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WHITE COAT EFFECT: THE MAKING OF THE PATIENT-PHYSICIAN RELATIONSHIP IN MODERN EUROPE

Vladan Hanulík

A white coat effect is the term used to describe the situation in which a patient experiences a physical reaction on interaction with a physician in connection with medical treatment. The white coat effect is historically rooted in the process of differentiation in the style of thought regarding patients' status and their role in the diagnostic and therapeutic process. In the period of bedside medicine, the medical profession commanded little corporate power and therapeutic nihilism led patients to distrust the outcomes of professional treatment. Relationships between medical professionals and patients were marked by patients' mistrust in the doctor as a professional who understood the secrets of nature. With modern scientific progress in the nineteenth century, the patient's status changed significantly. The patient's personal opinion and reflection of their health condition became irrelevant after the introduction of modern diagnostic tools. The patient's body no longer even needed to be present for the medical examination: diagnosis could take place using samples of the patient's tissue, blood, cells or genes and their voices and opinions were not required. Hierarchical and imbalanced interactions between patients and physicians became an integral part of modern medicine. As a result, interaction with medical professionals is accompanied by anxiety, fear, and an inferiority complex, physically embodied in the white coat effect.

Keywords: History of Medicine, Patient-Physician Relationship, White Coat Effect

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The white coat effect can be regarded as a type of experience widely shared by many members of society. Although this phenomenon is deeply rooted in both social and cultural determinants, thanks to embodied experience,[1] its objective manifestation can be measured and tracked as a part of a human body-mind reaction. Increased heart rate and rising blood pressure are merely the peak manifestations of inner physical and mental processes resulting from the fear and tensions that inevitably accompany the interaction between doctor and patient.[2]

According to statistics reflecting the social status of different occupations, the physician's is one of the most respected professional activities across the world.[3] Probably no other modern occupation can be associated so well with Max Weber's, or in this sense rather Martin Luther's, notion of a vocation (*Beruf*)[4] as employment that serves society. Despite this fact, we still experience strong feelings of anxiety, fear, and vulnerability in doctors' waiting rooms. When and why did this fear constitute itself and is it an inevitable part of patient-physician interaction?

The phenomenon of raised blood pressure caused by medical treatment was first described by Italian internist Scipione Riva-Rocci in 1897.[5] Riva-Rocci pointed out that the simple application of the measuring instrument (the sphygmomanometer) can cause a temporary rise in the patient's blood pressure.[6] Although the described phenomenon opened up an interesting field for medical expertise, it did not receive further scholarly attention until 1983, when the first comprehensive quantitative research began. A team led by Giuseppe Manci observed that the rise in blood pressure becomes evident at the very beginning

1 The concept of embodiment is used here as a notion developed in cultural anthropology. See KATHRYN LINN GEURTS, *Culture and the Senses. Bodily Ways of Knowing in an African Community*, Berkley 2002, pp. 17–18.

2 GIUSEPPE MANCIA, GUIDO GRASSI, GIANFRANCO PARATI, ALBERTO ZANCHETTI, *White Coat Hypertension: An Unresolved Diagnostic and Therapeutic Problem*, Heidelberg – New York – London 2015, pp. 1–3.

3 DONALD J. TREIMAN, *Occupational Prestige in Comparative Perspective*, New York 2013, pp. 237.

4 MAX WEBER, *The Protestant Ethic and the Spirit of Capitalism*, Chicago – London 2001, p. 39–40.

5 W. H. BIRKENHAGER, JAMES IAN SUMMERS, ALBERTO ZANCHETTI, *Hypertension in the Twentieth Century: Concepts and Achievements*, London 2004, p. 12.

6 GIANFRANCO PARATI, GIUSEPPE MANCIA, *White Coat Effect: Semantics, Assessment and Pathophysiological Implications*, Journal of Hypertension 21/2003, p. 481.

of the patient's visit to the physician and is accompanied by a parallel increase in heart rate.[7]

The term white coat effect was used for the first time in 1988 by an internationally renowned British clinical hypertension expert Thomas G. Pickering.[8] In his paper Pickering coined the term white coat hypertension to describe patient whose blood-pressure is elevated in medical environments and provided a useful analysis of the impacts of the white coat effect on patients' organisms. Pickering and his team studied a group of 292 patients with untreated borderline hypertension. Twenty one percent of those patients were found to have normal daytime ambulatory pressures. The changes in their organisms were more pronounced when their blood pressure was measured by a physician than when it was measured by a technician or nurse. Patients defined as having white coat hypertension were more likely female than male and, according to Pickering, were mainly younger. In contrast to these outcomes, other sources define older female patients as the most affected group,[9] while some sources define young men as the most typical group of patients associated with the white coat effect.[10] Clearly, scholars have so far been unable to agree on any specific group of patients (defined in terms of gender, age or social background) typically affected by the white coat effect.

In the Czech medical discourse serious reflection on the concept of the white coat effect began only at the start of the twenty-first century. According to researchers, higher blood pressure during visits to the doctor is a result of the patient having an alarm reaction to their interaction with the physician. Medical visits, or being in a clinical environment more generally, lead to increased blood pressure and anxiety.

Our goal in this paper is to identify the roots of these socially and culturally shared feelings. We will ask how it is possible that interaction with representatives of the most respected profession, which is generally associated with

7 GIUSEPPE MANCIA, GIOVANNI BERTINIERI, GUIDO GRASSI, LUISA GREGORINI, GIANFRANCO PARATI, GUIDO POMIDOSSI, *Effects of Blood-Pressure Measurements by the Doctor on the Patient's Blood Pressure and Heart Rate*, Lancet 2/1983, p. 698.

8 THOMAS G. PICKERING, GARY D. JAMES, CHARLENE BODDIE, *How Common is White Coat Hypertension?* JAMA 2/1988, p. 225.

9 JAN FILIPOVSKÝ, *Hypertenze bílého pláště a maskovaná hypertenze* [*White Coat Hypertension and Masked Hypertension*], Vnitřní lékařství 61/2015, p. 401.

10 ELIŠKA SOVOVÁ, JAN JUKL, *100+1 Otázek a odpovědí pro kardiaky. Vyšetření, rizikové faktory, srdeční onemocnění* [*100+1 Questions and Answers for Cardiacs. Diagnostics, Risk Factors, Pulmonary Disease*], Praha 2005, p. 35.

altruism and the highest codes of moral honour, causes deep uncertainty and anxiety, and manifests itself in physical reactions?

