | .64 |
| 7. Sharp-Dull | .58 | .31 |
| 8. Hot-Cold | .60 | -.44 |
| 9. Fast-Slow | .57 | .41 |

TABLE 7

Factor Loadings of Nine Semantic Differential Items Measuring Attitudes Toward Tubercular Person, Physician Sample

| Item | Factor I | Factor II | Factor III |
|---|---|---|---|
| 1. Happy-Sad | .81 | .18 | .29 |
| 2. Tasty-Distasteful | .12 | .25 | .82 |
| 3. Pleasant-Unpleasant | .46 | .69 | .08 |
| 4. Hard-Soft | .00 | .70 | .12 |
| 5. Large-Small | .00 | .34 | .80 |
| 6. Rugged-Delicate | .50 | .18 | .26 |
| 7. Sharp-Dull | .13 | .69 | .18 |
| 8. Hot-Cold | .46 | .36 | .58 |
| 9. Fast-Slow | .04 | .76 | .03 |

TABLE 8

Factor Loadings of Nine Semantic Differential Items Measuring Attitudes Toward Tubercular Person, Medical Student Sample

| Item | Factor I | Factor II | Factor III |
|---|---|---|---|
| 1. Happy-Sad | .66 | .02 | .13 |
| 2. Tasty-Distasteful | .77 | .15 | -.15 |
| 3. Pleasant-Unpleasant | .82 | .03 | -.05 |
| 4. Hard-Soft | -.01 | -.11 | .78 |
| 5. Large-Small | -.14 | .61 | .08 |
| 6. Rugged-Delicate | -.03 | .24 | .78 |
| 7. Sharp-Dull | -.01 | .64 | .00 |
| 8. Hot-Cold | .36 | .64 | -.17 |
| 9. Fast-Slow | .30 | .64 | .09 |

TABLE 9

Factor Loadings of Nine Semantic Differential Items Measuring Attitudes Toward Dying Person, Physician Sample

| Item | Factor I | II | III |
|---|---|---|---|
| 1. Happy-Sad | .73 | .02 | .01 |
| 2. Tasty-Distasteful | .59 | .38 | .40 |
| 3. Pleasant-Unpleasant | .07 | .88 | .03 |
| 4. Hard-Soft | .06 | .55 | .03 |
| 5. Large-Small | .80 | .05 | .04 |
| 6. Rugged-Delicate | .48 | .62 | .03 |
| 7. Sharp-Dull | .07 | .11 | .82 |
| 8. Hot-Cold | .26 | .31 | .60 |
| 9. Fast-Slow | .01 | .07 | .69 |

TABLE 10

Factor Loadings of Nine Semantic Differential Items Measuring Attitudes Toward Dying Person, Medical Student Sample

| Item | Factor I | II | III |
|---|---|---|---|
| 1. Happy-Sad | .76 | .00 | .16 |
| 2. Tasty-Distasteful | .69 | .12 | -.13 |
| 3. Pleasant-Unpleasant | .82 | .03 | -.04 |
| 4. Hard-Soft | -.30 | .02 | .72 |
| 5. Large-Small | -.08 | .68 | .24 |
| 6. Rugged-Delicate | .09 | -.05 | .72 |
| 7. Sharp-Dull | .02 | .70 | -.02 |
| 8. Hot-Cold | .24 | .63 | -.15 |
| 9. Fast-Slow | .28 | .33 | .47 |

TABLE 11

Factor Loadings of Nine Semantic Differential Items Measuring Attitudes Toward Emotionally Disturbed, Physician Sample

| Item | Factor I | Factor II | Factor III |
|---|---|---|---|
| 1. Happy-Sad | .71 | .30 | .12 |
| 2. Tasty-Distasteful | .82 | .15 | .09 |
| 3. Pleasant-Unpleasant | .85 | .07 | .05 |
| 4. Hard-Soft | .20 | .14 | .77 |
| 5. Large-Small | .22 | .39 | .44 |
| 6. Rugged-Delicate | .13 | .04 | .79 |
| 7. Sharp-Dull | .20 | .78 | .24 |
| 8. Hot-Cold | .48 | .49 | .40 |
| 9. Fast-Slow | .20 | .82 | .11 |

TABLE 12

Factor Loadings of Nine Semantic Differential Items Measuring Attitudes Toward Emotionally Disturbed, Medical Student Sample

| Item | Factor I | Factor II | Factor III |
|---|---|---|---|
| 1. Happy-Sad | .62 | .25 | .01 |
| 2. Tasty-Distasteful | .72 | -.09 | .11 |
| 3. Pleasant-Unpleasant | .81 | -.07 | .08 |
| 4. Hard-Soft | -.08 | .78 | -.04 |
| 5. Large-Small | .34 | .41 | .12 |
| 6. Rugged-Delicate | .06 | .77 | .04 |
| 7. Sharp-Dull | .00 | .22 | .74 |
| 8. Hot-Cold | .27 | -.29 | .58 |
| 9. Fast-Slow | .11 | .03 | .77 |

TABLE 13

Factor Loadings of Nine Semantic Differential Items Measuring Attitudes Toward Alcoholic, Physician Sample

| Item | Factor I | II | III | IV |
|---|---|---|---|---|
| 1. Happy-Sad | .78 | .12 | .34 | .14 |
| 2. Tasty-Distasteful | .71 | .24 | .29 | .18 |
| 3. Pleasant-Unpleasant | .78 | .31 | .18 | .09 |
| 4. Hard-Soft | .04 | .22 | .76 | .07 |
| 5. Large-Small | .13 | .19 | .11 | .86 |
| 6. Rugged-Delicate | .19 | .20 | .74 | .25 |
| 7. Sharp-Dull | .21 | .73 | .03 | .14 |
| 8. Hot-Cold | .07 | .56 | .00 | .64 |
| 9. Fast-Slow | .05 | .87 | .04 | .03 |

TABLE 14

Factor Loadings of Nine Semantic Differential Items Measuring Attitudes Toward Alcoholic, Medical Student Sample

| Item | Factor I | II | III |
|---|---|---|---|
| 1. Happy-Sad | .69 | .05 | .04 |
| 2. Tasty-Distasteful | .70 | .10 | -.03 |
| 3. Pleasant-Unpleasant | .77 | .16 | -.15 |
| 4. Hard-Soft | -.17 | -.02 | .68 |
| 5. Large-Small | .16 | .47 | .48 |
| 6. Rugged-Delicate | -.24 | .41 | .57 |
| 7. Sharp-Dull | .29 | .70 | -.20 |
| 8. Hot-Cold | .45 | -.17 | .56 |
| 9. Fast-Slow | .07 | .71 | .14 |

K=65 (judges) and N=7 (scale items). The degree of concordance between the judge's rankings of the items was expressed by W=.788 which was significant at the .001 level. Therefore, it was concluded that the items arranged in the above order formed a scale in which each succeeding item described a less intimate relationship than the preceding item. The scale yields a social distance score which ranges from 1 through 7, in which the greater the score the greater the social distance between the subject and the person concept being rated.

Part IV consisted of twelve statements dealing with attitudes and behavior toward death and the dying person. The respondents were asked to indicate their level of agreement with each statement on a five point scale in the following manner: (1) strongly agree, (2) agree, (3) neutral, (4) disagree, and (5) strongly disagree.

# CHAPTER THREE

# ANALYSIS OF DATA

## Tests of the Hypotheses

The attitudes elicited by dying persons, executives and four other person concepts were measured by the ratings of the respondents on semantic differential and social distance scales and may be used as a comparative measurement. Hence, if the dying person is given a negative rating, this may give insights into the respodents feelings toward dying persons and death in general. However, when using the rating given the dying person and comparing it to the ratings given to other person concepts, i.e., the executive, the insights become even more valuable. This was the reason for having the respondents rate the five additional person concepts as well as the dying person.

