

STEREOTYPING: A COMMUNICATION BARRIER TO THE
EFFECTIVE MEDICAL CARE OF THE URBAN POOR

by
Diane C. Beyer

Submitted in partial
fulfillment of the requirements
for the degree of Bachelor of
Arts in Speech and Drama with
Honors

Redacted Signature

Instructor in Charge

For the department

Introduction

The medical profession in the United States has long acknowledged its inadequacy in effectively caring for patients of the lower social classes, and in recent years this problem has become increasingly more obvious.¹ Members of the lower classes often hesitate to consult a doctor, neglect to follow through on treatments recommended by a doctor, or change periodically from physician to physician, never allowing one member of the medical profession to establish a consistent pattern of care. But although the actions of the lower class patients point out a severe shortcoming to the medical profession, the profession has not been able to define the problem beyond a mere blanket description: a failure to communicate, and many physicians have only a surface understanding of what is lacking.

It is the thesis of the following discussion that the common process usually referred to as stereotyping has much to do with the lack of communication between doctor and lower class patient. Therefore, I shall define stereotyping as it exists in a medical confrontation; explore the patients' stereotype of the physician and the physician's stereotype of the patients, what constitutes each of these stereotypes and why they exist; and explain how these attitudes affect communication in the doctor-patient relationship.

The term "lower class" will be used throughout the remainder of the discussion to refer to the urban poor, those members of the American urban population with an annual income of less than \$4000.² The government of the United States has declared the problems of urban life to be among the most serious facing our nation in this decade,³ and, in addition, the attention of many institutions, both governmental and private, has been directed towards better communication in the urban ghettos, with medical services high on the list of would-be reformers.⁴

Definition of the Problem

Stereotyping is the process of assigning to a person or group of persons a specific role to fulfill, a role being, according to Samuel Bloom, "a pattern of expected behavior,"⁵ or, according to Ralph Linton, "a reciprocal pattern of behavior in society."⁶ Persons in society occupy certain places, and their role performances in these positions is decided by social norms, demands, and rules; by the role demonstrations of other persons in their respective positions; by those persons who watch and react to the performance; and by the individual's particular personality and ability. In essence, the role perspective assumes that performance results from the social prescriptions and behavior of others.⁷

In a medical confrontation, then, the way the patient behaves towards the doctor and the way the doctor behaves towards the patient is strongly influenced by the set of expectations each one of these persons has developed about the other and by the set of rules each has developed for his own behavior relative to that of the person in the other position. Not only does the doctor fit each patient into his concept of what a patient is or should be, but the doctor also fashions his own behavior to fit the patient's set of expectations. Not only does the patient view the doctor within the framework of his own layman's preconception, but he also patterns his own behavior after the way he thinks the physician expects him to act. In other words, stereotypes, with their sets of prior expectations, determine, to

a great extent, how patient and physician will interact with one another, how they will communicate in an actual confrontation.

Insofar as stereotyping defines a medical situation and gives the doctor and/or the patient some idea of what to expect and how to act, it is not detrimental. But when the set of role expectations constituting the stereotype becomes constrictive and the patient and physician fail to see each other as individual persons, each with his own peculiar variations from the stereotype, then the practice of stereotyping becomes a significant problem. Today's lack of communication between physician and urban poor patients is obvious evidence of this problem.

The following discussion will show why a lack of communication does, indeed, result from stereotyping tendencies of the doctor and his patients who are members of the lower socio-economic class, and why such a lack of communication is more noticeable among the lower classes of American society.

First, it will be necessary to differentiate between the upper and lower socio-economic levels in the American population and their respective positions in a medical confrontation, after which the urban poor patient's stereotype of the physician will be developed to include the following in contrast to the stereotype devised by an upper or middle class citizen: 1) the doctor as an inordinately busy man 2) the doctor as a healer with a purely physical function 3) the doctor as a responsible man with more than an average amount of prestige 4) the doctor as a sort of "pseudo-mythical figure" 5) the doctor as a man of much authority 6) the doctor as a "substitute father" 7) the doctor as a messenger of news, both good and

bad. Several of these are also facets of the upper class stereotype. However, they usually have a less pervasive influence on communication with this group than on the lower class groups.