The Manifestation of Patriarchal Hegemony in the Representation of Medical Culture

An American drama series, "House, M.D.", narrates the career of a doctor named Gregory House, who is the head of the diagnostic department at a fictional hospital, and the medical cases he is involved in. The main character could be characterized as an extrovert, intelligent man, who constantly insults the patients he is treating, interferes in his colleagues' personal lives, and bends both the written and unwritten rules of his profession; despite this, he earns his colleagues' respect and trust and his patients' gratitude.[11]

According to Paul Challen, the popularity of this TV show was driven by the contrast between the viewers' general expectations of the lead character, who works in a profession devoted to helping people, and his habitual insulting and offending his patients, local residents and humanity in general. This discrepancy between Dr House's personal characteristics and the needs and cultural stereotypes connected with the role of a medical professional create a permanent tension.

In the first episode of this TV series, the fictional Dr House uses the phrase "everybody lies", to suggest that there is no point talking to patients about their conditions, because there is nothing in a patient's mind that could be useful for a successful diagnosis. Every aspect of the human condition can, instead, be analysed using specialized methods and modern diagnostic devices or arrived at through the medical practitioner's own intellectual operations. Although every episode follows different patients' stories, patient's voices are marginalized; the only important people are the doctors, in particular the leading figure – Dr. House, incorporating the performative power of masculine identity.

A contrast to this character can be found in the leading female characters: the hospital's director Dr. Cuddy and other female doctors are depicted as emotional and understanding female professionals. The series leaves its viewers with the impression that a man's career in the medical profession is usually performed with insensitivity towards the patients and with a preference for a systematic

11 ALISSA BURGER, *Masculinity and Medicine: House as Doctor and Patient in House M.D.*, in: Gender Scripts in Medicine and Narrative, (edd.) Marceline Block, Angela Laflen, Cambridge 2010, p. 351.

analytical approach to the patient as an object. In contrast, female practitioners tend to talk and listen to the patients' expressions of fear, anger and anxiety and involve them in the process of medical diagnosis and treatment. The script writers have intentionally stressed perceived gender differences. And yet the white coat effect affects patients visiting both male and female medical practitioners. The results of medical studies have suggested that there is no significant association between gender and white coat hypertension.[12] Should we interpret the interaction between a patient and a physician as gender-neutral, at least as far as we talk about the quantitative and measurable aspect of the white coat effect? And what really causes anxiety during visits to medical professionals?

French Revolution in Medicine

According to Erwin Heinz Ackerknecht, the main turning point is to be found in the development of modern continental medicine around the time of the French Revolution. Where medicine was concerned, the revolution applied the same principles as to other aspects of the old regime. In March 1791 all the old corporative regulations in the field of medical practice were abolished, to be replaced by the free market. "Everyone could, on payment of a fee, be not only his or her own physician, but provide medical services to whoever chose to consult them."[13] This previously unimaginable liberation of the medical sphere, removing all obstacles for anyone wishing to offer medical advice or treatment posed a threat of potential disaster.

The War of the First Coalition against the French First Republic between 1792 and 1797 led to mass mobilization. The French army was driven to form the first citizen army and had to care about the health of its members. Learning from the outcomes of the first battles, the leading politicians of the republic soon realized that appropriate treatment of soldiers' wounds, broken bones and shattered limbs was not only beneficial for the soldiers themselves but also crucial for the future of the political system they had established. There was soon an urgent

12 KATHERINE STREITEL, JENNIFER GRAHAM, THOMAS PICKERING, WILLIAM GERIN, *Explaining Gender Differences in the White Coat Effect*, Blood Pressure Monitor 16/2011, p. 1.

13 STEPHEN JACYNA, *Medicine in Transformation, 1800–1849*, in: The Western Medical Tradition 1800 to 2000, (edd.) W. F. Bynum, Anne Hardy, Stephen Jacyna, E. M. Tansey, Cambridge 2006, p. 39.

need for skilled medical practitioners, not least because of the 2 700 medical officers in service in 1793, almost 1 000 had fallen by spring 1794.[14]

The creation of a new system of medical education, nowadays associated in medical circles with the term French revolution in medicine, thus commenced in 1794. Medical schools were established in Paris, Montpellier and Strasbourg in 1795. The old tradition of distinct training for surgeons (focused on practical treatment and physical intervention) compared to that of physicians (more theoretically based with a holistic approach to treatment) was changed in favour of a comprehensive, universal training for all doctors.

One of the authors of that reform, Antoine-François de Fourcroy, defined the new principles of schooling with the following words: "Reading little, seeing and doing much: this will be the basis of a new teaching."[15] The main element of the new system was the clinic, where medical students learned the three main principles of the new era, the first of which was the detailed observation of the patient. The age of the medical gaze had begun, as Michel Foucault suggested.[16] All possible kinds of physical examination were used and new technical devices, for example, the stethoscope, were developed for that purpose. The second principle was that of open access to human bodies. Every pathological state was examined after the patient's death, to the level of tissues, in order to locate the illness and identify its effects on the body. Third, thorough medical statistics were analysed to assess the efficacy of applied forms of treatment.

So extensive was the influence of the revolution on the medical field that the period between 1790-1850 is referred to by Ackerknecht as the Paris Period of Medicine. However, while its epicentre was situated in revolutionary France, this wave of change spread across the globe, shaping the development of modern medical practice in Western and Central European countries, Russia, the Americas and Asia.

Bedside Medicine

Erwin H. Ackerknecht suggested, in *Medicine at the Paris Hospital*, that we can trace three main periods in the development of the medical field as far as the patient-physician relationship is concerned. Ancient, medieval and early mod-

14 MATTHEW RAMSEY, *Professional and Popular Medicine in France, 1770–1830: The Social World of Medical Practice*, Cambridge 1988, pp. 75–76.

15 S. JACYNA, *Medicine in Transformation*, p. 41.

16 MICHEL FOUCAULT, *The Birth of the Clinic*, London 2003, p. XIV.

ern medicine is associated with the term bedside medicine, The French revolution in the medical field followed, bringing a less patient-oriented approach (1790–1848). By the mid-nineteenth century, medical practice began to acquire key signs of having entered a new period, which we might refer to as laboratory medicine. Each of these periods were distinct not only in terms of the scientific paradigm of medicine, but also the status of medical practitioners as bearers of unique professional expertise.

