

# Relationship Patterns Between Surgeons and Heart Surgery Patients in a Thai Cultural Context

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## ABSTRACT

This qualitative study focused on relationship patterns between surgeons and heart surgery patients. The study site was a central hospital in Eastern Thailand. Data were collected from December 2011 to May 2012, mainly through narrative interviews with 7 patients and semi-structured interviews with 68 patients (altogether 75 patients), all of whom had undergone coronary artery bypass grafting surgery, and also through participant observation. The validity of the data was checked using data triangulation from interviews with patients, in-depth interviews with medical experts, and medical chart record reviews. The findings indicated that there were various kinds of power inequalities between the patients and the surgeons in a Thai cultural context. Firstly, the patients' health was in a critical condition, so the surgeons' role was that of life savers. They were trusted to make decisions over the patients' lives and they had the power to use medical technology while operating on the patients' hearts to save their lives. Secondly, the surgeons were in a position of superiority toward their patients; they prescribed treatments the patients had to accept. Thirdly, the surgeons also had a role as merchants and the patients as customers, as capitalism played an important role in the treatment of heart disease and heart surgery in private hospitals. These findings reflect relationship patterns between surgeons and heart surgery patients from the patients' point of view. The findings can be used to improve the balance of power between physicians and patients in health services.

**Keywords:** medical technology, surgeon-patient relationship, heart surgery, medical technology in Thai culture

## บทคัดย่อ

การวิจัยเชิงคุณภาพในครั้งนี้ มีวัตถุประสงค์เพื่อศึกษาแบบแผนความสัมพันธ์ระหว่างศัลยแพทย์และผู้ป่วยที่ผ่าตัดหัวใจ พื้นที่ศึกษาเป็นโรงพยาบาลศูนย์แห่งหนึ่งในภาคตะวันออกเฉียงเหนือของประเทศไทย เก็บรวบรวมข้อมูลระหว่างเดือนธันวาคม 2554 ถึงเดือนพฤษภาคม 2555 ข้อมูลหลักได้จากการสัมภาษณ์แบบ

เล่าเรื่องของผู้ป่วยที่ผ่านการผ่าตัดทำเบี่ยงหลอดเลือดหัวใจจำนวน 7 ราย และสัมภาษณ์ผู้ป่วยที่ผ่านการผ่าตัดทำทางเบี่ยงหลอดเลือดหัวใจแบบกึ่งโครงสร้างจำนวน 68 คน ร่วมกับการสังเกตการณ์แบบมีส่วนร่วม รวมทั้งสิ้น 75 คน ความน่าเชื่อถือของข้อมูลมีการตรวจสอบสามเส้าด้านวิธีเก็บรวบรวมข้อมูลและด้านข้อมูลด้วยวิธีการสัมภาษณ์ผู้ป่วย การสัมภาษณ์เชิงลึกผู้เชี่ยวชาญทางการแพทย์ และการ

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ทบทวนเวชระเบียนผู้ป่วย ผลการศึกษาพบว่าแบบแผนความสัมพันธ์ระหว่างศัลยแพทย์และผู้ป่วยที่ผ่าตัดหัวใจในบริบทสังคมไทยมีลักษณะของความไม่เท่าเทียมดังนี้ (1) แบบแผนความสัมพันธ์ระหว่างผู้ช่วยชีวิตกับคนใกล้ชิด โดยศัลยแพทย์ได้รับความไว้วางใจในการตัดสินใจเกี่ยวกับชีวิตของผู้ป่วย มีอำนาจในการใช้เทคโนโลยีทางการแพทย์ในการผ่าตัดหัวใจเพื่อช่วยชีวิตผู้ป่วย (2) แบบแผนความสัมพันธ์ระหว่างผู้ใหญ่กับผู้น้อย โดยศัลยแพทย์เป็นผู้สั่งการรักษาและผู้ป่วยเป็นเพียงผู้ปฏิบัติตามอย่างเชื่อฟัง (3) แบบแผนความสัมพันธ์ระหว่างพ่อค้ากับลูกค้า ซึ่งระบบทุนนิยมได้เข้ามามีบทบาทสำคัญในการรักษาและผ่าตัดหัวใจ มักพบในสถานพยาบาลเอกชน ผลการศึกษาค้นคว้าครั้งนี้แสดงให้เห็นรูปแบบความสัมพันธ์ระหว่างศัลยแพทย์และผู้ป่วยที่ผ่าตัดหัวใจในมุมมองของผู้ป่วย ซึ่งเป็นข้อมูลพื้นฐานในการจัดบริการสุขภาพที่มีความสมดุลทางอำนาจระหว่างแพทย์และผู้ป่วย