The Patient's Stereotype of his Physician What Constitutes It and Why It Exists

All social classes view the doctor as an almost inhumanly busy man. Interviews conducted by Eliot Freidson have shown: "Almost every patient interviewed, irrespective of social class, expressed reluctance to bother the physician about medical matters." Yet Freidson observed that members of the lower socio-economic classes tend to hesitate longer before seeing a doctor than do upper class citizens, expressing for their reason a reluctance to "bother" the physician.⁸ Thus, it would appear that that facet of the stereotype which labels the doctor as "busy" interferes more with the doctor's effectiveness in treating lower class patients than with his success in caring for patients of the upper or middle classes.

Another difference between upper and lower class stereotypes of the physician is that while the upper class patient has a great tendency to call on the doctor for psychological as well as physical help, the lower class patient sees the physician's function as a purely physical one. The lower class patient, on the whole, is much less prone to view his problems in psychological terms than is the citizen from a higher position on the

socio-economic scale.⁹ And, as a result, the doctor is stripped of an important facet of his function. He is seen by the poor only as a physical healer and not as a man who can also help solve personal problems.

The third aspect of the physician stereotype is the doctor's place in the community. Both the urban well-to-do and the urban poor see him as "responsible, emotionally stable, and an assertive leader, who is socially responsive."¹⁰ In other words, they see him as an important part of the efficiently-functioning community. However, whereas the rich are inclined to think of the doctor as functioning in their own social stratum, e.g. belonging to the same country club, sending his children to the same private schools and summer camps, visiting the same vacation spots --- in short, sharing prestige with others in the community; the urban poor view the physician as one who has attained a special status, who performs some of his work in the poor community, but who returns home each evening to a comfortable house and an admirable social life --- a man of prestige. Indeed, Koos found that the lower classes tended to "place a halo" around a doctor much more frequently than around a priest or preacher.¹¹

No one would deny that at least some aura of prestige, with the power and trustworthiness it implies, is necessary for a physician to perform his duties effectively. A degree of power aids the doctor by allowing him access to personal and intimate matters without embarrassment on the part of the patient. Perhaps it is this aura of prestige and this unusual type of power which help to develop the fourth facet of the physician stereotype.

In the eyes of the poor, as to a greater extent in the eyes of children, the doctor appears as a somewhat "mythical figure." The doctor's work, dealing with the most personal parts of the self and giving medicines, performing surgery, etc., attains an almost magical significance, and whether or not a person believes in magic or divine power, he maintains a certain amount of awe for the work of the doctor. With the more prevalent lack of education among the urban poor, with the absence of abundant scientific knowledge in the ghetto, one would expect to find the feeling of awe more pervasive here than in suburbia.¹²

Closely associated with the feeling of awe about the physician's function is the unquestioning acceptance of his authority by the urban poor. Wealthier and better-educated citizens have more occasion to question a diagnosis or a decision made by the doctor, for in many cases they have a layman's knowledge of the disease or injury and the methods used in its treatment, and they are not hesitant about asserting themselves. The poorer, less-educated people have little or no technical background information to fall back on except what their peers know, and this, in most cases, is little more than the patient himself knows already.

In a way, such a phenomenon is helpful to the physician, for it saves him time by allowing him to give an uncontested diagnosis and plan for treatment. In the long run, however, this unquestioning acceptance of power can hinder the doctor in his treatment of the patient. For example, the aura of authority can set the physician on such a high pedestal that the patient hesitates to ask even necessary questions. One such instance is cited in The Annals of a Country Doctor: A housewife with severe high

blood pressure was advised by her physician to go on a stringent low-sodium diet. At this time the woman wondered about the advisability of using monosodium glutamate as a substitute seasoning, but she did not ask the doctor about it. Instead, she used it, deciding that monosodium must mean less sodium even though the seasoning tasted salty. When she was hospitalized later with a blood pressure flare-up, she explained to a nurse: "I wondered about monosodium glutamate before I left the doctor's office that day, but I didn't ask him about it. I knew he'd think I was really stupid for not knowing that, and I thought one of my friends could probably tell me what monosodium glutamate was."¹³

When such a situation occurs, the patient's condition does not improve because the patient failed to understand exactly what he, the patient, was supposed to do in the plan of treatment or why it was mandatory that he do what the physician prescribed. Either the patient goes uncured, or he changes doctors, due to dissatisfaction with the treatment he did not have a chance to follow, or he returns to the physician to get an explanation or lecture that takes twice the time it would have taken to answer a question at the time of diagnosis and prescription.