In the period of bedside medicine, the physicians' profession commanded little corporate power and therapeutic nihilism led patients to distrust the outcomes of professional treatment.[17] Traditional medical reasoning afforded no grounds for believing that physical examination would be useful for diagnosing patients' conditions. Traditional doctors did not practice any kind of clinical investigation, in the sense of examining the patient. On the contrary, they spent considerable time analysing patients' personal histories and their own references about medical conditions. The relationship between the medical professional and the patient was substantially imbalanced in the patient's favour. Patients were responsible for providing histories of their personal health, which doctors then used to make the diagnosis. Sick people would visit or write to their doctors to tell them when and how their condition had developed, what kind of symptoms they had observed and what treatment they had already used. Patients would inform their physicians about their diet, everyday lifestyle, emotional state and personal opinions about possible treatments. The best clinicians were the best listeners, doing the detective work of identifying the source of the pathological condition not from the patients' bodies, but from their words.[18] The diagnostic process and the medical treatment that followed were inseparably connected with the patient's personality.

Furthermore, bedside medicine was often practised at the patient's bedside or at least in their bedchamber. The spatial dimension of medical practice played a key role in its hierarchical constitution: being invited into a patient's house, the physician was subject to the patient's (or their family's) rules. Doctors were considered merely guests, not rulers over the patient's body. They were respected or distrusted, according to their performance, but were certainly never granted

17 ERWIN H. ACKERKNECHT, *Medicine at the Paris Hospital 1794–1848*, Baltimore 1967, p. XI.

18 ROY PORTER, *The Eighteenth Century*, in: The Western Medical Tradition 800 BC to AD 1800, (edd.) Lawrence L. Conrad, Michael Neve, Vivian Nutton, Roy Porter, Andrew Wear, Cambridge 1995, p. 403.

a paternalistic dominant position like that seen in the modern period. The patient him/herself was the judge of the practitioner's qualities and it was in the patient's power to prevent the implementation of potentially risky innovative types of treatment. The patronage model maximised patient (or client) control and minimized the authority of the doctor; the patient was seen as a conscious human whole.[19] The physician's task was to seek to grasp this whole and come up with a treatment and regimen adapted to the maintenance of health. As N. D. Jewson defined, the patient's phenomenological account of his bodily state was essential to the process of medical examination and treatment.[20]

Patients were also empowered by the fact that many consultations were conducted through written correspondence. Written questions containing lay descriptions of illnesses or symptoms were commonly used as a method of acquiring the physician's expert medical knowledge.[21] The practitioner took a rather passive role – composing an answer based on the patient's own opinion and description.

Traditional medical consultation was characterized by a history-taking, holistic approach. Varied competences were therefore considered essential for a successful career. Advice given by the skilled medical professionals to young practitioners about how to achieve success in a medical career at the end of the eighteenth-century reflected the medical culture of the time: in contrast to the modern era, moral qualities, physical appearance and the ability to act in a trustworthy way were considered more important for a successful doctor than the acquisition of education and scientific knowledge through studying medicine at university.[22] The traditional doctor's therapeutic nihilism coupled with lay patients' lack of belief that medical professionals understood the secrets of nature determined their relationship until the nineteenth century.

19 S. JACYNA, *Medicine in Transformation*, p. 54.

20 N. D. JEWSON, *Medical Knowledge and the Patronage System in 18th Century England*, Sociology 8/1974, p. 370.

21 ROBERT WESTON, *Medical Consulting by Letter in France, 1665–1789*, Farnham 2013, pp. 105–106.

22 WILHELM GOTTFRIED PLOCQUET, *Der Arzt, oder über die Ausbildung, die Studien, Pflichten, Sitten, und die Klugheit des Arztes*, Tübingen 1797, pp. 66–68.

Hospital Medicine

The distinction between bedside and hospital medicine was described by Ivan Waddington.[23] According to his analysis, the turning point in the distribution of power and the constitution of the modern medical regime occurred in the Paris Period of Medicine. New forms of treatment and diagnosis emerged in place of cutting, bleeding and purging. Medicine went through substantial change in the late eighteenth and early nineteenth centuries. Morbid anatomy and dissection were introduced and the clinic was established, alongside new medical schools as centres of education and scientific research based on the principles of observation, physical examination and comprehensive medical statistics. From then on, patients' encounters with physicians took place, largely, in a hospital-type space and this had direct implications for the patient-doctor relationship.[24] In the reformed clinical environment, the doctor was in a dominant position. His power over the patient enabled him to set the medical agenda and, in line with scientific progress, make use of a wide variety of diagnostic, analytical and therapeutic innovations. As Stephen Jacyna suggests, "the patient ceased to be a person, with whom the practitioner was obliged to negotiate and to whom he was obliged to defer, and became a body upon which an ever-increasing repertoire of procedures might be performed".[25]

Social Hierarchy

Ivan Waddington explains the shift in hierarchy of power relationships by pointing to the differences in social status between doctors and medical students on the one hand and the patients on the other. Even in the nineteenth century, hospital care was associated with poverty – only the poorest needed to seek help at hospitals, which were often associated with prostitutes, beggars, and members of the proletariat. As Waddington maintains, hospital consultants in the revolutionized Paris medicine system were recruited from the wealthy bourgeoisie. These educated and well-situated hospital doctors frequently dealt with uneducated, often even illiterate patients. The inequalities in social, economic

23 IVAN WADDINGTON, *The Medical Profession in the Industrial Revolution*, Dublin 1973, p. 215.
24 M. FOUCAULT, *The Birth of the Clinique*, pp. 67–68.
25 S. JACYNA, *Medicine in Transformation*, p. 55.

and cultural capital[26] between doctor and patient led to doctors developing an attitude of superiority over their patients, who were not in a position to dispute or challenge the practitioners' decisions about their bodies. They were expected to follow the doctors' orders and submit to their will. If they tried to protest, they risked being dismissed from institutional care, which was usually their last refuge.[27]

This deficit of patient power rendered the hospital space an ideal location for the introduction and application of new methods of medical examination and treatment. Social statutes and the fact that poor patients had to yield to the doctors' power were abused to enable the exposure of the patients' naked flash and intimate body parts to the physician's gaze and often even to that of a large crowd of students who stood at the bedside to learn from their tutors' live demonstrations. The patient's personhood was reduced to that of a demonstration model serving a pedagogical purpose.

