

- managed care. The emerging health care system* (pp. 136–161). San Francisco: Jossey-Bass.
- Weiner, M., & Biondich, P. (2006). The influence of information technology on patient-physician relationships. *Journal of General Internal Medicine*, 21(Suppl. 1), S35–S39.
- Weingart, S. N., Rind, D., Tofias, Z., & Sands, D. Z. (2006). Who uses the patient internet portal? The PatientSite experience. *Journal of the American Medical Informatics Association*, 13, 91–95.
- Werner, R. M., Alexander, G. C., Fagerlin, A., & Ubel, P. A. (2002). Lying to insurance companies: The desire to deceive among physicians and the public. *American Journal of Bioethics*, 4, 53–59.
- Widman, L. E., & Tong, D. A. (1997). Requests for medical advice from patients and families to health care providers who publish on the World Wide Web. *Archives of Internal Medicine*, 157, 209–212.
- Winkleby, M. A., Flora, J. A., & Kraemer, H. C. (1994). A community-based heart disease intervention: Predictors of change. *American Journal of Public Health*, 84, 767–772.
- Wynia, M. K., Cummins, D. S., VanGeest, J. B., & Wilson, I. B. (2000). Physician manipulation of reimbursement rules for patients: Between a rock and a hard place. *Journal of the American Medical Association*, 283, 1858–1865.

Exploring the Institutional Context of Physicians' Work

Professional and Organizational Differences in Physician Satisfaction

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The health care system in the United States has changed dramatically in the last 30 years. Health organizations are under pressure from patients for access to high quality, affordable care. Employers, insurance companies, and federal agencies want lower costs, accountability, and safety. Hospitals and medical groups, as well as insurance companies and government agencies, are adopting management methods that emphasize efficiency, predictability, calculability, and control (Ritzer, 2004). Despite the efforts to more tightly manage health care in the United States, however, medical expenses continue to rise (Strunk, Ginsburg, & Gabel, 2002), and patients and payers are not alone in their expressions of dissatisfaction. Both nurses and physicians also have expressed concern about working conditions and quality of care in managed care arrangements (Harvard School of Public Health, 2000). The concerns of so many involved in the health care system at multiple levels (patients as well as providers, organizations as well as government agencies) present an opportunity to health services researchers in the form of research of keen interest to a broad audience. The changes in health care also present a mandate to address our field's lack of theoretical models that explain developments at both personal and organizational levels in health services.

The widely-used term *managed care* (see Real & Street, this volume) is the catch-all that describes developments in health care over the last 30 years. Managed care commonly refers to health services arrangements that employ prepayment for services, require pre-authorization from officials for services, and involve contracts among patients, providers, and administrators (Lammers, Barbour, & Duggan, 2003). The broadest definition includes

Health insurance plans intended to reduce unnecessary health care costs through a variety of mechanisms, including: economic incentives for physicians and patients to select less costly forms of care; programs for reviewing the medical necessity of specific services; increased beneficiary cost sharing; controls on inpatient admissions and lengths of stay; the establishment of cost-sharing incentives for outpatient surgery; selective contracting with health care providers; and the intensive management of

high-cost health care cases. The programs may be provided in a variety of settings, such as health maintenance organizations and preferred provider organizations. (National Library of Medicine, 2008)

These types of arrangements now dominate health care in the United States (Barbour & Lammers, 2007; Lammers et al., 2003; Lammers & Duggan, 2002). The administrative context or "peri-consultation interaction" (see Real & Street, this volume) of patient-provider communication now has changed. Administrative policies for care delivery and payment form important new organizational structures (McPhee, 1985) in which communication between physicians and patients takes place. These structures also contextualize the relationships between physicians and managers, and among managers of the health care systems, which tends to bureaucratize health care (Lammers & Geist, 1997).

Managed care itself is not a unified entity, however, as a number of writers have observed (Hacker & Marmor, 1999; Real & Street, this volume). The term loosely covers many arrangements from highly corporate approaches to cost controls, to loose confederations of cooperating providers. From its least organized manifestation (independent practitioner associations) to its most comprehensive arrangements (staff model health maintenance organizations), the meaning of managed care involves the establishment of written guidelines for the provision of medical services (Mechanic, 2000, p. 103). The formal rules and guidelines of managed care have been the subject of considerable dissent in the medical community (Bloche, 1999; Feldman, Novack, & Gracely, 1998; Gonsoulin, 1997; Mechanic, 2000; Potter, 1999; Rodwin, 1998). For example, Sullivan (1999) worried that managed care and its financial imperatives threaten the professionalism of medicine.