The reasoning behind the employment of the procedure used to test hypothesis 1 was that if the dying person were rated negatively and the executive, a traditionally nondveiant type, were rated postively, and the traditionally deviant types were rated negatively, then the argument could be made

that the dying person elicits attitudes of greater similarity to the attitudes elicited by deviant types than by nondeviant types.

A modified form of the Bogardus social distance scale was employed for the measurement of behavioral tendency. The two most extreme responses--would limit person contact and would avoid personal contact--are the responses that can be adjudged with certainty to be indicative of a behavioral tendency toward avoidance. The respondents rated the six person concepts on the social distance scale and their ratings were analyzed in the same manner as were the semantic differential scale.

Hypothesis 1 stated that the dying person elicits attitudes from medical students significantly more aversive than the attitudes elicited by a nondeviant category of persons, the executive. The first stage of the analysis of the semantic differential scores was to compare the mean evaluative semantic differential scores for the executive and the dying person. Among the medical students, the mean evaluative semantic differential score for the executive was 10.44. The mean evaluative semantic differential score for the dying person was 16.87 (See Table 15)

An additional point to be made from these scores is the 6.43 scale unit difference between the two scores. Osgood (1957:328) and his associates point out that

TABLE 15 MEAN SEMANTIC DIFFERENTIAL SCORES AND DIFFERENCE IN MEAN SCORES OF SIX PERSON CONCEPTS, MEDICAL STUDENT SAMPLE

| | Mean Scores | | | | | |
|---|---|---|---|---|---|---|
| | Executive | Atheist | Emotionally Disturbed | Dying Person | Alcoholic | Tubercular Person |
| | 10.44 ( 3.60)* | 14.17 ( 3.93) | 16.13 ( 2.56) | 16.87 ( 2.76) | 17.37 ( 2.70) | 20.07 ( 3.39) |
| Executive | | | | | | |
| Atheist | 3.73** | | | | | |
| Emotionally Disturbed | 5.69** | 1.96** | | | | |
| Dying Person | 6.43** | 2.70** | .74** | | | |
| Alcoholic | 6.93** | 2.20** | 1.24** | 0.50 | | |
| Tubercular Person | 9.63** | 5.90** | 3.94** | 3.20** | 2.70** | |

*Figure in parenthesis indicates standard deviation.
**Figure indicates a significant difference at .05 level.

"For group data (cultural meanings) changes or differences in measured meanings as small as one-half of a scale unit are significant at the .05 level."

Ranking the six person concepts from the most positive to the most negative, the medical students in this sample ranked the executive first, the atheist second, the emotionally disturbed third, the dying person fourth, the alcoholic fifth and the tubercular person sixth. (Table 15)

The atheist, tubercular person, the emotionally disturbed person and the alcoholic were included in the six person concepts because they carry stigmata and are therefore considered deviant in our culture.

According to Table 15, the mean semantic differential scores for the dying person and the emotionally disturbed person were ranked by the medical students as 16.87 and 16.13 respectively. The difference in the mean semantic differential scores was .74, a significant difference. Since, the emotionally disturbed person does carry stigmata and is considered a deviant in our culture and since the dying person was ranked similarly to the emotionally disturbed person, the dying person can also be regarded as deviant.

The second hypothesis stated that <u>medical students exhibit a tendency of avoidance of dying persons</u>. Only 24 respondents, or 10.1 percent, reported they would feel comfortable sharing sleeping quarters with a dying person.

(Table 16) Whereas, 117, or 48.7 percent, reported they would do so with the executive. Only 18.9 percent reported that they would feel comfortable having the dying person as a weekend guest, while 21.2 percent agreed that they would with the executive. Hence, the cumulative proportion of respondents who agreed with the first and second statements with respect to the dying person was 29 percent as compared to 69.9 percent for the executive. On the other extreme, 41.1 percent reported that they would either limit or avoid contact with the dying person while only 4.2 percent said they would do so with the executive. The complete distribution of social distance scores for the dying person and the executive as rated by the medical students may be seen in Table 16.

TABLE 16 DISTRIBUTION OF SOCIAL DISTANCE RESPONSES FOR DYING PERSON AND EXECUTIVE

| | Dying Person Percent | N | Executive Percent | N |
|---|---|---|---|---|
| 1. Would feel comfortable sharing sleeping quarters. | 10.1 | 24 | 48.7 | 117 |
| 2. Would feel comfortable having as a weekend guest in my house. | 18.9 | 45 | 21.2 | 51 |
| 3. Would feel comfortable working beside everyday. | 20.2 | 48 | 12.1 | 29 |
| 4. Would feel comfortable having as a neighbor on my street. | 21.4 | 51 | 11.7 | 28 |
| 5. Would feel comfortable attending civic club meetings with. | 6.3 | 15 | 2.1 | 5 |
| 6. Would limit personal contact. | 20.6 | 49 | 2.1 | 5 |
| 7. Would avoid personal contact. | 2.5 | 6 | 2.1 | 5 |
| TOTAL | 100.0 | 238 | 100.0 | 240 |

The social distance scores for all six person concepts are ranked in Table 17. Although the order in which the six person concepts are ranked varies with the semantic differential and social distance scores, the executive is still clearly set apart from the other person concepts. The social distance scores show the dying person ranked similarly to other deviants.

TABLE 17 MEAN SOCIAL DISTANCE SCORES AND DIFFERENCE IN MEAN SCORES OF SIX PERSON CONCEPTS, MEDICAL STUDENT SAMPLE

| | Mean Scores | | | | | |
|---|---|---|---|---|---|---|
| | Executive | Atheist | Dying Person | Emotionally Disturbed | Alcoholic | Tubercular Person |
| | 2.12 (1.45)* | 2.80 (2.00) | 3.66 (1.69) | 4.47 (1.73) | 4.72 (1.83) | 4.74 (1.85) |
| Executive | | | | | | |
| Atheist | 0.67** | | | | | |
| Dying Person | 1.54** | .86 | | | | |
| Emotionally Disturbed | 2.36** | -1.68** | -0.79** | | | |
| Alcoholic | 2.61** | 1.92** | -1.05** | 0.24 | | |
| Tubercular Person | 2.63** | 1.96** | -1.07** | 0.26 | -.00 | |

*Indicates standard deviation.
**Indicates significant difference at .05 level in a two-tailed test.

The third hypothesis stated that the stronger the medical student's aversive attitudes toward the dying person, the higher the probability that he avoids dying persons. To test this hypothesis, a correlation coefficient analysis was utilized to determine the relationship between aversive attitudes and behavioral avoidance tendency. This hypothesis was not supported as Table 18 illustrates.

TABLE 18 PEARSON'S CORRELATION COEFFICIENT BETWEEN SEMANTIC DIFFERENTIAL AND SOCIAL DISTANCE SCORES

| | Percentage of Explained Variance | N | Level of Significance |
|---|---|---|---|
| Medical Students | 0 | 244 | not significant |

The fourth hypothesis stated that aversive attitudes toward the dying person vary directly with year in school. The semantic differential scores rating the dying person by year in medical school show a significant increase in aversion from the first to the second year students and a significant decrease in aversion from the second to the third year.

The third and fourth year students rated the dying person similarly, 16.18 and 16.62 respectively. (Table 19)

TABLE 19 MEAN SEMANTIC DIFFERENTIAL SCORES AND DIFFERENCE IN MEAN SCORES FOR THE DYING PERSON, BY YEAR IN MEDICAL SCHOOL.

| | Mean Scores | | | |
|---|---|---|---|---|
| | First | Second | Third | Fourth |
| | 16.57 (2.83)* | 17.42 (2.52) | 16.18 (3.23) | 16.62 (2.68) |
| First | | | | |
| Second | .8** | | | |
| Third | .39 | 1.3** | | |
| Fourth | .05 | .80** | .40 | |

*Indicates standard deviation.
**Significant at .05 level in a two-tailed test.