Sometimes the lower class patient's acceptance of the physician's authority goes as far as to view the physician as a sort of "substitute father figure." According to Fox and Talcott, this action is explicable: "The analogy of the physician and parents in part is simple and obvious. These are the stronger and more adequate persons on whom the child and the sick person, respectively, are made to rely; they are the ones to whom he must turn to have those of his needs fulfilled, which he is incapable

of meeting through his own resources."¹⁴

The doctors are also the messengers of news, good or bad, about the diagnosis or the improvement or the worsening of the patient's condition. They are also the withholders of news, hence the tendency for a patient sometimes to view a doctor suspiciously. Renee Fox contends that communication from a doctor to a patient is characterized by "duplicity, evasion, and other forms of strain," and that patients of any social class often sense a discrepancy between what the doctor knows and what he tells the patient.¹⁵ Whether the patient's sensed discovery leads him to seek out another doctor or other type of practitioner, or whether it leads him to divest himself of any dealings with real or would-be members of the medical profession, he does include the "information-dispensing" function in his stereotype of the doctor. The physician's refusal to dispense information or his decision to conceal his knowledge can make the patient worry about his illness or injury even more, and make his stereotype of the physician more rigid, due, according to the findings of Weiss and Silverman, to the increased anxiety the patient experiences from a fear of the unknown.¹⁶ In other words, because the patient feels unsure and uneasy about his condition, he makes some object connected with it more predictable to compensate for his feelings of anxiety.

This last facet of the physician stereotype --- this view of the physician as messenger -- is characteristic of both upper and lower socio-economic classes. However, the greater tendency of the lower class citizen to display awe at the physician's power, prestige, and authority makes this last aspect of the stereotype more prohibitive to him than to the upper

class citizen, for it creates a wider gap between physician and patient.¹⁷

Other factors that characterize the urban poor citizen's stereotype include the following: a) Members of the lower socio-economic levels appear to be less sensitive about their status as patients and usually more passive in their response to medical care.¹⁸ This phenomenon could well occur because as one goes from the top to the bottom of the socio-economic scale, one finds that patient and doctor share progressively fewer criteria for the diagnosis. The rich patient criticizes the doctor because his layman's knowledge is more extensive than that of the poorer patient.¹⁹ b) Another essential difference between the medical stereotypes of the urban poor and the suburban rich, as pointed out by Rosenblatt and Suchman, is that while the middle or upper class patient expects to be a mere cog in the bureaucratic wheel, the member of a lower socio-economic class does not, because he is not as aware of the bureaucratic system.²⁰ He is likely to expect more direct contact with the doctor, may resent waiting long hours in the doctor's office and become confused with filling out forms for physician's and government records, since he is not accustomed to the formalities and red tape so much a part of middle class life. c) The urban poor are less prone to make their own individual decisions than are the middle or upper class Americans, since the urban poor exist in a "parochial" social system rather than in the "cosmopolitan" system in which the upper classes exist.²¹ Rosenblatt and Suchman report that urban workers with an annual income of less than \$4000 score significantly higher in their parochialism than do other workers, the five indices being: family orientation to tradition and authority, family togetherness, religious attendance, reliance on friends, and friendship

solidarity.²²

Many of the urban poor work, eat, play, and sleep in one part of the city with one particular group of people, this ghetto group remaining essentially the same all their lives. Since an individual in this type of community knows nothing else, the beliefs of his fellow ghetto dwellers become his own beliefs. Because of the community's relative cohesiveness, he is forced to rely on the lore of the community quite heavily and on the advice of his peers. As Eliot Freison points out: "In the practice of medicine among the urban poor, the community forms the outermost framework of practicality for the doctor-patient relationship, and the community features lay interpersonal influence as a ubiquitous part of everyday life."²³ Thus, the lower class citizen is less prone than the upper middle class citizen to make his own unique decisions, since lay consultants are at his free disposal, and in dealing with the stereotype problem, we are dealing, not with the tendency of isolated individuals, but with the composite tendency of a whole community to stereotype the doctor, to suit him to a particular role, which is perpetuated in large degree by community expectancy. From research on this point, Rosenblatt and Suchman suggest: "On the whole, we find that, for the blue-collar workers, differences with regard to socio-medical data tend to become sharper once we introduce the factor of cosmopolitan-parochial."²⁴ And the researchers continue their explanation to specify: "For the most part, this addition of the cosmopolitan-parochial index only serves to heighten the differences between the blue-collar workers and the white-collar workers with regard to their information and attitudes toward medical care."²⁵

