The Profession of Medicine and the Public: Examining Americans' Changing Confidence in Physician Authority from the Beginning of the 'Health Care Crisis' to the Era of Health Care Reform*

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Recent work on the sociology of the professions, in general, and on the profession of medicine, in particular, target dramatic changes in the organization of social institutions, "boundary work" among professionals, and the implications of both for professional power. However, public attitudes cited in theories as a critical linchpin of professional status remain relatively unexplored in the face of these changes and widespread contentions of public dissatisfaction. Using data from the 1976 National Survey of Access to Care (Aday, Andersen, and Fleming 1980) and the 1998 General Social Survey (Davis, Smith, and Mardsen 1998), we take advantage of a unique opportunity to compare the public's attitudes across a 20-year period. We examine individuals' evaluations of the way physicians do their work and their ability to confront health problems. Three findings support a complex view of public sentiments. First, while public confidence in physicians remains relatively high, we document a crystallization of attitudes reflecting greater negative and fewer positive sentiments. Second, while neither the structure of attitudes nor the role of sociodemographic characteristics in explaining attitudes has significantly shifted over time, in 1998 health status and insurance status are correlated with negative attitudes. Third, using General Social Survey time trend data on the confidence in medicine compared to other professions (science and education), we find support for a general public response to social institutions, with confidence in medicine tracking closely with confidence in science in level, and education in pattern. We end with four possible explanations of our findings, including and a general discussion of the role of the public in the professional status of physicians and its implications for social change in the institution of medicine.

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Amid claims of "collapse," social scientists have questioned the role of major social institutions in providing solutions to society's problems or to individuals' dilemmas (Pescosolido and Rubin 2000). However, whether the public lost its faith in religion, science, or the clergy's ability to provide remedies has taken a secondary role in intellectual debates on how professionals circumscribe their niches (e.g., Abbott 1988; Gieryn 1983; Halpern 1992; Light 1993) or how they face major organizational restructuring (Light 2000). Rather, claims of the erosion of public support are often asserted (see Rothman 1984 on the legal profession). There is little question, for example, that medicine in America has undergone dramatic shifts, moving, for example, from a office-based, fee-for-service system to an increasingly group or organization-based managed care system (Pescosolido and Boyer 2001). Medicine also faces a changed relationship with the state, the insurance sector, and the allied health professions (McKinlay and Marceau 1998).

Alongside these changes and amidst these general claims of public disenchantment, socio-medical researchers have suggested that the "public's view of doctoring" has shifted considerably, moving from the "unquestioning acceptance of physician authority" embedded and reflected in Parsons' (1951) early theory of professions to a more "consumerist" stance accompanied by a questioning and bargaining approach to medicine, physicians, and the medical encounter (Lavin et al. 1987). Citing media, legal judgments, and their cross-sectional studies of the public's willingness to challenge the way doctors do their work as prima facie evidence of the changing professional-client relationship, Lavin et al. (1987) contend that the once powerful position of medicine has declined. More importantly, these authors look to the effect of age on attitudes as a harbinger of change. Younger individuals, they report, are more negative toward the authority of physicians (Haug and Lavin 1983). These attitudes, as well as consumer behavior, are central to the doctor-patient relationship, and ultimately to professional power.

Even with the work cited here, we contend, along with Halpern and Anspach (1993:286), that there is an empirical gap. In the face of claims that professional dominance is unraveling, what is missing are historically comparable, data-based analyses that substantiate claims of changing levels of public disaffection sufficient to erode the profession's powerful position. Our purpose in this paper is to provide an empirical examination to fill one small part of that gap. Simply stated, we ask whether there has indeed been a serious erosion of the public's faith in medicine and its practitioners. We target Freidson's (1970) notion of "authority," that is, public beliefs about *how* physicians do their work, rather than "expertise," or the public's beliefs about the efficacy of modern medicine.[1] Data from two national surveys, both collected in face-to-face interviews by the same survey organization (NORC), provide information to contrast public opinion soon after the period claimed to be the beginning of the "health care crisis" with more recent data collected in the era of health care reform. Using the same questions in 1976 (Aday, Andersen, and Fleming 1980) and 1998 (Davis, Smith, and Marsden 1998), we (1) compare levels of public confidence in the way that physicians do their work, (2) examine similarities and differences in the underlying structure of public attitudes, and (3) provide multivariate analyses of the characteristics of Americans who are more or less confident in physicians. Further, using time-series data from the General Social Survey, we place these findings in a larger context, exploring the public's confidence in medicine over time and in comparison to other social institutions.

We proceed in four steps. First, we review theories of the rise of the profession of medicine, tracing the role of the public in these theories. Second, we lay out turning points in sociological concern and research on the profession of medicine, contrasting widespread claims about public disaffection with the lack of high quality data. Third, we analyze cross-sectional data on the level (i.e., the percent of Americans challenging physician authority), the underlying structure (i.e., the weight given to dimensions of physician authority by the

General Social Survey, the Pressing Issues in Health and Medical Care Module team of the 1998 General Social Survey, and the *Journal of Health and Social Behavior* reviewers for their comments and assistance. Institutional Review Board approval for the entire 1998 GSS was given by the Division of Social Sciences, University of Chicago. Address all correspondence to Bernice A. Pescosolido, Department of Sociology, Indiana University, 744 Ballantine Hall, Bloomington, IN 47405.

public), and the correlates of attitudes toward physicians, targeting public confidence in physician authority. We also examine trend data from 1973 to 1998 on the public's confidence in medicine as a social institution. Finally, we discuss the findings of these analyses in light of current debates about the status of medicine and larger sociological discussions of the current fate of social institutions.

