

**UCLA**

**UCLA Electronic Theses and Dissertations**

**Title**

Your Money or Your Life: How Doctors Learn the Business of Health

**Permalink**

<https://escholarship.org/uc/item/4xm0f0hc>

**Author**

Oh, Hyeyoung

**Publication Date**

2014

Peer reviewed|Thesis/dissertation

UNIVERSITY OF CALIFORNIA

Los Angeles

Your Money or Your Life:

How Doctors Learn the Business of Health

A dissertation submitted in partial satisfaction of the

Requirements for the degree Doctor of Philosophy

in Sociology

by

Hyeyoung Oh

2014



## ABSTRACT OF THE DISSERTATION

Your Money or Your Life:  
How Doctors Learn the Business of Health

by

Hyeyoung Oh

Doctor of Philosophy in Sociology

University of California, Los Angeles, 2014

Professor Stefan Timmermans, Chair

With one of the highest health care expenditures in the world, phrases such as “a broken system” and “expensive medical waste” are commonly used to refer to the U.S. healthcare system. With numerous cost-cutting initiatives in place, what are the consequences for the medical profession as they provide care? My dissertation, a three-year ethnography of physicians on the Internal Medicine (IM) Service of a teaching hospital, examines how financial issues become salient for physicians in inpatient care delivery. Situating my work within medical sociology’s socialization literature and the theory of professions, I reveal the emergence of a hidden curriculum of finances during residency training on the IM service. This curriculum exposes novice physicians to the financial dilemmas and pressures present in the current health care system. I focus on three key components of care delivery by which this curriculum emerges: the medical record, consultations, and discharge management. As trainees proceed through the curriculum, they learn valuable profession lessons: (1) limitations to physicians’ autonomy via third parties; (2)

conflicting financial pressures present in care delivery; (3) increased agency of patients; (4) the intra-professional status hierarchy of the medical profession; and (5) risk of litigation.

This study fills the gap in the medical sociology literature on the socialization process of becoming a physician – revealing the financial socialization of physicians. This study also demonstrates the resilience of physicians as they develop strategies to mitigate the professional challenges they encounter in the clinical setting. And lastly, this study offers some explanations regarding the inefficiencies plaguing the nation’s medical system. The fact that the financial curriculum is *hidden* results in the routine deprioritization of finances in physicians’ decision-making – the consequence is unnecessary medical workups and delays of care. With minimizing medical waste placed at the forefront of national cost-cutting conversations, this study reveals a few pathways to the generation of inefficiencies in the inpatient setting. The consequences of this deprioritization of finances however extend far beyond the financial ramifications for the hospital and broader health care system: patients’ health and well-being are at stake as superfluous treatments expose them to avoidable physical and emotional risk.

The dissertation of Hyeyoung Oh is approved.

Edward T. Walker

Gabriel Rossman

Hannah Landecker

José J. Escarce

Stefan Timmermans, Chair

University of California, Los Angeles

2014

## TABLE OF CONTENTS

<b>Chapter 1: Introduction</b> .....	1
<b>Chapter 2: The Medical Record as Professionalizing Tool</b> .....	29
<b>Chapter 3: Hospital Consultations and Jurisdiction Over Patients</b> .....	50
<b>Chapter 4: Mastering the Art of Throughput: Physicians' and Patients' Strategies to Manage Hospital Discharge</b> .....	72
<b>Chapter 5: Conclusion</b> .....	97
<b>Appendix: The Study</b> .....	112
<b>References</b> .....	124

## ACKNOWLEDGEMENTS

First and foremost, I would like to thank the physicians(-in-training) on the Internal Medicine Service for embracing me into their lives to conduct this study. I am forever grateful for the time they set aside to meet with me – during their lunch breaks, while on-call, and even during their days off. Without their interest and active support for my research, this project would not have been possible. I would also like to express gratitude to the case managers, patients, family members, and other health care professionals at Pacific Medical Center for welcoming me into their lives to conduct this study. I am so appreciative of the time they took to speak with me, welcoming my presence on the clinical wards.

Next, I would like to thank my dissertation committee members, Edward T. Walker, Gabriel Rossman, Hannah Landecker, and José Escarce for their support throughout this process. They enthusiastically met with me to discuss my research and (re)read various drafts of my work – elevating my theoretical and analytical skills.

I would like to thank my advisor, mentor, and dissertation committee chair, Stefan Timmermans. I have worked closely with Stefan since my first year in the program – so I can unequivocally state that he has seen me through every step of this journey. His support and encouragement have been vital to my sociological training and emotional health (thank you for bringing Scout to the office countless times). His rigorous scholarship and his ceaseless dedication to graduate student education have shown me the scholar and mentor I will strive to be throughout my career.

I would like to thank the UCLA Department of Sociology for the rigorous theoretical and methodological training. I would like to thank the UCLA Sociology Department Staff, who have supported the graduate students in immeasurable ways. In particular, thank you to Allan Hill,



Patrick Padilla, and Herumi Baylon for numerous great conversations (and always cheering me up). I am also appreciative of the department's Health Working Group, which has been a wonderful experience to connect with fellow medical sociologists.

Thank you to my UCLA colleagues, Anthony Alvarez, Anthony Ocampo, Anup Sheth, Lianna Hartmour, and Lorenzo Perillo. You have supported me academically and emotionally during all of the vital stages of the graduate school process. Thank you to my Princeton colleagues, Dr. Nathalie Moise and Dr. Paulina Ortiz-Rubio, who have brainstormed with me numerous times – offering their medical expertise and knowledge. And thank you to my cohort colleagues - Elena Shih, Rennie Lee, and Sarah Morando. We have stuck together since Day 1 of graduate school and I am certain we will remain connected throughout our lives. Thank you for the love and support throughout this journey.

A version of Chapter 3 was published as “Hospital consultations and jurisdictions over patients: consequences for the medical profession” in the *Sociology of Health and Illness*, 2014, 36(4), 580-595. Thank you to the editors and the external reviewers, who undoubtedly strengthened the theoretical and analytical claims made in this chapter.

Thank you to my family – Ai Jung Oh, Mootak Oh, Soyoung Oh, and Stephen Ahnert – who have showered me with endless love, encouragement, and delicious nourishment throughout my entire life. Care packages, LA visits from Soyoung and Stephen, numerous phone calls, and visits home replenished me through every stage of graduate school. I look forward to finally living near you all again. Thank you to the Nelsons – Carl, Carmen, and Christopher – for all of the encouragement and love from near and afar. I left every Boulder trip revitalized and ready to be re-engaged in my research.

And lastly, thank you to Gabriel Nelson. Thank you for ceaselessly supporting my academic endeavors – for all of the brainstorming sessions and pep talks, and for (re)reading my work countless times. Thank you also for knowing when I needed to step away from the computer – being my partner-in-crime exploring and eating our way through the neighborhoods of Los Angeles. Your unconditional love and support have been vital to my growth.

## VITA

### EDUCATION:

C. Phil, Sociology, University of California-Los Angeles, 2012

M.A., Sociology, University of California-Los Angeles, 2009

B.A., Sociology, Princeton University, 2005

### PUBLICATIONS:

Oh, H. (2014). Hospital Consultations and Jurisdiction Over Patients: Consequences for the Medical Profession, *Sociology of Health and Illness*, 36(4), 580-595.

Oh, H. (2013). Consumerism in Action: How Patients and Physicians Negotiate Payment in Health Care, *Qualitative Health Research*, 23(3), 385-395. doi:10.1177/1049732312468507

Oh, H. and Timmermans, S. (2013). Can Physician Training and Fiscal Responsibility Coexist? *Virtual Mentor*, 15, 131-135.

Timmermans, S. and Oh, H. (2010). The Continued Social Transformation of the Medical Profession. *Journal of Health and Social Behavior*, 51, S94-S106.

### PRESENTATIONS:

Oh, H. (2013). Mastering the Art of Throughput: Physicians' and Patients' Strategies to Manage Hospital Discharge. Presented at the Annual Meeting of the *American Sociological Association* in New York City, NY.

Oh, H. (2010). The Continued Social Transformation of the Medical Profession: Policy Implications. Co-presented at the Annual Meeting of the *American Sociological Association* in Atlanta, GA.

Oh, H. (2009). Your Money or Your Medical Care: Conflicts Between Patients and Doctors in the Clinical Encounter. Presented at the Annual Meeting of the *American Sociological Association* in San Francisco, CA.

Oh, H. (2009). The Continued Social Transformation of the Medical Profession. Presented at the Annual Meeting of the *American Sociological Association* in San Francisco, CA.

## **Chapter 1: Introduction**

It is approximately 11 AM on a Friday in February on the 3<sup>rd</sup> floor of Pacific Medical Center (PMC)<sup>1</sup>, a prestigious, 500-plus bed academic medical center located in the Western United States. The hallway on the 3<sup>rd</sup> floor is busy as usual at this time of day. Patients walk the halls completing their morning exercise, family members roam in search of the correct patient room, nurses enter in and out of rooms – administering therapies for patients and inputting information into the computerized medical system at designated computer stations. Several Internal Medicine teams cross paths as they proceed through their morning rounds – discussing and examining patients admitted to their service. In the midst of the bustle, four individuals are deeply engaged in a conversation regarding the care of 33 year-old Mr. Bankston.

Mr. Bankston was admitted to Pacific Medical Center earlier in the week after presenting at the Emergency Department (ED) with increased weakness, instability, and the presence of brain lesions. Prior to autumn of 2010, Mr. Bankston had no previous medical history. In October however, he began to experience headaches, weakness, fatigue, and fever. The symptoms became so severe that he admitted himself to a local hospital. What ensued were numerous hospital visits over a two-month span where a full body workup was completed. Infectious Disease specialists and Neurologists consulted on the patient after preliminary tests indicated lesions on his brain. HIV and other infectious disease panels, as well as two bone marrow biopsies, all came back negative. Unfortunately even with numerous consultations, a slew of blood panels and biopsies, and additional tests, the patient's condition remained inconclusive. He progressively felt worse over several months and in February 2011, he brought himself to the ED at Pacific Medical Center.

---

<sup>1</sup> All names of individuals and institutions used in the manuscript are pseudonyms. Furthermore, to ensure anonymity locations have been changed (e.g., floor numbers).

Once admitted, the Internal Medicine (IM) team treated Mr. Bankston for his symptoms, and within a few days the general weakness (e.g., frail grip) and limited movement (e.g., inhibited vertical leg mobility) troubling him at admission had improved considerably. Mr. Bankston's acute symptoms had been addressed so successfully that he was deemed fit for discharge from the hospital. Mr. Bankston's primary care team was concerned with his pending discharge however because his diagnosis remained inconclusive. They were suspicious that he may have lymphoma, but because all tests and other medical workups were still pending at the time, they could not be certain. Typically this would be less worrisome as patients would already be scheduled for immediate follow-up care with all necessary PMC physicians. However Mr. Bankston was an uninsured patient and therefore would be unable to return to the center for any further care. With the uncertainty, and potential severity, of Mr. Bankston's medical condition, it was up to these 4 individuals to find care options for this man.

Oblivious to the hustle and bustle of the 3<sup>rd</sup> floor, where most IM patients are housed at PMC, Mr. Bankston's primary care team launches into an intense conversation outside of his room. They consider the best care options for Mr. Bankston, who is potentially facing a life-threatening condition. Christopher, the intern on the team, asks whether the patient can remain in the hospital until all test results come in and a definitive diagnosis can be reached, despite the patient's insurance status. Dr. Max, the attending physician and Christopher's superior, responds that that would be impossible since Mr. Bankston no longer needs any inpatient therapies (e.g., IV medications). He explains that if he were to stay, Mr. Bankston would pay out of pocket and would become bankrupt or the hospital would have to pay for it. Dr. Max proceeds to reassure Christopher that this decision is not motivated by Mr. Bankston's financial status, explaining that even if the patient had been insured, at this stage of recovery, he would be released from the

hospital. Therefore the primary problem was not whether he could stay in the hospital but how he would receive follow-up care.

Jessica, the team's second-year resident, and Christopher are silent as they contemplate possible follow-up care options for Mr. Bankston. Dr. Max proposes a possible solution, asking the intern whether or not he would be working at PMC's outpatient clinic in the near future. If Christopher were indeed rotating on the outpatient clinic, Dr. Max states that they could schedule an appointment with the intern directly and make him the primary care physician (PCP) for Mr. Bankston. Christopher responds that unfortunately he was scheduled at other institutions and would not be rotating at the clinic for at least another four weeks. The attending dismisses this potential solution stating that four weeks was too long a time period for Mr. Bankston to go without care.

Dr. Max offers a second potential solution, asking Jessica if she could act as the patient's primary care physician at an affiliated PMC hospital. Unfortunately due to bureaucratic protocols, Jessica explains to the team that she cannot simply schedule an appointment for Mr. Bankston but rather he would need to go to Urgent Care at the affiliated PMC hospital with a prescription under her name. Lauren, the case manager overseeing the social and financial aspects of patient care on this team, chimes in and reminds everyone that even with the prescription, the wait at Urgent Care typically lasts 24 hours before anyone is seen by a doctor. The resident confirms this as the unfortunate reality of Urgent Care at her primary institution, but explains that if Mr. Bankston did wait and was seen, from that point on it would be easier for him to make appointments. The attending dismisses this solution. He states that this process may be too arduous for the patient, resulting in him opting not to receive care.

Lauren offers a third solution: a small, free clinic in a neighboring area. She explains that this clinic used the same computer system as Pacific Medical Center. This did not facilitate access to records but since the notation system was the same, once the PMC records were obtained, the physicians could easily read and interpret the notes. Dr. Max ponders this proposed solution and eventually agrees that this was the best option, stating that the patient should be directed to go there. Christopher remains unhappy with the solution but agrees with the decision.

Extending beyond the typical five to ten minute presentation time for each patient during morning rounds, Mr. Bankston fills up a large portion of the team's rounding time because of his uninsured status and the potential severity of his conditions. While a plan for follow-up care was determined, Christopher's emotional response reflects a tension between what he would like to offer the patient and what actually can be done. This demonstrates the struggle for young physicians who have been unexposed to the realities of providing care within a highly bureaucratized and highly commodified system of health care.

Through the case of Mr. Bankston, Dr. Max and Lauren teach Jessica and Christopher a critical practical lesson: how to provide care for under-resourced patients. Dr. Max teaches the trainees how to capitalize on limited care options, to provide the patient with the best available care. He explains his thought process, discussing why he eliminates particular follow-up care options and why he ultimately selects the small free clinic for Mr. Bankston. Accordingly, the story of Mr. Bankston demonstrates one example of trainees encountering firsthand the financial obstacles present in care delivery at Pacific Medical Center. Attending physicians and case managers are integral to teaching trainees how to manage these obstacles to ensure that patients receive proper care. Subsequently, the process of deciding on the best therapeutic options for Mr. Bankston reflects the heart of this study: through interactions with peers, superiors (attending

physicians), and third parties (e.g., case managers), physicians-in-training learn how to manage financial constraints placed upon them in the current health care system.

\*\*\*

The financial constraints limiting the decisions the physicians can make regarding Mr. Bankston's care is one consequence of a highly commodified health care system struggling to curb health care costs. Unabated health care spending has been a problem plaguing the U.S. health care system since the late-20<sup>th</sup> century. From 1980 to 2010, health care spending in the United States catapulted from \$256 billion to approximately \$2.6 trillion (California HealthCare Foundation, 2012). This increased expenditure has been associated with advancements in technology, increases in pharmaceutical use, health administration costs, and the growth of chronic illnesses associated with longer life expectancy (Weisbrod, 1991). Hospital care, which has been chiefly targeted by cost-cutting policies in recent years, accounted for 30% of health care expenditure in 2010 (California HealthCare Foundation, 2012), with an average of \$8,233 spent per year on a single person (Kane, 2012). The nation's health care expenditure has generated great criticism because while the United States has the most expensive health care system in the world, it does not necessarily have the best health outcomes (e.g., lower life expectancy, higher infant mortality compared to OECD countries) (Kane, 2012).

Concerns of excessive spending – without better health outcomes – intensified after the publication of the 2008 Dartmouth Atlas report. This report, which largely motivated the health care mandate proposed by President Barack Obama, demonstrated variations in hospital length of stay and resource utilization for the same conditions across the United States. Two specific concerns generated from the report were the overreliance on specialists and unnecessary lengths of stay in the hospital. The Dartmouth Atlas report indicated that hospitals that relied heavily on



specialists and consultants spent proportionally more Medicare dollars without exhibiting better health outcomes (Wennberg, Fisher, Goodman, & Skinner, 2008). In addition, the report demonstrated that prolonged lengths of stay in the hospital simply resulted in exorbitant hospital bills but not in improved health outcomes (Wennberg et al., 2008).

Predictably, hospital discharge has been positioned at the forefront of inpatient cost-cutting initiatives with hospitals experiencing external pressure to reduce average lengths of stay. In recent years, attention has been placed not only on hospital stays, but also on hospital readmissions, largely due to Medicare's restructuring of its reimbursement policy in hopes to deter hospital readmissions. The "crackdown on readmissions is at the vanguard of the Affordable Care Act's effort to eliminate unnecessary care and curb Medicare's growing spending, which reached \$556 billion [in 2012]" (Rau, 2012, p. np). A 2013 Robert Wood Johnson Foundation report targeted hospital readmissions as driving higher costs, arguing the emergence of a "revolving door syndrome" at U.S. hospitals. The report announced that, "the U.S. health care system suffers from a chronic malady – the revolving door syndrome at its hospitals... one in five elderly patients is back in the hospital within 30 days of leaving... Many of these readmissions can and should be prevented" (Lavizzo-Maurey, 2013, p. 3).

This report placed the onus of responsibility on health care professionals, stating that many of these readmissions were consequences of poor care coordination and insufficient discharge planning (Goodman, Fisher, & Chang, 2013). The federal government shed light on the financial stakes of this "revolving door syndrome", reporting "the cost of readmissions for Medicare patients alone at \$26 billion annually, and... more than \$17 billion of [the \$26 billion] pays for return trips that need not happen if patients get the right care" (Lavizzo-Maurey, 2013, p. 3). These reports, combined with concerted efforts of the ACA to minimize unnecessary health

care spending via financial incentives (Chow, 2013), have resulted in hospitals and medical practitioners experiencing pressure to both (1) expedite hospital discharge and (2) to prevent hospital readmissions that are deemed “avoidable”. For instance, in October 2012, Medicare financially penalized 2,217 hospitals in the United States for too many readmissions (Rau, 2012).

With these cost-cutting initiatives in place, what are the consequences for the medical profession as they provide care in an inpatient setting? This study demonstrates how macro- and meso-level financial pressures and incentives trickle down and impact physicians’ everyday decision-making at the micro-level. Through ethnographic methods, I demonstrate when and how financial issues become salient for physicians in inpatient care delivery, and how financial considerations become inevitably embedded in the medical decisions they make. Of particular interest was how physicians-in-training learn to provide care amidst various financial pressures and constraints.

## **THE EMERGENCE OF A HIDDEN CURRICULUM OF FINANCES**

The inability of the trainees to offer solutions for Mr. Bankston’s follow-up care predicament reflects that learning how to practice financially conscious medicine is not emphasized in their formal medical school training. Confirming this claim, all of the attendings, residents, and interns interviewed stated that they had little, if any, formal training on financial issues during medical school. They all agreed that their training in financial concerns began through practice in the clinical setting during residency training and early practice as attending physicians<sup>2</sup>. Medical school lessons on financial issues were so infrequent that the few lessons that were taught stood out in trainees’ minds. The following interview excerpt is a 2<sup>nd</sup> year resident’s recollection of the one and only financial lesson taught during medical school:

---

<sup>2</sup> More seasoned attendings reported no training on financial issues in residency as well. This demonstrates a shift towards placing some attention on financial issues in residency training in the last five to ten years.

“It’s not something that has ever been explicitly taught, there’s no course in medical school that teaches you this. And maybe that’s what we need – a course in medical school just about billing, and just about thinking about expenses... But I remember as a medical student the only time I was really exposed to thinking about how much a treatment cost was when I did a radiology rotation and had to complete one of their assignments. In the radiology office they had a binder of different costs of tests and they told us, ‘Ok think of a diagnosis, look up the radiology that you believe goes along with that diagnosis and then tally up the costs of working it up from a radiographic standpoint. That was really the only exposure I had to putting dollar signs behind a test [or anything]” (R19).

In another interview, an intern also noted that there were very few, if any, lessons in medical school. One of the few financial exercises was the disclosure of pricing of particular tests.

“I don’t think anybody learns financial issues [in medical school] – I didn’t.

Sometimes they give us these tables of what things actually cost to the patient, which is nice. It is kind of an eye opener. We get routine labs every morning because you are a hospitalized patient – no other reason. So sometimes they will show us the breakdown of those costs and that is pretty eye opening. Like a liver panel is almost \$1,000 and the routine labs [run] everyday are a couple hundred bucks. So yea they show us that. I think you [also] learn a lot when you have patients that can’t get certain tests” (I4).

While the dissemination of pricing tables was useful in alerting physicians of some of the financial repercussions associated with the decisions they make, encountering patients with financial restrictions were much more pivotal to their education (than formal course work). The few physicians who indicated greater exposure to financial issues prior to residency had to seek

out financial training themselves. One 2<sup>nd</sup> year resident (R10) explained that she was always “interested in health disparities so I’ve done research in that area on my own” during medical school.

The common theme across the physicians’ experience was that financial lessons were not formally taught but rather were encountered through practice, on a case-by-case basis. One attending, who had just completed her residency four months ago, explained that she never thought about financial issues until a financial dilemma emerged for one of her patients:

During my residency training, we had a Clinic that was often hard to get into because we were so booked. It could take 6-9 months for a patient to be seen for a consult. [Because of this delay] I would push patients to stay in the hospital. One patient was discharged and afterwards received a \$78,000 hospital bill under my team. I felt so bad. That was when I began to rethink the idea of maybe not getting labs everyday and maybe just rethinking what the “routine” things should and shouldn’t be.

It was only after the physician’s patient was left with an astronomical hospital bill that the physician became more attuned to financial issues in care delivery – reflecting that financial lessons are learned primarily through practice.

Inadequate training on financial issues during medical school and residency training is further evidenced by the absence of financial dilemmas within the extensive literature on the socialization<sup>3</sup> process of becoming a physician (Becker, Geer, Hughes, & Strauss, 1976; Bosk, 2003; Fox, 1979b; Lempp, 2009; Riska, 2009). This literature elucidates the professional and personal challenges all trainees encounter – the “rites of passage” – as they progress through their training (Fox, 1979b; Hafferty, 1988; MacLeod, 2001). Of particular interest to medical

---

<sup>3</sup> Socialization refers to “the process whereby a person internalizes the knowledge, skills, values, and behaviors deemed appropriate by...those who instruct or influence” (Coombs, 1978, p. 14).

sociologists has been the uncovering of a hidden curriculum, which informally socializes and professionalizes medical trainees (Hafferty & Castellani, 2009) – shaping their professional values (Becker et al., 1976; Bosk, 2003), actions (MacLeod, 2001) and perceptions (of both medicine and the medical profession) (Becker & Geer, 1958; Fox, 1979b; Morley, Roseamelia, Smith, & Villarreal, 2013).

Through managing the various dilemmas that present themselves during training, physicians learn the professional expectations and responsibilities that are of greatest value to the medical profession. For instance, trainees learn how to manage professional expectations such as mastering the wealth of knowledge in biomedicine (Becker et al., 1976) and coping with the uncertainties and limitations of medicine in clinical practice (Fox, 1979b; Light, 1979). In his ethnography of surgery residency, Bosk (2003) demonstrated how error management socializes residents to learn the moral values of the medical profession. They are also made aware of the presence of an informal, internal control system (Bosk, 2003) – demonstrating the high degree of professionalism granted to physicians (Freidson, 1970b). Other scholars have documented trainees’ emotional socialization – learning to restrain one’s emotional response in order to provide both objective and empathetic care; young physicians confront this dilemma through firsthand experiences with autopsies (Coombs, 1978; Fox, 1979a; Hafferty, 1988) and through early encounters with dying patients (MacLeod, 2001).

These socialization studies have analyzed how physicians-in-training encounter professional and personal challenges that informally socialize them to learn the key characteristics of “good doctoring.” These challenges are revealed interactionally, as trainees engage with colleagues, superiors, and patients (Becker et al., 1976; MacLeod, 2001). Absent

however in this literature is how trainees learn to practice medicine when faced with professional challenges inherent in a health care system entrenched with financial (dis)incentives.

### *Changes in “Doctoring”*

Physicians have been deeply impacted by the transformation of the U.S. health care system over the course of the 20<sup>th</sup> century. In the first half of the century, physicians experienced high levels of autonomy, professional dominance (Freidson, 1970b), and professional jurisdiction (Abbott, 1988); they held private, fee-for-service practices, set the qualifications of health professionals, and controlled the relations they had with external parties (Light, 1989; Starr, 1982). However by the mid-20<sup>th</sup> century, health care was no longer a direct fee-for-service transaction between patient and physician, but rather a complex marketplace encounter involving various third parties (Conrad & Leiter, 2004; Fennell & Alexander, 1993; Light, 2000a). The emergence of these third parties directly impacted how physicians administered care by taking over tasks formerly under the control of physicians (Casalino, 2004), determining costs of care, and placing limits on physicians’ treatment options for patients (Mechanic, 1996).

Physicians experienced further limitations to their autonomy in the wake of cost-cutting initiatives that were implemented in the late-20<sup>th</sup> century. Concerned with the nation’s exorbitant health care expenditure, health insurance companies restructured reimbursement policies of diagnosis and treatment through the inception of Diagnosis Related Groups (DRG) – incentivizing hospitals to shorten patients’ length of stay (Holliman, Dziegielewska, & Datta, 2001). As expediting hospital stays became central to cost-cutting policies, hospitals began to incorporate discharge planners into care delivery. Discharge planners ranged from social workers to former nurses, and were dedicated to decreasing delays of disposition from hospitals

(Holliman et al., 2001). These discharge planners were to work closely with physicians in the clinical setting, shaping the care decision-making process to ensure efficient hospital disposition.

These transformations in care delivery have threatened the professional autonomy and authority of physicians as they have increasingly been expected to answer to various third parties (including third party payers, managers, and discharge planners) (Brown & McCartney, 2000; Holliman et al., 2001; Light, 2000a). As these different parties strive to meet their respective goals, physicians are routinely met with often opposing pressures (financial and social), which they must reconcile when making care decisions. Through the emergence and management of dilemmas via the hidden curriculum of finances, trainees soon realize that tradeoffs are inevitable as what is best for the hospital (and third parties) is not always best for the patient and vice versa; learning which tradeoffs are acceptable and which are not becomes a critical professional lesson for trainees.

\*\*\*

This study fills the gap in the socialization and professionalization literature on becoming a physician by revealing the emergence of a hidden curriculum of finances during residency training and early practice at Pacific Medical Center. I explore how trainees learn critical professional lessons through the emergence, and management of, financial dilemmas. To analyze this hidden curriculum, I draw from three theoretical literatures – commodification, professions and professionalism, and bureaucratization. These literatures serve as analytical guides to understand (1) why certain financial dilemmas surface in the inpatient setting; (2) why particular strategies are adopted in response to these dilemmas; and (3) the subsequent professional lessons learned. I discuss each theoretical framework in detail and the theoretical assumptions they make in the following sections.

## COMMODIFICATION

Commodification, a concept steeped in Marxian thinking, negatively connotes the encroachment of the economic sphere into aspects of social life that are deemed “priceless” (e.g., health and wellbeing, the body). In disagreement with economists’ perspective on exchange-goods, Marx (1936) argued that the value of an object is intrinsically linked to the human labor required to create the object. He asserted that all objects are characterized by both a use-value (its utility) and an exchange-value (quantitative); however as objects are commodified, their exchange value emerges as more salient in determining the actual value of the object (Marx, 1936). Marx warned that objects that trade according to the logic of capitalism come to be viewed solely based on their exchange value, which the market associates as an inherent characteristic of the object and divorced from the social labor performed to produce the product. Social scientists have continued to adapt this concept of commodification to unpack the process, and consequences, of the encroachment of economic life into the social sphere (e.g., the family, intimate relations, health care) (Almeling, 2007; Zelizer, 2005).