As Elum stresses: "To be a patient is to play a social role that is learned as part of the content of a culture."²⁶ Thus, a patient who comes from an urban poor family and social system will tend to stereotype the physician in the way that he has learned from the peers who make up his social system; he will include the same characteristics in his attitude towards the doctor that his neighbors do, for the lower class citizen is exposed to little else. He obtains the bulk of his education not from a variety of people and experiences but from the few people he has known most of his life, and his education in school is often prematurely concluded. His understanding of the causes and cures for illness and injury, then, is likely not as thorough as that of an average college graduate, and he probably has not associated enough with prospective medical doctors to achieve a very thorough understanding of the doctor as a man. Thus, the lower class citizen's lay medical knowledge coupled with a cultural deprivation helps to explain his stereotype of the physician.

A study done by G.M. Gilbert helps in part to illustrate the preceding statement. The study, entitled "Stereotype Persistence and Change Among College Students," points out several reasons why stereotyping does not exist among college students today as it did in 1932, two of the reasons being: a) the popularity of the social sciences today b) the wide opportunities for intergroup exposure and contact on college campuses.²⁷ One has only to consider the failure of the urban ghettos to provide these two advantages to understand another reason why stereotyping persists among the urban poor. For example, Eliot Freidson contends that members of the lower classes are much less prone to see their problems in psychological or social terms than to view the problems as purely physical. This un-

popularity of the social sciences among the poor does not permit a sophisticated awareness of the part that status and roles play in determining how a person perceives and, in turn, acts towards another person.

Second, the dwellers in the ghetto, by definition, have little opportunity for intergroup exposure and contact. When confronted with a member of another socio-economic group, e.g. the physician, the urban poor patient will tend to stereotype that other person in the only way he has learned from his peers. Then the doctor can be more predictable to the patient, and the patient can establish some kind of behavior pattern that makes him feel more comfortable in a situation which is threatening because the patient does not know what to expect,²⁸ and his status becomes vulnerable.

Indeed, as Eliot Freidson emphasizes, the vulnerability of any patient's status can understandably increase the patient's tendency to stereotype,²⁹ for when personal identity is basically at issue with the patient, the patient tries to combat his anxiety by constructing the situation to make it more predictable.³⁰ And devising a stereotype is one easy way of making the medical confrontation initially more familiar.

In summary, the urban poor patient's stereotype of the physician has seven prominent aspects, all of which contrast in prominence and effect with the components of the rich patient's physician stereotype. These are the seven aspects of the stereotype by the urban poor: 1) The doctor is a busy man. 2) The doctor is a healer whose function is purely physical. 3) The doctor is a responsible man with more than the usual amount of prestige. 4) The doctor is a sort of "pseudo-mythical" figure. 5) The doctor is a man of much authority. 6) The doctor is a "substitute father." 7) The doctor is a messenger of news, both good and bad.

The prime determiners of the stereotype are the influence of the urban ghetto parochial system, the lack of technical, social, and psychological education in the ghetto, and anxiety due to the differentiation of status. In short, the stereotype represents an attempt on the part of the urban poor patient to construct the medical confrontation and make it a less threatening experience.

A similar tendency to structure the medical confrontation, to stereotype, characterizes the physician's attitude towards the patient of a lower socio-economic class.