The sixth hypothesis stated that medical students have a greater aversion toward the dying person than physicians. This hypothesis was supported as shown in Table 21. The medical students' aversion (16.87) toward the dying person was greater than the physicians' (15.03).

TABLE 21 MEAN SEMANTIC DIFFERENTIAL SCORES AND DIFFERENCES IN MEAN SCORES FOR SIX PERSON CONCEPTS

| | Mean Scores | | |
|---|---|---|---|
| Person Concepts | Medical Students | Physicians | Mean Differences |
| Executive | 10.44 | 10.21 | .23 |
| Atheist | 14.17 | 15.17 | 1.00 |
| Emotionally Disturbed | 16.12 | 15.83 | .29 |
| Dying Person | 16.87 | 15.03 | 1.84* |
| Alcoholic | 17.37 | 17.20 | .17 |
| Tubercular Person | 20.10 | 13.50 | 6.60* |
| TOTAL | 243 | 76 | |

*Indicates a significant difference at the .05 level.

The seventh hypothesis stated that medical students avoid dying persons to a greater degree than do physicians. This hypothesis was not supported as indicated in Table 22.

TABLE @@ MEAN SOCIAL DISTANCE SCORES AND DIFFERENCES IN MEAN SCORES FOR SIX PERSON CONCEPTS.*

| | Mean Scores | | |
|---|---|---|---|
| Person Concepts | Medical Students | Physicians | Mean Differences |
| Executive | 2.12 | 1.81 | .31 |
| Atheist | 2.80 | 3.37 | .57 |
| Dying Person | 3.67 | 3.59 | .08 |
| Emotionally Disturbed | 4.50 | 4.54 | .04 |
| Tubercular Person | 5.75 | 4.74 | .01 |
| Alcoholic | 4.74 | 5.38 | .64 |
| TOTAL | 243 | 76 | |

*Indicates that none of the mean differences are significant at the .05 level.

The eighth hypothesis stated that there is no relationship between sex of medical student and aversive attitudes toward the dying person. The mean semantic differential score shows a slightly higher aversion toward the dying person for the female students, 17.45, than for the male students, 16.79. A scale unit difference of .66 was indicated. The difference however, was not significant.

The mean social distance scores show an .08 scale unit difference between the female students, 3.75, and the male students, 3.67, in their rankings of the dying person. The difference is not significant, however. In addition, due to the sample size of the female respondents, N=22, no valid generalizations can be made from the findings.

TABLE 23 MEAN SEMANTIC DIFFERENTIAL SCORES AND DIFFERENCES IN MEAN SCORES, BY SEX OF MEDICAL STUDENT.

| | Mean Scores | | |
|---|---|---|---|
| Person Concepts | Male | Female | Mean Differences |
| Executive | 10.58 | 8.71 | 1.87* |
| Atheist | 14.13 | 14.64 | .51 |
| Emotionally Disturbed | 16.18 | 15.59 | .59 |
| Dying Person | 16.79 | 17.45 | .66 |
| Alcoholic | 17.43 | 16.90 | .53 |
| Tubercular Person | 20.07 | 20.04 | .03 |
| TOTAL | 220 | 22 | |

*Indicates a significant difference at the .05 level.

The ninth hypothesis stated that there is no relationship between sex of medical student and avoidance tendency toward the dying person. As Table 24 indicates, medical students' avoidance tendency does not differ by sex, therefore, the null hypothesis cannot be rejected.

TABLE 24: MEAN SOCIAL DISTANCE SCORES AND DIFFERENCES IN MEAN SCORES FOR SIX PERSON CONCEPTS, BY SEX OF MEDICAL STUDNET

| | Mean Scores | | |
|---|---|---|---|
| Person Concepts | Male | Female | Mean Differences |
| Executive | 2.12 | 2.09 | .03 |
| Atheist | 2.80 | 2.71 | .09 |
| Dying Person | 3.67 | 3.75 | -.08 |
| Emotionally Disturbed | 4.53 | 4.14 | .39 |
| Tubercular Person | 4.69 | 5.23 | -.59 |
| Alcoholic | 4.71 | 5.95 | -.24 |
| TOTAL | 221 | 22 | |

# CHAPTER FOUR

# CONCLUSIONS AND IMPLICATIONS

## Interpretation of the Findings

Our finds confirm that medical students have a greater aversion toward the dying person than do physicians. The student's mean semantic differential score for the dying person was 16.87, whereas, the physicians' score was 15.03, a significant 1.84 scale unit difference. We feel that the greater aversion scores of medical students are a function of the situational aspects of medical school training, as the following section illustrates.

## The Process of Becoming

Cultural values toward death are a dominant force in the contextual framework of the medical school into which the student comes. However, we will attempt to illustrate how medical training contributes significantly to the depersonalization of the dying patient and succeeds in reinforcing the death-denial, death-avoidance patterns found in our culture.

Ritzer (1975:23) notes that a profession is more than the sum of the individuals within it. "A profession is a constellation of structures, groups, values and norms...." Therefore, we will attempt to analyze the medical profession and illustrate how it relates to and

manages death. What processes does the medical student go through in training to be a physician? What effects does medical school have on attitudes toward the dying patient? Raynaud (1956:124) notes that "the years of becoming a professional are both 'developmental socialization'--acquiring an adult role and 'resocialization'--from layman to professional." Hence, the novice entering the field of medicine is very highly influenced by the medical subculture of which he will eventually become a member.

Munford (1970:2) notes that internship "...offers a clearly perfect example of potentially effective adult socialization." She continues:

> The beginning physician is introduced and moved into patterns of behavior with his colleagues and with patients in an emotionally charged atmosphere. His encounters and experiences here can reinforce and protect some of the commit-tments he began to form in medical school.

Parsons (1951:205) addresses himself to the concept of socialization when he states that "socialization acts as an elemental constraint because it is the process by which individuals internalize rules. Once a person establishes a social relationship based on mutual expectations and gratifications, it is not problematical."

Dornbusch (1955:321) mentions that the novice does not enter into professional training without certain preconceived notions of the professional he is about

to become.

> There is in any profession a kind of bootlegging, in which the student, unwittingly or not, acquires from non-official vendors the ideas, values and ways of behaving and thinking that are attributed sometimes legitimately, sometimes not to the profession.

Therefore, the medical student entering training has certain preconceptions of what it will be like to be a doctor. As Anna Freud points out (1972:642-3):

> ...the wish to become a doctor. I remember vividly when I was a child myself, of being impressed by those fairy tales usually placed somewhere in the middle ages, where an unusually trained or gifted medical man took up straight-forwardly the battle of death, and proved that he could conquer death, at any time and save the patient's life. Death was his enemy. He was the savior and the hero.

Munford (1970:19) notes that it is characteristic of a profession "...that its members believe that their work is special and worthy of note and esteem and that laymen also accord it with prestige.. Professionals share a 'collective identity' with those who have gone through similar training, as well as attachment to work itself." She continues:

> ...the extended training that professions typically demand develops the sense of identity that is indispensable if members are to care about what happens to that profession...with this, the profession can fulfill some of its social functions. It can control its members through pressures and sanctions not available to the layman.

The medical student, therefore, enters medical school

with certain images of the professional he is about to become. In addition, the medical student enters school with certain preconceived notions about patients. What effects, then, does medical school have on the student's perception of the patient, and in particular, the dying patient? Becker et al (1961:94) found that during medical school training, students tended to go through various stages of attitude change. They labeled these stages perspectives. The "Initial Perspective" according to Becker et al is characterized by the beginning students' comments:

1. We want to learn everything as we will need it when we become physicians.
2. There is a tremendous amount to learn.
3. We love to work very hard--that is, many hours.
4. If our present hours of work are not enough to get everything, we'll do whatever we can to increase them.