According to Waddington, this phenomenon was enabled by the fact that the process of civilization among the lower social classes was relatively slow.[28] He builds on the work of Norbert Elias, who described the civilization process as the gradual cultivation of civilized manners, first adopted by the upper classes and later embraced by lower classes through mimicking the behaviour of court society in order to get as close as they could to the socially distinctive norms of behaviour of the higher ranks. Waddington reflects on the sociogenesis and psychogenesis of the feeling of shame and embarrassment associated with the public exposure of nudity at different stages of this civilizing process. Limitations on the exposure of bodily parts were not yet established among the urban and rural poor in the nineteenth century. Hospital clients tolerated public nudity without substantial embarrassment, and the supposed lack of modesty among typical hospital inmates permitted more intrusive medical practices. With the Paris Period of Medicine came a transition from a person-oriented to an object--orientated medical cosmology. The patient's role was marginalized. The truth of disease was to be uncovered through the physician's examination.

This development in medicine was further outlined by Michel Foucault. According to him, the patient and the practitioner formed a new dichotomy of empowered and powerless. Michel Foucault believes that the medical field and

26 PIERRE BOURDIEU, *The Logic of Practice*, Stanford 1990, pp. 56–57.

27 I. WADDINGTON, *The Medical Profession*, p. 216.

28 I. WADDINGTON, *The Medical Profession*, pp. 153–175; NORBERT ELIAS, *The Civilizing Process: Sociogenetic and Psychogenetic Investigations*, Oxford 2000, pp. 44–45.

all possibilities for action within it were defined by its means of knowledge production. Foucault developed the concept of biopower as a formative social strategy embodying intentions of their own, above those of individuals engaged in them. Medical practice was merely one small part of disciplinary power distribution. Similar processes took place in other spaces – schools, army, prisons, and factories. Hospitals were apparatuses of power that produced knowledge about human bodies and minds and this is how they brought the population under control.[29]

In contrast to Foucault, Ludwik Fleck's notion of a style of thought provides more space for historical actors and their subjectivity. Fleck views the development of medicine in the first half of the nineteenth century from a different angle.[30] As he suggests, a style of thought is a particular way of thinking, seeing, and practicing, which involves formulating statements that are only intelligible and achievable within that frame of thinking. Terms, concepts, references, relations, and practices are organized into configurations of a certain form that serve as arguments and explanations.[31] Thus medical spaces, practices, and the roles associated with the physician and the patient are linked up within complex practical arrangements.[32] When a style of thought becomes sufficiently sophisticated, the collective divides itself into the so called esoteric circle (meaning the professionals) and an exoteric circle (laymen), and so the new style of thought that took shape in the life sciences in the nineteenth century modified each of its objects, so that they appeared in a new way, with new properties, and new relations and distinctions to other objects and participants. Yet, a style of thought is not merely a new discourse. The hospital became a kind of factory for the creation of new forms of life. In doing so, it also created a new way of understanding the notion of life itself.

Every step in the development of scientific medical knowledge, every discovery, leads to alternation in thought, diagnostics, treatment and, more relevant to this analysis, changes both the patients and the doctor, and the relationship between them. Thus, the history of medicine does not seem to support Foucault's image of dominant and stable structures.

29 LILIAN V. FURST, *Between Doctors and Patients. The Changing Balance of Power*, London 1998, p. 131.

30 LUDWIK FLECK, *Genesis and Development of a Scientific Fact*, Chicago 1979, pp. 2–3.

31 The definition of the style of thought is similar to Kuhn's notion of paradigm, yet Fleck's concept is more oriented towards social practice.

32 NICOLAS ROSE, *The Politics of Life Itself. Biomedicine, Power, and Subjectivity in the Twenty--First Century*, Oxford 2007, p. 12.

On the contrary, medicine has been defined by a continual series of substantial, permanent changes. This is visible in contemporary medicine, in which the very same illness is treated differently almost every year. The only thing that does seem stable is the division of power. The hierarchy of the patient-physician relationship shifted during the second half of the nineteenth century in favour of medical practitioners. From then onwards, the skilled and educated physician would rule over the patient's body. The white coat effect has its roots in this revolution, emerging from a new style of thought regarding the status of patients and their role in the diagnostic and therapeutic process.

Laboratory Medicine

The year 1848 changed the medical field yet again. Ackerknecht and Jewson call the second half of the nineteenth century and the twentieth century the period of laboratory medicine. Many famous scientists made ground-breaking discoveries during this period – e.g. Louis Pasteur, Robert Koch, Paul Ehrlich – and all of them have one thing in common: their success was not based on their interactions with patients. They achieved undisputed fame and success thanks to the fact that they worked with samples of biological material. Under the laboratory medicine regime, the doctor no longer dealt with patients or their bodies; diagnoses were, and still are, made based on samples (or later diagnostic images) transported to the laboratory for analysis.[33]

The development of the patient-physician relationship influenced not only the balance and division of power in the medical profession, but also its habitus.[34] The unwritten rules of bedside medicine obliged the doctor to cultivate the personal qualities needed to engage in successful interaction with the patient. A physician without empathy and interrogation skills would not have much chance of succeeding in the medical market and would not be seen as a helpful practitioner.[35] Whether a doctor was considered a trusted medical authority or not depended not only on his skills, but also on his charisma, as judged by the patient as ultimate arbiter. The advent of laboratory medicine freed the doc-

33 TIMOTHY LENOIR, *Laboratories, Medicine and Public Life in Germany, 1830–1849: Ideological Roots of the Institutional Revolution*, in: The Laboratory Revolution in Medicine, (edd.) Andrew Cunningham, Perry Williams, Cambridge 1992, pp. 15–16.

34 Habitus is definded as a system of durable, transposable dispositions, as principles which generate and organize practices and representations, PIERRE BOURDIEU, *The Logic of Practice,* Stanford 1990, p. 53.

35 W. G. PLOCQUET, *Der Arzt, oder über die Ausbildung*, p. 90.

tor entirely of such judgment from the patient and enabled both diagnosis and treatment decisions to take place in the patient's absence.

