A principle of authority must then always occur, under all circumstances. . . . Its place is variable, but a place it necessarily has. . . . Thus the question is, not to know whether any. . . authority exists in an age of democracy, but simply where it resides and by what standard it is to be measured.

—Alexis de Tocqueville (1945: 10)

. . . the division of labour disrupts every organically unified process of work and life and breaks it down into its components. This enables the rational and artificially isolated partial functions to be performed in the most rational manner by 'specialists,' who are specifically adapted mentally and physically for the purpose. This rationalization and isolation of the partial functions has however the necessary consequence that each of them becomes autonomous and has the tendency to develop itself further independent of other partial functions of society. . . . As the division of labour becomes more pronounced and rationalized, this tendency understandably increases in proportion. For the more highly developed it is, the more powerful become the claims of status and the professional interests of the 'specialists'. . . .

—Georg Lukacs (1971: 103; translation modified)

Introduction

Medicine in American society has been described as a "sovereign profession" that is now in danger of losing its "autonomy" within corporate and bureaucratic organizations (Starr 1982). In this essay I focus on an aspect of the physician's "sovereignty" that is not directly altered by such institutional changes: the physician's authority over the bodies of others. More is involved here than physical intimacy and control. In providing 'medical care,' the doctor displaces 'the self,' taking from it its sovereignty over the body. The ethnographic portion of this article examines how this transfer of authority is made into legitimate and routine practice for persons who are becoming doctors. Focusing on the dissection of cadavers by first-year medical students, I argue that medical education resolutely maintains a double image of the physician's relationship to the bodies of others: representing this relationship as something managed routinely by 'professionals' and as something inspiring awe in others.

In a concluding postscript to my ethnographic analysis I argue that this double image reifies not only 'the patient,' but at the same time 'the doctor': the first as an object that can be known and handled through technical routines and the second as an agent who performs these routines impersonally and unemotionally—that is, 'professionally.' Medical training thus creates a radical division of authority between 'doctor' and 'patient.' Moreover, this coincident reification of doctor' and patient' instantiates the most extreme possibilities of technical rationalization, for it constitutes human beings as both rational human agents and disenchanted objects. In so doing, medicine affirms the value of technical rationalization and thereby serves the legitimation of this hegemonic social principle.

For ethnographic evidence my argument relies, most explicitly, upon nine months of participant-observation research at University Medical School (pseudonym), as well as interviews with medical students and physicians from other medical schools in the United States. Inevitably this essay strays beyond the boundaries of ethnographic inquiry and authority and makes use of my interactions with doctors as a patient, as a relative of patients, and as a friend. At home, more than abroad, the ethnographer finds himself in the midst of a multiplicity of
relations to his ethnographic subjects. Even as I conducted my research, the doctors and students I studied were always more than ethnographic informants, since I depended, and continue to depend, upon physicians for health care for myself and my family. These ‘natives’ were, in brief, people to whom I might turn for cures, comfort, and explanations—even as I explored the social and cultural contingencies of their professional practice. This essay encourages a similar multiplicity of relations from its audience of ethnographer-natives, patient-professionals.

‘Emotions’ and ‘Uncertainty’ in Medical Initiation

‘Laymen,’ according to medical students, react ‘emotionally’ to the human body, finding bodily fluids ‘disgusting,’ sexuality ‘exciting,’ and mortality ‘frightening.’ By contrast, ‘the physician’ must react ‘professionally,’ always fulfilling his or her duties regardless of any ‘personal feelings’ or ‘emotions.’ Thus to become a physician requires learning ‘to control’ one’s ‘feelings’ about human physicality. Dissecting a cadaver, drawing a patient’s blood, diagnosing a terminal illness—all of these for the students are ‘emotional’ experiences that they must manage ‘unemotionally.’ The students view this positively, as replacing ‘cultural taboos’ with rational enlightenment, and negatively, as risking a loss of ‘sensitivity’ and ‘compassion.’ Ideally, they report, a physician should neither be ‘emotionally involved’ nor ‘callous.’ In this way a balance is found in the absence of both positive and negative emotions.