Drawing on Marx, the traditional economic perspective assumes that the economic and social spheres should remain distinct entities, as overlap between these two spheres leads to moral corruption (Polanyi, 1957[1944]; Titmuss, 1971). Resonating with the assumption that the economic and social were inherently incompatible, Parsons (1951) argued that in the early 20<sup>th</sup> century physicians were unlike businessmen due to an institutionalized collectivity orientation that ensured physicians would not place financial gains above patients’ needs. The influx of money into the U.S. health care system over the course of the 20<sup>th</sup> century, and subsequent transformations in care delivery (e.g., the emergence of third parties), however made money increasingly central to the exchange of health care; health care progressively became conceived



as a service that could be sold by providers (physicians) and bought consumers (patients) (Conrad & Leiter, 2004; Haug & Lavin, 1983).

From a conventional economic framework, this transition towards a consumerist model of health care would indicate that health care exchange has become a simple market transaction; the patient is a rational utility maximizer paying the price deemed acceptable for the necessary care and money a neutral medium (Carruthers & Uzzi, 2000). In recent years however, micro economic sociologists have challenged this traditional economic framework, arguing against the assumption that the economic and social spheres are (and should be) separate. Rather than money being a neutral entity that has a homogenizing effect, Zelizer (1994) argued that monetary transactions commonly account for social relationships. Consequently, individuals do not always consider their own interests when engaging in bargaining and negotiation, and instead consider the ramifications of certain transactions and decisions on these relationships (Zelizer, 2005). Drawing on Zelizer, Healy (2006) argued that the commodification of health care was not a precursor to moral corruption; the presence of markets within medicine was not necessarily to the patient's detriment because market transactions are embedded in social interactions and cultural meanings.

By applying a micro-economic relational perspective to evaluate the financial socialization of physicians-in-training, one would conclude that the dilemmas physicians face originate from the tension between the financial structuring of contemporary health care delivery and the value placed by society on health, well-being, and the doctor-patient relationship (and the professional oath to "do no harm"). These dilemmas would be resolved via one of the following pathways: (1) physicians provide care based singularly on financial considerations (corrupting the patient-physician relationship); (2) physicians provide care without any financial

considerations (leading to substantial financial losses for the hospital); or (3) physicians develop strategies to maintain their social and professional responsibility to patients while adhering to a market logic. Consequently, the financial socialization of physicians-in-training is an examination of social nature of economic exchange.

## **PROFESSIONS AND PROFESSIONALISM**

In the literature on professions published in the late-20<sup>th</sup> century, the hallmarks of a professional included full autonomy and authority over one's work, prestige and status, and protections from external evaluation and interference from third parties (Abbott, 1988; Freidson, 1970a, 1970b; Leicht & Fennell, 2001). High levels of formal educational training, specific entrance requirements, and strict credentialing protocols further demarcated professions from other occupational groups (Freidson, 1970b; Starr, 1982). Subsequently, professionals exercise legitimate control over their work as well as the ability to exclude others from impinging, or interfering, in their work (Abbott, 1988).

Professionals are subject to both internal and external stratification (e.g., the presence of status hierarchies). Intraprofessional status hierarchies reflect internal differentiation within a profession based on the degree of specialization of formal knowledge, skills, and expertise (Abbott, 1981, 1988; Freidson, 2001). Stratification within the hierarchy is further evidenced by markers that include the clients an individual works with (e.g., higher vs. lower status clients) and a disregard for “nonprofessional matters” (Abbott, 1988, p. 118). Interprofessional stratification, on the other hand, is established through the emergence and resolution of jurisdictional disputes among different professional groups. “Each profession is bound to a set of tasks by ties of jurisdiction...[these] professions make up an interacting system, an ecology. Professions compete within this system, and a profession's success reflects as much the

situations of its competitors and the system structure as it does the profession's own efforts" (Abbott, 1988, p. 33). As different professional groups vie for control over work domains, those who emerge successful in boundary disputes are associated with higher levels of prestige compared to those who are not (Leicht & Fennell, 2001).

In the early 20<sup>th</sup> century, physicians represented the archetypal professional: they held solo practices, set fees for the services they provided, and maintained full jurisdiction over their work (Beisecker & Beisecker, 1993; Emanuel & Emanuel, 1992; Parsons, 1951). Over the course of the 20<sup>th</sup> and 21<sup>st</sup> centuries however, physicians, like other professional groups, experienced challenges to their autonomy and authority in the workplace (Freidson, 1994), becoming privy to interference from external parties (MacDonald, 1995) due to economic and institutional transformations (Greenwood & Lachman, 1996; Reed, 1996). The increased specialization of medicine<sup>4</sup>, advancements in medical technologies, and the consequences of an increasingly commodified health care system have posed both inter- and intra-professional challenges for physicians, as different groups have contested physicians for jurisdictional control (Serra, 2010; J. Zetka, James R., 2001; J. R. Zetka, Jr., 2011). Amidst these various professional threats, the medical profession has remained relatively successful in combating competing professional groups through exclusionary and co-optation techniques (Curran, 1974; Hartley, 2002; Saks, 1995; Timmermans & Oh, 2010; Winnick, 2005; Wolpe, 1985).

From a professionalism perspective, the hidden curriculum of finances exposes physicians to inherently professional, not financial, dilemmas. These dilemmas are generated because of the interactions between physicians and other (para)professional groups involved in

---

<sup>4</sup> The medical profession became increasingly specialized post-World War II in the U.S. due to three structural factors: (1) there was "no regulation of the size or distribution of the specialties"; (2) "hospitals had strong incentives to set up training programs for specialists"; and (3) "government subsidies, the high returns to specialty practice created by health insurance, and the lack of a corrective mechanism that would have reduced specialist incomes as their numbers increased gave physicians strong...incentives." (Starr, 1982, p. 356).

health care delivery. The complex nature of health care delivery – and the subsequent division of labor – requires collaboration among these different groups. These encounters precipitate professional conflicts over autonomy, authority, and jurisdiction in patient care. Physicians-in-training learn to resolve these dilemmas by developing strategies that minimize professional threats and/or conflicts, reinforcing physicians’ professionalism vis-à-vis other actors in the clinical setting.

## **BUREAUCRATIZATION**

Bureaucratization, from a Weberian perspective, refers to a general turn to hierarchical organization in the name of efficiency within social institutions. Bureaucracies have a top-down centralized authority structure, and are both highly rational and “strongly committed to... organizational goals” (Etzioni, 1959, p. 48). A bureaucracy’s productivity and competency is contingent on the presence of a formal set of established rule and regulations (Kallinikos, 2004; Nelson & Winter, 1982). These rules and regulations determine the actions of its social actors; bureaucracies “expect their members to comply with directives of the organization” (Roberts & Donahue, 2000, p. 368). While providing high levels of efficiency and effectiveness, scholars have argued that this form of organization comes at a social price.

The scholarship has documented the incompatibility of professionalism and bureaucratization, finding that a professional’s rejection of a bureaucracy’s regulations, standards, and authority structure often led to conflict (and failed goal attainment) (Corwin, 1961; Dalton, 1959; Sorensen & Sorensen, 1974). Consequently, scholars argued that deprofessionalization was a common phenomenon in bureaucratic organizations (Blau & Scott, 1962; Scott, 1966). Furthermore, formal organizations were associated with the dehumanization of individuals through the emergence of an iron cage and a waste of “human potential” (Katz & Kahn, 1978).

Others however have opposed this perspective, arguing that bureaucracies do not unequivocally lead to a loss of professional autonomy (Adler, 2012; Gouldner, 1954; Morrissey & Gillespie, 1975). Scholars have found that bureaucratic institutions grant professionals authority over specific organizational dilemmas that require professional expertise for proper goal attainment (Goss, 1961). In addition, professionals working in formal organizations have been given access to various tools and opportunities (e.g., funding, technologies) – typically unavailable in solo practices – facilitating achievement of professional goals (Bucher & Stelling, 1969; Engel, 1969; Ritzer, 1975).

With the complete transformation in health care delivery over the course of the 20<sup>th</sup> century, physicians were unable to escape the increased bureaucratization of health care. The financial restructuring of care delivery required physicians to seek employment in institutionalized settings – no longer able to hold solo practices (Grumbach, Osmond, Vranizan, Jaffe, & Bindman, 1998; Kletke, Emmons, & Gillis, 1996; Light, 2000a; Waitzkin, 2000). Scholars in turn have bemoaned the deprofessionalization, proletarianization, and post-professionalism of physicians (Haug, 1972; Kritzer, 1999; McKinlay & Marceau, 2008; McKinlay & Stoeckle, 1988), as physicians have become subject to greater external evaluation and supervision, particularly with the rise in managerialism (Beardwood, Walters, Eyles, & French, 1999; Scott, Ruef, Mendel, & Caronna, 2000) and the transition towards standardization (Timmermans & Berg, 2003) within health care.

Accordingly, adapting a bureaucratization approach to evaluate the emergence of a hidden curriculum of finances would generate the following argument: the financial dilemmas that physicians face are essentially dilemmas that reveal the incongruence between the professional goals of Internal Medicine physicians and the organizational goals of Pacific

Medical Center. Learning to resolve these dilemmas subsequently requires an alignment between professional and organizational goals, primarily through physicians' adherence to the hospital's rules and regulations to achieve its primary objectives. Thus, physicians are not becoming financially socialized, but rather, are learning to engage in professional work within a bureaucratized setting.

\*\*\*

While all three theoretical approaches offer useful analytical tools to understand the financial socialization of physicians-in-training, each theory alone is insufficient in explaining this process. I argue that the dilemmas physicians face stem from the increased specialization of medicine, and the increased commodification and bureaucratization of health care delivery. As these dilemmas are both professionally and organizationally produced, trainees must become well-versed in the inter- and intraprofessional dynamics present in shared work settings and the bureaucratic nature of care provision. With this knowledge – which is acquired through the hidden curriculum of finances – trainees develop strategies to offset these dilemmas. Physicians-in-training subsequently continue their socialization, learning an indispensable professional lesson: how to protect their professionalism (e.g., professional autonomy and cultural authority) amidst a progressively complex model of care provision.

By revealing the financial socialization of physicians, this dissertation offers theoretical insights on the experiences of professionals in the 21<sup>st</sup> century. In an era associated with increased accountability, evaluation, and standardization of practices within health care (and beyond), the classic theory of professions fails to represent the experience of contemporary professionals. As professional groups continue to experience limitations and constraints in how they perform their work, what are the hallmarks of professionals today? In what ways are

professionals able to maintain professional dominance and professional jurisdiction in their daily work? This study informs how a professional group, which has come under siege by financial incentives and third parties, learns to take different professional, organizational, and institutional concerns into consideration as they develop strategies to maintain jurisdiction over their work.

From an interdisciplinary perspective, what is the practical value of studying the financial socialization of the medical profession? This study has the potential to inform policy and practice, dedicated to curbing the nation's trillion-dollar health care expenditure. By analyzing when and how financial dilemmas become salient for physicians in the inpatient setting, this dissertation sheds light: (1) the varied ways in which macro- and meso-level policies (e.g., new readmission policies; standardization of care; evaluation and accountability measures) manifest in the daily work of physicians and (2) *how* some inpatient costs are incurred. These findings may draw attention to varied levels of effectiveness of current policies, as well as signal to other aspects of patient care that have remained under-addressed in cost-containment policy initiatives.

## **OVERVIEW OF THE STUDY**

To examine the salience of financial issues in inpatient care delivery, I conducted ethnographic research on the Internal Medicine Service at Pacific Medical Center from September 2010 to August 2013. Pacific Medical Center is prestigious academic medical center in the Western United States. It is a 500-plus bed medical center that often runs over-capacity, with more patients than beds available in the center. Internal Medicine, a general medicine service, cares for patients of all adult ages. These individuals are battling numerous conditions in addition to the acute health episode that brought them to the hospital. Due to the highly specialized nature of PMC, the patient population on the Internal Medicine Service is highly complicated, ranging from transplant patients that may be experiencing rejection to patients with unknown, serious

conditions. In addition, many of these patients have been transferred from other hospitals because they required a higher level of care.

Gaining access to the Internal Medicine Service took time, negotiations, and some good fortune. After searching for over two years for a field site, I first became acquainted with the IM Service at PMC by joining a research team planning to conduct research on the wards. The team was just beginning negotiations to obtain access, and fortunately I was able to take part in the process. I attended several meetings with various Internal Medicine physicians to discuss both the team's and my own proposed projects. We also explained the merits of the ethnographic approach and how the projects' findings could be useful not only for social scientists, but also for health care professionals alike. After approximately 3 months of negotiation, we were granted access to the Internal Medicine Service at Pacific Medical Center.

My primary contact was the Director of the Hospitalists within the Department of Internal Medicine at PMC. Similar to other scholars who had the good fortune of meeting medical practitioners' valuing the sociological perspective (Mizrahi, 1986), the Director of the Hospitalists at PMC was particularly interested in my project, believing that social scientists could shed valuable light on some of financial concerns surrounding inpatient care delivery. With the Director taking me under his wing and introducing me to his colleagues, I was able to easily gain physical access to the teams, with the attending physicians embracing my presence without question.

There are 6 Internal Medicine teams that oversee all of the patients admitted to PMC's Internal Medicine Service on any given day. Each Internal Medicine team is comprised of an attending physician, a resident, 2 interns, 1-2 medical students, and a case manager. Internal



Medicine attending physicians are a combination of hospitalists<sup>5</sup>, physicians who only provide inpatient care, and internists, physicians who work at both the hospital and an outpatient setting at Pacific Medical Center. Hospitalists primarily run the teaching wards on the IM Service with most internists only rounding a couple of weeks a year<sup>6</sup>. The attending is the physician on record for the patients assigned to his/her team. As the physician on record the attending is both medically and legally responsible for the patient's care. The attending physician is also responsible for the training of the interns and residents that are a part of the team – teaching trainees about differential diagnosis, guiding their decision-making, educating them about consultations, and so forth. The attending is available to trainees throughout the day and night to answer any questions they may have. Interns and residents typically must run most medical decisions regarding a patient by the attending before proceeding with care<sup>7</sup>. Attending physicians rotate every 5 to 14 days on the wards.

Interns and residents (referred to as housestaff) are trainees undergoing their residency in Internal Medicine. For some residents, IM training is mandatory training they must receive prior to beginning further residency training in a specialized field (e.g., Cardiology). For others, Internal Medicine is the end goal. Interns are first year trainees while residents are in their second or third year of residency. Interns typically answer to the resident on the team, and the

---

<sup>5</sup> The Society of Hospital Medicine (SHM) defines a hospitalist on their web site as “a physician who specializes in the practice of hospital medicine.” Hospital medicine refers to “a medical specialty dedicated to the delivery of comprehensive medical care to hospitalized patients” (Society of Hospital Medicine, 2011). By working in a single setting, hospitalists were perceived to improve quality of care, as they would be more accustomed to the conditions of hospitalized patients (Wachter, 1999). Academic medical centers predominantly adopted this hospitalist model of care, utilizing hospitalists for most of their internal medicine teaching services. The nature of hospitalist work allowed physicians to not only spend more time with hospitalized patients, but also to dedicate more time teaching interns and residents.

<sup>6</sup> Academic medical centers frequently utilize hospitalists for their teaching services. Studies have indicated high evaluations of hospitalists among interns and residents – indicating the positive impact they have had on teaching services. Furthermore, many hospitals have announced reductions in health care costs, decreased lengths of stay, and increased efficiency without a drop in quality of care (Bellet & Whitaker, 2000; Palmer Jr. et al., 2001; Wachter & Goldman, 2002).

<sup>7</sup> This does not always happen (particularly regarding consultants' recommendations) and can become a source of conflict.

resident then primarily communicates with the attending physician. Interns and residents are on a single team for 28 days before rotating to another facility. Their training includes practicing medicine at different hospitals in the region and in an outpatient Internal Medicine clinic.

Medical students are in their third or fourth year of medical school and have begun rotations on clinical wards. These rotations are in place to help them select which specialty they would like to train in upon completion of medical school. Medical students primarily tend to tasks delegated to them by the intern. Like interns and residents, medical students also rotate every 28 days to different specialties at PMC.

Lastly, a case manager is appointed to each team on the IM service. There has been variation in the number of employed case managers during my research period, thus at times one manager would cover two teams and consequently would not always be present during rounds. The case manager is primarily in place to expedite social and financial issues that emerge as barriers to discharge. They directly correspond with the patient and the patient's family regarding the financial aspects of the patient's hospital stay. They also directly correspond with health insurance companies regarding patient care (e.g., receive approval for a particular medication), communicate with outside facilities (e.g., nursing homes), and secure placement for a patient. The case manager is assigned to a specific team and never rotates to another team (in contrast to attendings and housestaff, who rotate on different teams).

#### *Caring for Patients on the IM Service*

Each team is designated as "admitting" patients on a weekly basis. An "admitting" team refers to a team accepting patients from the ER to the IM service that day. Each team can have a maximum total of 20 patients; each intern is assigned up to 10 patients. On these days, interns and residents are caring for patients on the IM wards while also seeing patients in the ER and

admitting them onto their teams. Patients are typically randomly assigned to teams based on availability on the service. While interns and residents monitor patients throughout the day on their own, the team assembles in its entirety every weekday morning to discuss and examine all of the patients on the service that day.

Morning rounds normally begin around 9:30 AM and last until approximately 12 PM from Monday through Friday. During these rounds, the team walks to each patient room to discuss and see the patient. Once outside the patient room the intern (or medical student) assigned to the patient presents an overview of the patient's condition. This overview provides the patient's current condition, the patient's history in the hospital upon admission, and the patient's general medical history. The intern also raises any social and financial issues associated with the patient and his/her care. The attending physician frequently asks questions regarding the patient's condition. For instance, if the patient has not been diagnosed yet, the attending asks the trainees what the possible diagnoses could be. If the patient has been diagnosed, the physician asks what treatment recommendations they would suggest for the patient. Based on this discussion, the team may opt to run additional tests or to call consultants on to the case. Some attendings allow for interns to separate from the team during rounds to order tests or initiate consults. Others prefer for the entire team to round together and to have interns complete consult and test requests after teaching rounds have ended. Upon completion of the presentation of the patient, the entire team then enters the patient room and a physical exam is completed. A treatment plan is also further discussed with the patient. Sometimes treatment decisions are altered upon leaving the patient's room as the clinical exam changes the attending's perspective regarding patient care.

In the afternoon, the attending physician and the senior resident also attend

interdisciplinary afternoon rounds. During these rounds, the attending and resident meet with the case manager, the social worker, and other parties (e.g., physical therapy) to discuss potential social and financial barriers to the patient's discharge. The team meets in a small room and verbally runs through the list of patients. The resident usually presents the different patients and the potential barriers and the case manager discusses next steps as well as issues that have been resolved.

This study relies on data from three sources: (1) observations during teaching and interdisciplinary rounds, (2) observations of monthly hospitalist meetings, and (3) interviews with IM attending physicians and trainees<sup>8</sup>. I shadowed IM teams between 2-5 days a week during their morning rounds and afternoon interdisciplinary rounds, and occasionally for longer periods of time. Many of the physicians preferred to be observed only during rounds because of their workloads. I also attended monthly IM hospitalist meetings, held at either PMC or another PMC-affiliated hospital. These meetings were primarily dedicated to improving the consultation process at the hospital. I attended meetings that addressed consultations with Endocrinology, Gastro-enterology, Pulmonology, Cardiology, and Rheumatology. Lastly, I interviewed 40 Internal Medicine attending physicians and 19 Internal Medicine trainees for a total of 59 interviews. These interviews were semi-structured; the topics included physicians' perspectives on general financial issues, consulting colleagues, and delays of care and discharge. The disparate numbers of interviews with attendings and trainees reflects not only the heavily burdened workloads of trainees (Szymczak & Bosk, 2012), but also personal obstacles encountered in the field (which are explored in the appendix).

I focus on trainees for this project, analyzing how physicians learn which financial issues

---

<sup>8</sup> Greater detail of the methods is provided in the appendix.

matter most in their daily work, and how consequently financial considerations become embedded in the medical decisions they make. Specifically, my dissertation contributes a critical component of the professionalization process of becoming a doctor that has remained absent in the literature: learning how to manage financial aspects of care delivery within a highly commodified health care system. Previous studies have examined how physicians become professionalized through medical school and residency training, learning the goals and values of the medical profession through problem-solving and conflict-resolution. This study expands the professionalization literature within medical sociology, uncovering on how physicians learn to navigate financial dilemmas prevalent within the current U.S. health care system. It must be noted that trainees are not necessarily just interns and residents, but rather they include inexperienced attending physicians, as many valuable financial lessons are encountered beyond residency training.

The rest of this dissertation is organized in chapters that address different dilemmas that physicians-in-training encounter through practice. While these dilemmas may not explicitly seem financial at first-glance, failure to manage these dilemmas properly results in costly consequences for the hospital, exacerbating inpatient costs.

Chapter 2 examines how the medical record serves as a professionalizing tool for trainees. The medical record is how the Internal Medicine team corresponds with fellow team members, consulting physicians, and external third parties – specifically health insurance companies. As trainees use the medical record, they learn formal lessons on proper notation and communication with various parties. Improper or insufficient notation can result in various dilemmas. Through the emergence and management of these dilemmas, trainees learn valuable professional lessons.

Chapter 3 evaluates how physicians-in-training working within a highly specialized hospital learn to share patients with consulting specialists without incurring unnecessary costs for the hospital. As a generalist service, Internal Medicine heavily relies on consulting specialists, leading to additional medical tests and treatments, which can become very expensive. Furthermore, improper management of intra-professional work dynamics among different specialty physicians can lead to jurisdictional conflicts over patients that have costly ramifications for the hospital.

Chapter 4 analyzes how physicians-in-training appropriately handle the discharging of patients when faced with countervailing financial incentives. Through the emergence and management of rocks – patients who remain in the hospital unnecessarily – physicians encounter countervailing financial pressures: physicians are pressured to prolong patients' hospital stays to avoid financial penalties associated with premature discharge, yet are also encouraged to quickly discharge patients to reduce lengths of hospital stay. Subsequently, physicians must learn to make discharge decisions that consider these conflicting financial consequences.

Chapter 5 is the concluding chapter, expanding on theoretical themes explored in the introduction. This chapter also assesses current cost-cutting initiatives from a sociological perspective, and offers policy recommendations for health care practitioners and institutions. My findings show that universal insurance coverage is just one component to improving health care access and reducing costs, pointing to physicians as a second critical component. Physicians act as gatekeepers to both health care access and costs; their ability to navigate financial constraints directly translates to a patient's ability to receive care as well as whether the hospital will incur unnecessary costs. Accordingly, policies should be geared towards improving how physicians learn to navigate financial dilemmas, providing incentives to not only practice financially savvy

care, but also to gain greater acuity regarding affordable care options available to patients. In addition, sporadic closures of care services, the structuring of care delivery in training hospitals, and the financial restrictions placed on physicians contribute to barriers to care and discharge. Subsequently, policy initiatives should also be directed at hospital practices as well as towards strengthening relationships between hospitals and other care organizations to improve transitions of care.

Lastly, the Appendix offers a detailed discussion of the methodology and my personal ethnographic experiences in the field.

In sum, this dissertation presents a nuanced look at how physicians-in-training learn to practice medicine within a highly commodified health care system. Returning to the case of Mr. Bankston, unlike in typical marketplace encounters, the nature of the doctor-patient relationship prevents the physicians from merely dismissing the patient due to lack of financial resources, but rather they try to provide Mr. Bankston with the best available care. Nonetheless, as trainees learn to filter through and determine when finances matter, physicians inevitably become agents of commodification. As they make decisions within the limitations of the system, they ration care, altering patients' health care trajectories based on financial status, and inevitably produce commodified care. Rationing is not necessarily a consequence of physicians seeking financial profit, but rather the result of physicians learning to manage the financial incentives in place within the health care system – in order to benefit both the hospital (and the physicians) and the patients as well.

## Chapter 2: The Medical Record as Professionalizing Tool

What are the professional challenges of hospital physicians working within a highly commodified health care system? The increased commodification of care over the course of the 20<sup>th</sup> and 21<sup>st</sup> centuries has transformed health care delivery from a rather straightforward exchange between physician and patient to a complex transaction involving patients, physicians, and various third parties (Conrad & Leiter, 2004; Light, 2000a). With the subsequent emergence of numerous powerful stakeholders within health care delivery, countless social scientists have inquired about the state of the medical profession and its ability to maintain professional autonomy and authority in this new medical landscape. Many have lamented the medical profession's loss of professional dominance – leading to physicians' "deprofessionalization" and "proletarianization" (Haug, 1988) – while others have championed the profession's continued resilience in protecting their jurisdiction from encroaching third parties (Timmermans & Oh, 2010). Whereas we know a good deal about how competing professional groups have contested the profession's authority and autonomy, less is known of *when* physicians – specifically trainees – first encounter these professional challenges and *how* these challenges directly shape their socialization into the profession.

While the socialization and professionalization of physicians have been well-documented in the social science literature (Becker et al., 1976; Fox, 1979b; Hafferty & Castellani, 2009), there is little discussion of how learning to practice medicine within a highly commodified and bureaucratized health care system shapes the learning process. With the restructuring of health care delivery over the course of the 20<sup>th</sup> century, trainees undoubtedly confront professional challenges associated with the commodification and bureaucratization of care (e.g., intervening third parties (Light, 2000a); managerialism (Scott et al., 2000); standardization of care



movement (Timmermans & Berg, 2003)). This chapter examines how professional challenges associated with the current health care landscape shape the socialization of trainees. Drawing from ethnographic and interview data, I argue that the medical record plays an essential professionalizing role – serving as a site for the emergence, and management of, these professional dilemmas. The medical record has a dual function: (1) it provides an overview of a patient’s condition and treatments; and (2) it functions as the primary mode of communication between all parties involved in the coordination of patient care. Structuring interactions between physicians, nurses, case managers, insurers, and other health care actors, this chapter demonstrates that physicians-in-training confront valuable professional lessons through routine use of the medical record. As inter- and intraprofessional disputes surface from (mis)use of the medical record, trainees contend with challenges to their professional dominance and autonomy in their day-to-day tasks. As they learn to navigate these dilemmas, trainees realize what “good doctoring” entails in clinical practice.

### **The Medical Record in Care Delivery**

Social scientists have extensively detailed the effects of the growing use of medical technologies within health care delivery (Heath, Luff, & Sanchez Svensson, 2003). Scholars in the social science and medical fields have emerged on both sides of a debate regarding the effectiveness and advantages of increased medical technology use. Proponents have emphasized the definitive strides made in medicine, improved patient safety, and greater efficiency in the administering of care (Heath et al., 2003). Opponents have argued that these technologies contribute to the dehumanization of medicine and the deprofessionalization of physicians (Haug, 1988), as medical decision-making increasingly privileges computer algorithms and protocols over individual thinking and clinical experience (Haug, 1977). Furthermore, scholars have

argued that some technologies have a detrimental impact on workplace relations, (re)enforcing hierarchical relationships among different medical (para)professionals (Dent, 1990; Tjora, 2000; J. Zetka, James R., 2001).

Of specific interest within the literature on medical technologies is the considerable role the medical record plays in care delivery. Sociologists have asserted that the medical record is a formal organizing tool of medical information, favoring particular forms of information (Berg, 1997) and actively shaping how care is provided (Berg & Bowker, 1997; Heath, 1982). Many have championed the role the medical record has played in improving efficiency, reducing costs, and improving quality of care (Fisher & Shortell, 2010; Greenhalgh, Potts, Wong, Bark, & Swinglehurst, 2009).

In recent years, scholars have also revealed how different parties use the medical record to meet particular professional and organizational goals. For instance, physicians have capitalized on the presence of the medical record, utilizing it to preserve their status and jurisdiction in relation to other health care professionals (Håland, 2012). Similarly, health care administrators and managers have also taken advantage of the medical record – utilizing it to implement evidence-based medicine protocols, to review physicians' adherence of these guidelines, and to pressure physicians to abide by precise standards of care (Reich, 2012). The fact that the medical record is shared across various health care actors reflects the complex role it performs in care delivery; this document has the ability to both reinforce and challenge the authority of the medical profession.