**คำสำคัญ:** มานุษยวิทยาการแพทย์ ความสัมพันธ์ระหว่างศัลยแพทย์และผู้ป่วย การผ่าตัดหัวใจ เทคโนโลยีทางการแพทย์ในวัฒนธรรมไทย

## INTRODUCTION

Coronary artery bypass grafting surgery is a type of open-heart surgery performed to prolong the lives of patients with cardiovascular disease (Lhojaya, Phongpanich, & Sakhonphan, 1993). In the process of surgery, the surgeon-patient relationship plays an important role. Open-heart surgery can take place under two kinds of circumstances: by appointment or in an emergency. When such surgery is performed at an appointed time, there is time to prepare the equipment, the treatment facility, the staff, and also the patient. In an emergency, for example when the patient is incapacitated or unconscious and needs urgent medical intervention, the surgeon will need to make

professional decisions concerning the patient's life. In such cases, the surgeon will not have the opportunity to talk with the patient or consider other treatment options together with the patient. After surgery, the patient will need to return for follow-up visits and take anti-coagulant medication for the rest of his or her life to prevent future cardiovascular thromboses (Blumental & Mark, 1994).

Parsons (1991) has described the physician-patient relationship as one determined by the roles of a patient and a medical professional. Lock, Young, and Cambrosio (2000) have noted that when medical technology is used, these relationships are characterized by unequal power, and the technology is a tool of conveying medical ideology or beliefs from the physician to the patient. Doyal (1994) has critiqued that the medical practice, resulting when decisions over the use of medical technology to perform surgery are made by the surgical team, puts patients in a socially subordinate role. Cardiovascular disease is characterized by constricting chest pain and breathing difficulties and these symptoms make patients suffer (Camp, 1996). Only surgeons are able to help their patients to continue living and to keep their symptoms in check. Relationship patterns between surgeons and patients after heart surgery are of research interest because capitalism is involved in the surgery through the management of service provision and the provision of the equipment that is used. Gabe, Kelleher, and Williams (1994) have considered surgeons as technology users and as individuals who give advice on medical treatment. Although medical technology can be miraculous in saving patients' lives, ethical dilemmas arise about whether the use of medical technology really is aimed at benefiting patients or surgeons.

However, no previous studies have focused on the relationships between surgeons and heart surgery patients in the Thai cultural context, making this present study necessary. As Eawsriwong (1994, p. 23) has noted, "if one were to think that doctors have to be practitioners of Western medicine, and if

one only considered Western doctors, one would not be able to understand ways of thinking like that of Thai people. Even if they have studied Western medicine, their ways of thinking and their culture of practice are still grounded in Thai society.” In Thailand, contemporary medicine and medical technology are cultural imports from the West. With advances in medical science, a more industrial kind of culture has emerged, and so Thai society is becoming more industrialized and commercialized. Thus, studies on the relationship patterns between surgeons and heart surgery patients will need to engage in systemic analyses of society in general as well as of the medical system in the Thai socio-cultural context.

This study used a critical medical anthropology perspective to analyze physician-patient relationships in a health care context with capitalist involvement. In such a context, physicians constitute a professional class that reaps financial rewards through its control over medical knowledge and expertise. In financial terms, the patients lose, as they have to depend on the physicians (Bear, Singer, & Susser, 1997). Cyborg anthropology was another concept used in this study. This perspective views the physician-patient relationship in terms of physicians constructing the humanity of the patient with medical technology, in a specific cultural context characterized by “life saving” as well as by religious and regional beliefs (Gammeltoft, 1999). These beliefs relate to the experience of imminent danger of death and of heart surgery (which involves the heart stopping and beginning to beat again) in terms of Buddhist notions of birth and death, and as appreciation for and the debt of gratitude for a life saver—the surgeon. They also relate to the power of surgeons through their knowledge and expertise, which appear too complex for their patients to understand. Thus the latter tend to accept whatever treatment the former prescribe. The study of relationship patterns between surgeons and their heart surgery patients in the Thai socio-cultural context helps us to

understand these relationships better, especially the implications of the fact that surgeons have power through their use of medical technology, while patients are dependent on their surgeons. These understandings, in turn, can play a role in developing Thai health services.