The Physician's Stereotype of his Patient What Constitutes It and Why It Exists

According to Eliot Freidson, the stereotype of many doctors towards the poor includes the belief that members of this class are "irrational patients." In other words, the doctor's stereotype emphasizes the "helplessness and need of help, technical incompetence and emotional involvement of the patient, so that a high level of rationality of judgment is particularly difficult for the patient to develop."³¹ The doctor assumes that the a priori trust and confidence the patient places in him is a sign of the patient's irrationality.³² Upper and middle class patients are, on the whole, more objective, wary, and questioning about the medical services they receive and will not hesitate, in some instances, to argue with the

physician. On the other hand, the patient who belongs to the lower socio-economic class does not possess in his vocabulary the smattering of professional terms familiar to the upper classes, and he may feel he cannot express himself adequately enough to the physician to contradict or question the doctor's advice.³³

Thus, the lower class patient appears submissive to the doctor and uninquisitive, and the physician --- however unconsciously--- interprets these signs of timidity as irrationality or stupidity on the part of the patient who has not been educated as the doctor has. Without many qualms, the doctor extends this conception of one urban poor patient to every other member of that patient's lay referral group, and a stereotype of the ghetto patient as ignorant and irrational takes shape.³⁴

In addition, the doctor harbors a moral stereotype about any patient, but especially about a patient of the lower socio-economic class, since none of its members are members of the doctor's own social class, and he has no non-medical obligations to them. Samuel Bloom writes: "In spite of the developemnt of modern social science, man's preference when dealing with human behavior continues to be to moralize rather than to understand ... In medicine this is exemplified by the common tendency to judge patients on a moralistic basis. That is, rather than perceiving patients as they are, the doctor views the patients according to preconceived attitudes of how good patients should behave. Apparently this practice begins early in the medical career and is more like to intensify during medical school than to decrease."³⁵ The physician develops a remarkable facility for labeling the good and the bad, the moral and the immoral, the attitudes to be sought

and those to be avoided; and he employs this conception as an integral part of his stereotype.

Thus, the doctor views the lower class patient prematurely as stupid and irrational, and then, as the doctor observes and reacts to the patient, he pronounces his private moral judgment on the patient.

Actually, it is not surprising that the physician stereotypes the patient in such an automatic way, since medical practitioners also have their own lay referral systems. Elum quotes Saunders (1953) as saying: "The medical profession itself is a kind of subculture. In this respect, the differences between physicians and the other members of society are based on professional rather than on ethnic or geographical boundaries. The physician has a special language, and by virtue of his social role and training he also possesses specific beliefs and behavior not shared by others. These differences between the physician and the other members of the community, however, are centered about the interpretation and treatment of illness."³⁶

To be sure, the doctor does get away from his professional lay referral group. He plays golf, goes to church, the theater, school P.T.A. meetings, etc. with men and women who are not physicians. He does not spend all his time with members of his own profession, and he does not employ his professional language with his non-professional friends in ordinary conversations. However, in explaining a doctor's stereotype of the urban poor, one can legitimately consider the doctor's lay referral system, since, in this instance, the doctor's fellow professionals play the largest part in shaping his attitudes. His family and outside friends have little cause even to consider the poor, and, thus, have little reason to influence the doctor on this matter. The influence of the physician's professional lay referral

system is strongest when the doctor deals with professional matters.

In connection with professional influences on the doctor, the printed word must also be mentioned. Freidson stresses throughout his book that much has been written about the way patients and doctors should behave.³⁷

It appears that doctors not only learn informally from their conversations with professional colleagues but that they also learn from written material--- journals, medical textbooks, etc. These also contribute to the doctor's formation of an urban poor stereotype.

Thus, as Ozzie Simmons states: "A social class constitutes a membership group, and promoting and maintaining one's acceptance by the group calls for conformity with the perceptions and behavior deemed proper by the group, whether it be in relation to health and illness or anything else."³⁸ The unfortunate thing about a stereotype formed in this way by a physician is that such an attitude gets perpetual reinforcement, since the doctor is working with patients every day, and much of his conversation with his colleagues deals with medical matters.

In summary, the physician may stereotype his urban poor patient in two ways: 1) as stupid and irrational 2) as bad, disobedient, or immoral. This stereotype is formed for several reasons, the most obvious being the influence of the physician's professional community, either in the form of the spoken word or in the form of the written word. And the stereotype formed by the doctor and reinforced in his every day medical life coupled with the stereotype formed by the urban poor patient can hinder communication between these two human beings, often to the point of complicating treatment of an illness or injury.

Mutual Stereotypes of Physician and Patient
How They Hinder Communication and Treatment

It has been shown that doctors and patients do, indeed, stereotype each other, and the possible reasons for these stereotypes have been given. Now I shall discuss how these mutual patient-physician stereotypes and the lack of communication that results from them can prove a hindrance not only to the doctor-patient relationship itself but also to the effective treatment of the whole patient from the onset of his illness to its cure.