THE POWER OF PHYSICIANS, THE PUBLIC, AND THE CHANGING LANDSCAPE OF SOCIAL INSTITUTIONS: SOCIOLOGICAL CONCERNS AND THEORETICAL EXPLANATIONS

A rigorous body of sociological and historical research presents a clear and consistent picture of medicine's fortunes in America over the last hundred years. Over the course of the early 20th century, the power and reach of the modern physician grew dramatically. From the mid-1800s to the early 1900s, the patchwork of itinerant healers, homeopathists, chiropractors, "granny midwives," and apprentice-trained "physicians" were replaced by a core of scientifically trained men (and few women) who were well prepared to take the newly established state licensing exams after their four years at the recently established science-based medical schools (Brown 1979; Freidson 1970; Starr 1982). The scientific medical profession became a successful, if not total, monopoly with internal self-regulation and control over the medical division of labor (Berlant 1975; Larson 1977; Starr 1982). Guided by an increasingly powerful American Medical Association, large infusions of wealth indirectly were poured into the emerging system of modern medicine through the newly established philanthropic foundations of industrial capitalists building medical schools and hospitals. In the United States, unlike many European nations, the government, whether federal or state, played a minimal role in the design of the American health care system, avoiding either organizing a strong public system of health care or providing insurance to its citizens (Berlant 1975).

The period from 1910 through 1970, then, represented an era of great growth, success, and power for the medical profession. The U.S. health care system, aided after World War II by federal support for research and development as well as infrastructure, became one of the most prominent in the world. It was the "Golden Age of Doctoring" (McKinlay and Marceau 1998), the "Era of Professional Dominance" (Pescosolido and Boyer 2001). Physicians in a primarily private health care system determined both the nature of medical care and the arrangements under which it was provided. Physicians set prices, worked out of solo-practices, and joined the American Medical Association. For the most part, patients could choose whom they wanted to visit for their problems and, starting in the 1940s, they purchased private health insurance to do so.

In sum, the now well-established institutional sociological theories, developed primarily in the 1970s and early 1980s, rejected the "manifest destiny" explanations of the rise of the medical profession seen in medical histories and earlier functionalist theories (Parsons 1951). Instead, they emphasized the role of social structures, powerful groups, and the larger socio-cultural environment. These theories of the rise of the modern profession of medicine were quick to point out the importance of the role of politics and economics in what was an intentional "professional project" (Larson 1977), rather than an inevitable ascendance due to modern medicine's greater demonstrated efficacy (McKinlay and McKinlay 1977). They did not, however, ignore the role of the public. In particular, Freidson (1970) separated two important phenomena: the establishment of "professional dominance" and the securing of "consulting status." The former, he argued, was a political phenomenon hinging on the granting of near or quasi-monopoly by the state. The latter, in contrast, was a social phenomenon cementing professional status by securing the public's willingness to support and use services. That is, even with a granted monopoly, public acceptance of the ideas and services of medicine constituted an important linchpin in gaining professional power and status. State supported monopoly was seen as a necessary but insufficient condition for the establishment of a profession. The ability of the profession to convince the public of the value of its services and the trustworthiness of its practitioners was essential. Without it, as was demonstrated by two earlier but unsuccessful attempts to establish dominance through state licensing, the professional status of medicine could not be

achieved. In these attempts, the ideological climate—marked by doctrines of the free market, laissez-faire politics, as well as a "spirit of 'medical nihilism'" (Larson 1977) and embraced by the public—resulted in the repeal of political efforts to support only one form of medical care (Berlant 1975; Brown 1979, Starr 1982).

Given this solid body of rigorous, historically grounded research on the rise of the professions, with medicine as a—if not "the"—classic case, sociologists turned their attention to three issues. First, the maintenance of professional status became the central focus among sociologists. With modern professions established, sociologists began to ask how professionals recognize and come to deal with "encroachment," that is, challenges to their ideologies, resources and power, more likely at their boundaries rather than their core (e.g., see Abbott (1988) on the "system" of professions; Gieryn (1983) on "boundary maintenance;" Light (2000) on "countervailing powers;" see also Halpern and Anspach (1993) on these trends). This turn toward the battles between professionals and potential competitors produced important sociological contributions but had the unintended effect of ignoring public attitudes. Second, those sociologists interested in the public's use of the scientific-medical system focused squarely on the public's access to services and to important issues of differential treatment within the medical system (Pescosolido and Kronenfeld 1995). The focus on the public's stance regarding medicine, then, found a new focus in reference to individuals' willingness to use health care services, and in their experiences in care (Halpern and Anspach 1993). Third, at the same time, sociological research began to appear that questioned the dominance of medicine in both the larger social landscape and in the public mind. We turn to these latter studies below.

THE END OF THE "GOLDEN AGE" AND SOCIOLOGICAL THEORIES OF PROFESSIONAL DECLINE

The last decades of the 20th century confronted sociologists with the "End of Medicine" debate (Imber 1991). Ironically, the publication of sociological works that established the well-regarded institutional theories of professional dominance described above also produced debates over whether medicine has sustained its power or lost ground. Mounting concerns of a "health care crisis" in the United States were reflected in an increasing list of contentions and critiques: the rising numbers of uninsured Americans; spiraling health care costs and the revolt of employers as "payers;" increasing limitations on reimbursement for medical services; the "two-tier" medical system exacerbated by the introduction of Medicaid and Medicare; the lack of quality services available to the working poor; the "corporatization" of medicine; the "return" of alternative medicine; the growth of self-help, feminist, and environmental movements; and the mismatch between the "germ theory" and the increasing burden of chronic illness (Halpern and Anspach 1993; Light 1998; McKinlay and Stoeckle 1988; Starr 1982). With the election of Bill Clinton, who had made health care reform a centerpiece of his political platform in 1990, the public's concerns with the health care system seemed to offer a formidable challenge. Scholarly debates, fueled by health care reform and the introduction of managed care, sparked sociological discussion of whether medicine was being "deprofessionalized," "proletarianized," or "corporatized" (see Wolinsky 1993 for a comprehensive review).