For the most part, these changes in the context of the physician-patient relationship have not been linked to physicians' work by theoretically guided systematic research. Researchers concerned with the medical care setting of physician-patient communication, for example, have understood its context in terms of the privilege and authority of the physician and the privacy of the physician-patient encounter (Ray & Donohew, 1990, p. 29). Real and Street (this volume) pointed out that the specific formal organizational context, however, is rarely distinguished. Moreover, specific types of providers—such as primary care providers or specialists—are rarely distinguished in research on physicians' work (although they are distinguished in health policy research; see Robinson, 2001).

Nonetheless, managed care alters both professional roles as well as the organizational contexts of physicians' work (Barbour & Lammers, 2007; Lammers & Geist, 1997). As physicians are drawn into ever more rational social structures (Scott, 2003), principles and theories of organizations are likely to apply to their work. MCPhee (1985) labeled organizational structure as "explicit, authoritative, metacommunication" (p. 162). This view of structure is espe-

cially congruent with the circumstances of managed care, because now, in contrast to their traditional autonomous roles as professional healers, physicians work by fixed routines (Weber, 1946, 1947), subject to organizational rules (Euske & Roberts, 1987). Thus, the case of physicians' roles in managed care provides an opportunity to study specific roles and the structural context of health services.

Role configurations, such as physicians' specialization (a socially micro-level phenomenon), and structures, such as practice settings (a socially macro-level phenomenon), can be understood together through the application of the institutional theory of organizational communication (ITOC) (Lammers & Barbour, 2006). An institutional approach considers "established and enduring patterns of beliefs and practices that apply at both the microlevel within organizations and at the macrolevel across organizations" (p. 262). ITOC thus provides a vehicle for examining how medical professionals' institutionalized beliefs and practices in particular organizational settings may result in greater or lesser satisfaction and effectiveness. Moreover, a hallmark of institutions, and a guiding aspect of ITOC, is the role of formal, written rules, contracts, and regulations that cut across organizational boundaries. From the regulations that govern Medicare reimbursement to the contracts that bind providers to patients in health plans, managed care represents an institutional structure of influence on health organizations and the providers who work in them.

This study identifies institutional contexts and role configurations in the provision of medical care. To study institutional contexts, we surveyed physicians in a community dominated by three organizations: a specialty clinic established as a treatment center for medical problems, a community clinic established with a public interest philosophy, and a loose federation of solo physicians known as an independent practitioner association (IPA). Physicians' role configurations in this study include their perceptions of satisfaction, autonomy, and ability to make clinical decisions, their attitudes toward medical practice, and their reports of communication with patients and managed care organizations. This characterization of role configuration is defined by individuals' perceptions of their roles. In other words, our analysis focuses on the relationship between individual physicians' perceptions and their institutional situations.

To this end, we first review physicians' administrative contexts and their professional medical roles as primary care or specialists providers. We suggest that both the administrative context and professional roles can be understood using an institutional perspective, which we also outline below in more detail. Next, we provide background on the community and the three organizations we studied, and we hypothesize the likelihood of satisfaction or dissatisfaction for physicians in the practices. Survey data of physician satisfaction is then presented and compared for specialist and generalist physicians practicing in each of the three organizations. Results suggest that the histories of the organizations, as well as specialty and practice arrangements, affect physicians'

attitudes toward medical practice both in terms of satisfaction and clinical autonomy. Implications for health services research bridging organizational structures with physicians' work are discussed.