Earlier in the discussion it was established that stereotyping is necessary to some extent when the physician and his urban poor patient confront each other for the first time. However, when the overt goal of stereotyping is no longer to establish a basic background for communication between the doctor and his patient, when stereotyping, instead, begins to hinder communication and create problems with the doctor's diagnosis or the treatment he knows is best for the patient, then something needs to be done to narrow the pervasiveness of the stereotype.

Examining the difficulties that stereotyping creates with the doctor's initial diagnosis, one is particularly struck by the difference the inclusion of the morality factor in the doctor's stereotype of the patient could make in the doctor's diagnosis. For example, when a physician is confronted by a ghetto prostitute complaining of abdominal pains, he probably thinks first of gonorrhea rather than appendicitis, and the type of questions he asks the woman will probably imply her lack of morals and make her less willing

to communicate with the physician. She likely may not return to see the doctor. In essence, the doctor's stereotype has made him less effective as a healer.

No less unfortunate is the inclusion of the irrationality factor in the doctor's stereotype of his urban poor patient. Because he views the patient as lacking in his intellectual capacities, the physician may avoid prescribing the best treatment for the patient, choosing instead a less effective but simpler method of treatment that he is relatively certain the patient can follow. Or, if no such simple home treatment exists for a particular condition, the physician may commit his patient to the hospital unnecessarily, not trusting the patient's ability to follow complicated instructions. But the exorbitant cost of a hospital stay and/or the somewhat "bureaucratic" atmosphere in the hospital can likely upset the patient and discourage him from further contact with the medical services. Thus, in this case, too, the physician's stereotype of the patient has subtracted from his success as a healer, since by losing contact with the patient upon his release from the hospital, the doctor loses his chance to practice preventive medicine with this patient later on and fulfill the function most public health experts and urban physicians deem most important in today's society.³⁹

The various facets of the patient's stereotype of the doctor may also hamper the doctor's effectiveness in treating the patient by establishing a communication blockade between the two human beings.

When the patient sees his doctor as an extremely busy man, he may fail to see the doctor as soon as he should, feeling that a little pain or discomfort is hardly worth the time of a man who has so much to do. Or,

once the patient has made a visit to the doctor, he may obliterate his chances to get some needed reassurance about his condition because he is afraid to take up too much of the doctor's time. As a result, he may worry so much that his condition does not improve with treatment.

Along the same line, when the patient regards the doctor as a purely physical healer, he will neglect to discuss feelings and psychological problems with the physician which might give clues to the diagnosis and treatment of his condition. The physician will not be able to fulfill his function as effectively as he could if he knew more about the patient personally, about the person's background, his family and homelife, his attitudes and fears. He can only treat the physical man, not the whole man, and, in such a way, his effectiveness diminishes.

The urban poor patient's tendency to view the doctor as a man of prestige, authority, and power, as a pseudo-mythical figure, or as a substitute father may achieve similar effects, for if the patient sets the physician on a towering pedestal, the patient may again fail to ask necessary questions or disclose valuable psychological information.

Finally, the patient's predisposition to see the physician as a messenger can also hamper success in the treatment of the patient's condition. At the outset it would seem that viewing the doctor as a messenger could be an asset to communication, and it can be.⁴⁰ However, if the patient senses that the doctor is withholding some of the information, he becomes uncomfortable, and the possibility of spontaneous communication between the two human beings is lost.⁴¹ The patient is likely to become anxious or to refuse

his feelings or any other useful information to the doctor. The holding back of information on both sides puts a great strain, then, on the doctor-patient relationship and complicates treatment.

This frustration both doctor and patient experience in trying to communicate with each other or to avoid more than surface communication can create a tendency towards further stereotyping.⁴² Thus, the stereotyping process becomes its own food for growth, and it follows that communication worsens between physician and patient, and treatment of medical problems decreases in effectiveness.

It would seem that if: a) the doctor would not guard his privilege of information-dispensing carefully behind professional jargon and professional silences b) the patient were reminded and reassured of his importance in medical treatment c) the parochial social system of the ghettos were to become more cosmopolitan ; that less stereotyping and, thus, more and better communication would occur between the doctor and his urban poor patient. Within the next few years these three changes can quite conceivably occur.