Physicians first encounter the medical record during their residency training, where they learn proper documentation and use of the record. Although it plays a significant role in health care delivery, the medical record is notably missing from the socialization literature, which has

detailed how specific experiences during medical training (e.g., error management (Bosk, 2003), autopsies (Fox, 1979a), treating terminal patients (MacLeod, 2001), encountering the limits of biomedicine (Fox, 1979b)), teach trainees the responsibilities, values, and expectations of the medical profession (Bosk, 2003; Hafferty, 1988; Hafferty & Castellani, 2009). For instance, the act of cadaver dissection for trainees is one of their earliest encounters with death and dying. The repeated act of dissection, combined with the sharing of stories of cadaver experiences among peers, mark the emotional socialization of trainees (Hafferty, 1988); they eventually view “cadaver dissection as an occupation quite divorced from living human beings” (Charlton, Dovey, Jones, & Blunt, 1994). In addition, morning report – organized meetings where residents discuss issues related to patient care to peers and faculty (Amin et al., 2000) – is another valuable component of trainees’ professionalization (Apker & Eggly, 2004). Through interactions with, and assessments by, their superiors, residents are socialized to privilege the following professional characteristics above all else: “objectivity, emotional distance, and scientific authority” (Apker & Eggly, 2004, p. 426). These studies emphasize that peer-peer and peer-superior *interactions* are how trainees implicitly learn critical professional lessons. Subsequently, as the medical record structures interactions across different health care actors present within the current health care system, this document may expose physicians-in-training to valuable professional lessons as well.

Two consequences of the increased commodification of care may offer insights into the types of professional challenges confronted through use of the medical record: the presence of third parties and the risk of litigation. As a bridge connecting different parties in health care delivery, the medical record may alert physicians to the professional implications of the presence of third parties in care provision. The sociological scholarship has investigated the consequences

of the presence of third parties on the medical profession (Mechanic, 1996; Quadagno, 2008). The medical profession has faced challenges to its professional dominance and jurisdiction (Light, 2000a) as third parties have increasingly intervened on tasks formerly under their control (Casalino, 2004). Managed care companies, especially, threatened physicians' professional autonomy and authority (Quadagno, 2008), as they limited the treatment options physicians could administer to patients (Mechanic, 1996). Physicians were also required to obtain approval from insurers before proceeding with care (Mechanic, 1996). Additionally, managed care companies controlled costs of care and determined the amount of time physicians could spend with patients; average lengths of office visits, for instance, were shortened for cost-containment purposes (Mechanic, 1996).

As financial issues became increasingly salient in the commodified health care system, physicians also experienced a loss in cultural authority as patients questioned whether physicians still placed patient welfare above personal financial gains. The growing distrust of physicians – and subsequent diminished cultural authority – was witnessed by the exponential growth of malpractice lawsuits during the 1970s and 1980s in the United States (DeVecchio Good, 1995). In light of these legal troubles (which had ramifications for medical professionals and health care institutions alike), health care organizations implemented professional and organizational changes dedicated to “risk-management”, in order to avoid further litigation. Consequently, physicians were subjected to peer review and external evaluations, and were encouraged to improve their interactional skills with patients to alleviate patient dissatisfaction (Annandale, 1989; Ginsberg, 1983; Robinson, 1986).

Diminished professional dominance and cultural authority are just some of the professional challenges the medical profession has confronted within the current health care

landscape. This chapter demonstrates how the medical record is one pathway by which trainees encounter these professional challenges in their daily work. I argue that through use of the medical record, physicians-in-training become exposed to the presence of third parties in health care delivery and the implications of this presence on the medical profession itself. To date, little is known of the role the medical record plays in the socialization process of becoming a physician. Consequently, drawing on the literature on professionalism and the commodification of care, this chapter examines how the medical record emerges as a pivotal professionalizing tool for physicians-in-training at Pacific Medical Center.

### **Learning Proper Use of the Medical Record**

The medical record serves as an account of a patient's ongoing condition(s), physicians' daily care decisions, medical evaluations and test results, future treatment plans, and/or prognosis of a patient on the Internal Medicine Service at Pacific Medical Center. Each patient's medical record is a large binder filled with paper records of all information relevant to patient care (e.g., patient intake information including demographics, insurance status, emergency contact information; medical history (both self-reported and/or previous records if transferred from another facility; current care; etc.); and acute conditions; etc.). The records of all currently admitted patients are kept in an office on the Internal Medicine Service wards. It is the trainees' responsibility to retrieve the record, fill out all of the paperwork documenting care decisions throughout the day, and return the record back to the office. Along with documenting a patient's condition and care, the medical record becomes a primary form of communication between the Internal Medicine physicians and other medical professionals and ancillary staff. For instance, consulting specialists leave recommendations of treatment plans for the IM team in the record,

and night floats and nurses provide information of overnight events to housestaff. Therefore, learning how to read and write in the medical record is a critical component of residency training.

Trainees' first exposure to reading the record begins as third and fourth year medical students rotating on the clinical wards. As medical students, they are familiarized with the medical record, mastering literacy of the record in order to make presentations on patient's conditions during morning rounds. Medical documentation in the record, on the other hand, becomes more central during the first year of residency training. The medical record facilitates communication across the various parties involved in patient care.

Proper medical record documentation and use allows for efficient care coordination and minimal (if any) face-to-face interactions between the primary care team (in this case Internal Medicine), other physicians, and external third parties (e.g., health insurance companies). The medical record allows the Internal Medicine team to communicate with consulting physicians through a series of notes, pages, and occasional phone calls between the trainees and the fellows on the consulting team. It is common for trainees from the primary care team to not have real-time interactions with consultants, with one resident stating that he has had numerous "consultants that I'm meeting face-to-face for the first time 6 months [after the first page or phone call]".

Stemming from minimal clinical experience, inadequate or improper medical documentation is a common problem for trainees. Case managers explained that first year residents in particular do not know how to write up the charts to prevent the generation of disputes. One case manager noted that one of the key problems is that trainees are often too vague and fail to provide enough information to prove why the patient should be in the hospital. An attending agreed that trainees' lack of clinical experiences results in many disputes that could

easily be resolved (e.g., a quick editing of the hospital record):

“It [financial issues] is very salient at all times especially since the case manager is telling us about the patient’s insurance status – that they are out of network or that the health insurance company has rejected the patient’s stay. In these cases usually all you have to do is change the wording on the hospital notes. Early on in my training it was unclear what a “justifiable hospital stay”<sup>9</sup> was but now I know better.”

Accordingly the case manager and attending physician help trainees with their medical documentation, teaching them three practical lessons: (1) *when* to write in the record; (2) *where* to write in the record; and (3) *what* to write in the record.

Attendings and case managers play a significant role in teaching trainees *when* to write in the medical record. As noted previously, patients’ records typically remain in an office on the IM wards, except for during morning rounds. Morning rounds are when the bulk of decisions regarding a patient’s care are determined; the IM team typically decides whether additional tests, procedures or consultations are needed or whether the patient is stable enough to be discharged from the hospital. As all of these decisions require documentation, the case manager rounding with the team usually compiles all of the records and brings them along during rounds. Having the records readily available expedites care delivery, particularly in instances when the IM team is requesting an order for a specific procedure or consultant; the earlier in the day the order is placed the higher the likelihood that the patient will receive the test or be seen by a consultant that same day.

Case managers, who are in place to expedite care delivery, remind trainees of the importance of timing; trainees soon learn which information is time-sensitive and must be

---

<sup>9</sup> A justifiable hospital stay refers to a stay that is deemed medically necessary, and subsequently will be financially covered by the patient’s insurance company.

written in the record without delay, and which information can be input at a later time. For instance, one patient was ready to be discharged from the hospital and merely needed transportation scheduled for his departure. The case manager told the intern that an ambulance was needed and that it needed to be “done by 2:30 to 3:00 PM today” in order for the patient to be discharged the same day. As a result, she told the intern to write the orders “*right now*” (approximately 10 AM) in the medical record, to ensure that the ambulance would be secured. Through daily reminders by the case manager and attending, trainees recognize when information that must be input into the medical record is “time-sensitive” (e.g., procedures or tests required for discharge). Subsequently, the interns or resident take turns staying behind to write in the medical record during morning rounds, and catch up with the team shortly after, which has proceeded to see the next patient.

Similar to learning when to write in the medical record, case managers are especially vital to teaching trainees *where to write* particular forms of information (usually orders related to discharge) in the record. The following fieldnote excerpt demonstrates the case manager’s knowledge of the paperwork trainees are required to fill out in the patient’s record.

An 81-year-old female with Advanced Alzheimer’s needed a walker in order to be discharged from the hospital. After evaluating the patient, the team exited the room and the case manager presented the resident with order papers [for the walker] that would be included in the patient’s record. As the resident scanned the paper, she glanced over to the case manager confused and asked, “do I write it [the order for the walker] here?”, pointing to a section for the case manager to see. The case manager said, “Yes you write it there, and then I can handle the rest”. The case manager explained that she could then have the walker brought to the patient’s bed prior to her discharge.



In order to facilitate a smooth and efficient hospital discharge, case managers are concerned with ensuring that trainees use proper notation in the record, for improper documentation could result in delays of orders leading to delays of discharge.

Lastly, attending physicians invest a considerable amount of time teaching trainees *what to write* in the medical record. They frequently offer a verbal outline of exactly *how* a condition should be written up in the patient's records, exposing trainees to the "language" of health insurance companies. This "language" refers to the specific set of terms that health insurance companies acknowledge as billable conditions and therapies. There is frequently a disconnect however between insurers' "billable language" and the biomedical terms physicians use in everyday practice. "Proper" notation in the medical record is critical as health insurance companies assess the documentation in the record in lieu of being physically present to assess patients' hospitalizations. These assessments are then used to determine financial coverage of therapies administered to patients and the length of the patient's hospital stay. Effective communication between physicians and insurers therefore is contingent on trainees learning the "language" of health insurance companies. Improper notation can result in denial of coverage, leading the health insurance company to contact the attending physician or the case manager on the primary care team. The attending or case manager proceeds to notify trainees of problems related to health insurance claims and approval, resulting in delays of care. These delays result in additional work for trainees, as they must address these concerns in order to proceed with care (e.g., additional medical notation, notify consultants of delays, notify consultants). Not only does this add to the already overworked trainees during their residency training (Szymczak & Bosk, 2012), but also results in costly delays of care and discharge.

In the following fieldnote excerpt, an attending teaches the housestaff the "right" and

“wrong” way to document a 63 year-old woman’s urosepsis, an infection of the bloodstream that stems from a urinary tract infection, in her medical record.

Upon examining the woman, the attending found that the patient was experiencing worsening right flank pain, a cough, and little urine output; the urine output she had was cloudy. After leaving the patient’s room, the attending discussed with the resident and intern how to document her condition on her medical record. He stated that the intern should not notate the condition as urosepsis in the medical record but as “sepsis from a urinary source” to ensure that the health insurance company would not dispute their medical assessment. He explained to the housestaff that often times, the condition is “incorrectly” written as urosepsis and health insurance gets involved because they do not “recognize” this condition as a “billable” one.

Subsequently, to the frustration of trainees, while they may correctly document the condition from a medical standpoint, if the notation does not meet the criteria of insurers’ guidelines, coverage will be denied. Attending physicians play a significant role in educating interns and residents on the specific language of billing to ensure unimpeded communication with insurance companies.

Attendings also adopt a “micro-management” approach in cases when a proposed treatment is not completed or when a hospital stay is shortened (typically at the request of the patient). For instance, while waiting for an MRI for several days, a patient’s condition resolved itself. In light of the patient’s change in condition, the attending opted to forego the MRI scan. However, upon deciding to skip the MRI, the attending physician told the intern to specifically write the following note in the patient’s record: “condition had resolved itself before the study could be completed”. He explained that this documentation was necessary to explain the “failure”

to complete the prescribed scan. In another case, a patient with stage-4 gastrointestinal cancer refused to receive a PET scan at PMC due to limited financial resources. After leaving the patient's room, the attending directed the intern to clearly document (1) the physician's recommendation for the patient to remain at PMC for the PET scan; (2) that the patient has full capacity to make decisions; and (3) that the patient explicitly refused the therapy upon multiple visits with the primary care team. Attending physicians' attention to documentation demonstrates the importance of what is written in the record for the medical profession itself.

### **The Medical Record as Professionalizing Tool**

As physicians-in-training routinely work with the medical record, they learn three valuable professional lessons: (1) the impact of third parties on physicians' daily work; (2) the implicit intraprofessional hierarchy within the medical profession; and (3) the professional concern of litigation. The *impact of third parties on physicians' daily work* becomes evident through the inevitable emergence of disputes generated from the medical record between IM physicians and insurance companies. While some disputes with insurers are solely "language" related (a quick switch of a term resolves the problem), others are generated when insurance companies challenge the actual decisions the primary care team made. A common problem is disagreement over a patient's length of hospital stay; insurers often urge a patient's discharge before the physicians feel the patient should leave the hospital.

In these instances, attendings teach trainees strategies to bypass the interference of insurers in their medical decision-making. For instance, they demonstrate how altering a treatment plan, and in turn changing the documentation on the medical record, can resolve the conflict and justify the patient's prolonged hospital stay. One attending physician explained the process:

Let's say they are on Oral Lasix, you will put them on IV Lasix dose and say we are diuresing the patient with IV Lasix that you can't do as an outpatient so that will help you justify. Or if they happen to have a simple infection that would probably be ok to just put them on pill antibiotics, you just put them on IV antibiotics. Actually we just admitted this patient overnight that had a pancreatic mass and they went to an outside hospital to get the biopsy and to have a stent placed in their pancreas. The endoscopist there could not do the procedure – they were not technically advanced enough so they tried to get the patient transferred over to here. But their insurance company wouldn't cover it so they [discharged] the patient because they had nothing else to do. The patient had continued abdominal pain and came to our ER and we were already hearing from the insurance company that he needs to be transferred elsewhere. So what we are going to do in this situation is we are going to say because the patient had a fever two days ago if they want to transfer him we are going to say that he is unstable for transfer and just put him on IV antibiotics (H7).

This example provides two critical aspects of medical documentation. First and foremost, attendings are extensively involved in the editing of records, often dictating verbatim what interns and residents should include in the record. Second, the above quote demonstrates how care decisions and treatment plans are altered for the purpose of medical documentation; physicians are highly successful in convincing insurers to prolong a patient's hospital stay by changing treatment plans (frequently changing therapies from Oral to IV treatments). This strategy reflects a critical component of the medical record in relation to clinical care: what is written in the record becomes the official (and only) reflection of care decisions and therapies administered.

Physicians-in-training also encounter the consequences of an *intraprofessional status hierarchy in the medical profession* as Internal Medicine physicians have disputes with their colleagues over inadequate, and at times, misuse of the medical record. Some services are notorious for their lack of notation in the patients' records, leaving Internal Medicine physicians in the dark regarding clinical observations and treatment recommendations, or write in medical orders without clearing them with the primary care team. Surgery and Transplant Services top the list as the worst offenders, leaving little to no notation in the patient's medical record. For instance, IM physicians were frustrated with Renal Transplant's disregard of communication with the IM team. In one case, the IM team was unable to continue treating a hypotensive, immuno-compromised patient without discussing the patient with the Renal Transplant service.

An Arterial Blood Gases Test had been performed on the patient at 5 AM that morning. The resident reported that she knew that the Renal Transplant team had administered the test however there was no information on *who* had administered the test. Without knowledge of the RT physician treating the patient, the IM team was unable to receive any information on the test results which were integral to determining the patient's treatment options. The resident was visibly frustrated, muttering that she wished that Renal Transplant "had just recorded it so we could know [what was done] without having to contact them".

In another similar case, the Internal Medicine team was at a standstill because of lack of information regarding a male patient with a mass on his head:

During morning rounds, one resident explained to the team that the Neurosurgery physicians had been concerned with a mass protruding from a patient's skull. The consulting team subsequently ran an Emergent Computerized Tomography (CT scan) on

the patient. The CT scan indicated there was a mass present that should be drained. When the Internal Medicine resident saw the patient earlier that day, there was a wrap on his head however the resident was told only the Neurosurgery team was allowed to examine the wrap. Unfortunately there was no information regarding the procedure or the status of the mass in the patient's record. Therefore the resident was unsure if the mass had been drained and if so, what the mass had been and how to proceed with the patient's care.

These communication failures often result in delays in care delivery and additional work for IM housestaff to obtain information from these specialist services.

The previous examples point to no/absent notation as the primary cause of improper communication. In the following example, improper communication also stems from misuse of the medical record; consulting physicians disregard the role of the primary care team (in this case Internal Medicine) and fail to properly communicate recommendations to the IM team. A conflict emerged when the IM attending realized that a surgery resident had written orders for the nurse to take a patient off of Heparin, an anti-clotting medication, in preparation for a surgical procedure the following day. This order was problematic because the patient had recently had a stroke and subsequently the IM team had specifically placed the patient on anti-clotting medication to avoid another stroke. During morning rounds, the Internal Medicine attending became furious when he realized that the Surgical resident had written the orders into the patient's record without confirming with the Internal Medicine intern.

The attending demanded if the intern had confirmed the order or at least spoken with the surgical resident and she stated no, there were "no order or pages to her over night" and that the surgical resident had written them in without her confirmation. He told his intern to page the surgery resident ASAP and to require that he/she contact him immediately.

He then continued saying the primary team always needs to write orders. Improper notation and use of the medical record can not only delay care and generate intraprofessional disputes, but also have the potential to lead to poor health outcomes for patients. Through their experiences actively documenting and using the medical record, trainees quickly recognize that disregard of notation and “misuse” of the record reflects the implicit status hierarchy among physicians, where highly specialized physicians primarily focus on procedures and leave documentation to the primary care team (Abbott, 1981; Hugman, 1991).

Lastly, trainees are exposed to the salience of *fears of litigation for the medical profession*. Attending physicians’ dictation of medical notation stands in stark contrast to other aspects of care delivery, where trainees are given greater license to make their own decisions and cultivate their own “doctoring” style (e.g., requesting lab work; bedside manner). The investment that attending physicians place in trainees’ medical documentation reflects a critical professional concern: the medical record is an area where physicians are vulnerable to external authority and control. The following fieldnote excerpt demonstrates the concern of litigation shared by attending physicians:

The team left the patient’s room and the attending physician stated he was concerned with the patient’s vegetative state. He explained to the team that they may need to start thinking about how to approach the family about her condition, for she remained in this non-responsive state for 5 days. However, before discussing this with the family, the attending told the intern to place an order for a non-contrast MRI so they could look for evidence for an altered mental status. Before the intern could begin to write up the order however the attending stated, “You don’t want to write ‘evidence of a brain injury’ but rather write an ‘altered mental status and/or the patient has been ‘less

responsive in the past few days” [in the medical record]. He continued stating, “you should always write ‘less-responsive’ not ‘non-responsive’”, explaining that “you don’t want to *not* say something, but at the same time, you just need to be as nonspecific as possible. You never know – and hopefully won’t ever be – involved in a court case, at which time they may tell you to turn to a particular page and it may be your notes. And then you need to explain why you wrote and did not write certain things in the order.”

Not all attending physicians are as explicit with the team of the potential risks of litigation, however in interviews, the attending physicians all raised concerns of litigation. This is unsurprising as the attending physician is the physician-on-record for the patient, and is ultimately deemed medically and legally responsible for the patient’s care. With heightened concerns of potential litigation (Catino, 2011), widely acknowledged distrust of physicians (Mechanic, 1996) and proactive patients (Mangione-Smith, McGlynn, Elliott, Krogstad, & Brook, 1999), many physicians opt to practice defensive medicine (Catino, 2011); taking comprehensive notes and clearly justifying care decisions in medical documentation could be considered another form of defensive medical practice.

Trainees, in contrast to attendings, are shielded from the medical and legal responsibilities of patient care. Subsequently, it is unsurprising that trainees consider medical documentation to be a time-consuming task with little pedagogical value; many expressed frustration regarding the amount of time Internal Medicine attendings spent writing “very complete notes where they document *everything*” (Third Year Resident). This frustration reflects the misalignment between professional expectations of what “doctoring” entails and the reality of inpatient work trainees encounter (Becker & Geer, 1958; Newton, Barber, Clardy, Cleveland, & Patricia, 2008). However, the experience of medical documentation also provides trainees



introduction to the anticipatory actions of physicians to minimize the risk of litigation.

## **Conclusion**

This chapter demonstrates the medical record's role in (1) structuring interactions among physicians, insurers, and other external parties; and (2) serving as a professionalizing tool for trainees during residency training. At Pacific Medical Center, the medical record is the primary form of communication between the Internal Medicine physicians, consulting specialists, insurance companies, and other relevant parties in care coordination. Proper use and notation in the medical record ensures smooth care delivery, which is characterized by minimal interactions across these various parties; the medical record configures health care actors to primarily interact through written communications.

This preferred structuring of care delivery however becomes disrupted through the generation of physician-physician and physician-insurer disputes. These disputes arise due to improper use and/or insufficient documentation in the medical record. In order to resolve these disputes, written communications via the medical record becomes insufficient; physicians must engage in face-to-face or phone communications with different parties. Accordingly, the medical record consequently re-configures actors in relation to one another – structuring interactions among health care actors that typically would not occur. For instance, poor, or improper, notation can result in third parties – specifically health insurance companies – directly interfering in the medical decision-making process. In addition, misuse of the record also results in the inversion of the structuring of care delivery at PMC. When a consultant disregards the information in the patient record and proceeds with care, the IM attending physician bypasses trainees and directly contacts the attending physician on a Consulting service to resolve disputes.

Through the emergence and management of these disputes, trainees learn important professional lessons. The improper use of the medical record by colleagues exposes trainees to the consequences of a highly specialized field: the presence of an *intraprofessional hierarchy* within the medical profession (Abbott 1988; Nancarrow & Borthwick, 2005). The highly specialized nature of medicine (Leicht & Fennell, 2001; Nancarrow & Borthwick, 2005) has resulted in a hierarchy differentiating individuals by expertise, skillset, and prestige (Nancarrow & Borthwick, 2005). The divergent approaches to the medical record among different specialty physicians demarcate and reinforce these intraprofessional status distinctions. Patterned disregard of notation by consulting specialists reminds IM trainees that these specialists are located higher up in the medical hierarchy than they are. This finding resonates with the professionalism literature, which asserts that physicians of higher status have a tendency to avoid mundane and “non-professional” tasks (e.g., note-taking) (Abbott, 1981).

Trainees also experience firsthand the constraints and limitations placed on physicians’ decision-making within a commodified health care system (Light & Levine, 1988) as insurance companies interfere with the decisions they make (Mechanic, 2003). Improper documentation in the record can lead to insurers questioning physicians’ treatment decisions and denying coverage of care. This interference can result in costly delays of care as physicians must directly correspond with insurance companies to resolve disputes. In response, physicians however have developed techniques to prevent insurers from interfering in the decisions they make by making basic modifications to care and editing medical notation. These findings resonate with the sociological scholarship on the medical record and the active role it plays in shaping medical-decision making and care delivery (Berg & Bowker, 1997; Heath, 1982). In addition, while physicians do face some constraints on the decisions they make, the medical record also reflects

the authority physicians continue to hold within health care delivery. The ability to resolve a dispute with insurers by simply changing medical documentation shows how a clinician's written words become the "true" reality; insurers subsequently remain largely dependent on the clinician's documentation, revealing that the autonomy and authority of physicians remains largely intact.

Lastly, through (mis)use of the medical record, physicians-in-training learn a significant professional concern shared by medical practitioners: litigation. Attending physicians' attention to medical notation resonates with the medical profession's fear of litigation, which accelerated over the course of the 20<sup>th</sup> century due to the rise in malpractice lawsuits (Annandale, 1989). Reports of over-treating and over-testing for financial gain (Gray, 1997), combined with increased patient agency associated with a consumerist health care model (Burrows, Nettleton, Pleace, & Muncer, 2000; Kravitz et al., 2005), mobilized patients to question physicians not only in the clinical setting but in the legal one as well. While physicians have responded with strategies to regain and preserve patient trust (Mechanic, 2008), and some patients still prefer a paternalistic model of care (Henwood, Wyatt, Hart, & Smith, 2003; Lupton, Donaldson, & Lloyd, 1991), the fear of litigation remains a pressing professional concern for physicians.

Observing the copious medical notation practiced by their superiors, IM trainees learn that medical documentation extends far beyond disputes with colleagues or insurance companies, and can lead to real professional ramifications. Trainees are often exasperated at this comprehensive note-taking which can partly be attributed to the responsibilities they must manage during residency training (Szymczak & Bosk, 2012), as well as their mismatched expectations of what residency training *should* be compared to what it *is* (e.g., clinical practice rather than paperwork) (Morley et al., 2013). Most importantly however, the training status of

interns and residents shields them from legal responsibility, making concerns of litigation minimally, if at all, present. Nonetheless, trainees' are exposed to the importance of documentation in matters of litigation, a concern that will undoubtedly become more relevant as they proceed in their careers.

The medical record subsequently is a critical component to the hidden curriculum of finances. Far more than just a legal document that reflects a patient's condition and care, the medical record bridges together the numerous parties (e.g., physicians, insurers, legal institutions) involved in care coordination. As different parties work from, and with, the medical record, this shared document leaves physicians vulnerable to both internal and external evaluations and controls (Reich, 2012). As disputes are generated through (mis)use of the record, trainees realize the professional challenges present in inpatient care delivery.

Nonetheless, although IM physicians are met with the financial constraints of the system and the interference of third parties in their daily work, my findings also demonstrate the medical profession's refusal to succumb to professional threats. Physicians are able to keep insurers at bay with changes in medical notation, regaining control over the decisions they make via the medical record. Thus even when met with potential challenges to their autonomy and authority, the structuring of care delivery enables physicians to use the medical record to meet their own professional needs (Håland, 2012). The medical record therefore emerges as yet another arena where the medical profession encounters and effectively responds to professional challenges and threats, reaffirming the profession's resilience.

### **Chapter 3: Hospital Consultations and Jurisdiction Over Patients**

What are the professional consequences of hospital physicians relying on other physicians to provide patient care? The increased specialization of medicine, the emergence of new medical technologies, and the complex nature of chronic conditions associated with longer life spans have made collaborations among specialists an integral aspect of care delivery in the United States (Wennberg et al., 2008) and abroad (Smith Jr., Stein, & Jones, 2012). This collaboration within medical work has both sociological and policy relevance. The sociology perspective is concerned with how the sharing of medical decision-making and patients affects intraprofessional claims for jurisdiction. We know how the medical profession has been able to stave off inroads on its jurisdiction from third parties and allied professionals (Light, 2000a). We know less, however, on how in an era of greater specialization, clinicians maintain *intraprofessional* boundaries. The stakes are high for medical professionals because intraprofessional infighting may compromise claims-making and negatively affect patient care. Indeed, while justified to expedite and improve quality of care, policy makers are concerned that an overreliance on consultations with specialists has led to inflated costs and inadequate resource utilization. An influential U.S. policy report indicated that the use of medical specialists was one of the major factors driving up Medicare costs; hospitals that relied heavily on consultants spent the most Medicare dollars without demonstrating better health outcomes (Wennberg et al., 2008).

This chapter examines when and how jurisdictional boundaries are maintained and challenged within a single profession. The increased specialization of the medical profession requires physicians to work together frequently in the inpatient hospital setting through the consultation process. Medical specialization has resulted in physicians carving out particular areas of jurisdiction within the medical field. The potential for conflicts emerges as these

jurisdictions become ambiguous due to the overlap in medical knowledge and the complexity of medical conditions. Subsequently, this study asks when do jurisdictional conflicts emerge in the consultation process and how are they managed?

Drawing upon ethnographic and interview data, I examine when and how Internal Medicine (IM) physicians at Pacific Medical Center maintain, share, and challenge jurisdiction over patients through the inpatient consultation process. Unlike in previous studies demonstrating that jurisdictional conflicts are rooted in attempts to expand or protect personal jurisdictions, I argue that the IM team works to establish the jurisdictions of different specialty physicians to minimize potential conflicts. The IM service emerges as the generalist counterweight to the presence of medical specialists in the inpatient setting. Internal Medicine physicians take on an additional role as consultation facilitators, managing the collaboration process of different specialists.

### **The Medical Profession Staking Claim**

During the first half of the 20<sup>th</sup> century in the United States, designated sometimes as the Golden Age of Medicine, health care professionals experienced high levels of autonomy and professional dominance (Freidson, 1970b). Medical practitioners amassed a vast degree of professional jurisdiction; they held “legitimate control of a particular kind of work” and were able to “exclude other workers as deemed necessary” (Abbott 1988: 60). The nature of the medical profession shielded physicians from conflict with allied medical professionals (e.g., nurses). Physicians found themselves at the top of a medical hierarchy they established based on skill and expertise (Freidson, 1970a).

Transformations in the U.S. health care system in the late-20<sup>th</sup> century however challenged the dominance of the medical profession (Light 2000). The commodification of care

created a new medical landscape; various external parties (e.g., managed care companies) jockeyed for position within the health care system (Light & Levine, 1988). Competing medical professional groups also emerged (e.g., complementary and alternative medicine practitioners (Winnick, 2005) and certified nurse midwives (Hartley, 2002)) and fought for a spot within the medical field.