Assumptions about Professions and Organizations: Toward an Institutional Perspective

Although professional powers may transcend administrative or organizational arrangements (Freidson, 1986), many medical care providers today view managed care as a challenge to their professional discretion (Feldman, Novack, & Gracely, 1998; Real & Street, this volume; Rodwin, 1998). Perhaps the autonomy of physicians could be taken for granted before 1980, when the majority of practitioners saw their patients under fee-for-service reimbursement arrangements, and the number of physicians in group practice was smaller than it is today (Scott & Lammers, 1985). Many medical groups today depend on prepaid contracts or membership in preferred provider organizations to sustain revenues (Bodenheimer & Grumbach, 2002, p. 197); however, the administrative arrangements that accompany group practices intervene in physicians' conduct (Gross & Budrys, 1986). Physicians themselves have called into question managed care rules as they relate to their decision-making powers as well as their ethical responsibilities (Feldman, Novack, & Gracely, 1998; Friedman & Savage, 1998; Kralewski et al., 1998; Minogue, 2000). In this section, we review the role configurations and the organizational context of physicians as understood by past health services research. We make the case that the advent of managed care significantly affects these configurations and contexts, and we suggest that an institutional perspective is an appropriate lens for the study of these changes.

There are at least two directions in which professional medical roles have developed (Thomas, 1983). The literature on medical professional socialization has for many years highlighted the tension between the humanistic and scientific requirements of the role (Becker, Geer, Hughes, & Strauss, 1961; Conrad, 1988; Miller, 1993). This tension has been characterized in terms of caring versus curing (Conrad, 1988); holistic versus biomedical approaches (Longino, 1997); and the healer versus the scientist (Laine & Davidoff, 1996). A number of writers have laid these developments at the feet of the medical school training experience (Becker et al., 1961; Conrad, 1988; Miller, 1993).

One could argue, on the basis of this literature, that the longer a physician in training is exposed to the training environment, the more likely that she or he will adopt a scientific outlook. The scientific professional outlook is cultivated in the recruitment and selection process for medical schools. Candidates are selected on the basis of scientific acumen and an orientation toward systematic knowledge. Faculty members employed in careers of research rather than treatment reinforce the professional scientific outlook throughout graduate and postgraduate education (Bloom, 1989; Jefferys & Elston, 1989). The

scientific outlook is further reinforced by the drive toward specialization in medicine that began during the middle part of the 20th century. Specialists became even more closely tied to academic medical centers to remain well informed and to have access to sophisticated technologies, facilities, and colleagues (Simmonds, Robbins, Brinker, Rice, & Kerstein, 1990).

In contrast, the American Academy of Family Physicians (2001) defined the primary care physician as "a generalist physician who provides definitive care to the *undifferentiated* patient at the point of first contact and takes continuing responsibility for providing the patient's care" (p. 2, emphasis added). The generalist outlook is an older, more traditional configuration of the health professional's role. Starr (1982) discussed the conflict early in this century between specialists, who sought control over particular types of procedures and practices, and their generalist forebears. In the United States, this eventually resulted in higher barriers to entry into medical practice by nonphysicians (such as technologists and midwives), but "fluid boundaries within the profession" (p. 325). Nonetheless, as in other fields, because of the cultural value placed on technical knowledge, physicians have found it difficult to remain generalists (Vanselow, 1998).

These two strands of professional roles in medicine are not exclusive. It would be inappropriate to say that some physicians are healers whereas others are scientists, but the emphasis on science in medical training is well-documented, and the differences in distribution, prestige, and earnings of generalists (including internists, family practitioners, and pediatricians) versus specialists (such as dermatologists or surgeons) is also well-documented (Bureau of Labor Statistics, 2000; Donabedian, 1986). Perhaps most important for our purposes, the undifferentiated nature of generalists' work compared to the specialist would lead us to expect different communication patterns, behaviors, and attitudes. For example, as gatekeepers in a managed care regime, generalists make initial diagnoses and referrals to specialists, whose narrow range of practice and expertise allows them to focus on treatment options. Indeed, Smetana et al. (2007) found a bias toward efficacy in research evaluating specialists, who typically focused on a single condition, in contrast to generalists, who concerned themselves with a wider spectrum of patient diseases and ailments. Stille, Primack, and Savageau (2003) found that the practice styles and communication habits of pediatric generalists and pediatric subspecialists made coordination of care difficult.

Managed care may be expected to affect these role configurations in various ways. As a program driven by cost-conscious insurance companies, employers, and governments, managed care does not reimburse physicians for training, research, or education. It favors the healing role in this respect. But managed care also involves practice guidelines, review panels, credentialing, scheduling, and other mechanisms that create efficiencies in the provision of care. We should, therefore, be able to observe managed care arrangements frustrating physicians in their ability to serve patients. In general, we suspect that