Notably, these commentaries clearly did not exclude the public's view. Most prominently, the work of Haug and Lavin suggested that increasing medical knowledge in the public had combined with a greater skepticism to affect the professional power of medicine (e.g., Haug 1973, 1988; Haug and Lavin 1983; Lavin et al. 1987). More recently, Imber (1991) contrasted the 1950s, when the "authority of medicine was secure," with conditions in the 1980s, where "the autonomy of physicians to practice medicine as they saw fit" (p. 298) was at stake. The "popular perception," he claims, is a view of physicians as "uncaring, uncommunicative, self-interested and ambitious" (1991:300).

This work raises four research questions that form our central foci. First, have there been significant changes in the level of public confidence regarding the manner in which physicians work? That is, has the percentage of Americans who question the information provided, risks taken, and concern exhibited by physicians increased, decreased, or stayed the same from 1976 to 1998? Questions such as

these tap the kinds of items that Freidson (1970) noted as central to the "consulting status" of medicine and to physician authority, and these items reflect the recent debates concerning the erosion of professional power summarized above. Second, has the underlying structure of public attitudes toward physician authority changed over the last few decades? That is, if we consider the *set* of items together, does the public's response to physician authority display the same underlying structure in 1976 and 1998? Third, which Americans report more confidence in the profession of medicine? Social and behavioral science researchers have consistently pointed to the importance of social characteristics associated with different experiences, relative power, and resources in the medical encounter (e.g., gender, race, education, age, income, marital status, and residence) as affecting whether individuals use services, how they are treated in the medical encounter, and how they fare as a result (Bell 2000; Szasz and Hollender 1956). Further, with the emphasis on the growing number of uninsured Americans, particularly for those who may have poorer health status, we consider the influence of both insurance and health status. Fourth, how do trend data placing these results in larger social context that tracks the public's confidence in medicine as a social institution inform the cross-sectional analyses? While the detailed analyses are limited by existing data at only two points in time, existing time series data on the institutions which house other major professions (science and education) allow us to examine whether larger sociological debates suggesting that the public's response to any social institution merely reflect a larger secular decline in institutions (Gieryn 2000).

DATA AND METHODS

Data for these analyses are taken from the Access to Medical Care in the United States: 1975–76 (AMCUS) Survey and the Pressing Issues in Health and Medical Care Module (PIHMC) of the 1998 General Social Survey (GSS). The AMCUS, conducted in late 1975 and early 1976 by the Center for Health Administration Studies (CHAS) and the National Opinion Research Center (NORC) of the University of Chicago, was the fifth in a series of national household surveys of health care utilization and expenditures. The PIHMC-GSS was conducted for the National Data Program for the Social Sciences. The 1998 GSS is the 20th in a series of national face-to-face interview surveys beginning in 1973, and it represents the longest standing, on-going cross-sectional survey of American public opinion.[2]

The 1975–76 AMCUS-CHAS utilized a self-weighting area probability sample design and reports data on 3,870 respondents.[3] The response rate for the 1975–76 interview was 85 percent. The 1998 GSS utilized a three-stage full probability sampling design and reports data on 2,832 respondents collected in two independent samples. The analyses reported here are based on the responses of one sample of approximately 1,400 respondents who were administered the 73-item PIHMC module. The response rate for the 1998 GSS was 76.4 percent. Both samples are representative of the adult (i.e., 18 years old and above), non-institutionalized population of the contiguous United States (for a complete discussion of sampling and methodologies see Davis, Smith, and Mardsen 1998, and Aday, Andersen, and Fleming 1980).

While these data present a unique opportunity to compare public attitudes, they are not without limitations. For example, the choice of 1976 as the baseline is not ideal since the pronouncement of a "crisis" in health care came in 1970. As such, 1970 data may represent the peak of consumer confidence. Further, while there have been other national surveys of public attitudes toward the medical profession, none have attended to issues that permit a comparability of items that allow for a rigorous analysis of change in public sentiments across time.

Measures: Attitudes Toward Physicians

The 1975–76 AMCUS-CHAS survey included 43 items tapping respondent's general evaluations of the health care system. Respondents were asked to "think about the medical care they are now receiving," and for each statement to indicate whether they agreed, disagreed, or were uncertain about that item. Fifteen of these items asked for specific assessments of how respondents perceived the quality of care provided by physicians. Eight of these items, tapping public confidence in

how physicians do their work, were included in the PIHMC-GSS module.[4] These are: (1) "doctors always do their best to keep the patient from worrying;" (2) "doctors always treat their patients with respect;" (3) "doctors cause people to worry a lot because they don't explain medical problems to patients;" (4) "doctors never recommend surgery unless there is no other way to solve a problem;" (5) "doctors aren't as thorough as they should be;" (6) "sometimes doctors take unnecessary risks in treating their patients;" (7) "doctors are very careful to check everything when examining their patients;" and (8) "the medical problems I've had in the past are ignored when I seek care for a new medical problem." Responses of "strongly agree," "agree," "disagree," and "strongly disagree" were originally coded 1, 2, 4, and 5, respectively. Respondents indicating that they were uncertain about a statement were coded 3 on that item. For our descriptive analyses, responses were collapsed into three categories: "agree," "disagree," and "uncertain." Early analyses indicated that respondents in the residual "don't know" category were not comparable to respondents who answered the questions and were, as a result, dropped from the analyses. The original five-level, non-recoded response categories were used in a series of factor analyses to construct multi-item summative scales for the multivariate analyses.

Measures: Confidence in Modern Institutions

Extending back to 1973, the GSS has collected data on public confidence in 13 major American social institutions and societal sectors (e.g., organized religion, business and financial enterprises, organized labor, elected federal officials and Supreme Court judges, medical and scientific institutions, print and electronic media, etc.) In each year respondents were asked, "as far as the people running these institutions are concerned, would you say you have a great deal of confidence, only some confidence, or hardly any confidence at all in them?" For the purposes of the current analyses, we track levels of expressed public confidence in three major modern social institutions-professions: education, medicine, and science. For each institution-profession, a response of "a great deal of confidence" was originally coded 1, "only some confidence" was coded 2, and "hardly any confidence at all" was coded 3. For our analyses, we focus on the percentage of respondents reporting "hardly any" confidence in these selected institutions for each year.

