Social Science Research 48 (2014) 171–184

Contents lists available at ScienceDirect

Social Science Research

journal homepage: www.elsevier.com/locate/ssresearch

When do doctors follow patients' orders? Organizational mechanisms of physician influence

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ARTICLE INFO

Article history:
Received 26 February 2013
Revised 8 May 2014
Accepted 30 May 2014
Available online 20 June 2014

Keywords:
Physicians
Organizations
Patients
Negotiations
Hospitals
Influence

ABSTRACT

Physicians, like other professionals, are expected to draw from specialized knowledge while remaining receptive to clients' requests. Using nationally representative U.S. survey data from the Community Tracking Study, this paper examines the degree to which physicians are influenced by patients' requests, and how physicians' workplaces may mediate acquiescence rates through three mechanisms: constraints, protection, and incentives. We find that, based on physicians' reports of their responses to patients' suggestions, patient influence is rare. This influence is least likely to be felt in large workplaces, such as large private practices, hospitals, and medical schools. We find that the protection and incentives mechanisms mediate the relationship between workplace types and physician acquiescence but more prescriptive measures such as guidelines and formularies do not affect acquiescence. We discuss these findings in light of the ongoing changes in the structure of medicine.

1. Introduction

All professionals encounter clients who seek influence. The professional musician is pressured into playing the clichéd songs that patrons request (Becker, 1951; Grazian, 2003). Teachers are pushed to calibrate portions of their curriculum to the needs of children with overzealous parents (Horvat et al., 2003). Even the highest-status members of a field are held to account; for example, the corporate lawyer frequently acts as a handmaiden to the interests of the firms she represents (Abbott, 1981; Heinz and Laumann, 1982). Studies in this tradition frequently center on professionals' efforts to "keep their distance in order to not let any one client interfere with one's own ongoing program of work and leisure" (Hughes, 1952). This literature's underpinning theme is that much of one's occupational life is spent negotiating one's independence.

But, given the significant changes to the structure of medicine in the last two decades, how much space for resisting patients' influence do physicians really have? Paralleling the trend in the legal profession, the percentage of medical professionals in large bureaucracies has grown, expanding from 10% in 1965 to about 33% of the U.S. physician population in 1999.[1] This trend noted by Parsons (1963a) has continued, to the point that in 2008 more than 50% of doctors worked in practices owned by hospitals or large organizations known as "integrated delivery systems" (Kocher and Sahni, 2011).

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[1] See CTS Physician Survey (1997–1999) and Leicht and Fennell (2001). The most recent study of Chicago lawyers finds that solo practitioners and those in small firms constituted only 28% of the profession, down from 42% 20 years earlier (Heinz et al., 2005).

http://dx.doi.org/10.1016/j.ssresearch.2014.05.012
0049-089X/

In many ways, these workplace venues now may strengthen or weaken physicians' capacity to exercise independent judgment, according to how they recontextualize state mandates, mediate the access of local populations to health care, and establish payments for physicians. Yet this literature remains incomplete because it has not connected such workplace changes to a key unit of analysis in medicine: professional influence. In this paper we study the relationship between various workplace controls and the way that physicians respond to patients' requests. Earlier research focused on workplaces that were different—particularly those that were much smaller and more insulated from the market and the state. Because the market and the state were minimally important before the 1960s and 1970s, when the social organization of medicine underwent transformations, the key social influences on physicians' decisions could be traced to their relationships with colleagues and the community. Alongside influential studies of doctor–patient interactions (e.g., Maynard, 1991; Stivers, 2007) as well as direct-to-consumer advertising (Peyrot et al., 1998; Bell et al., 1999; Feldman et al., 2006), focus has been placed primarily on the relationship between referral and collegial ties and the content of the consultation (Hall, 1946; Freidson, 1960, 1970:89–90; Coleman et al., 1966).[2]

This paper builds on this research by accounting for the massive shift in the forms taken by medical workplaces, testing the mechanisms through which these venues constrain or facilitate the influence of patients. And as the number of doctors working in large workplaces rises, we might expect—theoretically, at least—that we need to study not only ties to outside colleagues, but also systems of social control inside organizations. This paper, then, is about how workplaces control the degree to which physicians can maintain influence, with a particular focus on acquiescence to patient requests. Considering changes in the way workplaces arrange physicians, it asks: in the exercise of their influence, when do physicians decide whether or not to acquiesce to their patients' requests, and what features of the social organization of medicine influence their decision? However, rather than focusing on the individuals who mediate client crises—the janitor's wife who protects her husband from untimely tenant requests, the receptionist who ensures the physician can control his or her time (Hughes, 1951:66)—we demonstrate how acquiescence operates when a workplace mediates the relationship between clients and professionals. In addition to the benefits of moving beyond characterizing professional action in role-based terms, understanding this process is valuable because, in practical terms, when a doctor does not influence a patient and instead acquiesces to a request, it can have durable effects on a community (e.g., treating viruses with antibiotics, where inappropriate use leads to new forms of resistance and threatens the effectiveness of antibiotics in treating bacteria that cause pneumonia, strep throat, and ear infections [Stivers, 2007:4]). Consequently, the outcomes of physicians' abilities to negotiate space in which to exercise influence can be as important for studies of individual and public health as they are for studies of the social organization of professional work. In evaluating the mechanisms underpinning physician acquiescence, then, this paper contributes to work on physician decision making (Feldman et al., 2006; May, 2007; Lutfey et al., 2012; Lin, 2014) and on medical and other types of professional bureaucracies (Dobbin and Kelly, 2007; Dixon-Woods et al., 2009; Currie et al., 2010; Waring and Bishop, 2011; Chiarello, 2013). And, by describing the differentiated landscape of medical work and the crucial traits of professional action and its contingencies, this study can begin to counterbalance analyses of changes in the medical profession that engage in what Stevens (2001) referred to as oversimplified "theories of decline and fall."

2. Three workplace-based mechanisms influencing physician acquiescence

Since Simmel, a central focus of sociological theorizing has been the relationship between social forms and their contents. The workplace changes we have outlined above would open new possibilities for patients to influence doctors, and so the doctors would feel pressure to acquiesce. We will study how influence is organized by looking at the relationship between physicians' experiences of being influenced and the features of the work setting. We can identify three kinds of mechanisms through which doctors might be influenced to acquiesce. First, these new workplace forms—which housed a threefold greater proportion of all physicians in 1999 than in 1965 (Leicht and Fennell, 2001)—require new kinds of bureaucratic constraints on physicians' ability to make decisions including acquiescence. Second, new protections provided in the workplace against the demands of the market and competition may provide a mechanism that allows doctors to selectively respond to patients' demands. Finally, an organizational emphasis on reputation and positive evaluation for services rendered may provide a mechanism that directs physicians' attention toward or against patients. We call these mechanisms: constraints, protection, and incentives.

2.1. Constraints

The first mechanism is that of constraints that are imposed on the discretion of physicians to order certain tests and procedures.

The success of an organization is largely dependent on control of participants. Yet control is especially problematic in a professional bureaucracy whose success depends on high-status employees. Organizations want participants to internalize their obligations and voluntarily carry out their assignments, but must contend with the fact that employees who are

[2] Although Freidson (1975) later studied a medical group of about 50 physicians, he chose that site precisely for its atypicality. In *Profession of Medicine*, Freidson (1970) was so conscious of the importance of state-led changes that he pointed out that his analysis was relevant to the institutional landscape of American medicine only in what he called its pre-1965 "Golden Age."