This shift in power could also be described in terms of economic determinants. In the bedside medicine era, the doctor relied on the patient paying him directly for his services. Under the hospital medicine regime, patronage was dispensed by the institutional structure of the medical profession. Later, in the age of laboratory medicine, the economic aspects of medical practice shifted again, becoming centred on universities and scientific laboratories rather than hospital wards and clinics. Authority was derived from the physician's status in the frame of the institutional system, whether clinical or academic. The patient no longer played a key role in constructing or judging the authority of medical staff. According to Jewson, the social distance between patients and practitioners increased significantly under laboratory medicine, in which the collective of medical investigators appears to inhabit an insulated intellectual island.[36]

Experimental medicine was motivated by the effort to achieve control over the workings of the body and its functions. L. S. Jacyna suggests that in this period the determination to achieve control over the body became fundamental to the ethos of Western medicine.[37] Technological development consolidated the notion of dominance over the rules of nature. Genetic engineering is the most obvious example of evidence that human bodies are, like the rest of nature, available for intervention motivated and justified by the goal of achieving well-being.

Cartesian dualism as a new paradigm of human body

The trend for human body optimization has become more important over the last seventy years. Prior to the second half of the twentieth century, expert medical interventions were performed to cure pathologies, to rectify generally accepted deviations from desirable functioning and to promote strategies of biopower through lifestyle modifications. Later, the recipients of these interventions became consumers, making choices on the basis of their – at least partially narcissistic or irrational – desires that are, shaped not by medical necessity but by the laws of the market and consumer culture. Ian Hacking has suggested that

36 N. D. JEWSON, *The Disappearance of the Sick-Man from Medical Cosmology*, Sociology 10/1976, p. 237.

37 L. S. JACYNA, *Medicine and Modernism: A Biography of Sir Henry Head*, London 2008, p. 120.

based on the recent changes in the medical field we must once again reassess the notion of Cartesian dualism.[38]

The progress of medical developments in replacement body parts and organs – hearts, kidneys, hips – and new surgical techniques that have enabled patients to observe the creation of new organs on screen during operations or observe the living foetus inside the womb – reinforce the idea of an analogue body with interchangeable body parts, a body distinct from the mind. We are, Hacking suggests, finally becoming Cartesian, "in the sense my body [is seen] as something other – something mechanical, subject to engineering, and with interchangeable parts. A body as already envisaged by Descartes."[39]

During the twentieth century, states' responsibilities expanded from collective measures to ensure health, which were widely adopted in the nineteenth century process of hygienization, such as clean water, sewers, improved food quality, to include the active encouragement of healthy practices in the home. Now the maintenance and promotion of personal, child, youth and familial health – regimen, personal hygiene, the identification and treatment of illnesses – became central to forms of self-management that authorities began to inculcate into the citizens of post-industrial societies. All these norms of health and hygiene began to spread through the practices of state medical authorities as a matter of their own self-maintenance and self-formation – to maximize the citizens' biological capital and, in turn, the states' biological capital.

The New Style of Perception in the Medical Field

The establishment of laboratory medicine resulted in the creation of new social forms necessary for effective collaboration within the laboratory environment, with its technical facilities and rules. New techniques of cooperation and participation in teamwork research were introduced which later strengthened medical professionals' growing corporate identity. The popularization of the microscope, broadened by its greater affordability after the mid-nineteenth century, changed the way medical students of medicine learned to perceive the world.[40]

38 IAN HACKING, *The Cartesian Vision Fulfilled: Analogue bodies and digital minds*, Interdisciplinary Science Reviews 2/30, p. 163.

39 I. HACKING, *The Cartesian Vision*, p. 165.

40 STELLA BUTLER, R. H. NUTTALL, OLIVIA BROWN, *The Social History of the Microscope*, Cambridge 1986, p. 5.

The microscope possessed an ideological function – a sign of rational, experimental and scientific medicine. This deepened the notion that any further development in medicine would be inseparably connected with the scientific essence of the discipline and by the turn of the twentieth century this dogma had come to dominate Western medicine.[41] A scientific approach to the human body helped to distinguish an orthodox medical practitioner from other competitors in the medical market.[42] This was true even though identification with the scientific aspect of medicine also had economic implications.

Identification with the ideals of science sank a portion of potential earnings from clinical practice. The division between theoretical research and clinical practice stands starkly, even in contemporary society, in the face of every medical student.[43] Choosing a career in science entails the subordination of wealth accumulation to higher ideals. Jacyna posits that a dedication to science can be interpreted as a form of altruism – a gesture towards the superiority of gentlemanly codes over the mercantile motivation of clinical practitioners.[44] Engagement in science is endowed with political and social significance – a career in medicine has become the embodiment of altruism and benefit to mankind and this has helped to hide doctors' economic interests.

The general practitioner's profession became less popular after the Second World War. Many doctors who became general practitioners had originally wanted to become specialists. The internal hierarchy of the medical profession meant that even though general practitioners remained the first point of call in many European countries (including Czechoslovakia and later the Czech Republic), the general practitioner was often seen merely as a gatekeeper, opening the door to the more sophisticated treatment provided by specialists. In Czechoslovakia numerous polyclinics were established, where patients could consult both general practitioners and specialists, but recommendation from a general practitioner was still required to gain access to specialized treatment.

41 W. F. BYNUM, *Science and the Practice of Medicine in the Nineteenth Century*, Cambridge 1994, p. 219.

42 S. S. BROWN, *Social Context and Medical Theory in the Demarcation of Nineteenth-Century Boundaries*, in: Medical Fringe and Medical Orthodoxy 1750–1850, (edd.) W. F. Bynum, Roy Porter, London 1987, pp. 216–217.

43 JAN BRUTHAUS, *Šest let, cestou necestou* [*Six Years, Up Hill and Down Dale*], in: O duši medika. Jak vzniká lékař [About the Soul of Medical Practitioner. The Birth of a Medical Doctor], (edd.) Ctirad John, Štěpán Svačina, Praha 2011, p. 49.

44 S. JACYNA, *Medicine in Transformation*, p. 79.

After World War II the relationship between doctors and patients was asymmetric and favoured doctors more than ever before. Confidence in doctors and their professional prestige had never been higher. During the war, medical practitioners had proven that investments in medical research were useful and valuable. New types of medication – antibiotics, steroids, analgesics – together with pioneering surgical operations forged a dynamic and powerful picture of modern medicine and the welfare state system guaranteed its potential for a broad population.