In addition to being affect-laden, medical training has a second problematic feature for medical students—‘uncertainty.’ In their medical training, students find that to act as a doctor, they must regularly make decisions on the basis of incomplete information, and with little certainty about the consequences of their actions. The students also find that medical practice involves uncertainty about ends as well as means. Decisions about maintaining or terminating life-support for comatose patients, decisions about providing pain-killers for drug-dependent patients, decisions about ordering diagnostic tests for patients without means of payment—these are moral rather than technical problems, for they involve choices about what ought to be done (cf. Weber 1970). In the students’ view, such moral decisions lie outside of the ‘empirical’ domain of ‘science,’ and thus are inherently uncertain.

Finally, it is important to note the manifold connections between ‘emotions’ and ‘uncertainty’ in the students’ understanding and experience. Moral problems are uncertain because they are matters of ‘personal feeling’; to be ‘emotional’ is to lack ‘objectivity’; and professional responsibility for the uncertain consequences of medical care is seen as a common cause of ‘anxiety’ and ‘stress.’ Moreover, for the students these are all aspects of a single problematic, namely, that medicine is an inexact science that deals with human problems.

The Trials and Dialectics of Medical Initiation

Examined as an entirety, medical training is organized and experienced as a series of ‘trials’ in which students ‘confront,’ and then ‘overcome,’ the conjoined problems of ‘emotions’ and ‘uncertainty.’ As the students in a given cohort first encounter one of the ‘disturbing’ activities of their future profession, their instructors emphasize both the technical difficulties and moral complexities of the particular task they are about to take on. These prefatory comments reinforce the notion that the problem confronting the students is beyond the boundary of ordinary human capacities. Thereafter the instructors present the students with an extensive body of ‘facts’ and a well-defined procedure for handling the particular problem ‘professionally.’ Precise mastery of this ‘knowledge,’ the students are told, will insure that each of them performs properly as a physician. The facts and algorithm provided by the instructors redefine the problem in technical terms, that is, as a question of ‘how to do something,’ rather than a question of ‘what should be done?’ The students learn both the technical solution, and the redefinition of the problem. The transformation of the problem into a technical operation excludes its most indeterminate aspects and allows success to be measured in terms of the well-defined instructions presented as ‘medical science.’ Finally, with comments recalling the initial difficulties of the ‘trial,’ the students are congratulated for having professionally mastered the problem at hand. In turn, this congratulation becomes the preface to the next ‘trial.’ Thus the students’ passage through medical school involves an ongoing dialectic of intimidation and congratulation, with intense congratulation predominating at the end, when the students become doctors.

Through this dialectical process, handling the human body ‘professionally’ becomes something routine, but not without a heroic struggle, and not without frequent reminders of what handling the body means for others—and their former selves. Medical practice is routinized, but the management of its routines is imaged as a charismatic sign distinguishing ‘doctors’ from the uninitiated. Thus as medical training proceeds, the distinction between
those 'admitted' to the profession and those outside it—marked from the beginning as a matter of 'achievement' and 'merit'—attains more and more significance. Pragmatically, and through myriad reiterations, 'the physician' becomes a person who can manage human physicality, and 'laymen' become persons who cannot, and hence persons who, as 'patients,' must have their bodies managed for them. Thus whereas 'the patient' is reified as a body to be treated technically like any other object, 'the physician' is reified as a human embodiment of objectifying routines.

In presenting this model of medical education, I have framed the 'trials' of medical education as discrete events. This is, of course, a simplification. Medical education is composed not of a linear series of discrete events, but of many overlapping 'trials.' On a given day during the first year of medical school, for instance, a student may be dissecting a cadaver in one class, performing surgery on an anesthetized dog in another, and listening to a senior physician interview a patient in yet another. Moreover, each of these long-term initiatory episodes is itself composed of any number of briefer 'trials,' for example, uncovering the wrapped corpse to begin the dissection, making the first incision, locating an obscure anatomical structure, cutting into a particularly disturbing organ. Thus, even though medical education involves a clear progression from intimidation to congratulation when framed as an entirety, for the student in the midst of this complex process, the recurring pattern is frequently experienced as a set of contradictory messages. This experience of medical initiation's dialectic of intimidation and congratulation is well illustrated by Figure 1, a cartoon composed by a first-year medical student and distributed to his classmates as the post-script to a transcription of a lecture.9 The cartoon depicts a medical student standing dwarfed and bewildered next to a giant doctor, whose most detailed feature is a glittering stethoscope. The physician does all of the talking.