The purpose of this study was to explain the relationship patterns between surgeons and heart surgery patients in a Thai cultural context.

## RESEARCH METHODOLOGY

Qualitative methodology was used in this study. Data were collected from patients who had undergone coronary artery bypass grafting surgery (a type of open-heart surgery), and were receiving follow-up care at a central hospital in Eastern Thailand. Narrative interviews were conducted with 7 key informants and semi-structured interviews were conducted with 68 patients, resulting in altogether 75 participants. Data collection spanned from December 2011 to May 2012. The validity of the data was established by methodological and data triangulation. Multiple methods were used for the purpose including narrative and semi-structured interviews with patients, in-depth interviews with medical experts, participant observation with patients, and medical chart record reviews.

### Informant selection

The first author was a dentist and involved in a project to follow up patients after their open-heart surgery at the study site hospital. Her work duty was to give advice on oral care to the patients. During the research period, she purposively sampled informants, who had to (1) be patients who had undergone coronary artery bypass grafting surgery either at the study site hospital or at some other hospital, and to be visiting the study site hospital for follow-up care, and (2) have undergone the surgery no less than six months and no more than 10 years prior to their recruitment as informants. From a total of 75 informants involved in the

preliminary stage, 7 key informants were selected for narrative interviews based on having the follow criteria: (1) good communication skills (2) undergone heart surgery either by appointment or emergency (3) experienced sudden cardiac arrest or myocardial infarction prior to the surgery (4) unsuccessful surgery outcome or wound infections following surgery, and (5) other chronic diseases.

### **Ethical considerations**

Research ethics were adhered to in this study. Approval was obtained from the Social Science Institutional Review Board at Mahidol University. In every interview, the informant had to be fully willing and to give their written consent to participate in the study. The first author always explained the study to potential informants to reach a shared understanding before collecting data. The interviews were conducted in private spaces where there were no interruptions and the resulting data were treated as confidential. The presentation of the findings was also done in a way that would not harm the participants in any way.

### **Data analysis**

Narrative analysis was performed to tease out the sequence of events (Elliot, 2005), whereas content analysis was used to identify major themes in the dataset. To this end, the audio recorded interviews were transcribed, collated, checked, indexed, and summarized. Data presentation aimed at highlighting particularly interesting opinions among the diverse views of the participants with quotations. Although these quotations were handpicked excerpts from narratives, this did not change their meaning (Creswell, 1994; Miles & Huberman, 1994).

## **RESEARCH FINDINGS**

Of the 75 participants, 62 were male and 13 were female. Most of the patients underwent heart surgery by appointment (72 cases) and the

operations took place mostly at public hospitals. No improvement in the heart condition from medication treatment was the main reason that led to the surgery, followed by myocardial infarction and sudden cardiac arrest. In all but one case the surgery was successful. Three in four patients had other chronic diseases. All participants were Buddhists. See Table 1 for participant details.

The participants, all of whom had undergone coronary artery bypass grafting surgery, were aware that they had undergone heart surgery, which meant that their internal organs had been operated on. They did not know the details of the artery grafting procedure aimed at replacing an obstructed artery, which demonstrated a gap in the communication between the surgeons and their patients. The findings indicated three main relationship patterns.

### **Surgeons as life savers**

This relationship pattern was characterized by the patients' critical condition and imminent risk of death (some had already experienced heart failure) and its implications on their relationship with their surgeons, to whom they had to entrust their life. They were well aware how short a time their body could remain alive if their heart stopped beating, and how great the risk was that their heart would permanently stop working. Thus, the idea of accessing "hi-tech" heart surgery was laden with hopes of being able to return to a normal life. Because the surgery involved an unavoidable risk of death or disability, the surgeons had to request written consent from the patients and their relatives before operating. After the patients had recuperated from the surgery, their surgeons were not shy to communicate to the patients how grateful they should be for having saved their lives, while asserting that surgeons should not be blamed for unsuccessful operations, as exemplified by the following quotes:

"The doctor told me to decide whether to get the operation or not, but the doctor could not be held responsible for my recovery or death, because my

**Table 1** Participant characteristics

		(n = 75)
Characteristic	n	
Age		
50–59 years	18	
60–69 years	46	
Over 70 years	11	
Marital status		
Single	5	
Living with spouse	44	
Widowed	11	
Separated	15	
Hospital providing the surgery		
Public	71	
Private	4	
Condition prior to surgery		
Sudden cardiac arrest	3	
Myocardial infarction	11	
Other internal medicine procedures ineffective	61	
Surgery outcome		
Unsuccessful	1	
Infection of the surgical wound	1	
Successful	73	
Occupation prior to surgery		
Civil servant	24	
Laborer	8	
Trader	29	
Farmer	10	
Buddhist monk	4	
Occupation after surgery		
Not employed	25	
Civil servant	18	
Laborer	2	
Trader	24	
Farmer	2	
Health care coverage		
Buddhist monk	4	
Universal Coverage Scheme	43	
Civil servant health care scheme	32	

symptoms were pretty heavy already. When I signed the consent form, I did so lying on the bed. The doctor just kept talking about death—what I was afraid of. I could hardly breathe. So I told the doctor,

‘I get it, doctor, if I die I won’t sue you, go ahead and operate.’” (Female, 64 years, emergency surgery.)

“When the doctor said they’d operate me,

they couldn't guarantee I'd survive. They said to my wife they'd do a bypass. The doctor said the artery to my heart was blocked—if they didn't do it there would be no way for me to get better—if they didn't operate I would die. So, my wife decided to sign the consent and said to the doctor, 'do what's best to him.' I wasn't conscious; my heart had stopped beating." (Male, 65 years, emergency surgery.)

"When I recovered, there were lots of doctors around me, looking at the wound from the surgery. They told me I'd already died the day before, but the doctors had helped me back to life. So, I thanked the doctors that they had not let me die." (Female, 54 years, surgery by appointment.)

### Surgeons in a position of superiority

Surgeons had a higher social position than their patients, especially in public hospitals, where the surgeons were employed as civil servants. This further bolstered their social status. Surgeons not only have specialized knowledge about medical treatment; they also have the power to prescribe treatments and implement them through the use of various kinds of medical technology. If patients do not follow what their surgeons have told them to do, they may get punished—in minor cases, by verbal admonishment from their physician, and in major cases by a note made in their case history. This is a way for surgeons to protect themselves against allegations of malpractice in case the patient should die or get worse, and they would use this method without consideration for the life context of the patient that may make it impossible for them to follow the medical advice they have received, as exemplified by these quotes:

"If my weight went up, I got scolded, but if I did well, the doctor praised me and encouraged me. As for the medicines—sometimes I told the doctor that I didn't have the money to buy them, so the doctor shouldn't prescribe a lot. So the doctor gave them for free!" (Male, 60 years, laborer.)

"In 2005, a doctor at this hospital told me to do a balloon angioplasty, but in the province, there

was a flash flood from the forest. My daughter lost her life, my wife became depressed, and the company lost several million baht worth of its property. I was cheated in the shrimp export business. So I told the doctor that I wasn't ready for the balloon job. The doctor wrote in my case notes: 'the patient has refused the treatment.'" (Male, 67 years, trader.)

"After the surgery, the doctor scolded me that I had to take care of my eating and exercise. I always did what the doctor told me to. So, the doctor gave me foreign medicine (original brand name medicine from abroad) to treat my heart disease, but for those who don't do as the doctor advises, perhaps the doctor might not give such good medicine." (Male, 50 years, civil servant.)

### Surgeons as merchants

This relationship pattern between heart surgery patients and their surgeons was characterized by the financial gain the surgeons received from their use of medical technology. It would typically be encountered in private hospitals. The available financial gain is one factor that drives surgeons to use expensive medical technology in their processes of diagnosis, check-up, and treatment. In private hospitals, patients have to pay a large sum of money in exchange for their life, because expensive medical technology, such as expensive medication to control the illness, is used without consideration for other aspects of the patients' health, as exemplified by these quotes:

"After the heart surgery, the doctor had me go to the (MRI) tunnel twice. I think the doctor gets a certain percentage when the patient goes to the tunnel." (Buddhist monk, 79 years, surgery by appointment in a private hospital.)