According to Abbott (1988), interprofessional conflicts are common as different professional groups vie for jurisdiction over a specific social arena. Jurisdictional claims are made to three audiences: the public, the legal system, or the workplace. Claims made to the public often seek social or cultural legitimacy, legal claims demand formal control over work, and workplace claims are the most informal with outcomes contingent to each setting.

Regardless of audience, Abbott (1988) asserts that full jurisdiction is the ultimate goal of all jurisdictional disputes. Full jurisdiction however is difficult to achieve and limited settlements of jurisdiction are generated instead. Limited settlements vary in how professions are configured in relation to one another. Some settlements result in one professional group becoming subordinate to another while others allow a single professional group to retain “cognitive control of the jurisdiction” with many groups sharing practical jurisdiction (Abbott 1988: 69). In other instances, a division of labor is generated with professional groups designated as “structurally equal parts that are functionally interdependent” (Abbott 1988: 74).

*Inter*professional conflicts between physicians and other professional groups have been well documented (e.g., Hartley 2002; Winnick 2005), with resolutions resonating with Abbott’s settlements of subordination and intellectual subordination. Relatively unexplored however is how different specialty physicians within the medical profession manage *intra*professional conflicts.

*Intraprofessional* jurisdictional claims-making is particularly salient because of the highly specialized nature of medicine, with subgroups organized around different levels of medical expertise and technological sophistication (Leicht & Fennell, 2001; Nancarrow & Borthwick, 2005). Medical specialization has created an intraprofessional hierarchy, with some subspecialties allotted greater prestige and status than others (Nancarrow & Borthwick, 2005). Intraprofessional hierarchies are determined by factors such as income and the perceived difficulty of the acquired knowledge (Abbott, 1981; Rosoff & Leone, 1991). Individuals higher placed in the hierarchy may exclude “nonprofessional issues or irrelevant professional issues from practice”, thus maintaining “professional purity” (Abbott 1981: 823). This hierarchy shapes how physicians interact with one another (Sanders & Harrison, 2008), which may increase the potential for intraprofessional conflicts with the routine inclusion of specialists in medical decision-making (Jordan, Conley, & Ghali, 2008).

Few studies consider the interplay of specialties within a single profession and the intraprofessional conflicts that are generated (Hibbert et al., 2003; Martin, Currie, & Finn, 2009; Sanders & Harrison, 2008; Serra, 2010; J. Zetka, James R., 2001). Some scholars examined jurisdictional disputes that emerged as different specialists acquired the same technological skill (gastroenterologists and surgeons (Zetka 2001); hepatologists and surgeons (Serra 2010)). Others evaluated the jurisdictional disputes that ensued with the introduction of a new occupational or specialty group within the profession (general practitioners specializing in genetics (Martin *et al.* 2009); specialist heart failure nurses (Sanders and Harrison 2008); pelvic surgeons and gynecologic oncologists (Zetka 2011)). While these studies offer insights into the generation and resolution of intraprofessional conflicts, they may be particular to cases of acquisition of technological skills or the emergence of a new professional group.



With resolutions of jurisdictional conflicts primarily contingent on one group remaining on the periphery of the medical world, the literature on interprofessional conflicts fails to address the dynamics of jurisdictional disputes among groups solidly situated within the medical profession. The literature on teamwork in health care delivery however offers insights on the types of jurisdictional conflicts that may occur among physicians. In the United States, academic medical centers structure their care delivery around teams comprised of physicians and trainees rather than individual physicians (Hauer and Wachter 2001). Teamwork in health care delivery is associated with improved patient outcomes (Wells et al., 2006), greater patient satisfaction and expedited care (Mickan, 2005). Successful interdisciplinary teamwork depends on shared responsibility and decision-making (Solheim, McElmurry, & Kim, 2007), and mutual respect (Wells et al., 2006).

While many scholars champion successful outcomes associated with teamwork, conflicts inevitably emerge within teams. An overlap of skills among group members lead to disputes over shared functional tasks (Herrman, Trauer, & Warnock, 2002). Disputes also surface as hierarchies develop within teams (Sands, Stafford, & McClelland, 1990), undermining the team's ability to meet its goals as member divisions are reinforced, excluding particular individuals from decision-making and tasks (Finn, Learmonth, & Reedy, 2010). The structuring of care delivery in teaching hospitals, professional hierarchies, and work assimilation may all dictate how jurisdictional disputes emerge and are resolved as different specialty physicians collaborate with one another.

In sum, while the literature on medical professions has extensively examined interprofessional conflicts, little is known whether professional conflicts between specialties are created and solved differently. Using Abbott's work on jurisdictions as an analytical guide, this

chapter examines the emergence and resolution strategies of intraprofessional conflicts.

Specifically, drawing from the research on teamwork in medicine, I examine the organizational and professional factors that affect such conflicts.

### **The Consultation Process**

Consultations are called at Pacific Medical Center due to the complicated nature of patients. A hospitalist (H1) described the patient population as requiring more than “bread and butter medicine.” These patients tend to require inter-specialty care as they battle numerous conditions in addition to the acute health episode that brought them to the hospital. Many of the patients are also transferred from other hospitals to PMC to receive a higher level of care.

Most observed consultations have a routine character. In a typical example, the Internal Medicine intern immediately called a Cardiology consultant when the echocardiogram of a 70-year-old man on the IM service indicated a worsening heart condition. During rounds, the trainee relayed the consulting team’s preliminary assessment to the attending.

The intern stated that the Cardiology consulting team planned to change the patient’s medications. Furthermore, although the fellow’s official recommendations would not be formally provided until later that day (after speaking with his attending), the intern had been urged to begin preparing the patient for future treatments. Specifically, the Cardiology fellow requested the patient be started on Heparin, an anti-clotting medication, since the patient would likely be catheterized. Furthermore, the fellow also noted that the Cardiology team may recommend an eventual Cardiothoracic Surgery consult because of a possible worsening valve. The attending (H24) agreed with the recommendations and told the intern to proceed and begin to administer the consultant’s medication suggestions.

This example demonstrates a routine consultation, where collaborations among different specialty physicians are smooth: the consultant's recommendations align with the Internal Medicine team's prospective treatment plan and a single plan is easily reached.

Recommendations can range from additional medical tests to requests for other services to be consulted. As the principal medical team assigned to the patient, the IM team has the discretion to accept or refuse a recommendation. In routine consultations, recommendations are accepted with minimal interactions across services other than the pages, notes, and phone calls necessary to coordinate care. Interactions are limited to the IM intern and the consulting fellow; attendings rarely get involved. Each team maintains jurisdiction over the problem(s) that falls within their specialization.

Consultations called for greater expertise or procedures establish clearly delineated jurisdictions and result in routine outcomes. Jurisdictional disputes do not emerge when insufficient skill or knowledge is apparent among the physicians involved, as evident in two of the primary reasons why consults are called: (1) *diagnostic* when the IM team's expertise is inadequate to determine a diagnosis; or (2) *procedural* when the patient requires a procedure that only a specialist may perform. Conflicts also are avoided when a division of labor regarding patient care has already been determined among the different physicians. "*Automatic*" consults, which are initiated when patients have conditions included in a prior agreed upon list between the specialty and IM services, establish such a division of labor. These lists were created through a dialogue between IM hospitalists and specialty service attendings during meetings geared towards improving the consultation process.

### **When Do Jurisdictional Disputes Emerge?**

The designation of the Internal Medicine team as the principal medical team assumes that

IM physicians would have full jurisdiction should a conflict emerge among specialists during patient care; this outcome however rarely occurs as boundaries dividing physicians become ambiguous. Blurred boundaries can largely be attributed to the overlap of medical knowledge across specialties. For instance, during a hospitalist meeting, the Endocrinology service requested to be consulted on all cases of hyponatremia, a metabolic condition characterized by insufficient sodium levels in the body's fluids. Internal Medicine physicians voiced their disagreement noting that other specialist services, such as Neurology, consulted the IM team to manage hyponatremia in their patients. At the same meeting, the Endocrinologists noted that insulin management was specific to their specialty and thus they should be consulted for insulin administering and management. The Internal Medicine physicians disagreed, arguing that insulin management fell within the generalist knowledge expected of internists.

This overlap of medical knowledge complicates the consultation process as services have different expectations of which specialty group should have jurisdiction over a particular condition. Similarly, jurisdictional disagreements over certain medical procedures also may emerge. Unlike interactions between physicians and medical paraprofessionals, the professional status of physicians makes jurisdictional claims less straightforward compared to those made between physicians and nurses for instance. As physicians share similar privileges, the hierarchical distinctions between physicians by specialty are more ambiguous than those between physicians and other health care professionals. Accordingly, jurisdictional conflicts are often generated between the principal medical and consulting physicians. In particular, two categories of conflicts emerge: physicians *ignoring shared jurisdictions* and physicians *refusing jurisdictions*.

Ignoring shared jurisdictions results when a single team (the principal medical or

consulting team) seeks complete ownership of patient care and fails to acknowledge an interdependent division of labor in patient care or fails to recognize subordination to a specialist regarding certain aspects of the patient's care. One attending physician (H3) discussed the difficulties encountered when several teams try to dictate patient care rather than collaborate with one another:

I remember a consultation on a patient who was admitted with some finger swelling which suggested a rheumatologic condition but was pretty vague and also in my opinion was relatively benign. I don't think it was something that warranted an acute hospital stay necessarily. But the referring physician was a subspecialist and had then done the consultation. They asked for at least 3 or 4 separate consultations involving vascular surgery, gastroenterology, and hematology--involving a series of things that were you know certainly excessive in my opinion. That I think certainly led to some conflict over what to do. Because particularly housestaff who are more junior are put in this position where they are caught between the primary attending and the consultant who is trying to drive the course of management. Instead of a collaborative approach sometimes you have a situation where they're telling the house officers what to do and the house officers feel obliged to do it since the consultant is more senior.

This quote demonstrates how the hierarchical structuring of care delivery may exacerbate jurisdictional conflicts. Interns may receive orders, rather than recommendations, from consultants, which they may feel compelled to carry out. As a result, the role of the IM team as principal medical team is overlooked; specialists make decisions and ignore the collaborative nature of medical decision-making within the hospital.

This disregard by specialty consultants also manifests through minimal to no notation in

patients' medical records of assessments and work done. Some services, as noted in the previous chapter, frequently fail to contact the principal medical team of their recommendation of future treatment, leaving physicians unsure of how to proceed with patient care. Failure to communicate may result in minor delays in care delivery and extra work for the IM team to obtain information from the consulting service.

Unfortunately, ignoring shared jurisdictions has the potential to cause serious negative health outcomes. An Endocrinologist presented a case at the monthly hospitalist meeting demonstrating the severe ramifications associated with the Internal Medicine team hesitating to include consultants on a case.

A patient with hyperpituitism had been admitted to the hospital. The patient received prednisone (steroid) treatment. His condition worsened and he required intubation. While being intubated, the patient went into cardiac arrest. He was transferred to the Intensive Care Unit where he eventually died. The Endocrine team's consultant was contacted after the patient went into cardiac arrest. The physician stated that the patient had been in the hospital for 6 days prior to consult and the endocrine team felt that had the team been consulted earlier perhaps this outcome could have been averted.

By delaying the inclusion of the endocrinology team in the patient's care, the IM team failed to share jurisdiction of the patient, which the endocrinologists believed may have contributed to the undesirable health outcome. The Gastro-enterologists voiced a similar concern regarding delayed consultations.

They explained that instances when gastrointestinal conditions resulted in mortality and morbidity cases, it was primarily due to slow communication in acute cases. They explained that the problem tended to be when a patient with a gastrointestinal bleed was

treated as a medicine case rather than a surgical one. They stated that if the patient is losing blood, there is no time to waste.

In response to these concerns, the IM physicians agreed that their trainees were inappropriately hesitant to call consultants, providing anecdotes highlighting the consequences of such hesitation. One physician (I32) described the following account at the monthly hospitalist meeting, explaining that the resident failed to consult the Rheumatology service after a patient had fallen at home.

The patient received an X-ray and just lay in the hospital bed unable to move. After several days, the Rheumatology consult was called and within two days the patient was mobile again. This delayed consult prolonged the patient's discomfort and extended the patient's hospital stay.

The IM attendings agreed to educate their trainees to initiate consults quickly and that when they are uncertain if a consultant is necessary, they should err towards calling the consultant.

The second jurisdictional dispute is when physicians *refuse jurisdiction* over patient care by either “blocking” patients or signing off on patients very quickly. Physicians can refuse to take on a patient or assess the patient once and refuse to follow the patient's care any further, regardless of the IM service's opinions. In this case, one team recognizes intellectual inadequacy while the other team disagrees. Typically, the consulting team asks for the details of the patient over the phone at which point they can decline to see the patient. Similar to the hesitation exhibited by IM interns to initiate consults, consulting fellows may be reluctant to accept jurisdiction over a patient due to overburdened workloads.

Financial disincentives may also discourage consultants from taking on patients. An attending physician (I5) discussed the financial barriers to successful consultations:

Consultants from surgical subspecialties are asked to cover for many different services. There are few [surgical] housestaff for many patients and many consultations. So they generally do not [come] by as much. The attendings often do not come in to see those patients unless they are going to go operate. And at that point, they only see them in the operating room. They only do that because they get paid to operate not to consult. So... their time is better spent in the OR [operating room]. They don't bill for the consultation where as in the department of medicine they do. So the [surgeons] have a financial disincentive to do things unless there is an indication to take a patient for a procedure. So you have less input and sometimes you have to prod them more to do things.

The explicit hierarchical nature of medical training can further influence this process with some specialists, who are situated above interns on the status hierarchy, less likely to be convinced by an intern to follow a patient. One attending (H8) pointed to the hierarchical dynamics that emerge during consultations:

And other services you have to sit down for 20 minutes with the intern to coach them on exactly what to say or else basically the consulting fellow is going to try to block the consults and be downright condescending towards your intern and abusive, almost hostile towards your intern and try to block it... I've had some very bad experiences at [PMC] recently with consult services.

The medical hierarchy places interns at a disadvantage when trying to convince fellows and attendings to consult on a patient.

Furthermore, trainees' inexperience can increase the likelihood of a blocked patient. One Gastro-enterologist explained that consultations could be improved with better education of IM interns. The physician stated that occasionally an intern would call the Gastro-enterology fellow



about a patient that the intern had never actually seen. This becomes problematic when the fellow requests the mandatory information required before accepting patients: (1) the patient's name; (2) the patient's location; and (3) the time sensitivity of the patient's condition (e.g., can be seen in 30 minutes, 1 hour, etc.). In cases when the intern has not seen the patient, some of these questions are unanswerable; this lack of information leaves consultants questioning whether their expertise is truly needed or if the intern merely assumes it is.

### **Consultation Facilitators: Managing Jurisdictional Conflicts**

To prevent the escalation of jurisdictional conflicts, the Internal Medicine team has developed three strategies to expedite routine consultations and minimize jurisdictional disputes. The first strategy, *managing the presentation of medical evidence*, helps the principal medical team convince a reluctant specialist to see a patient. The attending may directly contact the consulting fellow with comprehensive information about the patient's condition, elaborating on details that may not have been shared in the initial correspondence with the consultant. The IM attending may also request additional medical tests in order to provide compelling medical data that demonstrates the need for the consultant. The attending may also alter care plans to convince the consulting team to accept the patient. In one case, the Gynecology consultant refused to provide inpatient care to a patient. The IM attending (H19) disagreed, arguing that the patient needed to remain in the hospital because of her pain levels.

While discussing the patient during morning rounds, the Internal Medicine attending urged the team to be careful when administering pain medications; he did not want her pain to go away too quickly. His reasoning was to prevent the Gynecology consultant from dismissing the patient because her pain had dissipated so quickly with treatment (allowing her to be discharged from the hospital). He would rather prolong the patient's

discomfort so that the Gynecology consultant would treat her in the hospital.

The primary goal of this strategy is to demonstrate that the consultant's expertise is necessary for care provision, and therefore the IM team should be subordinate to the specialty service in determining the patient's care.

In the second strategy, *promoting collegiality*, the principal medical team executes the consultant's recommendation even though they feel the order is unnecessary. By accepting the recommendation, the IM team defers an aspect of the patient's care to the specialist's expertise. Collegiality is common when the recommendation does not drastically alter or delay care. One hospitalist, who was only observed, explained that if her team calls a consult and the consultant requests an additional service be called, she accepts this recommendation. She explained that even if she does not want the additional consultant on board, she still chooses to in order to "keep it collegial." Another hospitalist (H1) reflected a similar sentiment:

If the primary team and the consulting team disagree, it's ultimately the primary team's decision to make the decision. However, you also have to take into account, that most of us work in the same hospital for the whole time. If I consulted Pulmonary, and they want to do a bronchoscopy and I disagreed, I often will say ok to the bronchoscopy because I don't want to anger my Pulmonologist because I know that I am going to have to consult them again tomorrow or the next week, right? So there is some congeniality. If it's a small thing or your goals are pretty close to each other, then you will often go with what the consultant says even if you don't think it's necessary.

The decision to follow a recommendation is influenced by the collaborative nature of medical work within the hospital; recognizing that good relations across specialties are requisite to facilitate care delivery, physicians frequently opt to defer to specialists' expertise even when

unnecessary. This strategy designates each service responsible for a particular aspect of the patient's condition.

The third strategy, *moving up the medical hierarchy*, dispels conflicts when physicians ignore the joint nature of medical work. Ignoring shared jurisdictions over patients manifests through a team proposing a treatment plan that contradicts or ignores the plan suggested by another service. In such encounters, there is an inversion of the care delivery model at PMC. In routine consultations, housestaff from the principal medical team and fellows from the consulting team correspond with one another throughout the patient's hospital stay. In contrast, when conflicts emerge due to opposing recommendations from various consulting services, the principal medical team reconciles this issue by *moving up the medical hierarchy*: housestaff and fellows are bypassed, and the IM attending physician directly contacts the attending physicians on the consulting services. Of 38 physician interviews, all of them stated that when divergent opinions emerged among specialists, the IM attending acted as an intermediary between the different parties. S/he bridges the divergent opinions until a single treatment plan is reached. The IM physician either speaks to each physician individually or coordinates a meeting with the attendings. In the hospitalist meetings, the consulting physicians across services agreed on the importance of directly contacting attendings in certain cases. This strategy establishes an interdependent division of labor among physicians; the specialty services' recommendations are combined to create one comprehensive treatment plan.

### **Discussion and Conclusion**

The hospital is an ideal site to examine intraprofessional jurisdictional disputes as it blurs distinctions of jurisdiction as physicians share not only the same workplace but also the same patients (Bucher & Stelling, 1969). The close work environment assimilates tasks and diminishes

divisions, increasing the likelihood for jurisdictional disputes (Abbott 1988).

Consultations are routine on the Internal Medicine Service at Pacific Medical Center in part because Internal Medicine is a generalist medicine specialty that regularly consults other specialty services in care coordination. Additionally, the growing specialization of medicine results in increasingly compartmentalized approaches to the body, requiring cooperation across specialists for care delivery. Lastly, PMC's status as a highly specialized hospital generates a complex patient population.

The three common forms of consultations – diagnostic, procedural, and automatic – resemble two forms of Abbott's (1988) jurisdictional settlements: subordination and division of labor. The IM team accepts inadequate knowledge and skill regarding a condition and seeks specialized expertise when faced with diagnostic or treatment uncertainty or when a particular procedure is required. The team assumes subordination and defers jurisdiction to the consultant. In automatic consults, the physicians have accepted a division of labor where the principal medical and consulting teams are interdependent on one another for care delivery.

Jurisdictional settlements, however, are often tenuous and temporary solutions at best. Abbott (1988) specifically points to the workplace as an environment where jurisdictional settlements are especially uneasy; single setting workplaces frequently result in boundaries between professional groups becoming “correspondingly obscure” (Abbott 1988: 74) and jurisdictions contested. Therefore physicians may set out to adhere to these settlements, yet in practice divisions become ambiguous as physicians experience an overlap of skills. This overlap generates questions regarding the superiority of one specialty over another or failure to recognize the need for collaboration.

As the principal medical team, the IM team is publically acknowledged as the physician

on record in all formal medical documentation. This designation legally grants IM physicians full jurisdiction of the patient. Nonetheless, in practice, the team's jurisdiction is negotiated and contested through the emergence of jurisdictional disputes.

Ignoring shared jurisdictions and refusing jurisdictions are two common jurisdictional disputes. Specialists fail to acknowledge the collaborative nature of medical decision-making, disregarding and dismissing the principal medical team (and other consulting teams) when determining treatment plans. This disregard may partly be a consequence of the specialization of medicine; "each of the groups attributes different weights to the same sickness situations, according to the perspectives and approaches that characterize each of the skills" (Serra 2010: 174). In addition, failure to share jurisdictions may reflect notions of "professional purity" (Abbott, 1981), often characterized with specialized expertise; specialists may deem mundane tasks as far removed from their professional duties.

These disputes reflect the inconsistency between the IM team's jurisdiction within the legal system and the jurisdiction the team holds in practice. This resonates with Abbott's (1988) assertion of the potential contradiction between the claims made in legal and public settings versus those made within the workplace due to high work assimilation. This finding however challenges Abbott's (1988) claim that elite institutions such as university teaching hospitals minimize the blurring of boundaries and avoid disputes because of the presence of each professional group's "best members" (p. 66).

This contradictory finding is rooted in Abbott's conceptualization of workplace assimilation. Abbott (1988) defines workplace assimilation as the consequence of variation of competency within professions; incompetent professionals require tasks to become shared and completed by others within the workplace, blurring boundaries between (non)professional

groups. In contrast, at PMC, the overlap of tasks between the IM and consulting teams is symptomatic of the training process of the profession itself – particularly in the case of Internal Medicine and Medicine subspecialties<sup>10</sup>. Within Medicine subspecialties, residents must first complete training in Internal Medicine before proceeding onto specialized training; for instance, Gastro-enterologists train longer in Internal Medicine than in Gastro-enterology in the U.S. (J. Zetka, James R., 2001). In the United Kingdom, some medical specialties require training in Internal Medicine as well (Smith Jr. *et al.* 2012), thus similar dilemmas may emerge in UK hospitals. Shared training experiences confuse jurisdictional claims over patients. Accordingly, physicians may contest subordination or refuse to recognize the interdisciplinary nature of care delivery.

The structuring of care delivery in teaching hospitals further increases the likelihood for jurisdictional disputes. Care delivery is organized around teams comprised of attendings and trainees. Although attending physicians possess full medical discretion, trainees monitor and coordinate the bulk of patient care. Accordingly, the extensive workload associated with residency training (Mizrahi, 1986; Szymczak & Bosk, 2012) may deter trainees from calling consultants because consultations are associated with added tasks: additional tests and frequent correspondence with specialists. Therefore the organization of residency training may de-incentivize trainees from calling consultants to avoid extra work. Moreover, trainees' desire to gain proficiency and demonstrate mastery of skills to their superiors (Bosk, 2003) may explain the hesitation to share or defer jurisdictions.

The hierarchical nature of the medical profession may further facilitate consultants'

---

<sup>10</sup> Subspecialties of Medicine in the U.S. include adolescent medicine, allergy and immunology, cardiology, endocrinology, gastroenterology, geriatrics, hematology, infectious disease, nephrology, oncology, pulmonology, rheumatology, and sports medicine.

ability to refuse to accept or share jurisdictions. Typically interns would have minimal interactions with fellows and attendings. However, in teaching hospitals, interns initiate communication with consulting fellows and attendings. This status distinction (Freidson, 1970a) between the intern and consultant may encourage a consultant's refusal of jurisdiction over a patient and impede an intern's ability to challenge this decision (Kobayashi et al., 2006).

The potential for jurisdictional disputes is further exacerbated by the intraprofessional hierarchy that gives preference to specialists over generalists (Abbott, 1981). Hierarchical structuring within health care teams is associated with disputes (Sands et al., 1990) because they reinforce divisions and exclude groups from decision-making (Finn et al., 2010). Subsequently, some specialists may ignore the concerns of other physicians or refuse patients with conditions perceived as tedious. This resonates with the notion of the "virtuoso role" (Hugman, 1991). While Hugman (1991) differentiates the virtuoso roles from the general caregivers by distinguishing between different occupational and professional groups, the same logic can be applied when comparing IM physicians (generalists) with consulting specialists. The desire to only practice specific skills may explain some specialists' refusal to follow patients.

Lastly, there are financial disincentives that may deter the calling of consultants and facilitate the blocking of patients. Excessive resource utilization has been targeted as one of the primary sources of sky-rocketing health care costs in hospitals across the U.S. (Wennberg et al., 2008). Consequently, physicians may hesitate to call consultants, which are associated with costly medical work that has not translated to improved health outcomes (Wennberg et al., 2008).

While jurisdictional conflicts are common, professionals develop strategies to avoid the escalation of disputes in workplaces. Abbott (1988) noted that speech and attire are common solutions to demarcate professional jurisdiction and prevent workplace disputes. These solutions

are insufficient modes of division however at Pacific Medical Center, as physicians engage in jurisdictional boundary work with other physicians. Subsequently, the IM team adopts interactional strategies that diminish jurisdictional conflicts through the creation of a division of labor or a subordination settlement (Abbott 1988).

The three strategies employed are managing the presentation of medical evidence, practicing collegiality and moving up the medical hierarchy. The IM team presents medical evidence to demonstrate the subordinate status of the IM team to the specialty service. In the second strategy, IM physicians promote collegiality and accept an “unnecessary” recommendation to establish a division of labor among physicians: medical conditions and tasks are allocated to each specialty’s jurisdiction. This strategy echoes the approach taken by hepatologists in Serra’s (2010) study of boundary work within a liver transplant unit. In the post-operative phase, hepatologists allowed surgeons to perform a test on patients that they could easily have performed themselves.

Lastly, the team inverts the organization of care delivery and directly involves attendings on the principal medical and consulting teams to avoid jurisdictional conflicts. This inversion diffuses unwanted interactions generated by the hierarchical nature of the medical profession and medical training in teaching hospitals. Through communication among superiors, a division of labor is established where each team is granted distinct jurisdiction over a patient.

When utilizing these strategies, the IM team adopts the role of consultation facilitator, going “behind the scenes” to maintain a collegial consultation process. This approach entails making medical decisions without explicitly threatening the jurisdictions of other physicians. These strategies help the IM team mimic the dynamics of routine consultations where either subordination or a clear division of labor are accepted by all physicians involved.



The IM service has numerous incentives to avoid jurisdictional conflicts during the consultation process. First, IM physicians are assessed on the average length of stay of patients on their service. Conflicts during the consultation process can extend hospital stays and reflect poorly on their evaluations. Second, extensive workloads encourage physicians to avoid disputes as resolutions may take time and additional work. Third, the generalist nature of Internal Medicine and the complex patient population increase repeat collaborations with specialists.

Recognizing the potential consequences of physicians embroiled in conflicts, in some cases, the IM team imposes jurisdictions when they are not wanted, and in others, they accept subordination of their own jurisdiction to ensure quality care is provided. The focus on hospitalists may appear to limit the generalizability of these findings, however the increased growth of hospitalists in the U.S. demonstrates the relevance of these findings.

Emerging as a specialty group in the U.S. in the late-20<sup>th</sup> century (Wachter & Goldman, 1996), hospitalists have become a fixture in the U.S. health care system. Their presence has been found to generate high patient satisfaction, positive health outcomes, and reduced health care costs (Wachter & Goldman, 2002). In particular, academic medical centers rely heavily on hospitalists to train residents (Hauer, Wachter, McCulloch, Woo, & Auerbach, 2004). Thus these findings may resonate with intraprofessional dynamics in teaching hospitals. Furthermore, even with the low representation of internists, the similar concerns voiced by internists and hospitalists indicate that intraprofessional jurisdictional disputes are organizationally-driven; the structuring of care delivery in the *inpatient* setting shapes the generation and resolution of disputes more so than whether a physician works primarily in the inpatient or outpatient setting.

Within the medical literature, there is recognition that consultations in hospitals may lead to conflicts (C. Kessler, Kutka, & Badillo, 2012). Clinicians blame their colleagues for being

“difficult,” “unresponsive, or “inexperienced.” The preferred solution to manage and prevent such conflicts is to improve the flow of information (Sutcliffe, Lewton, & Rosenthal, 2004) with the use of communication guidelines. This data however provides a different perspective, demonstrating that many of these conflicts are professionally and organizationally produced and resolved.