---

Figure 1. Cartoon from medical school note cooperative illustrating the ongoing dialectic of intimidation and congratulation.
providing a lecture composed of pairs of contradictory statements. For every element of intimidation ("You're stupid," "The Race Goes To The Swiftest"), there is a complementary assurance that the student will indeed be able to succeed ("You're the cream of the crop," "You're all on the right track")—and vice-versa.

Fox's seminal essay on "Training for uncertainty" (1979 [1957]) draws fundamentally different conclusions from very similar ethnographic data gathered some two decades before my research. She argues that medical education prefigures, and hence provides "effective" training for, the "uncertainties" encountered by practicing physicians (pp. 29, 49). In support of this interpretation, Fox presents evidence that as students progress through medical school, they develop "greater confidence and equipoise" (p. 45). This increase in professional "confidence" is indisputable. Fox's analysis does not, however, consider the organization of knowledge in medical education. By contrast, I argue that the increased "equipoise" described by Fox results from a structuring of knowledge which places uncertainty under erasure.9 A second difference in our arguments concerns our accounts of medical students' initial experience of "uncertainty." In discussing "kinds of uncertainty" (pp. 20-1), Fox never mentions the moral ambiguities of medical practice, and thus her analysis does not have to account for their subsequent displacement. In sum, my ethnography challenges Fox's functionalist analysis on at least two points of evidence. As an alternative to Fox's functionalism, I provide an account that regards the institutional form of medical education as a system of social relations structured not by 'needs,' but by contingent principles of social organization.

Dissecting a Cadaver

At almost all medical schools in the United States, the first human body a student is asked to handle 'professionally' is a cadaver provided for dissection. With few exceptions, the dissection occurs as part of the first-year curriculum, two years before students begin their clinical training.

In the weeks before they began dissecting cadavers, the students I worked with frequently spoke of their anxiety about seeing and cutting the body. They expressed fears that they would be sickened, that they might faint or vomit, and that these reactions would raise doubts about their capacity to become physicians. The students' sense of the intellectual and emotional challenge of the dissection was heightened by the professor in charge of the anatomy course. In his introductory lectures he repeatedly described the dissection as a 'confrontation with mortality' and told the students that in dissecting a human body there would be so much to learn that "in two weeks, you [will be] in over your head."

A special schedule marked the first day of the students' "confrontation" with the cadaver. The day's lecture was canceled, and the students attended an extended laboratory session. During this session they went from the dissecting room, where they unwrapped and prepared their cadavers, to a demonstration room, where they viewed pre-dissected cross-sections of human bodies, and finally to a seminar room, where they were asked to discuss how they felt about dissecting a human body.

Frosted windows and doors labeled "UNAUTHORIZED PERSONS MAY NOT ENTER" enclosed the dissecting rooms. Within this marked boundary the rooms were brightly lit and occupied by precise rows of high-set stainless steel tables, each with a well wrapped corpse. The students worked in groups of four, and I had arranged to join one of these groups as a fifth. The five of us, four men and a woman, unwrapped the cadaver, finding how remarkably un-human it looked. When we had removed the shroud, I thought there must be another layer of covering, since the exposed layer looked so ashen and rough. The skin had large wave-like folds that held their shape as the corpse was moved about. The most immediate interests were in the cadaver's sex and the cause of its death. The sex was not evident until we had uncovered the pubic region, since the head was shaved of hair and the chest was so crushed that the breasts were flattened out. We quickly covered her genitals and face. The teaching assistant informed us that our cadaver was a sixty-one year old female who had died of cardiac arrest. We were instructed to replace the single sheet that covered the body with a number of smaller rags, so that we would be able to work on one section of the body without exposing the others. As we rewrapped the body, we moved it about. In certain positions—when it was sitting up, for instance—it took on a more human, and disturbing, appearance. Though eight groups worked in close proximity, talk was sparse and quiet.