"I had to pay up to 800,000 baht for the heart surgery. The doctor at the provincial hospital did not advise me to go to a public hospital in Bangkok. The only advice was to go for a private hospital, because my heart had already stopped beating, the symptoms were acute, and so I could not enter the queue."

(Male, 65 years, emergency surgery in a private hospital.)

“Soon after my heart surgery, the private hospital doctor had me check my heart waves, and the medicines were also expensive. Every visit to the doctor cost no less than 15,000 baht. I tried to request the private hospital doctor that I be moved to a public hospital to be able to use the 30 baht card, but the doctor told me it wouldn’t be a good idea—my symptoms would need to be followed up. Then the heart doctor went to work elsewhere so I switched to this public hospital. I’ve taken the medicine and haven’t got any symptoms, just the same as when I went to the private hospital. But the costs have been lower.” (Male, 55 years, surgery by appointment in a private hospital.)

## CONCLUSION, DISCUSSION AND RECOMMENDATION

The three relationship patterns described in this article between surgeons and their heart surgery patients in a Thai cultural context were all power relationships. The relationship pattern between a life saver and a patient at imminent risk of death involves a culture of obtaining consent before surgery, as Thai law determines, to protect surgeons from malpractice lawsuits in cases of unsuccessful surgery. The second relationship pattern, commonly found in public hospitals, is characterized by the superiority of the surgeons over the patients. The patients dare not contest their surgeons’ opinions, surgeons have the power to bestow free-of charge treatment to their patients, the power to prescribe medicine or other treatments using medical technology, and the power to make notes in their patients’ chart record. The final relationship pattern, where the surgeons act as merchants, is common in private hospitals. In such cases, surgeons use expensive medical technology to control the illness in question. The surgeons choose to use these

technologies in their processes of diagnosis and treatment because of the financial benefits they themselves can gain by doing so.

These relationship patterns are in contrast to the four doctor-patient relationship models—paternalistic, informative, interpretive and deliberative—proposed by Emanuel and Emanuel (1992). This difference demonstrates that traditional patron-client relationship, which is characteristic of a rural society and still influences social relationships in Thai society. In this case, individual ties between the heart surgeon and the patient have been reinforced by a debt of gratitude—a virtue valued in Thai culture. That debt of gratitude felt toward the heart surgeons as their life savers has prevailed over institutional factors in determining their relationship. The first and second relationships between surgeons and their heart surgery patients in a Thai cultural context were described by the former reasons; these relationships have been designated ‘doctor-centered’ (Morgan, 2003).

In the first relationship pattern, heart surgeons focus on medical technology, which is for them a tool to save life, while patients focus on their own survival. The patient relies on the surgeon’s ability to use medical technology to save the patient’s life. Patients do not associate with medical technology directly, but only through their surgeon. Patients believe that their lives were resuscitated by the surgeon not medical technology. However, since medical technology is one of many factors that could determine success in open-heart surgery, heart surgeons naturally caution that the patients need to bear in mind the potential failure of heart surgery. Another factor is the patient’s vital health condition. Therefore relationships between heart surgeons and their patients are based on different sets of knowledge. Surgeons have knowledge about heart surgery from the medical and technological point of view while patients are preoccupied with their survival and depend on their surgeon’s ability to save them.

The second relationship pattern, where the



surgeons are in a position of superiority, is a common one between surgeons and their heart surgery patients in public hospitals. Patients respect their surgeons regardless of social status because surgeons are civil servants. Furthermore, while the Universal Coverage Scheme has made heart surgery affordable for many patients, they view these benefits as charity rather than social welfare to which every citizen should be entitled. This attitude has reinforced the superiority of the provider of these services—the surgeon. The third relationship pattern would be typically encountered in private hospitals. Medical technology and heart surgery in private hospitals are treated as commercial products. The surgeon-patient relationship changes from life saver versus desperate soul and expert versus layperson to one between a merchant and a customer. This relationship represents a proposition by Stone (2004) that the power and greed of the management of private hospitals has turned physicians from ethical and science-based professionals to booming financial businessmen.