## **Chapter 4: Mastering the Art of Throughput: Physicians' and Patients' Strategies to Manage Hospital Discharge**

Expedited hospital discharge has become a critical goal for hospitals nationwide, especially after an influential U.S. based policy report indicated that prolonged lengths of stay in the hospital, associated with extensive medical workups, did not result in improved health outcomes (Wennberg et al., 2008). Health care professionals and policymakers are optimistic that shortening patients' length of stay in the hospital will reduce hospital care expenditure, which totaled \$850.6 billion in 2011 (Centers for Medicare and Medicaid Services, 2013). While the goal is clear, hospital discharge is not a straightforward process as physicians encounter conflicting financial and organizational pressures that complicate discharge decision-making. Insurance reimbursement policies are structured to both incentivize and de-incentivize quickly discharging patients from the hospital. On the one hand, once a patient's hospital stay has reached a set number of days, hospitals will receive the same reimbursement sum regardless of whether the patient remains in the hospital for additional days. Thus hospital administration encourages expedited discharge to allow for a new patient to be admitted into the hospital. On the other hand, changes in insurance reimbursement policies that penalize hospitals for patient readmission combined with fear of litigation of medical negligence, encourage physicians to prolong patients' hospital stays. With the presence of these countervailing financial pressures, how do physicians appropriately handle the discharge of patients from the hospital?

Dilemmas of discharge leave physicians caught between the demands of patients and management. As managers value hospital efficiency, they pressure physicians to expedite discharge. However increased patient consumerism has resulted in a patient population comfortable in making demands and disagreeing with physicians' decisions regarding patient

care and discharge. Subsequently I situate this chapter within the sociological scholarship on the medical profession, drawing from literature on the rise of new managerialism in health care and patient consumerism. I demonstrate that hospital discharge management emerges as a site where physicians encounter threats to their professional authority and autonomy. Therefore, hospital discharge management becomes an opportunity for physicians to counteract these threats and maintain and/or regain their professional dominance.

Drawing from ethnographic and interview data, this chapter analyzes how physicians try to achieve the goal of expedited discharge. As physicians aim to meet the hospital's financial goal, they adopt strategies to safely and efficiently discharge patients out of the hospital. Successful discharge is contingent on reaching a consensus regarding a discharge plan among physicians, patients and family members, health insurance companies, and other relevant third parties. In this chapter, I focus on delays of discharge that emerge when consensus regarding discharge is not reached between physicians and patients and/or family members. As physicians try to discharge these patients out of the hospital, they are met with push back from patients and family members, who engage strategies to prolong a patient's hospital stay. Through these interactions between patients and physicians, physicians are faced with the countervailing financial pressures entrenched in hospital discharge. Physicians inevitably delay discharging patients as they weigh the risk of financial and legal penalties.

### **Managerialism and Consumerism in the 20<sup>th</sup> Century**

Scholars have well-documented the professional consequences due to the increased commodification and bureaucratization of health care delivery over the course of the 20<sup>th</sup> century (Conrad & Leiter, 2004; Fennell & Alexander, 1993; Mechanic, 1996; Quadagno, 2008). The emergence of countervailing powers has been of particular interest to those studying the medical

profession (Light, 2000a). Third parties have been attributed to physicians' decreasing autonomy, deskilling, and loss of cultural authority, spurring concerns of the deprofessionalization (Haug, 1972), proletarianization (McKinlay & Stoeckle, 1988), and post-professionalism (Kritzer, 1999) of physicians. Two critical professional challenges to physicians that have contributed to these concerns were the rise of health care managerialism and patient consumerism during the late-20<sup>th</sup> century (Harrison, 2004).

Managerialism in health care delivery emerged in the 1980s, with a market logic driving the development of an institutional environment dedicated to efficiency and cost containment (Scott et al., 2000). With this shift, managers became increasingly involved in care delivery (Beardwood et al., 1999), impinging on physicians' autonomy as they oversaw physicians' work (Hunter, 1996). Managers privileged the goals and needs of the organization rather than those of the profession (Brown & McCartney, 2000; Exworthy & Halford, 1999); their presence in turn became a reflection of the rise of an entrepreneurial ethos in health care (Learmonth, 1997), with profit maximization and efficiency embedded in medical decision-making. In order to meet these goals, managers developed various approaches to monitor the effectiveness, efficiency, and performance of medical professionals (Exworthy & Halford, 1999). Physicians' autonomy and authority was progressively challenged as managers relied on performance indicators (Exworthy et al., 2003) and incident reports (Waring & Currie, 2009) to evaluate physicians.

Yet the presence of management has not necessarily translated to "professional subjugation" (Kitchener, Caronna, & Shortell, 2005). This may partly be attributed to the dual authority structure of hospitals (Scott, 1983). In this structure, physicians, rather than administrators, are dominant actors at the "field level"; therefore physicians yield a great deal of power in shaping organizational behavior as management does not possess the same level of

control over physicians that they may hold in institutions (Scott, 1983). Indeed physicians have been able to protect their autonomy by shaping management policies and avoiding managerial scrutiny in certain areas of their work (Waring & Currie, 2009).

Similar to the rise of new managerialism, patient consumerism accelerated over the late-20<sup>th</sup> century. The transition towards a consumerist health care model resulted in patients shedding the identity of the passive patient seeking paternalistic care (Parsons 1951), and taking control of their care. In the clinical literature, patients increasingly became labeled as “difficult”, stemming from emotional states (e.g., anxiety and depression), unrealistic expectations, and dissatisfaction with care (DiMatteo, Lepper, & Croghan, 2000; Hahn, Thompson, Wills, Stern, & Budner, 1994). Social scientists also evaluated the transitions in patient identity, with patients repeatedly characterized as “proactive”, “well-informed”, “demanding”, “empowered”, and “experts” (Barker, 2008; S. Epstein, 1995; Kravitz et al., 2005). This new patient population revealed pushback against the traditional model of the patient-physician relationship, which relied on an asymmetry of knowledge between patient and physician (Parsons, 1951).

Growing distrust of physicians in the wake of reports of corruption, negligence, and malpractice (Gray, 1997; Haug & Lavin, 1983; Reeder, 1972) accelerated patient consumerism, agency, and autonomy (Campbell, 1971; Hibbard & Weeks, 1987; Winnick, 2005). The widespread use of the Internet<sup>11</sup> (Burrows et al., 2000; McKinlay & Marceau, 2008), the rise of the pharmaceutical industry and direct-to-consumer advertising (D. A. Kessler & Pines, 1990; Kravitz et al., 2005), and the growth of nontraditional sources of treatment in the United States (e.g., CAM) (Hartley, 2002; Winnick, 2005, 2006) became valuable resources and/or alternative options that encouraged patients to navigate their own health care. Privy to endless amounts of

---

<sup>11</sup> The Internet gave patients access to electronic health books, health forums, and other online sources that offered a wealth of information that enabled patients to self-diagnose, to learn about treatment options, and to evaluate the financial costs associated with different treatments (Hardey, 1999; McKinlay & Marceau, 2008).

information, patients became increasingly “well-informed and knowledge empowered”; they were able to enter medical encounters knowing a great deal about their condition (Borkman, 1999; Burrows et al., 2000; Davison, Pennebaker, & Dickerson, 2000), and felt comfortable demanding specific medications and other treatments (McKinlay & Marceau, 2008). In an era focused on patient-centered care delivery, patient satisfaction has become a critical component of care delivery and physician (and hospital) evaluations (Brown & McCartney, 2000; R. M. Epstein, Fiscella, Lesser, & Stange, 2010; Milewa, Valentine, & Calnan, 1998). Therefore it is unsurprising that physicians often cave to patient or parental expectations and frequently prescribe unnecessary treatments (Butler, Rollnick, Pill, Maggs-Rapport, & Stott, 1998; Kravitz et al., 2005; Mangione-Smith et al., 1999; Nyquist, Gonzales, Steiner, & Sande, 1998).

An increasingly patient-centered perspective on care delivery combined with changes in patient behaviors and the rise of managerialism, have undeniably influenced how physicians practice medicine. What remains unclear however is *how* physicians respond to regulations, constraints, and demands placed upon them in the inpatient setting. Discharge management becomes a critical site to explore this question, as physicians must make discharge decisions while caught between the often conflicting demands of patients and managers.

What autonomy do physicians have when determining hospital discharge? Patient consumerism has witnessed patients increasingly dictating the care they receive, with physicians complying with patients’ requests for particular medications and treatments (Kravitz et al., 2005). Furthermore, organizational theorists have suggested that hospital physicians, specifically, may experience significant limitations to their ability to control their daily work due to the presence of institutional rules and regulations. These rules and regulations “exercise increasing control over physicians, altering their character by making them more formally rational and in turn,

contributing to deprofessionalization” (Ritzer & Walczak, 1988, p. 4). Thus one may predict that inpatient physicians will be unable to freely manage hospital discharges, bending to the financial goals of hospital management and the demands of patients. Nonetheless, the sociological literature has also proven the ability for physicians to maintain and regain professional and cultural authority within medicine, revealing that physicians may have the ability to depart from the institution’s financial goals and patients’ requests. Drawing from the literature on managerialism in health care and increased patient consumerism, I analyze the dilemmas encountered and the strategies developed by inpatient physicians when discharging patients from the hospital.

### **The Art of Throughput**

Throughput refers to turning beds over – preferably before noon of a workday – so that a new patient can be admitted. One attending at Pacific Medical Center explained the process as follows:

All medical centers are under pressure to save money and to rein in costs. So you have the situation where you are in an environment where you’re teaching trainees and you want to be thorough and you want to encourage them to examine the patients and you want them to in essence rule in and rule out their hypotheses and follow the patient through time whilst they’re in the hospital. At the same time you have this pressure to get the patients in and out as quickly as possible because our emergency rooms are filling up and there is a bed crunch. And the whole concept of throughput...throughput is something I never heard of until maybe 3 or 4 years ago and throughput is the ... pressure to ... open up beds for patients that are coming through or paying customers that are coming through. So you know somebody can continue their workup as an outpatient you



know you want to discharge them as soon as possible and not only discharge them but discharge them before noon or discharge them before 11 so that you can turn the room around and bring in the next patient (H3).

As evidenced in the physician's words, at Pacific Medical Center, length of stay has become one of the most prominent financial concerns of the hospital. For hospital administration, one of their primary dilemmas is to ensure that PMC is able to generate profit and minimize unnecessary health care spending. The solution to this dilemma is to expedite the discharging of patients from the hospital to allow for new patients to be admitted.

Successful discharge is contingent on physicians, the patient and family members, health insurance companies, and other relevant third parties reaching a consensus regarding a discharge plan and date for the patient. Nonetheless, even when consensus is reached, delays of discharge from the hospital inevitably occur due to a set of patients that physicians at PMC refer to as rocks. As a prime example of objectification, rocks are patients who remain in the hospital for no medical reason. Some patients become rocks due to organizational issues: lack of transportation to move patients out of the hospital, unavailable beds at skilled nursing facilities, and delays in setting up Home Health care are just some examples of barriers to discharge.

Others become rocks when consensus cannot be reached among the different parties regarding a discharge plan and date; disagreements may emerge among the various specialists overseeing a single patient. Divergent opinions regarding discharge among consultants are common as they zero in on a particular condition and argue that continued inpatient treatment and monitoring are necessary. In other instances, patients or patients' family members disagree with physicians regarding a discharge, claiming that the patient should remain in the hospital for

a prolonged period of time. In this chapter, I focus on this last set of patients, which I refer to as Obstinate Rocks.

### **Finding and Moving Obstinate Rocks**

Obstinate rocks are patients and/or family members who disagree with physicians' assessments to discharge the patient from the hospital. Physicians find these patients to be the most frustrating to deal with because there is no medical or organizational reason for them to remain hospitalized, yet they are often very time intensive and require a great deal of emotional support. One attending who had completed her residency three months prior to the interview demonstrated her frustration with such patients during her residency: "You know the stress of residency can make you irritated and you think ugh I have one more person to round on. It's one more patient to have to deal with" (H33).

Others have voiced exasperation regarding these individuals stating that by staying in a bed, another individual who truly needs to be in the hospital is unable to be admitted. As a result, discharging these patients as soon as possible becomes a collective goal for the medical team. The first task to meeting this goal is for physicians to identify whether a rock is obstinate or not; this is done by "testing" the patient. The following excerpt demonstrates how the team tests whether a patient with severe colon impaction and gastro-intestinal problems does not want to leave the hospital:

After physically examining the patient, the resident told her that she probably could go home today. The patient responded that she did not want to go home today because she was too weak. The resident and attending physician agreed with the patient, stating it would be ok, "but then you have to go tomorrow." The resident then asked, "Would you want to go to a rehab facility?" The patient vehemently disagreed, stating she had been at

a rehab previously and it had been abusive and she did not want to go back. The attending then asked if she had any help at home. The patient stated that she had her daughter. The attending asked if her daughter was enough and she said yes she was. The physicians wrapped up the examination and told the patient they would check in on her later today. We then left the room. The attending said ok it is fine for her to stay today but tomorrow before noon she would have to be discharged even if she does not want to go. The attending said that since they told her that she will be discharged tomorrow, if she had a new complaint in the morning then they would know that she was just trying to stay longer. The attending said that her pain may be real but it may also be because she wants (to stay here) since there is more help at the hospital.

This example portrays a baiting strategy – where the physicians disclose a discharge date to test the patient to see if s/he comes up with a new symptom or problem the next day.

Other obstinate rocks are identified through word of mouth. While attendings may rotate every seven to fourteen days, housestaff stay on the same team for 28 days. Subsequently, while a patient may be new to an attending, housestaff may already have experienced difficulties discharging the patient in the previous week. Thus, housestaff share stories of problematic patients and/or family members, forewarning the attending physician of possible barriers to discharge.

In line with the fast throughput goal of the hospital, once obstinate rocks have been identified, physicians adopt strategies to discharge patients as quickly as possible. Strategies can be differentiated into two basic categories: using medical explanations to justify a patient's discharge and capitalizing on the presence of third parties. Physicians invoke medical rhetoric, explaining to patients that staying in the hospital is not in the best interest of the patient or his/her

health. The physician demonstrates with medical data that the patient has received all necessary care and the acute condition has been managed. Then the physician reviews the health risks associated with remaining in the hospital; one attending explained her approach, “I go over the risks of being in the hospital for infection, clots, a fall, etc. I explain what has been done thus far. I go over their concerns” (H17). Another physician also discussed the consequences of unnecessarily prolonging a hospital stay:

“Well a lot of times people staying in the hospital - it’s a dangerous place to be in if you don’t need to be here. So I try to remind them what are some of the risks of staying in the hospital - like getting an infection or having some sort of medical error, a nurse could accidentally come into the room and give you a medication by mistake. I just try to tell them that there are many reasons to be in the hospital, but if you don’t need to be in the hospital there are risks also associated with being in the hospital. So I try to tell them that. I try to come up with a good plan for them going home or wherever they are going to go so that they feel more comfortable with the plan” (H14).

All physicians interviewed reflected these sentiments; they made it clear to the patient that they were simply looking out for the patient’s best interests.

In the second set of strategies, physicians capitalize on the presence of third parties, deflecting blame regarding discharge decisions to health insurance companies. They explain that patients will be left financially responsible for the remainder of their hospital stay due to the restrictions of their health insurance companies. Physicians point to the denial of coverage from the patient’s health insurance company as the reason patients cannot stay in the hospital, shifting decision-making power away from physicians. One physician explained the process as follows:

“And then there are other people that really can’t tell you why they just say well I just want to stay one more day and I think to those patients you just have to be very clear that you know that when they’re ready to go they really need to go um that there’s no medical reason to keep them here. We often will tell them too if their insurance doesn’t find an acute medical need for hospitalization that they could end up with the bill because we [the hospital] won’t get paid and that often is very motivating I think for people” (H13).

Physicians emphasize to patients the authority health insurance companies in determinations of lengths of stay.

Some physicians note to patients that they are disclosing private or special information regarding the financial proceedings of the patient’s care. In the following excerpt, the physician explains that while he discusses finances he tries to broach the subject as an ally to patients rather than merely stating that the patient will be responsible for all health care costs:

Sometimes they feel like you guys are just a business, you don’t care about me, you’re just doing this because of the money. In those cases what I will do is I’ll often go in and say I just want you guys to know for full disclosure there’s a very good chance that any day after today is not going to be covered [by your health insurance company] (H1).

These final two examples demonstrate the physician attempting to align him/herself with the patient, placing the decision to discharge the patient on the financial motives of third parties.

Thus third parties, and not physicians, are responsible and should be held accountable for determining a patient’s length of stay in the hospital

### **Pushing Back**

Discharging patients however is not a uni-directional process with physicians and hospital administrators solely wielding the power to hold or move patients from the hospital.

Patients and patients' families find several different ways to prevent, or at least delay, a hospital discharge. There is only one official strategy to delay discharge from the hospital: patients and family members can legally appeal the discharge. Many insurance plans, such as Medicare, allow for patients to formally contest a discharge decision. The patient is subsequently held in the hospital for a minimum of 48 to 72 hours while the insurance company processes and assesses the request. If the insurance company agrees with the patient's family, the patient remains in the hospital; however if the company agrees with the physician, the patient must leave the hospital immediately. Patients and family members appeal the discharge decision without necessarily speaking with the physicians; physicians are alerted by nurses and case managers during rounds that an appeal has been filed.

All other strategies to prevent a discharge are done informally. Similar to physicians invoking medical explanations to justify discharging patients, patients and patients' family members utilize medical explanations to prove to physicians that the patient's stay is medically necessary. Common explanations include either noting a new symptom has manifested (e.g., the patient vomited, had diarrhea, spiked a fever, etc.) or by arguing with observational data against a physician's diagnostic or prognostic decision. In the case of symptoms, the patient or family member frequently explains that these events occurred overnight, when physicians and nurses were unavailable. In the case of vomit or diarrhea, once an episode has been reported, physicians and nurses request that future episodes not be flushed down the sink or toilet so that it can be assessed. However patients and family members explain that they accidentally flushed the materials down the toilet or they needed to flush it down the toilet so that others could use the bathroom. Because these symptoms may emerge at any time and are possible in light of the

patient's condition, even if the physician has not witnessed the event, it is difficult for them to definitively state that these symptoms did not occur.

The following fieldnote excerpt is an example of how family members argue that the physician incorrectly assessed the patient's medical condition. The family had called in the physician because they had observed a change in the patient's medical condition that they believed justified further stay in the hospital.

Upon assessment, the attending said that the patient never tracked with her eyes or squeezed her fingers. The family however was convinced that the patient was lucid at times and told the physician this was the case. The physician requested the nurse be called who was tending to the patient. The nurse arrived outside of the patient room and told the team that indeed the patient was lucid but she never experienced any alertness [from the patient]. The attending agreed that she was not lucid and that there was no neurological activity from her for five days. The physician stated that the family's belief that the patient was lucid however was delaying potential discharge because they refused to agree with the proposed discharge plan. The attending told the team that the only solution was for him to bring the family members to her bedside and ask them to show him what they believe indicates that she is responsive. In order to prove to the family that she was unresponsive, the attending also asked for the intern to request a brain-imaging scan to show the family that she indeed had an altered mental status.

In this case, the limited medical knowledge of the patient's family becomes the primary reason why the family argues against the decision to discharge a patient. Accordingly, the attending needs to teach the family and demonstrate with clear medical evidence that his medical assessment is correct. When met with these medical concerns, physicians question their

discharge decision as such medical symptoms could be an indication of a serious condition, and if disregarded could result in a hospital readmission or a potential lawsuit. Consequently, physicians often prolong the patient's stay and try to closely monitor the patient's condition to ensure that there have been no changes in the patient's condition.

A second category of strategies that patients and family members utilize is capitalizing on the presence of numerous parties in care delivery. This strategy can take on multiple forms. First and foremost, patients and family members recognize the role they play in the decision-making process regarding discharge and thus can influence how quickly consensus regarding discharge can be reached. Patients and family members delay discharge plans by failing to engage in conversations with physicians and other parties in order to push plans forward. For instance, patients' family members are unavailable for physician coordinated meetings or fail to return physicians' phone calls regarding the status of the patient.

They may also delay visits to placement centers, such as Skilled Nursing Facilities and Nursing Homes. For patients who cannot simply be discharged home, the case manager determines all eligible facilities a patient can be transferred to; eligibility is determined by the patient's health insurance plan and bed availability. Once a list of facilities is available, the patient's family members may take the time to visit each facility in order to make their decision. When family members fail to visit these centers in a timely fashion, discharge becomes delayed, for without the family's consent, the patient cannot be transferred out of the hospital. In some cases, family members refuse all offered centers, preventing discharge as the physicians and case manager must find alternative solutions to discharge the patient from the hospital.

Furthermore, patients and family members may play different parties off of one another. The fieldnote excerpt below demonstrates how family members delayed the discharge of their



loved one without explicitly refusing physicians' decisions. One patient's family was debating between requesting thoracentesis, an invasive procedure to remove air and fluid from the pleural space, or transferring the patient to Hospice Care. Hospice Care would result in the patient being discharged from the hospital. The physicians believed the procedure was unnecessary and told the family that they should not consider this procedure. The patient's children agreed that thoracentesis should not be performed. In order to facilitate the transition to Hospice, the General Hospice Center was working with the family and case manager in order to set up all necessary medical equipment in the patient's home; once everything was set up, the patient could be discharged from the hospital.

During rounds, the resident said he had to clarify if the family had spoken with General and put in a request for everything. The case manager interjected and explained to the team that there were unfortunately more issues with the family again. She had spoken with her contact person over at General, recounting to the team that she had a specific person she was corresponding with to help expedite this process. "The family had told me [the case manager] that the paperwork was at home and then told the Center when they offered to come over to the house last night that the paperwork was at the hospital."

This example shows how family members provide different information to different parties, delaying care delivery without explicitly refusing the physicians' recommendations.

Similarly, patients and family members may also play physicians off of one another, arguing that one physician said the patient could stay longer while another did not. This however may not reflect a strategy to delay discharge by patients, but rather the consequence of having numerous consultants on a patient case. They may say different things and approach care in contradictory ways. Physicians try to offset this potential conflict and delay of discharge by

meeting with consultants and agreeing on a single plan before having any physicians on the case speaking with the patient further.

### **Holding Rocks**

While expedited hospital discharges are the goal, in some encounters, physicians extend a patient's length of stay in the hospital. They ignore the hospital's financial objective and exercise agency in *when* they discharge patients. The physician allies with the patient and grants the patient an additional day(s), disregarding the financial costs incurred by the hospital. Most of the physicians offered an extra day rather than embroiling themselves in a battle to discharge patients on a given day. Some physicians draw from medical reasoning in order to justify the extended stay. One attending explained the factor that typically determined his likelihood of letting the patient stay an extra day:

Um there's some patients that are so sick you know they are coming back to the hospital probably 2 weeks later a month later and you know that if you give them an extra day and say ok let's compromise I'm going to give your wife an extra day here. We'll see how much oxygen she needs tomorrow, let's give her some more physical therapy, set her up for outpatient pulmonary rehab. ... You kind of make some compromises [when] you know that when they come back 2 weeks later [they say] oh doctor good to see you again, thanks for trying to help us it didn't really work. Whereas if you kick them out 1 day earlier and say no get out of here you have no acute medical needs, your insurance company keeps calling me and says we can't take care of you anymore, then they come back 2 weeks they're gonna say I told that doctor she wasn't ready to go and now she's back and she might die because she's even more hypoxemic and it's all his fault (H2).

The condition of the patient largely shapes the decision making process for physicians. Very sick patients who inevitably must return to the hospital are granted an extra day to avoid conflicts down the road. Physicians justify these decisions as acting not only in the patient's best interest, but also preventing future conflicts between the patient and physician.

Age is an important component in determining the decision to hold patients as well. Elderly patients have greater potential for unexpected adverse health outcomes, and thus may be held for a condition when a younger patient would be discharged. For example, an 87-year-old woman had fallen down in her home and fractured her arm. She required outpatient surgery however she was kept in the hospital for "pain control." Her family had complained that she should not leave the hospital with limited mobility and high pain, and the physicians agreed.

The attending explained during rounds that typically with arm fractures there is not much of a mortality difference so they don't usually keep the patient in the hospital. "They sometimes put a cast on it, re-evaluate it, and then fix it. Sometimes they won't even fix it – especially if the patient is older and debilitated." In cases of hip fractures, the patient stays inpatient. The family was uncomfortable with the arm fracture and the attending agreed. In order to justify her stay to the insurance company, the notation on the patient's medical record was changed to indicate that the patient was on pain control through IV medications.

The physician opted to keep the patient hospitalized because her age increased the likelihood of further injury even though the arm fracture itself was a "non-urgent" matter.

As noted in the previous example, another common strategy is to change notation in the medical record or alter treatment plans to justify a prolonged hospital stay. Physicians work to justify the patient's hospital stay to third parties, placing the patient's well-being over

administrative and financial regulations. For example, a male patient had cellulitis in his leg that was not improving. However the case manager was notified that the patient's insurance company believed the patient should be discharged from the hospital.

The attending said to the team that this decision was problematic since his leg was not getting better. She stated she would not feel comfortable discharging him with his [current] leg [condition] and no one to monitor [it]. She told the intern to change the orders on the patient's medical record and to request an IV medication, which would ensure that he could stay in the hospital without any interference from health insurance companies.

In such cases, physicians argue that they act in the best medical interest of the patient. These strategies allow physicians to avoid interference from third parties in their care decisions.

As explored in Chapter 2, there is one significant incentive in place for attending physicians to avoid expediting discharges from the hospital: risk of litigation. As the physician on record – and ultimately legally responsible for the patient's care – the attending physicians must consider litigious patients responding to perceived inadequate care provision. Accordingly, physicians may be further driven to protect the patient-physician relationship. One physician explained,

“[Patients argue] I'm not better and that you know if I don't get better, if I'm not better and I get readmitted [after being discharged] I'm going to – not sue but something along those lines. And if that's the case then you need to get legal involved” (H7).

With even perceived threats of litigation, physicians tend to be cautious and avoid immediate discharge. One physician extended a patient's stay for at least another four days after the patient's family involved the legal department. In another case, physicians were hesitant to push

discharge prematurely because the patient's brother was a medical malpractice lawyer and the patient's wife's sister was a registered nurse. These examples demonstrate leniency around the hospital discharge policy; physicians approach obstinate rocks with strategies that result in extended hospital stays, rather than expedited discharges.

## **Conclusions**

Successful discharge from the hospital is dependent on consensus being reached among physicians, patients and family members, health insurance companies, and other relevant third parties regarding a discharge plan and date. Reaching consensus however can be a complicated process as physicians encounter countervailing financial pressures and demands from hospital administration, patients, and patients' family members. On the one hand, hospital management pressures physicians to expedite discharge, in order to reduce inpatient health care spending, a goal that has been embraced by hospitals nationwide (Holliman et al., 2001). On the other hand, changes in reimbursement policies discourage physicians from discharging patients prematurely as hospitals are now financially penalized for immediate readmissions (Stone & Hoffman, 2010). In addition, at a time when patients are more informed and empowered regarding their health care (Barker, 2008; McKinlay & Marceau, 2008), patients and family members voice disagreement with physicians' recommendations regarding discharge. Physicians consequently are caught between hospital managers and patients as they manage hospital discharge decisions. Therefore, discharge management is an ideal site to examine how physicians respond to the regulations, constraints, and demands placed upon them within a health care system associated with increased managerialism (Hunter, 1996; Learmonth, 1997) and patient consumerism (Lupton et al., 1991; McKinlay & Marceau, 2008).

Delays of discharge from the hospital occur for two main reasons: (1) consensus has not been reached among the various parties involved, or (2) consensus has been reached, yet organizational factors (e.g., lack of transportation, unavailable nursing home bed, etc.) prevent discharge. In this paper, I examined delays of discharge that emerged due to disagreement regarding a discharge plan between physicians and patients and/or patients' family members; I refer to these patients as "Obstinate Rocks."

Obstinate rocks are problematic for physicians as they directly interfere with the hospital's discharge goal. Therefore physicians adopt strategies to push patients out of the hospital. These strategies can be differentiated into two categories: working within a medical context and capitalizing on the presence of third parties by deflecting blame and responsibility to these groups. These techniques not only facilitate expedited discharge, but they also reflect the professional dilemmas physicians have encountered with the increased commodification of care. In the first strategy, physicians cite medical reasons and patient's welfare and safety as justification to discharge patients. Physicians adopt a rhetoric that counteracts the distrust of physicians that has developed over the course of the 20<sup>th</sup> century (Mechanic, 1996) as physicians acting on financial incentives had been widely publicized (Gray, 1993); physicians discuss discharge in terms of the patients' health and well-being and avoid any discussion of financial issues (Parsons, 1951).

