HOW I LEARNED WHAT A CROCK WAS

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IN FALL 1955, I MOVED to Kansas City to begin fieldwork at the University of Kansas Medical School as the first field-worker in a project led by Everett Hughes, part of a team that eventually also included Blanche Geer and Anselm Strauss.[1] We were going to study medical students and medical education, but, to be truthful, I had very little idea of what I was going to do beyond "hanging around with the students," going to classes, and whatever else presented itself.

I had even less idea what the problem was that we were going to investigate. There was a field of sociology called "socialization," and Robert Merton and his students had been studying the socialization of medical students to the role of doctor. My dissertation, a study of schoolteachers' careers, could have been said to be in the "sociology of education," but that didn't prepare me to study medical students. As far as I had gone in conceptualizing my problem was to say to myself that these kids came in at one end and 4 years later came out at the other end and that something certainly must have happened to them in between.

In any event, I was more concerned with our family's move from Urbana (what a relief to get out of there!) to Kansas City (which I hoped, and it turned out to be true, would provide a better place to practice my other trade of piano playing) and with getting to know my way around what appeared to me enormous buildings that were the University of Kansas Medical Center.

I knew next to nothing about the organization of medical education and consoled myself about my ignorance with "wisdom" that told me that therefore I would have no prejudices either. How scientific! I didn't even know, and had to be told, that the first 2 years of the 4-year medical course were mostly

JOURNAL OF CONTEMPORARY ETHNOGRAPHY, Vol. 22 No. 1, April 1993 28-35

academic; only during the last 2 "clinical" years did students actually work on hospital wards, attending to patients.

Fortunately, the dean of the school took me in hand and decided that I should begin my investigations with a group of third-year students in the Internal Medicine Department. There were two third-year student groups, superintended by different faculty members, and he took care that I ended up with the one run by the "benign" doctor. I learned soon enough that the other was one of those legendary terrors who cowed students, house staff, and most of his patients with his temper.

I didn't know what internal medicine was but learned quickly enough that it had to do with everything that wasn't surgery or pediatrics or obstetrics or any of a lot of other named specialties. I soon learned too that the people who practiced internal medicine considered themselves, and were considered by others, to be the intellectuals of the medical business, as opposed to the surgeons, who were thought to be money-grubbing brutes, or the psychiatrists, who were thought to be crazy themselves.

With no problem to orient myself to, no theoretically defined puzzle I was trying to solve, I concentrated on finding out what the hell was going on, who all these people were, what they were doing, what they were talking about, finding my way around and, most of all, getting to know the six students with whom I was going to spend the next 6 weeks. I was a Jewish smart aleck from the University of Chicago and they were several varieties of small-town and larger-city Kansans and Missourians, but we got on well from the start. They were interested in what I was doing and curious about my work and job ("How much do they pay you to do this?" they wanted to know). They thought it was nice that I got paid to study them and did not doubt that they were worth the trouble.

None of us was sure what I was "allowed" to do or which things they did that were "private" while others were OK for me to follow along on. Clearly, I could go to class with them or make rounds of the patients with them and the attending physician. But the first time one of the students got up and said, "Well, I have to go examine a patient now," I could see that I had to take matters into my own hands and set the right precedent.

Neither the dean nor anyone else had said I could watch while students examined patients. On the other hand, no one had said I couldn't do that. My presence during a physical examination might have been construed as a violation of patient privacy except that it would be a joke to raise that matter in a medical school, where such intimate procedures as rectal and vaginal exams were often carried out before a sizable audience. The student, being new at examining patients, wasn't too eager to have me watch him fumble. But if I let the situation get defined as "the sociologist can't watch us examine patients" I'd be cut off from one of the major things students did. So I said, with a confidence I didn't feel, "OK. I'll come with you." He must have thought I knew something he didn't and so did not argue the point.

Making rounds worked like this. The physician whose group I was working with had a "service," a number of beds occupied by his patients. A resident or two and an intern worked on the service, and six students were assigned to it. Every patient was assigned to a student, who was responsible for doing a physical exam, taking a history, ordering diagnostic tests, making a diagnosis, and planning a course of treatment. Mind you, all that work was done again by an intern, a resident, and the physician.