Modern science has become linked inseparably with technology and this marriage was reinforced during the twentieth century. Of course, not all doctors welcomed this development. Worries about losing the empathy and the art of medicine, not treating the patient as a holistic entity, or following every new discovery without sufficient criticism were common. Science thus did not achieve its dominant position within the medical culture without controversy and resistance but rapid developments in histology, bacteriology, immunology, pathology, and later in specialized diagnostics lay the foundational principles of the scientific approach to the human body and medical education that are still present in contemporary discourse.[45] Besides medical schools and hospitals, as existing institutions of progress, independent research institutes were established in response to these dynamic changes. We should not consider them equal, especially in terms of progress. Historians of medicine have recently shown that ideas and practices take time to become assimilated. New approaches developed in laboratories had a less immediate impact on ordinary medical practice and treatment than older historiography had assumed.

Nevertheless, the disappearance of the patient from the most honourable part of medicine had further consequences. Patients remained only as the objects of experiments and scientific thoughts. For the purpose of diagnosis, the medical specialist needed the patient's tissue, blood, cell or gene samples, but not their voice or opinion. No wonder patients feel anxious in the waiting room. Their personality is not relevant to the medical practitioner nor to the process of medical treatment.

45 W. F. BYNUM, *The Rise of Science in Medicine, 1850–1913*, in: The Western Medical Tradition 1800 to 2000, p. 111.

Socialization into the Role of a Physician

Although the traditions of medical education varied across the world, in the eighteenth and nineteenth centuries young aspiring medical professionals found themselves in one of five institutional educational settings, depending on their region of origin, their financial resources and their career ambitions.

The most basic form of education in conventional medicine was the apprenticeship. It played an important role in career preparation in the less prestigious branches of medicine – it was the path for surgeons, apothecaries, dentists and, in some regions, also general practitioners. Under their masters' supervision, apprentices learned all aspects of medical practice, not only diagnostics and treatment but also how to keep ledgers and force patients to pay their bills. This practically oriented education was generally combined with a period of study at a medical school in order to satisfy the formal aspects of licensing for the profession. Of the four different types of medical schools, the most typical type for apprentices were proprietary schools, led by skilled individuals or a group of masters. These were typical in the late eighteenth and early nineteenth centuries in France and Germany, and in America they dominated the education system until the 1860s.

The second type of medical school – the practical secondary school – was common in continental Europe, primarily in Germany, France, and the Habsburg monarchy. These provided education for lower medical specialists – surgeons. Education at these schools was usually practically oriented, and their graduates were expected to go on to provide medical treatment for lower-class patients or to specialize in surgical operations, which was a specialism not suitable for theoretically educated physicians. These practical schools began to lose their importance at the turn of the nineteenth century because of changes in the education system, which introduced surgery as an integral part of the educational process for students at medical faculties.[46] But in some German-speaking countries these types of schools survived until the 1870s.[47]

Medical schools of the third kind were associated with hospitals. Introduced at the end of the eighteenth century in the Paris Period of Medicine, hospital schools largely divided the educational process between the university and the

46 PETR SVOBODNÝ, LUDMILA HLAVÁČKOVÁ, *Dějiny lékařství v českých zemích* [*History of Medicine in Bohemian Lands*], Praha 2004, pp. 93–101.

47 CLAUDIA HUERKAMP, Der *Aufstieg der Ärzte im 19. Jahrhundert. Vom gelehrten Stand zum professionellen Experten: Das Beispiel Preußens*, Göttingen 1985, p. 36.

hospital, although not necessarily. The core of their curriculum was focused on practical education, preparing future practitioners for the reality of their professional encounters with patients. This development did not only take place in continental Europe; the most famous medical schools in Britain shared a similar approach to education. University College London and King's College London both offered the possibility to study at the university while learning practical diagnostics and treatment at the hospital. The connection between hospital and university was beneficial for both institutions. Teachers at the clinics benefited financially from student fees. Despite those fees, hospital medical schools were dependent on their parent institutions – universities. Charitable donations were also collected but, as the nineteenth century progressed, the demands for new technological equipment and materials grew significantly.

As the importance of research-based medicine grew and laboratory medicine developed, the best opportunities for future practitioners were provided by university medical schools. There, students could be taught by doctors actively engaged in research rather than merely from practitioners.[48] Only graduation from a university would provide access to the social status of a well-educated professional. This was enabled by revolutionary changes in the medical field during the Paris Period of Medicine. A similar and often independent development can be traced in other countries as well. The Habsburg monarchy was at the forefront of these developments. The planned foundation of hospitals during the reign of the Habsburg emperor Joseph II established the basis for a more practically oriented education even before the French revolution. Following the pro-populationists' directions (in Foucauldian reasoning) the emperor and his chancellors implemented the disciplinary system of biopower. The state would prosper only if it was densely inhabited by citizens and peasants. Those inhabitants would only pay their taxes and fight for king and country in battles if they were healthy. Medical practitioners were thus seen as a key element of power distribution.[49]

Over the course of the nineteenth century, the medical marketplace became crowded. Representatives of professional interests began to formulate codes of behaviour and point out the main elements of their interests. Professions tended

48 CLAUDIA HUERKAMP, *The Making of the Modern Medical Profession? 1800–1914: Prussian Doctors in the Nineteenth Century,* in: German Professions, 1800–1950, (edd.) Geoffrey Cocks, Konrad H. Jarausch, Oxford 1990, pp. 67–70.

49 In Czech historiography Daniela Tinková applied the concept of biopower in her excellent works. See, for example DANIELA TINKOVÁ, *Tělo, věda stát. Zrození porodnice v osvícenské Evropě* [*Body, Science, State. The Birth of the Infirmary in Enlightenment Europe*], Praha 2010, pp. 27–30.

to form occupational monopolies, whether determined by the state or by "nature". The tendency to claim a monopoly over the medical field ran counter to the tenor of the liberalism ideology. A *laissez-faire* policy in the medical field was declared a dangerous hazard for citizens' health because it enabled nonconventional medical systems of homeopathy, hydropathy, herbalism, etc. to spread.

Before the establishment of state regulation of medical personnel, professional directives had been in the jurisdiction of a college or professional collegium. In Britain, the Royal Colleges of Physicians and Surgeons controlled medical practice in London, and similar institutions existed in other major cities. In smaller towns and in the countryside there was an open medical marketplace and persecutions of unconventional practitioners were rare. New regimes of regulation were first introduced in the Habsburg monarchy and in France. At the turn of the nineteenth century, both these countries developed qualification systems for the medical professions: only those with a doctorate of medicine or surgery from a medical school could practice medicine. From that time on, charlatans were strictly prosecuted.[50] Similar regulation was brought into force in Britain by the Medical Act of 1858. This legislation perpetuated the eclectic system of education and licensing that had grown up with the establishment of different types of medical schools, but failed to prohibit irregular practice. Patients could, in theory, rely upon the annual Medical Register of qualified doctors, which provided sufficient information for a knowledgeable choice of a medical practitioner.