As time passes, the students are faced with the overwhelming amount of work and materials that they are expected to master. Their initial idealism begins to wane. It is at this time that the "Provisional Perspective" comes into being. Becker et al (1961:111) describe the "Provisional Perspective" by comments from the medical students:

1. In spite of all our efforts we can't learn everything in the time available.

2. We will work just as hard as ever but now we will study in the most effective and economical ways and learn only the things that are important.

Becker et al (1961:111) use the term provisional because it is the bridge between the students' initial perspective and their final views.

The "Final Perspective," according to Becker et al (1961:163) is defined by the students' comments:

1. We select the important things to study by finding out what the faculty wants us to know. This is the way to pass exams and to get through school.

2. We will continue to study hard and in the most economical and efficient ways.

3. We will try to find out, in any way we can, short of cheating, what questions will be on the exams and how they should be answered and share this information with other members of the class.

It is seen, in the comments from the students themselves, that the perspective of the medical student changes as he makes his way through medical school. Humanitarian ideals are put aside temporarily, and the primary objective becomes that of passing exams and basically keeping up with the tremendous amount of work that is expected.

Therefore, one can see the increasing emphasis on the technical approach to the patient and the shift away from the holistic, patient-as-person approach. Some authors, Becker and Geer (1958) and Bloom (1963), have termed this shift in perspective as the shift from

idealism to cynicism. This shift from idealism to cynicism can also be observed in the nursing profession, as Olesen and Whittaker (1968:163) note:

> ...there were three stages and the first one was the one is which students felt sorry for the patients...that they joke among themselves about how unfortunate it was that the patient had to put up with them and their lack of skill and general incompetence...Secondly, they began to rationalize and say, "well, we are student nurses and maybe we have more time to look after the patients' immediate needs than the regular staff...In the last stage they were prone to take the attitude that the patient was damned lucky to have someone who would give them this much attention and care. (Field Notes, Class of '62, 3rd Year)

Leonard Eron (1958:27) addresses himself to the shift from idealism to cynicism when he states that "...although law students profess to significantly more cyncial attitudes by far than do freshmen medical students, the seniors in these same schools are equal in the extent of cyncial attitudes expressed."

Schwartz (1967:242) notes that the "...initial enthusiasm and humanistic motivation of fledgling medical students, fresh from the liberal arts, are frequently smothered." Milton Davis (1968:335) deals with the discrepancy in idealism between junior and senior physicians when he notes:

> Junior physicians, however, are more likely to note the importance of interpersonal skills, 65 percent of the junior physicians and only 47 percent of the senior physicians mentioned that it

> was important for the "good doctor" to know how to establish rapport with patients or have knowledge about the doctor-patient relationship.

Leonard Eron (1958: 125-53) found in his research that medical students "grow cynical and lose their humanitarianism." Olesen and Whittaker (1968:260) note in reference to the nursing students' altered idealism that:

> ...the initial bravado and confidence, encouraged for some by a long sense of ownership towards the role to be acquired, and for all by success-oriented parents, were accompanied in the student by a diminished perception of the inevitable constraints involved in role assumption. In meeting the vicissitudes of the education institution and of the ward, the student comes to a realization. The world of her chosen occupation was infinitely more complicated than she had imagined, the tasks infinitely more detailed and manually difficult, the psychological investment more soul-drenching and bitter and the greatness and the glory rather remote and nonexistent.

Though cynicism cannot be attributed as a causal factor in aversive attitudes toward death and the dying patient, the assumption can be made that in the shift from idealism to cynicism, there is a shift in attitudes toward and treatment of the patient. The idealism to cynicism shift in attitudes can be viewed as a contributing factor to the depersonalization of the patient.

An additional factor that contributes to the depersonalization of the patient in the medical subculture, is what Fox (1959) has labeled "training in detached concern." The medical student assimilates the medical

subcultural perspective of viewing patients and their diseases with a detached, scientific objectivity. This medical perspective of "detached concern " and "scientific objectivity" are indeed functional for the medical social system, for they serve as protective devices against getting involved with the patient on a personal level. Leif and Fox (1958:53) note:

> By the end of the first day in the laboratory, some students have become so absorbed in the work of dissection that they have begun to forget their emotional response and to feel more casual about what they're doing. Here is the first instance in which the vast amount of intellectual work necessary in medical school serves as a protective device against intense emotions. The anxiety involved in learning the material sufficiently well so that they can pass examinations becomes a counter-irritant for students.

Leif and Fox (1958) also mention that there are various defense mechanisms utilized by medical students to maintain emotional control, one of which is that the medical student must maintain his composure in the face of emotionally-laden laboratory experiences in order to gain the respect and acceptance of his peers. A second method of maintaining composure for the medical student is that of "intellectualizing" what he is doing. These concepts of "detached concern" and "scientific objectivity" are introduced by the teaching staff in the first years of medical school and are further reinforced in the last years in medical school--the clinical years.

(Fox's "training in detached concern" is identical in meaning to Parsons' "affective neutrality" mentioned earlier.) The student has little choice but to adopt these views as his own and to internalize the perspective of the medical social system of which he is now apart.

Becker and Geer (1958:50-56) note that "...this apparent cynicism is a collective matter." Group activities are built around this work-a-day perspective, constraining the students in two ways. "First, they do not openly express the lay idealistic notions that they may hold, for their culture does not sanction such expression; second, they are less likely to have thoughts of this deviant kind when they are engaged in group activity." They go on to say:

> ...the collective nature of this cynicism is indicated by the fact that the students become more openly idealistic whenever they are removed from the influence of the student culture--when they are alone with a sociologist as they near the finish of school and sense the approaching end of student life, for example, or when they are isolated from their classmates and therefore are less influenced by this culture. (1958:54)

We can see the groups' influence on the medical student entering the medical profession. Warriner (1956: 549-54) notes on the influences of groups: The group is just as real as the person...the group is understandable and explicable solely in terms of distinctly social processes and factors, not by reference to

individual psychology. He (1956:554) goes on to say:

> ...if we treat groups as real units or systems; if we cease to identify group phenomena with a particular personnel and with personality, if we cease to look for group pheonomena in persons and if we study groups for the sake of learning more about groups, only then will we make real strides in a uniquely sociological problem.

Therefore, the medical subculture's influence on the neophyte medical student is extremely powerful and serves as the primary agent of resocialization of the student from layman to professional. Hence, the medical student can best be understood in the organizational context of which he is apart. The "detached concern" that he exhibits toward the patient is not necessarily out of personal choice but rather, is functional and necessary for the maintenance of order in the medical social system and necessary for the learning of technical material. The medical student learns that there must be a certain degree of "professional distance" between physicians and patient to insure objectivity.

Rushing (1974:50) makes the observation that the nurse also is placed under certain structural constraints, and it is the medical social system that defines the role she will play:

> There are certain structural constraints placed on the nurse's hospital role that deter her from giving comprehensive nursing care. Furthermore, the types of nurs-patient interaction that are becoming increasingly frequent deter the development

> and reinforcement of the sentiments and attitudes that are at the heart of programs designed to encourage interaction with patients as "whole persons," ...it is the organization of the hospital more than the attributes of the individual nurses that prevents the nurse's performance of functions demanded in comprehensive nursing care.

To the layman, the medical student's attitudes toward and treatment of the dying patient may seem hard and callous, but to the medical profession, these attitudes are functional in that they serve as a means of dealing with catastrophic illnesses and death in a manner that is not disruptive to the social order of the medical subculture. Becker et al (1961:421) note that there are two sets of characteristics of medical students that seem cyncial to the layman:

> As a result of their experience in medical school, students acquire a point of view and terminology of a technical kind, which allow them to talk and think about patients and diseases in a way quite different from the layman. They look upon death and disabling disease, not with the horror the layman finds appropriate, but as problems in medical responsibility. The technical attitudes which prevent the student from becoming emotionally involved in the tragedy of patient's diseases seems to the layman, cruel, heartless, and cynical.