From the dissecting room we went to a demonstration room containing pre-dissected bodies, including some steak-like cross-sections that were not recognizably human. An instructor provided a fast-paced lecture about each section. Unlike the students, the instructors did not keep their limbs fixed at their sides, they spoke no more quietly than usual, and they did not hesitate to move close to the
exposed organs. Quickly, they identified numerous parts of the body, using words the students did not recognize, and then told the students that they would soon become familiar with these anatomical facts.

Following these demonstrations, the students were organized into small groups, each with some twenty students, to discuss their feelings about dissecting a cadaver. Such discussions, the students knew, were not a regular part of their training, and indeed at U. M. S. they occurred at no other point in the curriculum. As the single moment in which the medical school scheduled time for the students to talk about their feelings, the discussions marked a transition in the students’ lives. At this point in their careers, upon first seeing and handling a dead body, the students would be treated as people who would need to talk about dissecting human bodies. Thereafter no such need would be recognized. In effect then, the scheduled discussions institutionally memorialized their “confrontation” with the cadaver as a landmark experience in their professional initiation.

In the discussion I attended, some twenty students talked about the cadavers and death with intensity and evident emotion. One student commented that though she admired the generosity of the people who donated their bodies, she felt that she could not herself do so because, as she put it, “I don’t want to be that dead.” This comment sparked a heated debate over whether donating one’s body was something one ought to do. A second student argued that it was inconsistent to want the benefits of dissecting a cadaver if one was unwilling to offer that opportunity to others. Nonetheless, he added, he too would refuse to leave his body for dissection. Indeed, all of those who spoke to the issue agreed that they would find it difficult, if not impossible, to donate their own bodies for dissection. Yet, many added, they would be quite willing to donate organs for transplants. To “give life,” they argued, was a very different matter than having one’s body—complete with the “imperfections” of disease and age—exposed and dissected. To “give life” was a very different matter than being so dead.

In the days following this discussion, I used the opinions the students had expressed as the basis of interviews with a wider sampling of the first-year class. Again I found that the questions were of considerable interest to the students, and again the students consistently praised the generosity of the people who had donated their bodies. Nonetheless, all of the students I spoke to rejected donating their own body for anatomical study, though, again, they did not object to leaving their organs to help save a life.

As they worked together during the first weeks of the dissections, the students repeatedly likened their cadavers to patients, and themselves to doctors. When one of my dissecting partners accidentally destroyed a vital blood vessel, for instance, one of the other students turned to him, assumed a grave expression, and said, ‘Dr. Li, I’m afraid your patient is not going to survive.’ With ‘humor’—a communicative style marked in our culture as detached from ‘deep feelings’—the students again and again compared the dissection to a surgical operation. To cite a more extended example, one of the students left the following letter on the chest of his cadaver for one of his dissecting partners. The note speaks with the cadaver’s voice:

Dear Dr. Eisenstein,

I am an unmarriageable monster, but I long for your gifted hands to turn me into a ravishing beauty. True, in life, I was called ORCA, but already you have removed much of the unsightly fat. Continue to improve my looks—I love the feel of you running your fingers over my viscera. Then when I look good enough for your high standards, put me back together and kiss me on the lips and I will magically come to life and we can live happily ever after on my father’s money.

Love,

ORCA

The wish to produce health from the dead body—expressed in the humorous fantasy of being a doctor who could give an overweight corpse sexual vitality—paralleled the students’ willingness to donate their organs for transplantation, but not their bodies for dissection. As persons becoming doctors, the students perceived the cadavers not simply as dead, but more specifically, as bodies that were medically inoperable. It was with this most extreme challenge to their professional future that the students first encountered ‘a patient,’ and in consequence, their instruction in human anatomy defined their professional identity at the very limits of medical practice—that is, in the treatment of a patient so dead.