Summary

The urban doctor and his urban poor patient have separate worlds of experience; they have different social roles, a different language, different referral systems. All of these factors contribute to the formation of stereotypes.

From some points of view it appears that stereotypes can aid in the doctor-patient relationship. They give the patient and the physician at least some type of expectation, some type of groundwork for their medical confrontation. In the sense that the stereotype is merely the determination of a role, it is good, but when that stereotype begins to hinder communication, e.g. to make the physician bored with the patient or the patient afraid of the doctor, it becomes a real hindrance. Many of the reasons why harmful stereotyping may occur have been accounted for, and several of its possible effects have been noted.

What now needs to be done is to work to get rid of stereotyping when it begins to hamper communication. Stereotyping of the urban poor by the medical profession and of the medical profession by the urban poor creates one noticeable gap in communication in our nation's cities, and the bridging of this gap will bring us as American citizens one step closer to the understanding necessary in a country with vast expanses of cities, vast numbers of people, and all-encompassing problems.

Backnotes

1. Roger O. Egeberg, "The Country's #1 Health Problem," U.S. News and World Report, LXIII (February 23, 1970), 67
2. S.M. Miller, "The American Lower Classes: A Typological Approach," in Mental Health of the Poor, ed. Frank Riessman, Jerome Cohen, and Arthur Pearl, 141
3. Thomas J. Watson, Jr., "Goals --- The Need for Priorities," Vital Speeches, XXXVI, (March 1, 1970), 302
4. Roger O. Egeberg, "The Country's #1 Health Problem," U.S. News and World Report, LXIII (February 23, 1970), 67-73
5. Samuel W. Bloom, The Doctor and his Patient: A Sociological Interpretation, 67
6. Ralph Linton, The Study of Man: An Introduction, 103
7. Introduction, Role Theory: Concepts and Research, ed. Bruce J. Biddle and Edwin J. Thomas, 4
8. Eliot Freidson, Patients' Views of Medical Practice, 99
9. Eliot Freidson, Patients' Views of Medical Practice, 107
10. Gayle G. Marsh and Jacob L. Halberstam, "Personality Stereotypes of U.S. and Foreign Residents," Journal of Social Psychology, 187
11. Earl Loman Koos, The Sociology of the Patient, 117
12. Eliot Freidson, Patients' Views of Medical Practice, 149
13. L.J. Beyer, The Annals of a Country Doctor, 111
14. Renee Fox and Parsons Talcott, "Illness, Therapy, and the Modern Urban American Family," in Patients, Physicians, and Illness, ed. Gartly Jaco, 235
15. Renee Fox, "Uncertainty in Medical Prognosis," American Journal of Sociology, LXVI (July 1960) 41

16. Robert L. Weiss and Julian Silverman, "Anxiety and Response Stereotypy: An Experimental Critique," Perception and Motor Skills, XXII, (1966), 101
17. Eliot Freidson, Patients' Views of Medical Practice, 87
18. Eliot Freidson, Patients' Views of Medical Practice, 211
19. Eliot Freidson, Patients' Views of Medical Practice, 222
20. Daniel Rosenblatt and Edward A. Suchman, "The Underutilization of Medical Core Services by Blue Collarites," in Blue Collar World: Studies of the American Worker, ed. Arthur Shostak and William Gamberg, 346
21. Eliot Freidson, Patients' Views of Medical Practice, 151
22. Daniel Rosenblatt and Edward A. Suchman, "The Underutilization of Medical Core Services by Blue Collarites," in Blue Collar World: Studies of the American Worker, ed. Arthur Shostak and William Gamberg, 330
23. Eliot Freidson, Patients' Views of Medical Practice, 192
24. Daniel Rosenblatt and Edward A. Suchman, "The Underutilization of Medical Core Services by Blue Collarites," in Blue Collar World: Studies of the American Worker, ed. Arthur Shostak and William Gamberg, 330
25. Daniel Rosenblatt and Edward A. Suchman, "The Underutilization of Medical Core Services by Blue Collarites," in Blue Collar World: Studies of the American Worker, ed. Arthur Shostak and William Gamberg, 332
26. Richard Elum, The Management of the Doctor-Patient Relationship, 10
27. G.M. Gilbert, "Stereotype Persistence and Change Among College Students," Journal of Abnormal Psychology, XLVI (1951) 245-254
28. Eliot Freidson, Patients' Views of Medical Practice, 175
29. Eliot Freidson, Patients' Views of Medical Practice, 131
30. Eliot Freidson, Patients' Views of Medical Practice, 52
31. Eliot Freidson, Patients' Views of Medical Practice, 184