Dana Farnsworth (1956:34) notes that some observers speak of the cynicism that overwhelms the student as a lack of concern for patients as human beings. In addressing the idealism to cynicism shift, she observes

"...this change does take place, but it is not produced solely by the anxiety brought about by the presence of death and suffering. The student becomes preoccupied with the technical aspects of the cases with which he deals because the faculty requires him to do so." Therefore, even if the medical student wanted to be more empathetic toward the dying patient, he is not supported in doing so, and his main interest consists in getting through school.

Medical school training does not lend itself to the cultivation of a "bed-side manner." Emphasis is placed on the acquisition of technical, medical material, passing examinations and earning the respect and approval of the instructors. The group's influence is paramount to understanding the actions of the individual medical student and physician alike. Crane (1975:185) cites a description of the groups' influence in this way:

> ...the writer was constantly faced with the dilemma of putting down what he would like to do personally, or voting for certain procedures which would be unavoidable in a hospital situation. We are constantly pressured to carry out diagnostic and therapeutic procedures because of established customs and expectations.

Crane (1975:118) cites a neurosurgeon's description of his perception of the groups' influence:

> There is a gentleman's agreement. Nothing is written or stated as policy. But there is an understanding which everyone has. It's a dynamic thing.

> It waxes and wanes. You're exposed to it in training and it's modified over time. It's an unwritten law. It's an agreement about how these cases should be handled. You find this gentlemen's agreement in any group. In other institutions they might have different standards, but they would all agree among themselves.

The medical student, therefore, is forced to learn as much technical medical information as he can in a brief time span. He, therefore, is interested in cases and diseases that are unusual and through which he can learn new knowledge. Becker and Geer (1961:336) note in remarks from medical students in their work with dying patients that "...students feel rightly or wrongly that they learned little from this time-consuming exercise and so are apt to look with disfavor on terminal cases, although in some circumstances, terminal cases may actually take less of the students' time and correspondingly be regarded as good." They go on to say:

> Where the physician's work does not afford at least in some symbolic sense the possibility of saving a life or restoring health through skilled practice or losing him through ineptness, the physician himself lacks some of the essence of "physicianhood." This perspective, which we believe to be an important one in medical culture generally furnishes a basis for classifying and evaluating patients. Those patients who can be cured are better than those who cannot. Furthermore, those patients who are not sick in the first place are the worst of all.

An example of the extent to which the medical student

is eager to learn new knowledge about a disease is illustrated by Becker and his associates (1961:224) in which they observed a staff member and a group of medical students making rounds in the hospital. While they were at a patient's bed-side, the patient began vomiting blood and a few minutes later, died of a perforated ulcer. The observer, being new to the situation, expected the students would be very upset by this sudden death (which for some, was their first experience of death on the ward) and would resort to the focusing of attention on this tragic event. However, quite the opposite occured as Becker et al (1961:224) note:

> ...the students' first reaction, reinforced by the interpretations presented by the staff, was to inquire into who was to blame. It is clear that even though the staff member insists that no one is to blame in such a situation, he has raised the question of blame and responsibility for the death in a very frank way; even had the students not been aware of this possible response to the event before his speech, they must necessarily have been after it.

Crane (1975:81) writes in her research on internists, that on a questionnaire in which they were asked to note a number of professional considerations which would affect treatment of debilitated, chronically ill patients, "opportunity to learn, practice or teach new techniques was rated among the top three out of six items by 28 percent of the internists." Crane pointed out that the difference between the residents and the physicians was negligible.

When asked about the importance of professional values upon decision to treat infants with congenital anomalies, 39 percent of the pediatricians ranked "opportunity to learn, practice or teach new techniques among the top three out of six items."

These professional value judgments are not based solely on individual attitude differences between physicians, but are a part of the medical subculture's value system that the medical student finds pre-established...already made... and imposed more or less on him.

An illustration of the emphasis in medical school that is placed on learning new techniques is mentioned in the following excerpt by Crane (1975:81)

> Some members of the house staff claimed that there were fewer resuscitations at the end of the academic year (which runs from July 1 - June 30 than at the beginning, the performance of resuscitative procedures in order to practice new techniques was said to produce this result. In fact, a study of hospital records of all patients who died or were successfully resuscitated during one entire year showed that there were substantially fewer (35%) resuscitations in May and June than in the other ten months of the year (53%).

Therefore, the student entering the medical profession comes with certain attitudes and feelings toward patients that will be shaped, molded and continually processed until their attitudes comply with those of the medical profession itself. The medical profession's attitudes toward patients,

in particular, the dying patient, are functional to the reinforcement of the view of "the physician as healer" and are functional with respect to maintenance of order in the medical subculture.

The dying patient is a deviant in the medical subculture because death poses a threat to the image of the "physician as healer," and it also creates embarrassing and emotionally upsetting disruptions in the scientific objectivity of the medical social system. Hence, the disruption caused by death in the medical social system, if not controlled, could lead to a great deal of conflict. Parsons (1971:282-3) addresses himself to the notion of death as a disruptive influence when he states:

> The possibility is potentially so dangerous to the stability of a given institutional system that it may be presumed that one of the major functions of the mechanism of social control is to forestall the claim to legitimacy (for acts) which are alienative relative to the major institutionalized patterns of the social system.

Therefore, death is controlled in the medical social system due to its assumingly catastrophic potential in creating disorder.

In addition, there are three norms of the medical profession which contribute to the depersonalization of patients in general, and the dying patient in particular. The first of these, according to Munford (1970:158) is

to the problem of death. Instead of decreasing anxiety over death, the "Norm of the Open Mind" accelerates it.

A second norm of the medical profession according to Munford (1970:170) is the "Norm of Graduated Specification." This norm is becoming increasingly prevalent in today's medical and nursing schools. Along with the increased complexity in the field of medicine itself, there has been an increase in distance between the patient and the medical staff. This increased specialization creates a close-knit group through which the individual medical student is forced into acceptance of group values and norms, the more specialized the group is, the greater influence the group has on its individual members. Blau states (1956:55) "...for exclusion to be a threat that discourages deviant tendencies, the individual must first wish to be included in the group...." Hence, in a specialized field, the group is smaller, more cohesive and dependance is on the group for knowledge, acceptance and support. As Munford (1970:171) notes:

> The fact that interns and residents in the larger hospitals are more fully exposed to observations by their specialty peers but somewhat protected against observation from the outside, gives the specialty group the opportunity to reinforce its own expectations when they conflict with what others, for example--patients and their families expect.

the "Norm of the Open Mind." Strauss (1968:142) defines this norm as the acceptance of the fact "...that medicine is a science of uncertainty and an art of probability." Hence, that no diagnosis or prognosis is absolute. However, instead of accepting the uncertainty of medicine and therefore, accepting death as an uncertain, inevitable fact of life, the physician seeks instead to conquer death and once again, to reinforce the image of "physician as healer." Merton and Barber (1963: 108) note that "...this uncertainty is an area of stress, for in the nature of the patient's position of anxiety, possible pain and fear, he develops an insatiable desire for information of the kind that would be supplied by definite diagnosis and firm prognosis." Therefore, the members of the medical profession see death as a failure and a reminder of their own limited capabilities as Lifton (1975:35 and Olson note:

> Even in hospitals, death is embarrassing and has no place. The doctors and technicians are committed to using their science and equipment to keep people alive--at least to keep them breathing. Death becomes defeat and is not accepted as a human event that has its place in the seasons of life....As one prominent engineer said "we will lick the problem of aging completely so that accidents will be the only cause of death."