The instruction the students received did not, moreover, make the dissection an experience from which they could learn to help other, still living ‘patients.’ Their course made no connections, for instance, to the study of surface anatomy, something which physicians do indeed use in treating patients. Rather, as the students expressed it, the anatomy course at U. M. S.—like the very similar courses at most other American medical schools—taught them ‘nothing clinically significant.’ Instead it required mastery of two quite challenging technical tasks: (i)
learning the canonical nomenclature of anatomical structures, and (ii) dissecting those structures and matching them to their names. Day after day their dissection manual gave them such instructions as:

Note that inferior to the femoral triangle many of these structures run undercover of the sartorius muscle; these and other muscles must be clearly separated in order to trace the following structures: the saphenous nerve; nerves to psosas and iliaceus muscles (within the false pelvic cavity); the peltineal nerve.

And so on. Day after day the students were lectured and quizzed by the instructors on the numerous names of the parts of the body, and soon they started to quiz each other. Day after day they would challenge each other by pointing to various structures, and when someone demonstrated an unusually fluent knowledge of the anatomy, the other students would respond with respect: 'Dr. Williams knows his shit today. Watch out, he's hot.' It was frequently difficult to find some nerve or vessel or muscle, and the accomplishment of such trials often produced minor collective celebrations.

The difficulty of having so much material to commit to memory intimidated the students, and this simultaneously increased the value of successfully mastering the material. The students found that there were always more details for them to memorize. Furthermore, the emphasis on the quick recall of technical nomenclature meant that the students learned "human anatomy" as a set of systematized, rule-abiding "facts." Even though they often found organs out of place (in front rather than behind a particular nerve), even though blood vessels showed remarkable variation, the students were assured that they would not be tested on anything "anomalous." In brief, dealing with the cadaver had become the difficult and time-consuming, though fundamentally determinate, task of learning the matter-of-fact "facts" of the matter.

In the dissecting room the students learned that a successful dissection required active and forceful manipulation of the cadavers. At first the students had been cautious as they dealt with the body. In one of the early dissections, for instance, the chest of one of the cadavers filled with fluid, making it impossible for the students to see clearly. The students working on the cadaver tried, with little success, to sponge up the liquid with paper towels. Their teaching assistant, a second-year medical student, saw their efforts and told them that they had to be more aggressive. She briskly took a probe and punched a hole through the cadaver's back so that the liquid would drain away. The students laughed nervously and joked about how she had just "ripped into" the flesh. Frequently in the first few days of dissection the students were told not only to cut more aggressively, but to tear and pull as well. Within a few weeks the students were forcefully manipulating the numerous parts of the body.

The dissection of the cadaver was the first in a series of experiences that would make the students feel comfortable pushing and pulling flesh and organs: later in their first year they would perform surgery on dogs in their physiology experiments, and in subsequent years they would aggressively manipulate parts of their patients. As the first step in the students' gradual realization that they could handle bodies in this socially privileged way, the cadaver—or more precisely, its silence—imparted a significant message: as one of the students put it, 'the cadaver never complained that anything hurt.'

As the course went on, the students' initial caution in cutting and damaging the cadaver gave way not only to more aggressive dissecting, but to a casual attitude toward it as well. The destruction that initially disturbed the students had become routine, everyday practice, and some of the students expressed their newly acquired casualness in the exaggerated form of profane jokes. On Valentine's Day one of the male students cut a heart out of the buttocks of his cadaver and jokingly gave it to a female friend of his. Other students carved their initials in their cadavers.

Though the students' initial hesitancy with the dissection quickly disappeared, even toward the end of the course the dissection of certain anatomical structures could disturb the routine approach they had developed. The most dramatic of these moments for the students was the dissection of the genitals. Previously they had been careful to cover the cadavers' genitals if they were inadvertently exposed. To dissect the genitals the students were instructed to uncover the body from above the waist to the toes, and then using a large saw, to sever the body at the waist, and cut the lower portion into a right and left half, thereby bisecting the sexual organs. While they performed this "trisection," as the operation was named, the students joked more loudly than usual, commenting in particular on the sight of disconnected limbs and trunks. Anticipating the day's activities, one dissecting team had come to class wearing helmets and face masks. The students who were most visibly disturbed were the male students with male cadavers, many of whom refused to cut their cadaver's penis, leaving the job to the female students. This was particularly striking since the male students generally sought to perform a disproportionate amount of 'the surgery.'