Every morning the whole group assembled and walked around to see all the patients on the service; that was making rounds. At each bed, the physician talked to the patient, asked the house staff about any developments since yesterday, and then made that patient the occasion for an informal quiz of the student to whom he or she had been assigned. The quiz could be about anything, and students were nervous about what might come up.

During my first week in the school, while I followed the students and others through the ritual of making rounds, I made my discovery. It wasn't the "ah-ha" that researchers often report. Rather, it was a piece of detective work that took me and several of the students most of the next week. Its ramifications occupied me and my colleagues for the duration of the project.

One morning as we made rounds, we saw a very talkative patient, who had multiple complaints to tell the doctor about—all

sorts of aches, pains, and unusual events. I could see that no one was taking her very seriously, and on the way out, one of the students said, "Boy, she's really a crock!" I understood this, in part, as shorthand for "crock of shit." It was obviously invidious. But what was he talking about? What was wrong with her having all those complaints? Wasn't that interesting? (By the way, this first patient was a woman and the "non-crock" that followed was a man, which exactly suited the medical stereotypes that said crocks were overwhelmingly women.)

As I've already said, my discovery of what the word "crock" meant was not a lightning bolt of intuition. On the contrary, it was guided by sociological theorizing every step of the way. Like this. When I heard Chet call the patient a crock, I engaged in a quick but deep theoretical analysis. I had a piece of theory ready to put to work here. To put it most pretentiously, when members of one status category make invidious distinctions among the members of another status category with whom they regularly deal, the distinction will reflect the interests of the members of the first category in the relationship. More specifically, perhaps less forbiddingly, the invidious distinctions that students made between classes of patients would show what interests they were trying to maximize in that relationship, what they hoped to get out of it.

So, when Chet called the patient a crock, I made this theoretical analysis in a flash and then came up with a profoundly theoretical question: "What's a crock?" He looked at me as if to say that any damn fool would know that. So I said, "Seriously, when you called her a crock, what did you mean?" He looked a little confused. He had known what he meant when he said it but wasn't sure he could explain it. After fumbling for a while, he said it referred to someone with psychosomatic illness. That let him off the hook for the moment by partially satisfying my curiosity, though I still wanted to know what interest of his as a student was violated by a patient with psychosomatic illness.

But, as a good scientist, I wanted to check my finding out further, so I held my tongue. The next patient we saw, as it turned out, had a gastric ulcer, and the attending physician made him the occasion for a short lecture on psychosomatic illness, with

ulcer the example at hand. It was quite interesting, and, when we left the room, I tried out my new knowledge and said to Chet, "Crock, huh?" He looked at me as though I were a fool and said, "No, he's not a crock." I said, "Why not? He has psychosomatic disease, doesn't he? Didn't you just tell me that's what a crock is? Didn't we just spend 10 minutes discussing it?" He looked more confused than before, and another student, eavesdropping on our discussion, undertook to clear it up: "No, he's not a crock. He really has an ulcer."

I don't remember all the details of what followed. What I do remember is that I got all the students interested in the question, and, between us, with me asking a lot of questions and applying the results to succeeding cases, we ended up defining a crock as a patient who had multiple complaints but no discernible physical pathology. That definition was robust and held up under many further tests.

But my problem was only half solved. I still had to find out why students thought crocks were bad. What interest of theirs was compromised by a patient with many complaints and no pathology? When I asked them, students said that you couldn't learn anything from crocks that would be useful in your future medical practice. That told me that what students wanted to maximize in school, not surprisingly, was the chance to learn things that would be useful when they entered practice. But if that was true, then it seemed contradictory to devalue crocks because there were many such patients. In fact, the attending physicians like to point out that most of the patients a physician saw in an ordinary practice would be like that. So a crock ought to provide excellent training for practice.

When I pursued that paradox, students told me that you might have a lot of patients like that later on, but you couldn't learn anything from seeing them here in school. Not what they wanted to learn, anyway. Which was what? They explained that all their teachers ever said about what to do with crocks was that you should talk to them, that talking made crocks feel better. The students felt they had learned that with the first one. Succeeding crocks did not add to their knowledge of crockdom, its differen-

tial diagnosis, or its treatment. A crock presented no medical puzzles to be solved.