Therefore, even though in the medical profession there is the "Norm of the Open Mind," this norm gives even greater impetus to the search for absolutes and solutions

Hence, for the medical student, the primary legitimators of his "physicianhood" become his colleagues and the teaching staff. Munford (1970:175) notes "...he comes to feel like a physician more through identifying with his colleagues than through his relationships with his patients. He may become less subject to discomfort over the way a patient responds to him, but he is likely to stay relatively alert to approval from his colleagues."

Thus the "Norm of Graduates Specification" can be seen as a contributing factor to the depersonalization of the dying patient for it shifts the important role of legitimator from the patient to fellow colleagues and the teaching staff.

The third norm of the medical profession according to Munford (1970:163) is that of "Relay Learning." This norm basically emphasizes the exchange of new knowledge among physicians. This norm does not pertain directly to the topic at hand so further discussion is not needed.

In conclusion, we have attempted to illustrate through the combined use of structural-functionalism and the labeling perspective why the dying patient is considered a deviant in the medical social system and how the deviant label is imputed to him by medical student and physician alike. We have shown how the various norms, beliefs and values of the medical profession serve the manifest fucntion of reinforcing

the goals of the medical subculture and achieving the functional prerequisites of pattern maintenance, goal attainment, integration and adaptation that Parsons considers imperative to the survival of any social system.

The norms, beliefs and values of the medical profession are assimilated by the neophyte medical student through the process of medical socialization, in which he passes from layman to professional. The student is introduced to the medical subcultural value system in the first years of schooling and these values are further reinforced in the clinical years of school.

The medical subcultural value system serves the manifest function to maintaining order in the medical social system and insuring the survival of the system, as well as meeting the functional prerequisites previously mentioned. However, this same value system results in the latent function of depersonalizing the patient, in particular the dying patient.

Death is seen as a threat in the medical school system because if violates several well-established norms. On a societal level, it violates the traditional image of the "physician as healer" and is a reminder to the medical staff of their limited capabilities in combating it. However, we cannot place the sole responsibility for the depersonalization of the dying patient on the medical profession as

Cassell (1974:46) points out:

> ...we explain depersonalization by saying that it is the physician's psychological defense against the emotional burden imposed by the care of the dying. Though, this may be true, it is only part of the truth. The problem cannot solely lie among physicians, or the society would not let them get away with it. Social forces would drive doctors back towards a more holistic view of their patients.

Therefore, if we view the depersonalization of the dying patient in the functionalist perspective, the medical social system is merely reinforcing the cultural attitudes toward death. Hence, for changes to occur in the treatment of the dying patient, all segments of the social system must combine their efforts and strive to work toward a more humane approach to the dying patient as Mauksche (1975:45) notes:

> Our hospitals and our health professions have built super highways of medical technology in which the patient's diseases loom large and we focus the efficient specificity upon the disease process which we seek to cure. Patient care, however, writes its own script and the dying patient is but one extreme example of the time when the professional challenge demands that we abandon the comfortable road of predictable mileage and dare to venture into the narrow byways which adapt themselves to the individuality of the real world--in this case to specific needs and human processes of the patient who has entrusted himself to the care of people who could most effectively use themselves as the instruments of help and hope.

## The Dying Person as a Deviant in the Medical Social System

This research does not confirm the hypothesis that dying persons are avoided by medical students. However, the data do support the first hypothesis that dying persons elicit aversive attitudes from medical students. The sixth hypothesis, that medical students have a greater aversion toward the dying person than do physicians, was also confirmed. In the remaining pages, possible explanations for the medical students' attitudes toward the dying person will be discussed.

One possible explanation for the medical students' greater aversion toward the dying person may be caused by what Becker (1958:59) and his associates have termed the shift from idealism to cynicism. As we noted earlier, the freshman student, upon his entrance into medical school, experiences a rude awakening, for he finds that he must temporarily set aside his humanistic notions of "service to mankind" and assign as his top priority the passing of exams and "getting through school." Therefore, the student must postpone his eagerness to work with patients until the clinical years of schooling.

During the first two years of medical school, the student gradually begins to assimilate the entire medical subculture value system which includes, according to

Thorner (1955:537), "...the pattern variables of disinterest, affective neutrality, universalism, functional specificity, and achievement in meeting role-required responsibilities."

The emphasis throughout medical training is on the acquisition of technical, medical material and the development and perfection of technical skill. This increasing emphasis on the technical, medical aspects of a disease and away from the holistic approach toward the patient must certainly have a dehumanizing influence on the patient's treatment. As Bloom (1963:83) points out: "The very essentials of a scientific approach become the source of dehumanization, of the creation of an 'emotional callous'." Harper's comment is illustrative of this phenomen (1953: 125-6): "To be really scientific, it became necessary for the doctor to impose an instrument of some sort between himself and the patient. The patient was ignored in order to obtain a coned-down view of a single part."

A second possible explanation for the medical students' aversion toward the dying person may be that the student, interested in learning new knowledge about interesting cases and diseases and their cures, feels that he cannot learn anything from the dying patient. He may, in fact, have dismissed the dying person from his list of priorities since he does not view his skills as being of benefit any longer. Therefore, the student may spend time with patients

will recover due to his skills in diagnosis. Thorner agrees (1955:536) when she notes:

> ...when there is little or no possibility of full recovery as in the case of the aged, sick or incurable insane, and when consequently, the chief purpose of nursing and medicine is frustrated, the operation of the pattern variables may be twisted so as ot render the helpless patient the victim of callousness and aggressive impulses on the part of the doctors and nurses.

She goes on to say that "...this is permitted by the very role elements of impersonality and functional specificity which protect them in their performance of their therapeutic duties." The scientific objectivity and detached concern that were initiated to maintian order in the medical social system may indeed be dysfunctional for meeting the needs of the dying person.

A third possible explanation for the aversion elicited from medical students by dying persons may be that the student, having been trained in the technology of medicine and not in the holistic approach to the patient, may feel ill-equipped to deal with the dying patient's unique human needs and consequently, may seek to avoid the dying patient. Kastenbaum and Aisenberg (1972:xiii) note:

> ...we "out-group" the dying person, we shrink from the prospect of intimate contact with a dying person...a major reason for our avoidance is that we do not know what to do when we are with a dying person. Nobody has given us adequate instruction. We do not like to find ourselves in a situation--especially an important situation for which we lack...responses.

Crane (1975:187) agrees when she states that in her research, "The house staff were not prepared to deal with the psychiatric aspects of their cases...They often abandoned patients by rejecting both their emotional and physical care."

A fourth possible explanation for the medical students' aversion toward the dying patient may be that the dying patient is a flagrant reminder to the student and to the medical profession as a whole, of their limited capabilities in combating death. Death may be seen as a mark of failure.

> ...a physician will encounter two types of patients who are most discouraging. One is the patient who makes him sick (literally, not in any idiomatic sense of the word) from emotional antagonism or irritation. The other is the patient who aggravates the physician's own ailments by displaying the same symptoms or by confounding medical wisdom by refusing to get well. (Dunbar. 1947:42)

Consequently, any result less than complete recovery may be seen as a failure. Cassell (1975:42) points out that "The problem of depersonalization depends in part on the degree to which the dying person's disease is understood..." He goes on to say:

> If it is correct that the persons dying of a poorly misunderstood process are more likely to become depersonalized by their physicians, we can better understand why the accusation of depersonalization is most often brought against young physicians. To the inexperienced doctor, almost everything about the dying person is unfamiliar or poorly

> misunderstood. Thus requiring the abstraction that leads to depersonalization. Effective integration of the learned technique material with human needs, values and desires comes only at a later stage of learning.