32. Eliot Freidson, Patients' Views of Medical Practice, 181
33. Eliot Freidson, Patients' Views of Medical Practice, 222
34. Eliot Freidson, Patients' Views of Medical Practice, 176
35. Samuel W. Bloom, The Doctor and His Patient, 36
36. Richard Elum, The Management of the Doctor-Patient Relationship, 10
37. Eliot Freidson, Patients' Views of Medical Practice, 90
38. Ozzie Simmons, "Implications of Social Class for Public "health," in Patients, Physicians and Illness, ed. Jaco, 112
39. Roger O. Egeberg, "The Country's #1 Health Problem," U.S. News and World Report, LXVIII (February 23, 1970) 67
40. Renee Fox, "Uncertainty in Medical Prognosis," American Journal of Sociology, LXVI (July 1960) 41
41. Renee Fox, "Uncertainty in Medical Prognosis," American Journal of Sociology, LXVI (July 1960) 47
42. Robert L. Weiss and Julian Silverman, "Anxiety and Response Stereotypy: An Experimental Critique;" Perceptual and Motor Skills XXII (1966) 101

Bibliography

- Balint, Michael, The Doctor, His Patient, and the Illness, New York, International University Printers, Inc., 1957
- Beyer, L.J., Annals of a Country Doctor, Unpublished Memoirs, 1966
- Biddle, Bruce J., Role Theory: Concepts and Research, New York, John Wiley and Sons, Inc., 1966
- Eloom, Samuel W., The Doctor and His Patient, New York, Russell Sage Foundation, 1963
- Elum, Richard, The Management of the Doctor-Patient Relationship, McGraw-Hill Book Company, Inc., 1958
- Bowers, Warner, Interpersonal Relationships in the Hospital, Springfield, Illinois, Charles C. Thomas Company, 1960
- Egeberg, Roger O., "The Country's #1 Health Problem," U.S. News and World Report, LXVIII (February 23, 1970) 67-73
- Fox, Renee, "Uncertainty in Medical Prognosis," American Journal of Sociology, LXVI (July 1960) 41-47
- Freidson, Eliot, Patient's Views of Medical Practice, New York, Russell Sage Foundation, 1961
- Gilbert, G.M., "Stereotype Persistence and Change Among College Students," Journal of Abnormal Psychology, XLVI (1951) 245-254
- Jaco, Gartly, Patients, Physicians, and Illness, Glencoe, Illinois, Glencoe Free Press, 1958
- Koos, Earl Loman, The Sociology of the Patient, New York, McGraw-Hill, 1959
- Linton, Ralph, The Study of Man: An Introduction, New York, Appleton-Crofts, Inc., 1936
- Marsh, Gayle and Jacob L. Halberstam, "Personality Stereotypes of United States and Foreign Medical Residents," Journal of Social Psychology, LXVIII (1966) 187-196
- Riessman, Frank, Jerome Cohen and Arthur Pearl, Mental Health of the Poor, New York, The Free Press, 1966

- Rosenblatt, Daniel and Edward A. Suchman, "Blue Collar Attitudes and Information Toward Health and Illness," in Blue Collar World: Studies of the American Worker, ed. Arthur Shostak and William Gomberg, Englewood Cliffs, New Jersey, Prentice-Hall, Inc., 324-333
- Rosenblatt, Daniel and Edward A. Suchman, "The Underutilization of Medical Core Services by Blue Collarites," in Blue Collar World: Studies of the American Worker, ed. Arthur Shostak and William Gomberg, Englewood Cliffs, New Jersey, Prentice-Hall, Inc., 341-349
- Ruesch, Jurgen, Therapeutic Communication, New York, W.W. Norton and Company, Inc., 1961
- Watson, Thomas J., "Goals --- The Need for Priorities," Vital Speeches, XXXVI (March 1, 1970) 301-303
- Weiss, Robert L. and Julian Silverman, "Anxiety and Response Stereotypy: An Experimental Critique," Perceptual and Motor Skills, XXII (1966), 95-104