What they wanted to learn, students said, was a certain kind of knowledge that could not be learned from books. They studied their books dutifully, preparing for the quizzes that punctuated rounds and other such events, but believed that the most important knowledge they would acquire in school was not in those books. What was most worth learning was what my colleagues and I eventually summarized as "clinical experience"—the sights, sounds, and smells of disease in a living person: what a heart murmur really sounded like when you had your stethoscope against a patient's chest as opposed to its sound on a recording, how patients whose hearts sounded that way looked and talked about how they felt, what a diabetic or a person who had just suffered a heart attack looked like.

You could only learn those things from people who had real physical pathologies. You learn nothing about cardiac disease from a patient who is sure he's having heart attacks every day but has no murmurs to listen to, no unusual EKG findings, no heart disease. So crocks disappointed students by having no pathology you could observe firsthand. That showed me an important and characteristic feature of contemporary medical practice: the preference for personal experience over scientific publications as a source of the wisdom you used to guide your practice. We eventually called this the "clinical experience" perspective and found its traces everywhere. Perhaps most important, even faculty who themselves published scientific papers would say, in response to a student question about something reported in a medical journal, "I know that's what people have found but I've tried that procedure and it didn't work for me, so I don't care what the journals say."

Crocks had other irritating characteristics, which students eventually explained under my barrage of questions. Students, perpetually overworked, always had new patients to work up, classes to go to, books and articles to read, notes to record in patients' charts. Examining patients always took time, but examining crocks took forever. Crocks had dozens of symptoms

to describe and were sure that every detail was important. They wanted to describe their many previous illnesses in similar detail. Many of them had been able to persuade physicians (who, the students thought, should have been less pliable) to perform multiple surgeries—which they also wanted to describe fully. (I remember a patient who had had so many abdominal surgeries that her navel had been completely obliterated. She made a deep impression on all of us.)

So crocks took much more of your time than other patients and gave you much less of anything you wanted for your trouble. That showed me another important feature of medical school life: Everything was a trade-off of time, the scarcest commodity for a student or house officer, for other valuable things. We found the traces of that proposition everywhere too. For instance, students often traded patients with each other. Why? Well, if I've had three patients with myocardial infarcts (as I learned, with the students, to call a heart attack) and you've had three patients with diabetes, it's obviously mutually advantageous for us to trade, so that neither of us wastes our time learning the same facts three times while missing another equally useful set of facts altogether.

Students disliked crocks, I eventually learned, for still a third reason. Like their teachers, students hoped to perform medical miracles and heal the sick, if not actually raise the dead. They knew that wasn't easy to do and that they wouldn't always be successful, but one of the real payoffs of medical practice for them was to "do something" and watch a sick person get well. But you can't perform a medical miracle on someone who was never sick in the first place. Because crocks, in the student view, weren't "really sick," they were useless as the raw material of medical miracles.

We eventually called this attitude the "medical responsibility" perspective and saw its traces everywhere too. Perhaps its most bizarre outcropping was the idea that you weren't fully operating as a doctor unless what you did could, if done wrong, kill people. This was enshrined in a putdown of the specialty of dermatology we heard several times: "You can't kill anybody and you can't cure anybody." A more accurate rendition of the general princi-

ple involved would have been "You can't cure anyone *unless* you can kill them."

Learning what a crock was was thus a matter of carefully unraveling the multiple meanings built into that simple word, rather than the Big Ah-Ha social scientists sometimes describe. This little ah-ha may have a lesson for us when we experience the Big Ah-Ha. Intuitions are great but they don't do much for us unless we follow them up with the detailed work that shows us what they really mean, what they can really account for.

NOTE

1. The study was reported in full in Howard S. Becker, Blanche Geer, Everett Hughes, and Anselm Strauss, *Boys in White* (Chicago: University of Chicago Press, 1961). A one-paragraph description of the discovery of the meaning of "crock" appears in Howard S. Becker, "Problems of Inference and Proof in Participant Observation," *American Sociological Review* 23 (December 1958): 658.

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