Wheeler (1972) found that older physicians with more years of experience exhibited less aversive attitudes toward the dying person than their younger counter-parts. It may be that the older physician, having seen death in many situations, some in which it may actually have been a welcomed event, may come to view death in a much more acceptable light. The younger physician may not have the sensitivity of his older counter-part, when dealing with the dying patient. There was moderate evidence to support this assumption in our data.

## Implications for Future Research

The main objective of this research was to expand Wheeler's (1972) conceptualization of the dying person as deviant in the medical subculture by including the medical student, and to test the proposition that the dying person is a deviant from the medical student's perspective. A second objective was to determine whether there was a significant differenc between physicians and medical students in their attitudes toward the dying person and to provide explanations for any differences discovered. The results of this research show that dying persons do elicit aversive attitudes from medical students. However, the

hypothesis indicating the medical students' avoidance of the dying person was not supported, even though there was a strong probability that avoidance would occur. Therefore, in our opinion, there is a need for further research in the area of medical audiences' attitudes toward and treatment of the dying person.

A second area which needs further investigation is the expansion of the dying person concept as used here to include various types of dying person. Age should be an extremely important factor in addition to type of terminal disease and the patient's social status.

A third area for further investigation should deal with the sex of the medical audience and its attitudes toward the dying person. Due to the small number of female respondents, N=27, no valid generalizable conclusions could be drawn form our data.

A fourth area for further investigation should include the expanison of the present research to include a community hospital setting in addition to our data from a university hospital setting and making comparisons of differences in attitudes toward and treatment of the dying person in the two.

## Summary

Our findings demonstrate the viability of the conceptualization of the dying person as a deviant in the medical social system. A preponderance of evidence indicates that physicians and medical students possess aversive attitudes toward them. It would seem that a research model permitting adequate measurement of avoidance behavior would confirm or disconfirm whether or not dying persons are indeed deviants.

ABSTRACT

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ABSTRACT

This thesis was addressed to four problems. First, Wheeler's (1972) conceptualization of deviance based on the reactions of the actor's audiences was tested to include an additional medical audience, e.g., the medical student. Second, the proposition that the dying person elicits significantly greater aversion from medical students than physicians was tested. Third, the proposition that medical students avoid dying persons to a significantly greater degree than physicians was tested. Finally, some explanations for the medical students' higher aversion scores were suggested.

Employing a combination of a labeling perspective and

structural-functionalism for a theoretical framework, a conceptualization of deviance was constructed. In this research a deviant was defined as a person who elicits aversive attitudes of sufficient strength to motivate significant proportions of these audiences to practice avoidance behavior and to control him such that aversive attitudes are reduced to tolerable limits.

Eighty-one physicians and two-hundred and forty-five medical students completed questionnaires collecting demographic and attitudinal data. Two attitude scales, a semantic differential and a social distance scale were employed to measure the attitudes of physicians and medical students toward a dying person, alcoholic, tubercular person, atheist, emotionally disturbed person, and an executive. These data indicated that the physicians' and medical students' attitudes toward the dying person bore greater similarity to the deviant person concepts than to the executive. It was also found that the medical students exhibited significantly greater aversion toward the dying person than physicians. This phenomenon was explained as a function of the situational aspects of medical school training. The medical student is concerned with passing examinations, earning the approval of the teaching staff and mastering a tremendous amount of technical, medical material. It was suggested that the dying person may be a hindrance to these concerns for the dying person arouses anxiety, violates

expectations of conduct and appearance, possesses the power to inflict serious loss of status and is not subject to the usual means of control. Only modest evidence of avoidance behavior was discovered among the two samples. Medical students did not show a greater tendency of avoidance toward the dying person than did physicians. However, the findings suggest that more sophisticated methods of observation may reveal extensive avoidance of dying persons.

It was demonstrated that the conceptualization of deviance utilized in this research is useful for studying the social situation of the dying person. It also demonstrated the necessity for extensive research on the situational aspects of medical school training and its effects on the treatment of the dying person.

# APPENDIX

# APPENDIX

## MEDICAL SCHOOL FORM

### PART I

1-2. Age___. 3. Sex: (1) Male___ (2) Female___

4. Class: (1) 1st Year___. (2) 2nd Year___. (3) 3rd Year___. (4) 4th Year___. (5) Graduate___.

5. College: (1) School of Medicine___. (2) School of Nursing___. (3) Graduate School___.

6. Family income: (1) Less than $5,000___. (2) $5,000-$9,999___. (3) $10,000-$14,999___. (4) $15,000-$19,999___. (5) $20,000-$24,999___. (6) $25,000 or over___.

7. Number of years of schooling completed by father: (1) 6 years or less___. (2) 7-8 years___. (3) 9-11 years___. (4) 12 years___. (5) 13-14 years___. (6) Baccalaureate___. (7) Master's degree___. (8) Doctor's degree___.

8. Number of years of schooling completed by mother: (1) 6 years or less___. (2) 7-8 years___. (3) 9-11 years___. (4) 12 years___. (5) 13-14 years___. (6) Baccalaureate___. (7) Master's degree___. (8) Doctor's degree___.

9. Religion: (1) Baptist___. (2) Methodist___. (3) Presbyterian___. (4) Church of Christ___. (5) Pentecostal group___. (6) Episcopalian___. (7) Lutheran___. (8) Catholic___. (9) Other (Please specify)_____.

11. Home town (town in which you spent your most formative years): (1) in Mississippi___.
(2) in the South other than Mississippi___.
(3) in the Southwest___. (4) in the Northeast____.
(5) in the Midwest___. (6) in the Northwest___.
(7) in the West___. (8) Other (Please specify)_____
_____.

12. Size of hometown: (1) Less than 1,000___.
(2) 1,000-4,999___. (3) 5,000-9,999____.
(4) 10,000-19,000___. (5) 20,000-29,999___.
(6) 30,000-49,999___. (7) 50,000-99,999___.
(8) 100,000-500,000___. (9) Over 500,000___.

13. Marital Status: (1) Married___. (2) Single___.
(3) Divorced___. (4) Widowed___.

14. Area of specialization I anticipate entering._____
_____.

PART II

DIRECTIONS

On the following pages you are asked to describe a number of concepts and persons using a seven point scale. Since many of the descriptions do not logically apply to the concept or person being described, you need simply to indicate your first impression or immediate feeling.

THE VALIDITY OF THIS INSTRUMENT VARIES WITH THE AMOUNT OF TIME THE RESPONDENT TAKES TO COMPLETE IT. PLEASE DO NOT TAKE OVER 3 MINUTES TO COMPLETE THIS SECTION. WHEN YOU HAVE FINISHED JUDGING ONE CONCEPT CONTINUE IMMEDIATELY TO THE NEXT. DO NOT TURN BACK TO A CONCEPT YOU HAVE ALREADY JUDGED.

Here is how to use the scales:

Unpleasant Pleasant

| | | | Neutral or | | | |
|---|---|---|---|---|---|---|
| Very Much | Quite Closely | Slightly | Can't Decide | Slightly | Quite Closely | Very Much |
| ___: | _____: | _____: | _____: | _____: | _____: | ____: |

Place an "X" on the scale at the point between the colons in the space which appropriately describes the concept at the top of the page. For example, if you are rating the concept teacher and "Pleasant" slightly describes the concept teacher, then your rating would appear as below.

Unpleasant___:___:___:___:_x_:___:___Pleasant

On the other hand, if "unpleasant" slightly describes the concept teacher, then your rating would appear as shown below:

Unpleasant___:___:_x_:___:___:___:___Pleasant

PLEASE BE SURE TO CHECK ONE BLANK ON EACH OF THE 9 POLAR-ADJECTIVE SCALES FOR EVERY PERSON CONCEPT.