In the second strategy, physicians deflect discharge decisions to health insurance companies, demonstrating that health insurers, not physicians, consider financial issues related with care. Physicians once again shift discussions of finances away from the medical profession. Furthermore, they capitalize on notions of deprofessionalization and lack of autonomy over their work, depicting hospital discharge as a consequence of the increased presence of third parties

and the control they hold over care decisions (Fennell & Alexander, 1993; Haug, 1988).

Physicians use these transformations in the health care system to their advantage to convince patients and family members that such decisions do not reflect the desires of the physician but rather those of third parties.

Discharging patients however is not a uni-directional process. As a prime example of patients exercising greater agency regarding their health care (Mangione-Smith et al., 1999; McKinlay & Marceau, 2008; Winnick, 2005), patients and family members frequently disagree with physicians' discharge plans and argue for an extended hospital stay. Patients and family members have the option to formally appeal a discharge decision to their health insurance company; all other approaches are informal in nature. Similar to physicians, patients and family members also draw from medical explanations; they provide medical evidence (e.g., fever, diarrhea, lucidity, etc.) to explain why they believe a patient should remain in the hospital and continue to receive inpatient care. They also capitalize on the presence of third parties in care delivery: delaying correspondence with physicians, playing different parties off of one another. These strategies reflect the transition away from a paternalistic patient-physician relationship over the course of the 20<sup>th</sup> century, with patients and family members actively shaping the decision-making process as well as holding medical professionals accountable for their decisions.

While this data cannot explain patients' and family members' exact intentions to prolong a patient's hospital stay, one can consider some of the possible motivating factors to delay discharge. First and foremost, their desire to keep the patient in the hospital could stem from fear; fear that remains after a loved one suffers a serious health episode (Steinhauser et al., 2001). In addition, some family members may experience difficulty facing the prognosis of loved ones (e.g., transitioning to hospice care) (Kaufman, 2005), and thus may hold on to the hope that with

continued inpatient treatment the patient's prognosis may change. The desire to extend a patient's hospital stay may also reflect the inherent asymmetry of medical knowledge between physicians and laypeople (Light, 2000b); patients and family members may expect full recovery prior to leaving the hospital, even when this is medically impossible.

In turn, physicians encounter countervailing financial incentives and demands through their interactions with hospital administrators, patients, and family members regarding hospital discharge. Accordingly, physicians must weigh the consequences associated with their discharge decisions. First and foremost, patients' and family members' medical claims leave physicians faced with the risk of readmission due to an adverse health outcome experienced outside of the hospital. Physicians therefore recognize the financial penalties the hospital may incur for a premature discharge. In addition, adverse health outcomes and patients' and family members' perceptions that their concerns were neglected increase the risk for litigation against both the physician and the hospital. Subsequently, physicians must face the financial and professional implications of pushing patients out of the hospital.

Nonetheless, the professional expectations and the structuring of care delivery in teaching hospitals also complicate the discharge process. At PMC, like other academic medical centers, trainees are primarily in charge of medical care and are often overloaded with work during residency (Mizrahi, 1986; Szymczak & Bosk, 2012). Consequently, for trainees, discharging patients as quickly as possible is a way to reduce their extensive workloads. Attending physicians also take into consideration the workload of the housestaff when making discharge decisions, but primarily are focused on the evaluations they receive in their ability to manage "systems issues." The ability to expedite hospital disposition will reflect positively in their



evaluations. Thus, expedited discharge becomes a desirable goal for both trainees and attending physicians for different professional reasons.

While expedited discharge is the collective goal of physicians and hospital administrators, in some cases, even without disagreement from patients or family members, physicians choose to extend a patient's hospital stay. They change treatment plans and medical record notation in order to justify an inpatient hospital stay. Similar to the other strategies, this technique allows physicians to reclaim cultural authority from their patients while distancing themselves from external parties.

Cultural authority and trust are important components of the professional status of physicians (Freidson, 1970b). Thus it is unsurprising that the physicians at PMC were focused on maintaining a therapeutic relationship between patient and physician. With the increased commodification of care, the cultural authority of physicians has been challenged with proof of over-testing and over-treatments by physicians motivated by financial gain (Gray, 1997), numerous malpractice lawsuits (Annandale, 1989; Robinson, 1986), and increasingly short, impersonal visits with physicians (Furnham & Smith, 1988); the public questioned whether physicians acted in patients' best interests or merely sought financial profit (Reeder, 1972). In response, physicians have attempted to regain the trust of patients by making changes to how they provide care and interact with patients (Mechanic, 2008). Similarly, the management of obstinate rocks becomes another space for physicians to regain and re-enforce identities of trust.

Physicians also regain their professional autonomy by limiting the role of health insurance companies in the discharge decision-making process. Care delivery has transformed to an exchange involving numerous parties, placing limitations on physicians' autonomy and authority (Conrad & Leiter, 2004; Light, 2000a; Mechanic, 2008; Waitzkin, 2000). Physicians

are able to regain control over their work through the discharge management strategies they employ.

In addition, there are incentives for attending physicians to prolong patients' hospital stays. As the physician-on-record, the attending is both medically and legally responsible for the patient. Any negative health outcomes and perceived premature discharges would result in an investigation of the attending physician's decision-making. Subsequently, attendings may be more likely to allow for additional days in the hospital due to the fear of litigation. National policy changes in Medicare may further facilitate this process; in order to reduce rehospitalizations of Medicare patients, the government restricts reimbursement opportunities for readmitted Medicare patients (Stone & Hoffman, 2010). To reduce readmission, physicians may not only need to run additional workups on patients but also choose to extend their lengths of stay in the hospital to avoid quick readmissions of patients.

While most physicians align themselves with the hospital's discharge policy, they vary in how strictly they enforce the policy. This variation reflects a discomfort physicians experience when discharging patients. This discomfort may be explained by physicians' awareness that patients perceive that finances are being placed above their health needs – undermining the nature of the patient-physician relationship (Light, 2000b; Parsons, 1951) As a result, physicians frequently choose to delay discharging patients from the hospital. Some physicians bargain with patients and offer them an additional day or two to stay in the hospital. Others alter treatment plans to demonstrate a medically necessary reason for the patient to remain in the hospital. Subsequently, a decoupling emerges between the rules of the institution and the practices of the actors (Meyer & Rowan, 1977), in this case regarding discharge policy.

Some scholars have argued that physicians experience deprofessionalization by working within hospitals due to institutional rules and regulations (Ritzer & Walczak, 1988). However, the dual authority structure of hospitals (Scott, 1983) may afford physicians with greater agency than expected. In this structure, physicians are dominant actors at the “field level” rather than administrators; therefore physicians yield a great deal of power in shaping organizational behavior as management does not possess the same level of control over physicians that they may hold in institutions (Scott, 1983). Thus, the professional authority of physicians may be protected, granting them high levels of autonomy while working in the hospital.

With this agency, hospital discharge management emerges as an opportunity for physicians to resist institutional constraints and patients’ demands and regain autonomy over their work. In many cases, hospital administrators are aware of physicians’ decisions to prolong patients’ stay and choose not to intervene. Tolerance of physicians’ discharge practices resonates with the emergence of gray zones in organizations where the independence and identities of workers can be created and sustained (Anteby, 2008a, 2008b). Physicians may not only take advantage of gray zones, but may have a hand in creating and maintaining gray zones, because their social position within the hospital may increase their ability to modify or defy institutional objectives (Battilana, 2011). Their status combined with the dual authority structure of hospitals (Scott, 1983) arguably make gray zones rather common in hospitals. Nonetheless, similar to findings in Anteby’s (2008a, 2008b) work, physicians capitalize on these gray zones to shape and reaffirm their professional identities through their interactions with patients regarding hospital discharge. Subsequently, hospital discharge management becomes an opportunity for physicians to exercise agency, regain autonomy, reinforce professional identities, and maintain a therapeutic patient-physician relationship.

## **Chapter 5: Conclusion**

This study reveals a hidden curriculum of finances that physicians-in-training encounter during their residency training and in their early years of practice as attending physicians. Without any formal training in financial issues, trainees (in)directly encounter financial dilemmas on the clinical wards; through the management of these dilemmas, they learn how to navigate the financial issues salient in today's health care system. Along with revealing a critical, and to this point ignored, component of the socialization process of becoming a physician, this dissertation also offers theoretical insights on the experiences of contemporary professionals; it demonstrates how a profession responds to the presence of countervailing financial incentives and intervening third parties within a highly bureaucratized institution.

Scholars have extensively explored the relationship between professionalism and bureaucratization; several have argued that they are inherently incompatible (Corwin, 1961; Dalton, 1959; Sorensen & Sorensen, 1974) and others have declared that they can coexist within a single setting (Adler, 2012; Gouldner, 1954; Morrissey & Gillespie, 1975). Far from the archetypal solo professional – who enjoyed full autonomy and authority over his/her work and controlled relations with external parties (Abbott, 1988; Freidson, 1970a, 1970b; Leicht & Fennell, 2001) – the physicians at Pacific Medical Center are employed within a highly bureaucratized health care institution and routinely experience challenges to their professionalism.

Many of the financial dilemmas that PMC's Internal Medicine physicians routinely face stem from the presence of third parties, primarily hospital administration and insurance

companies<sup>12</sup> (MacDonald, 1995). As third parties intervene in physicians' medical decision-making, physicians develop strategies that enable them to preserve their professional dominance and jurisdiction (Hartley, 2002; Timmermans & Oh, 2010; Winnick, 2005; J. Zetka, James R., 2008). A common dispute that emerges is when insurers disagree with a physician's decision to keep a patient in the hospital and choose to deny coverage for the patient's care. Physicians respond with minor, yet effective, changes to treatment plans and the patient's medical record, which lead to a quick reversal in decision. Physicians successfully preserve their autonomy and authority over patient care by learning the practices of insurance companies and distinguishing loopholes in their protocols. In other instances, physicians welcome the bureaucratization of care delivery, utilizing this transformation in the health care system to their professional advantage. When embroiled in disputes regarding discharge with patients and family members, they place the onus of responsibility onto hospital administrators and insurers. They demonstrate the limited capabilities of physicians due to the constraints placed upon them in the health care system; in so doing, they deflect accusations of placing financial needs over patient welfare and are able to maintain a therapeutic patient-physician relationship.

Along with protecting the cultural authority of physicians, this strategy also reveals the discomfort physicians have with engaging in explicit financial dialogue with patients and family members, potentially making an argument for the need to keep the economic and social spheres distinct (Polanyi, 1957[1944]). However, while this particular strategy may reflect physicians' avoidance of directly making care decisions based on financial considerations, this dissertation demonstrates that through the hidden curriculum of finances, physicians routinely make care

---

<sup>12</sup> Some of the dilemmas that emerge (from the medical record and consultation process) are generated because of the presence of intraprofessional status hierarchies within the medical profession (Abbott, 1981, 1988; Freidson, 2001).

decisions with financial considerations in mind. The fact that not all decisions are uniformly made – with physicians discharging some patients while opting to hold others “unnecessarily” in the hospital – reflects that physicians make decisions based on both financial and social considerations (Zelizer, 1994). Ultimately, physicians cannot avoid the financial (dis)incentives present in the current health care system as evidenced by the hidden curriculum of finances. However, the medical profession can directly shape *how* it responds to these financial pressures by adapting to the institutional environment. Physicians learn the practices and perspectives of the various health care actors present in care delivery, and utilize them in different ways – enabling them to preserve their professionalism within the hospital.

### **The Hidden Curriculum of Finances: Explanations and Implications**

The hidden nature of the financial curriculum was a finding in and of itself. All of the physicians interviewed in this study reported minimal, if any, formal training in financial issues during medical school and residency. Thus it is unsurprising that the trainees at Pacific Medical Center had difficulties managing financial dilemmas that emerged in practice. There are numerous potential explanations for the absence of financial issues in formal medical education. First and foremost, the *sheer breadth of biomedical knowledge* that must be mastered within a relatively short span of time results in other aspects of care to be pushed to the wayside. Second, similar to the importance of actual clinical practice (not just text-book learning), financial lessons may be *difficult to teach* within a lecture or classroom setting. One attending emphasized that lectures on financial issues were ultimately ineffective, and that encountering financial dilemmas firsthand were the best educational opportunities: “We did get *some* lectures but it’s different to get a lecture and *actually* have to fill out the billing cards and do all of that yourself” (H13).

Third, and perhaps most critical, is the *lack of transparency* in the financial structuring of care delivery; formal training on financial issues is incredibly difficult when it is unclear what information is “correct” – and accordingly, what should be taught to trainees. For instance, the presence of third party payers makes billing processes and costs of therapies unclear and inconsistent – pricing changes on a patient-to-patient basis due to variations in health care plans. One attending voiced frustrations because of these inconsistencies:

I never learned about financial issues as a resident. In general you’ll find that doctors are *very very* poorly educated on finances and the flow of finances through a hospital. And to some extent I believe that people don’t want you to have that information; you can’t even find out what it costs to take care of someone in a bed on the wards. No one will tell you a straight answer. [They say], ‘Well it depends on the payer, depends on the insurance company, depends on the level of nursing, depends on this or that...’ (H2)

The fact that standardized pricing and general financial information are unavailable to health care professionals presents a dilemma for those who wish to become financially informed about the health care system. The attending noted that the lack of transparency of financial issues ensured that formal training on such issues would be nearly impossible:

I think we need to start educating people what the different tests cost but nobody knows – I can’t do it because I can’t quote what a CBC or a Chem 10 lab test costs...even though I am probably more interested in these issues than most people.... I would love to be able to quote the numbers and then make a very convincing argument but I don’t think this hospital, or any hospital, has that level of financial sophistication (H3).

A 2<sup>nd</sup> year resident voiced similar frustrations explaining that the lack of uniformity of financial pricing and billing protocols made it impossible learn:

I don't think we really learn any financial stuff in medical school. I'm still very much in the learning phase. I had a patient just now in clinic that I wanted to give a shingles vaccine to. So two weeks ago I had a similar patient that I sent to go to the pharmacy to pick up the vaccine and it was going to cost him \$250. I sent my patient today for the same thing to see how much it was and it cost him only \$4. How am I supposed to learn this when it doesn't make any sense? I have a patient ask me how much something costs and I have no idea because it completely depends on what their insurance is...it is completely out of my hands (R14).

The difficulty discovering “correct” information – along with the fact that there can be multiple “correct” prices and protocols for the same condition – largely contributes to the absence of formal training of financial issues in medical school and residency training.

\*\*\*

As the hidden financial curriculum will likely continue to remain hidden unless there is a complete restructuring of care delivery and of financial payment systems, what are the professional, organizational, and social consequences associated with a *hidden* curriculum of finances? First, physicians-in-training are rarely evaluated on their ability to provide cost-effective care (even though attendings reported that they felt housestaff *should* be evaluated on this). While many of the physicians commented that trainees were largely unable to provide financially savvy care, they were lenient in their (few) assessments. Unsurprisingly, trainees reported never feeling evaluated on their ability to manage financial dilemmas, reflecting that positive or negative evaluations were of little consequence to the perceived professional trajectory of housestaff. This (non)evaluation approach has professional consequences for physicians. The socialization literature has emphasized how evaluations of trainees by superiors



is critical in teaching them the expectations, values, and behaviors held in highest regard by the medical profession (Apker & Eggly, 2004; Becker et al., 1976; Bosk, 2003). Accordingly, as trainees experience little to no evaluation on their ability to manage financial dilemmas in care delivery, they are socialized to position financial concerns far below other professional responsibilities.

Fittingly, physicians frequently deprioritize financial matters in their daily decision-making at Pacific Medical Center. For instance, primarily concerned with intraprofessional work relations, physicians frequently accept an unnecessary recommendation for a test or procedure from a colleague – maintaining collegial relations during consultations. While consultations can undoubtedly improve the quality of patient care, unnecessary consultations and medical workups place patients at emotional and physical risk (Cassel & Guest, 2012) and contributes to the expensive medical waste present in the current health care system (Wennberg et al., 2008). Similarly, I would like to recall the attending physician who as a resident had recommended a patient remain hospitalized for inpatient care (due to difficulties accessing the outpatient clinic); the end result was a \$78,000 bill for the patient. Physicians' disregard of the financial implications of care can lead not only to health risks, but also to dire financial situations for patients.

In interactions with patients (particularly regarding discharge), physicians often relent to patients' and families' requests – performing additional medical workups and extending hospital stays. Professional concerns of litigation (Robinson, 1986), organizational pressures to focus on patient-centered care and satisfaction (Annandale, 1989), and a desire to maintain a therapeutic patient-physician relationship all contribute to physicians' responses to patients' demands. The inherent asymmetry of knowledge between the patient and physician (Light, 2000b) however can

make compliance to these demands problematic; scholars have found that physicians frequently prescribe unwarranted treatments and medications for patients (Kravitz et al., 2005) – adding to unnecessary health care spending.

Medical professionals are not singularly to blame for unnecessary inpatient costs. Rather, medical waste is also organizationally produced. The institutional pressure to maintain collegial relations with colleagues, the default mode of communication within the hospital (where health care professionals rarely to speak to one another), and the hierarchical nature of medical training promote inefficiencies in care delivery at Pacific Medical Center. These organizational practices continue to promote interactions and relationships among health care actors that impede care delivery; the end result is inefficient care and money wasted.

### **U.S. Health Care: A Broken System?**

By examining the financial socialization of physicians, this study offers micro-mechanisms that explain some of the rising inpatient costs – an area of health care expenditure that has been targeted in recent years in hopes to fix the “broken” U.S. health care system. Plagued with exorbitant health care spending and poorer health outcomes compared to its OECD counterparts, the passage of the Patient Protection and Affordable Care Act on March 23, 2010 was primarily seen as a step towards repairing this system. A piece of legislation that has been in the making since the early 20<sup>th</sup> century (Quadagno, 2005), the ACA was first and foremost intended to provide coverage to approximately 45 million Americans living in the United States without insurance coverage. Health care professionals, economists, and policy makers however were also hopeful that the passage of the Affordable Care Act would simultaneously reduce costly medical waste. Inpatient care has been the target of these legislative changes, with all eyes

primarily focused on the process of hospital discharge: both shortening hospital stays and deterring unnecessary hospital readmissions.

Hospital length of stay however is not a new target, but rather has been included in conversations of health care cost reduction since the 1970s. Optimistic that reducing the average length of stay of a hospitalized patient would markedly reduce health care expenditure – combined with changes in insurance reimbursement policies in the late 20<sup>th</sup> century (Holliman et al., 2001; Sox, 1999) – hospitals embraced the goal of expedited discharge with the inclusion of hospitalists and discharge planners in inpatient care delivery. The assumption was that having hospitalists, who worked full-time in the inpatient setting and therefore were accustomed to navigating barriers to discharge (Wachter, 1999), and discharge planners, specifically focusing on patient discharge (Holliman et al., 2001), would decrease costs. While some studies did indicate reduction in health care costs – especially with the implementation of a hospitalist model of care (Bellet & Whitaker, 2000; Palmer Jr. et al., 2001; Wachter & Goldman, 2002), this solution was clearly insufficient with health care costs ballooning from approximately \$256 billion in 1980 to \$2.6 trillion in 2010 (California HealthCare Foundation, 2012).

Even with limited success in stymieing health care spending via hospital discharge in the past, it has prominently remained in the debates on how best to reduce health care spending in the United States. Hospital discharge and readmission were catapulted back to the forefront of cost-cutting debates largely due to the publication of the 2008 Dartmouth Atlas report, which blamed excessive health care spending on variations in treatments and lengths of stay for the same condition across U.S. hospitals (Wennberg et al., 2008). What was especially concerning about these findings was that the hospitals that utilized the most resources, kept patients the longest, and in turn spent the most money, did not necessarily have the best health outcomes.

With other publications piggy-backing off of the Dartmouth Atlas findings, concerns grew not only regarding hospital length of stay, but also hospital readmissions. Publications by the Robert Wood Johnson Foundation and the Centers for Medicare and Medicaid propelled hospital readmissions into the conversation on cost-reduction, arguing that improper discharge planning resulted in unnecessary hospital readmissions that financially drained the system (Goodman et al., 2013; Lavizzo-Maurey, 2013). Subsequently, financial incentives have been established by the ACA to deter “unnecessary” hospital readmissions, along with Medicare policy changes that penalize hospitals for immediate readmissions. With these particular legislative and policy changes in place, the trillion-dollar question remains whether these initiatives will be successful in eliminating unnecessary health care spending in the United States?

*Reducing Health Care Costs: A Numbers Game?*

From a sociological perspective, there is a critical flaw in the current cost-cutting initiatives dealing with hospital discharge and readmission: it has simply been reduced to a numbers game. In line with the broader movement towards standardization within medical care in the United States (Timmermans & Berg, 2003), evaluation and penalization of hospitals is inevitably contingent on the collection and comparison of numerical data that reports average lengths of stay and readmissions for individual hospitals. Standardized care privileges scientific evidence, usually in the form of statistical data, to shape how care is administered. By focusing on metrics, this evaluation process ignores the broader social context in which a series of decisions determine why a patient remains in, or leaves, a hospital (Dixon-Woods, Bosk, Aveling, Goeschel, & Pronovost, 2011).

One of the hallmarks of the standardization of medical care has been the implementation of evidence-based medicine (EBM), which relies on clinical practice guidelines and protocols

(Timmermans & Angell, 2001). Of particular concern here is the actual *use* of EBM guidelines; physicians may report that they all follow EBM but in practice, implementation varies greatly (Timmermans & Angell, 2001). This variation reflects in part the autonomy and authority physicians continue to maintain in clinical practice, allowing them to forego guidelines without penalty. Physicians are shielded from particular forms of evaluation allowing them to take liberties in following protocols and rules implemented from administrators and other third parties (Scott, 1983). Nonetheless, even if physicians adhere to EBM guidelines, there are conflicting reports on the efficacy of these guidelines in making real improvements to care delivery. There is arguably too much focus on individual choice; the guidelines do not acknowledge the physician is embedded within a larger system comprised of interdependent health care actors that must collaborate with one another to ensure proper care delivery (Timmermans & Mauck, 2005).

In addition, these external evaluations of hospital discharge and readmissions may result in the adoption of practices that simply fulfill a checklist of requirements to meet numerical benchmarks; without considering the institution's social context – the perceptions of its employees and other contextual factors – these policy changes may have limited outcomes (Dixon-Woods et al., 2011). Subsequently, not only may physicians (and hospitals) find ways to navigate the discharge process to “win” the numbers game to avoid penalizations, but also, without focusing on the broader social context of specific institutions, many of these newly adopted practice and policy changes may have very disappointing results.

Some hospitals across the United States have found one solution to reducing their hospital lengths of stay and readmission rates by establishing observation units. These observation units allow hospitals to house patients without officially “admitting” them into the hospital. Considered outpatients, these individuals will not be included in data examining

average lengths of stay and hospital readmissions. While there is some indication that these observation units may actually save costs at their respective hospitals (Carrns, 2014), only one-third of U.S. hospitals have such units, which may not be a substantial enough population to reverse national health care expenditure. Lastly, with this heavy reliance on numerical data, while there may be *some* indication of cost reduction, is the goal of eliminating *unnecessary* health care spending truly being addressed?

I argue that unnecessary health care spending will remain a problem if assessments of inpatient costs will be simplified to calculating rates of hospital discharge and readmission. This emphasis on numerical data will merely facilitate the persistence of an inefficient health care system and the continued generation of medical waste unless we consider the broader social context of care delivery in the inpatient setting (Dixon-Woods et al., 2011; Timmermans & Mauck, 2005). This dissertation sheds light on some of the aspects of care delivery that contribute to (or promote) unnecessary inpatient spending. These factors include: (1) the highly specialized nature of medicine, (2) the role of third parties in care delivery, and (3) patient empowerment.

The *highly specialized nature of medicine* structures interactions among physicians at Pacific Medical Center that have costly consequences. The specialization of the medical profession results in the generation of an implicit intraprofessional hierarchy organized around expertise, skill set, and prestige (Abbott, 1981; Nancarrow & Borthwick, 2005). This hierarchy becomes self-evident through the (mis)use of the medical record and during the consultation process. For instance, intraprofessional hierarchies drive jurisdictional conflicts over patients when IM physicians consult other specialists. The end result is costly as care is inevitably delayed until the disputes are resolved.

The *role of third parties*, specifically health insurance companies, in care delivery also exacerbates health care spending. Physicians encounter firsthand the role (and interference) of third parties in medical decision-making (Light, 1989) through daily use of the medical record at PMC. Health insurance companies deny coverage of care decisions based on their interpretation of the medical documentation in the patient's record. This denial of coverage results in delays of care (and discharge) from the hospital. Physicians subsequently must learn (1) proper billing language to prevent miscommunication with insurers and (2) develop strategies to bypass insurers, particularly when making discharge decisions. Inevitably disputes emerge between physicians and insurers resulting in costly delays of care.

Lastly, *patient empowerment* results in patients and family members challenging physicians' care decisions (Kravitz et al., 2005; McKinlay & Marceau, 2008). Patients and family members often fight for additional treatments (Kravitz et al., 2005) or a prolonged hospital stay. Decreased cultural authority and fear of litigation (Annandale, 1989; Robinson, 1986) can persuade physicians to adhere to patients' and family members' requests, resulting in unnecessary medical workups and delayed discharges from the hospital. One delay of care or delay of discharge due to intraprofessional conflicts or patient request may not seem very consequential in the grand scheme of health care expenditure. However, collectively, each delay of care and discharge can result in very costly consequences for the hospital and subsequently deserves attention when considering cost-cutting initiatives.

### **Cost-Cutting Initiatives in Practice: Recommendations**

I would like to offer some potential practice and policy recommendations. Similar to the policy makers, I agree that the actions of the medical profession are critical to control costs in the U.S. health care system. My dissertation ultimately points to physicians as gatekeepers to both care

and inpatient health care costs. Their ability to navigate financial issues and pressures directly translates to a patient's ability to receive care and the degree of costs incurred to the hospital. The physicians in my study demonstrated the resilience of the medical profession, developing strategies to mitigate intraprofessional conflicts, patient demands, and interference from insurers. These strategies facilitated care delivery, preventing unnecessary delays of care and discharge. Accordingly, policies should be geared towards improving how physicians learn to navigate financial dilemmas, developing greater incentives to not only provide financially savvy care, but also to learn more about the affordable care options available to patients to ensure continuous care.

Nonetheless, the medical profession alone however cannot stymie health care spending. Health care delivery has evolved to a complex exchange that involves a configuration of various parties. These parties must align in order for care delivery to run smoothly. Subsequently, my recommendations focus on the training process of physicians as well as intra- and inter-organizational issues.

*Training and Evaluation on Financial Care.* Since beginning fieldwork in 2010, the Pacific Medical Center's Internal Medicine service has implemented information sessions on financial issues for interns and residents. Most prominently they held a session on improving the consultation process to ensure quality care while reducing unnecessary costs. While there may have been a few informational sessions included in training, medical school and the majority of residency training remains focused on mastering clinical knowledge and skills, which is unsurprising given the sheer scope of biomedical knowledge (Becker et al., 1976). However disregarding financial dilemmas is impractical within the current health care environment and thus must be incorporated into daily training in a more formal way. Attending physicians and



case managers are valuable resources but more must be done to improve trainees' anticipation of these issues; informal lessons and trial and error alone cannot be the primary mode of financial education. If dealing with financial aspects of care delivery can be incorporated into the formal curriculum through coursework, clinical rotations, and enforced evaluation, trainees may develop a stronger background in navigating these issues upon starting residency training – preventing costly consequences.

*Intra-organizational factors.* Sporadic closures of care services at PMC and scheduling constraints contribute to barriers to care and delays of discharge. One of the most common (and costly) problems is the emergence of patients that remain in the hospital because of organizational issues (e.g., no transportation available to take them home, no case manager available on the weekend to coordinate transitions of care, etc.). Addressing some of these organizational constraints may alleviate inpatient costs.