When I interviewed them at the end of the
course, the students singled out the trisection as one of the few tasks that had been emotionally difficult to perform, but I could not get them to discuss why it had so perturbed them. Indeed they told me that my questions about the matter were ridiculous: the matter needed no explanation, for it was 'obvious.' Relying on my observations of the students, as well as my own experience, I would argue that there were two reasons why the trisection was so self-evidently upsetting for people who for some months had regularly and routinely dissected cadavers.

(i) The trisection began by treating the body as a totality, for the students were instructed to divide the cadaver into two, and then three, portions. By contrast, during most of the previous dissections the students had worked on small isolated areas, each of which had been demarcated by the sheets covering the remainder of the body. The trisection thus echoed the wholeness the students had encountered when they had first unwrapped their cadavers. By first recalling this wholeness, and then requiring that the corpse be dismembered, the trisection reminded the students that the object they cut had a meaning beyond its correspondence to the rationally mapped terrain of their dissecting manuals. Concomitantly it recalled their sense that their 'surgery' was an act of destruction.

(ii) At the center of the trisection lay what the students considered the most private part of the body. As something private it was, in the students' conception, something personal. Furthermore, because of the social import of genital difference, the genitals fragmented the students' shared identity as 'student-doctors,' for the genitals called attention to something 'personal' that distinguished the students from each other. In pragmatic consequence they became 'males' and 'females' rather than 'doctors.' Similarly, in subsequent courses in which the students studied human pathologies, the students reacted very personally to diseases that were linked to gender. As people prone, say, to prostate cancer, they were 'males' rather than 'future physicians.' The medical significance of the non-professional feature of their identity implicitly, and temporarily, placed them outside of the social grouping of professional initiates—and thus, for a time at least, they were situated not as people who could 'manage' the problems of human bodies, but as people vulnerable to those problems. In the trisection the students experienced a similar identification between their personhood and the object of medical practice, for the trisection ended with the cutting of genitals. The male students with male cadavers were, I suspect, most strongly implicated by this conjunction, because of the students' greater familiarity with castration than clitoridectomy. In brief, cultural precedents made the dissection of the penis more recognizable—and hence more disturbing—than the dissection of the vulva.

Over Death

Toward the end of the course I conducted a second round of interviews, and I raised some of the more indeterminate issues that had fired the students' discussion on the first day of dissection. I asked them again whether they would be willing to donate their own bodies for dissection. Some of the students now were willing; others still rejected the idea. But this question, which had once inspired a heated debate among the students, no longer seemed to be an issue of great concern. Grappling with such moral issues was, it turned out, beside the point in learning to examine, handle, and cut dead bodies. Once the course began, there was no provocatio to consider such issues, and success in the course depended upon devoting one's energy elsewhere. Thus the construction of anatomical knowledge as technical routines produced a professional disenchantment of the cadavers' deadness.

As the anatomy course at U. M. S. drew to a close, the students marked their collective success with both organized and impromptu celebrations. The students held a dinner at a Greek restaurant which most of the students and professors attended. The students and their professors sat as a group on a raised portion of a larger dining room, and the restaurant's owner increased their already festive mood by announcing their presence to the rest of the patrons. Speaking through a well amplified microphone, the owner asked the patrons for a round of applause for "the young doctors," and then offered a toast in their honor. In response the students did not hesitate to join in their own public congratulation.

On the final day of the course one of the professor's assistants wheeled a covered dissecting table into the lecture room; the sheet was pushed away from below, and the professor arose from the table wearing novelty eyeglasses with popping, spring-loaded eyeballs. He proceeded to lecture on both the difficulty and success of the course. He read to the students from Gentle vengeance, Charles LeBaron's memoir of life as a first-year student at Harvard Medical School. The passage he selected described LeBaron's difficulties in knowing what to study from the overwhelming amount of material that had been assigned in anatomy (1981: 225-228). The students applauded the performance enthusiastically.