A PERSON WHO IS DYING
FROM AN IRREVERSIBLE CONDITION

| | | |
|---|---|---|
| Happy | ___:___:___:___:___:___:___ | Sad |
| Soft | ___:___:___:___:___:___:___ | Hard |
| Sharp | ___:___:___:___:___:___:___ | Dull |
| Distasteful | ___:___:___:___:___:___:___ | Tasty |
| Large | ___:___:___:___:___:___:___ | Small |
| Cold | ___:___:___:___:___:___:___ | Hot |
| Pleasant | ___:___:___:___:___:___:___ | Unpleasant |
| Rugged | ___:___:___:___:___:___:___ | Delicate |
| Slow | ___:___:___:___:___:___:___ | Fast |

AN ALCOHOLIC

| | | |
|---|---|---|
| Happy | ___:___:___:___:___:___:___ | Sad |
| Soft | ___:___:___:___:___:___:___ | Hard |
| Sharp | ___:___:___:___:___:___:___ | Dull |
| Distasteful | ___:___:___:___:___:___:___ | Tasty |
| Large | ___:___:___:___:___:___:___ | Small |
| Cold | ___:___:___:___:___:___:___ | Hot |
| Pleasant | ___:___:___:___:___:___:___ | Unpleasant |
| Rugged | ___:___:___:___:___:___:___ | Delicate |
| Slow | ___:___:___:___:___:___:___ | Fast |

A PERSON WHO HAS TUBERCULOSIS

| | | |
|---|---|---|
| Happy | ___:___:___:___:___:___:___ | Sad |
| Soft | ___:___:___:___:___:___:___ | Hard |
| Sharp | ___:___:___:___:___:___:___ | Dull |
| Distasteful | ___:___:___:___:___:___:___ | Tasty |
| Large | ___:___:___:___:___:___:___ | Small |
| Cold | ___:___:___:___:___:___:___ | Hot |
| Pleasant | ___:___:___:___:___:___:___ | Unpleasant |
| Rugged | ___:___:___:___:___:___:___ | Delicate |
| Slow | ___:___:___:___:___:___:___ | Fast |

AN ATHEIST

| | | |
|---|---|---|
| Happy | ___:___:___:___:___:___:___ | Sad |
| Soft | ___:___:___:___:___:___:___ | Hard |
| Sharp | ___:___:___:___:___:___:___ | Dull |
| Distasteful | ___:___:___:___:___:___:___ | Tasty |
| Large | ___:___:___:___:___:___:___ | Small |
| Cold | ___:___:___:___:___:___:___ | Hot |
| Pleasant | ___:___:___:___:___:___:___ | Unpleasant |
| Rugged | ___:___:___:___:___:___:___ | Delicate |
| Slow | ___:___:___:___:___:___:___ | Fast |

AN EMOTIONALLY DISTURBED PERSON

| | | |
|---|---|---|
| Happy | ___:___:___:___:___:___:___ | Sad |
| Soft | ___:___:___:___:___:___:___ | Hard |
| Sharp | ___:___:___:___:___:___:___ | Dull |
| Distasteful | ___:___:___:___:___:___:___ | Tasty |
| Large | ___:___:___:___:___:___:___ | Small |
| Cold | ___:___:___:___:___:___:___ | Hot |
| Pleasant | ___:___:___:___:___:___:___ | Unpleasant |
| Rugged | ___:___:___:___:___:___:___ | Delicate |
| Slow | ___:___:___:___:___:___:___ | Fast |

AN EXECUTIVE

| | | |
|---|---|---|
| Happy | ___:___:___:___:___:___:___ | Sad |
| Soft | ___:___:___:___:___:___:___ | Hard |
| Sharp | ___:___:___:___:___:___:___ | Dull |
| Distasteful | ___:___:___:___:___:___:___ | Tasty |
| Large | ___:___:___:___:___:___:___ | Small |
| Cold | ___:___:___:___:___:___:___ | Hot |
| Pleasant | ___:___:___:___:___:___:___ | Unpleasant |
| Rugged | ___:___:___:___:___:___:___ | Delicate |
| Slow | ___:___:___:___:___:___:___ | Fast |

PART III

DIRECTIONS

This instrument is designed to measure your reactions to certain types of people. In the left hand column there is a list of different types of people. To the right of each type named there are seven blanks in which to place check marks. Each blank space represents a statement describing a reaction to the type of person in the left hand column. You are being asked to check the statement that best describes your reaction to the person named in the left hand column.

EXAMPLE: Teacher 1___: 2___: 3___: 4___: 5___: 6___: 7___:

If you responded in the above manner, you would be saying that you would feel comfortable sharing sleeping quarters with a teacher.

Remember to give your <u>first</u> <u>feeling</u> <u>reactions</u> in every case.

Give your reactions to each type as a group. Do not give your reactions to the best or to the worst members that you may have known, but think of the picture of stereotype that you have of the whole group.

1. Would feel comfortable sharing sleeping quarters.
2. Would feel comfortable having as a weekend guest in my house.
3. Would feel comfortable working beside everyday.
4. Would feel comfortable having as a neighbor on my street.
5. Would feel comfortable attending weekly civic club meetings with.
6. Would limit personal contact.
7. Would avoid personal contact.

1. A person who is dying from an irreversible condition. 1___: 2___: 3___: 4___: 5___: 6___: 7___:
2. An alcoholic 1___: 2___: 3___: 4___: 5___: 6___: 7___:
3. A person who has tuberculosis 1___: 2___: 3___: 4___: 5___: 6___: 7___:
4. An atheist 1___: 2___: 3___: 4___: 5___: 6___: 7___:
5. An emotionally disturbed person 1___: 2___: 3___: 4___: 5___: 6___: 7___:
6. An executive 1___: 2___: 3___: 4___: 5___: 6___: 7___:

PART IV

Twelve statements concerning your feelings and reactions toward dying persons and death follow. There are five blanks below each statement for you to indicate your level of agreement with the statement. Please check the blank that best describes your own opinion.

1. When one of my patients dies, I nearly always wonder if something could have been done to save him.

   Strongle agree___. Agree___. Neutral___. Disagree___. Strongly disagree___.

2. Treating dying patients is nearly always a rewarding experience.

   Strongly agree___. Agree___. Neutral___. Disagree___. Strongly disagree___.

3. I probably spend less time with patients when I know their dying course is irreversible than when I do not know.

   Strongly agree___. Agree___. Neutral___. Disagree___. Strongly disagree___.

4. I think doctors refer dying patients primarily to avoid them more often that they do nonterminal patients.

   Strongly agree___. Agree___. Neutral___. Disagree___. Strongly disagree___.

5. I feel as comfortable with dying patients as I do with any other patient.

   Strongly agree___. Agree___. Neutral___. Disagree___. Strongly disagree___.

6. I do not think about death very much.

   Strongly agree___. Agree___. Neutral___. Disagree___. Strongly disagree___.

7. Treating dying patients is one of the most unpleasant aspects of my profession.

   Strongly agree___. Agree___. Neutral___. Disagree___. Strongly disagree___.

8. Whenever possible, I avoid people who are dying from an irreversible condition.

   Strongly agree___. Agree___. Neutral___. Disagree___. Strongly disagree___.

9. I try to avoid telling patients directly that they are dying.

   Strongly agree___. Agree___. Neutral___. Disagree___. Strongly disagree___.

10. Families of dying patients seldom cause me any more trouble than do families of other patients.

    Strongly agree___. Agree___. Neutral___. Disagree___. Strongly disagree___.

11. Having a patient die when there was nothing to do to save him does not depress me very much.

    Strongly agree___. Agree___. Neutral___. Disagree___. Strongly disagree___.

12. Telling a person he is going to die is not particularly difficult for me.

    Strongly agree___. Agree___. Neutral___. Disagree___. Strongly disagree___.

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