Measures: Socio-demographic Variables

Our multivariate analyses focus on seven socio-demographic attributes suggested by previous research to tap differential experiences within the medical care system. Our basis for choosing these variables also lies in a joint consideration of availability in the GSS and AMCUS data and recent research on the "illness experience," with its foci on "racial/ethnic, gender identities, and locations in the social structure" that "have shaped illness experiences" (Bell 2000:188). These include: *age* (measured in years); gender (1 = women, 0 = men), *race* (1 = whites, 0 = blacks and others); *family income* measured in actual dollars in 1976 and in 1998 by a 21-category ordinal metric ranging from 1 (under $1,000 per year) to 21 ($75,000 and over per year); *education, measured* on a 8-category ordinal metric ranging from 1 (none) to 8 (16 years or more) in 1976 and in actual years of schooling completed in 1998; *marital status,* coded in a series of binary variables indicating if the respondent was married, divorced-separated, widowed, or never married; and *place of residence,* coded in a series of binary variables indicating if the respondent resided in an urban, suburban, or rural place.[5]

Measures: Health-Related Variables

The two final independent variables examined in these analyses are self-reported global *health status* and *health insurance status.* In both data sets these variables are measured by single items. Response categories for the self-report of health status item are "poor," coded 1; "fair," coded 2; "good," coded 3; and "excellent," coded 4. Insurance status is measured with a dummy variable coded 0 if the respondent indicated he or she was personally responsible for medical expenses, and 1 if the respondent indicated she/he had some form of private or public medical insurance.

Analysis

The research problem outlined above suggests a four-step logic of analysis. First, we evaluate whether public assessments of the way physicians do their work and their ability to confront medical problems are more positive, more negative, or unchanged between 1976 and 1998. Second, using a principal components factor analysis with a varimax rotation to a terminal solution we examine similarities and differences in the underlying structure of Americans' attitudes toward physicians. Third, using a series of multivariate models we examine whether socio-demographic attributes of respondents, general health status, and access to health insurance are predictive of positive and negative evaluations of physicians. Finally, we graphically compare time series data on the level of public confidence in three modern social institutions (i.e., education, medicine, and science) between 1973 and 1998.

RESULTS

Attitudes Toward Physicians in 1976 and 1998

Data relative to the first aim—determining whether public assessments of the way physicians do their work and their ability to confront medical problems are more positive, more negative, or unchanged between 1976 and 1998—are displayed in Table 1. In this table we report the percentage of respondents who agree, disagree, or are uncertain with respect to eight positive and negative statements assessing care provided by physicians.

Turning first to the 1976 data, respondents are particularly positive in their assessments of the amount of respect physicians show patients and whether physicians do their best to reduce patient worry. In both cases, more than 6 of 10 (67%) respondents agreed that physicians treat patients with respect and also do their best to reduce patient worry (60.4%). Similarly, nearly 7 of 10 (69.7%) respondents disagree with the statement that their previous medical problems are ignored when they seek care for new medical problems. Public opinion is less positive, however, on the remaining five items. For example, roughly equivalent numbers of respondents agree (38.9%) and disagree (39.1%) with the notions that physicians are as thorough as they should be; that physicians cause patients to worry by not explaining problems (39.9% vs. 39.5%); and that physicians are careful to check everything when examining patients (37.2% vs. 36.9%). Curiously, in

TABLE 1. Attitudes Towards Physicians: Item Distributions (%), 1976 Access to Medical Care in the U.S. (AMCUS, n = 3,775), and 1988 General Social Survey (GSS, n = 1,387).

	1976 AMCUS			1998 GSS			Change 1976–1998		
Attitudes Toward Physicians.	A	D	U	A	D	U	A	D	U
1. Doctors aren't as thorough as they should be.	38.9	39.1	21.9	51.3	33.7	14.0	+12.4****	–5.4*	–7.9***
2. Sometimes doctors take unnecessary risks in treating patients.	21.6	35.9	42.5	34.5	40.4	25.1	+12.9***	+4.5**	–17.4***
3. Doctors cause people to worry a lot because they don't explain medical problems.	39.9	39.5	20.6	41.0	42.9	16.1	+1.1	+3.4*	–4.5**
4. The medical problems that I've had in the past are ignored when I seek care for a new problem.	12.9	69.7	17.5	18.1	67.0	14.9	+5.2***	–2.7*	–2.6*
5. Doctors always do their best to keep their patients from worrying.	60.4	15.9	23.7	52.0	28.1	20.0	–10.4**	+12.2***	–3.7*
6. Doctors are very careful to check everything when examining their patients.	37.2	36.9	25.9	34.2	45.1	20.7	–3.0*	+8.2** *	–5.2**
7. Doctors always treat their patients with respect.	67.0	17.0	16.0	51.4	34.4	14.2	–15.6***	+17.4**	–1.8
8. Doctors never recommend surgery unless there is no other way to solve the problem.	41.3	22.8	35.9	44.2	35.9	20.0	+2.9*	+13.1***	–15.9***

Note: A = strongly agree & agree combined; D = strongly disagree & disagree combined; U = uncertain
*** significant change P < .001; ** significant change P < .010; * significant change P < .050

this earlier period, large numbers of respondents say they are uncertain whether physicians occasionally take unnecessary risks (42.5%) or never recommend surgery unless there is no other way to solve the problem (35.9%). Indeed, across all eight items, on average, approximately 1 in 4 respondents indicated that they were uncertain in their evaluations of the quality of care provided by physicians.