*Inter-organizational factors.* Transitions of care out of the hospital could be expedited with the strengthening of local health infrastructures. If hospitals could be more closely tied to local clinics and placement centers, this may help streamline hospital discharges. Furthermore, a clear network could facilitate the training of physicians to quickly learn affordable care options for under-resourced patients, to prevent delays of discharge that result when physicians are unable to place patients. Currently, some hospitals have begun to rely on post-discharge clinics, which are clinics “located on or near a hospital's campus...The patient can be seen once or a few times in the post-discharge clinic to make sure that health education started in the hospital is understood and followed, and that prescriptions ordered in the hospital are being taken on schedule” (Beresford, 2011, p. 41). Hospitals in various cities across the United States, such as Boston, Seattle, and Tallahassee, have utilized these post-discharge clinics to facilitate transitions of care

out of the hospital and have reported decreased rates of hospital readmissions (Caramenico, 2011). Still in the early stages of implementation, the efficacy of post-discharge clinics remains to be seen. However there is strong indication that establishing secure follow-up care options for patients via these clinics could dramatically decrease hospital readmissions.

\*\*\*

As all aspects of the Affordable Care Act are gradually implemented, only time will tell if the legislation will be successful in reducing health care costs. There are reports of health care spending increasing at a slower rate in recent years, which indicates some signs of improvement. Nonetheless, to continue along this trajectory, practice and policy recommendations must address the nature of inpatient care today. Cost-cutting initiatives must acknowledge what “doctoring” entails in the current health care system, recognizing that physicians are deeply embedded within a configuration of health care actors; these actors must all work together collectively to achieve efficient, high quality care delivery.

## **Appendix: The Study**

This ethnographic case-study took place at Pacific Medical Center, a highly specialized, academic medical center in the Western United States. The ethnographic nature of this project allowed for me to become immersed within the setting, to observe the routine interactions and encounters that take place. Along with being able to provide thick description of daily life events, through this immersion, ethnographers are able to generate new theories (Emerson, 2001a) and inform practical recommendations; ethnography is “particularly useful...because we come closest to the people who are being studied. We can tell policy experts what the implications are of their policy on other people. We can tell policy people what the people that we have studied need in the way of policy” (Becker, Gans, Newman, & Vaughan, 2004, p. 265). By focusing on one site, case studies allow for the researcher to understand the “dynamics present within single settings” (Eisenhardt 1989, p. 534). Bringing together various forms of data (e.g., observations, interviews, documents) (Yin, 2009), they also allow for the generation of new hypotheses and theories (Eisenhardt, 1989).

I selected the Internal Medicine Service as my site, in part due to the access I was granted, but also because Internal Medicine was the ideal medical specialty to conduct my study on financial socialization. The general nature of the service requires Internal Medicine trainees to learn not only specific procedures and therapies but also how to make universal medical decisions regarding the patient (ranging from differential diagnosis to possible prognosis); the emphasis on a global perspective when dealing with patients encourages interns and residents to consider all of the possible causes of particular symptoms and conditions. Subsequently, IM physicians commonly run numerous tests as well as consult other sub-specialists regarding patient care. Unsurprisingly, the utilization of resources (financial and human) can rise quickly

on the Internal Medicine service, especially due to the training process; financial issues are therefore very salient on the IM service.

Inpatients costs are also exacerbated by the nature of PMC patients on the IM service. The available health care services and the prestige of PMC draw very ill patients from around the country. The complex nature of patients' conditions increases the likelihood of running extensive tests and therapies and the calling of consultants to facilitate patient care. The generalist nature of Internal Medicine, the patient population at PMC, and the process of training new physicians consequently result in the emergence of various, and opposing, financial incentives that the physicians must manage while providing care.

#### *Data Collection*

Data collection consisted of (1) observations during teaching and interdisciplinary rounds, (2) observations of monthly hospitalist meetings with specialty services, and (3) interviews with IM attending physicians and trainees. After obtaining IRB approval, data collection took place from September 2010 to August 2013 on the Internal Medicine Service. There are 6 Internal Medicine teams that oversee all of the patients at Pacific Medical Center. Each team is comprised of an attending physician, a resident, 2 interns, 1-2 medical students, and a case manager (see Table 1 for description of responsibilities). Each Internal Medicine team had an equal likelihood of being observed. I obtained the contact information of attending physicians from the Director of Hospitalists at PMC. I then directly emailed individual attending physicians and requested to observe their teams. In cases when I received no response, I would wait outside the rounding room – where the teams meet prior to beginning their rounds – and would approach the first attending who arrived. I explained the project and my methodology of participant observation. If the attending consented to the study, I presented the study to the rest of the team.

All team members approached consented to participate.

Hospitalists are the majority of the sample due to their predominant presence on the teaching wards; only one internist consented to be observed. In total, 44 attending physicians, 60 trainees, and 5 case managers consented to participate in the study (see Table 2). I shadowed each team weekly during morning and interdisciplinary rounds, and occasionally for longer periods of time in the day; I spent between 2 to 5 consecutive days with each team per week – the length of time with the team was contingent on their availability (some teams requested I only observed for 1-2 days due to work-load and team size). Many of the physicians also preferred to be observed only during morning rounds because of their schedules. I took notes while observing and typed up detailed fieldnotes at the end of each day.

I also observed five of six Internal Medicine hospitalist meetings dedicated to improving the consultation process. These meetings were a venue for the Internal Medicine attending physicians to engage in critical dialogue regarding the consultation process with other special service attendings. Each meeting began with a presentation by the specialists; topics addressed included general experiences consulting with the IM service, problematic cases, and recommendations to improve the consultation process in the future. An open discussion between IM and specialty physicians followed the presentation where physicians could ask questions and/or comment on the issues raised. Discussions ranged in length from 30 minutes to 1 hour. The specialty meetings I attended were with Endocrinology, Gastro-enterology, Pulmonology, Cardiology, and Rheumatology. I did not attend the meeting with the Infectious Disease Service because I had not been notified of it.

Lastly, I interviewed 40 Internal Medicine attending physicians and 19 Internal Medicine trainees for a total of 59 interviews (see Table 3). Of the 40 attending physicians, 33 were

hospitalists and 7 were internists. The interviews were conducted at a location of the physician's choice. The attending physician interviews generally took place in their personal office or in a hospital meeting room. The trainees' interviews took place in the hospital cafeteria, local restaurants or cafes near the hospital, in the hospital lobby areas, and in one case, via video-chat. The interviews were audio-recorded (unless the physician did not consent to being recorded) and fully transcribed. Interviews ranged in length from approximately 20 minutes to 2 hours. As evidenced by the disparate numbers, it was very difficult to secure interviews with trainees largely due to their unresponsiveness to numerous personal emails. For those who did agree to be interviewed, I offered to buy them a meal for their time – allowing them to merely include me into their lunch-time, rather than requiring that they schedule an additional 30 minutes to 1 hour to meet with me outside of their work schedule. Nonetheless, even with meal offerings, it remained very difficult to secure interviews within this study period.

Like all researchers, throughout data collection I was concerned with ensuring the anonymity of my research subjects (Bosk, 2003; Casper, 1998; Millman, 1977; Timmermans, 1999). Drawing from others' well-documented strategies, I used pseudonyms for individuals and places in this dissertation and also throughout my ethnographic fieldnotes. To ensure anonymity in this dissertation (other than in the first vignette), I distinguish study participants by their level of training (e.g., attending, resident, intern, and so forth). The interview excerpts are differentiated by the initial H#, I# or T# which refers to the Hospitalist, Internist, or Trainee and the order in which they were interviewed within each group respectively (Trainees would be numbered from 1 through 19, hospitalists from 1-33, and internists from 1-7). I never included patients' and families' names in my fieldnotes. In the study I refer to them only by gender, age, and the acute condition or issue relevant to the observed interaction (in other words, no

discussion of the patient's larger medical history).

### *Data Analysis*

I approached data collection and analysis from an abductive analytical perspective, entering the field with the “broadest theoretical base possible” (Timmermans & Tavory, 2012). Once all fieldnotes and interview transcriptions were compiled, I conducted an open line-by-line coding with emerging themes (Holton, 2007). Comparisons were drawn of the data and the codes (Kelle, 2007). I focused on cultivating “surprising empirical findings against a background of multiple existing sociological theories” (Timmermans & Tavory, 2012, p. 169). Once I completed coding, I located the most relevant themes: the medical record as professionalizing tool; intraprofessional work dynamics associated with the consultation process; and countervailing pressures prevalent in discharge management. I finished a second round of coding that focused on the selective themes and wrote up integrative memos that analyzed the data and addressed these themes (Holton, 2007). I then incorporated relevant sociological literature in the memos, including the theory of professions, socialization and professionalization, the commodification of care, the standardization of care, and organizational theory.

### **Concerns in the Field and Study Limitations**

One of the most common methodological concerns in ethnography is gaining physical access, particularly in the case of “studying up” (Cassell, 1988; Hertz & Imber, 1995; Thomas, 1995). Medical ethnographers have well-documented the difficulties of securing physical access – demonstrating the various strategies utilized to gain access as well as the importance of both time and persistence (Bosk, 2003; Chambliss, 1996; Mizrahi, 1986; Timmermans, 1999; Zussman, 1992). After searching for over two years for a field site, I gained access to this particular site by joining a research team planning to conduct research on the Internal Medicine

Service at Pacific Medical Center. While that project was never completed, I took part in the process of negotiating access into the Internal Medicine Service. I attended numerous meetings with various physicians working at PMC to discuss the merits of the project and the ethnographic approach. After approximately 3 months of negotiation, I was granted access to the Internal Medicine Service.<sup>13</sup>

My primary contact was the Director of the Hospitalists within the Department of Internal Medicine at PMC. Similar to Mizrahi (1986) who was aided by the sociological interests of the IM Chairman, the Director of the Hospitalists at PMC also believed that social scientists could shed valuable light on some of financial concerns surrounding inpatient care delivery. With the Director taking me under his wing, he introduced me to the various Internal Medicine teams and I was easily able to gain physical access to the teams, and in particular the attending physicians.

I experienced little difficulty physically fitting in to the IM teams during their rounds as they were accustomed to additional members joining the team – whether it be trainees in other fields (e.g., nursing, pharmacy) or external reviewers studying the efficiency and model of care delivery of the hospital. I was merely one additional member of the team. I believe they were even more comfortable with my presence at PMC, for similar to other teaching hospitals, the physicians and other medical (para)professionals were accustomed to research projects being conducted regularly (Zussman, 1992). Furthermore, as many of the team members jotted notes down during rounds, it was very easy for me to write notes unobtrusively (Mizrahi, 1986; Zussman, 1992); I adopted a strategy utilized by many ethnographers, offering to share my notes whenever anyone expressed interest or concern regarding my note-taking.

---

<sup>13</sup> After 2 years of data collection at PMC, I also tried to gain access to a county facility affiliated with the Pacific Medical Center. However after a few correspondences with Internal Medicine physicians at the county hospital, I was unable to negotiate access for this study.



Social access, which is contingent on gaining the trust (and camaraderie) of the study participants (Anspach, 1993; Emerson, 2001b; Millman, 1977), was much more difficult to achieve compared to physical access; I feel I attained social access in varying degrees of success with the study participants. As I regularly attended morning rounds (even those that were conducted at 7:30 AM), the attendings and trainees began to recognize me and were much friendlier. The attending physicians especially embraced my presence on the wards. This may be a consequence of the Director's avid interest in my work, and his strong urging of his colleagues to participate in this project.

The trainees, on the other hand, remained a much more closed network. Similar to other ethnographers' experiences (Anspach, 1993; Heimer & Staffen, 1998), I found it difficult to garner meaningful relationships with the housestaff during morning rounds. Therefore one study limitation is the disparate numbers of interviews between attendings (n=40) and housestaff (n=19). Consequently, these interviews primarily reflect the insights and experiences of attending physicians compared to those of interns and residents. One explanation for the variation in social access could stem from trainees' status: they were just beginning full immersion within the clinical setting, are subsequently were focused on learning biomedical and clinical knowledge and skills above all else (Becker et al., 1976; Morley et al., 2013). This combined with their overburdened workloads due to the organization of residency training (Szymczak & Bosk, 2012), could arguably leave trainees less interested in my project, and available to participate in individual interviews. In contrast, attending physicians simply had more physical time to meet with me. In addition, many of the attendings had been practicing medicine for at least several years, and thus had time to (1) garner a perspective on the advantages and disadvantages of working within the U.S. health care system, and in turn, (2)

develop much greater concern for financial aspects of care delivery, and subsequently be interested in my project.

While I would have liked to reach equal numbers of interviews between attendings and housestaff, I do not believe this necessarily diminishes the story of financial socialization that emerges within the study. The ethnographic observations of the Internal Medicine team, and the informal conversations held with housestaff during morning rounds, provide a clear picture of the financial struggles housestaff encounter during their residency training. Furthermore, financial socialization extends beyond residency training, thus attending physicians are also physicians-in-training within the hidden curriculum of finances, with some of the most critical lessons encountered as attending physicians rather than as interns or residents (e.g., litigious patients).

Another study limitation was the fact that I did not always enter patient rooms. While I had IRB approval to see patients, my access to the patients' rooms depended on the attending physician (some preferred I not enter the room), the team size (when teams were too large I did not enter the room), and the patient and/or family<sup>14</sup>. Furthermore I did not approach any patients or family members for interviews. The end result is that my study is primarily focused on the opinions and experiences of physicians. Hospital discharge is one area in particular where greater access to patients' and families' perceptions and self-reported experiences would undoubtedly have strengthened the data. Nevertheless, as this study is a financial socialization study of physicians, limited access to patient rooms and opinions was not necessarily problematic – especially since the majority of financial conversations occurred outside of the patient room (e.g., during rounds, private conversations with case managers, etc.).

---

<sup>14</sup> When patients were extremely sick (in quarantined rooms), I did not enter the rooms. Furthermore when family did not want me present I also did not enter the room. In some cases however, physicians preferred my presence when dealing with patients with highly demanding family members.

Similar to the limited access to patients, I was unable to interview physicians from the consulting services. I was limited to observations of consultants from chance meetings during morning rounds and during the monthly hospitalist meetings. I contacted the various services to conduct interviews with physicians however never received any responses. Subsequently I could not get the perspectives of sub-specialists. While the study is primarily focused on the financial socialization of Internal Medicine physicians in particular, sub-specialists' self-reported experiences would have enriched the data on the consultation process.

Lastly, I failed to formally interview case managers, nurses, or other medical staff. These individuals are all undeniably involved in care delivery and discharge. Their perceptions of the root cause of financial dilemmas, and the role of physicians in managing and/or exacerbating these issues, remain absent. However, I believe the ethnographic observations provide me with rich data on the interactions between physicians and case managers and clearly demonstrate the vital role of case management in helping physicians navigate the process. With only 5 case managers assigned to the Internal Medicine service, they were too busy to meet with me for interviews. The nurses also remained inaccessible; researching the nurses at PMC required additional IRB and other research protocols that were too prolonged for this study period. While garnering the perceptions of these health care professionals would have enriched the study further, the nature of the hidden financial curriculum and the lessons learned by trainees were clearly revealed through my ethnographic observations and interviews with physicians.

Along with these access concerns, one common ethical issue I encountered was not always being able to receive informed consent from all of the individuals in the setting (Bosk, 1992; Diamond, 1992). Morning rounds tended to be unpredictable with the IM physicians unexpectedly running into consulting physicians, family members, and hospital administration in

the hallways. To avoid delays in care and to save an extra page or phone call, these individuals would opt to briefly meet in the hallway. In those instances, I was unable to gain informed consent, as the different individuals would come and go in a haphazard fashion. In more organized settings (e.g., meetings or official consultations), my presence would at least be verbally acknowledged by the attending physician, letting the others know that I was researching interactions on the IM service. However in some interactions, when even verbal communication was not given regarding my researcher status, I opted not to write down notes and did not include any non-consenting individuals within the study data presented in this dissertation.

Another ethical concern I faced was my intrusiveness on patient's and family's harrowing moments. I observed patients crying as they received poor diagnoses and as families struggled with the decision to transition their loved ones to Hospice Care. In acutely sensitive cases, the attending physician would notify me that they would be sharing difficult news with the patient and/or family and I stayed outside of the room. Since I could not always be sure that the attending would alert me of a difficult issue, I always stood near, or with easy access to, the doorway – facilitating a quick exit during emotional encounters. In some cases, the family allowed for my presence; many meetings with family took place outside of the patient's room and even when alerted of my presence, they did not mind. In all of these encounters I never took notes during these types of interactions and often struggled with including these private, life-changing moments in my notes.

### **Future Directions**

I returned to the field in May 2014. I plan to continue to conduct ethnographic observations from May through July 2014. I also hope to conduct interviews with housestaff over the next 3 months, once again offering them meals for their time. I plan to return to PMC in

the Winter and Summer of 2015 to conduct further research (continuing with observations on the wards and conducting more interviews). As I will be in New York City beginning in August 2014, I am also considering conducting ethnographic observations on the Internal Medicine Service at New York-Presbyterian Hospital or Montefiore Medical Centers (both academic medical centers) to add a comparative site.

Table 1. Composition of Internal Medicine Team, By Medical Training

<b>IM Team Member</b>	<b>Expertise Level</b>
<b>Attendings</b>	Primarily Hospitalists. Medically and legally responsible for the care administered to IM patients in the hospital. Supervises residency training.
<b>Interns and Residents (Trainees)</b>	Undergoing medical residency training after graduating medical school.
<b>Medical Students</b>	In medical school. On clinical ward rotations to determine interests (to select residency).
<b>Case Managers</b>	Oversees social and financial aspects of patient care delivery. Frequently collaborates with attendings and trainees.

Table 2. Study Participants

<b>Internal Medicine Service</b>	<b>In Study</b>
Attending Physicians	44
Trainees and Students	60
Case Managers	5
Total	109

Table 3. Study Interviews

<b>Internal Medicine Service</b>	<b>Interviews</b>
Hospitalists	33
Internists	7
Trainees	19
Total	59

## References

- Abbott, A. (1981). Status and Status Strain in the Professions. *American Journal of Sociology*, 86(4), 819-835.
- Abbott, A. (1988). *The System of Professions: An Essay on the Division of Expert Labor*. Chicago: The University of Chicago Press.
- Adler, P. S. (2012). The Sociological Ambivalence of Bureaucracy: From Weber via Gouldner to Marx. *Organization Science*, 23(1), 244-266.
- Almeling, R. (2007). Selling Genes, Selling Gender: Egg Agencies, Sperm Banks, and the Medical Market in Genetic Material. *American Sociological Review*, 72(June), 319-340.
- Amin, Z., Guajardo, J., Wisniewski, W., Bordage, G., Tekian, A., & Niederman, L. G. (2000). Morning Report: Focus on Methods Over the Past Three Decades. *Academic Medicine*, 75(10), S1-5.
- Annandale, E. C. (1989). The Malpractice Crisis and the Doctor-Patient Relationship. *Sociology of Health and Illness*, 11(1), 1-23.
- Anspach, R. R. (1993). *Deciding Who Lives: Fateful Choices in the Intensive-Care Nursery*. Berkeley, CA: University of California Press.
- Anteby, M. (2008a). Identity Incentive as an Engaging Form of Control: Revisiting Leniencies in an Aeronautic Plant. *Organization Science*, 19(2), 202-220.
- Anteby, M. (2008b). *Moral Gray Zones: Side Productions, Identity, and Regulation in an Aeronautic Plant*. Princeton, NJ: Princeton University Press.
- Apker, J., & Eggly, S. (2004). Communicating Professional Identity in Medical Socialization: Considering the Ideological Discourse of Morning Report. *Qualitative Health Research*, 14(3), 411-429.
- Barker, K. (2008). Electronic Support Groups, Patient-Consumers, and Medicalization: The Case of Contested Illness. *Journal of Health and Social Behavior*, 49(March), 20-36. doi: 10.1177/002214650804900103
- Battilana, J. (2011). The Enabling Role of Social Position in Diverging from the Institutional Status Quo: Evidence from the UK National Health Service. *Organization Science*, 22(4), 817-834.

- Beardwood, B., Walters, V., Eyles, J., & French, S. (1999). Complaints Against Nurses: A Reflection of 'the New Managerialism' and Consumerism in Health Care? *Social Science and Medicine*, 48(3), 363-374.
- Becker, H. S., Gans, H. J., Newman, K. S., & Vaughan, D. (2004). On the Value of Ethnography: Sociology and Public Policy: A Dialogue. *The ANNALS of the American Academy of Political and Social Science*, 595(1), 264-276.
- Becker, H. S., & Geer, B. (1958). The Fate of Idealism in Medical School. *American Sociological Review*, 23(1), 50-56.
- Becker, H. S., Geer, B., Hughes, E. C., & Strauss, A. (1976). *Boys in White: Student Culture in Medical School*. New Brunswick, NJ: Transaction Publications.
- Beisecker, A. E., & Beisecker, T. D. (1993). Using metaphors to characterize doctor-patient relationships: paternalism versus consumerism. *Health Communication*, 5(1), 41-58. doi: [10.1207/s15327027hc0501\\_3](https://doi.org/10.1207/s15327027hc0501_3)
- Bellet, P. S., & Whitaker, R. C. (2000). Evaluation of a Pediatric Hospital Service: Impact on Length of Stay and Hospital Charges. *Pediatrics*, 105(3), 478-484.
- Beresford, L. (2011). Is a Post-discharge Clinic in Your Hospital's Future? *The Hospitalist*, 15(12), 41-42.
- Berg, M. (1997). Of Forms, Containers, and the Electronic Medical Record: Some Tools for a Sociology of the Formal. *Science Technology Human Values*, 22(4), 403-433.
- Berg, M., & Bowker, G. (1997). The Multiple Bodies of the Medical Record: Toward a Sociology of an Artifact. *The Sociological Quarterly*, 38(3), 513-537.
- Blau, P., & Scott, W. R. (1962). *Formal Organizations*. San Francisco, CA: Chandler.
- Borkman, T. (1999). *Understanding Self-help/Mutual Aid: Experiential Learning in the Commons*. New Brunswick, NJ: Rutgers University Press.
- Bosk, C. L. (1992). *All God's Mistakes*. Chicago: The University of Chicago Press.
- Bosk, C. L. (2003). *Forgive and Remember: Managing Medical Failure* (2nd ed.). Chicago: The University of Chicago Press.
- Brown, R. B., & McCartney, S. (2000). Professionalism Definitions in 'Managing' Health Services: Perspectives on the Differing Views of Clinicians and General Managers in an NHS Trust. In N. Malin (Ed.), *Professionalism, Boundaries and the Workplace* (pp. 178-194). London: Routledge.



- Bucher, R., & Stelling, J. (1969). Characteristics of Professional Organizations. *Journal of Health and Social Behavior*, 10(1), 3-15.
- Burrows, R., Nettleton, S., Pleace, N., & Muncer, S. (2000). Virtual Community Care? Social Policy and the Emergence of Computer Mediated Social Support. *Information, Communication and Society*, 3(1), 95-121. doi: 10.1080/136911800359446
- Butler, C. C., Rollnick, S., Pill, R., Maggs-Rapport, F., & Stott, N. (1998). Understanding the Culture of Prescribing: Qualitative Study of General Practitioners' and Patients' Perceptions of Antibiotics for Sore Throats. *British Medical Journal*, 317, 637-642.
- California HealthCare Foundation. (2012). Health Care Costs 101: Slow But Steady *California Health Care Almanac*: California HealthCare Foundation.
- Campbell, J. L. (1971). Working Relationships Between Providers and Consumers in a Neighborhood Health Center. *American Journal of Public Health*, 61(1), 97-103.
- Caramenico, A. (2011, December 9). Hospitals use post-discharge clinics to cut readmissions. Retrieved on 4/29/2014 from [www.fiercehealthcare.com](http://www.fiercehealthcare.com)
- Carrns, A. (2014, March 18). When a Hospital Stay is Not a Stay. *The New York Times*.
- Carruthers, B. G., & Uzzi, B. (2000). Economic Sociology in the New Millennium. *Contemporary Sociology*, 29(3), 486-494.
- Casalino, L. P. (2004). Unfamiliar Tasks, Contested Jurisdictions: The Changing Organization Field of Medical Practice in the United States. *Journal of Health and Social Behavior*, 45(Extra Issue), 59-75.
- Casper, M. J. (1998). *The Making of the Unborn Patient: A Social Anatomy of Fetal Surgery*. New Brunswick, NJ: Rutgers University Press.
- Cassel, C. K., & Guest, J. A. (2012). Choosing Wisely: Helping Physicians and Patients Make Smart Decisions About Their Care. *JAMA*, 307(17), 1801-1802.
- Cassell, J. (1988). The Relationship of Observer to Observed When Studying Up. In R. G. Burgess (Ed.), *Studies in Qualitative Methodology: Conducting Qualitative Research* (Vol. 1, pp. 89-108). Greenwich, CT: JAI Press Inc.
- Catino, M. (2011). Why Do Doctors Practice Defensive Medicine? The Side-Effects of Medical Litigation. *Safety Science Monitor*, 15(1), 1-12.
- Centers for Medicare and Medicaid Services. (2013, January 9). NHE Fact Sheet. Retrieved on 4/25/2014

- Chambliss, D. F. (1996). *Beyond Caring: Hospitals, Nurses, and the Social Organization of Ethics*. Chicago: The University of Chicago Press.
- Charlton, R., Dovey, S. M., Jones, D. G., & Blunt, A. (1994). Effects of cadaver dissection on the attitudes of medical students. *Medical Education*, 28(4), 290-295.
- Chow, L. (Producer). (2013, March 19). 3 Ways Obamacare is Changing How a Hospital Cares for Patients. *All Things Considered*.
- Conrad, P., & Leiter, V. (2004). Medicalization, Markets and Consumers. *Journal of Health and Social Behavior*, 45(Extra Issue: Health and Health Care in the United States: Origins and Dynamics), 158-176.
- Coombs, R. H. (1978). *Mastering Medicine: Professional Socialization in Medical School*. New York: The Free Press.
- Corwin, R. G. (1961). The Professional Employee: A Study of Conflict in Nursing Roles. *The American Journal of Sociology*, 66(6), 604-615.
- Curran, W. J. (1974). Acupuncture and the Practice of Medicine. *The New England Journal of Medicine*, 291, 1245-1246.
- Dalton, M. (1959). *Men Who Manage*. New York: John Wiley and Sons, Inc.
- Davison, K., Pennebaker, J., & Dickerson, S. (2000). Who Talks: The Social Psychology of Illness Support Groups. *American Psychologist*, 55(2), 205-217.
- DelVecchio Good, M.-J. (1995). *American Medicine: The Quest for Competence*. Berkeley, CA: University of California Press.
- Dent, M. (1990). Organisation and Change in Renal Work: A Study of the Impact of a Computer System within Two Hospitals. *Sociology of Health and Illness*, 12(4), 413-431.
- Diamond, T. (1992). *Making Gray Gold: Narratives of Nursing Home Care*. Chicago: The University of Chicago Press.
- DiMatteo, M. R., Lepper, H. S., & Croghan, T. W. (2000). Depression Is a Risk Factor for Noncompliance With Medical Treatment: Meta-analysis of the Effects of Anxiety and Depression on Patient Adherence. *Archives of Internal Medicine*, 160(14), 2101-2107.
- Dixon-Woods, M., Bosk, C. L., Aveling, E. L., Goeschel, C. A., & Pronovost, P. J. (2011). Explaining Michigan: Developing an Ex Post Theory of a Quality Improvement Program. *The Milbank Quarterly*, 89(2), 167-205.
- Eisenhardt, K. M. (1989). Building Theories from Case Study Research. *The Academy of Management Review*, 14(4), 532-550.

- Emanuel, E. J., & Emanuel, L. L. (1992). Four Models of the Physician-Patient Relationship. *Journal of the American Medical Association*, 267(16), 2221-2226. doi: 10.1001/jama.1992.03480160079038
- Emerson, R. M. (2001a). *Contemporary Field Research: Perspectives and Formulations*. Prospect Heights, IL: Waveland Press, Inc.
- Emerson, R. M. (2001b). Fieldwork Practice: Issues in Participant Observation. In R. M. Emerson (Ed.), *Contemporary Field Research: Perspectives and Formulations* (pp. 113-151). Prospect Heights, IL: Waveland Press, Inc.
- Engel, G. V. (1969). The Effect of Bureaucracy on the Professional Autonomy of the Physician. *Journal of Health and Social Behavior*, 10(1), 30-41.
- Epstein, R. M., Fiscella, K., Lesser, C. S., & Stange, K. C. (2010). Why The Nation Needs a Policy Push on Patient-Centered Health Care. *Health Affairs*, 29(8), 1489-1495.
- Epstein, S. (1995). The Construction of Lay Expertise: AIDS Activism and the Forging of Credibility in the Reform of Clinical Trials. *Science Technology Human Values*, 20(4), 408-437.
- Etzioni, A. (1959). Authority Structure and Organizational Effectiveness. *Administrative Science Quarterly*, 4(1), 43-67.
- Exworthy, M., & Halford, S. (Eds.). (1999). *Professionals and the New Managerialism in the Public Sector*. Buckingham, UK: Open University Press.
- Exworthy, M., Wilkinson, E. K., McColl, A., Moore, M., Roderick, P., Smith, H., & Gabbay, J. (2003). The role of performance indicators in changing autonomy of the general practice profession in the UK. *Social Science and Medicine*, 56(7), 1493-1504.
- Fennell, M. L., & Alexander, J. A. (1993). Perspectives on Organizational Change in the US Medical Care Sector. *Annual Review of Sociology*, 19(1), 89-112.
- Finn, R., Learmonth, M., & Reedy, P. (2010). Some Unintended Effects of Teamwork in Healthcare. *Social Science and Medicine*, 70(8), 1148-1154.
- Fisher, E. S., & Shortell, S. M. (2010). Accountable Care Organizations: Accountable for What, to Whom, and How. *JAMA*, 304(15), 1715-1716.
- Fox, R. C. (1979a). The Autopsy: Its Place in the Attitude-Learning of Second-Year Medical Students *Essays in Medical Sociology: Journeys into the Field* (pp. 51-77). New York: John Wiley & Sons.