The steady increase in hospital care by the turn of the twentieth century contributed to the spread of asymmetric power relationships between doctors and patients to broader society, but this does not signify a wholesale transformation of the medical field. Middle and upper-class patients sought help from their family general practitioners even at the beginning of the twentieth century, and the relationships between these family doctors and their patients were more equal. Fee-paying patients could still choose their doctors according to their own preferences. In that sense, they were masters of their own destiny. The exception, which allowed practitioners' paternalistic hospital manners into the public sphere, was the surgical operation, which always took place in hospital. The

50 ROGER COOTER, *Alternative Medicine, Alternative Cosmology, in: Studies in the History of Alternative Medicine*, (ed.) Roger Cooter, Oxford 1998, pp. 70–73; ROBERT JÜTTE, *Ärzte, Heiler und Patienten, Medizinischer Alltag in der frühen Neuzeit*, München 1993, pp. 30–32.

process of medical specialization and the discourse of scientific progress resulted in the codes typical for hospital environment spreading to the whole society.[51]

Gender Differentiation?

The gender roles of nineteenth-century society were shaped, among other things, by gendered double standard in education. This dualistic approach to male/female education prevented women from access to universities. At the end of the nineteenth century male physicians published a number of texts that discouraged women from entering the medical profession. The women's liberation movement challenged women's lesser position in society and demanded access to medical studies for women. Its legal anchoring was delayed in Austria-Hungary until 1900, and social acceptance of female physicians took much longer.

According to article 18 of the Austro-Hungarian constitution, dating from December 21st 1867, everyone in the monarchy was free to choose their own occupation and education. The university cultural environment was created by men and was shaped – especially in the nineteenth century – by the codes of masculinity. Even the first steps on academic ground were related to ritualized forms of hegemonic code of bourgeois masculinity. The so-called *Burschenschaften* were the dominant power of academic life both in Germany and in the Habsburg monarchy. Universities were exclusive man-ruled social networks, interconnected through corporations and academic societies, reading societies, academic choirs, etc. A position in these closed social circles was crucial for further career development, and of course, all the codes of social behaviour created within the academy were directed towards a male-oriented and man-ruled patriarchal society.[52]

Thus, by the time female students entered the university medical schools, the habitus of the (male) physician had been firmly formed as a social normative for many decades and socialization into the performativity of that habitus had become an integral part of the education process. For female practitioners to succeed in their new field they had to accept the already created (male) professional

51 UTE FREVERT, *Krankheit als politisches Problem 1770–1880, Soziale Unterschichten in Preußen zwischen medizinischer Polizei und staatlicher Sozialversicherung*, Göttingen 1984, pp. 75–79.

52 FELICITAS SEEBACHER, *„Gleiches Gehirn, gleiche Seele, gleiches Recht!" Der medizinische Blick auf die bürgerliche Geschlechterordnung als Einflussfaktor auf die Legalisierung des Medizinstudiums für Frauen*, in: Strukturen und Netzwerke. Medizin und Wissenschaft in Wien 1848–1955, (edd.) Daniela Angetter, Birgit Nemec, Herbert Posch, Christiane Druml, Paul Weindling, Wien 2018, p. 183.

perfomative. In order to achieve professional success in the medical field it was essential not to introduce any aspects viewed as feminine in the patient-physician interaction, such as sensitivity or empathy. The first *alumnae* of medical faculties in the Bohemian lands accepted the challenge to equalize themselves with the codes and manners of the medical profession as performed by their male colleagues. Hostile reactions from the part of their fellow male students forced the female students to produce evidence that they could participate in the same field and observe the same rules.[53] The interaction between patients and physicians thus remained unchanged – hierarchical and asymmetric in favour of physicians.

Welfare-State Medicine

Four principal types of economic relationship between doctor and patient have been tracked in history: fee-for-service, charity, prepayment through mutual aid association or private insurance, and payment regulated by a government or municipality through taxes and social contributions.[54] Most of the time, patients paid a fee for the medical services they received directly to the practitioner who provided them; charity treatment was associated with the poor and with the hospital environment. The nineteenth century witnessed an increase in mutual aid associations and, on the continent, even the foundation of a health-security system, based on the model of mutual illness insurance introduced by German chancellor Otto von Bismarck in 1883. Many practitioners resented these developments. The salaries this system offered were modest and being the employee of a working-class group or association hardly raised professional self-esteem. On the other hand, mutual-aid groups and health insurance enabled participating doctors to distance themselves from the fee-for-service model and move on to the economic principle of capitation. In this model, the doctor was paid according to the number of patients for whom he was responsible and not according to the number of consultations provided to the patients. Changes in the system were very slow. It has been estimated that in 1900, 80 percent of medical practice in Germany was still on a private, fee-for-service basis.[55] The new German

53 For a comprehensive reflection, see PETR SVOBODNÝ, *Lékařky v českých zemích v první polovině 20. století* [*Female Medical Practitioners in the Bohemian Lands in the First Half of the Twentieth Century*], Acta Universitatis Carolinae. Historia Universitatis Carolinae Pragensis 35/2003, pp. 61–73.

54 W. F. BYNUM, *The Rise of Science in Medicine*, p. 216.

55 Compare with U. FREVERT, *Krankheit als politisches Problem*, pp. 220–241.

system was later introduced in the Habsburg monarchy, France and several other countries on the continent.

At the end of the nineteenth century aseptic surgery, trained nurses, professionally trained doctors and the discourse of modernization brought all classes of patients into hospitals. This change was enabled by the increase in hospitals' symbolic status. Between the First and the Second World Wars, hospitals consolidated their position as centres of high quality medical practice. University hospitals became prominent places for medical education and seats of medical excellence. More and more people who would previously have been treated at home were treated in hospitals, which the concentration of resources and technologies rendered specialized centres for research and therapy, equipped with large X-ray and ECG machines. Laboratories became integral parts of major hospitals and hospitals were often described as "health factories" referring to the fact that all major hospitals were constantly expanding, both in terms of the number of beds available for patients and in their numbers of medical personnel. For example, in the United States the number of hospitals almost doubled from 4 500 to 7 000 between 1909 and 1923; in 1929 almost 100 000 of 140 000 practising doctors were attached to hospitals.[56]

Postmodern Medicine

In the post-war period, the Western medical tradition became widely influential. With its emphasis on science, education and distinctive ways of approaching the human body, medicine emerged as the core professional contributor to the modern world culture of progress. Its dynamic internationalized research ethos combined with welfare models to establish a unique professional identity and credentials. Between 1945 and 1970s Western medicine remained confident in its ideals of permanent progress and prosperity and was often described as the ultimate benefit to humankind.