A somewhat different pattern of responses emerges when we turn our attention to the 1998 data. To begin, it is clear that 1998 attitudes toward physicians are significantly more negative when compared to earlier 1976 levels. In all but one case, the proportion of respondents who disagree with the positive statements and agree with the negative statements is increased over 1976 levels. These shifts are particularly evident in the percentage of respondents who agree that physicians aren't as thorough as they should be (51.3% in 1998 vs. 38.9% in 1976) or that physicians always treat their patients with respect (51.4% in 1998 vs. 67% in 1976; note also the over-time magnitude of change reported in Table 1). Only in the case of whether physicians never recommend surgery unless there is no other solution does public sentiment become nominally, but insignificantly, more positive across the 22 year interval (44.2% agree in 1998 vs. 41.3 in 1976). However, the percentage of respondents who disagree with this statement is also substantially higher in 1998. Finally, public opinion in 1998 appears to have become more crystallized, as evidenced in an "across the board" reduction in the proportion of respondents providing an "uncertain" response to the eight items. Indeed, one possible explanation for the apparent increase in negative evaluations of physicians may be the result of a shift in the number of Americans who were "uncertain" respondents in 1976, moving into the negative response categories in 1998.

To examine whether the structure of public attitudes toward physicians has changed over time, we conducted exploratory factor analyses within each time period to determine whether the eight items in Table 1 tap any underlying factor or factors. Results of these analyses are reported in Table 2. Examination of these data reveals three important findings. First, the eight items summarize two distinct dimensions of attitudes toward physicians. The initial dimension is comprised of four items expressing negative assessments of physician functioning (i.e., doctors aren't thorough; doctors take risks; doctors cause worry; and previous problems are ignored). Second, the factor structure underlying seven of the eight total items is essentially the same in both 1976 and 1998. Also consistent across the study interval are three items in a second dimension that appear to tap a set of positive attitudes toward

TABLE 2. Principal Components Factor Analysis of Attitudes Toward Physicians and Scale Statistics, 1976 Access to Medical Care, U.S. and 1998 General Social Survey

	1976 AMCUS		1998 GSS	
Attitudes Toward Physicians:	Factor 1	Factor 2	Factor 1	Factor 2
1. Doctors aren't as thorough as they should be.	.730	–.182	.618	.334
2. Sometimes doctors take unnecessary risks in treating patients.	.642	–.106	.641	.179
3. Doctors cause people to worry a lot because they don't explain medical problems.	.669	–.269	.672	:198
4. The medical problems that I've had in the past are ignored when I seek care for a new problem.	.655	–.078	.763	–.007
5. Doctors always do their best to keep their patients from worrying.	–.170	.731	.326	.669
6. Doctors are very careful to check everything when examining their patients.	–.415	.642	.216	.797
7. Doctors always treat their patients with respect.	–.166	.752	.076	.822
8. Doctors never recommend surgery unless there is no other way to solve the problem.[a]	–.051	.714	.512	.268
Eigenvalue	3.071	1.104	3.174	1.085
Pecent of Variance	38.4	13.8	39.7	13.6
Scale Mean	1.130	1.649	1.438	1.373
Standard Deviation	1.156	1.091	1.114	1.115
Chronbach's Alpha	.651	.700	.701	.718

[a] item not used in scale construction

physicians (i.e., doctors do their best; doctors check everything; and doctors treat patients with respect). The eigenvalues suggest that the two dimensions are meaningful (both over 1). Third, one statement (doctors never recommend surgery) loads on the positive dimension in 1976, but this item loads on the negative dimension in 1998.[6]

To examine over-time public confidence in medicine, we created two summated scales, a four- item measure of negative attitudes and a three-item measure of positive attitudes. In both scales, responses indicating agreement with the statement were coded 1, and responses indicating disagreement or uncertainty were coded 0. Thus, the scale of negative attitudes ranges from 0 to 4, with higher scores indicating more negative attitudes. Similarly, the measure of positive attitudes ranges from 0 to 3, with higher scores indicating more positive attitudes. Summary statistics for the resulting scales are displayed at the bottom of Table 2. With Cronbach's alpha of .651 and .718, respectively, the measures of negative and positive attitudes demonstrate acceptable internal consistency. More relevant to our substantive concerns, examination of the scale data indicate that, compared to 1976 levels, respondents in 1998 agree with fewer positive statements and more negative statements about how physicians do their work and their ability to confront medical problems.

Correlates of Positive and Negative Attitudes Toward Physicians

Having documented what appears to be an increase in critical evaluations of the way physicians do their work and their ability to confront medical problems, we next ask two questions. First, do these changes reflect community-wide attitudes or do certain societal segments and groups report more positive or negative attitudes? Second, have been changes in these correlates over time? Specifically, we focus on whether socio-demographic attributes of respondents, general health status, and access to health insurance are predictive of these attitudes.

Table 3 displays the unstandardized Ordinary Least Squares estimates in both 1976 and 1998, for the regression of the separate scales of positive and negative attitudes toward physicians on respondents' socio-demographic characteristics, self-reported health status, and health insurance status. In the model of negative attitudes, estimates for the 1976 data indicate that non-whites (b = –.294), younger respondents (b = –.006), and respondents at lower levels of income (b = –.001) and educa-

TABLE 3. Estimates for the Regression of Negative and Positive Attitudes Toward Physicians on Socio-Demographic Characteristics, Self-Reported Health Status, & Medical Insurance Status, 1976 Access to Medical Care in the US and 1998 General Social Survey.

	Negative Attitudes		Positive Attitude	
	1976	1998	1976	1998
Socio-Demographics.				
Gender (1 = women)	–.030	.126	.131***	–.163***
Race (1 = whites)	–.294***	.014	–.065	–.264***
Age (years)	–.006***	–.004	.009***	.008***
Income	–.001*	.019	–.001	–.032***
Education	–.042**	–.045***	–.081***	–.028*
Never Married[a]	–.097	–.141	–.110	–.027
Div/Sep.[a]	.083	.032	–.009	–.284**
Widowed[b]	–.005	–.215	.093	.020
Urban[b]	–.059	.059	.059	–.065
Rural[b]	–.079	.304***	.083	–.285***
Health Variables.				
Global Health Status	–.181***	–.169***	.002	.118*
Insurance (1 = yes)	.040	–.265**	–.030	.280*
Intercept	2.631	2.800	1.653	1.732
R square	.040***	.050***	.059***	.080***