- Fox, R. C. (1979b). Training for Uncertainty *Essays in Medical Sociology: Journeys into the Field* (pp. 19-50). New York: John Wiley & Sons.
- Freidson, E. (1970a). *Profession of Medicine: A Study of the Sociology of Applied Knowledge*. Chicago, IL: The University of Chicago Press.
- Freidson, E. (1970b). *Professional Dominance: The Social Structure of Medical Care*. New York: Atherton Press, Inc.
- Freidson, E. (1994). *Professionalism Reborn: Theory, Prophecy and Policy*. Cambridge: Polity.
- Freidson, E. (2001). *Professionalism: The Third Logic*. Cambridge, UK: Polity Press.
- Furnham, A., & Smith, C. (1988). Choosing Alternative Medicine: A Comparison of the Beliefs of Patients Visiting a General Practitioner and a Homeopath. *Social Science and Medicine*, 26(7), 685-689.
- Ginsberg, L. G. (1983). Detect the Warning Signals Sent By Suit-Prone Patients. *Dental Economics*, 73(3), 115-122.
- Goodman, D. C., Fisher, E. S., & Chang, C.H. (2013). After Hospitalization: A Dartmouth Atlas Report on Readmissions Among Medicare Beneficiaries. Hanover, NH: The Dartmouth Institute for Health Policy & Clinical Practice.
- Goss, M. E. W. (1961). Influence and Authority Among Physicians in an Outpatient Clinic. *American Sociological Review*, 26(1), 39-50.
- Gouldner, A. W. (1954). *Patterns of Industrial Bureaucracy*. Glencoe, IL: Free Press.
- Gray, B. H. (1993). *The Profit Motive and Patient Care: The Changing Accountability of Doctors and Hospitals*. Cambridge, MA: Harvard University Press.
- Gray, B. H. (1997). Trust and Trustworthy Care in the Managed Care Era. *Health Affairs*, 16(1), 34-49.
- Greenhalgh, T., Potts, H. W. W., Wong, G., Bark, P., & Swinglehurst, D. (2009). Tensions and Paradoxes in Electronic Patient Record Research: A Systematic Literature Review Using the Meta-narrative Method. *The Milbank Quarterly*, 87(4), 729-788.
- Greenwood, R., & Lachman, R. (1996). Change as an Underlying Theme in Professional Service Organizations: An Introduction. *Organization Studies*, 17(4), 563-572.
- Grumbach, K., Osmond, D., Vranizan, K., Jaffe, D., & Bindman, A. B. (1998). Primary Care Physicians' Experience of Financial Incentives in Managed-Care Systems. *The New England Journal of Medicine*, 339, 1516-1521.

- Hafferty, F. W. (1988). Cadaver Stories and the Emotional Socialization of Medical Students. *Journal of Health and Social Behavior*, 29(4, Theme: Continuities in the Sociology of Medical Education), 344-356.
- Hafferty, F. W., & Castellani, B. (2009). The Hidden Curriculum: A Theory of Medical Education. In C. Brosnan & B. S. Turner (Eds.), *Handbook of the Sociology of Medical Education* (pp. 15-35). London: Routledge.
- Hahn, S. R., Thompson, K. S., Wills, T. A., Stern, V., & Budner, N. S. (1994). The Difficult Doctor-Patient Relationship: Somatization, Personality and Psychopathology. *Journal of clinical Epidemiology*, 47(6), 647-657.
- Håland, E. (2012). Introducing the Electronic Patient Record (EPR) in a Hospital Setting: Boundary Work and Shifting Constructions of Professional Identities. *Sociology of Health and Illness*, 34(5), 761-775.
- Hardey, M. (1999). Doctor in the House: The Internet as Source of Lay Health Knowledge and the Challenge to Expertise. *Sociology of Health and Illness*, 21(6), 820-835.
- Harrison, S. (2004). Medicine and Management: Autonomy and Authority in the National Health Service. In A. Gray & S. Harrison (Eds.), *Governing Medicine: Theory and Practice* (pp. 51-59). Berkshire, England: Open University Press.
- Hartley, H. (2002). The System of Alignments Challenging Physician Professional Dominance: An Elaborated Theory of Countervailing Powers. *Sociology of Health and Illness*, 24(2), 178-207.
- Hauer, K. E., Wachter, R. M., McCulloch, C. E., Woo, G. A., & Auerbach, A. D. (2004). Effects of Hospitalist Attending Physicians on Trainee Satisfaction With Teaching and With Internal Medicine Rotations. *Archives of Internal Medicine*, 164(17), 1866-1871.
- Haug, M. R. (1972). Deprofessionalization: An alternative Hypothesis for the Future. *Sociological Review Monograph*, 20(S1), 195-211.
- Haug, M. R. (1977). Computer Technology and the Obsolescence of the Concept of Profession. *Work and Technology*, 10, 215-228.
- Haug, M. R. (1988). A Re-Examination of the Hypothesis of Physician Deprofessionalization. *The Milbank Quarterly*, 66(Supplement 2: The Changing Character of the Medical Profession), 48-56.
- Haug, M. R., & Lavin, B. (1983). *Consumerism in Medicine*. Beverly Hills, CA: Sage Publications.
- Healy, K. (2006). *Last Best Gifts: Altruism and the Market for Human Blood and Organs*. Chicago, IL: The University of Chicago Press.

- Heath, C. (1982). Preserving the Consultation: Medical Record Cards and Professional Conduct. *Sociology of Health and Illness*, 4(1), 56-74.
- Heath, C., Luff, P., & Sanchez Svensson, M. (2003). Technology and Medical Practice. *Sociology of Health and Illness*, 25 (Silver Anniversary Issue), 75-96.
- Heimer, C. A., & Staffen, L. R. (1998). *For the Sake of the Children: The Social Organization of Responsibility in the Hospital and the Home*. Chicago, IL: The University of Chicago Press.
- Henwood, F., Wyatt, S., Hart, A., & Smith, J. (2003). Ignorance is Bliss Sometimes: Constraints on the Emergence of the 'Informed Patient' in the Changing Landscapes of Health Information. *Sociology of Health and Illness*, 25(6), 589-607.
- Herrman, H., Trauer, T., & Warnock, J. (2002). The Roles and Relationships of Psychiatrists and Other Service Providers in Mental Health Services. *Australian and New Zealand Journal of Psychiatry*, 36(1), 75-80.
- Hertz, R., & Imber, J. B. (1995). Introduction. In R. Hertz & J. B. Imber (Eds.), *Studying Elites Using Qualitative Methods* (pp. vii-xi). Thousand Oaks, CA: Sage Publications.
- Hibbard, J. H., & Weeks, E. C. (1987). Consumerism in Health Care: Prevalence and Predictors. *Medical Care*, 25(11), 1019-1032.
- Hibbert, D., Hanratty, B., May, C., Mair, F., Litva, A., & Capewell, S. (2003). Negotiating Palliative Care Expertise in the Medical World. *Social Science and Medicine*, 57(2), 277-288.
- Holliman, D. C., Dziegielewsk, S. F., & Datta, P. (2001). Discharge Planning and Social Work Practice. *Social Work in Health Care*, 32(3), 1-19.
- Holton, J. A. (2007). The Coding Process and Its Challenges. In A. Bryant & K. Charmaz (Eds.), *The Sage Handbook of Grounded Theory* (pp. 265-289). Los Angeles: Sage Publications.
- Hugman, R. (1991). *Power in Caring Professions*. Houndsmill, United Kingdom: Macmillan.
- Hunter, D. J. (1996). The Changing Roles of Health Care Personnel in Health and Health Care Management. *Social Science and Medicine*, 43(5), 799-808.
- Jordan, M. R., Conley, J., & Ghali, W. A. (2008). Consultation Patterns and Clinical Correlates of Consultation in a Tertiary Care Setting. *BMC Research Notes*, 1, 96.
- Kallinikos, J. (2004). The Social Foundations of the Bureaucratic Order. *Organization*, 11(1), 13-36.

- Kane, J. (2012, October 22). Health Costs: How the U.S. Compares With Other Countries. *The Rundown*. Retrieved on 4/25/2014 from www.pbs.org
- Katz, D., & Kahn, R. L. (1978). *The Social Psychology of Organizations*. New York: John Wiley & Sons.
- Kaufman, S. R. (2005). ... *and a time to die: How American Hospitals Shape the End of Life*. Chicago: The University of Chicago Press.
- Kelle, U. (2007). The Development of Categories: Different Approaches in Grounded Theory. In A. Bryant & K. Charmaz (Eds.), *The Sage Handbook of Grounded Theory* (pp. 191-213). Los Angeles: Sage Publications.
- Kessler, C., Kutka, B. M., & Badillo, C. (2012). Consultation in the Emergency Department: A Qualitative Analysis and Review. *The Journal of Emergency Medicine*, 42(6), 704-711.
- Kessler, D. A., & Pines, W. L. (1990). The Federal Regulation of Prescription Drug Advertising and Promotion. *JAMA*, 264(18), 2409-2415.
- Kitchener, M., Caronna, C. A., & Shortell, S. M. (2005). From the Doctor's Workshop to the Iron Cage? Evolving Modes of Physician Control in US Health Systems. *Social Science and Medicine*, 60(6), 1311-1322.
- Kletke, P. R., Emmons, D. W., & Gillis, K. D. (1996). Current Trends in Physicians' Practice Arrangements: From Owners to Employees. *JAMA*, 276(7), 555-560.
- Kobayashi, H., Pian-Smith, M., Sata, M., Sawa, R., Takeshita, T., & Raemer, D. (2006). A Cross-Cultural Survey of Residents' Perceived Barriers in Questioning/Challenging Authority. *Quality and Safety in Health Care*, 15(4), 277-283.
- Kravitz, R. L., Epstein, R. M., Feldman, M. D., Franz, C. E., Rahman, A., Wilkes, M. S., Hinton, L & Franks, P. (2005). Influence of Patients' Requests for Direct-to-Consumer Advertised Antidepressants: A Randomized Controlled Trial. *JAMA*, 293(16), 1995-2002.
- Kritzer, H. M. (1999). The Professions Are Dead, Long Live the Professions: Legal Practice in a Postprofessional World. *Law & Society Review*, 33(3), 713-759.
- Lavizzo-Maurey, R. (2013). Report Introduction. *The Revolving Door: A Report on U.S. Hospital Readmissions* (pp. 3-6). Princeton, NJ: Robert Wood Johnson Foundation.
- Learmonth, M. (1997). Managerialism and Public Attitudes Towards UK NHS Managers. *Journal of Management in Medicine*, 11(4), 214-221.
- Leicht, K. T., & Fennell, M. L. (2001). *Professional Work: A Sociological Approach*. Malden, MA: Blackwell Publishers.

- Lempp, H. (2009). Medical-school Culture. In C. Brosnan & B. S. Turner (Eds.), *Handbook of the Sociology of Medical Education* (pp. 71-88). London: Routledge Taylor & Francis Group.
- Light, D. W. (1979). Uncertainty and Control in Professional Training. *Journal of Health and Social Behavior*, 20(4), 310-322.
- Light, D. W. (1989). Social Control and the American Health Care System. In H. Freeman & S. Levine (Eds.), *Handbook of Medical Sociology* (Fourth ed., pp. 456-474). Upper Saddle River, NJ: Prentice Hall.
- Light, D. W. (2000a). The Medical Profession and Organizational Change: From Professional Dominance to Countervailing Power. In C. E. Bird, P. Conrad & A. M. Fremont (Eds.), *Handbook of Medical Sociology* (Vol. 5th, pp. 201-216). Upper Saddle River, NJ: Prentice Hall.
- Light, D. W. (2000b). The Sociological Character of Health-Care Markets. In G. L. Albrecht, R. Fitzpatrick & S. C. Scrimshaw (Eds.), *The Handbook of Social Studies in Health & Medicine* (pp. 394-408). London: Sage Publications Ltd.
- Light, D. W., & Levine, S. (1988). The Changing Character of the Medical Profession: A Theoretical Overview. *The Milbank Quarterly*, 66(Supplement 2: The Changing Character of the Medical Profession), 10-32.
- Lupton, D., Donaldson, C., & Lloyd, P. (1991). Caveat Emptor or Blissful Ignorance? Patients and the Consumerist Ethos. *Social Science and Medicine*, 33(5), 559-568. doi: 10.1016/0277-9536(91)90213-V
- MacDonald, K. M. (1995). *The Sociology of the Professions*. London: Sage.
- MacLeod, R. D. (2001). On Reflection: Doctors Learning to Care for People Who are Dying. *Social Science and Medicine*, 52(11), 1719-1727.
- Mangione-Smith, R., McGlynn, E. A., Elliott, M. N., Krogstad, P., & Brook, R. H. (1999). The Relationship Between Perceived Parental Expectations and Pediatrician Antimicrobial Prescribing Behavior. *Pediatrics*, 103(4), 711-718.
- Martin, G. P., Currie, G., & Finn, R. (2009). Reconfiguring or Reproducing Intra-professional Boundaries? Specialist Expertise, Generalist Knowledge and the 'Modernization' of the Medical Workforce. *Social Science and Medicine*, 68(7), 1191-1198.
- Marx, K. (1936). Capital, Volume One. In R. C. Tucker (Ed.), *The Marx-Engels Reader* (pp. 294-329). New York: W.W. Norton & Company.



- McKinlay, J., & Marceau, L. (2008). When There is No Doctor: Reasons for the Disappearance of Primary Care physicians in the US During the Early 21st Century. *Social Science and Medicine*, 67(10), 1481-1491. doi: 10.1016/j.socscimed.2008.06.034
- McKinlay, J., & Stoeckle, J. (1988). Corporatization and Social Transformation of Doctoring. *International Journal of Health Services*, 18(2), 191-206.
- Mechanic, D. (1996). Changing Medical Organization and the Erosion of Trust. *The Milbank Quarterly*, 74(2), 171-189.
- Mechanic, D. (2003). Physician Discontent: Challenges and Opportunities. *JAMA*, 290(7), 941-946.
- Mechanic, D. (2008). Rethinking Medical Professionalism: The Role of Information Technology and Practice Innovations. *The Milbank Quarterly*, 86(2), 327-358.
- Meyer, J., & Rowan, B. (1977). Institutionalized Organizations: Formal Structure as Myth and Ceremony. *American Journal of Sociology*, 83(2), 340-363.
- Mickan, S. M. (2005). Evaluating the Effectiveness of Health Care Teams. *Australian Health Review*, 29(2), 211-217.
- Milewa, T., Valentine, J., & Calnan, M. (1998). Managerialism and Active Citizenship in Britain's Reformed Health Service: Power and Community in an Era of Decentralisation. *Social Science and Medicine*, 47(4), 507-517.
- Millman, M. (1977). *The Unkindest Cut: Life in the Backrooms of Medicine*. New York: William Morrow and Company, Inc.
- Mizrahi, T. (1986). *Getting Rid of Patients: Contradictions in the Socialization of Physicians*. New Brunswick, NJ: Rutgers University Press.
- Morley, C. P., Roseamelia, C., Smith, J. A., & Villarreal, A. L. (2013). Decline of Medical Student Idealism in the First and Second Year of Medical School: A Survey of Pre-clinical Medical Students at One Institution. *Medical Education Online*, 18, 1-10.
- Morrissey, E., & Gillespie, D. F. (1975). Technology and the Conflict of Professionals in Bureaucratic Organizations. *The Sociological Quarterly*, 16(3), 319-332.
- Nancarrow, S. A., & Borthwick, A. M. (2005). Dynamic professional boundaries in the healthcare workforce. *Sociology of Health and Illness*, 27(7), 897-919.
- Nelson, R. R., & Winter, S. G. (1982). *An Evolutionary Theory of Economic Change*. Cambridge, MA: Belknap Press.

- Newton, B. W., Barber, L., Clardy, J., Cleveland, E., & Patricia, O. S. (2008). Is There Hardening of the Heart During Medical School? *Academic Medicine*, 83(3), 244-249.
- Nyquist, A., Gonzales, R., Steiner, J. F., & Sande, M. A. (1998). Antibiotics for Children With Upper Respiratory Infections. *JAMA*, 279(11), 875-877.
- Palmer Jr., H. C., Armistead, N. S., Elnicki, M., Halperin, A. K., Ogershok, P. R., Manivannan, S., Hobbs, G.R., & Evans, K. (2001). The Effect of a Hospitalist Service with Nurse Discharge Planner on Patient Care in an Academic Teaching Hospital. *The American Journal of Medicine*, 111(8), 627-632.
- Parsons, T. (1951). Social Structure and Dynamic Process: The Case of Modern Medical Practice. In T. Parsons (Ed.), *The Social System* (pp. 428-479). New York: The Free Press.
- Polanyi, K. (1957[1944]). *The Great Transformation: The Political and Economic Origins of Our Time*. Boston, MA: Beacon Press.
- Quadagno, J. (2005). *One Nation Uninsured. Why the U.S. Has No National Health Insurance*. Oxford: Oxford University Press.
- Quadagno, J. (2008). Why the United States Has No National Health Insurance: Stakeholder Mobilization Against the Welfare State, 1945-1996. In P. Conrad (Ed.), *The Sociology of Health and Illness* (pp. 301-321).
- Rau, J. (2012, November 26). Hospitals Face Pressure to Avert Readmissions. *The New York Times*.
- Reed, M. I. (1996). Expert Power and Control in Late Modernity: An Empirical Review and Theoretical Synthesis. *Organization Studies*, 17(4), 573-597.
- Reeder, L. G. (1972). The Patient-Client as a Consumer: Some Observations on the Changing Professional-Client Relationship. *Journal of Health and Social Behavior*, 13(4), 406-412. doi: 10.2307/2136833
- Reich, A. (2012). Disciplined Doctors: The Electronic Medical Record and Physicians' Changing Relationship to Medical Knowledge. *Social Science and Medicine*, 74(7), 1021-1028.
- Riska, E. (2009). Gender and Medical Education. In C. Brosnan & B. S. Turner (Eds.), *Handbook of the Sociology of Medical Education* (pp. 89-105). London: Routledge Taylor & Francis Group.
- Ritzer, G. (1975). Professionalization, Bureaucratization and Rationalization: The Views of Max Weber. *Social Forces*, 53(4), 627-634.
- Ritzer, G., & Walczak, D. (1988). Rationalization and the Deprofessionalization of Physicians. *Social Forces*, 67(1), 1-22.

- Roberts, K. A., & Donahue, K. A. (2000). Professing Professionalism: Bureaucratization and Deprofessionalization in the Academy. *Sociological Focus*, 33(4), 365-383.
- Robinson, G. O. (1986). The Medical Malpractice Crisis of the 1970s: A Retrospective. *Law and Contemporary Problems*, 49(2), 5-35.
- Rosoff, S. M., & Leone, M. C. (1991). The Public Prestige of Medical Specialties: Overviews and Undercurrents. *Social Science and Medicine*, 32(3), 321-326.
- Saks, M. (1995). *Professions and the Public Interest: Medical Power, Altruism and Alternative Medicine*. London: Routledge.
- Sanders, T., & Harrison, S. (2008). Professional Legitimacy Claims in the Multidisciplinary Workplace: The Case of Heart Failure Care. *Sociology of Health and Illness*, 30(2), 289-308.
- Sands, R. G., Stafford, J., & McClelland, M. (1990). "I Beg to Differ": Conflict in the Interdisciplinary Team. *Social Work in Health Care*, 14(3), 55-72.
- Scott, W. R. (1966). Professionals in Organizations - Areas of Conflict. In H. Vollmer & D. Mills (Eds.), *Professionalization*. Englewood Cliffs: Prentice-Hall.
- Scott, W. R. (1983). Healthcare Organizations in the 80s: The Convergence of Public and Professional Control Systems. In J. Meyer & W. R. Scott (Eds.), *Organizational environments: Ritual and rationality* (pp. 99-114). Beverly Hills, CA: Sage.
- Scott, W. R., Ruef, M., Mendel, P., & Caronna, C. A. (2000). *Institutional Change and Health Care Organizations: From Professional Dominance to Managed Care* Chicago, IL: University of Chicago Press.
- Serra, H. (2010). Medical Technocracies in Liver Transplantation: Drawing boundaries in medical practices. *Health*, 14(2), 162-177. doi: 10.1177/1363459309353297
- Smith Jr., G. R., Stein, J. M., & Jones, M. C. (2012). Acute Medicine in the United Kingdom: First-Hand Perspectives on a Parallel Evolution of Inpatient Medical Care. *Journal of Hospital Medicine*, 7(3), 254-257. doi: 10.1002/jhm.1006
- Society of Hospital Medicine. (2011). General Information About SHM. Retrieved on 3/28/2012 from [http://www.hospitalmedicine.org/Content/NavigationMenu/AboutSHM/GeneralInformation/General\\_Information.htm](http://www.hospitalmedicine.org/Content/NavigationMenu/AboutSHM/GeneralInformation/General_Information.htm)
- Solheim, K., McElmurry, B. J., & Kim, M. J. (2007). Multidisciplinary Teamwork in US Primary Health Care. *Social Science and Medicine*, 65(3), 622-634.

- Sorensen, J. E., & Sorensen, T. L. (1974). The Conflict of Professionals in Bureaucratic Organizations. *Administrative Science Quarterly*, 19(1), 98-106.
- Sox, H. C. (1999). The Hospitalist Model: Perspectives of the Patient, the Internist, and Internal Medicine. *Annals of Internal Medicine*, 130(4), 368-372.
- Starr, P. (1982). *The Social Transformation of American Medicine*. New York: Basic Books.
- Steinhauser, K. E., Christakis, N. A., Clipp, E. C., McNeilly, M., Grambow, S., Parker, J., & Tulsky, J. A. (2001). Preparing for the End of Life: Preferences of Patients, Families, Physicians, and Other Care Providers. *Journal of Pain and Symptom Management*, 22(3), 727-737.
- Stone, J., & Hoffman, G. J. (2010). Medicare Hospital Readmissions: Issues, Policy Options and PPACA. In C. R. Service (Ed.), (Vol. 7-5700, pp. 1-37). Washington, DC: Congressional Research Service.
- Sutcliffe, K. M., Lewton, E., & Rosenthal, M. M. (2004). Communication Failures: An Insidious Contributor to Medical Mishaps. *Academic Medicine*, 79(2), 186-194.
- Szymczak, J. E., & Bosk, C. L. (2012). Training for Efficiency: Work, Time, and Systems-Based Practice in Medical Residency. *Journal of Health and Social Behavior*, 53(3), 344-358. doi: DOI: 10.1177/0022146512451130
- Thomas, R. (1995). Interviewing Important People in Big Companies. In R. Hertz & J. B. Imber (Eds.), *Studying Elites Using Qualitative Methods* (pp. 3-17). Thousand Oaks, CA: Sage Publications.
- Timmermans, S. (1999). *Sudden Death and the Myth of CPR*. Philadelphia, PA: Temple University Press.
- Timmermans, S., & Angell, A. (2001). Evidence-Based Medicine, Clinical Uncertainty, and Learning to Doctor. *Journal of Health and Social Behavior*, 42(4), 342-359.
- Timmermans, S., & Berg, M. (2003). *The Gold Standard: The Challenge of Evidence-Based Medicine and Standardization in Health Care*. Philadelphia, PA: Temple University Press.
- Timmermans, S., & Mauck, A. (2005). The Promises And Pitfalls Of Evidence-Based Medicine. *Health Affairs*, 24(1), 18-28.
- Timmermans, S., & Oh, H. (2010). The Continued Social Transformation of the Medical Profession. *Journal of Health and Social Behavior*, 51(S94), S94-S106.
- Timmermans, S., & Tavory, I. (2012). Theory Construction in Qualitative Research: From Grounded Theory to Abductive Analysis. *Sociological Theory*, 30(3), 167-186.

- Titmuss, R. (1971). *The Gift Relationship: From Human Blood to Social Policy*. New York: Pantheon Books.
- Tjora, A. H. (2000). The Technological Mediation of the Nursing-Medical Boundary. *Sociology of Health and Illness*, 22(6), 721-741.
- Wachter, R. M. (1999). An Introduction to the Hospitalist Model. *Annals of Internal Medicine*, 130, 338-342.
- Wachter, R. M., & Goldman, L. (1996). The Emerging Role of "Hospitalists" in the American Health Care System. *The New England Journal of Medicine*, 335(7), 514-516.
- Wachter, R. M., & Goldman, L. (2002). The Hospitalist Movement 5 Years Later. *Journal of the American Medical Association*, 287(4), 487-494.
- Waitzkin, H. (2000). Changing Patient-Physician Relationships in the Changing Health-Policy Environment. In C. E. Bird, P. Conrad & A. M. Fremont (Eds.), *Handbook of Medical Sociology* (Vol. 5th, pp. 271-283). Upper Saddle River, NJ: Prentice Hall.
- Waring, J., & Currie, G. (2009). Managing Expert Knowledge: Organizational Challenges and Managerial Futures for the UK Medical Profession. *Social Science and Medicine*, 30(7), 755-778.
- Weisbrod, B. A. (1991). The Health Care Quadrilemma: An Essay on Technological Change, Insurance, Quality of Care, and Cost Containment. *Journal of Economic Literature*, 29(2), 523-552.
- Wells, R., Jinnett, K., Alexander, J., Lichtenstein, R., Liu, D., & Zazzali, J. L. (2006). Team Leadership and Patient Outcomes in US Psychiatric Treatment Settings. *Social Science and Medicine*, 62(8), 1840-1852.
- Wennberg, J. E., Fisher, E. S., Goodman, D. C., & Skinner, J. S. (2008). *Tracking the Care of Patients with Severe Chronic Illness: The Dartmouth Atlas of Health Care 2008*. Hanover, New Hampshire: The Dartmouth Institute for Health Policy and Clinical Practice.
- Winnick, T. A. (2005). From Quackery to "Complementary" Medicine: The American Medical Profession Confronts Alternative Therapies. *Social Problems*, 52(1), 38-61.
- Winnick, T. A. (2006). Medical Doctors and Complementary and Alternative Medicine: The Context of Holistic Practice. *Health*, 10(2), 149-173.
- Wolpe, P. R. (1985). The Maintenance of Professional Authority: Acupuncture and the American Physician. *Social Problems*, 32(5), 409-424.

- Yin, R. K. (2009). *Case Study Research* (Fourth ed.). Thousand Oaks, CA: Sage Publications, Inc.
- Zelizer, V. (1994). *The Social Meaning of Money*. New York: BasicBooks.
- Zelizer, V. (2005). *The Purchase of Intimacy*. Princeton, NJ: Princeton University Press.
- Zetka, J., James R. (2001). Occupational Divisions of Labor and Their Technology Politics: The Case of Surgical Scopes and Gastrointestinal Medicine. *Social Forces*, 79(4), 1495-1520.
- Zetka, J., James R. (2008). The Making of the "Women's Physician" in American Obstetrics and Gynecology: Re-Foring an Occupational Identity and a Division of Labor. *Journal of Health and Social Behavior*, 49(September), 335-351.
- Zetka, J. R., Jr. (2011). Establishing Specialty Jurisdictions in Medicine: The Case of American Obstetrics and Gynaecology. *Sociology of Health and Illness*, 33(6), 837-852. doi: [10.1111/j.1467-9566.2011.01341.x](https://doi.org/10.1111/j.1467-9566.2011.01341.x)
- Zussman, R. (1992). *Intensive Care: Medical Ethics and the Medical Profession*. Chicago, IL: The University of Chicago Press.