Later that afternoon, during the final dissection,
the students demonstrated their own sense of accomplishment with a spontaneous high-jump competition. Between the rows of cadavers, a handful of male students exhibited their physical vitality. As they jumped higher and higher, the remaining students lined the dissecting room and cheered. No longer were their movements inhibited by the cadavers' deadness. In a room where they had at first been frightened and hesitant, they now displayed self-confidence. Certainly not all of the students had acquired this self-confidence. Some still felt troubled by their destruction of their cadaver's body, and many felt unsure of their knowledge of anatomy. Yet even those who felt insecure knew that finishing the course allowed them to claim mastery over this situation, and they enjoyed acting out this mastery even if they had not totally acquired it. Furthermore, acting out mastery was itself another step in the process of changing from people who conceived of themselves as vulnerable to death and disease, people who feared being 'that dead,' to people confident of their ability to manage these culturally dangerous, naturally indeterminate elements of human experience. With evident abandon the high jumpers raised their feet above the dismembered corpses.15

Some Concluding Observations

In *The birth of the clinic*, Foucault has argued that in modern medicine the human body becomes an object for scrutiny like any other object. However, for the students I worked with, the cadaver never became only an object like any other object. Rather the students learned to study and handle the cadaver as they would study and handle any other object, but without forgetting that in other social contexts, cadavers represent the enchanted difference between life and death. Professional initiation did not, as Foucault would have it, create "the possibility for the individual of being both subject and object of his own knowledge" (1963: 197); indeed, when the students came to dissect the bodily part that most forcibly reminded them that they shared an anatomy with their cadavers, the routine of their dissection was most noticeably disrupted. What this momentary rupture in the process of professional initiation reveals is that the objectification Foucault discusses requires a social division between persons who are treated routinely, like any other object, and persons who carry out those routines. It is thus not only 'the patient' that is reified, but 'the doctor' as well: 'being ill' and 'healing' become, as a result, diacritica of two specialized 'roles.'16

This two-fold reification instantiates the most extreme potentialities of technological rationalization: it creates both a person who is an object to be acted upon like any other object, and a person who follows rational routines no matter what the human circumstances. Medicine thus affirms that the principle of technical rationalization has legitimate reign even in the domain of the most human of affairs. To argue that medicine lives in the service of this hegemonic principle is, of course, to identify a social (and hence contingent) cause of its authority.

Starr (1982) argues that medicine in America is increasingly organized as a corporate bureaucracy, and that the decline of independent practitioners means a corresponding decline in the profession's "sovereignty." By contrast, I am arguing that medicine's authority lies not in its institutional organization, but in its instantiation and validation of the principle of technical rationalization. If this analysis is correct, then the rise of corporate, bureaucratic medicine will mean an increase, rather than a decrease, in the profession's "sovereignty," for it will make medicine's 'management' of human physicality even more impersonal. In brief, though the doctor may become less of a cultural hero, the profession will become more heroic. Authority will then rest in a corporate institution autonomous from both rational human agents and disenchanted human objects, that is, from both doctors and patients.

NOTES

Acknowledgments My research on medical education has benefited from the generous encouragement and suggestions of George Stocking and Stephen Toulmin. In addition, Don Brenneis, Judy Farquhar, Davydd Greenwood, Arthur and Claire Kohrman, Richard Handler, Ruth Mandel, Laurie Shrage, and the anonymous reader for *Anthropological Quarterly* provided helpful comments and criticisms on earlier drafts of this paper.

1 The published translation has been modified on the basis of a translation provided me by Harry Liebersohn.

2 In the following text I use double quotation marks (""") for spoken material only when I provide directly transcribed or recorded quotations. I use single quotations to indicate either spoken material that was not transcribed as it occurred, or terms routinely used by informants which I wish to employ without subscribing to their premises. The latter is particularly important here, since 'we' and 'the natives' share a great deal in this ethnographic case.

3 U. M. S. is a private medical school generally regarded as one of the most prestigious in the United States. I conducted research at ZU. M. S. from the fall of 1981 until the summer of 1982. Each initiatory cohort, or 'class,' at U. M. S. was comprised of approximately 100 students.

4 On the problems and possibilities of reflexive fieldwork in the ethnography of the professions, see Segal 1982.
A PATIENT SO DEAD

REFERENCES CITED