The critical medical anthropology perspective analyzes the unequal patient-physician relationship within a context shaped by the structure of society, culture, political factors, the capitalist economy, and the medical establishment (Bear, Singer & Susser, 1997). According to the study findings, heart surgery, as medical technology, might not have a meaning in itself in a Thai context; its significance is rather associated with the surgeons who utilize it. However, through this association, heart surgery could also be viewed as an attached meaning to a larger hospital over a small hospital, a private hospital over a public hospital, and an urban hospital over a rural hospital. From this perspective, medical technology can be a tool for status and upward mobility for surgeons who utilize it.

Cyborg anthropology asserts that physician-patient relationships are characterized by the construction of the patients' humanity through medical technology in cultural contexts

(Gammeltoft, 1999). In the context described in this article, using medical technology, surgeons construct new coronary arteries for their patients through surgery. The power to use such technology lies with the surgeon, and thereby also power over the patient's life or death. Thus, surgeons act as life savers for patients who are in a critical condition, as patrons in public hospitals, and as merchants who peddle medical technology as commodities in private hospitals. As public hospitals have to bear the costs of heart surgery for patients under the Universal Coverage Scheme, they have placed a cap on the number of cases to be performed in emergency and by appointment. This consideration has also influenced the quality of treatment and care provided. Private hospitals, on the other hand, base their medical services including heart surgery on a fee-for-service basis. This approach poses no limit on the treatment options; thus it usually involves more intensive utilization of medical technology. In private hospitals, patients assume the status of clients to business organizations, and consumerist relationship exists between them and their surgeons. Therefore, in a social structural context, the relationship between surgeons and their heart surgery patients is influenced by the respective systems of health care financing.

The findings can be used as baseline data in adjusting the power balance between physicians and patients in health services toward more balanced sharing of power and responsibility. Doing so would reduce social conflict, build social unity, and develop Thailand's health services.

## REFERENCES

- Bear, H. A., Singer, M., & Susser, I. (1997). *Medical anthropology and the world system*. New York: Garland.
- Blumental, J., & Mark, D. (1994). Quality of life and recovery after cardiac surgery. *Psychosomatic Medicine*, 56, 213–215.
- Camp, P. (1996). Having faith: Experiencing



- coronary artery bypass grafting. *Journal of Cardiovascular Nursing*, 10(3), 55–64.
- Creswell, J. W. (1994). *Research design: Qualitative and quantitative approaches*. London: Sage.
- Doyal, L. (1994). Changing medicine? Gender and the politics of health care. In J. Gabe, D. Kelleher & G. Williams (Eds.), *Challenging medicine* (pp. 140–159). London: Routledge.
- Eawswiwong, N. (1994). The body of knowledge on medical and public health history in Thailand: Its state, research agenda and future directions. In K. Chuengsatiansup & C. Muksong (Eds.), *Frontiers of knowledge in Thai medical and public health history* (pp. 18–34). Bangkok: Health Systems Research Institute. [in Thai]
- Elliot J. (2005). *Using narrative in social research*. London: Sage.
- Emanuel, E. J., & Emanuel, L. L. (1992). Four models of the physician-patient relationship. *Journal of the American Medical Association*, 267(16), 2221–2226.
- Gabe, J., Kelleher, D., & Williams, G. (1994). *Challenging medicine*. London: Routledge.
- Gammeltoft, T. (1999). *Women's bodies, women's worries: Health and family planning in a Vietnamese rural community*. Surrey: Curzon.
- Lhojaya, S., Phongpanich, B., & Sakhonphan, P. (1993). *Cardiovascular Disease Text* (2nd ed.). Bangkok: Krungthepvejchasan. [in Thai]
- Lock, M., Young, A., & Cambrosio, A. (2000). *Living and working with the new medical technologies*. Cambridge: Cambridge University Press.
- Miles, M. B., & Huberman, A. M. (1994). *Qualitative data analysis: An expanded sourcebook* (2nd ed.). California: Thousand Oaks.
- Morgan, M. (2003). The doctor-patient relationship. In S. Graham (Ed.), *Sociology as applied to medicine* (5th ed, pp. 49–65). London: Elsevier Health Sciences.
- Parsons, T. (1991). *The social system* (2nd ed.). London: Routledge.
- Stone, D. (2004). Doctoring as a business: Money, markets, and managed care. In P. Conrad (Ed), *The sociology of health and illness: A critical approach* (7th ed, pp. 309–316). New York: Worth.