***p < .001 **p < .010 *p < .050 (two-tailed tests)

[a] Reference category = married

[b] Reference category = suburban

tion (b = –.042) are significantly more negative in their assessments of physicians. Additionally, respondents who report poorer health (b = –.181) also report more negative evaluations of physicians. These patterns change somewhat, however, in the estimates reported for the 1998 data. In general, socio-demographic characteristics that separate more powerful from less powerful groups disappear in 1998, suggesting that negative attitudes have become more dispersed throughout American communities. In 1998, education is the *only* socio-demographic predictor that remains a significant correlate of negative attitudes toward physicians. Americans at lower levels of educational attainment report more negative attitudes toward physicians (b = –.045). In 1998, rural respondents also report more negative attitudes than those living in the suburbs (b = .304). As before, self-reported health status also has a significant negative impact on these attitudes (b = –.169). Importantly, in 1998, respondents without health insurance (b = –.265) emerge as significantly more likely to endorse negative assessments of physicians, a pattern not evidenced in the 1976 data.

While socio-demographic characteristics appear to lose much of their predictive power in accounting for negative attitudes toward physicians in 1998, a very different pattern of over time differences appears in the regression model of positive attitudes reported in Table 3. In 1976, women (b = .131) and older respondents (b = .009) are significantly more likely to agree with the three positive statements reflecting their confidence in the way physicians do their work, and better-educated respondents are significantly less likely (b = –.081) to agree with these statements. Moreover, neither of the health-related variables have important effects on positive attitudes.

In 1998, however, there are a number of shifts. Only older respondents (b = .008) are significantly more likely to report positive attitudes. Women (b = –.163), whites (b = –.264), or individuals who are divorced or separated (b = –.284), who reside in rural areas (b = –.285), or who have higher levels of education (b = –.028) or income (b = –.032) report significantly fewer positive attitudes. Finally, in 1998, respondents who report better health (b = .118) and who have medical insurance (b = .280) are significantly more likely to provide positive assessments of how physicians do their work.

In sum, while negative attitudes toward physicians appear to be spread more uniformly through American communities in 1998, powerful social groups (i.e., those with higher education and income) as well as those with greater care-taking responsibilities (i.e., women) are less inclined to report confidence in physician authority. Those with a greater stake in the medical system (i.e., those with poorer health status) are more likely to endorse negative items and are less likely to report favorable evaluations on the positive items. More importantly, those with institutional access to the health care system (i.e., those with some form of insurance) report fewer negative attitudes and more positive sentiments.

The Two-Point Comparison in Context: How Different is Medicine in the Public's Evaluations?

As noted earlier, the growing public disillusionment with physicians observed in these analyses may not be exclusive to modern medicine, and they perhaps reflect larger changes in modern society (Pescosolido and Rubin 2000). Some sociologists suggest that there is a larger secular decline in social institutions, while others argue that this is not the case (Gieryn 2000). Our concern with this argument stems, in part, from the low levels of explained variance in the multivariate analyses of either positive or negative attitudes in either 1976 or 1998. If neither socio-demographics nor relevant health status and access characteristics explain even a tenth of the variation in attitudes, we question whether some underlying public response to social institutions might be at issue. The secularization hypothesis provides, in concert with the GSS time series data, a way to think about and bring at least some empirical evidence to bear on this puzzle.

Here, we examine public reports of "lack of confidence" in three major and inter-related social institutions–education, science, and medicine-over a time frame that is more-or-less equivalent to the cross-sectional comparison (i.e., 1973–1998). The utility of this comparison was first suggested by the results of a principal components factor analysis of the seven positive and negative items tapping atti-

tudes toward physician authority combined with the single item assessing a lack of confidence in medicine. According to this analysis (data not shown), the General Social Survey's lack of confidence in medicine item loaded significantly on the negative attitudes dimension (factor loading = .605, communality = .390), suggesting that the lack of confidence in medicine indexes the same dimension that underlies negative sentiments toward physician authority.

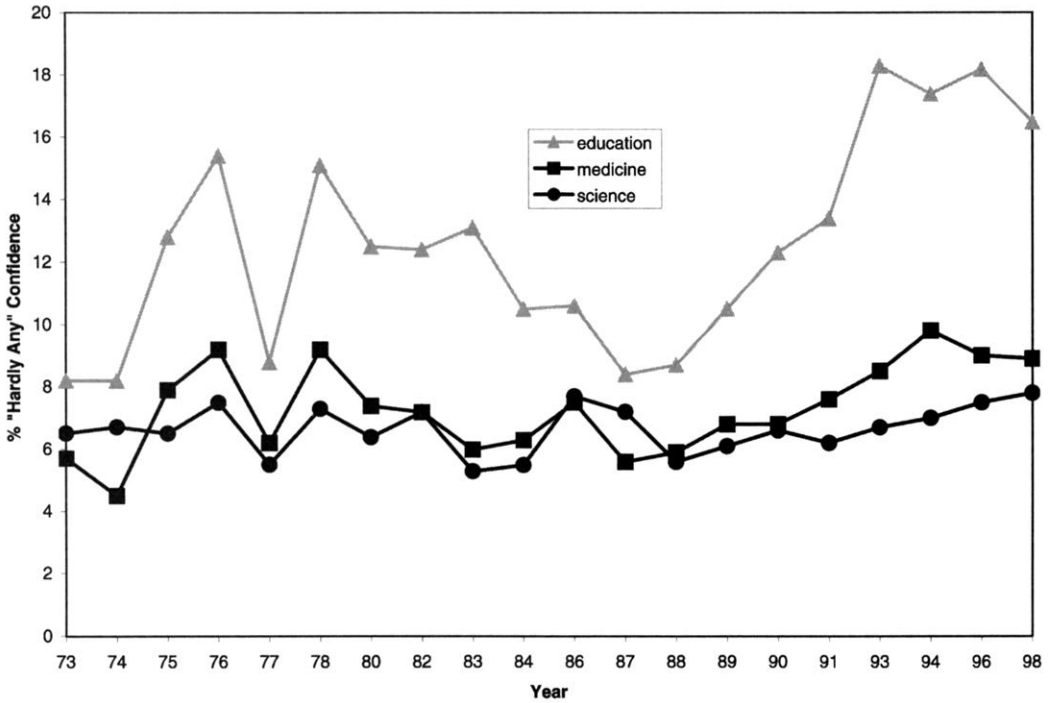
In addition to medicine, we also selected two related institutions from the General Social Survey's list of over two dozen societal sectors. Science's fundamental tie to modern medicine and its place in the sociology of the professions made it an obvious comparison. Education, as another of modern society's institution designed to provide better lives to individuals, offered a second comparison.