With the social and political changes in the 1960s a generation emerged that grew up in the age of antibiotics, without the fear of deadly infections. Members of this new generation began to question the way in which all the above--mentioned benefits were delivered. The rising costs of new technological advances in medicine served as a warning sign of a potential future crisis. Popular culture depicted some of the new medical approaches as dehumanizing,

56 CHRISTOPHER LAWRENCE, *Continuity in Crisis: Medicine, 1914–1945*, in: The Western Medical Tradition 1800 to 2000, p. 269.

as for example did Miloš Forman in his film *One Flew Over the Cuckoo's Nest* based on the novel by Ken Kesey, in which all the main characters were engaged in a constant struggle against the authority of the medical personnel of a psychiatric clinic. Changes in individuals' sense of personal identity and self-worth challenged the balance of the doctor-patient relationship. An especially strong critique was raised in the context of the feminist movement. Medical practice was criticized as a male tool for the oppression of women, as for example in the 1973 book called *Our Bodies Ourselves: A Health Book by and for Women*.[57] The idea behind the book was to give women back the right to be informed about their medical conditions and the power to make the final decisions regarding the medical procedures they underwent. In 1976 Ivan Illich introduced his publication *The Limits to Medicine*,[58] a harsh critique of the medicalization of life and the potential endangering factors of the modern health care system.

This new emphasis on patients' rights and publications of medical malpractice cases contributed to the introduction of new measures to protect patients' rights in some Western countries, such as Finland, France and the Netherlands. Power relations between doctors and patients were considered so outbalanced that patients required legislative protection. The internet later introduced new possibilities for gaining information and increased the number of patients who relied on self-diagnosis or asked their practitioners for treatments of their choice. These developments resulted in a struggle over the power balance between doctors and patients. Distrust and questioning of the advice given became a common occurrence for all postmodern practitioners.

The overuse of antibiotics and the increasing complexity of modern medical technology meant that the hospital environment in part returned to a state of nineteenth-century "hospitalism", in which hospitals represent a source of danger both for liberal rights of patients and their safety from ATB resistant bacteria. The history of medicine in the decades since the 1970s is often associated with the paradoxical phenomenon of "doing better and feeling worse".[59] In many senses, people in the West were healthier than they had ever been before. Improving standards of living, easier access to health care and the disappearance of epidemic diseases contributed to high levels of well-being. Yet despite growing

57 BOSTON WOMEN'S HEALTH BOOK COLLECTIVE, *Our Bodies Ourselves: A Health Book by and for Women*, New York 1973.

58 IVAN ILLICH, *Limits to Medicine: Medical Nemesis, the Expropriation of Health*, New York 1976.

59 W. F. BYNUM, *The Rise of Science in Medicine*, p. 408.

investments in medical research and the improvement of therapeutic and diagnostic methods, scepticism has spread across Western cultures. Patients once again began to feel anxious about going to hospital and letting themselves to be ruled and judged by medical professionals.

The development of new medical instruments, such as diagnostic imaging, dialysis, and minimal access surgery led to the further division of specialized professions – brain surgery, radiology, heart surgery, etc. Hospitals became a locus of new and distinct identities in departments and specialized units. The number of hospital beds grew most significantly in Eastern European countries. The socialist system provided the population with a twenty percent higher number of hospital beds relative to the population than the capitalist welfare state. This escalation of hospital patient care was later accompanied by increased concern for the quality, effectiveness, and cost-related benefit of that care.

The Struggle of Different Styles of Thought

Recently, as Nicolas Rose suggests, the apparatus of bioethics has achieved the level that it has in contemporary biopolitics because the problems of governing biomedicine are now in an age of choice and self-maximization in which the body and its capacities have become central to technologies of self-perfection.

The biology established in the nineteenth century was a biology of depth. It tried to discover the organic laws that lay behind and inside the skin and determined the functioning of a system of hidden entities. In this new episteme of medical science any vital element, cell or organ, could be freed from the biological substrate and set free to circulate and to be combined with other organisms, calculated, changed or used for procreation.[60] According to Nicolas Rose, we have moved from an age of social disciplinary techniques into an age of biological control. The biological self could be changed or even created. Contemporary medical technologies do not seek merely to cure diseases once they have manifested themselves but also to control the vital processes of the body and mind. They are, as Nicolas Roses suggests, technologies of optimization.

Optimization is a crucial tendency in the contemporary technological approaches to the human body. The new style of thought in medicine pushes the binary poles of health and illness, which dominated the medical field in the past, much further. More often than ever before, medical practice is used not only to keep a health condition under control but to achieve an optimal state for the

60 N. ROSE, *The Politics of Life Itself*, p. 16.

organism in question, based either on the individual wishes of patients or shared collective norms of the human condition.

Subjectification is the notion that new conception of biological citizenship reorganizes the relations between individuals and their biomedical authorities, reshaping the ways in which human beings relate to themselves as somatic individuals. The most recent developments in the medical field have made the patient more responsible for his own health and bio capital has become yet another source of social distinction and differentiation. Postmodern medicine has made patients responsible for their own corporeal existence. Thus, every visit to a physician might lead to a struggle between the new postmodern patient and the physician still practising according to the rules that emerged in the nineteenth century.

Every visit to a hospital, each preventive health check-up brings us back to the age of compulsory school attendance. Visiting the doctor is as awkward as it was to have our efforts to learn constantly assessed at school. We do not only fear potentially serious health complications, nor do we feel anxious because of the medical practitioner's overwhelming disciplining power, but because every visit to a doctor raises the question of how successful we have been in acquiring, maintaining and optimizing our own body – our bio capital. Within the liberal regime of self-government, growing narcissism and egoism, any visit to a general practitioner or medical specialist tips the balance out of our control and we are yet again measured, analysed and judged like schoolchildren – as the object of biopower invented in the nineteenth century. Thus, our interactions with medical professionals are accompanied by anxiety, fear, and an inferiority complex physically embodied as the white coat effect. The postmodern patient meets the modern medical practitioner.