Figure 1 presents a graphic depiction of General Social Survey data tracking the proportion of respondents who indicate that they have "hardly any confidence" in "the people who control" the institutions of education, science, and medicine. At first glace, what is remarkable in these data is the similar temporal contour of the patterns across these three institutions. While science and medicine appear to track one another quite closely, the public response to education is more negative and the shifts over time are more dramatic. Nevertheless, the pattern across all three institutions reveals extremely low rates of challenge in the early 1970s, followed by a jump which roughly coincides with the Watergate Era and its aftermath, a return to low levels of concern in the 1980s, and a steady climb in expressions of no confidence starting in 1988. While the percentage of the public that reports little confidence in medicine has roughly doubled from its lowest point in 1974 (4.5%) to its highest in 1994 (9.8%), the level of confidence in medicine is extremely high and is rivaled only by its ally, science. What these findings suggest, in concert with the cross-sectional findings, is that public concern with, and confidence in, medicine is connected to both larger (e.g., Americans' overall faith in social institutions) and specific conditions (e.g., changing insurance profiles and the penetration rate of managed care).

DISCUSSION

As Halpern and Anspach (1993) note, Freidson was "unimpressed with the claim that

FIGURE 1. Percentage of respondants Reporting "Hardly Any Confidence" in Three Social Institutions: 1973–1998 GSS.



medicine's position has substantially eroded" (p. 286). In his work (e.g., 1993), he explicitly discussed the notion that professions are dynamic entities and their fates tied to fluctuations in the larger society's economic and ideological resources. Our results suggest that he may have been correct, as least as public confidence in physician authority, while simultaneously more negative and less positive, is marked by only modest changes in public attitudes toward physicians as a professional group. We offer four explanations.

First, Haug and Lavin (1983) may have been premature is associating complaints, which may have always accompanied medicine and physician practice, with a larger loss of faith in the profession of medicine. In 1962, Wax commented on the "increasing" public controversy over medicine. However, he also noted that some of the "furor is actually praise, in so far [sic] as the discontent stems from the high price of publicly appreciated medical services, rather than from a condemnation of their efficacy" (p. 152). Even in the original "deprofessionalization" treatise, Haug (1973) drew a distinction between "authority" and "accountability." The "effective power of the client to criticize the professional and hold him responsible for his actions" (1973: 207) may or may not be a threat to professional dominance. Further, Haug and Lavin's (1983) extrapolation of the future influence of their documented age effect may have mistaken a coming trend with simple youth challenge. That is, they find, as do we, that younger Americans are more likely to report fewer positive and greater negative attitudes regarding the way physicians do their work in both time periods. However, the perspective provided by our two-point-in-time analysis indicates that the cohort that has aged across the 22 years between surveys has only nominally retained their level of challenge with regard to negative attitudes. Older individuals in 1998, like their counterparts in 1976, are more likely to report positive attitudes. Thus, the effect of age—which we document in the 1976 survey, and Haug and Lavin consistently point to in their regional and national studies in the 1970s—does not appear to have been a harbinger of a pervasive and growing challenge. Indeed, in the current data there is only slim evidence to suggest that the challenge of youth has carried forward.[7]

Second, perhaps as Freidson (1993) claimed, larger challenges have found their way into internal struggles rather than external ones. While there is no question that there is, and has been, a base level of dissatisfaction with the profession, our results suggest that, while this has changed significantly, levels of disaffection are still of relatively small magnitude. The discussions among nurses, the rise of the nurse-practitioner, and the return of the midwife (albeit primarily now under the canopy of scientific medicine) have fundamentally changed the contours of medical practice, and may well be the site of public challenge to physicians. Future research should expand its scope beyond public concern with physicians to these groups of providers, and perhaps to documenting public concern (or lack thereof) in the shrinking purview of physicians over medical decision-making. That is, the kinds of internal shifts that scholars like Halpern (1992) have documented historically should be further explored regarding the public's concern with who practices medicine and how.

Third, perhaps the challenge to the profession of medicine occurs within the physician's office, where, as Wax (1962) contends, the differential orientation of the physician and the public will result in referring to different entities (e.g., health as physiological imbalance versus health as the ability to maintain meaningful social relationships) and will always result in some dissatisfaction. At issue here are not attitudes, but what Haug and Lavin call "behavioral challenge." As the extensive research on the physician-patient relationship has documented, cultural, social, and other life circumstances mark differences between patients and clients and physician and providers, which stem from both the select social backgrounds of physicians and the process of socialization in medical school. Parsons' (1951) theory about the complacent, compliant, and quiet public was questioned early and often (for a review, see Pescosolido and Kronenfeld 1995). However, our ability to make claims about whether public challenge in the doctor-patient relationship has increased or decreased, and among which sectors of community, cannot be examined without precise, comparative data. Pursuing this would not be an easy task since the use of contemporary data on the physician-patient interaction in the office, clinic, or hospital alone cannot document whether there is an increasing challenge to the profession of medicine.

Fourth, it may be the case that the public's

options are severely muted, and their role in the maintenance of professional power less critical, precisely because they are being mapped in the face of professional dominance. Given the lack of alternatives (despite the reported increased use of alternative medicine and incorporation of alternative practices by scientific physicians; Goldstein 1999), coupled with the public's confidence in scientific solutions to "modern" society's problems and their socialization into a scientifically-based society (both reflected in Figure 1), attitudes toward physicians as a group are more positive than the scholarly and public policy debates suggest (see Freidson 1993 on this point as well). The percentage of Americans in our study reporting "hardly any" confidence in medicine *has* doubled from 1972, but medicine remains the social institution, along with science, receiving the greatest public confidence. We have suggested elsewhere that the importance of medicine's "capture" of public support may have been overstated in traditional theories of the rise of professional dominance (Pescosolido, McLeod, and Alegria 2000). The mechanism by which the public came to support political legitimation was the underwriting of a new medical marketplace which changed all of the "enabling" characteristics that Andersen (1995) sees as critical to people's use of services. Once fiscal resources were mounted to build or rebuild the medical marketplace in favor of one or another type of medicine, the hearts and minds (or at least the behaviors) of the public were virtually guaranteed. When the profession's attempts at monopoly combine with the financial means to convert political legitimation into institutional support (e.g., insurance coverage) and visibility (e.g., large and impressive medical centers), the public is *persuaded* in a subtle but nonetheless direct way. The building of institutions crystallize and reinforce power differences, placing limits on individuals' attitudes and behaviors and setting a context for individuals' socialization into a science-based society. Given the critical role of perceived geographical and financial accessibility in the public's use of health care (e.g., Andersen's 1995 "enabling" factors), what people do (and perhaps what they believe) regarding medical care is seriously constrained in a well-established scientifically-dominated medical marketplace (Pescosolido et al. 2000). We do see in our results an important change in the correlates of public opinion, with those without health insurance and in poorer health voicing more negative attitudes. However, these groups are vulnerable, not those in powerful societal positions. They may be the target of welfare policy advocates, or they may be successful in affecting changes in the delivery of care, but their complaints are suggestive of being denied access, not rejecting the underlying ideology or organization of modern medicine. As Imber (1991) notes: "the class interests of the worried well will determine the future direction of the medical profession" (p. 316).

Yet there is some indication that significant shifts have taken place. For example, we found that, while Americans continue to simultaneously hold a similar set of positive and negative attitudes, the movement of public opinion has been toward less confidence in physician authority. Overall, the endorsement of positive attitudes has decreased, while the endorsement of negative attitudes has increased. Further, we see a decrease in the proportion of Americans who are unclear about their sentiments. In fact, much of the "swing" toward lower levels of support for physician authority appears to be attributable to the crystallization of negative attitudes among those who earlier reported "don't know" responses to the physician authority items in the 1970s. Finally, there have been important changes in the sociodemographic characteristics of those Americans who endorse these more negative opinions. Women, as major societal caretakers, have shifted from support to critique. Those with higher levels of income, once reporting less challenge (i.e., negative attitudes), are now significantly less likely to endorse positive attitudes.

We believe these analyses suggest the need for social and behavioral scientists to periodically monitor the public's stand on physicians and medicine in order to mark the overlap of scholars', policymaker's, and advocate's claims regarding public support for physician authority. What may be critical to our understanding of the erosion of professional dominance is whether there is a "tipping point" that marks the connection between public attitudes and larger social policies to professional status. To date, our data do not indicate that physician authority, and the consulting status of medicine, faces serious public challenge. They do show, however, a set of trends toward greater disillusionment and a more widespread cri-

tique that requires tracking, particularly in the face of managed care.

NOTES

1. These concepts can also be distinguished from "trust" (see Mechanic 1996; Thom et al. 1999), "access" (Aday et al. 1980), and many other dimensions often conflated in attitudinal surveys.
2. Primary funding for the Access to Medical Care in the United States Study was provided by the Robert Wood Johnson Foundation. The General Social Survey core is supported by the National Science Foundation. Funding for the Pressing Issues in Health and Medical Care Module (GSS-PIHMC) was provided by Eli Lilly and Company, with supplemental support provided by the National Institute on Mental Health through the Indiana Consortium for Mental Health Services Research.
3. Principal investigators for the 1975–76 Access to Medical Care in the United States Study (AMCUS-CHAS) were Ronald Andersen, Lu Ann Aday, and Gretchen V. Fleming. Principal Investigators for the 1998 General Social Survey (GSS) were James A. Davis, Tom W. Smith, and Peter V. Mardsen. The total Access to Medical Care in the United States Study sample reports data on 7,787 respondents and includes 1,684 interviews conducted with children, 919 interviews conducted with a supplemental sample of African Americans, 865 interviews conducted with a supplemental sample of Hispanics, and 449 interviews conducted with a supplemental sample of individuals currently experiencing an episode of illness. For the purposes of these analyses, only the self-weighting sample of adults (n = 3,870) is utilized.
4. Due to limitations imposed by time and funding constraints, the Pressing Issues in Health and Medical Care research team was unable to include the entire 15-item battery on physicians or the larger 43-item set examining attitudes toward the health care system. Unlike the 1998 General Social Survey, the Access to Medical Care in the United States Study was a devoted health care survey. Thus, we examined the Access to Medical Care in the United States Study Codebook for items that operationalized Friedson's construct of physician authority and then chose appropriate questions for replication in the 1998 General Social Survey.
5. In subsequent multivariate model fitting, respondents who were married and who resided in suburban locations were selected as the reference categories.
6. Since the "recommend surgery" item demonstrated inconsistent loadings, this item is not used in the construction of multi-item scales.
7. Following suggestions offered by *Journal of Health and Social Behavior* reviewers, we invoked a strategy outlined by Firebaugh and Davis (1997) to systematically assess the impact of age and cohort replacement on attitudes toward physician authority. In this regard, we re-estimated our models, combining the 1976 and 1998 data sets, and added separate terms for survey year and respondent's age. These analyses indicated that, indeed, younger respondents do report more negative and fewer positive assessments of physician authority. These analyses also indicated, however, as cohorts age (i.e., via the developmental effects of aging), attitudes toward physician authority become less negative and more positive.

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